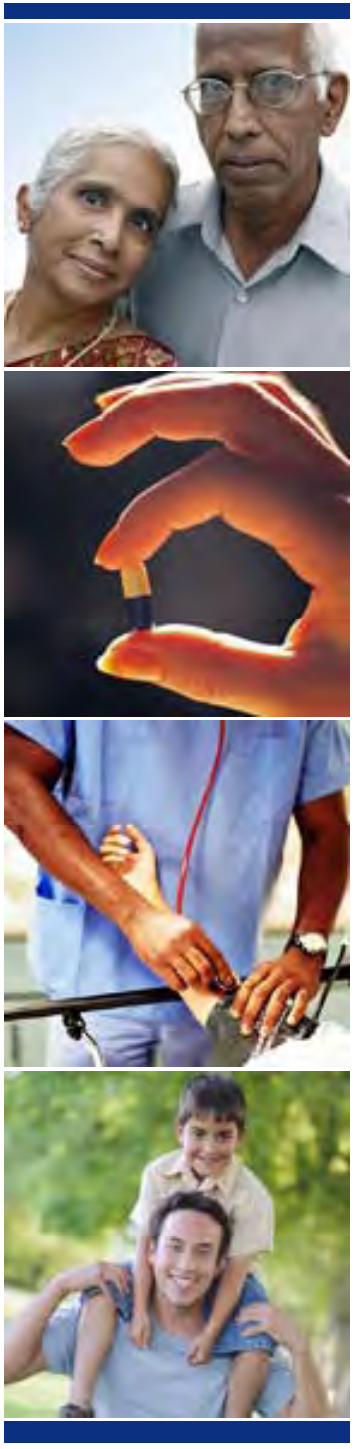

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Understanding the Potential Roles of Financial Incentives for Funding Health Care in Canada

Montreal, Quebec
April 27th, 2012

J. Sutherland, PhD, N. Repin, MA and RT Crump, PhD
Centre for Health Services and Policy Research, UBC

College of Health Disciplines
THE UNIVERSITY OF BRITISH COLUMBIA

Presentation?

- Update on CHSRF/MSSS/ASSSM project
  - Commissioned by CHSRF
  - Centre for Health Services and Policy Research, UBC
- Context
  - 2 Phase project
  - Phase I:
    - Literature review and synthesis of evidence
  - Phase II:
    - Focus on Quebec's organization, delivery and funding of health and social services

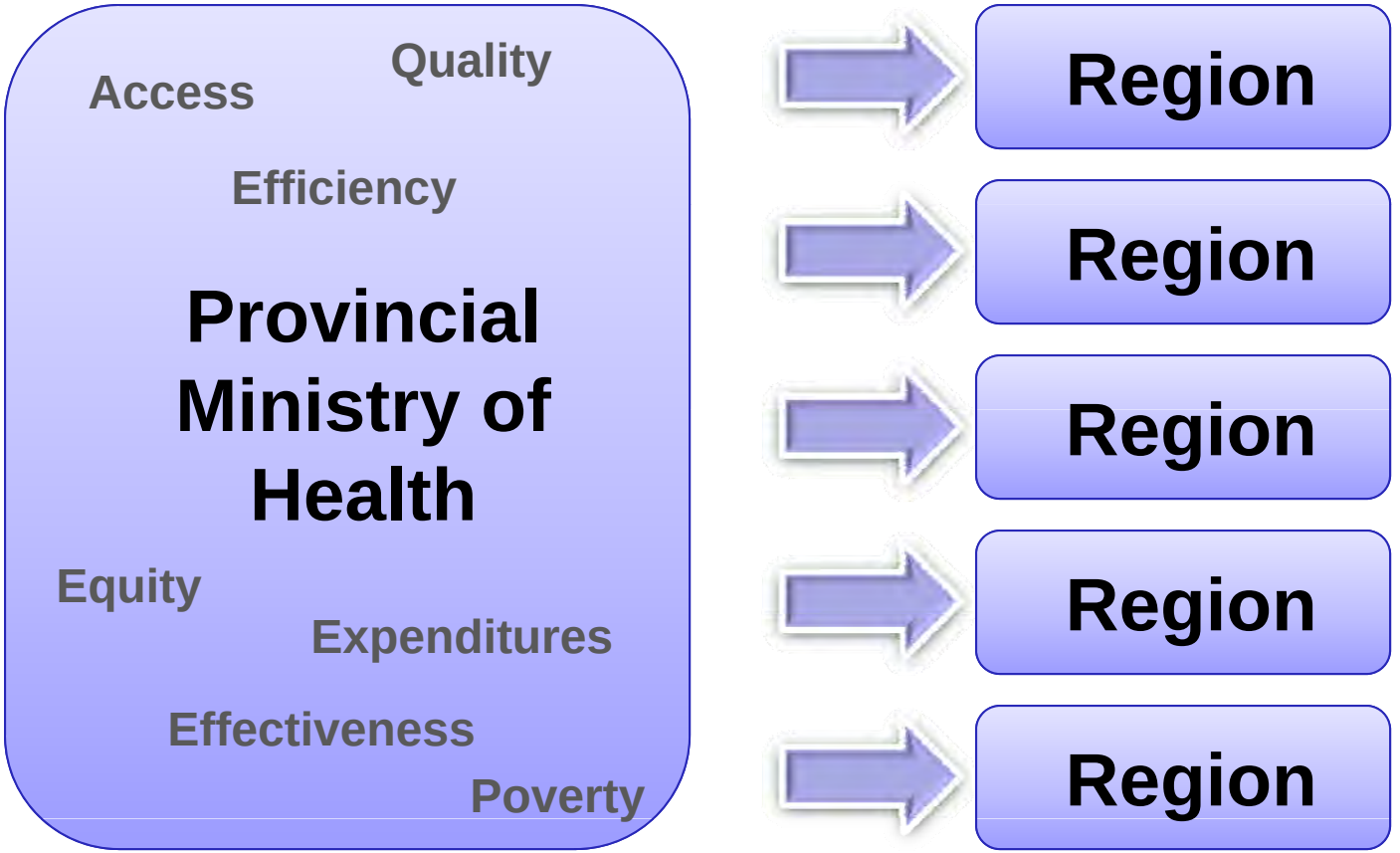
Presentation?

- Phase I
  - Review of rules and methods used to fund health and social care services
  - International perspectives
  - Canadian perspectives
  - Source of information (and education) for Quebec

- What is excluded?
  - Financing versus funding

Regionalization: Common Approach to Differences

- Regionalization:



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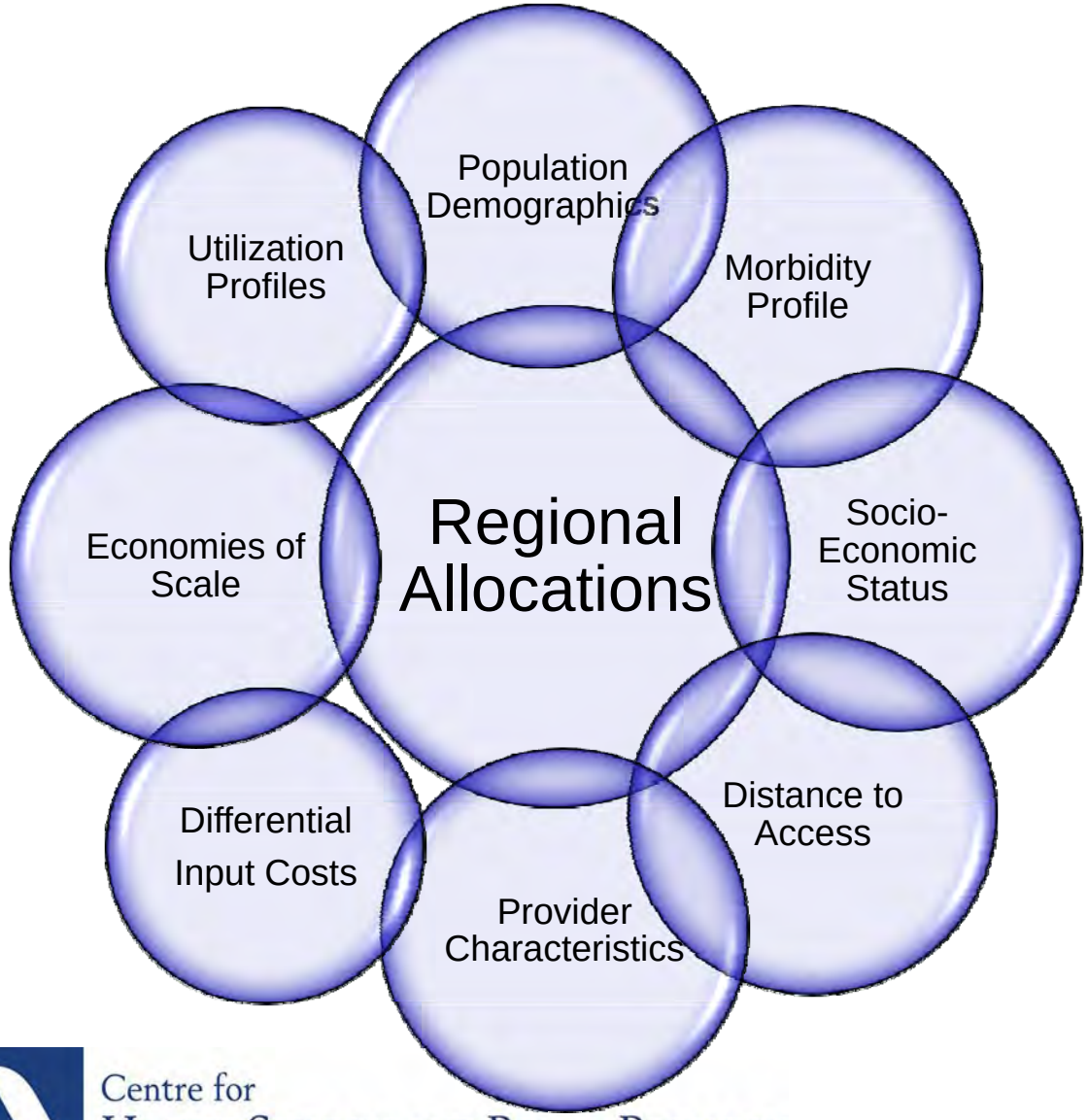
Regionalization: Common Approach to Differences

- Health care organization and delivery tends to be regionalized
  - Population-based funding
  - Informs funding allocations (but not necessarily the sole deciding factor)

Regionalization: Common Approach to Differences



- Historically, Global Budgets
- Adjustments:
  - Growth
  - Inflation
  - New Technologies

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Regionalization: Common Approach to Differences

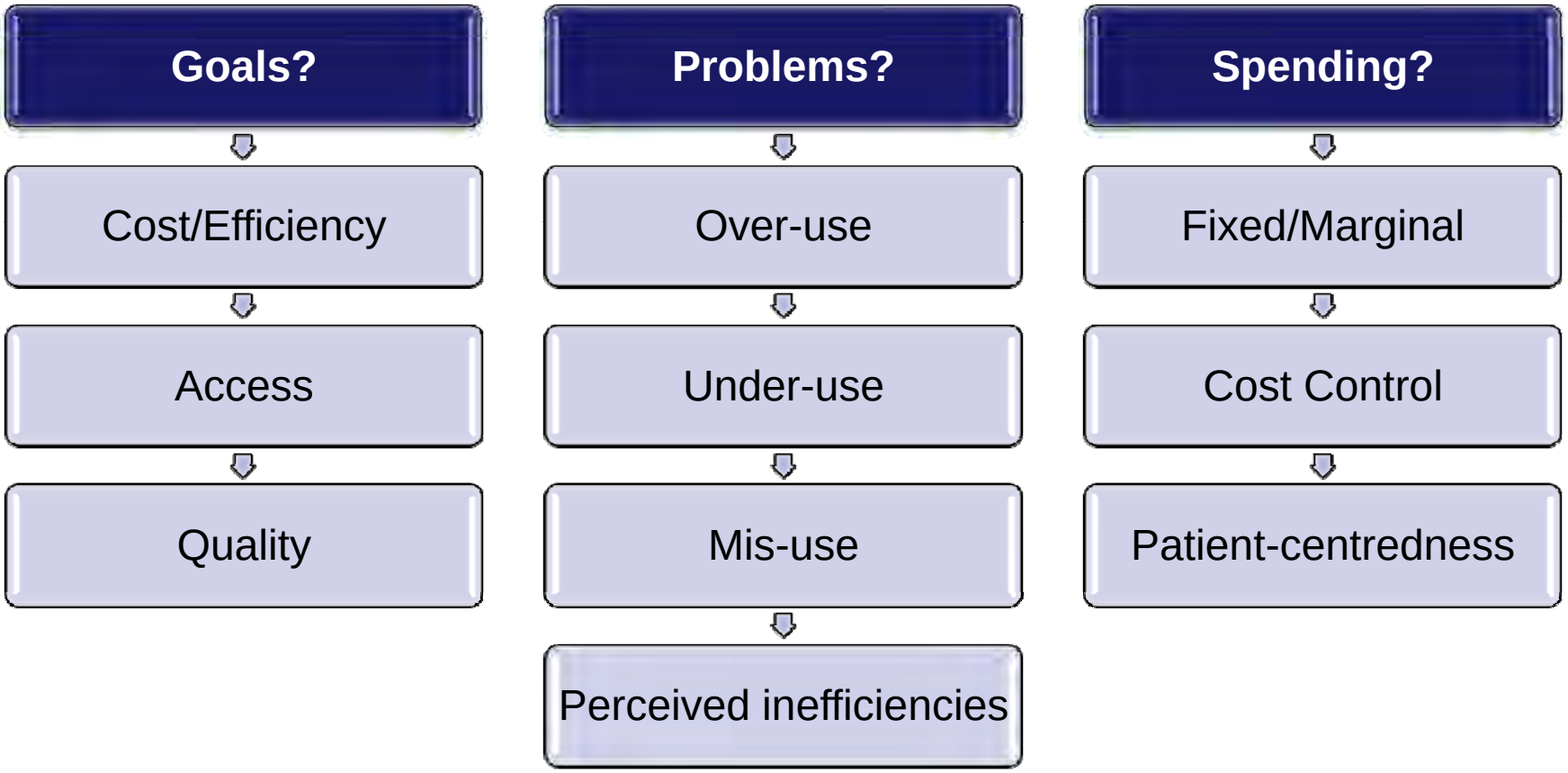
- What does Regionalization attempt to address?
  - Transparency
  - Reduce inequities between regions
  - Pressure on: Inefficiencies and Inequities
- Perceived Benefits:
  - Centralized expenditure control
  - Challenging to do well without comprehensive, timely and accurate data
  - Long ways from addressing all big system funding problems, but a start

Regionalization: Common Approach to Differences

- Regionalization
- Perceived Benefits

- Discussion

Drivers of Hospital Funding Reform



Hospitals = $55 billion in expenditures per year

Seeking strategies for limitations of Global Budgets?

Disadvantages of Global Budgets

- Transparency
- Perpetuates inequities
- 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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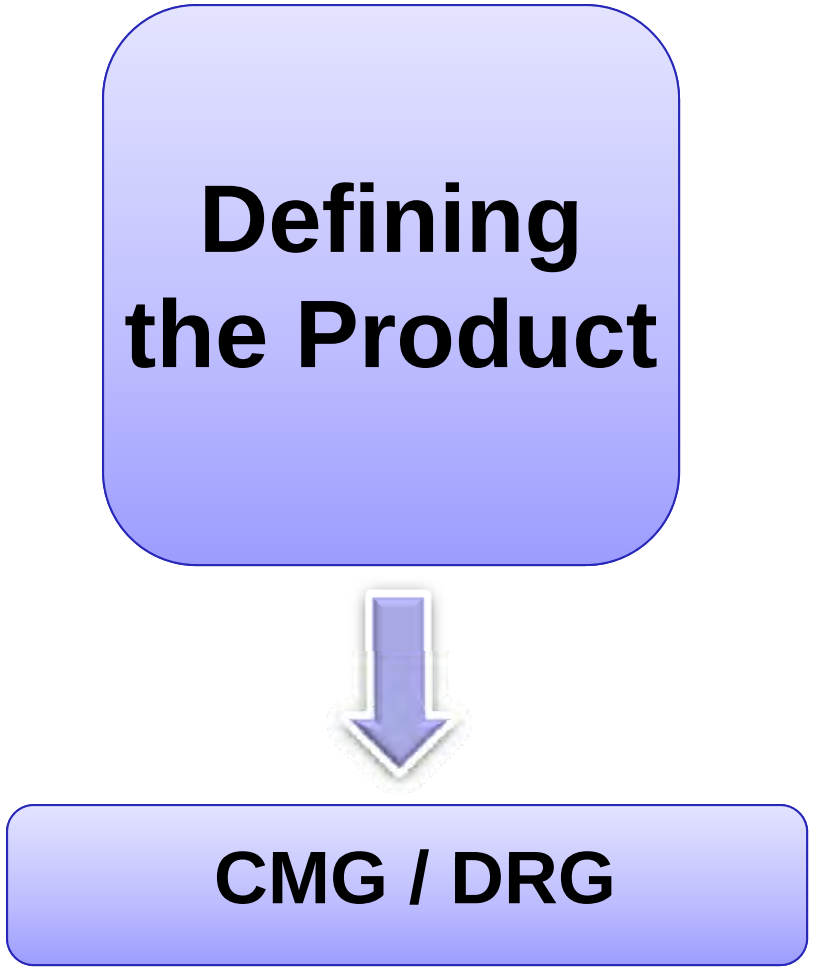
Activity-Based Funding 'Rushing In'

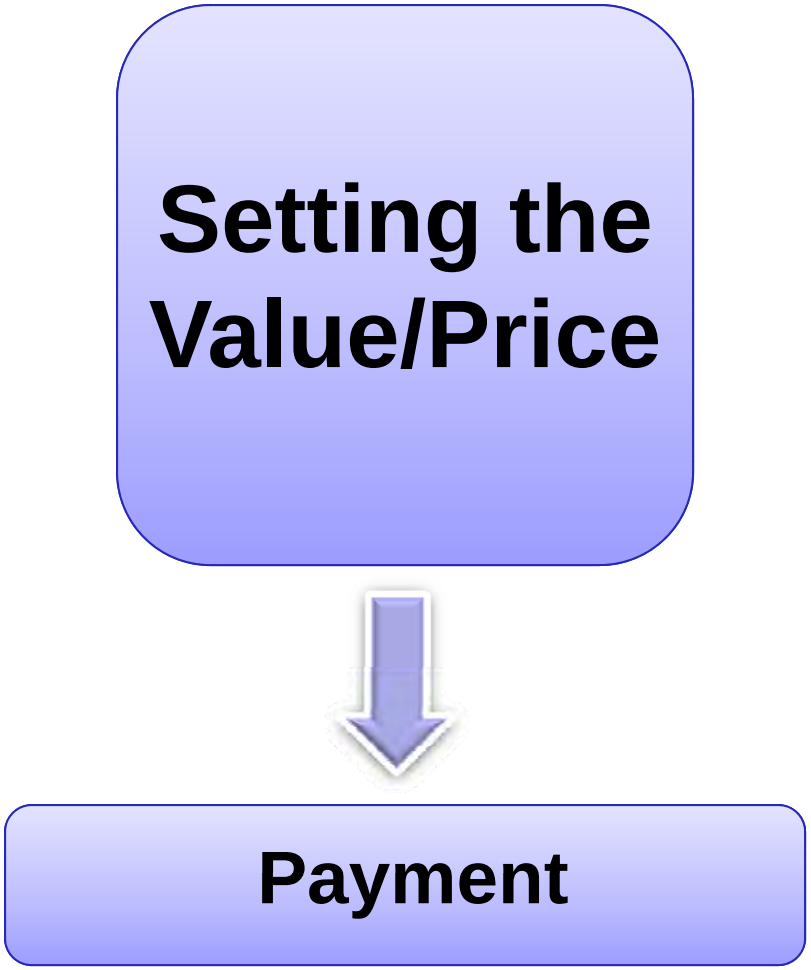
- BC, AB, ON; incremental funding in SK, NL
- CMA, BCMA, OMA, OHA, Kirby Commission (v.6)
- International norm
- Much more complex to administer

Major Motivating Factors

How Does ABF Work?

- 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)





- Cost data is used to set the value (price)
  - Ontario Case Costing Initiative, Alberta costing
  - Micro-costing studies, Australia (AR-DRG)
  - Hospital financial data (UK, HRG)
  - Maryland data
- What components are in?

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Drivers of hospital funding reform: ABF

- 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

Pluses and Minuses of Activity-Based Funding

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 ….

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Decades of Research and Application

Evidence	No 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	• 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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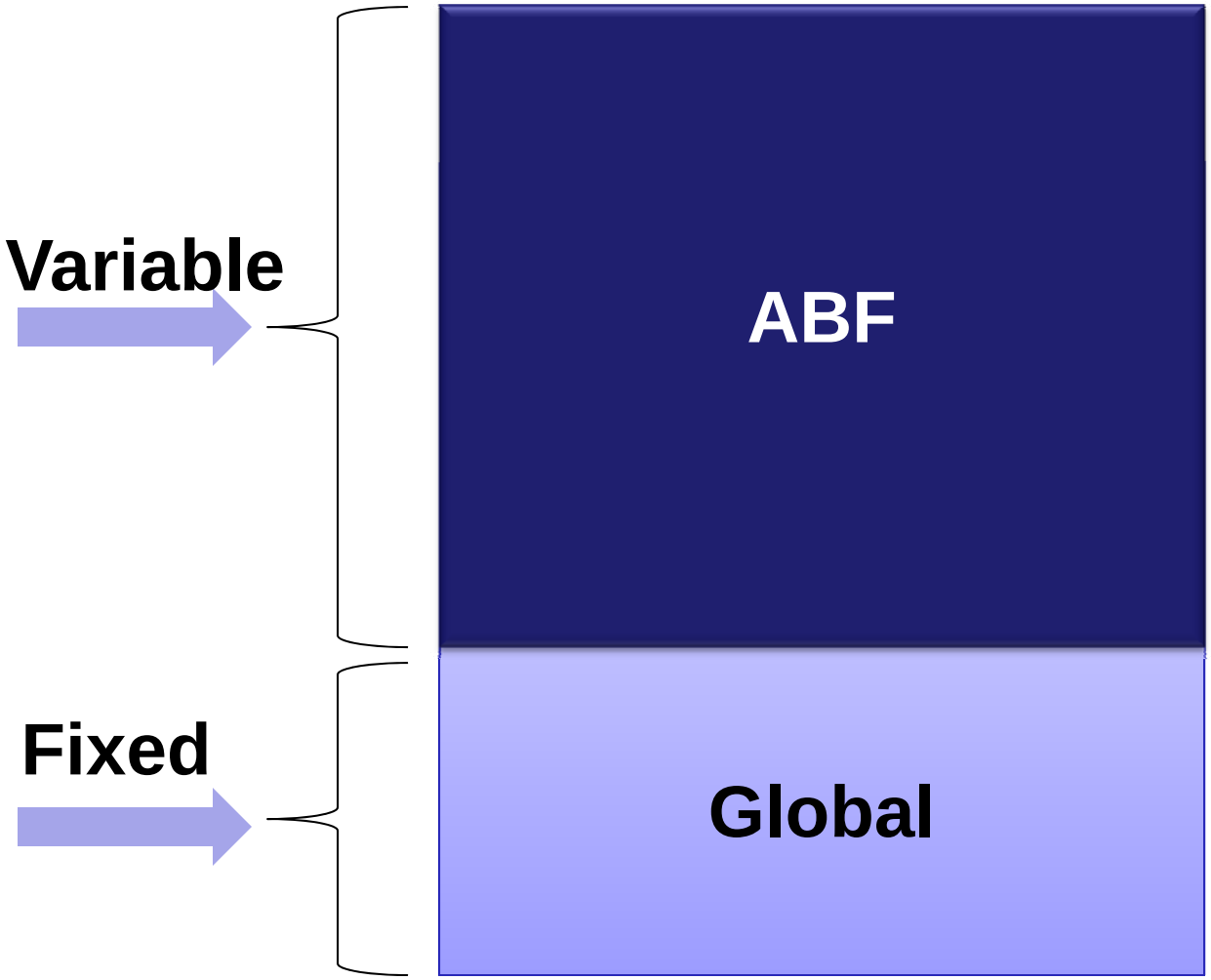
Decades of Research and Application



- Victoria (AUS)
  - 70% ABF
- Denmark
  - 39%-52%
- Norway
  - 40%
- Portugal, IRL
  - 50%
- Germany
- France

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ABF: Stakeholder Concerns

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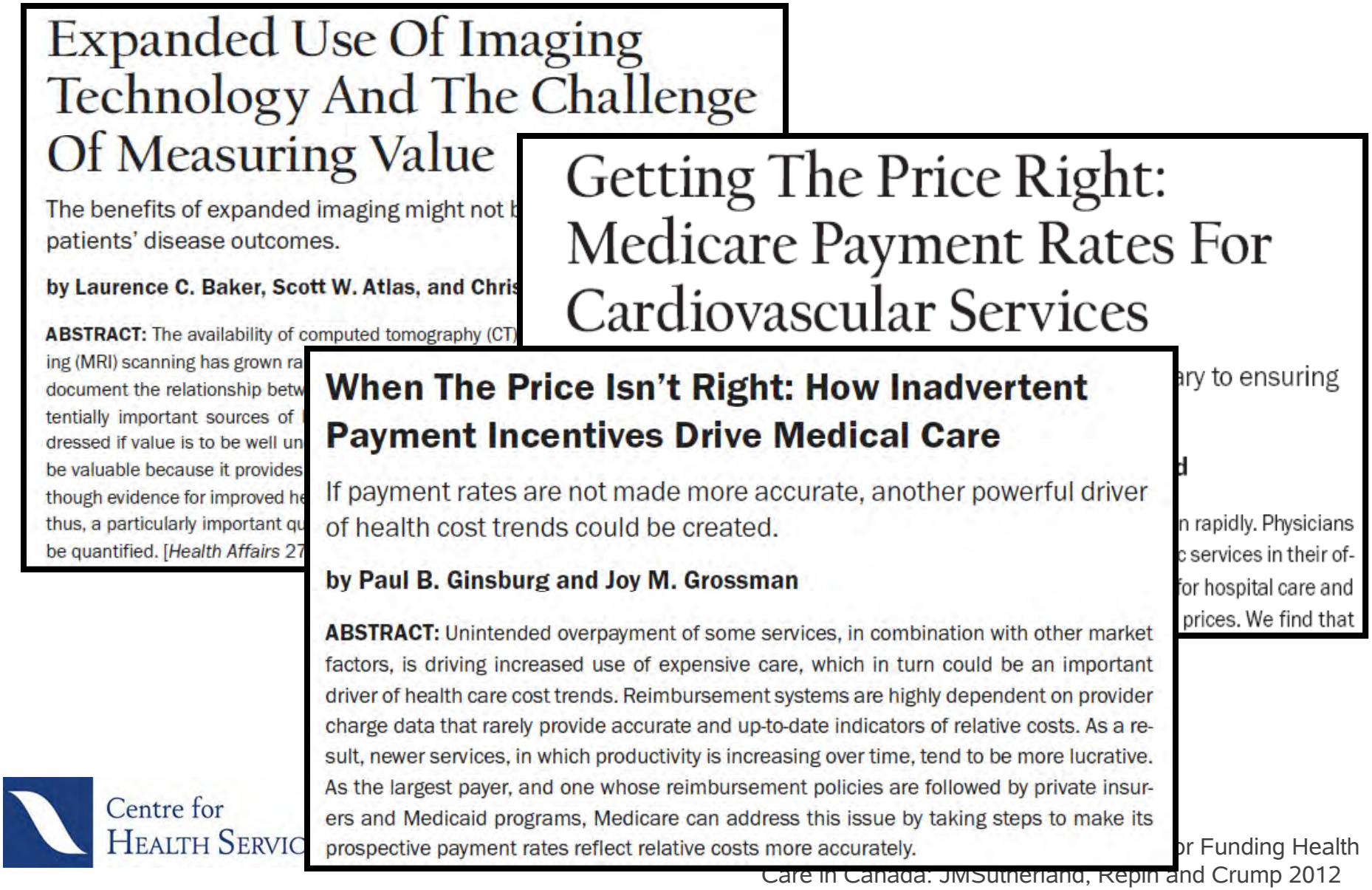
Intended and Unintended Consequences

Access

- Timeliness
- Geographic access
- Equity of access

….but, neither does global budgeting

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 availability of computed tomography (CT)
ing (MRI) scanning has grown ra
document the relationship betw
tentially important sources of
dressed if value is to be well un
be valuable because it provides
though evidence for improved he
thus, a particularly important qu
be quantified. [*Health Affairs* 27

Getting The Price Right: Medicare Payment Rates For Cardiovascular Services

ary to ensuring

d

n rapidly. Physicians
c services in their of-
for hospital care and
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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or Funding Health Care in Canada: JMSutherland, Repin and Crump 2012

Costing Methods

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

, WILLIAM A. GHALI[a,b,c], CAM DONALDSON[d]
DEN J. MANNS[a,b,c,*]

ences, University of Calgary, Calgary, Alta., Canada
iversity of Calgary, Calgary, Alta., Canada
es, University of Calgary, Calgary, Alta., Canada
l, University of Newcastle upon Tyne, Newcastle upon Tyne, UK

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 / Pub
© Springer-Verlag 2008

Abstract The aim of the study was to determine wh
the total cost estimate of a hospital service remains re
when the cost components of bottom-up microcosting
replaced by the cost components of top-down microc
or gross costing. Total cost estimates were determin
representative general hospitals in the Netherland
appendectomy, normal delivery, stroke and acute my
dial infarction for 2005. It was concluded that restri

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 which will not inadvertently distort patterns of patient care. Few health systems have very good sources of cost information, and specific studies to derive empirical cost relativities are

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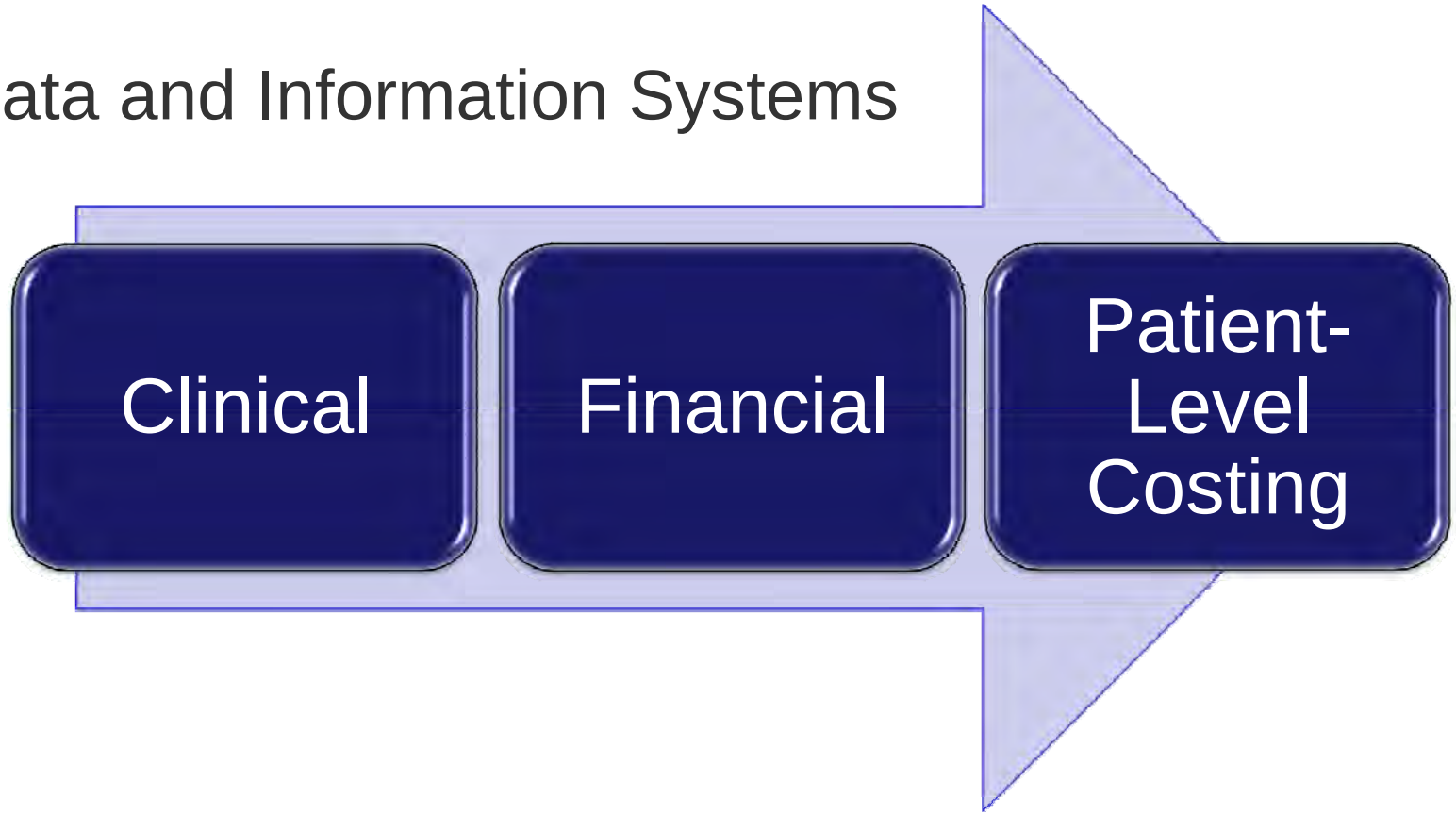
Can ABF be credibly executed?



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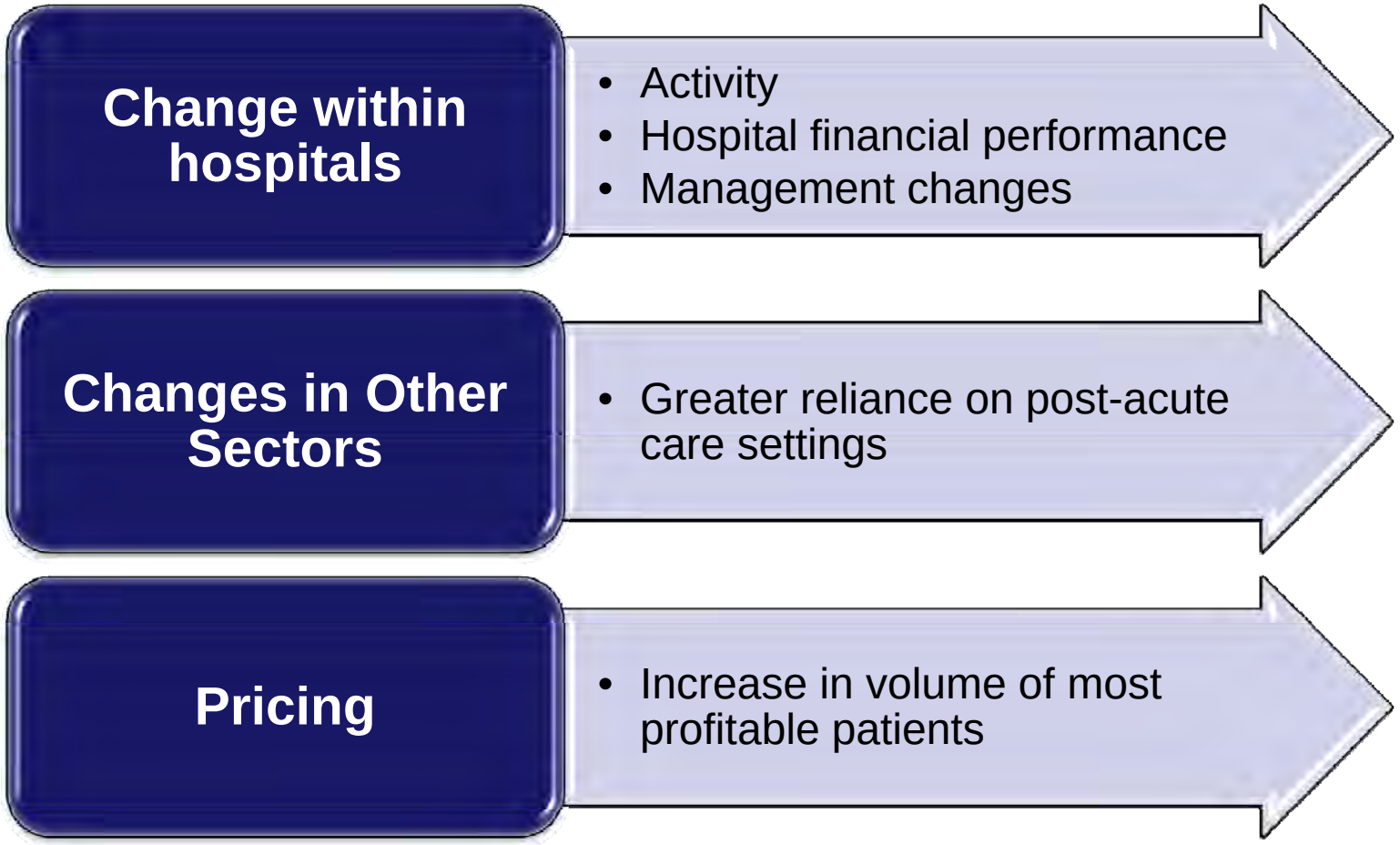
What are key implementation challenges?

- 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
- Transactional costs for designing, implementing and maintaining ABF

What are known risks?



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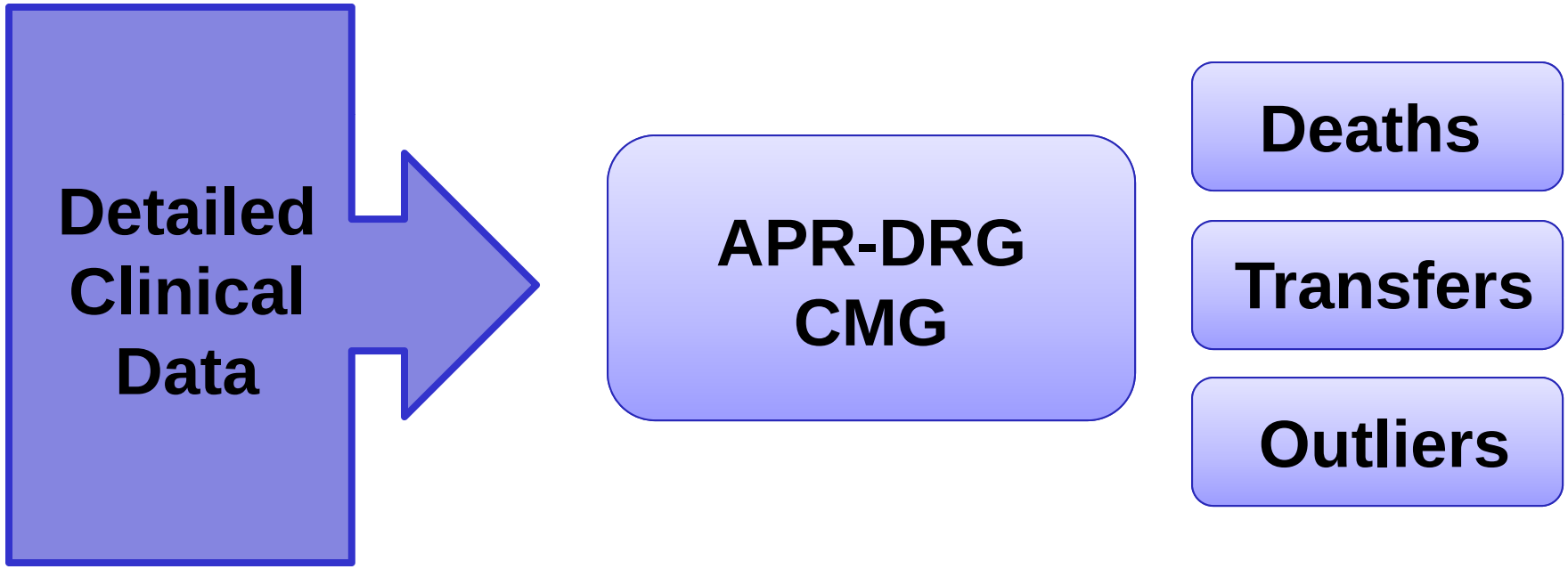
What are known risks?

Understanding the policy choices
'behind' product groups and prices



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

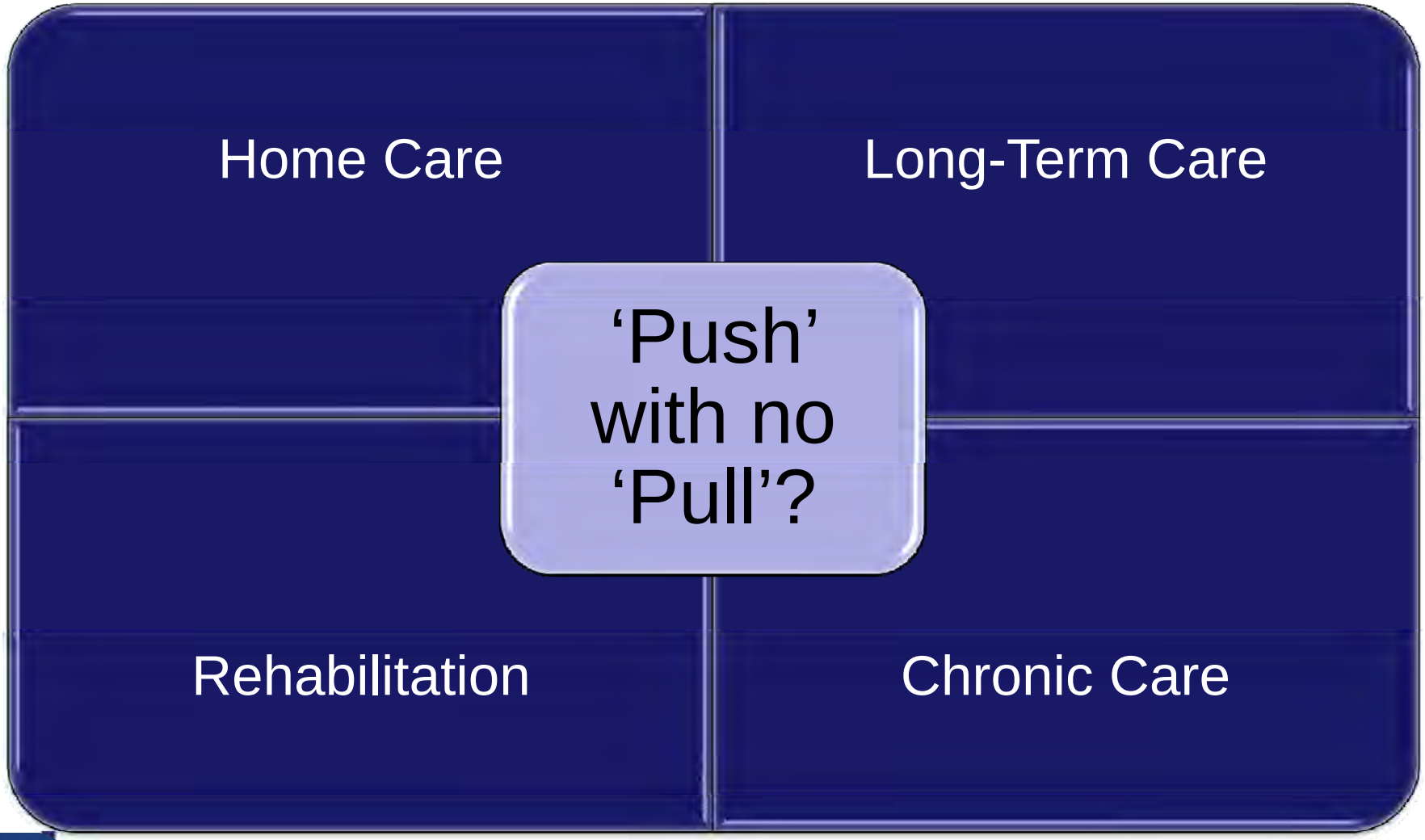
International 'Lessons Learned'

- ABF is one tool in the toolkit
- Common to remove some components
  - Capital, teaching, rural, EDs
- Setting the payment amount is really hard to balance incentives
  - 'best practice price', 'fair and achievable' or average
  - Mental health, pediatrics, palliative
- Funding for growth in cost and volume
- Episode splitting

Combining the Information on ABF

- Health care systems most like our own:
  - Mix of fixed cost/ABF
- Biggest benefit:
  - Transparency
- Long term commitment with phased implementation
- Spending increases are NOT equal to improvements in health
  - Cap overall spending when using ABF
- Payments shouldn't be 'average'
  - Target 'value' or health gain
- CMG+ is cost-based reimbursement

ABF in Hospitals: Interaction with Other Providers



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Chronic and Long-Term Care

Methods 1

- Case Mix Adjusted Daily Cost
- Incentive to reduce costs below funding (not shorten lengths of stay)

Application 2

- Common in US and Australia
- Ontario is ongoing already
- Alberta is phasing-in implementation

Evidence (US) 3

- Increased access
- Decreased therapy duration
- No change in quality

Clinical, behavioral and functional data

Inpatient Rehabilitation

Episode-based

- Physical and cognitive function
- Reduce cost below funding

Implementation

- Long-standing in Medicare
- Ontario ongoing (HBAM, not yet for funding)

Evidence (US)

- Mixed effects on quality and access
- Ongoing in Ontario

Home Care

Medicare

- Episode-based (60days)
- Objective: Restore function
- Basis: physical, behavioral and function, adjustments for morbidity
- Evidence: no effect on quality and access indicators

Canadian Provinces

- No large funding for home care activity programs
- Objectives: Maintain autonomy, independence and quality of life
- Some standardized data collection ongoing (AB)

Inpatient Mental Health

Medicare: Episode-based

- Diagnosis (DRG)
- Reduce cost below funding
- Little evidence

Ontario

- Ontario ongoing (HBAM, not yet for funding)
- Based on daily cost

Other research ongoing:

- UK, Nordic countries, New Zealand, Australia

Canadian Initiatives

- British Columbia
  - Health Services Purchasing Organization (HSPO) 2010
  - Patient-Focused Funding (PFF)
    - ABF
    - ED P4P
    - Community
    - NSQIP – Surgical improvement project

Canadian Initiatives

- Alberta
  - ABF for Long-Term Care
  - 6 year phase in with public and private providers
  - Objectives:
    - Align funding with patient needs
    - Transparency
    - Comparable clinical indicators
  - Fixed and variable components for per day costs
  - Quality-incentives funding (P4P)

Canadian Initiatives

- Ontario
  - ABF for Long-Term Care
    - Ongoing
    - Some data problems (upcoding/cost shifting)
  - Hospital care
    - Global budget
    - Health Based Allocation Model
    - Quality (procedures)
  - Health Quality Ontario
    - Working to inform quality-based pricing

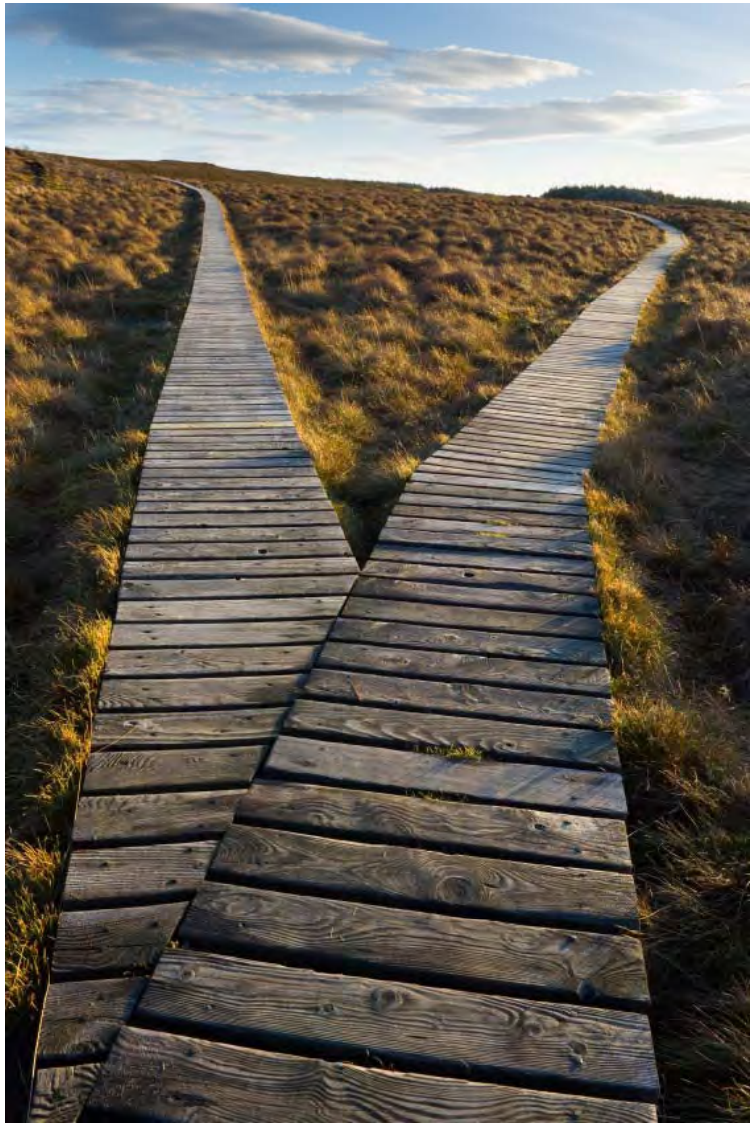
Some key points for Quebec

- What are *other provinces* reporting as key barriers to changing health funding policies?
  - High quality and accessible data
  - Expertise to guide implementation
  - Stakeholder resistance and support

Some key points for Quebec…

- Where to get information?
  - Literature review
  - External experts
  - Universities
  - www.healthcarefunding.ca

- How to build capacity?
  - Internally generated
  - Workshops and conferences (www.pcsinternational.org)
  - Provincial initiatives and working groups



Thank you!

jsutherland@chspr.ubc.ca

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