



NEWFOUNDLAND
AND LABRADOR

**HEALTH
BOARDS
ASSOCIATION**

**FUNDING MODEL
FOR THE HEALTH SYSTEM
OF NEWFOUNDLAND AND LABRADOR**

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1 Introduction

The Newfoundland and Labrador Health Boards Association established a Working Committee to identify and discuss appropriate principles for funding the Health Boards in the province. The goal for the committee was to formulate a funding model (to accompany a services and program model) for discussion with the Department of Health and Community Services (DOHCS). The proposed funding model would provide guidelines for the division of health funds with principles that supported appropriate funding for the provision of mandated services across our broad spectrum health system. As a set of principles and guidelines, the funding model would not deal with the level of funding, but only with the principles for allocation of health funding. Ideally, an annual health funding report will be published by DOHCS, setting out the allocation of health funds available each year according to the proposed funding model.

The health funding practices in other provinces across Canada were reviewed. The *Global Funding Manual* from Alberta (the Alberta Model) which is updated annually and the *Integrated Population Based Allocation (IPBA) Formula* prepared for the Ontario Joint Policy and Planning Committee on hospital funding offered the most fully-realised models for discussion in considering the health system funding in our province (see Appendix A).

2 Step 1: Establishing Stable Base Funding

This step proved to be the most difficult to work out in discussion. It is possible to argue that DOHCS has been attempting to arrive at standardized base budgets for Health Boards through its financial reviews. The ideal situation would be for equitable budgets to have been agreed upon as a basis for a Health Boards Funding Model. However, it is clear that this is extremely unlikely in the near future and would hold up the process of establishing clarity and predictability for annual funding. In many ways the principles for the Funding Model will be the basis for equitable Health Boards budgets across the province. It is the classic chicken and egg dilemma.

In order to avoid stalling the process, it was decided to recommend that:

Recommendation 1:

That the previous year's budgets be the foundation for the Funding Model, with adjustments to be made using data currently available and applicable standards where they exist. It is recognized that some inequities may be entrenched by this method. To address this, over a period of time (3 to 5 years) Health Boards' budgets should be gradually adjusted according to the Funding Model principles until an equitable funding situation across all regions is achieved. This would minimize the disruption due to regions readjusting their service delivery to meet standard funding guidelines and principles.

Minimum Guarantee: Stability in funding could be provided by a minimum guarantee over the previous year's funding. In 2000/01 in Alberta, for example, the minimum guarantee was 3.53% over the comparable base budget for 1999/2000 (the overall total raise in funding came to 5.6%). In Newfoundland and Labrador, there would have to be a period of equitable adjustment before achieving full implementation of a minimum guarantee.

Note: The minimum guarantee may not be appropriate for our province in view of the decreasing population.

3 Step 2: Division of Health Funds

Recommendation 2:

That the total amount of health funds available for a year be divided into Population-based Funding for health services delivered regionally by Health Boards and Non-Population Based Funding.

3.1 Population Based Funding

3.1.1 Funding Service Pools: The Population Based Funding amount is divided into funding pools, representing the services that are to be funded in the health system, proportionate to the most recent calculations of expenditure on each pool by all the Health Boards combined, hopefully as determined from Management Information System (MIS) data. This data would only be used to determine a distribution of the funding, not the actual funds required. Operating expenditures are assigned to the various funding pools/activities.

Recommendation 3:

That the appropriate service pool categories for Population-Based Funding for our province be:

- **Acute Inpatient**
- **Ambulatory Care, including salaried and fee-for-service physicians operating clinics**

Note:

Phase One: In the short term, Ambulatory Care funds should consist of current funding for salaried physicians and locums.

Phase Two: all physician services in a region should be funded through Health Boards in order to increase flexibility and effectiveness in funding and reduce current duplicate administrative time spent. This would amount to the total MCP budget being transferred to Health Boards.

- **Long term Care**
- **Protection, Prevention, Promotion (PPP) and Cancer Control Program**
- **Community Living and Support Services**
- **Child, Youth and Family Services**
- **Mental Health/Addictions**

Note 1: Residential Services will need to be assigned to a pool at some point

Note 2: Boundaries should be consistent for a region to facilitate regional funding. Alignments will therefore require revisiting.

3.1.2 Allocation of Service Pools: Funding in the service pools is divided amongst the Health Boards according to the relative health needs of the population in each region.

- (i) ***Social and Health Factors:*** It is recognized that these needs are affected by a number of factors, such as age, gender and socio-economic status, and it is assumed that it is possible to predict health needs by quantifying the distribution of these characteristics in a region. The residency, gender and socio-economic status of each

provincial resident gathered from various sources of data can therefore be used in order to calculate health needs in a region.

The Community Accounts currently under development provide data on employment, income level, social assistance status and educational level, which will be significant and useful indicators for socio-economic status in Newfoundland and Labrador (in Alberta, for example, calculations based on twenty age groups, two gender groups and four socio-economic groups (aboriginal, welfare, subsidy, other [includes population over 65] resulted in a total of 124 possible population groups). The Community Accounts also provide data in their *Health Accounts* on health status, preventative behaviours, emotional status, health practice and health care assessment which can contribute to assessment of relative health needs in the regions.

Cost values are attributed to each group based on participation in the health system by all members of that group across the province. The resulting estimated expenditures, divided by the provincial population for those groups, provide provincial per capita rates for each group to determine the relative percentage of a pool to be assigned to each region, not to determine the funding levels.

Note: the number of aboriginal residents in a region will also need to be factored in, depending on their usage of provincial, rather than federal, health funding.

(ii) Capitation Rates: are calculated by dividing the expenditures for each demographic group by the total provincial population in that group.

(iii) Import/Export Adjustment: Basing regional funding allocations only on a region's resident population fails to account for people who cross regional boundaries in order to access a health service in another region, thereby using the health resources of that region. It is important to be able to track this type of movement, in order to ensure funding for the service provided by a Health Board to a non-resident of the region. The identification of service categories where import/exports have been taking place is an important basis for the calculation of this activity. Import/export value will be included in the overall division of funding in each pool, so that individual Health Boards will receive a net gain or loss according to the volume of import or export activity in the region.

Note: In order to succeed, the Population Based Funding Model needs reliable utilization and cost (relative resource consumption) data for the health services provided by Health Boards. The Newfoundland and Labrador Centre for Health Information would be the logical centre for coordination and collection of relevant data from various sources.

3.2 Non-Population Based Funding

3.2.1 Assured Access: Assured Access special funding is provided to qualifying regions in recognition of the greater service delivery costs associated with sparsely populated areas. Regions receive an additional percentage of the per capita funding rate for each of their residents living outside of population circles (50 kilometre radius) in their region with a population concentration of at least 5,000.

3.2.2 Provincial Services: In Newfoundland and Labrador, provincial services include tertiary care (for which the Health Care Corporation of St. John's has a provincial mandate), cancer treatment and care, children's rehabilitation, genetics testing and counselling. Funding for these services should be separate from the Population/Needs Based Funding.

Note: Pilot projects for further provincial services should be rotated through the regions to avoid clustering project benefits in any one region and promote benefit to the entire province.

4. Annual Renewal

Recommendation 4:

That, using the steps outlined above, a new Funding Handbook be produced annually by the Department of Health and Community Services, giving the actual figures and percentages of available health funds assigned to each Health Board, together with the rationale for decisions made to implement the division of funds.

Recommendation 5:

The principles of this Funding Model should be used to develop a multi-year Funding Plan to be accompanied by a multi-year Services and Program Plan to allow for long-range planning by Health Boards.

APPENDIX A

Notes on the Alberta and Ontario Funding Models

Alberta

The Alberta Model in its present form began with the 1997-98 fiscal year, when Alberta adopted a new population-based method of funding regional health authorities to try and ensure that each region received its fair share of available health dollars. Funds are allocated to each regional health authority according to the population in the region and their estimated relative health funding requirements. The population's health funding requirements are measured by taking into account:

- total population base of each region
- age and gender of the population base
- socio-economic composition of the population base
- services provided by regions to residents of other regions

Because funds are allocated according to relative health needs in the population of each region, it is believed that all regions should be able to operate on a more level playing field than in the past. If compensating factors or adjustments to funding are applied to a particular region, they are based on sound evidence, easily explained, and open to regular validation. No loss and minimum guarantee provisions are also applied, meaning that total funding (population based funding plus other funding) for any region cannot be lower than its funding level for the previous year. Since the total value of the funding top-ups required to ensure this guarantee must be found within the total funding allowance for the year, any top-up amount is recovered through deductions to the funding allocations for the other regions. The Alberta Model is updated annually and offers a clear rationale to the health system and the public for the allocation of health funding.

Ontario

The Ontario Formula was prepared using up-to-date economic forecasting and calculation methodology in consultation with more than 95 hospital representatives after over 4,500 hours of formal meetings and additional hours of private discussion. The final product details the processes for developing the model, the hypotheses justifying specific rate and volume adjustments, and the rationale for the application of the models, together with the detailed technical methodology applied in developing the rate and volume methodologies and information on the methods employed to derive the expected rate and volume levels calculated for hospitals. This is a relatively technical document for the use of the Ministry of Health and Long Term Care, not aimed at the general public, although one of the principles identified was transparency, meaning that the process, logic and statistical methodology must be clear and open. ♦