



Canadian Federation of Nurses Unions

THE NATIONAL VOICE FOR NURSES

A Position Statement on Hospital Funding

Background

There is increasing discussion in health policy circles across the country about changing the way hospitals are funded. The Canadian Medical Association leadership, for example, is calling for a shift away from hospital block funding (or global budgets) and towards service or activity-based funding. The Standing Senate Committee on Social Affairs, Science and Technology, chaired by The Honorable Michael J.L. Kirby, in its Final Report in October 2002 recommended service-based or activity-based funding. This model is also referred to as patient-focused funding, payment by results, or payment by volume. In other words, hospitals would receive funding based on the number of patients seen and their course of treatment rather than on past expenditure.

Advocates for activity-based funding argue that global budget funding does not provide incentives for improving volume or quality of care. As a result, the argument goes, quality, access and productivity are substandard.

Hospital care is costly. Hospital costs vary significantly: a procedure in one region can cost double in another. Hospitals are often in deficit. An ongoing debate is whether hospitals are under-funded or poorly managed?ⁱ Activity-based funding advocates argue that it is the latter and that financial incentives will lead to greater transparency in hospital budgets and greater value for money. Others argue that provincial budget levels for hospital global budgets are insufficient to meet hospital rates of inflation and population growth.ⁱⁱ In Ontario, for example, base funding for hospitals is declining – from 2.4% in 2008 to 2.1% in 2009.ⁱⁱⁱ This will mean further cuts to staffing levels and clinical services.

The Ontario Hospital Association describes the limitations of global budgets as:

[F]unding inequities exist as global budgets reflect historical funding patterns and priorities; the funding formula is complex and does not capture all hospital activity; there are no clear performance targets; there is no method to determine appropriate funding levels; and ... there are data quality issues that impact the formula.^{iv}

It goes on to argue that:

Service-based funding approach will support the need to fund hospitals in recognition of the level of quality, complexity and volume of services that they provide to their communities. Under SBF, the unique attributes of hospitals are factored into funding levels. These attributes range from teaching and research status to location (rural and remote), size and, areas of specialization such as mental health, rehabilitation and complex continuing care.^v

This position statement reviews the known and suspected impacts of a shift to activity-based funding in the hospital sector in Canada on patient care and the public health system.

Possible outcomes from a shift to activity-based funding in the hospital sector

1. Increase in the volume of some procedures and a decrease in others.

Governments like this about activity-based funding as it assists them to encourage greater effort on those procedures with the longest wait times. By prioritizing some treatments over others, Dr. Postl, former federal adviser on wait times, noted that governments create "Cinderella diseases" – under-funded or often overlooked diseases that did not get invited to the ball. Performance must be measured for all aspects of hospital care however to ensure that “the balloon effect”, where progress in one area worsens performance in another, does not occur.^{vi} For example, activity-based funding to reduce emergency room waits could reduce performance in other areas of the hospitals if patients are transferred to other wards to meet ER targets.

Another danger is that high price procedures will starve out others for attention, resources and technology. In an August 2007 news release, Canadian Doctors for Medicare warned that “an overdependence on activity-based funding would also erode hospitals’ commitments to providing a full range of services to all patients.”^{vii} In an opinion piece in the French newspaper, *Le Monde Diplomatique*, three French doctors put it this way:

[ABF] is more or less adapted, or at least adaptable, to pathologies that require routine, technical acts and well-defined procedures such as radiology. However, it is not adapted and probably not adaptable to the essential activities of public hospital’s medical services (internal medicine, infectious diseases, diabetology, rheumatology, etc.)^{viii}

Some critics also argue that the focus on volume will compromise quality by encouraging hospitals to be overly cost-conscious, leading them to cut corners or shift costs onto other contributors in the care process.^{ix}

2. Some patients will be under-treated and others will be over-treated.

International experience shows that hospitals begin to select profitable patients and treatments, thereby ‘dehosting’ others.^x Establishing accurate costing for chronic disease and mental illness treatment is difficult, resulting in a concern that patients with these conditions will be under-treated. Children’s hospitals and orthopaedic services in the UK are under threat of closure as the complex work they do fails to turn a profit.^{xi} International experience also shows that patients are ‘up-coded’ in order to derive hospitals more revenue. For example, in the UK, more deliveries and C-sections are being reported as having complications since the implementation of ABF.^{xii} Similarly, the proportion of lobar, atypical or viral pneumonia episodes for treatment of patients under 70 years of age with complicating conditions have risen significantly for some hospitals using payment by results, but not for others still using block grants.^{xiii}

3. Overall costs are likely to increase.

In order to operationalize activity-based funding, huge amounts of data must be collected, and administrative costs rise significantly.^{xiv} Data collection demands are enormous in order to ensure appropriate pricing and payment. Higher monitoring costs to track activity, price negotiation and higher enforcement costs to protect against under- and over-treatment of patients are also a concern. Up-coding of diagnoses also results in higher payments and overall higher costs.^{xv}

Setting the price of treatment is difficult. If the government sets price based on the average cost of a procedure from different hospitals, then half of hospitals will be under-funded as the procedure will cost more in their setting, perhaps due to preexisting higher capital or labor costs. The risk is that hospitals with costs that exceed the tariffs for certain procedures may stop doing those procedures rather than working to improve efficiency.^{xvi}

Another risk is that governments will not be able to contain costs, especially if activity-based funding achieves its goal of increasing the volume of some procedures.^{xvii} In the UK, additional mechanisms have been introduced such as activity ceilings, two-part tariffs and demand management mechanisms to assist in cost containment.^{xviii} These systems require more oversight and administrative spending, and their effectiveness is still unproven.

4. Desired outcomes from activity-based funding are unlikely from hospitals that provide low-volume essential services such as rural and remote hospitals.
5. Proliferation of for-profit surgical centers and specialty hospitals.

Activity-based funding is designed to create competition among hospitals to treat more patients. The assumption is that patients choose where to seek treatment, and that ABF will encourage hospitals to provide better service to ‘attract’ patients. Promoters of ABF also typically advocate for an increase in the number of for-profit specialty hospitals or surgical centers that would compete with not-for-profit hospitals for government funding. However, the argument that competition among hospitals improves productivity is not grounded in evidence.^{xix} It also assumes sufficient healthcare providers for both the public not-for-profit system (which we currently do not have) and an expanded for-profit system, with increased patient volumes.^{xx} Evidence from the US and France shows that for-profit clinics are able to keep prices low in order to appear more competitive by shifting some costs to the patient, which contradicts the *Canada Health Act*, or by selecting only the patients with the least risk of complication.^{xxi} A study from France shows that in dispersal of case mix, private for-profit clinics need only about 60 diagnostic related groups to realize 80% of their activity, whereas a general public hospital needs at least 124 and university regional hospitals 200, because they do not have the constraints of public service and can refuse some patients and pathologies.^{xxii}

International experience, and even experience here in Canada shows that patient outcomes are worse in for-profit than not-for-profit facilities.^{xxiii} Evidence from the UK shows that costs are higher in for-profit clinics. A British House of Commons committee concluded in 2006 that independent sector treatment centers (ISTCs) had not improved capacity and did not offer more efficiency or better “value for money” than the public sector.^{xxiv}

CFNU Position

CFNU recognizes the strengths and weaknesses of current hospital funding models. We believe that in a single-payer system, activity-based funding will drive up costs and transfer wait times for one procedure to another for the reasons cited above.

Instead we support:

- Solving wait times through innovation in how care is provided in the public health system.^{xxv}

- Funding hospitals, at a minimum, to meet population needs recognizing staffing levels required for rising acuity, and inflation, and at the same time fund and work more effectively with other not-for-profit parts of the healthcare system, such as prevention and health promotion, primary care, home care and long-term care.^{xxvi}
- Implementing a national pharmaceutical strategy to contain drug costs. Drugs are the second highest hospital expenditure after doctors, the budget for which has more than doubled in the last eight years.^{xxvii}
- Increasing financial management, audit and oversight of hospitals^{xxviii} through means such as fiscal advisory committees made up of representatives of hospital workers and management with high levels of transparency.
- Governments must only contract with not-for-profit hospitals and clinics.
- Exploring and evaluating non-financial incentives for the improvement of quality and volume.^{xxix}
- Using targeted funding only when there are clear hospital accountabilities for the use of and reporting on the funding. Targeted funding, in addition to global budgets or block funding, could be used, for example, for health and safety or retention and recruitment initiatives.

Approved April 2009

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