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HEALTH SERVICES AND POLICY RESEARCH

Funding Policies and High Quality, Accessible and Effective Healthcare?

Jason M. Sutherland

Activity-Based Funding Conference

Toronto, January 29th 2014

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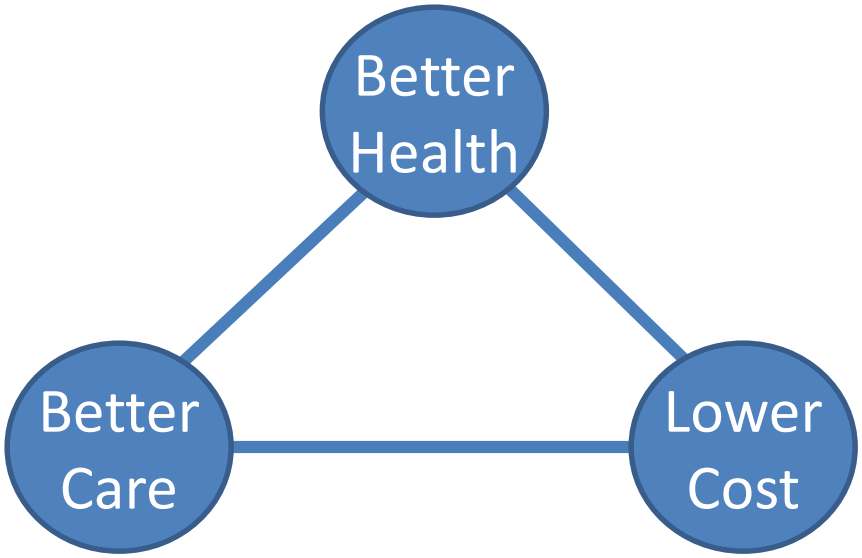
Measuring Performance

Effective
Outcomes



High Quality
Accessible

Efficient

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How Are We Doing?

- Last in access to specialist care
- Last in access to elective surgery

	Australia	Canada	France	Germany
Able to get Same/Next Day Appointment When Sick	65%	45%	62%	66%
Very/Somewhat Difficult Getting Care After-Hours	59%	65%	63%	57%
Waited Two Months or More for Specialist Appointment[a]	28%	41%	28%	7%
Waited Four Months or More for Elective Surgery[b]	18%	25%	7%	0%

Ref: Commonwealth Fund 2013

Persistent Wait Times

Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	United States
72%	78%	45%	57%	93%	70%	57%
33%	38%	45%	68%	43%	38%	63%
16%	22%	34%	31%	5%	19%	9%
5%	8%	21%	22%	7%	21%	7%

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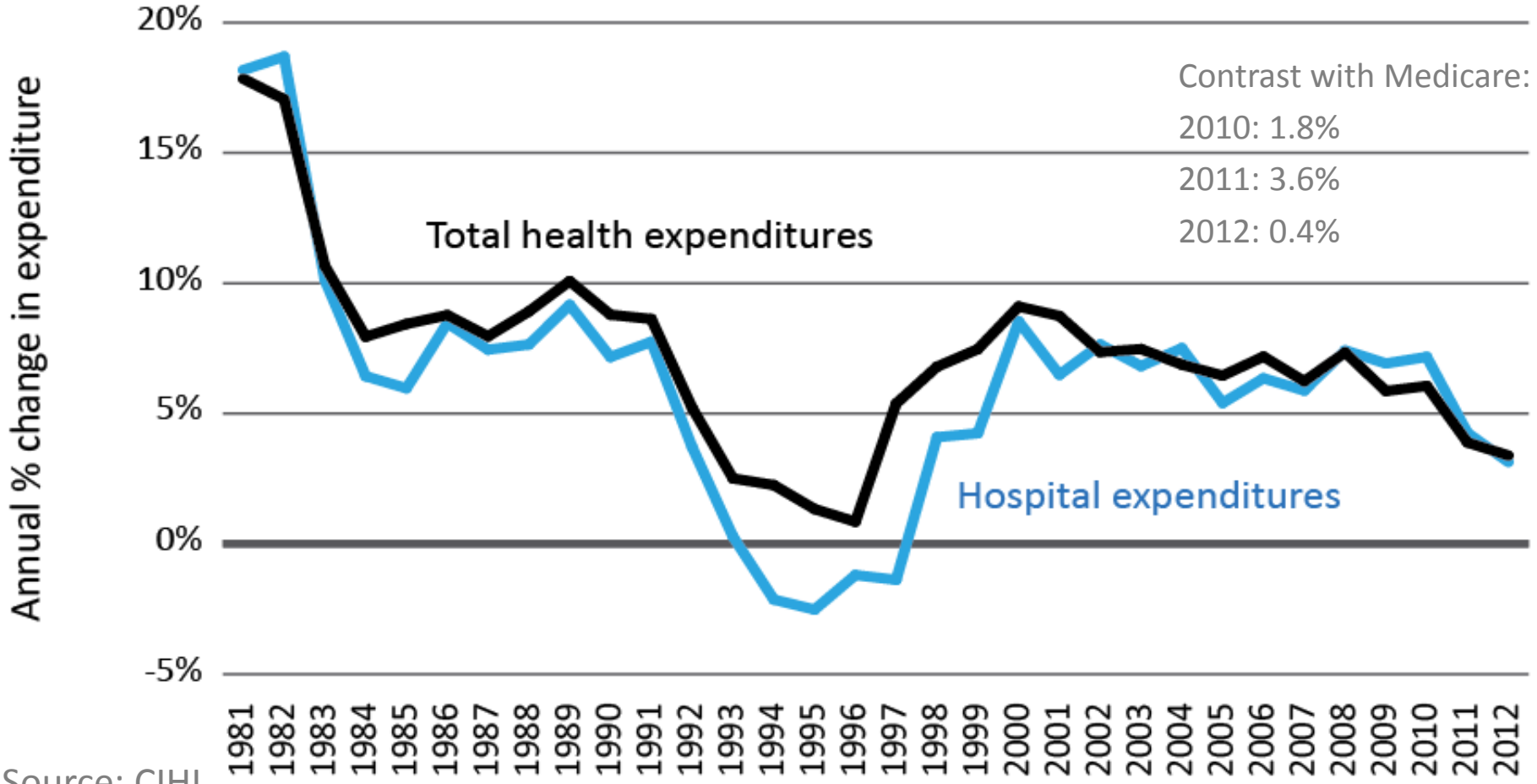
Spending: Annual % Change in total health and hospital spending



Source: CIHI

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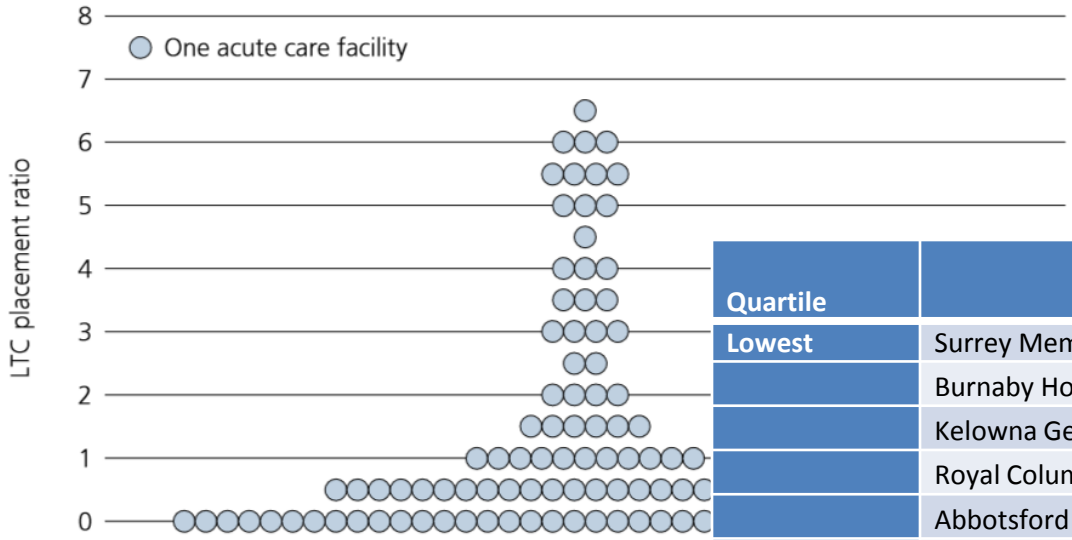
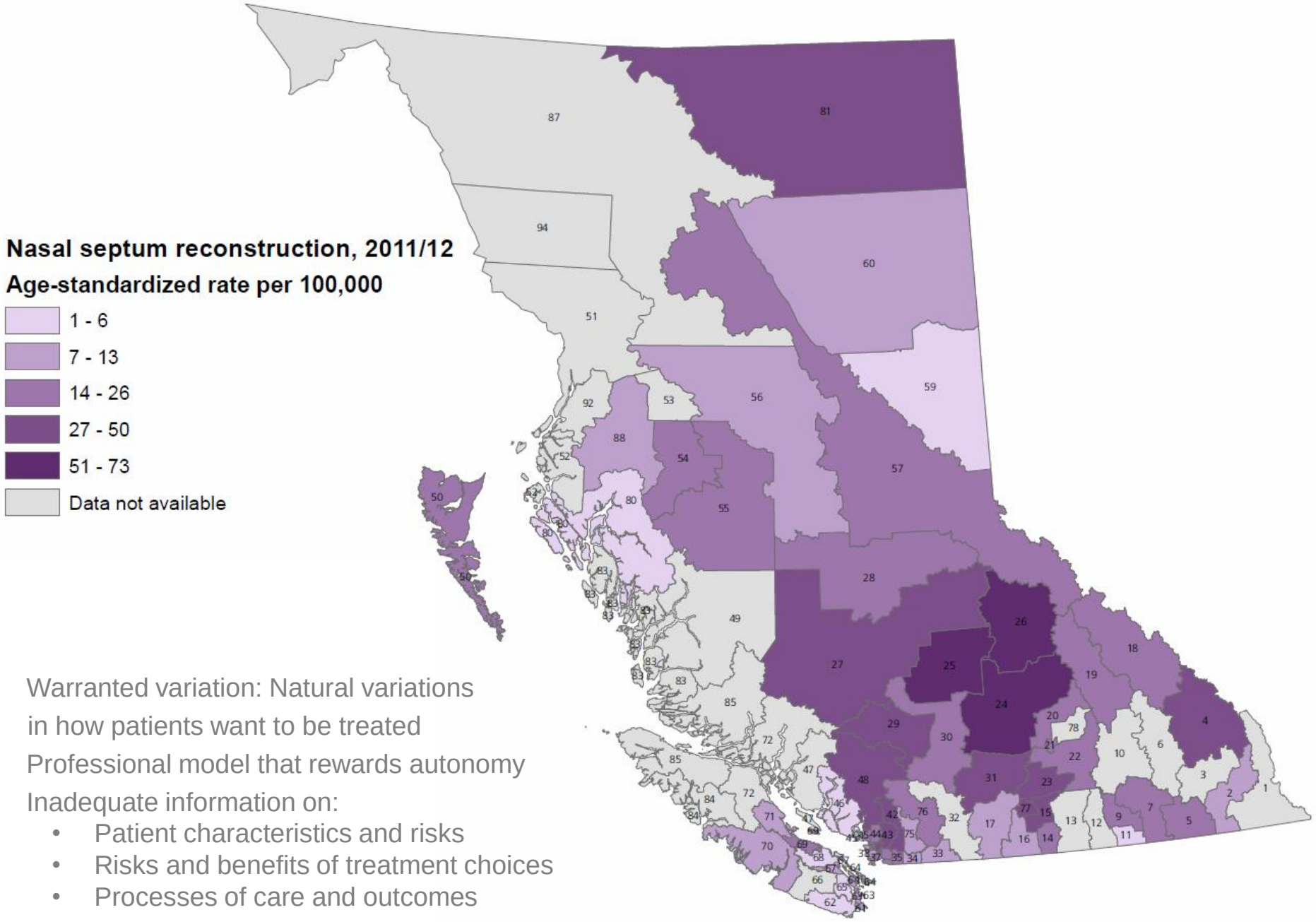
Questioning Variations

Adjusted ratio of placement to LTC for hospitalized medical patients, Alberta



Quartile	Hospital	Hospital Adjusted Rate per 100
Lowest	Surrey Memorial Hospital	49.4
	Burnaby Hospital	60.6
	Kelowna General Hospital	62.2
	Royal Columbian Hospital	63.3
	Abbotsford Regional Hospital and Cancer Centre	70.8
	Langley Memorial Hospital	75.2
Highest	Victoria General and Royal Jubilee Hospital	90.6
	Penticton Regional Hospital	91.6
	Nanaimo Regional General Hospital	91.7
	Kootenay Boundary Regional Hospital (Trail)	93.5
	St. Joseph's General Hospital [BC]	95.6
	Campbell River and District General Hospital	97.4

Highest and lowest rates of hip fracture surgery within 48 hrs
Source: BC DAD data from 2010/2011



- Warranted variation: Natural variations in how patients want to be treated
- Professional model that rewards autonomy
- Inadequate information on:
  - Patient characteristics and risks
  - Risks and benefits of treatment choices
  - Processes of care and outcomes

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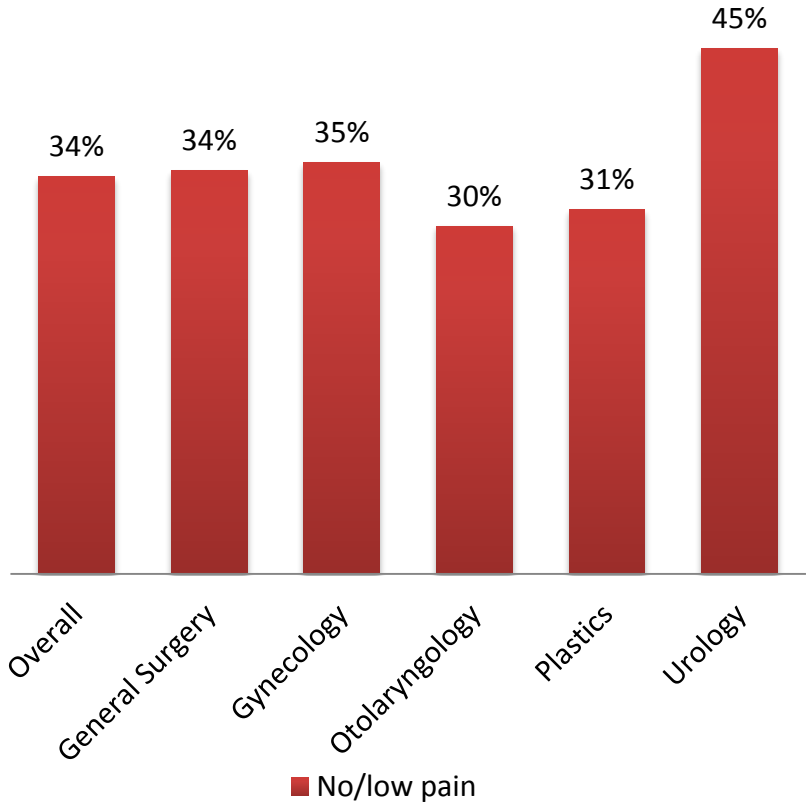
Reflections from Ontario: Hip Fracture Care

LHIN of Residence	Index Event	Average 90 day Cost
Overall	**$20,574**	**$37,882**
5	$19,171	$35,665
6	$18,817	$38,691
7	$20,632	$44,679
8	$19,941	$38,888
12	$20,475	$36,319
13	$27,366	$40,178
14	$20,581	$39,971

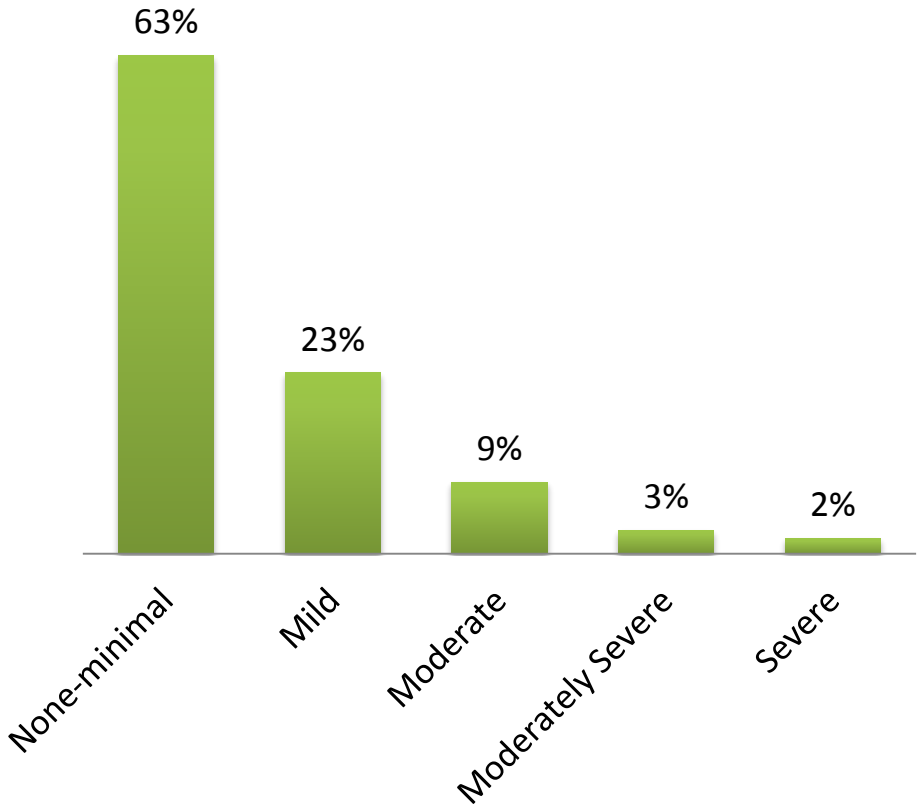
	First Discharge Location			
LHIN of Residence	CCC	LTC	NRS	HOME
Overall	**14%**	**20%**	**32%**	**34%**
5	20%	21%	27%	31%
6	13%	15%	45%	26%
7	19%	14%	48%	18%
8	11%	19%	46%	25%
12	12%	24%	21%	42%
13	8%	29%	10%	53%
14	22%	17%	22%	38%

90 Days Following Discharge from Acute Care			
LHIN of Residence	All Cause Inpatient Readmission	ED Visit	Doctor Visit <7days
Overall	**17%**	**28%**	**90%**
5	16%	25%	90%
6	17%	24%	91%
7	19%	32%	94%
8	18%	28%	94%
12	14%	26%	90%
13	19%	31%	78%
14	22%	38%	82%

Self-Reported Pain



Self-Reported Depression



Neurosurgery and Orthopedics are not shown.

N = 837.

…Taking Stock…

- On average:

  Access is poor relatively — Expensive, growing

  Effectiveness unknown — Quality is variable

- Governments don't run hospitals or community-based providers
  - What levers do governments have to change the direction of the health care system?
  - Turning to the use of new/different funding policies

Summarizing hospital funding incentives:

Type of Funding	Number of Cases	Spending Control	Transparency	Cost Efficiency	Quality
Per Diem / Cost Plus	Yes	No	No	No	Flat
DRG / Case-based	Yes	No	Yes	Yes	Flat
Global Budget	No	Yes	No	Flat	Flat

US Medicare

European Countries

Adapted from: R. Busse, EuroDRG project

Activity-based funding brings complex problems…

Incentive	Strategy	Potential Benefit	Potential Risk
Reduce Costs per Patient	Reduce length of stay	Variation (pathways)	Inappropriate discharge
	Reduce intensity of services	Avoid unnecessary	Skimping
	Select patients	Competitive advantage	Cream skimming
Increase Revenue per Patient	Change Coding Practices	Improve coding	Fraud
	Change Practice Patterns		Over-treatment
Increase Number of Patients	Change Admission Practices	Wait Lists	Admit for unnecessary
	Improve Reputation	Quality	Only focus on measured items

Adapted from: R. Busse, EuroDRG project

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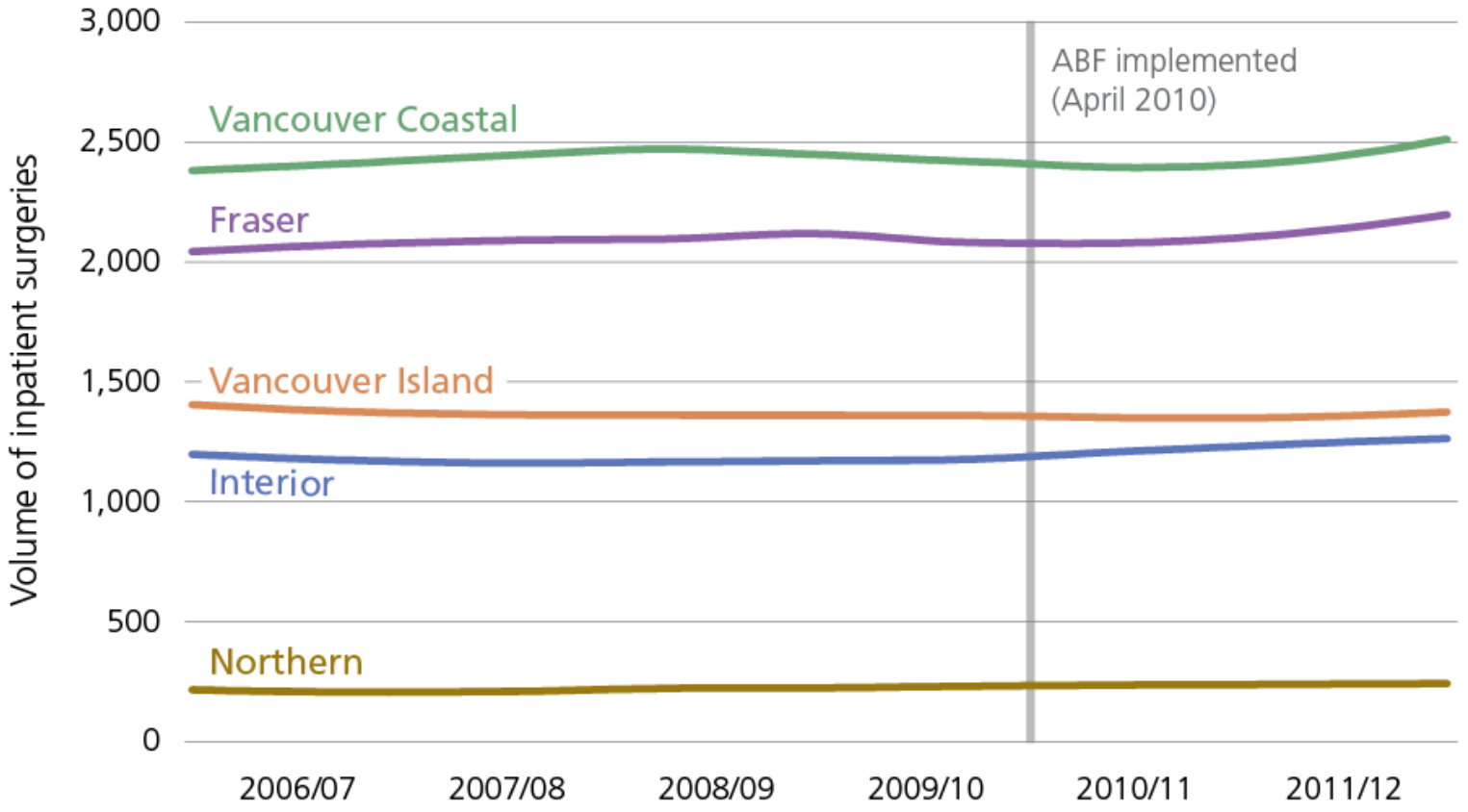
Activity-Based Funding
Inpatient surgical volume – smoothed



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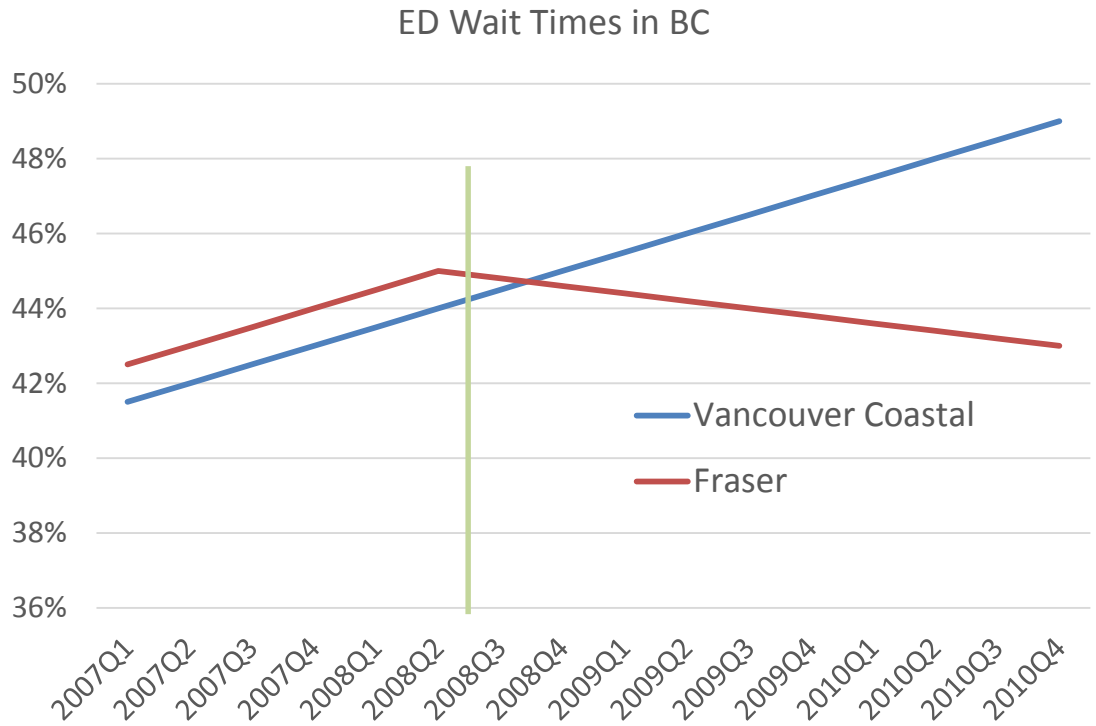
Pay-for-Performance

- Evidence is mixed
  - Tends to be physician-based
  - Less known about post-acute impacts



Source: Cheng and Sutherland, 2013

Refining the Message: Volume + Quality

- Value-based purchasing initiative (Medicare)
- Non-payment for related admissions

LHIN	All Cause Readm
6	9.6%
7	9.6%
8	9.5%
12	12.5%
13	12.3%
14	13.4%

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What's Missing?

Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries

15 Randomized Trials

Context Medicare expenditures of patients with chronic illnesses might be reduced through improvements in care, patient adherence, and communication.

Objective To determine whether care coordination programs reduced hospitalizations and Medicare expenditures and improved quality of care for chronically ill Medicare beneficiaries.

Design, Setting, and Patients Eligible fee-for-service Medicare patients (primarily with congestive heart failure, coronary artery disease, and diabetes) who volunteered to participate between April 2002 and June 2005 in 15 care coordination pro-

The NEW ENGLAND JOURNAL of MEDICINE

The Implications of Regional Variations in Medic Health Outcomes and Satisfaction with Care

Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Da and Etoile L. Pinder, MS

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending achieve better survival, functional status, or satisfaction with care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture (n = 614 503), colorectal cancer (n = 195 429), or acute myocardial infarction (n = 159 393) and a representative sample (n = 18 190) drawn from the Medicare Current Beneficiary Survey (MCBS) (1992–1995).

Exposure Measurement: End-of-life spending reflects the component of regional variation in Medicare spending that is unrelated to regional differences in illness. Each cohort member's exposure to different levels of spending was therefore defined by the level of end-of-life spending in his or her hospital referral region of residence (n = 306).

Outcome Measurements: 5-year mortality rate (all four co-

horts), chang (MCBS coho

Results: Co but those i 60% more c ing was ass fracture coh cohort, 1.01 cohort, 1.00 0.99 to 1.03 functional st ences in sati

Conclusio ceive more have better reduce spen better mana

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See related 347-348, 348

SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

ABSTRACT

BACKGROUND

Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs. However, we have limited informa-

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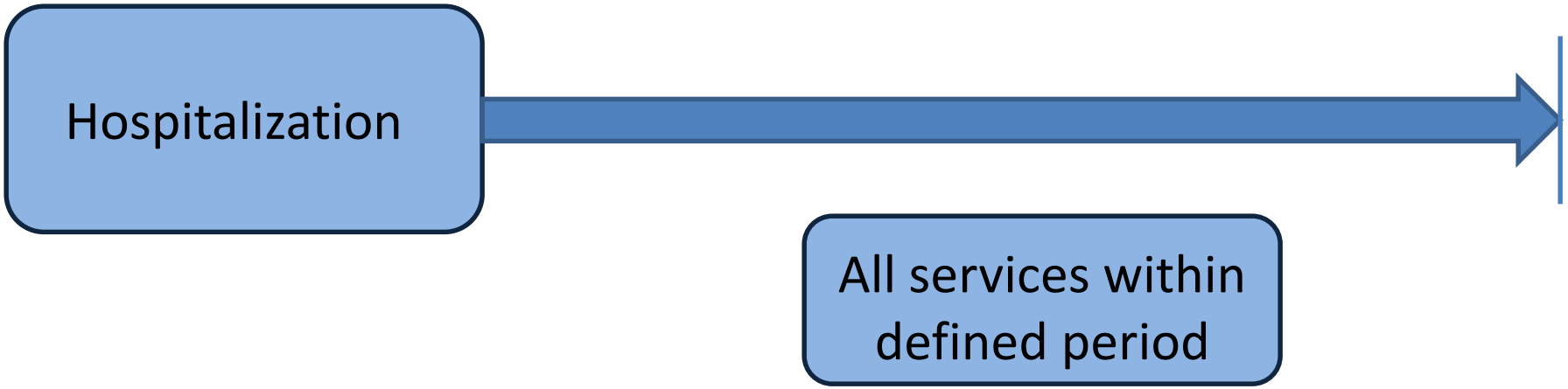
Focus on Episodes

Goal:	Align incentives for all providers	
Includes:	Inpatient	Physician
	Outpatient	Home Care
	Long-Term Care	Rehab



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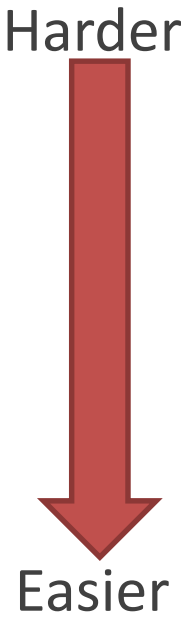
Medicare Bundled/Episode Payments

Strategies of providers:

$$$$	Reduce readmissions
$$$	Intensity of post-discharge care
$	Improve cost-efficiency and reduce ineffective care
	» Bulk purchasing of devices
	» Testing and diagnostics



Defining success:

- Quality improves and payments continue trend
- Payment growth decreases and quality stable

Re-alignment of incentives for providers not seen for several decades

What are other countries doing about the missing elements that case-based payment doesn't provide?

Lever	Quality	Fragmentation	Effectiveness
Funding Policy	Value-based Purchasing and Non-Payment	Episodes of Care	Episodes of Care
		Meaningful Use of EHR	Meaningful Use of EHR
Organization and Delivery System	Accountable Care Organizations	Accountable Care Organizations	Accountable Care Organizations
		Medical Home	Medical Home
System-Level	Cross Sector Data Standardization Patient Outcomes and Experience		

Discussion

- Canadian healthcare systems are laggards in efforts to achieve better value from healthcare spending
- Healthcare systems should perform better
- US-style organization-level reforms are unlikely:
  - No organization/entity analogue that assumes financial risk for:
    - Prevention and health promotion
    - Poor quality
    - Ineffective care and poor outcomes

Discussion

- No country has found a magic bullet to fund healthcare which simultaneously supports better population health, a better healthcare system and in a cost-efficient way
- Canada's provinces are on their own as they look for new types of relationships with providers that promote aspects of health other than volume.

Discussion

- Expect Ministries to continue to use funding policies for change in organization and delivery systems
  - Improve access and quality
  - Effectiveness
  - Constrain cost growth
  - Meaningful change in accountabilities will require physician participation
  - Long history of silo-based organization, delivery and funding

Summary

- In my opinion, what might unfold:
  - Short term:
    - Blended payments: ABF for easily-defined hospital-based care
    - P4P will expand across sectors
  - Medium term:
    - Cross-continuum care for acute conditions, maybe chronic
    - Including physician payment
  - Long term:
    - Patient reported outcomes, patient experience

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