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Funding Policy: 'Pushing' and 'Pulling'

UBC Centre for Health Care Management
Vancouver, British Columbia
September 20th, 2011

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Hospitals = $55 billion in expenditures/year

Seeking strategies for limitations of Global Budgets?

- Transparency
- Perceived inefficiencies
- Wait times
- Unexplained variation in utilization/cost
- No reward for innovation
- Emergency Departments
- Alternative Level of Care
- No incentive to improve quality

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Alternate Level of Care

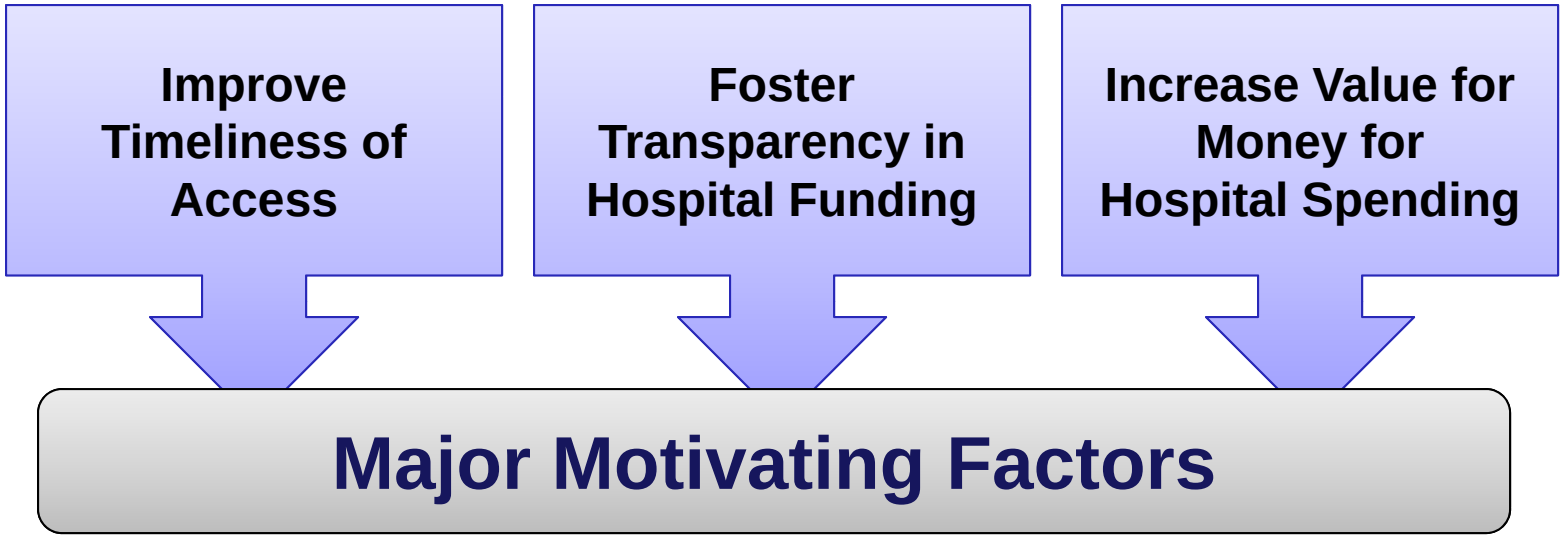
- Patients ready to be discharged from hospital
  - No appropriate discharge location (‘waiting’)
  - 14% of acute care beds
  - 7,500 hospital beds each and every day across Canada

- Discharge lowest cost patients and exchange for higher cost patient?
  - No change in funding

Drivers of hospital funding reform

- Stimulating productivity and efficiency
- Reducing lengths of stay
- Reducing hospital waiting lists
- Increasing competition between hospitals to improve quality
- Encouraging monitoring and benchmarking
- Reducing excess capacity, increasing transparency in hospital funding
- Facilitating patient choice
- Harmonizing payment mechanisms between public and private providers

Activity-Based Funding (ABF) 'Rushing In'



- BC, AB, ON; incremental funding in SK, NL
- CMA, BCMA, OMA, OHA, Kirby Commission (v.6)
- International norm
- Much more complex to administer

Pluses and Minuses of ABF

Opportunities

Using funding as a 'lever' to increase technical efficiency

- Economic incentives: retain surpluses
- Political incentives

Challenges

Problems well known:

Rewards Volume….

- No incentive to coordinate care, fragmented care
- Over-provide profitable services
- Upcoding ….

Decades of Research and Application

Evidence

- Tends to shorten lengths of stay
- Tends to increase the volume of hospitalizations
- Tends to increase spending
- Little evidence of effect on hospital quality

No Evidence

- Improves evidence-based care
- Improves effectiveness or appropriateness
- Impact on other sectors
- Provider engagement

….but, neither does global budgeting

Mixed Effects: Efficiency

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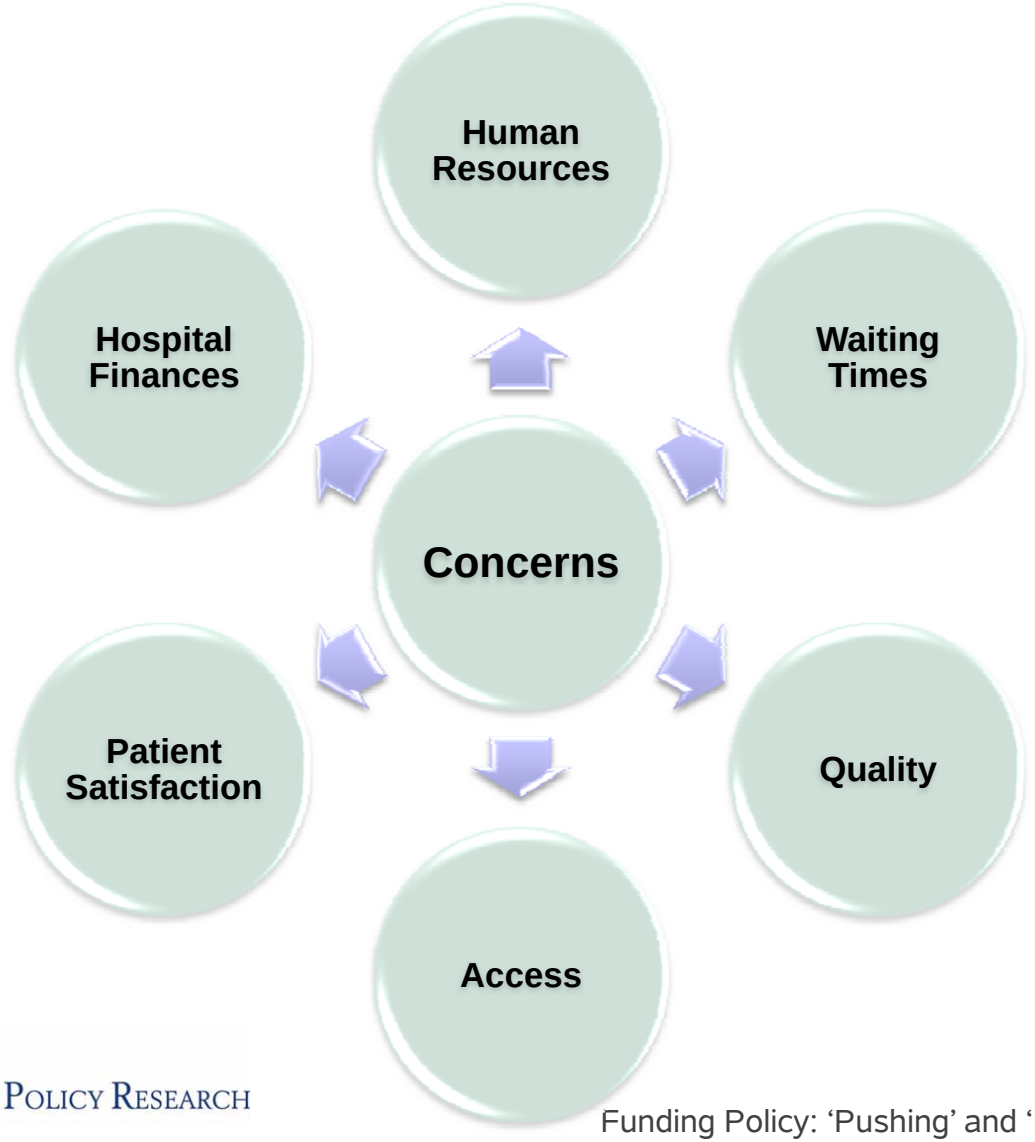
Intended and Unintended Consequences

Access

- Timeliness
- Geographic access
- Equity of access

….but, neither does global budgeting

Addressing Common Stakeholder Concerns



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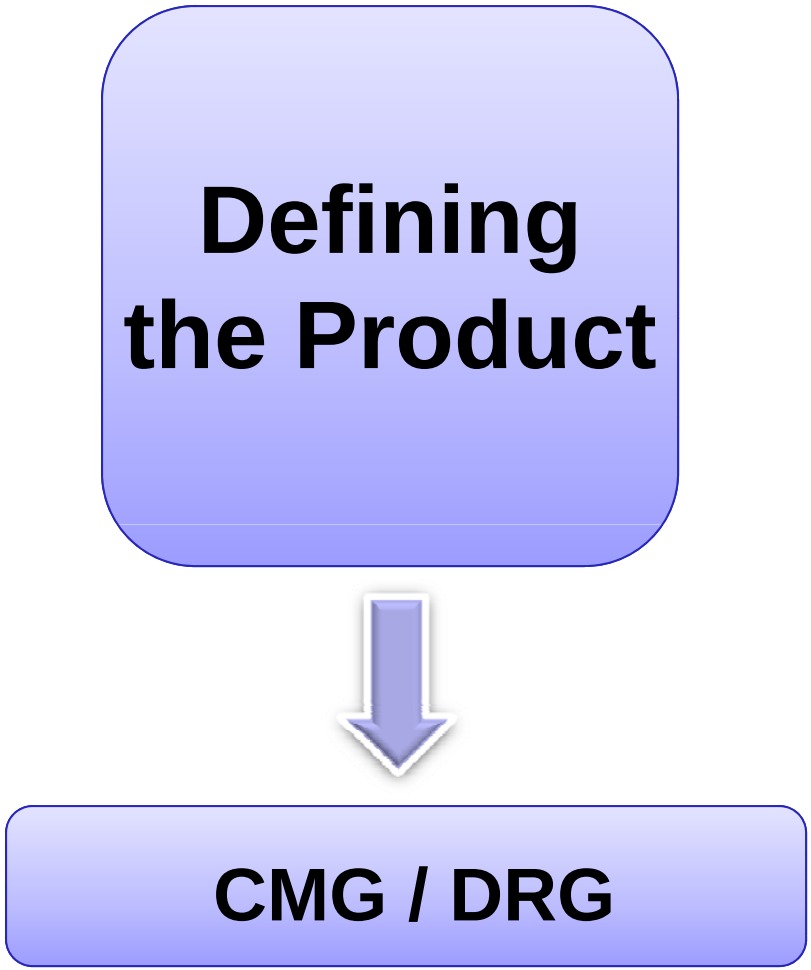
Payer Defines Product Groups

- Generally, the payer defines the product groups it is willing to pay for
  - Medicare (DRG)
  - Department of Health, UK (HRG)
  - Department of Health and Ageing, Australia (AR-DRG)



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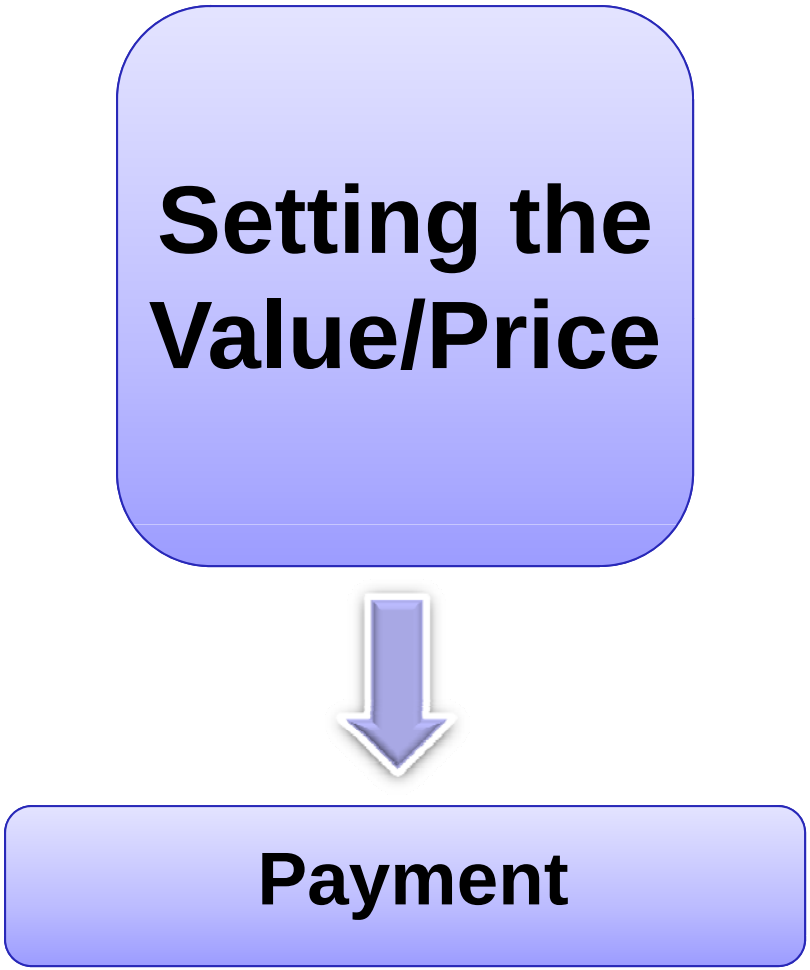
Cost Data Used to Set Price



What components are in?

- Ontario Case Costing Initiative, Alberta costing
- Charge data (DRG)
- Micro-costing studies, Australia (AR-DRG)
- Hospital financial data (UK, HRG)

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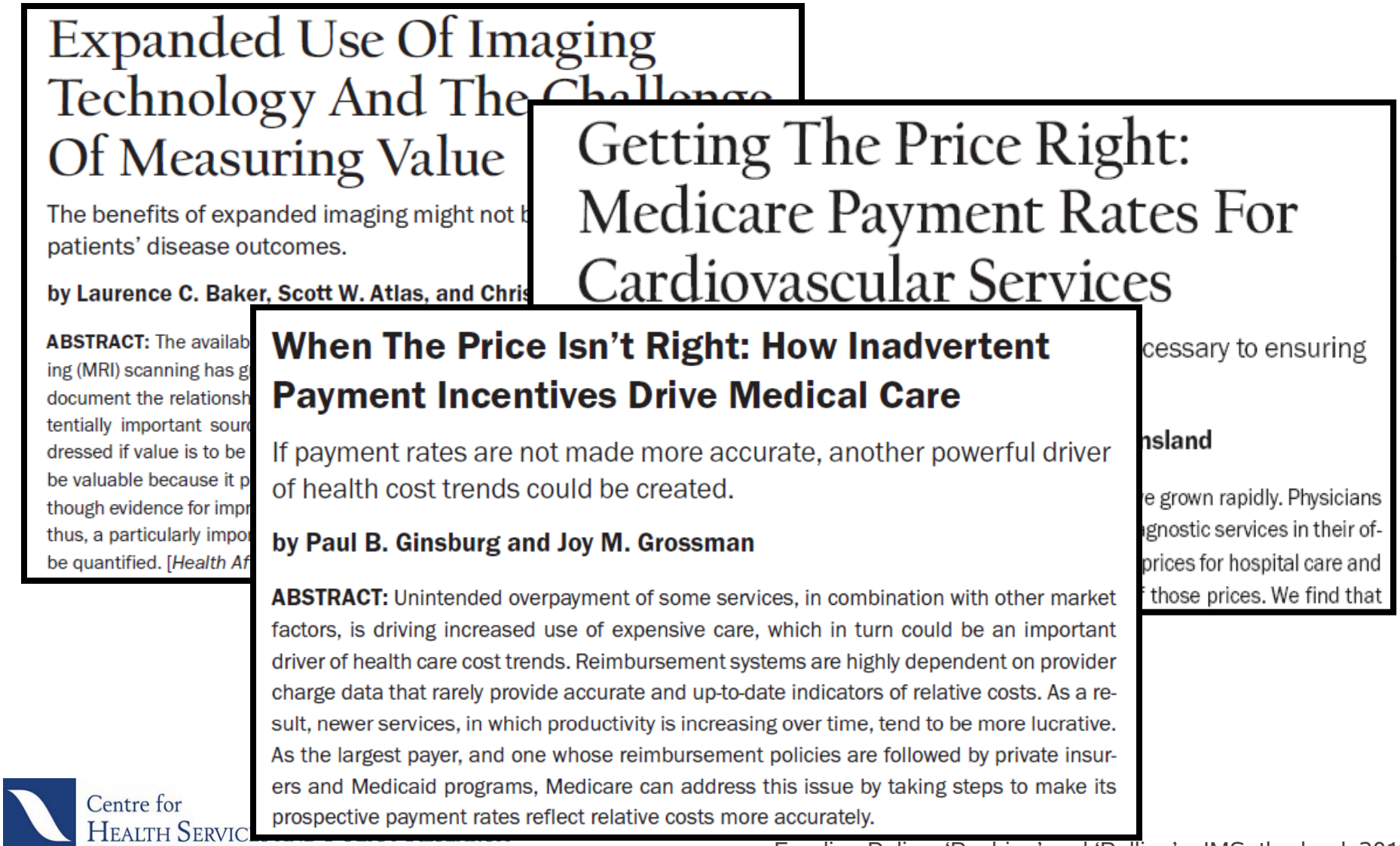
Incentives of Activity-Based Funding

- ABF creates incentives for hospital 'volume'
  - Salaried physicians
  - Fee-for-service physicians
  - Other incentives
- Aligning hospital and physician incentives: to what end?
- Transactional costs for designing, implementing and maintaining ABF framework

When the Price is Not Right



Expanded Use Of Imaging Technology And The Challenge Of Measuring Value

The benefits of expanded imaging might not b
patients' disease outcomes.

by Laurence C. Baker, Scott W. Atlas, and Chris

ABSTRACT: The availab
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Getting The Price Right: Medicare Payment Rates For Cardiovascular Services

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prices for hospital care and
those prices. We find that

When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care

If payment rates are not made more accurate, another powerful driver of health cost trends could be created.

by Paul B. Ginsburg and Joy M. Grossman

ABSTRACT: Unintended overpayment of some services, in combination with other market factors, is driving increased use of expensive care, which in turn could be an important driver of health care cost trends. Reimbursement systems are highly dependent on provider charge data that rarely provide accurate and up-to-date indicators of relative costs. As a result, newer services, in which productivity is increasing over time, tend to be more lucrative. As the largest payer, and one whose reimbursement policies are followed by private insurers and Medicaid programs, Medicare can address this issue by taking steps to make its prospective payment rates reflect relative costs more accurately.

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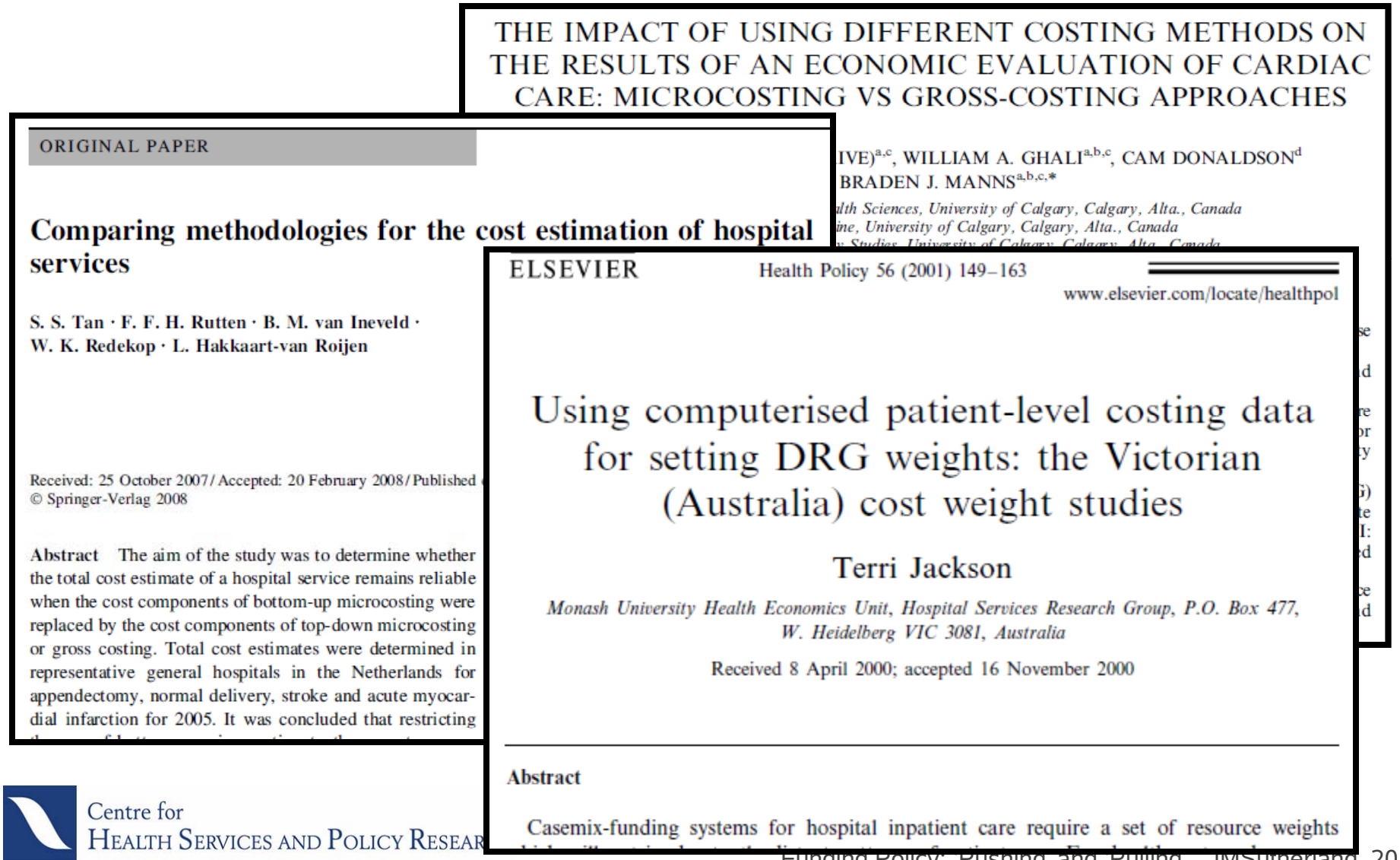
Costing Methods



THE IMPACT OF USING DIFFERENT COSTING METHODS ON THE RESULTS OF AN ECONOMIC EVALUATION OF CARDIAC CARE: MICROCOSTING VS GROSS-COSTING APPROACHES

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ORIGINAL PAPER

Comparing methodologies for the cost estimation of hospital services

S. S. Tan · F. F. H. Rutten · B. M. van Ineveld · W. K. Redekop · L. Hakkaart-van Roijen

Received: 25 October 2007 / Accepted: 20 February 2008 / Published
© Springer-Verlag 2008

Abstract The aim of the study was to determine whether the total cost estimate of a hospital service remains reliable when the cost components of bottom-up microcosting were replaced by the cost components of top-down microcosting or gross costing. Total cost estimates were determined in representative general hospitals in the Netherlands for appendectomy, normal delivery, stroke and acute myocardial infarction for 2005. It was concluded that restricting

ELSEVIER Health Policy 56 (2001) 149–163

www.elsevier.com/locate/healthpol

Using computerised patient-level costing data for setting DRG weights: the Victorian (Australia) cost weight studies

Terri Jackson

Monash University Health Economics Unit, Hospital Services Research Group, P.O. Box 477, W. Heidelberg VIC 3081, Australia

Received 8 April 2000; accepted 16 November 2000

Abstract

Casemix-funding systems for hospital inpatient care require a set of resource weights

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Can ABF be credibly executed in Canada?

Data and Information Systems

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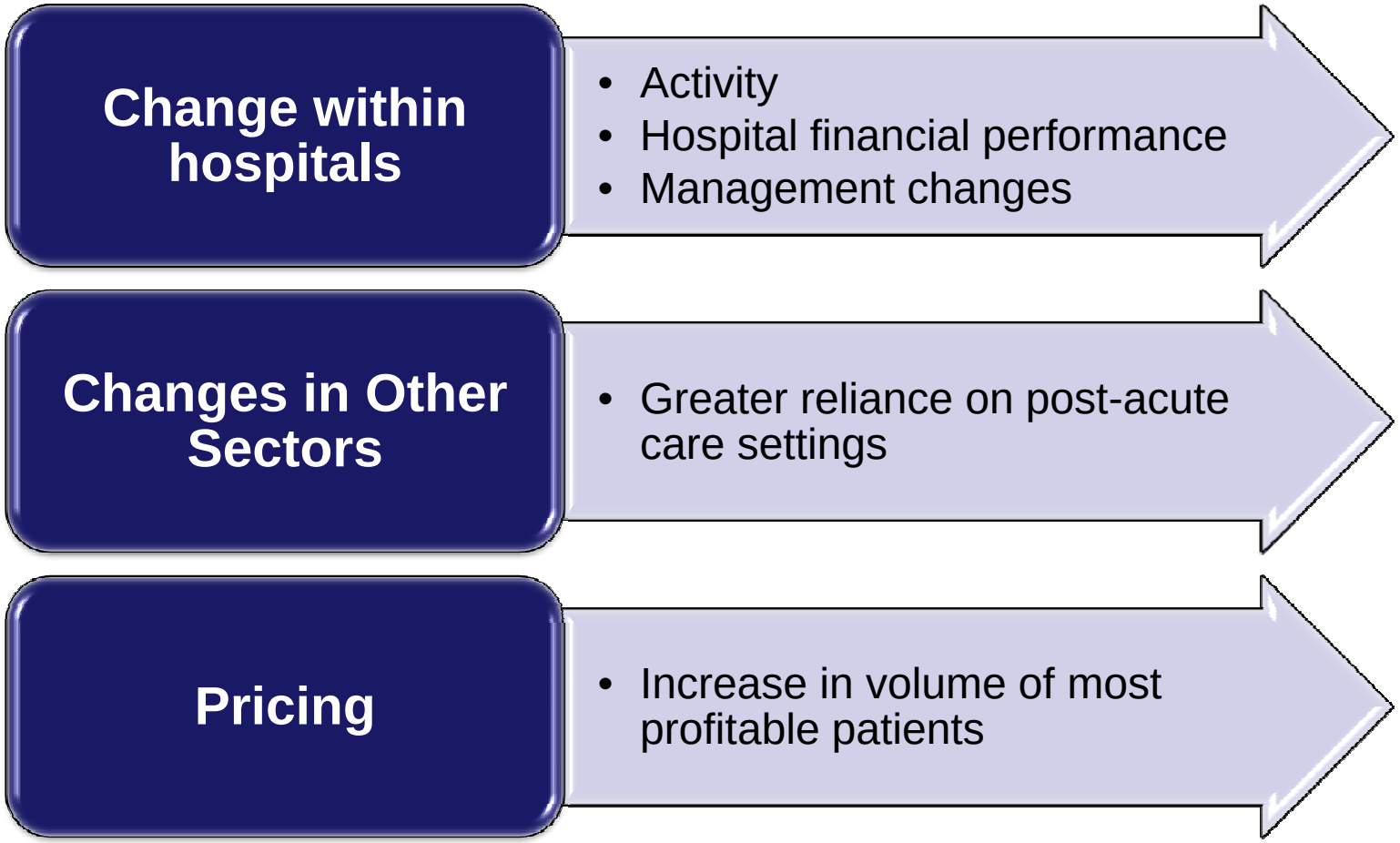
What are key implementation challenges?

- Determining desirable levels of activity
- Spending ‘caps’ to limit growth of activity
- Long-term commitment needed for hospitals to respond to incentives
- Phased implementation (How quickly and to what level)
- Adjust payment amounts away from ‘average’
- Quality

What are known risks?



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Important success factors?

- Vision and **leadership**
- **Political** risk related to changing hospital activity, capacity
- Understanding the effects of natural geographic **monopolies**
- Applicability in less-populated, **rural** provinces/regions
- Understanding demand and supply of **post-acute** services

Maintaining credibility

Coding Quality

- Surveillance efforts should be aligned with funding incentives
- Framework for non-adherence to standards
  - Attribution of responsibilities

Continuous Attention

- Quality
- Access
- Prices and Volumes

What's the 'Pull'?

- ABF creates incentives to increase volume of hospital-based care
- What are the incentives for post-acute providers?
  - Silo-based funding
  - Rehabilitation, Chronic care, Residential/Long-term care, Home care
- No incentives to change intensity/capacity to absorb changes in volume or intensity of acute care
  - Global funding, per diem funding

What's the 'Pull'?

Rehabilitation: Episode-based payment

- Incentives for volume
- Shortened lengths of stay
- Effects on quality unknown

Long-term care: Per diem-based payment

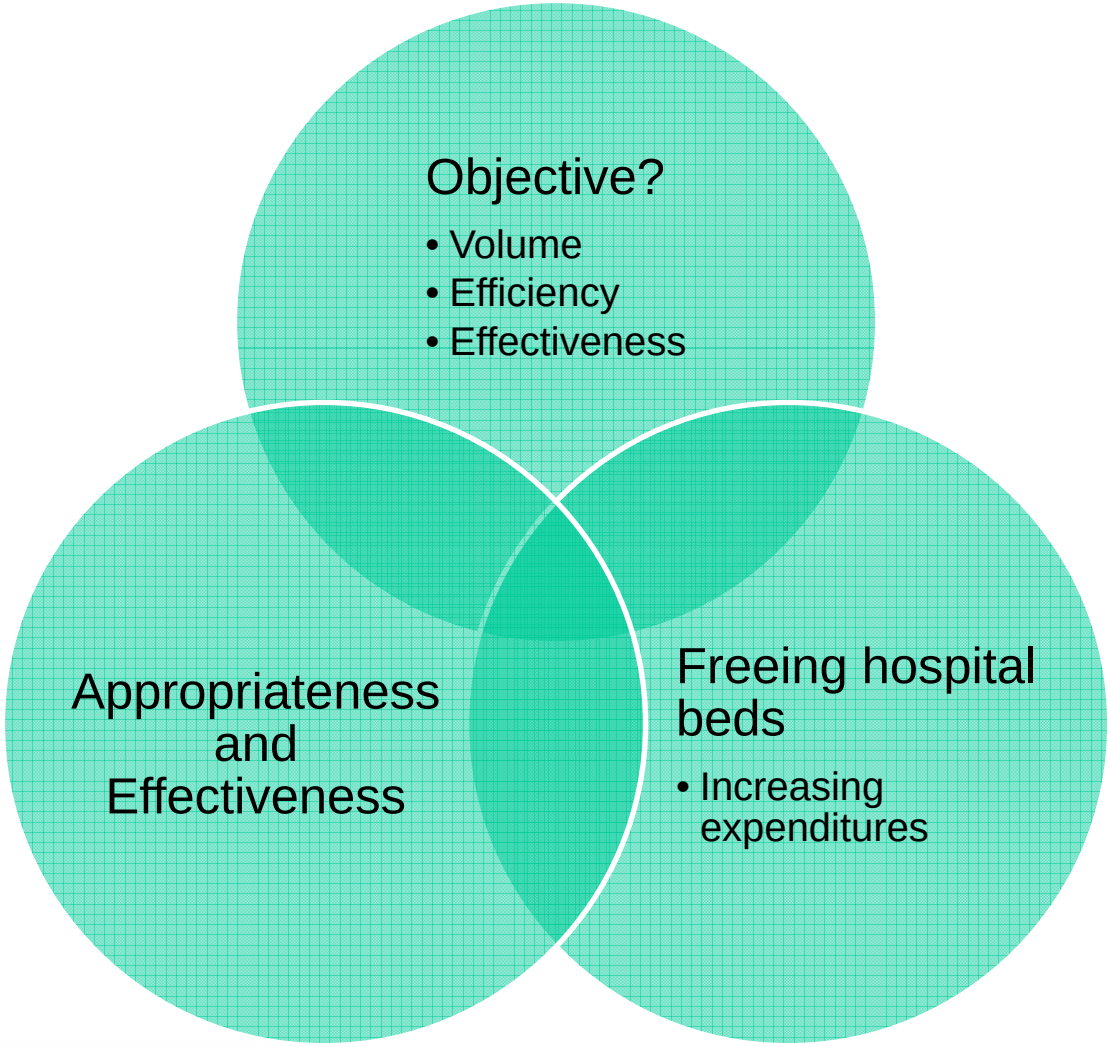
- Efficiencies observed
- Staffing mix changes
- Being implemented in Alberta

What's the 'Pull'?

Solving ALC…. Then what?

- Where and how to expand post-acute care?
- More hospital capacity?
- 'Jump' in expenditures?
- Close hospital beds?
- Maintain 'surge' capacity?

Understanding what is needed?



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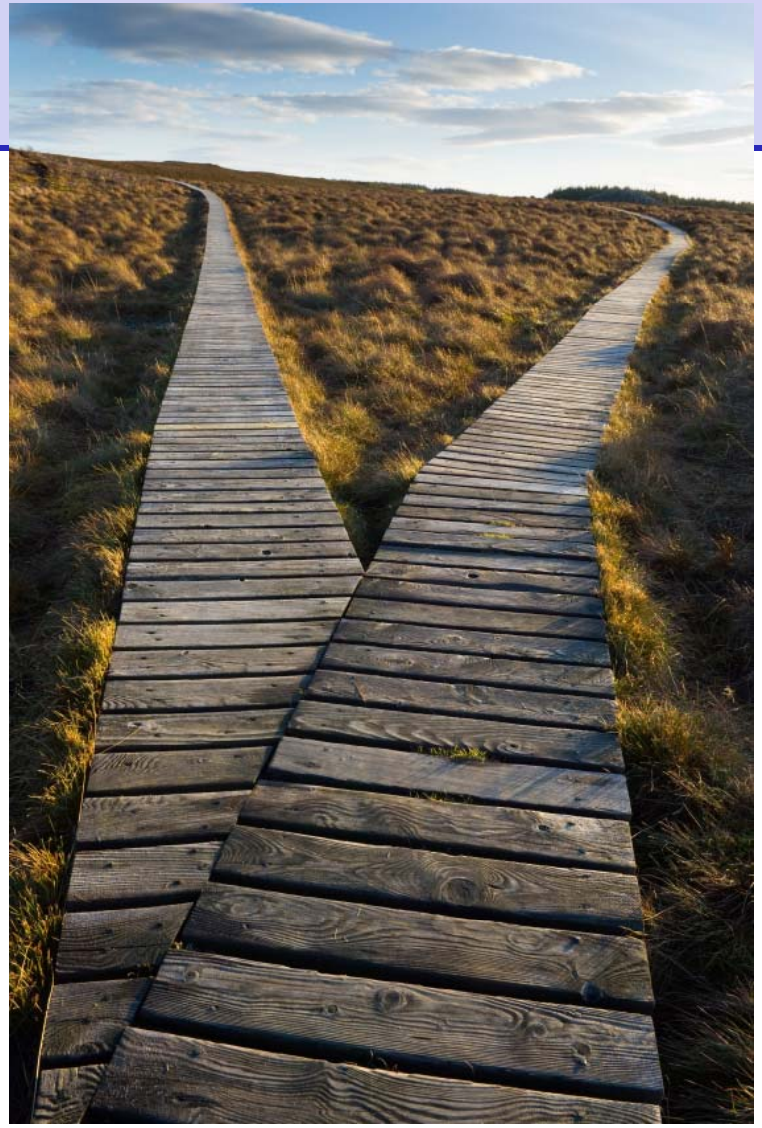

Thank you!

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