Free-standing health care facilities: financial arrangements, quality assurance and a pilot study

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This article has been peer reviewed.

Can Med Assoc J 1998;158:359-63

Abstract

FREE-STANDING HEALTH CARE FACILITIES now deliver many diagnostic and therapeutic services formerly provided only in hospitals. The financial arrangements available to these facilities differ according to whether the services are uninsured or insured. For an uninsured service, such as cosmetic surgery, the patient pays a fee directly to the service provider. For an insured service, such as cataract surgery, the provincial government uses tax revenues to fund the facility by paying it a facility fee and remunerates the physician who provided the service with a professional fee. No comprehensive, proactive quality assurance efforts have been implemented for either these facilities or the clinical practice provided within them. A pilot study involving therapeutic facilities in Ontario has suggested that a large-scale quality improvement effort could be undertaken in these facilities and rigorously evaluated.

Résumé

DES ÉTABLISSEMENTS DE SOINS DE SANTÉ autonomes offrent maintenant de nombreux services de diagnostic et de traitement auparavant fournis dans les hôpitaux seulement. Les arrangements financiers auxquels ces établissements ont accès diffèrent selon que les services sont assurés ou non. Dans le cas des services non assurés, comme une chirurgie esthétique, le patient paye directement le fournisseur. Dans celui des services assurés, comme une intervention chirurgicale pour une cataracte, le gouvernement provincial utilise les recettes fiscales pour financer l'établissement en lui payant des frais d'établissement et rémunère le médecin qui a fourni le service en lui versant des honoraires professionnels. On n'a mis en oeuvre aucun effort complet et proactif d'assurance de la qualité dans l'un ou l'autre de ces cas, ni dans celui des soins cliniques fournis. Une étude pilote sur les établissements de traitement de l'Ontario indique que l'on pourrait entreprendre un effort important pour améliorer la qualité dans ces établissements et qu'il faudrait évaluer rigoureusement cet effort.

Patients, physicians and policy-makers face a new setting for health care delivery: free-standing health care facilities that can deliver many diagnostic and therapeutic services formerly provided only in hospitals. These facilities range from the small x-ray unit in a medical arts building to the state-of-the-art surgical centre in a high-rise office tower. The push for these facilities comes from 2 groups, each with its own objectives. Provincial governments are seeking opportunities to move the provision of *insured* services to settings that may be less costly or (in the case of induced abortion) more accessible. In addition, entrepreneurs are seeking opportunities to provide both *insured* and *uninsured* services in their own facilities.

Many provinces have free-standing health care facilities that provide insured

services. As of mid-1997, 948 facilities in Ontario were providing insured diagnostic services such as pulmonary function studies (74 facilities), nuclear medicine (57), radiology (520) and ultrasonography (652), and many of these were performing more than one type of service (unpublished data, College of Physicians and Surgeons of Ontario). In addition, 22 Ontario facilities were providing insured therapeutic services, including plastic surgery procedures (7 facilities), renal dialysis (5), induced abortions (5), ophthalmologic procedures (2), gynecologic procedures (1), peripheral vascular surgery (1) and laser dermatology (1). Some of these therapeutic facilities were providing both insured and uninsured services, but data are not routinely collected on the uninsured services.

In this paper we seek to inform the discussion around free-standing health care facilities in Canada. First, we describe the financial arrangements available to free-standing health care facilities under the terms of the Canada Health Act. Second, we describe the approaches to quality assurance that could be used in these facilities. In both of these sections we provide concrete illustrations from Ontario, a province that has established a framework for both financial arrangements and quality assurance in free-standing facilities. Third, we describe a pilot study of quality improvement in therapeutic facilities in Ontario.[1] We conclude with a proposal for a more comprehensive framework for addressing financial arrangements and quality assurance in free-standing facilities.

Financial arrangements

Canadian free-standing health care facilities undertake different financial arrangements according to whether the facility provides uninsured or insured services. In the case of an uninsured service, such as cosmetic surgery, the patient pays a fee directly to the service provider. The "service provider" can be thought of as the facility, the physician who provides the service in the facility or both. Financing (raising revenue) and payment (funding the facility and remunerating the physician) are combined in a single market transaction, and the patient pays directly.

An insured service, such as a cataract procedure, is handled very differently. The provincial government (or provincial health insurance plan), not the patient, pays for the service. The Canada Health Act specifies that fees cannot be charged to patients for "medically necessary services," and the federal government has enforced the provisions of this act (most notably in Alberta). (For the purposes of this article we have assumed that "medically necessary services" are the same as "insured services," and we use the latter term preferentially.) The economic arguments in favour of this approach have been well described elsewhere.[2] In this situation, financing and payment are separate transactions.

In Canada, revenue is generated for insured health care services primarily through taxes, both on income and on goods and services. A provincial government or provincial health insurance plan uses these revenues to pay for services provided in free-standing health care facilities, and it does so through 2 distinct types of fees. The government or plan funds the facility by paying to it a facility fee (often for each service provided within the facility), and it remunerates the physician providing the service with a professional fee.

Facility fees, which fund a facility by covering the capital and operating costs associated with providing an insured service (e.g., the price of a new x-ray machine and the salary of a radiation technologist), are usually determined through negotiations between the provincial government and the owner or operator of the free-standing health care facility. Two factors complicate these negotiations. First, in contrast to the negotiation of professional fee levels with physicians or global budget levels with hospitals, the government must bargain with individual facilities, not a provincial association. Second, because many insured services have traditionally been hospital based and their costs buried in hospital capital allowances and global budgets, the government has no historical data on the capital and operating costs associated with specific insured services.

A provincial government faces 3 options in negotiating facility fees. With nonprofit facilities, the government can negotiate facility fees that closely approximate its estimates of incurred costs or it can negotiate facility fees that are higher than these estimates, with the understanding that a facility will be allowed to use budget surpluses only to upgrade the facility or increase the provision of supplementary programs. With for-profit facilities, the government can negotiate facility fees that yield a true profit directly to the owners of the facility. The latter option represents a substantial step toward the entrepreneurial perspective that dominates health care in the US.

Professional fees, which are used to reimburse a physician for providing an insured service (e.g., a radiologist's fee for interpretation of radiographs or a surgeon's fee for a cataract procedure), are usually determined through negotiations between a provincial government and the relevant provincial medical association. These fees are paid to the physician regardless of where the service is provided — a private medical office, a free-standing health care facility or a hospital. If a physician is not an owner or operator of the facility, the professional fee represents the physician's sole source of income for providing the service.

Ontario established a framework for financial arrangements involving free-standing health care facilities through the Independent Health Facilities Act, 1989,[3]

which was proclaimed in 1990. In accordance with the Canada Health Act, the provincial government undertook to fund free-standing facilities (called independent health facilities, or IHFs, in Ontario) by paying them facility fees for specified types of insured services. The provincial government continues to remunerate physicians by paying them a professional fee for providing these insured services. Patients pay a fee directly to the service provider for uninsured services. Thus emerged 3 groups of free-standing facilities: those that provide only uninsured services, those that provide only insured services and those that provide both types of services.

The Ontario government negotiates the facility fees directly with the individual owners and operators of the IHFs. To ensure the controlled growth of service volume in (and hence expenditures on) IHFs providing therapeutic services, the provincial government also sets firm ceilings on the number of services for which owners or operators can receive facility fees in a given period. For example, an ophthalmologic facility might be limited to performing 250 cataract operations per year and 300 laser procedures per year. Physicians working in the facility can perform services beyond the limit, but if they do, the government pays only the professional fee for the additional services, not the facility fee. Subsequent modifications to the Independent Health Facilities Act removed preferences for nonprofit Canadian companies; this change suggests that for-profit US companies are welcome to operate IHFs in Ontario.[4,5]

Approaches to quality assurance

Analogous to the distinction between funding a facility and remunerating a physician who provides a service in that facility, quality assurance could focus on either the facility or the clinical practice provided within it (or, ideally, both). The former would address issues similar to those faced by hospitals: the standards for staff working in the facility, the facility itself and the facility's policies and procedures. In the case of therapeutic services such as cataract surgery provided in free-standing health care facilities, the latter would address issues similar to those faced by physicians working in a hospital: indications for the service and preoperative, intraoperative and postoperative care (after-care and follow-up).

Broadly speaking, 2 different approaches to quality assurance might be used or mandated in Canadian free-standing health care facilities: reactive and proactive. The reactive or "bad apple" approach, usually the default option, looks to minimum acceptable standards and uses punitive sanctions to enforce them. This approach has traditionally been used by accreditation bodies for hospitals and by professional colleges for clinical practice. In contrast, the proactive approach looks to best practices (e.g., benchmarking) and uses an ethos of continuous quality improvement to encourage change, or it looks to optimal care (e.g., practice guidelines) and uses strategies for implementing practice guidelines to encourage change.

In Canada no organization has been charged with implementing a comprehensive proactive approach to quality assurance in any setting. The available options for bodies that might implement such an approach in free-standing health care facilities include the provincial government itself, a provincial medical college, a provincial medical association or a newly created quality council sponsored by the relevant provincial government. The first 3 options could suffer from duality of purpose, whereas the fourth might require more new investment in physical and human resources than the others.

Practice guidelines and related implementation strategies represent the most rigorously evaluated approach available to a quality assurance organization.[6–11] A number of implementation strategies have been described, and they differ in their costs and effectiveness. One strategy, audit and feedback, involves the assessment of current practice against recommended optimal practice. The results of the assessment are fed back to the providers, who can then address areas requiring change. Evaluations of audit and feedback suggest that the strategy sometimes meets with positive results,[12] particularly if feedback is personalized and takes place in a one-on-one setting.

A second strategy, academic detailing, involves personal introductory and follow-up visits by a "detailer" who is trained to discuss one or two key recommendations from the guidelines, to identify barriers to their implementation and to suggest means by which these barriers could be overcome. Academic detailing, a very labour-intensive strategy, has largely been used for prescribing practices, where it has resulted in positive change.[13] A related strategy — the use of opinion leaders — involves informal, "on-the-fly" discussions with a respected peer, who can both provide credibility for the recommendations and place them in the context of the local environment.[14]

Another strategy, problem-based continuing medical education (CME), involves a facilitator who stimulates service providers to discuss the practice guidelines, identify barriers to their implementation and seek means by which the barriers can be overcome.[15] Both the use of opinion leaders and problem-based CME have had mixed results in facilitating implementation of practice guidelines.[14,15]

As part of the Independent Health Facilities Act, 1989[3] Ontario has also established a framework to address proactively the quality of both the clinical practice of

physicians working in free-standing facilities and the facilities themselves. The provincial government charged the College of Physicians and Surgeons of Ontario with the responsibility for carrying out quality assessments in IHFs and, under contractual arrangement, gave the College the responsibility for establishing quality improvement processes in those facilities.

The College convened specialty-specific task forces to develop both facility standards and service-specific practice guidelines (called clinical practice parameters) for insured services. The College explicitly avoided the use of sanctions to punish noncompliance and instead sought to work with the IHFs to improve quality (using as a basis for these improvements the periodic assessment of clinical practices and the facilities themselves against the parameters).

The 3 groups of free-standing facilities described earlier differ not only in their mix of uninsured and insured services but also in the approaches to quality improvement that are possible, given the legislation's focus on insured services (Table 1). Quality improvement processes related to the facility have been mandated for free-standing facilities that provide *any* insured service, but not for those that provide exclusively uninsured services. Processes related to clinical practice have been mandated only for insured services, which resulted in the anomalous situation whereby these quality improvement processes covered some physician activities within a given free-standing facility but not others.

Pilot study of independent health facilities

To prepare for a large-scale implementation of practice parameters in the more numerous diagnostic IHFs in Ontario and to provide information relevant to facilitating parameter implementation in the therapeutic IHFs, the College of Physicians and Surgeons of Ontario convened a study team to design and conduct a pilot randomized controlled trial in the therapeutic IHFs.[1] The pilot study was designed with limited power to detect a clinically or statistically significant effect. Our experiences in conducting this pilot study suggest that quality improvement efforts can be undertaken in free-standing facilities and that these efforts can be rigorously evaluated.

Table 1: Mandated approaches* to quality assurance in Ontario's free-standing health facilities

	Type of services provided; approach to quality assurance		
Focus of quality assurance	Uninsured only	Mixed	Insured only
Facility	None	Proactive	Proactive
Clinical practice	Reactive	Reactive or proactive	Proactive

*Reactive approach: minimum acceptable standards, enforced by punitive sanctions. Proactive approach: either best practices (e.g., benchmarking) and continuous quality improvement to encourage change or optimal care (e.g., practice guidelines) and implementation strategies to encourage change.

Most therapeutic IHFs and physicians working in them cooperated fully with all parts of the quality improvement and evaluation process. Twelve IHFs were eligible to participate: 6 providing plastic surgery procedures, 4 providing induced abortions and 2 providing ophthalmology procedures. Eleven of the facilities agreed to participate in the study and completed the consent forms. One ophthalmology IHF chose not to participate, and the other was dropped from the study to preserve the balanced design. The final sample consisted of 10 IHFs with a total of 16 physicians. With the exception of 1 physician who did not complete the pre-intervention questionnaire and 2 who did not complete the post-intervention questionnaire, the physicians complied with all evaluation requests.

Half of the IHFs providing induced abortions and half of those providing plastic surgery procedures were randomly assigned to be offered a choice from 3 possible strategies to help implement the parameters; this menu approach was acceptable to the physicians, was financially and administratively feasible, and was instructive in its own right. The 5 IHFs assigned to the intervention arm were asked to choose one of the following strategies: a review process with feedback (with facility and chart reviews to be conducted 3 and 6 months after the facility entered the study), a personal visit by the chair of the task force charged with developing the parameters (who acted as a combination academic detailer and opinion leader) or problem-based CME (consisting of 4 to 6 sessions designed to stimulate the physicians to discuss the practice parameters, identify barriers to their implementation and seek means by which these barriers could be overcome).

Ongoing routine evaluation, such as that performed as part of the pilot study, is feasible and necessary, and an experimental approach to evaluation appears acceptable to physicians. The team's particular interest was in observing whether IHFs participating in a physician-selected strategy (the intervention group) would be more knowledgeable about the parameters and more favourably predisposed toward them and whether they would self-report and demonstrate a greater degree of implementation of the parameters than IHFs merely asked by the College to comply with the parameters (control group). The effectiveness of physician-selected strategies was assessed by measuring changes in attitudes, self-reported behaviour and objectively measured behaviour before and after the 1-year intervention period. This information was obtained through a self-administered questionnaire (modified from one developed by Tunis and colleagues[16]), facility and chart reviews, and debriefing sessions, each administered before and after the intervention. The results of these evaluations are summarized elsewhere.[1]

Conclusions

The potential exists for the planned expansion of free-standing facilities providing insured services and the market-driven expansion of facilities providing uninsured services. Provincial governments must develop a comprehensive framework for addressing both financial arrangements and quality assurance in these facilities.

To a large extent, the financial arrangements specified in the Ontario framework work well, at least on paper. The only technical drawbacks of the approach are the lack of historical data on the capital and operating costs associated with specific insured services and the payment of facility fees to free-standing facilities that provide both insured and uninsured services. The potential exists for governments to "overpay" facilities or to subsidize patients receiving uninsured services (and vice versa). No data are currently available to assess either of these possibilities or to determine whether insured services can be provided more cost effectively in free-standing facilities than in hospitals.

More significant drawbacks plague the quality assurance component of the Ontario framework. There may be concerns about quality in free-standing facilities providing uninsured services, as well as in facilities providing insured services. The proactive approach can easily, and should, be applied to free-standing facilities that provide uninsured services. The IHF pilot study reported here was a first step in developing quality assurance efforts that can be used in Ontario and other provinces.

This article is based on a report prepared for the College of Physicians and Surgeons of Ontario, entitled "Toward New Frontiers in Quality Improvement: the Independent Health Facilities Study." The small-scale evaluation described in the article was funded by a grant from the Ontario Ministry of Health to the College of Physicians and Surgeons of Ontario. These funds were then made available to an independent research team comprising John Lavis, Jonathan Lomas, Geoffrey Anderson, Allan Donner and Neill Iscoe. The team thanks Don Willison for his role as research coordinator in the late stages of the project.

Dr. Lavis was supported by a National Health PhD Fellowship (6614-1051-47), and Dr. Anderson was supported by the National Health Research and Development Program (6616-5073-48).

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