Ontario Health Coalition

HEALTH FACTS - CHRONIC CARE

Hospital Funding

In 1988, the provincial government introduced patient classification based funding. Previously hospitals had been funded through a "global" funding system. Under that model, each hospital received a global envelope of funds equal to its previous year's funding plus an increase to reflect higher operating costs.

Patient classification funding systems are based on the view that patients with similar characteristics (such as primary and secondary diagnoses) are likely to require similar treatments and so costs should be similar. The idea is to measure the amount of service each hospital provides through a patient classification system and modify funding accordingly. This, it is argued, encourages hospitals to provide a given service in the most cost efficient way.

In acute care, patients are classified into groups that use similar amounts of resources. Resource Intensity Weights (RIWs) measure the average consumption of resources associated with a patient classification group. A higher weight should reflect a higher average cost of treating patients in that group. Premature labour has a case weight of 1.0; radiation therapy 0.998; heart or lung transplant 10.0; liver transplant 12.0.

To date, patient classification funding has only modified the global funding base: only new funding dollars (and funding cuts) have been distributed using patient classification based funding. So even if a hospital's case mix changed rapidly, its funding would still change slowly. As well, until now, only acute care, newborn care and day surgery patients are classified for funding purposes, about 60% of total hospital services. Now, however, the government is introducing patient classification based funding for chronic care and rehabilitation. Patient classification based funding already exists in long term care facilities. (For more detail on chronic and long term care funding models see the OCHU/CUPE fact sheet *Patient Classification and Funding in Chronic Care Hospitals and Long Term Care Facilities*.)

Funding is Adjusted for Certain Factors Beyond a Hospital's Control

If new funding were based only upon the number of weighted cases, hospitals with the same number of weighted cases would receive the same amount of new funding. But there are certain costs that are beyond the control of a hospital. Successive Ontario funding models have attempted to account for these factors.

In recent years, patient classification based funding has been adjusted for most hospital by the intensity of teaching and the amount of tertiary care in the hospital. The rationale is that teaching introduces costs that are not found in other hospitals and that the existing weighing systems do not yet give sufficient weight to intense treatment. In the case of the smallest hospitals, patient classification funding has been adjusted for size and isolation.

Beginning in 1996-97, the government began adjusting hospital funding for restructuring costs to a limited extent. (Notably, hospital restructuring has made it difficult to obtain satisfactory data C causing significant problems for the funding system.)

There are also "one-off" pockets of funding for hospitals from the Ministry of Health: funding for areas experiencing high population growth, funding for priority programs (e.g. pediatric cardiac surgery), funding to create interim beds to relieve Emergency Room pressures, etc.

A New Funding Model is Emerging

Now, a new funding model is being developed. Funding would be based upon the demographic characteristics of the area served by the hospital, as well as its patient classification data. The demographic characteristics considered would include population, age, gender, income, and aboriginal profile (the latter point is included as aboriginals have a higher rate of illness). Reflecting its demographic and patient classification elements, the new model is called Rate and Volume Equity Funding (RAVE).

RAVE may be used for new funding for day surgery, acute care, and newborn care in 2000-2001. The idea is to use it at a later point for all funding, not just new funding. Eventually, the goal is to have one funding formula for all hospital services, acute and post-acute.

While patient classification funding encourages hospitals to treat an illness as efficiently as possible, demographic funding encourages hospitals to find out if they need to treat that illness at all, or if some other body could. Notably, some governmental authorities have found that there is significant variation in hospital use in different parts of the province. RAVE also raises the question of the division of resources between two hospitals serving the same area.

Like other funding models, RAVE is not an open-ended funding formula. The models only distribute among hospitals an amount of funds pre-set by the government.