

Hospital funding plan could open the door to privatized care

Increased competition won't improve efficiency if it ends up destabilizing the health-care system

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Last week's Speech from the Throne made public what had been previously rumoured: Ontario is poised to fundamentally change the way it pays hospitals.

The government asserts that the proposed changes facilitate the government's quality agenda.

But critics claim that these changes will facilitate the privatization of the system. What policy is the government planning and will it be medicare's salvation or destruction?

Currently, Ontario hospitals are largely paid through global budgets. Hospitals receive a fixed sum to manage all their functions and funding increments are added to this base. Over time, the province has developed targeted funding envelopes for specialized services such as cardiac care and dialysis.

The current model has its problems. There is little factoring for the health needs of the population served.

Fast-growing areas of the GTA have complained that there isn't enough adjustment for the increased numbers of people living in outlying areas. Other areas complain there is no adjustment for the age of the population or low education or income, all factors that increase illness and health-care utilization.

The throne speech announced that the government would be implementing activity-based funding for hospitals. Hospitals would be reimbursed for each patient they treated on the basis of the diagnostic group in which that patient was classified.

The Ontario wait-time strategy used a variant of this model to reduce delays for targeted procedures (cataracts, hip and knee replacements) over the last five years. As the hospitals got more efficient, the province decreased the per-case rates with the goal of eventually folding the funding into the hospitals' global budgets.

Ontario has reduced wait times for these procedures and this success has encouraged those within the government who wanted to spread these changes to the rest of hospital funding.

However, the devil is in the details for new funding policies. And perhaps we've seen this movie before in Ontario.

In the late 1980s Ontario applied activity-based funding for a small portion of overall hospital funding. Administrators pressured staff to discharge postpartum mothers and their newborns first because they were designated for the lowest payment. Hospitals cut their length of stay by 40 per

cent. As unprepared mothers went home early to inadequate community services, the readmission rate for newborns surged by 60 per cent. In other jurisdictions where community services were deployed, the readmission rates stayed the same.

This cautionary tale highlights some of the questions Ontarians should be considering as the province rolls out its new funding scheme.

First, the province should be clear about the purpose of the reform. Is the goal to recoup billions to pay down the deficit, as has been suggested by some media stories? Or is the goal to reallocate dollars to desperately needed community services?

The throne speech suggested that the new policies would offer more choice of where to receive care but Ontarians already have the right to seek care anywhere in the province. What would happen to hospitals that couldn't compete effectively? Would they close their doors? What would happen to their other programs like emergency services? Would there be special protection for rural and remote facilities?

A recent review of similar reforms in Britain has concluded that increased competition destabilized many hospitals in that country while not contributing to faster access to care.

I don't believe the McGuinty government wants to promote the development of private for-profit clinics to perform more medicare-covered procedures. But that is one of the aims of similar proposals in Alberta and British Columbia. And developing an infrastructure for activity-based funding would provide Conservative Leader Tim Hudak with a turnkey policy to privatize big chunks of Ontario's health system if he ever becomes premier.

Finally, what about the impact on health-care workers? What happens to the nurses and other staff who are laid off? What will happen to the doctors who lose their operating rooms? Will they get work in the hospitals that successfully attracted their patients?

The 2001 U.S. National Institute of Medicine bible of health reform, *Crossing the Quality Chasm*, specifically warns of major reorganizations with their inherent risk of serious side effects.

Ontario hospitals are already very efficient. Some, like the University Health Network and Trillium Health Centre, are international leaders in quality and efficiency.

The premier should clarify why the province is considering such a potentially disruptive competitive strategy when the available alternative is to cooperatively spread these exemplary best practices.

Dr. Michael Rachlis is a health policy analyst and an associate professor at the University of Toronto.