

Answers to Questions from Plenary (by Les)

Are there examples of activity based funding initiatives that incorporate a quality/outcome component (Les)?

Yes. The whole framework of ABF is built around quality. First of all, timeliness is one of the 6 definitions of Quality identified by the Institute of Medicine in their seminal paper "Crossing the Quality Chasm". So is "Patient Centredness". Activity Based funding specifically targets wait times and access, and places the patient at the centre of the Value system. These in themselves are big steps forward in Quality. ABF also inherently rewards quality because of the common pricing which forces people to learn from best practices elsewhere. Other aspects here in BC: the inappropriate boarding of admitted patients in our Emergency departments is a very specific target of our incentive structure, designed to correct the obstruction and delay at triage for new patients arriving in the ER, not to mention what is clearly suboptimal care for these patients in the first place. We have other measures in the works, but as I said at the session, we are taking care to make sure they are carefully designed so as to avoid unintended results.

How can you have robust patient-focused funding without a fully integrated electronic health record (Les and Jason)?

A fully integrated electronic health record would be wonderful. So would Santa Claus. First of all, the fully integrated version is a long way from reality and if we continue on the path we are on, we may never actually get there. Secondly, we already have more information than we know how to use and actually in BC (partly due to the pharmaNet advantage) we have most of what is needed already in place. Thirdly, I don't believe it's one before the other. Both have to be developed and made workable at the same time and the sooner we start, the faster we will learn how to do it.

With regard to "Thinking Different" and a private sector paradigm. What role should the BCMA and MSP play in setting physician's fee for service (Les and Mark)?

If you are talking about fees for non-MSP work, the BCMA already has a fee schedule for that. It doesn't get a lot of press, but they do.

How does the private sector respond to complex cases (share the load) given there is a public system available as well (panel)?

I don't pretend to have all the answers on this, but I do think that cooperation between the two sectors seems to work very well in every other area of health care aside from hospitals, and it is better than a turf war. Having said that, the exact nature of the cooperation needs to be worked out. I don't believe private care will ever supplant public

care, at least I hope not, but things work best when each stays within its area of natural strength, respects the role that the other plays and the experience for patients is seamless. There is a role for government to protect the public interest but good legislation ideally should also reflect that cooperation at the same time.

Private facilities are all staffed by publicly educated staff. Can you comment on how this is justifiable in terms of competing for limited resources?

So are dentists, teachers, accountants, musicians, and just about anyone else you can name. Besides, the “limited resources” reflects a misunderstanding of how shortages are created in the first place. Our so-called shortages are a reflection of how we have chosen to use (or not use) these staff in the first place. If we lay off nurses for long enough, they will go away and if we then decide we needed them after all, we will have a “shortage”. If we decide to pay them, (or perhaps pay someone else to do some of that work) then they will be there. The turn-around doesn’t happen overnight, but it does happen.

How does HSPO encourage "activity based funding" in new and innovative areas?

There is no magic formula for innovation. We study other jurisdictions, we study our own past, we ask some hard questions and try some things out that look promising. Usually we hedge our bets with new things in case they need fine-tuning or don’t work out, but if they do then we try to expand on the things that are working. In general innovation is less about big ideas and more about getting the details right.

Doesn't Canada Health Care Act reduce funding to province in direct proportion to private healthcare money earned dollar for dollar? If so, how does province reconcile this shortfall due to privatized healthcare? (Mark and Les)

Mark can speak to some of this but the question shows how bad the understanding is out there, about what private health care means, and what the Canada Health Act actually says. First of all, there is nothing in our activity based funding here in BC that involves “private” healthcare. We don’t pay private facilities. HSPO funds the Health Authorities, and if Health Authorities decide to subcontract some of the work, or rent space in a private building or lease some needed equipment, or hire part time staff, that is their business. It also does not constitute private healthcare as defined in the Canada Health Act because the HA is still providing “public administration”. If it were otherwise, BC would have to close 90% of our laboratories, all of our pharmacies, all of our physiotherapists, and most of our Xray imaging facilities and all of our doctors’ offices. And that would be only the start of it.

Directed to Mark for further comments! Your comments are upside down. What a deal! Physicians can keep driving volumes. They diagnose, they refer, they cause the waitlist. No appropriateness filter. No outcome measure. Then physicians get the hospital to cover all their overhead costs and hold no business risk. They admit. They discharge. Hospitals don't drive costs physicians do. The funding reform needed is on fee for service MSP system. Your comments.

I don't disagree with the need for MSP reform, but there are a lot of missing information contained in the statement that forms this question. Yes, doctors diagnose and they admit and they discharge. Who would you prefer did that instead? As for 'driving volumes', that would be true if the facilities were unlimited, but they are absolutely not. In fact, facility space & capacity are the major bottlenecks created by government to prevent that from happening. As for the statement about 'no appropriateness filter', there are actually tons of filters inside the medical profession called "indications" which have become pretty standardized. It doesn't take much to check and see who is following accepted indications and who is not, but that is rarely done by any governing bodies (outside of the College but they largely deal only with complaints). Instead, we have had a passive assumption that patients who are prepared to wait a long time have passed some kind of appropriateness test and must really need the procedure. I don't believe that was ever a reasonable test of anything to do with appropriateness.

To summarize a long complex question, doctors do have filters in place that are used every day but don't get a lot of press, and they are certainly constrained by the supply of public facilities from going full bore on whatever they might like to do. Should there be an additional appropriateness check by the ones paying the bills? Absolutely yes, but the method of payment doesn't change that. It has always been there and if anything will be easier to do once we bring the size of the waitlist down to tolerable levels.

Aren't the private facilities conflicted? If waitlists go down they lose business...

Yes, private facilities would benefit if they withdrew from helping the public system and watched waitlists skyrocket. By the same thinking, Ford motor company would also benefit by withholding their products from consumers, thereby letting demand hit the roof and then they could raise their prices. If you can answer the 2nd question, then you can also answer the first.

I would like to hear some discussion on why activity-based funding for hospital services would be a good idea, when we have experience with the physician fee-for-service payment system, which has many issues, such as rewarding volume rather than quality, encouraging physicians to "pick and choose" from a menu rather than providing comprehensive care, provision of inappropriate services, not providing services which are seen as paying poorly, etc.

I get this question all the time. Doctors get paid by FFS which is a form of activity based funding, and that hasn't gone so well, so why are we taking the hospitals there? The answer is that if we instituted ABF the same way we did doctors fees 30 years ago, paying them by the number of services they do without looking at what services we actually want, and to boot we also let them decide how to internally reallocate their own fees, we would get the same result. We don't intend to do that. ABF in hospitals pays for services, but we (the payer that is) defines what constitutes a "service", what services get included, what the quality parameters will be and which services get paid at preferred rates. In short, this time it is government (the payer) who is keeping control of both the gas pedal and the steering wheel. Maybe if we had done that with doctors' fees in the first place, we would have got a different result.