MYTH: ACTIVITY-BASED FUNDING LEADS TO FOR-PROFIT HOSPITAL CARE

Humans respond fairly predictably to economic incentives. Like mice in a maze, if someone moves the cheddar, we'll probably change course. So by putting a nickel here and removing a dime there, those that determine our income can tweak our behaviours to produce specific results. At the same time, we're not always at the whim of the almighty dollar. The resourceful among us often find ways of using the payment scheme to their advantage.

In healthcare, payment schemes are always contentious. When governments start talking about new ways of funding hospitals, the costliest component of healthcare in Canada, some get wary. Activity-based funding (ABF), a scheme that pays hospitals on the basis of "activities" performed, rather than the traditional lump sum per year, is a prime example. Critics fear that ABF may be a stepping stone toward greater for-profit hospital care in Canada, may lead to rural hospital closures and could be a disincentive for hospitals to provide much-needed, but high cost per unit, care. After close inspection, the evidence and expert commentary suggest that ABF can be employed in ways that benefit patients, increase transparency and lead to more efficient use of hospital resources.

THE ABCs OF ABF

Most hospitals in Canada receive lump-sum payments called global budgets. These sums are negotiated yearly based on a hospital's previous budget and other factors. This system of payment can do a reasonable job of containing total costs, but gets poorer grades for improving access and wait times and provides little information on how money is actually spent—the kind of information that can help decision-makers use resources wisely. Critics also argue that global budgets create a disincentive to providing care and so may contribute to wait lists, as every patient through the door is a drain on the global budget.

In contrast, ABF links a cost value to each patient served and helps identify how revenues are associated with patient care. It also stimulates productivity and reduces length of hospital stays and wait times. Though it has been packaged and labelled differently in different places—for example, patient-focused funding, service-based funding or payment by results—the rationale is the same: payment based on care delivered—not historical trends—enhances accountability. But critics fear that ABF provides profit incentives for greater throughput that may compromise the quality of patient care or leave the system open to manipulation by providers.

PAVING THE PATH TO PROFITS?

There are two main objections to ABF. First, because ABF operates on a flat rate per admission (based on a patient's diagnosis), it encourages higher patient volumes and shorter patient stays, which tend to increase total hospital expenditures. Uncertainty about who stands to benefit from this greater expenditure is what leads to mythologizing. The popular notion is that providers, hospital executives and/or private shareholders pocket profits generated by lower unit cost, while patients are rushed through the system.

* For-profit, in this context, describes organizations whose net earnings are distributed among private shareholders, as opposed to being reinvested in the organization.
Let’s dispense with the easy stuff. The vast majority of hospitals in Canada are private, not-for-profit organizations, meaning any profits are reinvested to achieve hospital goals, rather than distributed among shareholders as profit or dividends. Of course, hospitals may act out of self-preservation, aiming for higher profit margins to reinvest as they see fit. So, what about those incentives for higher volume?

Since under ABF payment is fixed for each diagnosis group, hospitals turn a profit only by providing care at costs below the price reimbursed. In other words, ABF encourages high volume at low per-unit cost (relative to payment). The fear is that, if the price reimbursed is based on best practice, to make any financial gain hospitals will have to deliver sub-standard care. As one health policy analyst puts it, there is “an incentive simply to discharge patients sicker and quicker.” Despite these fears, the evidence is mixed on the quality question. Recent research suggests blending ABF with payment models that improve quality can produce desired results.

The second main objection to ABF is that it opens up the system to “gaming.” For example, with knowledge of the reimbursement price of every diagnosis group, hospitals can manipulate patient data to receive higher reimbursement for services provided. This wouldn’t necessarily threaten quality of care, but would ensure higher hospital profits. There is also evidence of risk selection (prioritizing patients whose care is low cost relative to the reimbursed price) or performing profitable procedures even if they aren’t clinically indicated. These raise important quality concerns, but can be dealt with through policies that encourage appropriate care that aligns with patients’ clinical needs. As with most policy reform, it will take time (and leadership) to iron out all the wrinkles.

CONCLUSION

While the Canadian experience with ABF is limited, it is quickly becoming the norm for funding hospitals in the developed world. Experts suggest—and international evidence agrees—that blended models are most effective. Strong incentives can encourage greater productivity with ABF, external controls can ensure high-quality care and global expenditure caps can contain total spending. The blended approach enhances hospital accountability, can encourage shorter wait times and helps ensure healthcare dollars are spent wisely.

Implemented carefully, ABF can help us win our long-fought war on wait times. Still, governments must take into account the potential for abuse and minimize threats to quality. ABF must be employed as part of a broader incentive structure aligned with quality goals—one that centres care more on the patient and less on the system. ABF is one piece of the hospital funding jigsaw, not a conspiracy in favour of for-profit healthcare.

REFERENCES

5. Canadian Institute for Health Information. (2010). Discussion Paper Activity-Based Funding Unit. Ottawa, Canada: CIHI.