**OFFICE OF THE**
**MINISTER OF HEALTH**

**MEMORANDUM TO THE CABINET SOCIAL POLICY AND HEALTH COMMITTEE**

# DISTRICT HEALTH BOARD FUNDING: IMPLEMENTATION OF POPULATION-BASED FUNDING

**Paper 1 of 3**

## PROPOSAL

1. I propose that population-based funding for district health boards (DHBs) should begin when DHBs are responsible for all, or almost all, of the health and disability services which will be devolved to them (which is likely to be in the 2002/03 year). I also propose that a final population-based funding formula be submitted to the Committee by 30 June 2001.

## EXECUTIVE SUMMARY

2. DHBs will be funded using weighted population-based funding formulae [CAB (00) M 2/4 refers]. This process can be considered in two parts:

   i. moving to population-based funding, which is where funding is given to DHBs to ensure the provision of services for their resident populations; and

   ii. using a population-based funding formula to determine each DHB's fair share of funding.

3. Both of these parts should occur as part of a managed process in order to minimise risks to service provision, to the financial position of the DHBs, and to the Crown.

4. Population-based funding (the first part) should begin when DHBs are responsible for all, or almost all, of the health and disability services which will be devolved to them. According to an indicative timetable agreed by Cabinet, this will be the case in 2002/03. In 2001/02 DHBs should be funded on the basis of contracts for providers based in each DHB's district, for those services that the DHBs have responsibility for in this year.

5. The structure of a population-based funding formula is proposed in a paper submitted concurrently to the Committee (*Paper 3: Structure of the Population-Based Funding Formula*). A final population-based funding formula will be agreed by 30 June 2001, after consultation with DHBs and a review by an international expert.

## CURRENT FUNDING ARRANGEMENTS

6. At a district level, the HFA currently has contracts with individual providers to deliver particular services. In Taranaki, for example, the HFA buys hospital services from Taranaki Healthcare, pays subsidies to GPs and pharmacies, funds independent rest home providers, and so on. The HFA is now working through all of its contracts to determine the share of funding which is associated with providers in each of the DHB districts.

7. It is also possible to think of health resources in terms of which population groups *consume* these resources, rather than in terms of the providers of services. In particular, the population of each proposed DHB district currently consumes a certain share of overall health funding (from providers across the country as well as in their own district). The HFA is also working to estimate these historical shares of funding. These shares are difficult to estimate accurately, however, since the routine information collected for many services does not include the patients' usual residence.

## POPULATION-BASED FUNDING

8. DHBs are being formed from current HHSs. Twenty-one DHB districts have been proposed, and the populations of these districts will range in size from 32,000 people (West Coast) to 434,000 people (Canterbury).

9. DHBs will be population focussed: they have been charged with monitoring the health and disability support needs of their resident populations, ensuring the provision of services for these populations and enhancing their health status [CAB (00) M 2/4 refers]. DHBs will receive population-based funding in order to do this. The Taranaki DHB, for example, will receive population-based funding to ensure the provision of hospital, GP, rest home, etc, services to meet the needs of Taranaki residents. Some of these services might well be based in other DHB districts. As a rule, the Taranaki DHB will pay - out of it's population allocation - for services which are provided to Taranaki residents in other districts.

10. In order to distribute population-based funding between DHBs in a fair and equitable way, a weighted population-based formula will be used [CAB (00) M 2/4 refers] which takes into account the relative health and disability support needs of the DHB populations and the cost of services to meet these needs. This formula - the population-based funding formula (PBFF) - will give each DHB the same opportunity, in terms of resources, to respond to the needs of its population.

11. The greatest determinant of overall need in a DHB will be the size of the resident population. The Taranaki DHB, for example, will receive somewhere around 2.8 percent of available health funding because 2.8 percent of New Zealanders - 105,840 people - live in this district. The PBFF, however, will also take into account differences between district populations in factors such as age, ethnicity and socio-economic status. Advice on the structure of the PBFF for DHBs is contained in a paper

submitted concurrently to the Committee (*Paper 3: Structure of the Population-Based Funding Formula*).

## IMPLEMENTATION OF POPULATION-BASED FUNDING

12. From the passing of the New Zealand Public Health and Disability Bill, and for the remainder of the 2000/01 year, DHBs will be funded in the same way as HHSs are currently: that is, they will be directly funded by the Ministry of Health (as successor to the HFA) to provide hospital and related services. Over the following years, DHBs will take over the responsibility for health and disability services and will begin to be funded on a population basis. Funding DHBs using weighted population-based funding formulae can be considered in two parts:

    ***part one***: moving to population-based funding, which is where funding is given to DHBs to ensure the provision of services for their resident populations

    ***part two***: using the PBFF to determine each DHB's fair share of funding.

13. Both of these parts involve disrupting current funding arrangements and should therefore occur as part of a managed process in order to minimise risks to service provision, to the financial position of the DHBs and to the Crown.

## DISRUPTIONS TO FUNDING

### *Disruptions to funding from part one (moving to population-based funding)*

14. When population-based funding is introduced (part one), DHBs will need to arrange funding transfers between themselves, governed by service agreements, to recognise patient flows between DHBs. Up to 14 percent of all people discharged from hospital (around 86,000 discharges) are expected to use services that have not been provided by their 'home' DHB. Only about 8,000 of these inter-district flows are high-cost, high-complexity 'tertiary' services like neurosurgery and cardiac surgery.

15. For most DHBs the net result of patient flows into and out of their district will be relatively small. In the greater Auckland region, however, there will be three DHBs close together - Waitemata, Auckland and South Auckland. Auckland hospitals deliver services to people across the wider region, and in particular to many Waitemata residents.

16. Under population-based funding, the Auckland district will receive considerably less direct funding than it currently does on a provider basis. On the other hand, the Waitemata district will receive considerably more direct funding than at present. However, the DHBs in the greater Auckland region will have agreements between themselves to deal with inter-district patient flows, and this will see funding flow back into the Auckland DHB in

its role as a region-wide provider. It is not intended, nor desirable, that each DHB becomes self-sufficient in providing services to its own population.

***Disruptions to funding from part two (using the PBFF)***

17. The share of funding for each DHB, as determined by the PBFF, may be more or less than the share which its population implicitly receives now under provider funding arrangements. In other words, some districts may currently be 'under-funded' or 'over-funded' relative to their fair share of funding as determined by the PBFF. Historical shares of funding have been shaped by factors such as the patterns of hospital investment, where doctors have chosen to practice, and whether health funding has kept in step with population changes throughout the country. The purpose of the PBFF is to 'iron out' historical inequities in funding between districts.

18. The Committee should note that it is not possible at this stage to identify which DHB districts are under-funded and which are over-funded.

19. Using the PBFF to determine funding shares, rather than continuing with historical shares, may therefore mean a relative reduction in the level of services to some DHB populations from what they are getting now, and an relative increase for some other populations.

20. To show something of the scale of the resource shifts implied by parts one and two, Appendix 1 shows:

    i. each HHS's current share of hospital discharges (a very rough approximation of each DHB's share of provider funding)

    ii. each DHB population's current share of hospital discharges (a very rough approximation of its estimated current share of total health funding)

    iii. each DHB's share of the total New Zealand population (a very rough approximation of its PBFF share of funding).

## TIMING OF IMPLEMENTATION

***Timing of part one (moving to population-based funding)***

21. I propose that population-based funding should begin when DHBs are responsible for all, or almost all, of the health and disability services which will be devolved to them. Cabinet has agreed to the following indicative timetable for devolution of responsibilities to DHBs:

    i. baseline local personal, mental and Maori health services (mostly primary and community-based services and secondary health services delivered within their own districts and for their own populations) from 1 July 2001;

    ii. remaining personal health and mental health services (including Pacific health services), public health and disability support services (excluding funding for those service areas identified by the

Government) by July 2002 [CAB (00) M 24/1B(2) refers]. Note, however, if DHBs demonstrate the capacity to take on Pacific health services then funding will be devolved sooner than this.

22. The first year of population-based funding of DHBs should therefore be 2002/03. If the devolution of responsibility to DHBs is slower than this timeframe then further advice will have to be sought on when population-based funding should begin.

23. The reasons for implementing population-based funding in 2002/03, rather than a year earlier in 2001/02, are:

    i. to minimise the disruptions to funding caused by part one, as discussed above. Moving to population-based funding in 2002/03 gives DHBs time to develop a primary focus on their populations and to create systems to accommodate inter-district patient flows.

    ii. the 2001/02 year will be a transitional year, where DHBs will have responsibility for some, but not all, of the intended range of services. This range may be changing throughout the year and not all DHBs will have responsibility for the same services. Population-based funding is difficult to apply in these circumstances.

24. In 2001/02, DHBs will not be funded on a population basis, and therefore each DHB should be funded on the basis of contracts for providers based in that DHB's district, wherever patients come from to use their services. Details around these contracts will be determined in the funding agreements I will have with each DHB. Service responsibility and proposed funding methods over the next few years are summarised in Table 1.

**Table 1. Indicative DHB service responsibility and method of funding**

| | **2000/01 (from Nov 30)** | **2001/02** | **2002/03 and onwards** |
|---|---|---|---|
| **Services DHBs are responsible for providing** | public hospital and related services | public hospital and related services | public hospital and related services |
| **Services DHBs are responsible for planning and procuring (indicative)** | None | 'baseline' personal, mental and Maori health services | all services (except those to be funded by the MoH) |
| **Method of funding DHBs** | direct funding for existing HHS contracts | on the basis of provider contracts devolved to DHBs | population-based funding |

***Timing of part two (using the PBFF)***

25. I propose that if a DHB's PBFF share of funding is close to its population's estimated historical share of funding (that is, it is not considerably under-

funded or over-funded) then the DHB should receive its PBFF share of funding in the first year of population-based funding.

26. If a DHB's PBFF share of funding is a long way from its population's estimated historical share of funding (that is, it is considerably under-funded or over-funded) then the DHB should move to its PBFF share of funding over a number of years. This would give under-funded DHBs time to plan the use of their increased funding. There is no point in transferring resources rapidly if they cannot be used efficiently. Neither is it a good idea to reduce services so rapidly that facilities are wasted unnecessarily. Moving gradually to PBFF shares would therefore also give over-funded DHBs time to manage their expenditure in a way which minimises disruptions to service delivery.

27. The speed of the under- and over-funded DHBs' movement to PBFF shares will depend on a number of factors including the level of new funding for DHBs, impacts on service delivery and whether Ministers wish to maintain nominal funding levels for all DHBs (with enough additional funding, the distribution can be made so that over-funded DHBs do not actually lose funding). The speed of movement will also have to be managed so that the percentage increases of under-funded DHBs and the percentage decreases of over-funded DHBs balance each other.

28. It is likely that under-funded DHBs will press to move quickly to their PBFF share of funding, while over-funded DHBs will want to take as long as possible. This may lead to pressure from DHBs to increase the rate of growth of Vote Health to ease the movement of DHBs to their PBFF shares.

29. The concepts of 'close' and 'a long way' from PBFF shares will need to be defined, and recommendations made about the speed of movement to PBFF shares for those considerably under-funded or over-funded districts. Advice on the movement of DHBs to their PBFF share of funding will be the subject of a further report to the Committee once each DHB population's current share of funding and each DHB's PBFF share of funding are known.

**PATIENT FLOWS ACROSS DHB BOUNDARIES**

30. As discussed above, DHBs will need to make arrangements between themselves for inter-district patient flows. These arrangements could take a number of forms, such as billing for individuals, end-of-period 'wash-ups', bulk billing for some types of patients, or 'knock-for-knock' arrangements. Arrangements should, in principle, aim to minimise transaction and administration costs within the sector. The Ministry of Health will work with DHBs to facilitate the development of protocols around DHB patient flows, which may include elements such as schedules of fees, tertiary weightings, determination of patient residence, referrals between DHBs and treatment of emergency cases. DHBs will also need to work with local GPs to establish protocols to manage GP referrals to other DHBs.

31. Population-based funding will place a greater emphasis in the health sector on knowing where patients live, so that their 'home' DHB can be identified and costs attributed accordingly. This will result in the more widespread use of the National Health Index (NHI), which includes details of where patients live. The NHI is currently only used and recorded comprehensively on public hospital admissions.

32. Initially, the current pattern of service use across DHB boundaries is likely to continue. Over time, however, DHBs may want to change these relationships. Taranaki may wish to send patients to Auckland rather than Wellington for more complex surgery, or vice versa. There is a risk that rapidly changing patterns of referral will destabilise existing providers. There is also a risk to existing providers of inappropriate duplication of specialised services by DHBs who wish to provide these services within their own districts.

33. To manage these risks there will need to be protocols established around the exiting of services. Officials will report to the Ministers of Health and Finance by 30 September 2001 on what arrangements have been made by DHBs to manage inter-district patient flows, on the use of the NHI under population-based funding, and on a process for managing changes in the pattern of service use across DHB boundaries.

**TIMETABLE FOR WORK ON POPULATION-BASED FUNDING**

34. I have submitted a paper concurrently to the Committee (*Paper 3: Structure of the Population-Based Funding Formula*) which proposes the structure of the proposed PBFF. Technical work is currently underway to calculate the population projections, population weightings and formula adjustments necessary to determine each DHB's target fair share of funding according to this structure. Technical work is also underway to estimate each DHB district's current implicit share of funding under provider funding arrangements. Officials will report to me by 28 February 2001 on the estimated share of funding consumed by each DHB's population, and on each DHB's fair share of funding as determined by the proposed PBFF. Since the decision on whether, or which, DSS services will be devolved to DHBs may not have been made by this time, the February report may have to give some different scenarios for each DHB's PBFF share (that is, including DSS or leaving out DSS).

35. It is important that each DHB has an opportunity to comment on the proposed PBFF, since this formula determines their overall share of funding. It is also important, however, that there be no ad hoc changes to the PBFF as the result of lobbying by any individual DHBs and that any changes occur as a result of an even-handed review. Since the PBFF only divides up a set amount of funding, any change to the formula which advantages one DHB will necessary disadvantage one, or more, others.

36. I intend to ask DHBs to comment on the PBFF and suggest any changes to this formula which they consider necessary. This will occur after February

2001, when target PBFF shares resulting from the proposed formula have been calculated. At the same time I also intend to invite an overseas expert on resource allocation formulae to review the PBFF.

37. Any amendments which I approve to the PBFF will be submitted to the Cabinet SPH Committee by 30 June 2001. A final PBFF will then be agreed and be ready for use in calculating DHB funding for the 2002/03 funding year (the first year of population-based funding) and out-years. Advice will also be given to the Committee at this time on the method for moving DHBs to their PBFF shares of funding, and the speed of this movement.

## CONSULTATION

38. The Treasury, the Health Funding Authority, Te Puni Kokiri, the Department of Prime Minister and Cabinet, the Ministry of Agriculture and Forestry (Rural Affairs) and the Ministry of Pacific Island Affairs have been consulted on this paper.

## LEGISLATIVE IMPLICATIONS

39. This paper has no legislative implications.

## FISCAL IMPLICATIONS

40. This paper has no fiscal implications.

## HUMAN RIGHTS ACT 1993

41. This paper has no Human Rights Act 1993 implications.

## REGULATORY IMPACT STATEMENT

42. A regulatory impact statement is not required.

## PUBLICITY

43. Any publicity on matters related to this paper is being managed as part of the Communications Strategy on the health sector changes.

**AT THE MEETING ON 18 DECEMBER 2000, FOLLOWING REFERENCE FROM THE CABINET SOCIAL POLICY AND HEALTH COMMITTEE, CABINET:**

CAB (00) M 42/5 A

## DISTRICT HEALTH BOARD FUNDING: IMPLEMENTATION OF POPULATION BASED FUNDING

a **noted** that District Health Boards (DHBs) will be funded using weighted population-based funding formulae [CAB (00) M 2/4 refers] and that this can be considered in two parts:

i moving to population-based funding, which is where funding is given to DHBs to ensure the provision of services for their resident populations; and

ii using a population-based funding formula (PBFF) to determine each DHB's fair share of funding;

## MOVING TO POPULATION-BASED FUNDING

b **agreed** that population-based funding for DHBs should begin with DHBs that are responsible for all, or almost all, of the health and disability services which will be devolved to them;

c **noted** that, according to the indicative timetable for devolving responsibility agreed by Cabinet on 24 July 2000, it is intended that DHBs will have responsibility for all of their intended ranges of health and disability services from 1 July 2002 onwards [CAB (00) M 24/1B(2) refers];

d **noted** that funding DHBs on a population basis means that DHBs will have to arrange funding transfers between themselves to recognise inter-district patient flows;

e **agreed** that in the 2001/02 transitional year each DHB will be funded on the basis of contracts for providers based in that DHB's district, not on a population basis;

## USE OF THE POPULATION-BASED FUNDING FORMULA (PBFF)

f **noted** that Cabinet's decisions on the structure of the proposed PBFF are set out in CAB (00) M 42/5C;

g **agreed in principle**, **subject to** the report back referred to in paragraph (i) below, that:

i. if a DHB's PBFF share of funding is close to its population's estimated historical share of funding, then the DHB should receive its PBFF share of funding in the first year of population-based funding;

ii. if a DHB's PBFF share of funding is a long way from its population's estimated historical share of funding, then the DHB should move gradually to its PBFF share of funding over a number of years;

## FURTHER WORK

h **directed** officials to report to the Ministers of Health and Finance:

i. by 28 February 2001 on:

A. the estimated share of funding currently consumed by each DHB's population; and

B. each DHB's fair share of funding as determined by the proposed PBFF;

ii. by 30 September 2001 on:

A. the arrangements that have been made by DHBs to manage inter-district patient flows;

B. the use of the National Health Index under population-based funding; and

C. a process for managing changes in the pattern of service use across DHB boundaries;

i **invited** the Minister of Health to report to the Cabinet Social Policy and Health Committee by 30 June 2001 on:

i. the final structure of the PBFF (after consultation with DHBs and a review by an international expert);

ii. each DHB's fair share of funding as determined by this final formula;

iii. the method for moving DHBs to their fair share of funding, and the speed of this movement;

j **noted** that officials will report to SPH on the extent to which the PBFF would lead to significant changes in funding for DHBs between years, and will make recommendations on ways in which any significant funding decreases might be phased in to allow DHBs to enter into longer term funding contracts with local providers [CAB (00) M 42/5C refers].