PROTECTING ACCESS AND QUALITY IN OUR HEALTH CARE SYSTEM:

ADVICE TO GOVERNMENT ON FUNDING AND CAPACITY PLANNING POLICY IN ONTARIO

FEBRUARY 2009

OACCAC ACASCO
Ontario Association of Community Care Access Centres
Association des Centres d'accès aux soins communautaires de l'Ontario

Ontario Federation of Community Mental Health and Addiction Programs
Sharing Resources, Exploring Common Issues

Celebrating 50 Years of Leadership in Long Term Care
50 Years
OLTCA
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ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

OHA ONTARIO HOSPITAL ASSOCIATION

Preface

Ontario's health care system is on a new path with the current *Transformation*. While the gains to be had are many, so are the challenges. Success demands teamwork at all levels of the system and insight from different vantage points.

As a group of provider associations committed to building a better health care system, we believe that our perspective on current issues and challenges offers an important contribution to Ontario's changing system.

Together, we represent:

- The Ontario Association of Community Care Access Centres (OACCAC);
- The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS);
- The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP);
- The Ontario Hospital Association (OHA) and;
- The Ontario Long Term Care Association (OLTCA).

This report offers our advice to the Ministry of Health and Long-Term care on two key enablers of successful system transformation: funding policy and capacity planning policy in the new LHIN environment. We believe that clear and explicit policy and action in these two important areas will strengthen *Transformation* efforts, facilitate quality and better access to care and continue to foster efficiency throughout the system.

Introduction

Tremendous change is underway in Ontario's health care system. Under the Government of Ontario's *Transformation Agenda*, the Ministry of Health and Long-Term Care (MOHLTC), fourteen Local Health Integration Networks (LHINs) and hundreds of health service providers (HSPs) are striving to adapt to a new environment. Roles are changing, new relationships are forming, and expectations are continually adjusting to uncertain conditions. As this process evolves, a heightened level of anxiety is being felt by many in the system.

High quality, accessible and efficient health care—key goals of the current reforms—are of paramount concern. These goals can only be achieved through purposeful, proactive and coordinated means. While system integration and local-level management, through LHINs, are instruments to support these goals, provincial-level policy is critically important in providing the direction and structure necessary for success. As Steward of the system, the MOHLTC has a major responsibility to ensure that two fundamental enablers of quality, access and efficiency are in place:

- The development of standard, province-wide funding arrangements for the health services providers who are funded through LHINs; and
- The establishment of a provincial health care capacity planning framework.

Ontario currently lacks formal funding policies for the LHIN-funded health services providers. With the creation of LHINs, a two-stage process of distributing funding to providers now exists. While the Ministry has developed a methodology (the Health-Based Allocation Model or "HBAM") for determining LHIN budgets, it is not clear whether and how it would be used to assist LHINs in distributing funding shares to individual providers in an effective, systematic manner. Beginning April 2010, without further direction from the Ministry, each LHIN will have discretion for determining funding criteria and funding methodologies for providers within their boundaries. Negotiations in preparation for April 2010 will begin mid-2009.

Ontario also lacks a forward-looking provincial health care planning framework. Such a framework is necessary to: properly forecast future heath services requirements; ensure that the necessary system capacity exists to meet those needs and; realistically determine the overall size of the provincial health care budget. LHINs are now making critical decisions about the types and volumes of services to be provided within their respective geographic areas. Without a planning framework, these decisions are being made in the absence of consistent service-level benchmarks (e.g. per capita service volumes), without coordination across LHINs and within a health system budget that does not adequately reflect needs.

There is significant unease that these funding and planning "policy voids" allow for substantial variation in funding practices and service levels across the province. With providers being funded in an inconsistent manner, and with no planning framework to guide the LHINs, there is a substantial risk that quality of care and access to the most appropriate type of care could vary across and within LHINs to a degree that is unacceptable to both consumers and government. The chances are also high that the efficiencies the Ontario system has enjoyed in recent years, over other provinces in Canada, will begin to diminish.

In this new "insurer-purchaser-provider" environment, the Ministry as insurer is obligated to define the level of access to services and the level of quality that is expected to be provided in Ontario. In addition, the Ministry has a responsibility to ensure that access is equitable and that quality is consistent throughout the province. In helping to foster consistently high levels of quality, access and efficiency throughout the province, this report offers recommendations to the MOHLTC concerning: the need to employ a standard framework for funding health service providers and the need to incorporate capacity planning into the provincial health budgeting process.

A Standard Framework for Funding Health Service Providers

The importance of funding policy to system reform cannot be overstated—it can make or break transformation efforts. Throughout the world, health care reform typically involves re-designing the funding systems and methods that are used to share out resources. The power of funding systems in enabling or impeding success stems from the incentives and disincentives embedded within them. Financial "carrots and sticks" play a large role in driving behaviour, actions and decisions of players within the system, towards quality, access and efficiency. Carefully designed funding methodologies are key to "getting it right"; achieving goals while avoiding unintended consequences.

<u>The Current Situation</u>

Under LHINs, previous funding arrangements have or will be fundamentally changed for hospitals, long-term care facilities and community-based providers including Community Care Access Centres (CCACs), Community Health Centres (CHCs), community mental health and addictions services and community support services. Service Accountability Agreements between LHINs and service providers, which specify service volumes and funding amounts, are being phased in gradually, by service sector. Hospital Service Accountability Agreements (H-SAAs) were negotiated with LHINs for the 2008/09 and 2009/10 fiscal years. Currently, agreements are being negotiated directly between LHINs and the community-based providers for the 2009/10 and 2010/11 years. Agreements between LHINs and long-term care providers will be negotiated effective April 1, 2010. These agreements are referred to as Multi-Sectoral Service Accountability Agreements or M-SAAs.

Prior to the current negotiations already in progress, and the upcoming negotiations for 2010/11 and 2011/12 (to begin mid-2009), most funding and some service levels in the agreements have been calculated and expressly specified by the MOHLTC, reflecting a more co-ordinated, province-wide approach. The MOHLTC has been in a position to ensure that funding levels take into account the "big picture". In the case of hospitals, for example, funding levels have been determined largely by way of across-the-board funding (with the hospital funding formula playing a relatively small role) and a component of ad-hoc funding allocations. For other HSPs, such as long-term care providers, funding allocations have been specified in the *Ministry-LHIN* Accountability Agreements (MLAAs) largely in accordance with an existing funding methodology. Long-Term Care funding uses a per-diem methodology while CCAC funding has historically been a mix of across-the-board funding increases and allocations based on an equity funding formula. In the community mental health and addictions sector, funding is based on

transfer payment agreements between the Ministry and service providers by way of budgets for specific programs. These providers may receive several budgets for different programs offered and in some cases budgets involve detailed line-by-line funding.

The current and subsequent rounds of negotiations with HSPs, will see LHINs independently determining each service provider's funding allocations, where not otherwise specified in the MLAA. Due to a lack of a prescribed provider funding methodology, there is considerable uncertainty and anxiety about how these allocations, rates and service volumes will be decided. If provider funding levels are determined by each LHIN, potentially on a case-by-case basis, there is a real risk that funding variability will cause instability throughout the system, impacting both access and quality. In addition, funding variability could negatively impact the cost effectiveness of the health care system through reactive, variable investments in less effective or higher cost services.

The crux of the issue is that the SAAs between LHINs and providers inadvertently create "prices" or "rates" for individual health services which vary from agreement to agreement. Specifically, SAAs stipulate each provider's total budget allocation and the volume of services that are expected to be provided. What is not specified, but which occurs by "default" is the price or rate for a "unit" of service. For example, the current funding formula under SAAs is essentially as follows:

Total Budget =	**(Volume of Service) X**	**(Price or Rate per Unit of Service)**
↓	↓	↓
Fixed Amount	**Fixed Amount**	**"Default" Amount**
(Negotiated and specified in the SAA)	(Negotiated and specified in the SAA)	(Results from the prior calculation of Total Budget and Volume of Service)

With each LHIN's SAAs independently specifying total budget and volumes, different default pricing will occur across the province. The problem is that providers cannot offer similar services with similar quality levels under different pricing schemes. As a result, providers will be forced to sacrifice a level of quality to continue to provide a certain service volume, and/or will be forced to discontinue certain services. This will occur in a random, reactionary manner, unplanned by government and the MOHLTC. [1]

These quality and access issues are exacerbated in an environment of challenging budget pressures and a continued "uneven playing" field with respect to provider revenues and costs. Throughout the system, both within and across sectors, providers have vastly different capacities to generate revenue from non-Ministry sources. A long-standing issue for hospitals is the discrepancy in the ability to generate non-Ministry revenue[2] (e.g. parking revenue is more easily generated in downtown Toronto than in a rural location). This issue extends beyond the hospital

[1] A current example exists in the case of the CCACs in which the primary mechanism for determining service costs is through competition or negotiations that set a rate for a service unit based largely on quality and market pressures. While the quality standards are set, the challenge has been to maintain service volumes within a fixed allocation.

[2] In the hospital sector, on average, 14% of total operating revenue comes from non-Ministry sources. However, the percentage varies substantially between individual hospitals. Across LHINs, the figure varies from a low of 9.9% to a high of 17.7% (Source: MOHLTC Healthcare Indicator Tool).

sector to other providers, some of whom have virtually no ability to generate non-Ministry revenue.

There are also significant inconsistencies in allowances for different types of providers to carry over budget surpluses from year to year (allowing this would provide an additional incentive to find efficiencies) and there are considerable differences in practices regarding in-year funding adjustments. Moreover, significant differences in wages paid for specified job categories, within and across sectors also contribute to the variable financial situation of providers. Within a single sector, for example, some long-term care facilities are required to pay higher wage rates than other facilities due to different labour agreements, while the per-diem funding rates remain the same. Wage and benefit differentials also put some sectors and individual organizations at a disadvantage in recruiting and retaining staff. This is a particular challenge across the community sector. Fund raising and other revenue sources such as co-payments are used to maintain community programs as the Ministry's share of program funding has not been able to keep pace with demand.

With a system of variable rates, the uneven playing field becomes even more so. As well as creating instability, this situation reflects mis-aligned incentives that oppose or negate those which create efficiencies. This funding approach effectively brings in a form of price competition which by itself becomes a significant factor in determining whether services are provided, where services are located and the level of quality, rather than conscious, planned, rational decisions.

Proposed Solution: Service-Based Funding for Health Services Providers

Service-based Funding is our recommended approach to funding providers.[3] [4] SBF is effectively used in a number of specific areas in Ontario for: Wait Times funding, Provincial Programs funding, hospital Post-Construction Operating Plan funding and in Long-Term Care with its per-diem Ministry funding.

SBF is a *true* "rate times volume" approach in which funding is allocated based directly on the volume and rate of services offered. The funding equation is driven by a standardized rate and planned service volumes:

Total Budget =	**(Volume of Service) X**	**(Price or Rate per Unit of Service)**
↓	↓	↓
Planned Amount (Negotiated and specified in the SAA)	**Planned Amount** (Negotiated and specified in the SAA. Impacted by standardized rates.)	**Fixed Amount** (Pre-determined through a Provincial Rate-Setting Process)

[3] The term "Service-Based Funding" was coined in the October 2002 Final Report of the Kirby Committee (Standing Senate Committee on Social Affairs, Science and Technology).
See: http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm

[4] SBF has been more fully described in two previous OHA reports: *Advancing Accountability through Hospital Funding Reform, 2004* and *Shaping the Future through Funding Strategies, 2007*.

Total budget would be specified in Service Accountability Agreements. Service volumes would be determined through detailed planning and in consideration of total budget and rates. Rates would be determined by way of appropriate, validated case-mix measurement systems which reflect resource use for categories of patients and clients, for a given level of quality and efficiency.

Depending on the service sector and service type, rates would be expressed per-diem, per-case, per-visit, etc. Rates would be further fine-tuned using adjustment factors to reflect differences in provider cost structures that are beyond the control of the organization and that are not captured in the case-mix measurement system. Adjustment factors adjust rates up or down according to such factors as institution size or type (reflecting economies or diseconomies of scale), rural or remote location, for example.

On its own, SBF promotes efficiency as it creates clear incentives for organizations to keep actual unit *costs* in line with the reimbursed unit *rates.* In combination with the accountability agreements which promote overall cost-containment by specifying total budget amounts, SBF further advances efficiencies.

Given an available budget, given provincially set rates (established at levels to ensure acceptable quality and to encourage efficiency) and given critical planning and forecasting information, informed decisions about service types, volumes and configurations can be made. With SBF, government can determine and know both the quantity and quality of services LHINs can buy for the government allocations they receive. Standardized rates will factor into the decision about how much LHINs can buy.

Planning within the Provincial Health Care Budgeting Process

A provincial capacity planning framework is as important to access, quality and efficiency as the choice of funding mechanism. At the macro level, system-wide, comprehensive capacity planning enables the proper sizing of the overall funding "pie"—as opposed to its distribution—and the setting of standardized service levels across the province. At the micro level, planning enables appropriate configuration and distribution of services within a locale. A provincial planning framework to ensure that the available supply of health services is matched to the projected need constitutes a proactive approach to managing the system.

<u>The Current Situation:</u>

For the past several years, Ontario's health care system has been operating without such a cohesive, systemic, provincial capacity planning framework. No obvious planning tool has been in use since the development of the methodology to allocate 20,000 long-term care beds in the early part of the decade. While the demand for services has changed, often in predictable ways (as is the case with demographic shifts), providers in every sector have strived to adapt and meet demand within existing and often insufficient capacity. This situation has posed significant challenges for people in need of care, providers, government and will now challenge LHINs.

Over time, the unmeasured gap in services has contributed to reduced access, increased wait times and bottlenecks throughout the system. Lack of sizing and planning in one sector of the system affects other sectors. For example, insufficient capacity in the long-term care and home care sectors, has contributed to serious barriers in accessing acute care in hospitals due to high Alternate Level of Care (ALC) rates. While the Ministry has implemented strategies such as the Wait Times initiative, the Aging at Home Strategy and the ALC strategy to address demand issues in specific areas, serious challenges remain. In addition, there is huge variability, limited access and the lack of a framework to appropriately determine the needed capacity for other key services or residential options, particularly supportive housing for the elderly and people with physical disabilities and for a range of mental health services and supports.

The development of multi-year funding arrangements for providers (initially for hospitals), is an attempt to be more proactive, to improve predictability and stability in the system. Multi-year funding was intended to assist providers in improved management through better financial certainty. Efforts to achieve multi-year agreements have been undermined however, due to the absence of a good capacity planning framework that realistically projects future service need and service capacity. In the hospital sector for example, with the 2008/09 and 2009/10 H-SAA process, lack of planning has made it impossible to meet the terms of a two-year agreement. Instead, hospitals and LHINs have signed what virtually amount to one-year agreements.

Given government's desire to maintain existing levels of service and quality, its decisions about the sizing of the "pie" remain unrealistic. Foreseeable yet unacknowledged cost pressures have caused year-end funding investments to continue to be required, in order to avoid unwanted and unplanned reductions in service. In recent years, the Ontario government has had the financial flexibility to address funding shortfalls in targeted areas. This ability is now less certain, under current economic conditions. Regardless, annual, incremental increases cannot continue to be met, in the absence of proper capacity planning.

With LHINs actively working to ensure that service levels fit within their allocated budgets, without the aid of any type of provincial service level benchmarks or guidelines based upon evidence or best practices, there is a high risk that serious gaps in services, uneven access and quality will occur. In addition, because people often cross LHIN boundaries to receive care, local capacity decisions made in accountability agreements between LHINs and providers, absent any capacity benchmarks, may lead to uneven access in other LHINs.

<u>Proposed Solution: Development of a Provincial Health Care Capacity Planning Framework</u>

Our recommended approach to address growing issues related to system capacity and funding, and lack of coordination across LHINs is to develop a provincial health care capacity planning framework. A capacity planning framework would involve:

- forecasting prime drivers of utilization and related costs;
- considering best practices from other jurisdictions to optimize quality and costs;
- establishing service-level utilization benchmarks for use by LHINs; and
- forecasting supply-side capacity and related costs.

Major drivers of health care utilization, health care supply, and related costs are largely stable and predictable. These factors include, but are not limited to: demographic profile and demographic change (population growth and aging); supply of health human resources; price inflation; Ministry-imposed requirements for new programs; and diffusion of new medical technologies and treatments, including drugs. Moreover, capacity modelling can also incorporate best practices from other jurisdictions that optimize quality and cost.

Demographic modelling and forecasting is essential to the demand side of the planning process and is a standard, relatively straight-forward planning exercise. Supply side capacity planning depends on measuring "need" as estimated through the demand modelling process, as well as the establishment of population-based service volume benchmarks or "targets" based upon best or effective practices as may have been experienced in other jurisdictions.

These benchmarks could be developed at varying levels of detail for each service sector in the system. By way of a simplistic example, at a high level, hospital service volumes could be established as a set number of acute care beds per 1,000 people, with appropriate adjustments for demographic and health status profiles. More detailed measures would establish service volumes in terms of volumes of particular "cases" by type of case, per capita. Community services, long-term care, home care and mental heath services would have sector-specific benchmarks such as number of beds and number of specific service types for identified population groups. Under the provincial planning framework, benchmark service levels would be applicable across LHINs.

In addition, a provincial capacity planning framework could be used to establish required funding levels for the system. Funding limitations will always exist. However, a planning framework that enables realistic projections to be made will allow for conscious, planned decisions to be taken about how to organize the system, allocate resources, achieve efficiencies and deliver services.

Recommendations

To ensure consistent, appropriate levels of access and quality of care across the province, and to encourage efficiency, we recommend that the MOHLTC:

1. Commit now, to establishing a "rate and volume" service-based funding system for the allocation of operating funding to providers who are funded through LHINs.

2. Develop specific service-based funding methodologies directly in partnership with providers through a transparent forum, which also addresses issues related to differentials and inconsistencies in the following areas:

    a. non-Ministry revenue generation;
    b. ability to carry over a year-end budget surplus;
    c. in-year funding adjustments; and
    d. compensation rates.

3. Ensure that service-based funding rates be set and annually adjusted in accordance with:

    a. government's desired levels of quality;
    b. incentives for improved efficiency;
    c. price inflation pressures;
    d. diffusion of new technologies including those used directly in clinical practice and those which are supporting technologies such as eHealth; and
    e. appropriate adjustment factors to reflect differences in provider cost structures.

4. Develop a provincial health care capacity planning framework that provides:

    a. provincial and LHIN-level utilization benchmarks (e.g. service volumes per capita or per other appropriately adjusted population-based measure) based upon best practices from other jurisdictions;
    b. forecasts of future health services volume requirements;
    c. provincial expenditure levels reflective of service volume requirements.

Conclusion

Despite our health care system's complex interconnections, it has operated in a fragmented, sub-optimal manner. In response, the government has put forward a *Transformation Agenda* with the aim of reform through integration and local-level management. In order to achieve a better and truly integrated system however, the Ministry as Steward, must ensure that a balance is struck between supporting LHINs' autonomy and setting province-wide policies and standards.

While uncertainty abounds, Ontario's healthcare providers will continue to do their utmost to provide the best care possible, within available resources. Provincial policies to protect access and quality of care and provide incentives for efficiency include consistent provider funding methods, namely service-based funding and a provincial health care capacity planning framework.