HEALTH BUDGETING MODELS AND THE EXPERIENCE OF NEWFOUNDLAND AND LABRADOR: WHY HAVEN'T WE MOVED TO A NEEDS-BASED SYSTEM?

Dr. Stephen Tomblin and Jeff Braun-Jackson

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Funding for health care has become one of the most important policy issues to emerge

and few resources to sustain health systems. A critical feature of health funding deals with budgeting resources. Different g

Scope	Description
Comprehensive	Directs money to health organizations with multiple responsibilities including hospital-delivered acute care. Organizations often have wide latitude in terms of how resources are targeted and distributed to each area of responsibility.
Institutional	Directs money to specific acute-care hospitals and facilities or to groups of hospitals under a single corporate entity. These organizations may have some latitude with respect to how money is spent but usually are not permitted to target funds to other organizations.
Service Specific	Directs money to organizations that have responsibility for a specific service or disease. Organization has a mandate to provide care to patients from a large geographic area. Funds can only be used for the specific purposes identified in the organization mandate.

Funding approaches of a comprehensive scope are the most commonly used in Canada because of the implementation of regionalized delivery of health care services. The advantages of employing a comprehensive scope of funding are as follows:

Supports a total system perspective which permits approaches that reflect the interactions among different areas of the health system to be included;

Transfers responsibility for decision-making from the province to the regional health authority or organization receiving the funds;

Supports a system-level perspective in decision-making because savings achieved

Method	Description	Usually Relies Most on	Ability to Respond to Change	Stability of Funding
Population-based	Employs demographics and other characteristics of the population (age, gender, socio-economic status, education) to determine the relative needs of population groups in seeking health services.	Results controls	High	High

2. determine costs using a service recipient costing formula[5] and
3. for all groups in each region, add the cost of providing care to all persons in the population. For each region add the total costs across all population groups.[6]

Facility-based

1. determine the characteristics of a health facility that drive the cost of providing care.
2. fund the facility based on a per unit rate for each identified characteristic.

Case-Mixed based

1. determine how many cases for each type of procedure (e.g., hip and knee replacements, cardiac bypass surgery, dialysis) will be provided by a health service organization in period *x*.
2. obtain from the Canadian Institute for Health Information data to be used to determine the total weighted cases based

2. employ an allocation base appropriate for the specific issue (e.g., triage) then determine for each health service organization the portion of the total provincial amount.
3. calculate the actual amount for each health service organization.

Project-based

1. a one-time funding request is prepared by a health service organization (e.g., a new MRI).
2. the request is submitted to government for review.
3. the request is evaluated by government based on several criteria.
4. the funding decision is made and the health organization is informed of the decision.
5. the government actively monitors how the health organization spends the funds that were requested.

Ministerial Discretion

1. the Minister of Health becomes aware of a situation that affects the ability of a health service organization to carry out its mandate.
2. the Minister interacts with senior civil servants in the department to obtain the required information. The Minister may meet with other representatives from departments or the whole Cabinet and may seek further information from stakeholders, citizens, health administrators and providers.
3. a funding decision is then made by the Minister.

Table 3 shows the advantages and disadvantages of each method for health care budgets.

Table 3: The Advantages and Disadvantages of Health Budget Methods[7]

[7] . Adapted from McKillop, Pink and Johnson, 19-31.

Method	Advantages	Disadvantages
Population-based	objective: employs data from a variety of sources other than from those entities being funded. Comprehensive: the relevant characteristics of a specific population can be incorporated	Complex: requires sophisticated mechanisms to link databases together. Difficult to implement. Resource intensive: requires additional staff and information systems. Lack of transparency in that it is difficult to understand how funding amounts are determined.
Facility-based	Recognizes that the type of organizational structure can affect the coF3 9.6.69 43u28	

		use of services.
Line-by-line	Permits Departments to promote policy initiatives through direct spending. Some degree of predictability for the organization with respect to funding. Simple to understand.	Difficult to determine if previous base allocations represent efficient spending patterns. Fails to encourag7.1

	Participatory in that individuals and groups can lobby for change. Representative because it recognizes the role of politicians to govern. Flexible because the method eliminates non-discretionary restrictions on funding decisions.	where money is allocated for a quick fix solution. Government's strategic planning may not be equal for all parties involved. Funding decisions are politicized and lack transparency.

Table 4 compares provinces and territories in terms of funding scope and method employed, whether any surplus can be retained by a health service organization and

				non-transferable programs
Newfoundland and Labrador	Comprehensive	Ministerial discretion	N/A	Surpluses have not existed in recent years
Nova Scotia	Comprehensive	Ministerial discretion[13]	Yes	Yes: all surpluses are reviewed by department and an action plan is established
Ontario	Institutional	Global	Yes	None: recommend that surpluses be used for capital equipment
Prince Edward Island	Comprehensive	Ministerial discretion	No	
Quebec	Comprehensive	Global	Yes	Surplus must be approved by health board before facility can use funds
Saskatchewan	Comprehensive	Population-based	Yes	None
Yukon	Institutional	Ministerial discretion	Yes	None

Before we review the history of health care funding in Newfoundland and Labrador, it is important to understand that changes to budget models can be used as catalysts for reform. McKillop (2004) makes several recommendations as to what must happen for effective reform to occur in health funding:

> More investment in both the functionality and capacity of financial-information systems is critical. The lack of good financial data impede the ability to make good financial decisions.
>
> Evidence-based funding methods such as population-based and case-mix data must be encouraged because these hold the greatest potential for promoting

> from the fund to implement efficiencies and then repay the money through savings achieved as a result of reform.
>
> The continued use and improvement of performance measures is necessary so that the goals of government with respect to delivery are realized[14].

It will be clear that many of the recommendations suggested by McKillop have not been implemented in Newfoundland and Labrador with respect to health funding.

Newfoundland and Labrador's system of health funding currently does not incorporate a population-based model within its system of decision-making. In simple terms, the Department of Health and Community Services (DOHCS) submits its budget request to Treasury Board and the Department of Finance. Funds are then allocated to the individual regional integrated health boards by DOHCS. The boards, however, have moved, through their pan-provincial association, toward a needs-based funding model for medical services within their own jurisdictions. Since 2001, the Newfoundland and Labrador Health Boards Association (NLHBA) has lobbied the provincial government to develop a set of principles for funding the board

participants indicated that the provincial government has not seriously considered the issue although it has been raised periodically by the Newfoundland and Labrador Health Boards Association and professional groups such as nurses. However, a population-based funding model has not been adopted for two main reasons. First, government sees this model as being too expensive to implement. Second, there is a lack of policy capacity and resources to develop accurate data bases to supply information to drive a population-based funding method for health care. Our participants noted that[21]

I would suspect every time they decided... they thought about going to a needs based system, they would recognize it would cost more. So I think that you're not going to get a needs-based [funding model] in Newfoundland because the population is too scattered to allow it to be done efficiently. I mean, if it's not done efficiently, it's going to cost more [3].

Well, the public doesn't respond to concepts like needs-based [funding]. They just want to know is there an MRI if I need one? They don't look at it in a conceptual way and it's not sexy. I mean people just don't think about these things [9].

Is a $100 better spent on an additional paediatrician or on providing better nutrition in a school lunch program? Which makes more sense? And if you don't have enough money to do both, how do you choose? [9]

The issue of population-based funding received quite a bit of discussion about 5 years ago. We started to get this discussion about, oh, you know, in our area, you know, we're not being treated fairly. So they [government] were trying to look at funding based on population, which is somewhat needs based but it's not the full gamut of needs based. And there was some analysis done. Government hired a consultant, if I remember correctly, to determine whether we could go with a different kind of funding model, whether it's needs based or just population based or whatever and I think some of the discussion that came back to us was well, first of all, you're only 500,000 people. So it's difficult to create a model with your geographic disbursement that could be needs based, because you have to take into consideration all of the factors that mean that you have to have a certain service in a certain area because your population may not be there to have the service but geographic... for someone to have to travel to get that service would be totally unreasonable [12].

The issue [of needs-based funding] has been brought forward more from the regional health system itself. Are we [the regions] being fairly treated? For example, if you look at the health authority for the eastern region it will have 57% of the population. So that's a start - okay, you're more than half. We have more than half of the money or we have about half of the money but part of that is tertiary care service which provides services to the whole province. So I think

[21] . The numbers in brackets following the quotations refer to the individual participants interviewed for the project. Please see Appendix for a list of those persons interviewed.

We need identified principles for a needs based funding model. And the boards are still hankering after that. So every year when we do up our budget paper, we mention that we've got this model on how to divide up the money that there is. It wasn't just to start a discussion on how to have more money. It was on how to proportion the money that you've got. There's plenty of evidence out there. I mean, community accounts provide lots of evidence on the determinants of health that we might want to use for planning [17].

Now when you talk about funding, there's really two central issues. So were you talking about the size of the pie or how the pie gets allocated, and they're two very different questions in terms of funding formulas. So where we have... I would think that we probably will be looking at our funding formulas in the near future, we haven't done that yet. Now that we've got some integration issues under our belt, we'll probably take a look at how we fund the system overall [19].

I'll say generally there is that perspective within health care that when you look at the dynamics of the province in terms of its population, where its health care facilities are located now, that a needs based funding might not be a good way to go in terms of funding [19].

The biggest perspective that government brings forward is that population-based approaches are going to cost more; and, particularly, given the geography of Newfoundland and Labrador, they're going to cost more and that will mean that there will be even less money for us to do other things. So people are generally unwilling to look at anything which talks about redistributing the health pie at all [20].

I think it's [population-based funding] come forward from community interest groups, but also from the boards themselves - I know certainly from our board and certainly from the community based boards, which have a strong emphasis on population health [21].

There was some discussion about that and that discussion has come about - I'm just trying to think - probably a couple of years ago, government had an outside study of

So, I mean, we really need a good database with some really good data before you move to that type of system. I think our data are getting better, but I don't think they have been consistent and there's not consistency. I think four boards will help that because there should be consistent data collection. I mean, right now we have different data and different data sets from one site to another in one board. I mean, you can't even get good data, right? [26]

I think geography is presenting itself to be the major complicating factor in this province. There has been models developed, worked through; but when you apply them totally, you find out that you can strip your rural areas completely, and I think

concerned as to the quality of the physician or how the physician gets there or how the physician is paid - they just want a physician. And the lack of sophistication, I think, or the sort of public understanding of how the medical system works is really highlighted [13].

I think the people in government recognize that we will pay for a certain parcel of services. Now what's the priority need. We'll try some kind of methods of determining what are the priorities - squeaky wheel gets the grease [16].

What happened was we approached government and said you need to develop a funding model and we asked them to establish some criteria and some research and so on. We went through a couple of deputy ministers at that time and so finally we said, to hell with it. We got together a working group ourselves, and I remember the conversation then. They [government] got all uptight because we had this group and everybody didn't participate [18].

Well, at the moment, I think that the approach to funding health boards is so ad hoc and unstructured that it would require a major change in the way they work to introduce a structured sort of model an open way of doing it. And I just don't think they have the appetite for that at this time. Now they may do it. We have a very proactive and decisive deputy minister at the moment [17].

Alright. Squeaky wheels get grease - no question. I mean, I've said about the previous government - they were governing based on the Open Line program and th

department. I mean, that's one of my obsessions here and the resources to really apply themselves to those and do a formal analysis because if we recommend a major change, you're going to have a lot of hue and cry a lot of those. Whether they actually have the staff and the resources to do that level of analysis that they're comfortable with recommending a major change [24].

I don't know that anyone made a conscious decision not to do this, but if you look across this country, when people have tried to do this, you have to make sure there is an incentive and disincentive because, I tell you, people can do some strange things to make it come out the way they want it. I mean the best example of how this is difficult is in Ontario where government went to an intensity based funding system for

APPENDIX: LIST OF RESPONDENTS

Respondent 3 is a former hospital administrator in St. John's.

Respondent 7 is a senior researcher with the Newfoundland and Labrador Centre for Health Information.

Respondent 9 is executive director of the Newfoundland and Labrador Medical Association.

Respondent 12 is a former CEO of Health and Community Services, St. John's region.

Respondent 13 is employed with the Department of Health and Community Services.

Respondent 15 is a former CEO of the Avalon Institutions Health Board.

Respondent 16 is executive director of the Association of Registered Nurses of Newfoundland and Labrador.

Respondent 17 is director of advocacy for the Newfoundland and Labrador Health Boards Association.

Respondent 18 is executive director of the Newfoundland and Labrador Health Boards Association.

Respondent 19 is employed with the Department of Health and Community Services.

Respondent 20 is a former manager with the Western Health Care Board.

Respondent 21 is a former manager with Health and Community Services, Western.

Respondent 24 is a former Deputy Minister in the Department of Health.

Respondent 26 is President of the Newfoundland and Labrador Nurses Union.

Respondent 27 is CEO of the Eastern Regional Integrated Health Authority.

Respondent 29 is employed with the Department of Health and Community Services.

Bibliography

Government of Newfoundland, Health Study Group. *Health Care Delivery: An Overview*. St. John's: The Queen's Printer May, 1973.

McKillop, Ian. "Financial Rules As a Catalyst for Change in the Canadian Health Care System," in Pierre-Gerlier Forest, Gregory P. Marchildon, and Tom McIntosh (eds.). *Changing Health Care in Canada: Romanow Papers, Volume 2*. Toronto: University of Toronto Press, 2004, 54-82.

--------, George H. Pink and Lina M. Johnson. *The Financial Management of Acute Care in Canada: A Review of Funding, Performance Monitoring and Reporting Practices*. Ottawa: Canadian Institute for Health Information, March 2001.

Newfoundland and Labrador Health Boards Association. *Funding Model for the Health System of Newfoundland and Labrador*. St. John's: May, 2001.

Newfoundland Hospital and Nursing Home Association. *Matching Realities and Dreams: Report of the Health System Funding and Delivery Committee*. St. John's: September, 1992.

Report of the Royal Commission on Hospital and Nursing Home Costs to the Government of Newfoundland and Labrador.