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POLICY BRIEF

Current Hospital Funding in Canada

The limitations of Global Budgets

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Global Budgets

The most common mechanism for funding healthcare in Canada is through global budgets. Under global budgets, a fixed amount of funding is distributed to a healthcare provider, such as a hospital or long-term care home, and that provider then delivers services under its mandate to patients for a fixed period of time (usually one year) (*1*)(*2*).

Few developed countries other than Canada currently use global budgets for healthcare funding; many countries that had previously used global budgets have since transitioned to other funding mechanisms. The specific funding amounts provided to healthcare providers under global budgets are based on a number of factors, including historical budgets, rates of inflation, capital investment decisions, negotiation and politics (*2*).

Advantages of Global Budgets

Global budgets have several advantages (*3*)(*4*)(*5*):

- They provide both policy-makers and hospital administrators with yearly predictability.
- They do not create financial incentives to over-supply or provide unnecessary care.
- They are an effective tool for controlling growth in hospital costs.

Disadvantages of Global Budgets

There are also some disadvantages to global budgets, such as (*6*)(*7*):

- To stay within budget, a hospital may restrict services to patients or be more selective in terms of the patients to whom it provides services (a process known as cream skimming).
- A failure to provide financial incentives to shorten lengths of stays (i.e. moving less acute patients to lower cost care settings).
- Hospitals that do shorten length of stays are penalized because they exchange relatively lower cost patients for higher acuity, higher cost patients.

Other disadvantages to global budgets include:

- A lack of transparency in the allocation of funds.
- Perpetuating historical inequities or inefficiencies.
- Complaints from hospitals regarding inequity in funding allocations.

- Few financial incentives to increase quality or efficiency.

Global budget amounts are based on a combination of factors, including:

- Budget values from previous years
- Rates of inflation
- Capital investment decisions
- Negotiations
- Politics

Concerns for hospital funders

Given the disadvantages associated with global budgets, hospital funders (i.e. health ministries and health authorities) across Canada are looking for alternative funding mechanisms. Increasing costs, lengthy wait times and high alternate level of care (ALC) days, are all putting pressure on the global budgeting model for funding acute care.

Costs

In 2013, the cost associated with hospital care in Canada was $62.5 billion, representing 30% of all healthcare expenditures in the country (*8*). Spending on hospital care remains consistently the largest portion of healthcare expenditures, eclipsing expenditure on drugs and physicians. Although total spending is at an all-time high, the growth in spending on hospitals is slowing down; in 2013, hospital spending increased by 2.6% compared to a growth of 3.1% in 2012 (*8*).

Wait times

In 2004, the federal government agreed to provide provinces additional funding for the purpose of reducing wait times in four acute priority areas: cancer, heart, joint replacement and cataract surgery (diagnostic imaging was also a priority area, though not solely for acute purposes) (*9*). Despite this additional funding, wait times for these procedures still persist across the country and significant variations across the provinces have been observed (*10*).

Policy-makers are under pressure to reduce wait times beyond the federal priority areas. The Wait Time Alliance, the Canadian Medical Association, and the Health Council of Canada have all encouraged the expansion of wait time reduction strategies to other acute care procedures (*11*)(*12*).

Alternate level of care

Alternate level of care (ALC) is a growing issue facing policy-makers and hospital administrators nationwide. Commonly referred to as "bed blockers," ALC patients no longer require the intensity of acute-level of care but occupy hospital beds because there is a lack of appropriate post-acute discharge locations. It is estimated that 13% of all acute days across the country are occupied by ALC patients; this represents approximately 7,550 acute beds each day (*13*). ALC patients can prevent hospital admissions from the emergency department, or cause delays for some elective surgeries. It is of concern that over time, ALC stays are increasing which affects the ability of hospitals to provide services to patients needing hospital care.

International Hospital Funding

Few countries use global budgets as the sole basis for funding hospital activities. Instead, many countries use a blended approach, mixing global budgets with other funding mechanisms aimed at mitigating the disadvantages of global budgeting (*14*)(*15*). Some of these mechanisms include:

- Activity-based funding (a.k.a. patient-focused funding)
- Bundled payments
- Pay-for-performance

These mechanisms are discussed in detail in other areas of our web site; please see our activity-based funding discussion and our post-acute care content.

Post-Acute Care

Post-acute care generally refers to a system of care that provides health, social and other supportive services to incapacitated seniors and people with disabilities. Often referred to as "continuing care," it is most ommonly delivered at different levels of intensity ranging from in-hospital rehabilitation to long-term care, supportive/assisted living settings and finally home care. In general, this care is provided by a mix of public and private operators. Post-acute care terminologies and the provision of services at different levels of intensity differ across the provinces, impeding the ability to make any pan-Canadian characterizations.

Funding Post-Acute Care

Though well-developed internationally, funding policies aimed at improving the efficiency and quality of post-acute care are relatively undeveloped in Canada. In general, the remuneration of post-acute care is divided between the provision of healthcare services and accommodation (though this latter category does not apply to home care). These are often paid for through a mix of public and private funds (including private insurance or out-of-pocket), either on a global budget basis or on a per patient basis.

Under the current funding policies, the different levels of post-acute care largely operate in isolation from one another, acting as separate silos of care. This creates a fragmented system, one that is associated with numerous inefficiencies and limitations (*16*). Nor do the current funding policies create financial incentives for post-acute providers to ensure that the care they deliver is timely or at the appropriate intensity. The current methods for funding rehabilitation, long-term care and home care in Canada, are described separately.

Several different funding mechanisms exist that may offer policy-makers solutions to improving post-acute care. These mechanisms reward the coordination and continuity of care across acute and post-acute providers and offer potential for adaptation in Canada.

Challenges for funding reform in post-acute care

Clinical Guidelines

There is little in terms of scientifically-based guidelines substantiating the treatment protocols and the intensity level of care needed to appropriately care for patients after discharge (*17*). This makes it difficult to develop rigorous metrics required to carry out evaluation and performance assessments of post-acute care. Consequently, while patients may be safely cared for in a variety of settings, their level of care is not always optimized to their needs (*7*).

Data

The success of any funding reform hinges on the availability of timely and reliable data. Data surrounding the provision of post-acute care varies considerably by level of intensity and by province (*16*). Gaps in standardized data make it challenging for policy-makers and administrators to make informed decisions.

The challenges associated collecting these data should not be underestimated. Challenges include the mix of public and private providers; the lack of a standardized set of measures (whether clinical, process, quality measures or otherwise), the various silos created by different levels of care intensity and the various electronic platforms each post-acute provider uses. Each of these issues adds to the complexity of constructing the data needed to derive funding policies to promote efficiency and project population needs.

Conclusion

Under the current acute and post-acute funding mechanisms, there may be disincentives for discharging or transitioning the least costly patients, preventing patients who require this level of care from accessing it. This problem could be aggravated with the funding reforms in acute care currently underway in Canada (*1*). The activity-based funding (ABF) policies being implemented in some provinces will increase hospital volume; but for this to be effective, the post-acute system must have the capacity to deal with this increase in volume (*1*). Failing to do so would lead to inefficient resource utilization and, likely, an increase in alternate level of care (ALC).

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