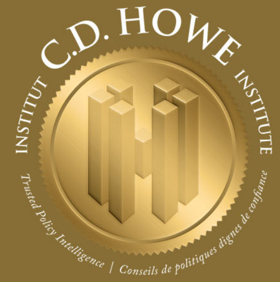
Intelligence MEMOS



From: Rosalie Wyonch

To: Healthcare Observers

Date: July 31, 2024

Re: **Addressing Canada's Bed-Blocker Problem**

Canadian hospitals are capacity-constrained and expensive and therefore not the best care setting for patients who no longer need acute care and the bed that comes with it. Yet these "alternate level care" (ALC) patients accounted for 17 percent of all acute-care bed days in Canada (excluding Quebec) in 2022-23. Reducing this unnecessary use of limited acute-care capacity could help ensure hospital beds are open for Canadians when they need them.

High ALC volume is one of the most vexing and complex health system challenges, but there are ways to address it. Relatively modest improvement could help reduce the risk of hospital bed shortages. ALC occupancy, which ranges from 14.5 to 26.1 percent across provinces, pushes the hospital system past 85-percent occupancy, the rule-of-thumb rate for avoiding bed shortages.

The average occupancy rate across Organisation of Economic and Cooperation and Development nations was 69.8 percent in 2021 and Canada was one of only three – with Israel and Ireland – with an occupancy rate above 85 percent. We also had the fewest hospital beds per capita in that high-occupancy group. Overall, we have 2.5 hospital beds per 1,000 population, putting us 35th out of 43 OECD countries.

Meanwhile, reducing ALC days by just one-sixth would bring acute-care close to the 85-percent threshold.

How do we do that? By improving incentives, smoothing discharge pathways and investing more in home and community-based care.

Although ALC patients, unsurprisingly, stay longer. Hospitalizations that include some ALC days involve an average of 22.4 days, compared to an average of just 8.1 total days of stay for all hospitalizations. And about half are seniors waiting for transfer into residential care.

Lack of access to preventive and primary care can result in emergency room visits when alternate care, including home care and other social services, would be more appropriate. And lack of capacity in home care or long-term care (LTC) can result in patients remaining in hospitals much longer than they should.

To fix this problem, we need to: Create more seniors' care spaces; expand home care; improve access to primary care; and ensure support services are accessible and affordable.

These policy prescriptions are decades old. Why haven't they been adopted? In many cases, incentives work against them or substitute services aren't available.

In many provinces, hospitals have an incentive to designate ALC patients as chronic and in need of long-term care. Designated patients, unlike those discharged home, can be charged a daily fee equivalent to what the patients would be charged for room and board in an LTC home.

And since those fees generally line up with the price of long-term care, patients have no incentive to leave the hospital, especially if an available LTC bed is not to their liking.

Ontario is trying a $400 a day stick, on top of its existing $66 daily LTC charge, for patients who decline an available bed. The result of the policy is that, in 2023, 60 percent of ALC patients transferred to LTC did not get their first choice of home, although only 99 were actually placed in a home without their consent.

Governments should consider ways to increase access to the less-intensive support services provided in homes. Many retirement homes provide advanced care services similar to those available in LTC but are too costly for many seniors. This unused capacity could help to alleviate the strain on hospital acute care, reduce the wait list for over-capacity LTC and meet the needs of the ALC senior in a more appropriate setting.

Administration can also contribute to the problem. Ten percent of patients have their hospital stay extended while waiting for home-care services or supports. About half of those stay nine or fewer days, but 10 percent stay more than 40 days. Coordination between hospitals and community care organizations is complex and many factors can contribute to delays in transfers. Re-orienting hospital discharge policies and pathways to support a "home first" strategy could ease LTC backlogs and reduce the number of ALC patients.

In sum, incentives for physicians, families and hospitals generally encourage both longer than optimal hospital stays and earlier eligibility for LTC than necessary. Hospitals need to review their discharge policies so clinicians and front-line workers aren't pushed toward recommending LTC when home care would be cheaper and better for patients. For their part, provinces need to examine their fees to ensure no one – clinician, hospital or patient – is encouraged to provide or receive more elaborate healthcare than necessary.

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