Intelligence MEMOS

From: Åke Blomqvist and Rosalie Wyonch

To: Christine Elliott, Ontario Minister of Health
Merrilee Fullerton, Ontario Minister of Long-Term Care

Date: November 12, 2019

Re: **Hospital Beds and Long-Term Care Wait Lists**

Waiting lists for long-term care beds are costly for patients and their families, and for the acute-care hospital system, which sees many of its beds occupied by Alternate Level of Care (ALC) patients who could be cared for elsewhere.

Long-Term Care (LTC) is also costly to taxpayers: Across the country, the public cost is projected to grow to more than $70 billion annually by 2050 as baby-boomers and their children retire. Your ministries can work together to shorten the wait lists and to better control both LTC costs and aggregate healthcare costs.

A good starting point would be to use some of the LTC budget to pay acute-care hospitals a daily rate for the care of ALC patients, similar to the amounts a nursing home would receive from the government for a resident.

Doing so would align well with the trend toward more reliance on Activity-Based Funding of acute-care hospitals. Under that scheme, a larger share of hospital funding comes in the form of "payment by results," in the form of specific amounts for episodes of care for patients with various conditions. This method of funding, applied to hip and knee joint replacement surgeries, has been shown to reduce the length of stay, operating room time, and the cost of prosthetics by a third or more in Ontario, and it could produce improved efficiency in the intersection of acute and long-term care as well.

Hospitals whose beds are heavily utilized by patients receiving acute-care procedures would still have an incentive to discharge their ALC patients as quickly as possible even if they were paid a for ALC patients at nursing home rates. However, some smaller hospitals whose acute-care beds are not as busy could then find it advantageous to convert some or all of their beds into permanent LTC beds, which could reduce nursing home waitlists.

Another possible step would be to change the rules according to which ALC patients are classified. Under current rules, hospitals may charge patients copayments for their room and board only if they require complex continuing care and are "more or less permanently resident" in hospital or waiting for an LTC bed. But they may not do so if the patient is awaiting discharge to home or community care.

This creates a perverse incentive for hospitals to recommend LTC in order to get copayments, leading to longer waiting lists.

Allowing hospitals to charge all ALC patients daily room-and-board co-payments, regardless of their discharge plan, would correct this. By the same token, if hospitals receive an additional subsidy for nursing-home bound patients as suggested above, there should also be some subsidy for those with lighter care needs that would be similar to the public cost of providing that care in a different setting.

As Canada's population ages and more people begin to need LTC, it will become more and more important to have a system where LTC is well integrated with the acute-care sector, and provides care in a flexible way that responds to the needs and preferences of patients and their families.

In the past, government support of LTC in Ontario and other provinces has focussed too much on a one-size-fits-all model of institutional care, and while we have begun shifting resources toward home care, we still lag far behind countries like France, Germany, and Australia where eligible patients have more choice between services in-kind or cash that they can use toward the cost of care they arrange themselves.

Ontario could learn useful lessons from their examples, and from the lively debate about integrating the funding and delivery of LTC and acute care that has been going on in the U.K. for a long time.

Increasing long-term care will be costly, but improved coordination in the management of long-term and acute-care resources might result in considerable savings. Moreover, the costs to the taxpayer can be limited by adapting the existing means-tested system under which patients and their families are required to contribute a share of their LTC costs if they have the means to do so. In cash-strapped Ontario, we think there is a strong case for larger copayments, from those with the means, that come closer to covering the entire cost of the care LTC patients receive.

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