

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

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**May, 2005**

Funding for health care has become one of the most important policy issues to emerge since the 1990s. Governments at all levels have been confronted with escalating costs

and few resources to sustain health systems. A critical feature of health funding deals with budgeting resources. Different governments across the country employ a variety of budgetary approaches to allocate health care dollars. Our interest here is why the government of Newfoundland and Labrador has not adopted or moved toward implementing a population needs-based budget model for health care. The first part of the paper will review the scope and methods of health budgets identifying advantages and disadvantages found with specific approaches. Next, we will review the reforms that have occurred in Newfoundland and Labrador since the 1980s in terms of budget models and examine the current funding model employed by government. The final sections of the paper will focus on the views of our participants who offer comments on the public agenda, decision-making agenda and policy choice as to why Newfoundland and Labrador has not moved toward or implemented a population needs-based budgeting model for health care funding. In sum, we argue that the fundamental reason why Newfoundland and Labrador is a “no go” with respect to budgetary reform in health care is because elected officials desire a degree of political control over how health resources are distributed and thus are reluctant to move toward a system that allocates funds on the basis of need.

### **Scope and Methods of Health Care Budget Models**

One way to distinguish among different patterns of health care budget models is to focus on the scope and method employed by government. Scope is defined as “the extent to which the funding targets money directly for hospital-based acute care, or whether the approach flows money to organizations that provide a variety of health services that includes acute care.”<sup>1</sup> Method is concerned with the technical components of the process employed to decide on the specific amount of money to be distributed. The scope of a budget model can be analyzed using one of three approaches: comprehensive, institutional or service specific. There are currently eight methods that are used across the country for health budget processes: population-based; facility-based; case mix-based; global; line-by-line; policy-based; project-based and ministerial discretion. These will be reviewed below.

There are three funding scopes used in Canada. Table 1 shows the different scopes and their descriptions.

**Table 1 Scope of the Funding Approach<sup>2</sup>**

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<sup>1</sup> . Ian McKillop, 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, 2001, 15.

<sup>2</sup> . *Ibid*, 16.

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 in one area can be funnelled into service improvements in other areas;
- Recognizes the strategic goals of a health organization and facilitates a shared sense of purpose across sectors, and
- Permits health organizations to respond more quickly to change than would be the case if funding were based on institutional or service specific approaches. A comprehensive approach allows health organizations to reinvest and redirect resources more easily across different sectors because of the wider service mandate inherent in entities such as regional health authorities.<sup>3</sup>

Eight methods have been identified in the literature to decide upon the actual amount of funding a health organization will receive in any given fiscal year. Table 2 shows the different methods and their descriptions.

#### **Table 2 Methods Used for Funding<sup>4</sup>**

<sup>3</sup> . Ian McKillop, "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 and Buffalo: University of Toronto Press, 2004, 61.

<sup>4</sup> . McKillop, Pink and Johnson, 18; McKillop, 64-65.

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
Facility-based	Employs the characteristics of the organization providing care (size, type, geographic isolation, rate of occupancy) to determine the amount of funding for operating the entity.	Results controls	High	High
Case Mix-based	Employs a profile of cases and volumes of service previously published to determine the cost of providing for specific procedures in future.	Results controls	High	High
Global	Employs a factor of previous spending or a forecast figure to determine a predicted spending level for a specified period of time.	Results controls	High	Medium
Line-by-line	Employs factors on an individual basis to previous costs to determine a proposed funding level for each budgetary item (housekeeping, inpatient nursing, x-ray technician services) for a specified period of time.	Results controls	Low	Medium
Policy-based	Employs a model that directs spending to meet specific policy initiatives set by the Ministry or Department of Health. These initiatives affect the administration of multiple health organizations within the Ministry or Department's bailiwick.	Results controls	Low	Low
Project-based	Directs funds to a single health organization in response to a program evaluation or proposal for one-time funding. Usually focuses on a major expenditure.	Action Controls	Low	Low
Ministerial discretion	The Minister of Health decides what specific amounts of money will be allocated to various health service organizations.	Action Controls	Medium	Low

Each method has a prescribed process in terms of how funding is determined. A review of each method is presented below.

### **Population-based**

1. assign each member of the population to a specific group based on an identifiable characteristics (e.g., gender);

*then either*

2. determine the per capita rate of spending for health services for each population group across the province and
3. for each geographic region, multiply the per capita rate by the number of persons in each group. Add the amounts for all groups in the region.

*Or*

2. determine costs using a service recipient costing formula<sup>5</sup> 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.<sup>6</sup>

### **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 on the number of cases treated for each case-mix type.
3. obtain the total actual costs for period  $x$ .
4. determine the average cost per weighted case (total actual costs  $\div$  total weighted cases).
5. multiply the average cost per weighted case by the weighted cases expected in period  $x+1$ .

### **Global method**

1. for each organization, start with a base amount of funding based on last year's base allocation or total actual spending.
2. take the amount and adjust it by a predetermined factor (e.g., the rate of inflation; percentage budgetary increase or decrease determined by government).
3. the adjusted amount constitutes the organization's funding for the current fiscal year.

### **Line-by-Line**

1. for each organization, start with a base amount of funding based on last year's allocation or spending on a line-by-line basis.
2. adjust the amount for each line item by a predetermined factor (rate of inflation). The factor for each line item can be different.
3. add the adjusted line items to calculate the amount of base funding for the current fiscal year.

### **Policy-based**

1. determine a province wide amount of money to be spent.

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<sup>5</sup> . Formula is employed to determine the cost of providing care to specific patient groups within health care organizations.

<sup>6</sup> . McKillop, Pink and Johnson, 19.

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<sup>7</sup>**

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<sup>7</sup> . Adapted from McKillop, Pink and Johnson, 19-31.

Method	Advantages	Disadvantages
Population-based	<ul style="list-style-type: none"> <li>• objective: employs data from a variety of sources other than from those entities being funded.</li> <li>• Comprehensive: the relevant characteristics of a specific population can be incorporated</li> </ul>	<ul style="list-style-type: none"> <li>• Complex: requires sophisticated mechanisms to link databases together.</li> <li>• Difficult to implement.</li> <li>• Resource intensive: requires additional staff and information systems.</li> <li>• Lack of transparency in that it is difficult to understand how funding amounts are determined.</li> </ul>
Facility-based	<ul style="list-style-type: none"> <li>• Recognizes that the type of organizational structure can affect the cost of providing identical services (rural facility versus a large urban teaching hospital).</li> <li>• Allows Departments of Health to establish funding incentives and disincentives for organizational features deemed desirable or undesirable.</li> </ul>	<ul style="list-style-type: none"> <li>• Does not reward efficiencies in utilization.</li> <li>• Not responsive to demographic or case mix changes.</li> </ul>
Case Mix-based	<ul style="list-style-type: none"> <li>• Funding is linked directly to services provided.</li> <li>• Establishes an incentive to provide care as efficiently as possible.</li> </ul>	<ul style="list-style-type: none"> <li>• Can create what is known as weighted-case creep where coding practices are altered to maximize the weighting assigned to a case.</li> </ul>
Global	<ul style="list-style-type: none"> <li>• Provides predictability because the base amount is usually similar to the current year's base.</li> <li>• Easy to calculate.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintains inequalities within the health system.</li> <li>• Does not encourage efficiencies and more appropriate</li> </ul>

		use of services.
Line-by-line	<ul style="list-style-type: none"> <li>• Permits Departments to promote policy initiatives through direct spending.</li> <li>• Some degree of predictability for the organization with respect to funding.</li> <li>• Simple to understand.</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to determine if previous base allocations represent efficient spending patterns.</li> <li>• Fails to encourage increased efficiency.</li> </ul>
Policy-based	<ul style="list-style-type: none"> <li>• Allows provinces to be sure that initiatives from government are adopted by health organizations.</li> <li>• Focus on desired behaviours or delivery of care issues.</li> <li>• Dynamic in that the method can be implemented at any time throughout the fiscal year in response to a need or crisis.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited ability for being comprehensive across all sectors of the health service organization.</li> <li>• Can be labour intensive because the method requires identification of an appropriate allocation base and data linked to that base from each sector of the organization.</li> </ul>
Project-based	<ul style="list-style-type: none"> <li>• Allows government to be active with respect to evaluating funding requests.</li> <li>• Easier for government to manage capital expenditures.</li> <li>• Allows for the use of expertise that may not reside within the health service organization (i.e., engineering and architectural services).</li> </ul>	<ul style="list-style-type: none"> <li>• Approval process is time consuming.</li> <li>• Difficult to prioritize between competing demands on limited capital resources.</li> </ul>
Ministerial discretion	<ul style="list-style-type: none"> <li>• Allows government to direct funds for major new initiatives and reforms.</li> <li>• Allows policy platforms to mesh with spending decisions.</li> </ul>	<ul style="list-style-type: none"> <li>• Inconsistent because significant changes in funding occur after elections when parties change office.</li> <li>• Short-term focus</li> </ul>



	<ul style="list-style-type: none"> <li>• Participatory in that individuals and groups can lobby for change.</li> <li>• Representative because it recognizes the role of politicians to govern.</li> <li>• Flexible because the method eliminates non-discretionary restrictions on funding decisions.</li> </ul>	<p>where money is allocated for a quick fix solution.</p> <ul style="list-style-type: none"> <li>• Government's strategic planning may not be equal for all parties involved.</li> <li>• Funding decisions are politicized and lack transparency.</li> </ul>
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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 whether or not restrictions are in place on how a surplus is used by the organization.

**Table 4: Funding Scope and Method and Treatment of Surplus by Province or Territory<sup>8</sup>**

Province/Territory	Funding Scope	Funding Method	Maintain Surplus?	Restrictions
Alberta	Comprehensive	Population-based <sup>9</sup>	Yes	None but province recommends using for capital equipment
British Columbia	Comprehensive	Line-by-line multiplier <sup>10</sup>	Yes	None but province recommends using for capital equipment except surpluses from specially funded services
Manitoba	Comprehensive	Ministerial discretion <sup>11</sup>	Yes	Maximum of two percent of budget may be kept and used at organization's discretion
New Brunswick	Comprehensive	Line-by-line and population-based <sup>12</sup>	Yes	Yes: health region retains surplus in

<sup>8</sup> . Northwest Territories and Nunavut did not report. Data sources: McKillop, Pink and Johnson (2001), pages 46 and 64; Canadian Centre for Analysis of Regionalization and Health, 2002.

<sup>9</sup> . In previous years, funding has been directed to specific organizations, agencies or programs based on the previous funding level.

<sup>10</sup> . The province has been moving toward adopting a population-based funding model for mental and public and preventative health. A three year transitional phase began in 2002 to change health service delivery and retreating from a targeted funding approach.

<sup>11</sup> . The government has been actively considering a move to a population-based model. A Funding Advisory Committee has been struck.

<sup>12</sup> . Government has moved toward a funding formula based on population as a way of providing more equitable funding for rural areas of the province.

				non-transferable programs
Newfoundland and Labrador	Comprehensive	Ministerial discretion	N/A	Surpluses have not existed in recent years
Nova Scotia	Comprehensive	Ministerial discretion <sup>13</sup>	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 predictability and equity especially for multi-service health organizations such as regional health authorities.
- Multi-year budgets should be used for building system capacity (i.e., capital projects and infrastructure) while annual budgets are to be used for activity costs (delivery of medical services).
- Governments must do a better job to deal with situations where there are gaps between needs identified through evidence-based funding methods and the size of the organization's funding envelope. Simply distributing shortfalls among all health service organizations in a jurisdiction undermined sound management principles.
- Innovation funds should be established to assist health service organizations to develop capital and infrastructure capacity. Organizations could borrow money

<sup>13</sup> . There have been discussions to move toward a new methodology for health funding.

- 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<sup>14</sup>.

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.

### **A Brief History of Health Funding Methods in Newfoundland and Labrador**

Health care funding and delivery has evolved slowly in Newfoundland and Labrador and can be divided into three distinct eras. The first, prior to the province's entry into Confederation with Canada in 1949, was characterized by a crisis approach to the use of health human and capital resources. Epidemics of various diseases were rampant, hospital care was found only in larger centres, and there were few physicians. The most significant organizational development was the establishment of the Cottage Hospital system in which physicians and nurses became employees of the government and medical facilities were established in rural and outport communities. The second era, from 1949 up to 1969, was characterized by expansion of the health system, the introduction of hospital insurance in 1957 and medicare in 1969. By the end of the 1960s, residents had access to universal health care. The emphasis of health was still on the curative or biomedical model rather than an acknowledgment of prevention. The funding model used during this era was line-by-line budgeting in which the Department of Health approved budget items for every hospital and medical facility across the province. By the early 1970s, health care practitioners began to lobby for changes to the funding method as a means of reforming the system to focus on community health and prevention programs and bringing control for service delivery to the local level. During the 1970s, a global funding model with ministerial discretion was adopted. Health organizations received an amount of funding and managers were responsible for allocating resources to various sectors within their units. The current era, from 1970 to the present, has been characterized by regionalization of health delivery and funding for health boards rather than individual organizations. Since the 1990s, reform has centred on the adoption of a population-based funding model to replace the current system of ministerial discretion.<sup>15</sup>

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<sup>14</sup> . McKillop, 2004, 77-78.

<sup>15</sup> . Government of Newfoundland Health Study Group, *Health Care Delivery: An Overview* (May, 1973); Government of Newfoundland, *Royal Commission on Hospital and Nursing Home Costs* (David B. Orsborne, Chair), February, 1984, pages 412-418; Newfoundland Hospital and Nursing Home Association, *Matching Realities and Dreams: Report of the Health System Funding and Delivery Committee* (September, 1992).

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 boards.

The NLHBA proposed a framework that focused on the ways to allocate health dollars rather than the amounts of money spent by government (which is a significant issue in its own right). The first step in this process is to establish a stable base funding system for the boards to cover medically necessary services. The NLHBA recommended that the previous annual budgets for the boards be used as a baseline to create a funding model with allowances for adjustments to be made based on current data. It was further suggested that over a period of three to five years, boards' budgets would be adjusted according to a set of funding principles agreed to by government until an equitable funding model is created.<sup>16</sup> This idea was derived, in part, from the funding model used in Alberta where budget stability is achieved through the use of a minimum guarantee over the previous year's budget.

The key recommendation adopted by the NLHBA is that the total basket of health money for one year be allocated on the basis of population-based funding and delivered by the boards in addition to fiscal allocations based on non-population funding. It was suggested that the amount of money for population-based funding be divided into pools representing the various baskets of services funded in proportion to the most recent calculations of spending by the boards combined. Data used to determine funding amounts were to be obtained from a management information system.<sup>17</sup> For population-based funding pools, the NLHBA recommended the following:

- acute inpatient;
- ambulatory care including both salaried and fee-for-service physicians operating clinics;
- long-term care;
- protection, prevention, promotion and Cancer Control Program;
- community living and various support services;
- children, youth and family services and
- mental health and addictions.<sup>18</sup>

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<sup>16</sup> . Newfoundland and Labrador Health Boards Association. *Funding Model for the Health System of Newfoundland and Labrador*. St. John's, NL: Newfoundland and Labrador Health Boards Association, May 2001, 2.

<sup>17</sup> . *Ibid.*, 2.

<sup>18</sup> . *Ibid.*, 3.

Funding for the various service pools is divided among the boards based on the health needs of each region's population. Health needs are affected by several determinants including age, gender, and socio-economic status (education, income, availability of housing, employment) and these can be quantified to predict levels of need. In Newfoundland and Labrador, the government has developed a data base (Community Accounts) which provide information on employment, income, social assistance levels, and level of education for all health regions. As well, Community Accounts provides information on health status, preventative behaviours, emotional status, health practice and health care assessment. These data allow decision-makers to calculate provincial per capita rates for each demographic and health group to allocate a percentage of each service pool for individual boards. There is also a component built into the health funding system that applies to patients seeking medical services outside their specific health region. In the event a patient is required to access services outside her RHA, additional funds will be allocated to the board treating the individual patient. Individual boards will gain or lose funding based on the amount of in-patient and out-patient flows.

With respect to non-population based funding, two categories are present: assured access and provincial services. Assured access consists of special funding for sparsely populated RHAs to compensate them for their greater service delivery costs.<sup>19</sup> These authorities are entitled to receive an additional percentage of the per capita funding rate for each resident living outside population centres of 5,000 or more persons. Provincial services funding includes the basket of tertiary medical services provided by the Health Care Corporation of St. John's, and its funding is separate from the RHA population-needs based model.

In conclusion, the NLHBA has been lobbying the provincial government since 2001 to establish a stable budgeting system for the health system. While the NLHBA has adopted its own population-needs based system to allocate resources, the overall health budget is still rooted in the ministerial envelope system<sup>20</sup>. The boards have also lobbied government to create multi-year budgeting so that administrators would have more information with respect to the availability of resources in any given fiscal year. The new Conservative government of Premier Danny Williams has shown little interest so far in reforming the health funding and budgeting systems. Most of the government's emphasis has been targeted toward reducing the number of health boards from 14 to four.

### **The Public Agenda**

We now turn to the first of our set of questions asking decision-makers and members of the policy community why Newfoundland and Labrador has not adopted a population-based funding model for health care. The public agenda focuses on the visibility of the issue in terms of the government's policy radar and the extent to which individuals and groups raised or championed the cause of population-based funding for health care. Our

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<sup>19</sup> . *Ibid.*, 5.

<sup>20</sup> . For a detailed discussion of both the activity and capital budget process, see McKillop, Pink and Johnson (2001), 150-166.

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<sup>21</sup>

**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**

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<sup>21</sup> . 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.

you're going to have this authority saying if we're providing services to 57% of the population, well, shouldn't we have 57% of the budget? Not only do we have 57% of the population but if you look at some of the health issues that we're dealing with, we have way more of the problems. A really good example would be in Child Protection Services. You know, we will have 70% of all child protection services - children coming into care, children needing service - in our region. We don't have 70% of the money. But we also have some of the more complex cases because what happens is people truly need support and services, they tend to migrate into the best system of services that's available. So I think we're going to continue to have that discussion but whether we're able... you know, whether things are going to shift... and then we have to make a decision about what level of services we truly are going to provide in rural Newfoundland. This will become rural/urban issue in terms of allocation of resources [12].

The government used to have a line by line budget. We lobbied government for a global budget. That's what it was called at the time. To some degree, I think, I think the word global was going to be used in some of the terminology in the budget envelope. The government had a line by line, which meant that they determined the number of nurses, the number of whatever spent in the organization. That tied the hands of the board and the board looked at their roles as being a governance board to make decisions on, not only policy, but the types of services within the money they had more or less. So we, as an organization, lobbied government to get away from the line by line budget [18].

So within the envelope of dollars that the boards are given, they have the flexibility to spend that money within certain guidelines and certain principles established by the Department of Health and Community Services. Now the boards then turn around and say, okay, what's the need of the population that we serve and they determine them. I'll give you a real example: dialysis. The Central West Board lobbied government for a dialysis unit. They had people lined up on the Open Line programs month in and month out, lobbying the politicians. The politicians finally gave in - this is a year or so ago - and said, okay, we're going to have a dialysis unit in Grand Falls. They funded the dialysis unit; I'd say about 30 beds. I'm not sure of the exact numbers. So the need was identified by the Central West Board, based on the population, based on the people with kidney issues and whatever. There was a need for a dialysis unit in Grand Falls. The board said, okay, we got the money now. We'll provide the unit. Government is funding us 30 units - 30 beds. The demand from the population is something like 60, alright, so the board has now got to make a decision. Do we live with the amount of money... or live with the amount of service we're going to give to 60 patients or are we going to say to first 30, we're going to provide with the full meal deal and the other 30 we're not going to touch? So that board now is providing services to 60 patients. So what they're doing is taking money from other parts of their budget because they've identified this need as being 60 patients on dialysis [18].

**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 options for funding, and there was a presentation on it, actually. It was a public presentation, but it was a presentation by representatives of the health boards and this type of thing [24].**

**We, I know, have advocated nationally to have health funding on a needs based versus a per capita based, but it's never really gone anywhere; and I think it's resources that are limiting that [26].**



**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 there's a very cautionary approach being taken to the rural areas these days [27].**

**I think there are some concerns about a needs-based approach. What if you find that you have high needs and there's just no way that you could actually meet those needs? That's a concern. I guess, when you're a policy or decision-maker, that's always a concern. As you go forward and you identify a major need in a certain area and you know there's no way that you might have the financial resources to do; but, even putting that aside, it may be a challenging area where nobody's going to want to go anyway. You may not be able to meet those needs [29].**

### **The Decision Agenda**

Our second set of questions concerns the decision agenda or what occurred inside government and away from the public and mass media. Since the provincial government has not formally adopted a population-based funding method for health care delivery, we were interested in the reasons why a non-decision to move forward was taken. Our participants indicated that the issue was driven by the Newfoundland and Labrador Health Boards Association, the pan-provincial body that represented the institutional, integrated and community services boards before their amalgamation in January, 2005. The Association has been a consistent supporter of a population-based funding approach to health but the issue has not found much support among representatives from government (especially Treasury Board). Funding decisions are often based on political considerations whether it is a Minister or the Premier who wants a facility improved or constructed or the mobilization of public opinion around a particular basket of medical services. As well, some decision-makers suggested that government has shied away from a population-based funding method because adoption of such a model would exacerbate the tensions between rural and urban communities. For example,

**It's never an issue in Newfoundland. There's no way they [government] could've publicly defended what the outcome would've been because it would've seen most stuff go to St. John's [3].**

**The public doesn't appear to be very sophisticated when it comes to sort of medical services. At the end of the day, the public just wants to know that when it needs medical services, that a physician will be available; and they don't seem to be as**

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 the Morning Show and Nightline, alright. This government, to some degree, yes, but not near as much as the previous government. So, to me, if the premier wants to do something for his district in Grand Falls or whatever from the point of view of that health care budget, safe to say it's going to be added [18].

I guess the approach right now has worked for the most part for most stakeholders in the sense that's how specific issues are looked at and judged on their own merits. So I guess if there is any unique issue for a particular client or population group in a particular area of the province, then that will be assessed on its own merits. A decision is made whether to fund it or not - that's probably partially too why the province really has not historically often had fiscal latitude to get into making long term fiscal commitments to the health care system, or any part of the provincial budget for that matter, in terms of their strategy for the next year [19].

Government is not set up to think outside the box with respect to funding models. They're focusing on budgets. They're focusing on deficit reduction, and there's currently not a mechanism in the current way we do budgeting in this province for consideration of different ways of doing things [20].

Before you go into a different model, you need to do a lot of analysis work and make sure what the pitfalls are and I'm not so sure if there's the resources to have it in the

**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].**

**The people that were against it were really back to the whole issue again of health care being seen as an important issue that was near and dear to everybody's hearts and that, regardless of any concerns with regards to quality or how much extra cost it would contain... and I... you know, there was a lot of small "p" and big "P" political sensitivities with that. I think the external drivers were from the province concerned about community uprising and site closures, service curtailments and I think there're a lot of sensitivities in this province around that issue [27].**

### **Policy Choice**

Our final set of questions focuses on policy choice. Policy choice refers to the decisions or non-decisions taken by government with respect to population-based funding for health care delivery. Here we were interested in the goals the government of Newfoundland and Labrador was seeking by not adopting a population-based funding model. We were interested, too, in the individuals involved in the non-decision and what drivers, if any, affected policy choice. In general terms, our participants noted that government did not move forward with a population-based funding model because it would remove political control from the funding process; government lacks the policy capacity to move forward on this issue; this particular funding method is difficult to implement; politicians are motivated by the mobilization of public opinion and not by objective indicators of health and that the province's small population and geography make a population-based model unfeasible.

**The distribution of the population would've prevented it from working in the beginning, I think, and I don't think it was a very heavy issue for them [government] to debate very long. And if it's the public determining the needs, acute care is going to win; and if it's acute care determining the needs, St. John's is going to win. So this is no win for anybody except acute care in St. John's [3].**

**What they do hear is Open Line. A lot of things they could get from the ministry – their data bases which are more flags than evidence [7].**

**I think the plan is to go there. It's just the recognition of the various steps that you have to go through get there. So the attention is to move, at least within primary care, and then, you know, with the idea of being is if it was successful in primary care, then you look at secondary and tertiary and other services to be funded in a similar manner. Not only building among the public, but sort of separating out this huge black box of public need versus public want [13].**

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 hospitals, which basically said, okay fine, we will go needs based. We'll go intensity based. What we'll say is we'll give you money based on how much work you do, how many really difficult heart attacks you treat, how many really sick patients you treat, how complicated their surgery was - this sort of thing - because, as you know, in any two patients any sort of surgery can have... can take a day and the next patient can take a week and also the principle of the matter is how good you are at doing what you do. So government went out and said, we'll do that. We'll put a resource intensity weighting on your funding. What did the hospitals do? The hospitals went out and hired computer programmers and consultants to absolutely maximize the intensity of their waits for each patient that they discharged, and they did it within the rules; but what it did then was suddenly it upset the entire national database for intensity waits. So the system isn't really out there that I'm aware of and it will take a lot of work to develop it; and to try to hinge it on or piggyback it onto some existing systems or indicators really hasn't worked very well and, in fact, has probably given them [government] a result that's not accurate [15].

I think that the problem has always been that we're constantly trying to restructure health care to deal with the funding challenges and therefore you don't look at the way in which the money is allocated. You simply move the men around the chessboard, and that's essentially what we and other jurisdictions have done with respect to budgeting and health care. I think the focus of the governments in the past has been to keep the financial boat afloat - from a macro perspective, health being one of those. I think it's been fairly recent that we have government acknowledgement or consciousness by government of the extent to which the Newfoundland system is in financial chaos. I don't think that it wasn't in chaos before - I should say that - but that we simply cannot afford to pay for the services we currently have. There also hasn't been, to date, a political appetite, particularly from my view of the world, which is the community view of the world, to deal with the policy decisions that are going to be able to contain the cost. So, for example given the population of Newfoundland, how many MRI machines do we really need, okay, and where should they be located, given the population base in Newfoundland [20].

So we have decisions being made for political reasons even though they are quite frankly against adding to the financial woes of the province. I think we've been containing stuff. I think we've been focusing attention on health care, but it's been focused in such a way that the average citizen does not believe we're in turmoil or in the trouble that we actually are. And I think, as I say, we continually focus on health care in a perhaps unsuitable way, if I may say it that way, or restructuring it every time you turn around [20].

**It was not on government's agenda that we look at how to fund. It was funded, I guess, on a global budget arrangement where it was more a combination of line by line and global, and global was built on what you did last year - on, you know, what services you did, but we... it's never got into the level of needs based and given to that... and... but there's... as I say, there's work done on it but why it hasn't progressed. I'm not sure if it hasn't progressed because the politicians don't want it to progress, I suspect [24].**

**I think the political sensitivities of how it would result in a redistribution of the health care funding and the impact that that was going to have on selected areas, and I guess to try to give them some more benefit of the doubt. The geography in this province is a particular problem, and we're widely dispersed and I guess that while your needs based model may say one thing, you have a responsibility to make decisions that are much broader and you choose to take that as opposed to what the evidence might be saying [27].**

Health care delivery funding methods are an important component of the larger system. As McKillop argues, the appropriate and proper use of a funding method can make the financial management of a health organization better and more accountable.<sup>22</sup> With respect to population-based funding methods, the government of Newfoundland and Labrador has not moved forward on this issue. While regional health authorities do allocate resources across sectors via a needs-based budgetary model, the disbursement of funds remains firmly tied to ministerial discretion. As we have argued in this paper, the provincial government has been reluctant to embrace a population-based funding model because doing so would mean relinquishing some political control over funding for the regional health authorities and the health system and it would require a tremendous investment of capital and human resources to create sufficient policy capacity to successfully implement such an approach. The poor fiscal capacity of the provincial treasury mitigates the possibility that reform will occur in the near future. For the present, the Newfoundland and Labrador Health Boards Association continues to pressure both the Department of Health and Community Services and Treasury Board to develop reformed funding methods for health care delivery.

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<sup>22</sup> . McKillop, "Financial Rules as a Catalyst for Change," 76.

### **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*. St. John's: The Queen's Printer, February 1984.