Activity-based hospital funding: boon or boondoggle?

It is a health care funding model with more names than a mobster on the run. In the United Kingdom it's known as activity-based funding or payment by results. Americans call it pay for performance, P4P for short. The moniker most often attached to the concept in Canada is patient-based funding.

Canadian hospitals currently receive yearly lump sums from the government to cover operational expenses, a payment model known as block funding. Many hospitals also receive heaps of criticism about excessively long wait times, and according to some health care professionals, including Canadian Medical Association President Dr. Brian Day, the former is in large part responsible for the latter.

"There is no incentive for being productive and no reward for being efficient and getting patients treated," says Day. "In fact, there's a financial punishment for treating patients. You've got your money up front at the beginning of the year, and every patient that comes along is using up your kitty."

The remedy, says Day, is to pay hospitals per individual treated, which would make each patient a value instead of a cost. Then hospitals would have a choice: be efficient or lose money. Shorter wait times would be sure to follow. Other prominent health care stakeholders agree with Day. In his February 2008 report *Getting Our Money's Worth*, commissioned by the Quebec government to find ways to stabilize health care budgets, Claude Castonguay, former Quebec health minister, recommended that money should "follow the patient." In January 2008, New Brunswick Health Minister Mike Murphy announced his intention to move his province toward patient-based funding.

But the idea is not without its critics. Some claim paying for performance will shift focus towards increasing patient volume at the expense of quality of care; they denounce it as "American-style" medicine. And while it's true that the United States pioneered the payment-for-results funding model, in 1982, most highly developed countries now use similar systems — a notable exception being Canada.

The Organisation for Economic Co-operation and Development, which promotes democracy and financial stability throughout the world, recommends that its 30 member countries adopt market-oriented methods of funding health care. "While the health care sector is one that involves many public-spirited motives, financial incentives do nonetheless have a significant influence on outcomes; appropriate incentives can increase outputs from a given level of spending, thus ensuring that public and private funds are used effectively," declares its 2005 report *Competition in the Provision of Hospital Services.*

Most member countries had already moved in that direction anyway. Hospitals in Victoria, Australia, introduced activity-based funding in 1993. Within a decade, it accounted for about 70% of hospital revenue. Norway followed suit in 1997, and by 2006 hospitals there received 40% of their funding based on patient volume, the remaining 60% coming from traditional block grants. Denmark didn't adopt a performance-based payment model until 2000, but within 5 years it accounted for as much as 52% of total hospital funding.

The shift towards incentive-based funding has reaped rewards for some countries. Australia has seen wait times drop. So has the United Kingdom,

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Canadian Medical Association President Dr. Brian Day says empty chairs in waiting rooms will be the norm if hospital funding is activity-based.

which is still in the process of implementing a new funding system, though some experts attribute the reduction to the government's introduction of more stringent wait-time targets. Other benefits of patient-based funding include transparency, because every dollar is associated with a specific task, and fairness between hospitals, because equal work receives equal pay.

In October 2008, 4 Vancouver hospitals enrolled in a patient-based funding pilot project for emergency rooms. The hospitals received extra payments for treating patients within a specified time frame. Treating someone with a minor problem within 2 hours, or someone with a moderate injury within 4, earned the hospitals $100 bonuses. The reward for finding a bed for a major case within 10 hours was $600. The Vancouver Coastal Health Authority claims that patients seen during the project were treated 10% faster than usual.

Critics of activity-based funding say the pitfalls outweigh the benefits. Establishing an appropriate fee for each procedure is difficult, and if incentives are too low, they have little effect. Measuring the benefits of the new funding model is complicated, especially for hard-to-quantify aspects like quality of care. Implementing the new system requires more administrators and data-tracking technologies, and the associated costs may offset any efficiency savings.

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Skeptics fret that patient-based funding will result in more unnecessary but profitable procedures being performed in hospitals.

Hospitals may also tweak certain practices solely to maximize earnings, something health care researchers call gaming. This could involve artificially reducing wait times in an emergency room by not registering a patient until a doctor is available. To increase throughput, some activity-funded hospitals have been known to favour simple cases over more time-consuming complex cases, a practice known as cream skimming or risk selection. Another form of gaming is upcoding: fraudulently placing patients in more lucrative payment categories.

With momentum towards adopting payment by results building in Canada, some critics are making their objections public. In an August 2007 news release, Canadian Doctors for Medicare warned that an "over-dependence on activity-based payments would also erode hospitals' commitment to providing a full range of services to all patients and reduce efficiency through higher administrative costs." Members of the National Health Service Consultants' Association, a British organization, criticized the Canadian Medical Association's endorsement of patient-based funding. In a publicly released letter addressed to Day, they wrote: "These policies have fragmented health care, discouraged collaboration between health care professionals, and wasted money ... From our UK perspective we have tried these policies and they have proved a mistake. We urge you to learn from our experience and to reconsider."

The Canadian Healthcare Association is also wary of a pay-for-performance funding model, fearing it would emphasize greater output over better outcomes. "The key message we want to get across is quality, not quantity," says Pamela Fralick, the Ottawa-based organization's president and chief executive officer.

Some of the research into incentive-based funding has found that its overall impact is negligible. A 2005 analysis of pay for performance in the United States (*JAMA* 2005;294[14]:1788-93) resulted in the finding that "paying clinicians to reach a common, fixed performance target may produce little gain in quality for money spent and will largely reward those with higher performance at baseline." A 2007 assessment of the available evidence (*JAMA* 2007;298[15]:1797-9) led a team of health care researchers to conclude that "the adoption of P4P [pay for performance] as a health policy initiative may have been premature and does not appear to have been based on clear evidence."

Andrew Street, an assistant director with the United Kingdom's Centre for Health Economics, has conducted extensive research on activity-based funding but claims more is required to conclusively determine its merit. In an email to *CMAJ*, Street wrote: "It's hard to identify a major effect in England — mainly because it hasn't been fully implemented, partly because lots of other reforms have been implemented at the same time."

Day claims Canada can learn from, and thereby avoid, the mistakes of other countries that have implemented patient-based funding models. He also believes much of the criticism is coming from people who suffer financially under performance-based systems: doctors from inefficient hospitals, who will lose patients to superior health care providers, or those who run private clinics, where business suffers when wait times at publicly funded hospitals decrease. Many of the problems critics cite, such as hospitals' reluctance to accept complex cases, will be resolved as governments learn to set appropriate fees, says Day. "That's just simple marketing and economics."

A hybrid funding model — part block, part patient-based — might be the best choice for Canada, says Walter Wodchis, a professor of health care finance at the University of Toronto. Wodchis claims activity-based funding's primary benefit is that it allows hospitals to steer their resources to meet particular targets, such as reducing emergency room wait times. The main advantage of block funding is cost control.

"Any fee-based service allows the opportunity for providers to make more money by doing more procedures," says Wodchis, "Even if they aren't necessary." — Roger Collier, *CMAJ*

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