Intelligence MEMOS

From: Will Falk

To: Christine Elliot, Ontario Minister of Health

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Re: Hallway Medicine and Value-based Funding

Talk of hallway medicine has drawn an image of people needlessly suffering because of an ill-organized and poorly funded non-system that puts institutional interests above patients. This image has defined the problem to be addressed.

Previous approaches tinkered with incremental change while allowing profound problems with our funding systems and payment models to linger and, in some cases, worsen. Ontario's contract dispute with its doctors, ongoing since 2014, is one of the most public examples. Health system participants know that dispute is a symptom of the underlying systemic flaws in the funding of care in Ontario.

Fundamentally, the payment system is too complex and incoherent. This often creates perverse incentives and makes it difficult for policymakers to achieve desired outcomes. The current acute care non-system includes an alphabet soup of HBAM, QBP, PPP, ICC, HQO, CCO, and POC. This problem calls for a radical simplification and a fresh, fundamental idealism about how we pay for value in our healthcare system.

Value-based funding pays healthcare providers for outcomes, not for each siloed service individually. For many well-defined treatment protocols in acute settings, it does this by establishing a known price based on current costs and allowing providers flexibility on how they deliver the service. The price is based on historic costs ("ABC or activity-based costing"). The innovative hospital with costs below the ABC price has more money for other things, which serves as an incentive to improve care and innovate, and in the long run the price can come down.

Under a version of this model, hip and knee joint replacement surgeries have become much less costly in Ontario. Length of stay, operating room time, and the costs of prosthetics have all been reduced by a third or more. Several Toronto hospitals are now experimenting with same-day surgery. The bundled price of $8,600 for knees and $9,600 for hips includes patient care outside the hospital when they return home and a readmission guarantee for 90 days. By comparison, both hip and knee replacements are priced at US$11,000 to US$70,000 in U.S. hospitals.

A natural extension of value-based care is "Bundled Funding." In this model, the price covers several types of service that often include a well-defined acute care stay and may also include home care or a stay in a rehabilitation centre. This bundle may include professional fees, drugs and devices. This model fits in well with another current idea; the Hospital Hub, which allows a core hospital to hold the funds for all the providers across the continuum of required care and pay for these other services. Once again, this model allows for innovation and competition. Ontario did experiment with this model through the ICC pilots that promote integrated and coordinated care.

Models for value-based care in home care, nursing homes and long-term care facilities have also been developed internationally. Australia is experimenting with giving a needs-based allocation to individuals and their family to spend and allow top ups by these individuals. The Dutch have created the "Buurtzog" model where neighbourhoods are treated as the unit of responsibility for the care team. In each case, the amount funded can be used in a way that best meets the needs of the patient – and keeps them out of hallways.

Value-based care for complex chronic conditions is more difficult, but here again we have some relevant experience to build upon. The successful system for funding chronic kidney diseases and the ICC pilots have shown promise.

Value-based funding allows an expansion of the players competing in the market and the introduction of new private capital into the system. Large Canadian grocery chains, telcos, distributors and insurers have all created major healthcare operations and want to expand those delivery systems. Private competition could be an important source of new capital investment and innovation.

The government and its new review commission should leverage market forces to improve healthcare efficiency and address hallway medicine. Competition based on value for money will allow the Ontario health system to do more with less. This is a tough message for several healthcare groups in Ontario which have operated in protected markets and/or have seen their income skyrocket as innovation has dropped their costs but not the prices charged. Competition and innovation are essential to restoring balance in our healthcare system.

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