A more rationale approach to funding NGOs operating in the Alcohol and Other Drug Sector in NSW

Introduction: The NSW Government through NSW Health has provided funding to Alcohol and Other Drug (AOD) Non-Government Organisations (NGOs) since the early 1980s. The majority of funding is for residential rehabilitation treatment, complemented by some non-residential treatment services and non-treatment services (health promotion and prevention). In most instances, the funds are provided as a contribution to the costs of operating services. The contribution varied across services and was not related to any specific measure of capacity (such as beds) or services delivered (such as bed days). Due to concerns about the absence of transparency in, and possible inequities arising from, the current arrangements, NSW Health commissioned a review of the method of funding AOD NGOs.

Methods: The methodology consisted of five major processes. First, data about the current funding arrangements including the funding amount and services supported were collated into the three sub-programs, residential rehabilitation; non-residential treatment; and promotion and prevention services. Second, taking account of best practice in health services resource allocation and the available data, potential funding options were developed for each sub-program. Third, the options were canvassed through a series of consultations with representatives of NGOs and Area Health Services (that manage the NGO contracts). Fourth, the impact of using the short listed funding options was evaluated by applying the capacity and activity data to 2007/08 funding levels. Fifth, a preferred option was recommended for each sub-program along with a transition strategy.

Results: The investigations showed that the most information was available for residential rehabilitation services. In 2007/08, NSW Health provided a total of $28.6m to AOD NGO services of which 52.8% was for residential rehabilitation services. Four options were considered for funding these services viz: incremental funding based on historical allocations; input based funding based on number of beds, output based funding based on bed days and blended inputs/outputs funding based on beds and bed days. The impact analysis showed considerable differential between allocated amounts under each of these options. Based on a state-of-readiness assessment, a blended inputs/outputs funding approach was recommended along with a series of refinements to data collection arrangements that would facilitate a transition to full outputs funding based on bed days over three years.

NSW Health allocated 26.8% of the $28.6m to non-residential treatment services. Data for these services were less available than for residential services. Nonetheless, four options were also considered for funding non-residential treatment services viz: incremental funding based on historical allocations; input based funding based on staff numbers, output based funding based on client attendances; and blended inputs/outputs funding based on staff numbers and client attendances. Again, there was considerable variation in what each service would receive under each option. Given the data issues, an inputs based approach was recommended along with a proposal for refinements to data collection arrangements that would facilitate a transition to outputs funding based on client attendances over three years.

NSW Health allocated the remaining (20.4%) of the $28.6m to promotion and prevention services. The review found that there were very little consistent data collected on these services. Only two funding options were considered viz: incremental funding based on historical allocations; and input based funding based on staff numbers. Input based funding based on staff numbers was recommended with the proviso that there be a systematic evaluation of the outcomes achieved by the funding at three-year intervals. It was also recommended that NSW Health prepare evidence-based guidelines on the promotion and prevention services that will be considered for funding.

Conclusions: The project demonstrated that it was very difficult to achieve rapid change to legacy funding arrangements in the NGO sector because of the wide variations between current allocations and what would be provided under a more rationale funding model. The quality and consistency of the available data on AOD NGO service activity levels was also a limiting factor. Nonetheless, for residential rehabilitation and non-residential treatment services productive change was achieved. Transparency of the funding method was improved and some casemix measures were introduced based on client characteristics (e.g. case complexity using dual diagnosis) and service characteristics (e.g. service location using rurality). Furthermore, a basis for further improvement in the funding approach towards full output based funding was developed.