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**“ACTIVITY BASED FUNDING”\*  
PRESENTED TO THE 3<sup>RD</sup> ANNUAL MEDICAL STUDENTS’  
ASSOCIATION’S HEALTH POLICY SYMPOSIUM**

**LIBIN THEATRE, HEALTH SCIENCES CENTRE  
FOOTHILLS MEDICAL COMPLEX**

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When you think about it, there are a limited number of ways to fund a hospital, a nursing home, a supported living facility. You can fund them on the basis of what you gave them last year, plus or minus a bit. This is the most common approach we have here in Alberta. You can fund them based on whether you like them, or like their politics, or their hair colour, or whether they are good negotiators. Or you fund them based somehow on what they do, how many people they look after, what sort of people they are and so on.

It is this latter approach that we want to move forward in Alberta. We are calling it Activity Based Funding. i.e. funding to a service based on its activity. It's that simple.

Once you have the concept, there are all sorts of bells and whistles, all sorts of rhetoric that can apply, like 'the money following the patient', but which bells and whistles you adopt is a choice. Here in Alberta we are still at the early stages and we've only made a few of the choices.

One prerequisite for activity based funding is a fair way of describing activity.

Developments over the last 30 years, for example, have advanced the science of how to describe hospital care. A way of standardising for hospital 'casemix', or the differences between patients with more or less complex conditions, is therefore required so that hospitals can be held accountable for efficiency variations in how they treat similar patients. One of the key advances in health economics and health services research over the last few decades has been the development of Diagnosis Related Groups (DRGs) called in Canada, Case Mix Groups (CMGs). DRGs and CMGs are ways of describing the inpatient activity of hospitals. Because of their design characteristics, in particular patients in the same DRG are expected to consume similar amounts of resources, DRGs can be used to standardise for differences in the casemix of hospitals to allow comparisons of hospital efficiency and for payment purposes.

Under 'casemix funding' or activity based funding as we are calling it here in Alberta, Alberta Health Services corporately would assume the risk for cost variations caused by variations in the number and type of patients treated, by setting differential prices for different types of patients and allowing budgets to vary somewhat with volume of patients treated. Each hospital or other funded entity therefore becomes more clearly accountable for variations in the efficiency of the services it provides.

Hospital payment should include incentives on hospital management to provide appropriate care efficiently. Hospitals should assume responsibility for the number of days of stay and number of services provided (pathology tests, nursing interventions), as well as the costs of each day of stay and of each service.

Similar arguments apply to seniors' care, but with different approaches to defining activity.

Once it becomes possible to identify the services that a hospital or a seniors' facility supplies, it immediately begs the question as to whether you should use these metrics to pay for those services. Funding on the basis of product descriptors does not equate to privatization or turning health care over to the market "red in tooth and claw", but rather it can be about an attempt to use market-like discipline in hierarchical decision making.

So turning to a specific application, nursing homes. Last year, nursing homes across the province were funded on a variety of bases. Essentially each of the previous regions developed different ways of paying for the capital costs of nursing homes, different ways of paying operating costs and different effective prices for a day of stay. Until a few years ago funding for nursing homes varied in accordance with the acuity of the residents of the nursing home, but this is not currently the case.

The same issues apply for other types of seniors accommodation such as designated assisted living. Again the funding arrangements vary across the province, the capital funding differs, and the amount that residents might contribute to their costs of accommodation and food etc. also varies. This is clearly inequitable to both providers and consumers.

Assuming we can describe the acuity of a resident of a nursing home adequately, is it not reasonable that proprietors of nursing homes get reimbursed in line with the types of residents they are caring for? Or phrased another way, if it is not reasonable to have proprietors' remuneration vary in line with the acuity of the resident, what would be a rational basis for funding?

There has been considerable work done, mainly out of University of Michigan Institute of Gerontology, to develop internationally accepted methods of measuring the dependency of nursing home residents, using a tool known as the Resident Assessment Instrument and, from that instrument, clustering the characteristics of the residents into 30 or so clusters which are clinically meaningful and yet represent groups of residents who are homogeneous in terms of expected resource consumption. These groups can then be used as a method of reimbursement. So under this approach the nursing home would get paid on the basis of its activity or rather the acuity of the residents of the nursing home.

Nursing homes were the first cab off the rack on 1 April, 2010.

We are considering implementing activity based funding for designated assisted living commencing 1 April 2011 and the same sort of timeframe for hospitals and emergency medical services. As those timeframes are further into the future, the

details of how we will approach that and the choices that need to be made in this funding design, are still under consideration.

Activity-based funding in hospitals is somewhat more complex than for nursing homes, in part because hospitals are themselves more complex than nursing homes with a broader range of activities that need to be incorporated in activity-based funding. So with hospitals, for example, one needs to identify and fund appropriately a heterogeneous range of “products”: teaching, research, outpatients and inpatients.

Activity-based funding helps to ensure the efficiency of funded services, that is there would be a financial incentive on the managers and proprietors to ensure that their costs are within the bounds of the funding envelope.

Implementation of activity based funding is not simple, of course, because you need to ensure that the things that are not able to be measured easily, such as the quality of care, are protected and here again in the case of nursing homes the work of the University of Michigan group has focused on ways in which one can measure quality in nursing homes.

So what we are saying in this is Albertans will be best served if all hospitals provide care efficiently. Inefficiency shouldn't be rewarded by being paid more. But we have to think carefully in the design of what we do, we don't want to sacrifice quality. We don't want to impact research so we are taking our time to design the best model so we can make sure we become the best performing, publically funded health system in Canada.

Thank you.