



MOVE TO FAIRER RESOURCE ALLOCATION

The NSW Health Department has begun using a Resource Allocation Formula (RAF) as a guide to achieving a fairer distribution of health resources.

The Formula is based on the principles that the need for primary and secondary level health services is mainly related to population size, and that tertiary services are best provided in a small number of established centres of excellence.

The Department is responsible for a Health budget of \$4.4 billion. Most of this budget (\$3.6 billion) is allocated to Area Health Services and Public Hospitals in NSW through Program 2.3. All acute care public hospitals and community health services are funded through this Program.

Before adoption of the Formula in 1989/90, Area Health Services and Country Regions were funded on a historical basis, ie. a matching of the previous year's budget plus extra funds for new or enhanced services. Allocating resources in this way failed to take proper account of changing population trends. It also tended to reinforce the status quo in the distribution and location of major health facilities.

As a result of using this method of allocation in NSW for decades, health infrastructure is heavily concentrated in the inner suburbs of Sydney. It has not matched the population growth of the western suburbs of Sydney and the North and Central Coast.

The primary and secondary component of the Resource Allocation Formula is determined by population adjusted for:

- age/sex structure
- standardised mortality ratio
- fertility weighting
- net interstate patient flows
- private hospital patient flows
- nursing-home type use of acute hospitals.

The tertiary component is determined by current tertiary (super-specialty) service provision in major teaching hospitals and an assessment of tertiary services to be established/upgraded in growth areas.

The Resource Allocation Formula sets target resource shares for 10 years hence and is used as a guide in the setting of Area/Regional recurrent budget forward estimates. There will be a redistribution of funds over a 10-year period through a process of:

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- targeting areas of high population growth for new capital works (eg. Gosford, Wyong, Nepean, Liverpool and Port Macquarie Hospitals)
- relocating services to areas of greater need when such opportunities arise (eg. the Royal Alexandra Hospital for Children move to Westmead)
- targeting under-resourced Areas/Regions in the allocation of growth funds (eg. Southern Sydney, Wentworth, South Western Sydney, Central Coast, North Coast).

The major transfer of resources will be timetabled to match the completion of new capital works. Recurrent funding will not flow in large lumps until Areas/Regions have the infrastructure in place to effectively make use of it.

Will the RAF improve health outcomes?

The most important consideration in the allocation of resources at the State level is ensuring that they are distributed to Areas/Regions fairly and equitably. The maximising of efficiency and health outcomes within Areas/Regions is considered to be the responsibility of the Area/Region administration.

An underlying principle of the RAF is to encourage Area Health Services and Regions to be self-sufficient in providing primary and secondary health services. The Department's aim here is to reduce the need for residents to travel outside their Area/Region for such services.

In so doing, and in conjunction with global budgeting, the Department is empowering Areas/Regions through a decentralised service management framework. Areas/Regions are more in touch with local health needs and are thus appropriately responsible for developing the most suitable range and mix of health services.

The linking of resource allocation to (adjusted) population sets an upper limit on funding. This encourages Areas/Regions to prioritise service development proposals, maximise activity efficiencies (eg. reduce acute hospital bed days) and examine the costs and benefits of public health and health promotion/prevention programs.

The extent to which the RAF will improve health outcomes by improving access to health services remains to be evaluated. However, it is considered that the population-based resource allocation approach provides greater incentives to improve health outcomes than alternative methods, such as historical funding or the case-mix approach.

The case-mix method is used in the US to pay hospitals on a prospective basis according to an average cost per patient treated, using Diagnosis Related Groups. This method is totally "process-oriented". While it provides incentives for hospitals to increase efficiency, it can also encourage hospitals to increase admission rates, particularly for the most "profitable" cases.

FUTURE DIRECTIONS

The Department intends to use the RAF to achieve a more equitable distribution of health funds over the next 10 years.

This initiative is one of many stressed in the Department's corporate strategy, which has set improvement in health outcomes as a major goal. In the future, it may be possible to develop a framework for resource allocation which is outcome, rather than demand, based.

At present, the application of funds between primary, secondary and tertiary services, and between treatment programs and prevention strategies, is largely activity and output driven, eg. reduction of waiting lists or increasing hospital throughput. These short-term strategies do not necessarily challenge the efficacy of the service being offered or the relative value of alternative applications of funding.

An important element of the Department's corporate direction is to continue to focus the emphasis of the health industry on its product, ie. determining health status problems and formulating prevention and treatment services. A framework could be developed for setting resource priorities that is not merely aimed at short-term objectives.

The link between resource allocation and health outcomes will be strengthened in the future with the development of hospital financial information systems, particularly cost-centre reporting. These developments will assist in the evaluation of the cost-effectiveness of health care services and programs. The development of clinical outcome indicators will enable more rigorous evaluation of efficacy and cost-benefit appraisal of these programs.

While the Resource Allocation Formula empowers this process, the future impact and success in improving the health of our community is beyond the portioning of resource shares. It rests with health managers and health care professionals.

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