Policy Statement

BCMA
BRITISH COLUMBIA MEDICAL ASSOCIATION

Activity-Based Funding

Last Updated: August 2011

BCMA Position

- *The BCMA supports, in principle, the expansion of activity-based funding in provincial health regions. Activity-based funding makes a direct link between the number of services performed and the funding of those services.*
- *The priority of activity-based funding is to improve the quality and timeliness of patient-focused care.*
- *Government must ensure that the development, implementation, and ongoing management of activity-based funding programs are achieved through a transparent, collaborative process that includes meaningful consultation with practising physicians who are representative of and accountable to the medical profession.*
- *To ensure the successful implementation of activity-based funding programs, government should:*
  - *base standards for activity-based funding programs on best practices or the best-available scientific evidence;*
  - *provide initial and ongoing support for innovations in care delivery;*
  - *allow for flexibility to provide care equitably and to reflect differences in system-level and practitioner needs.*
- *Government should work to optimize the impact of activity-based funding programs using accurate data and a clear understanding of available resources.*

Background

Activity-based funding (ABF) creates a direct link between a hospital's volume of activity and its funding. Hospitals are reimbursed at fixed rates based on the episodes of care for which patients are admitted and on the type of services or procedures performed (e.g., diagnosis-related groups). The rate usually covers the costs of care from admission of a patient to discharge. Cost overruns are the responsibility of the hospital, while cost-savings can be retained by the hospital.[i]

Proponents of ABF state that existing funding methods for hospitals (e.g., global budgets) lack incentives for increased hospital efficiency and productivity. In BC, the main funding approaches for hospitals are line-by-line and population-based.[ii]

Potential advantages of ABF include:

- Better data on the cost of services and performance measurement;
- Greater transparency and accountability;
- More equitable distribution of funds;
- Increased efficiency and performance;
- Competition between hospitals to provide the best services;
- Increased responsiveness by providers to patients' needs; and,
- Flexibility in changing volumes or patterns of work by altering the value attached to specific services.[iii]

Potential disadvantages of ABF include:

- Complexity of developing costing data and appropriate fees;
- Associated costs, which can reduce or exceed savings;
- Compromised quality of care by gaming behaviour (e.g., fraudulently placing patients in more lucrative payment categories, early discharge, patient selection);
- Uncontrolled global expenditures; and,
- Difficult implementation for rural/remote and teaching hospitals.[iv,v,vi]

Within Canada, Ontario has been using a form of ABF to carry out its Wait Time Strategy in the five priority areas of the 2004 First Ministers' Accord, and BC's Select Standing Committee on Finance and Government Services recommended in 2009 that the provincial government encourage more activity-based funding in health regions.[vii,viii]

In 2009, 85% of Canadian Medical Association delegates supported a resolution calling for more competition within the publicly funded health care system and the adoption of activity-based funding for hospitals.[ix]

Analysis

International experience suggests that the introduction of ABF can lead to an increase in hospital activity.[x] The OECD has found that countries without serious waiting times more often had ABF for hospitals compared to countries with serious waiting times.[xi] However, the OECD cautioned the need to mitigate against perverse incentives and budget overruns. Productivity gains incurred by ABF can also be temporary, as in Sweden.[xii]

A recent OECD report concluded that the introduction of market-orientated mechanisms like ABF can reduce the cost of hospital services.[xiii] The UK's ABF initiative has reduced unit costs of hospital care in the early years of implementation without a detrimental impact on the quality of care.[xiv]

Evidence from the US suggesting a negative impact on quality of care after the introduction of activity-based financing has not been reproduced for European countries adopting similar systems.[xv] However, whether these findings reflect the effects of the policy, the differences between healthcare systems, or the inadequacy of the proxies for quality remains a debatable issue.

The BC government should expand the use of ABF in provincial health regions primarily to improve the quality and timeliness of patient care. By paying hospitals for what they actually do, rather than for their anticipated needs, government can enhance their efficiency and performance. However, it is unlikely that a "pure" ABF model consisting of only activity-related payments would meet all the objectives of government and providers. Therefore, ABF funding should be flexible to accommodate differences in practitioners' needs (e.g., specialist, GP) and hospitals' size, isolation, and case-complexity, (e.g., urban vs. rural; community-based vs. academic institutions).

Successful implementation of ABF programs requires a transparent, collaborative process that incorporates meaningful consultation with practising physicians and voluntary physician participation. Government should provide initial and ongoing support for innovations in care delivery to realize cost efficiencies in hospital care.

The impact of ABF programs can be optimized using accurate, reliable costing data and methodologies, which need to be developed in BC. Efforts should be made to measure and monitor quality. A clear understanding of available resources and capacity levels by government can assist in setting realistic volume targets.

References

[i] Canadian Health Services Research Foundation. Service-Based Funding and Paying for Performance – A Briefing. (3rd Annual EXTRA CEO Forum). February 2009.

[ii] ibid.

[iii] Standing Senate Committee on Social Affairs, Science and Technology. Part II: Efficiency Measures. Chapter Two: Hospital Restructuring and Funding in Canada. In *The Health of Canadians – The Federal Role (Final Report). Volume Six: Recommendations for Reform.* 2002.

[iv] Canadian Healthcare Association. CHA's response to the principles outlined in the Standing Senate Committee on Social Affairs, Science and Technology report *Volume Five: Principles and Recommendations for Reform —Part 1.* Ottawa, 2002.

[v] Collier, R. *Activity-based hospital funding: boon or boondoggle?* CMAJ, 2008. 178(11): 1407-1408.

[vi] Association of Canadian Academic Healthcare Organizations. Presentation to the Standing Senate Committee on Social Affairs, Science and Technology. Ottawa, 2002.

[vii] Canadian Medical Association. *Patient-Focused Funding and Pay-for-Performance: A Discussion of the Concepts and Experience.* 2007.

[viii] BC Select Standing Committee on Finance and Government Services. *Report on the Budget 2010 Consultations.* Nov 2009.

[ix] Kondro, W. *Full speed ahead for CMA's transformation train.* CMAJ 2009.

[x] Miraldo, M. et al. *The Incentive Effects of Payment by Results.* London: Dr Foster Intelligence. 2006.

[xi] Hurst J, Siciliani L. *Tackling excessive waiting times for elective surgery: a comparison of policies in twelve OECD countries.* OECD Health Working Papers 6. Paris, 2003.

[xii] Street, R., et al. *Introducing activity-based financing: a review of experience in Australia, Denmark, Norway and Sweden.* Centre for Health Economics Research Paper. University of York. October 2007.

[xiii] Erlandsen, E. *Improving the efficiency of health care spending: selected evidence of hospital performance.* Economics Department Working Papers No 555. Paris, 2007.

[xiv] Farrar S., et al. *Has payments by results affected the way that English hospitals provide care? Difference-in-differences analysis.* BMJ 2009;339:b3047doi:10.1136/bmj.b047.

[xv] Dismuke CE, Guimaraes P. *Has the caveat of case-mix based payment influenced the quality of inpatient hospital care in Portugal?* Appl Econ 2002;34:1301-7.

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