Health Care Funding NEWS

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From the Editor

This summer edition of Health Care Funding News profiles Ontario's new health-based allocation funding model, summarizes a new discussion paper about methods for estimating the marginal costs of hospitalizations, and highlights the health care funding-related sessions that took place at the Canadian Association for Health Services and Policy Research annual conference in Montreal in May.

Feel free to use the articles as beach reading, and, as always, please feel free to contact us (**editor@hospitalfunding.ca**) with comments or suggestions.

PROVINCIAL PROFILE

Ontario's New Health-Based Allocation Model

In March, the Ontario government announced the health-based allocation model (HBAM), a new funding policy for the province. Initially, the HBAM will be used to partially fund hospitals and home care providers, but current plans are to expand this policy to other health care providers in the future. Ontarians are facing long wait times for this kind of care, and the HBAM is being touted as a solution to this problem, by rewarding efficient delivery and improving access.

For hospitals, the HBAM is comprised of two parts: 1) a services component, and 2) a unit cost component. The services component accomplishes two things. First, at an individual level, the HBAM creates a "person profile". This profile is used to derive the expected use of services given a patient's demographic and clinical characteristics. Second, at a population level, it estimates a community's services needs. This is based on the community's historical service use and population growth. It then divides these expected services amongst the community's hospitals based on their market share.

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RESEARCH BRIEF

Estimating the Marginal Costs of Hospitalizations

Estimating the marginal cost of hospitalized patients is a complex process, yet this piece of information is critical information for government and hospital decision-makers if they are to successfully navigate the changing policy environment. As provinces across Canada begin to implement activity-based funding models to fund some portion of hospital activity, there is a pressing need for hospitals to understand the capacity and revenue implications associated with such policies. Better understanding these costs was the primary motivation behind a new Discussion Paper by Dr. Jason Sutherland, entitled *Estimating the Marginal Costs of Hospitalizations*. The main objective of the paper is to develop the methods to estimate the marginal costs of day surgeries and inpatient hospitalizations.

A range of equipment, services, and staff are needed to provide hospital care. Some of these are paid regardless of how many patients are cared for; these are referred to as "fixed costs." Some are paid for every patient that is treated; these are referred to as "variable costs." The "marginal cost" refers to the change in total hospital expenditures associated with treating one additional patient. Understanding these marginal costs is helpful to administrators in order to make informed decisions about incurring additional volume and activity level. This is especially the case in provinces that are 'purchasing' additional surgical care to reduce wait lists.

Given the range of resources that are involved in hospital care, there are a number of different assumptions and sources of data needed to estimate marginal costs. These datasets include: statistical and financial data, activity-based costing data, workforce data, and clinical, demographic and administrative data. Dr. Sutherland's paper proposes a set of five scenarios, each with different underlying assumptions about fixed costs, to develop methods for estimating marginal costs.

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The unit cost component sets the estimated costs of delivering a service based on the average cost of its delivery in the province (with modifications for level of academic activity, geography, and degree of specialization).

In this approach to funding hospital care, hospitals are then funded based on the number of services they provide, the efficiency with which they deliver them, and the expected costs of those services. Thus, the HBAM's incentives for hospitals are for volume and efficiency (not unlike an activity-based funding model). The population-level estimated service use, however, is unique, and its consequences relatively unknown. For example, given that the estimate of service use is partly based on historical use of services, is the province at risk of perpetuating current, and sometimes inefficient, patterns of care?[1]

The HBAM is made in Ontario, for Ontario—it has not been implemented anywhere else. This lack of experience, and the dearth of published information on its effects, make it difficult to foretell what the HBAM has in store for the province. It is something to watch closely.

[1]Ho T, Barbera L, Saskin R, et al. Trends in the Aggressiveness of End-of-Life Cancer Care in the Universal Health Care System of Ontario, Canada. Journal of Clinical Oncology. 2011; 29(12): 1587-1591.

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The results detailed in the paper indicate that there are wide variations in the marginal costs of day surgery, inpatient surgical, and inpatient medical procedures. Sources of variation include high device costs and nursing intensity. While the discussion paper demonstrates that it is possible to estimate a hospital's marginal costs, this work is not without its limitations. The full paper is available at www.healthcarefunding.ca.

This newsletter was produced by the editorial team of www.healthcarefunding.ca, a reliable and impartial resource for literature, news, and discussion regarding health care funding policies in Canada and internationally.

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CONFERENCE SUMMARY

CAHSPR 2012: Innovations for Health System Improvement

This year's Canadian Association for Health Services and Policy Research (CAHSPR) conference, held May 29-31 in Montreal, focused on innovation. The presentations and discussions presented research in areas where the health care system comes up short for some Canadians, such as chronic disease management, mental health care, and optimum organization and delivery of primary care.

Canadian and international health services researchers, administrators, decision makers and students met to share evidence from their research and experiences of implementing change while finding a balance between cost control, quality and equitable access to care. Notable keynote speakers included Pierre Gerlier Forest, Ezekiel Emanuel, who gave a presentation entitled *Health Care Reform and the Future of American Medicine*, and Michael Rachlis, who delivered this year's Hall Foundation Lecture.

One session brought together panelists from Canada and the US to discuss positive and negative effects of financial incentives for health care. Meredith Rosenthal from Harvard spoke about the US experience with episode-based payments, which were introduced to address an historic misalignment between payments to doctors and funding to hospitals. Dr. Rosenthal noted that research on pay-for-performance in the US has not always correlated with improvements in quality. Next, Duncan Campbell from Vancouver Coastal Health described that health authority's implementation of pay-for-performance, activity-based funding, and the "home first" community incentive as "disruptive" innovations that aim to improve quality of care and outcomes by changing the ways money flows and the ways decisions get made. The panel concluded with a presentation from Rick Glazier from the Institute for Clinical Evaluative Sciences. Dr. Glazier discussed an evaluation of incentives to increase access to primary care in Ontario. The study found that the incentives provided by Ontario's Ministry of Health and Long-Term Care led to an increase in the size of the primary care work force but did not lead to increased access for vulnerable populations.

For more details, including many of the speaker presentations, please visit CAHSPR's 2012 Post-Event page.