THE GLOBE AND MAIL

B.C. pioneers new formula for funding hospitals

European-style system forces hospitals to compete for patients by linking funding to total volume of services

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Vancouver — Globe and Mail Update Published on Monday, Apr. 12, 2010 2:20PM EDT Last updated on Monday, Apr. 12, 2010 10:37PM EDT

British Columbia is entering the brave new world of funding hospitals on the basis of patient volume and services provided, rather than simply providing them with large sums of money, regardless of performance.

By 2012-13, the first province in Canada to venture into so-called patient-focused funding hopes to have as much as 20 per cent of "eligible" acute-care spending based on the approach, which is widely practised in Europe.

"With block funding [the long-standing, current system], there is absolutely no incentive to try and do things better for the patient," Health Minister Kevin Falcon said on Monday, as he announced the government's modest first steps to embrace a system decried by some as bringing the market place into health care.

Under patient-focused funding, hospitals will compete for patients and be rewarded financially if they attract patients and do things well, Mr. Falcon explained.

"That means not funding a facility just because it exists, but funding a facility because it's doing a good job of delivering services of very high quality."

He said the plan puts B.C. in the forefront of the cross-Canada struggle to both rein in escalating health care costs and reduce patient waiting times.

"We will get improved productivity, because the system will be responding to incentives, which is what happens in the real world."

The move follows Ontario's proposal last week to tie hospital executive pay packages to performances of the facilities they head.

In B.C., a new body called the B.C. Health Services Purchasing Organization will distribute $250-million among the provinces' 23 largest hospitals over the next two years on the basis of patient-focused services.

The initial goal is to reduce waiting times for common operations, increase day surgeries to cut down on costly overnight stays, and expand a successful pilot project in hospital emergency rooms based on patient-focused funding.

If that works well, and many details need to be fleshed out, the concept will then be expanded to virtually all B.C. hospitals, with a big jump in available money.

"We can't continue to spend to maintain the status quo," Mr. Falcon declared. "That is the way of the past. It is not the way of the future."

For example, a hospital could attract business by winning a contract to provide cataract operations for a set cost. That hospital would get added money for the procedures, while other hospitals would have to make do out of their regular block funding.

A similar test project at the University of B.C. Hospital has dramatically increased the number of hip and knee replacements and reduced patient waiting lists.

Thanks to an added $171-million in targeted government cash, surgeons are doing more operations, the cost per procedure has dropped, operating time per case is down by an average of 40 minutes, and the length of patient stay has dipped to three days from 3.5.

However, veteran health policy expert Bob Evans of UBC's Centre of Health Services and Policy Research was cautious about lauding the government's landmark proposal.

He noted that ramping up the number of procedures – while the right thing to do – does not necessarily save money, and there have been lots of problems in Britain, which has had a payment-for-results system in place for its hospitals since 2003.

"Linking hospital payments to the number of patients is not necessarily a bad thing, but it is important to go slow. Don't jump in right away," Dr. Evans said. "This is an initiative with a lot of potential: potential to go well, but also potential to go badly. It will require a nimble government to closely watch how it works."

Prominent health policy consultant Stephen Lewis said there is a danger that focusing on achieving efficiencies for certain procedures will lead to less attention paid to more complicated patients, such as the frail elderly.

"Just getting more efficient in a technical sense – lower unit costs – is important, but not the whole story."

NDP health critic Adrian Dix lambasted the concept, charging that it will increase hospital bureaucracy and administrative costs.

"They are planning to take 20 per cent of the acute-care budget from existing health authorities and then give it back to them through a new bureaucratic organization, rather than focusing on improving health care on the ground," Mr. Dix said.

"What we have here is the minister trying to impose market conditions on a hospital system that actually works far more efficiently than most other elements of the health-care system."