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

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Project objectives

The objectives of this funding methodology review project were to:

- to identify options for how to best provide funding to the AOD NGO sector based on the recommendations of the *Residential Rehabilitation Costing Study;*
- to identify options for how to best provide funding for non-residential drug and alcohol treatment services; and
- to identify the best buys for the funding of non-treatment AOD NGOs.

Types of AOD treatment services provided by NSW Health funded NGOs

- The AOD NGOs in NSW provide a range of AOD treatment services in a variety of settings that are focussed on three sub-programs as follows:
  - residential rehabilitation services;
  - non-residential treatment (day counselling, aftercare); and
  - non-treatment services (health promotion and prevention including education, family and community support).

- Although many NGOs offer services to more than one sub-program, NSW Health funding to an individual organisation relates to only one sub-program for all but one NGO (which is funded to provide RT and NRT services).

- NSW Health funds 37 residential rehabilitation services, 29 non-residential treatments services and 22 non-treatment services.

- AOD NGOs also receive funding from sources other than NSW Health

Current NSW AOD NGO funding arrangements -Government sources

Table 2.1: Funding provided to AOD NGOs by NSW Health and DoHA 2005-06 to 2007-08

	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
	Residential Rehabilitation Services			Non Residential Treatment Services			Health Promotion and Prevention (Non-treatment)		
	$m	$m	$m	$m	$m	$m	$m	$m	$m
NSW Funding:									
Core Funding	8.63	8.94	10.27	3.64	3.72	6.56	3.73	3.86	4.10
Drug Summit Funding	1.88	2.42	3.17	0.15	0.20	0.18	0.44	0.44	0.51
MERIT Funding	2.25	2.61	1.69	0.25	0.69	1.02	0.19	0.56	0.35
Once off/AHS funding	-	-	-						
Subtotal NSW Funding	12.76	13.96	15.13	4.04	4.83	8.16	4.45	5.05	5.34
Commonwealth Funding:									
NGO Treatment Grants Program	4.03	4.03	4.03	0.75	0.75	1.20	-	-	-
Improved Services Initiative	-	-	1.22	-	-	0.35	-	-	0.32
Ampthetamine Type Stimulants Grants	-	-	-	-	-	-	-	-	-
OATSIH	2.28	2.71	2.83	0.07	0.08	0.08	0.03	0.03	0.03
Subtotal Commonwealth Funding	6.31	6.73	8.08	0.82	0.83	1.63	0.03	0.03	0.35
Total	19.07	20.70	23.20	4.87	5.66	9.79	4.48	5.08	5.69
Per cent NSW funding	66.9%	67.5%	65.2%	83.1%	85.4%	83.3%	99.3%	99.4%	93.8%

Current NSW AOD NGO funding arrangements -Non Government Sources

Table 2.2: AOD NGO residential rehabilitation services – revenue

Source of funding	Proportion of funding (%, mean)
Government Funding:	*77.7%*
Other Contributions:	
Client contribution, rent, board, other	18.1%
Donations and other fundraising	0.9%
Member subscriptions and contributions	0.1%
Interest and dividends	0.5%
Other income	2.7%
Subtotal – Other contributions	*22.3%*
Total	**100.0%**

Source: **Health Policy Analysis** ***The NSW alcohol and drug residential rehabilitation costing study*****, 2005**
Note: The study did not include non residential treatment services and health promotion and prevention services

- In general client fees are not applied in the case of non-residential and health promotion and prevention (non-treatment) services

Current NSW AOD NGO funding arrangements -Management of NSW Grants

- Funding for NGOs is largely managed at the AHS level
- Core grants are generally provided under three year funding and performance agreements
- On an annual basis, NGOs provide:
  - An annual audited financial statement for each funded project/service; and
  - An annual program report, which provides aggregate statistics on the services provided.
- NGOs also collect data for the NSW Alcohol and Other Drugs Minimum Data Set (NSW AOD MDS)
- Currently there is no system for aggregating key information on these at a state level, except for details of total grants provided.
- A similar set of arrangements apply in relation to grants received from the Commonwealth Departments of Health and Ageing (DoHA)

Generic approaches to funding

- **Historical or incremental funding,** where funding reflects an accumulation of decisions over time, but often not necessarily reflecting an underlying principle or the current circumstance of a service.
- **Population needs based funding,** typically used to fund regional entities, or service providers responsible for a specified population. Funding is linked to the needs of the population served, relative to other populations.
- **Input based funding,** for example where funding is tied to numbers of staff or numbers of places. A major limitation for input based models is that there is little incentive to use resources efficiently.
- **Output based funding,** where funding is linked to the outputs delivered by the service (or the outputs planned to be delivered). Output based models sharpen incentives for efficient use of resources, but may have perverse effects where the measurement of outputs is problematic (eg not sufficiently accounting for differenced in the complexity of clients) or where there are elements of quality of care that are not measured.
- **Outcome based funding,** where funding is provided for achieving specific outcomes for a group of consumers/clients. Although attractive in theory, outcomes based approaches are extremely complex to implement in practice, becuase it is too difficult to define an acceptable system for classifying outcomes.
- **Performance based funding models** (sometimes known as pay for performance (P4P). These models create incentives around maintenance or improvements in quality of care measures. They are often blended with other models. A major challenge for these models is the development of valid and reliable measures of quality of care.

There is no one 'gold standard' model that should be used in all circumstances. As a result, in most instances actual funding model blend various features of these models.

Criteria used to assess the various funding options

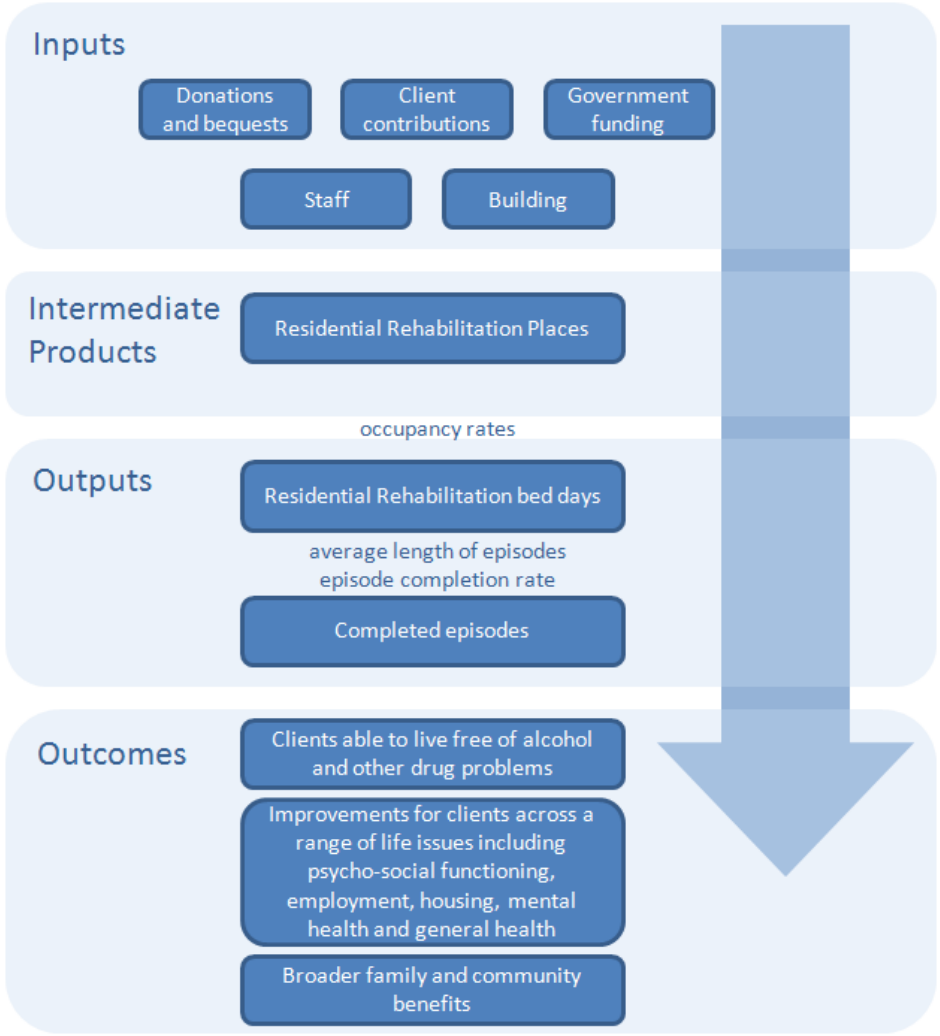
- Supports the goals of funding body.
- Is results-focused rather than input focused.
- Maintains or enhances quality of services delivered.
- Promotes equity between providers.
- Is technically robust yet easy to understand.
- Is simple to administer.

Funding Model Options

Other aspects of 'funding models'

- Certainty of funding over a reasonable period (e.g. three years)
- Clear systems for reviewing performance and funding arrangements at regular intervals (e.g. a three year review).
  - ➢ Clarity over the issues to be considered in a review
  - ➢ Good processes which give organisations adequate time to prepare for and respond to review
  - ➢ Harmonisation of accountability processes/reporting between different funders (e.g. NSW and Commonwealth Departments)
- Funding needs to be set at rates that adequately covers basic infrastructure costs (e.g. administrative support, travel).

Overview of residential rehabilitation services -program logic



Overview of residential rehabilitation services -Recorded activity levels

Table 4.2: Activity recorded through the NSW AOD MDS, 2005-06 to 2007-08

Service	2005-06	2006-07	2007-08
Number of Services reporting activity data	34	32	28
Percentage of total services	89%	86%	75%
Estimated Places in services reporting activity data	926	939	892
Estimated Percentage of total places	93%	93%	87%
Episodes:			
Assessment Information & Education Episodes	858	979	769
Other non residential episodes	289	187	149
Residential Rehabilitation	3,001	2,573	2,186
Detoxification	1,344	1,375	1,144
Total	5,492	5,114	4,248
Estimated Bed Days			
Residential Rehabilitation	176,441	188,909	151,310
Detoxification	24,909	33,064	39,039
Total	201,350	221,973	190,349
Estimated Average Length of Stay			
Residential Rehabilitation	59	73	69
Detoxification	19	24	34

Overview of residential rehabilitation services -Recorded activity levels

- Not all 37 services report through the NSW AOD MDS and reporting is less complete for the most recent year (2007-08)

- There are an estimated 1,020 residential rehabilitation places available in the 37 funded services across NSW.

Overview of residential rehabilitation services -previous costing study

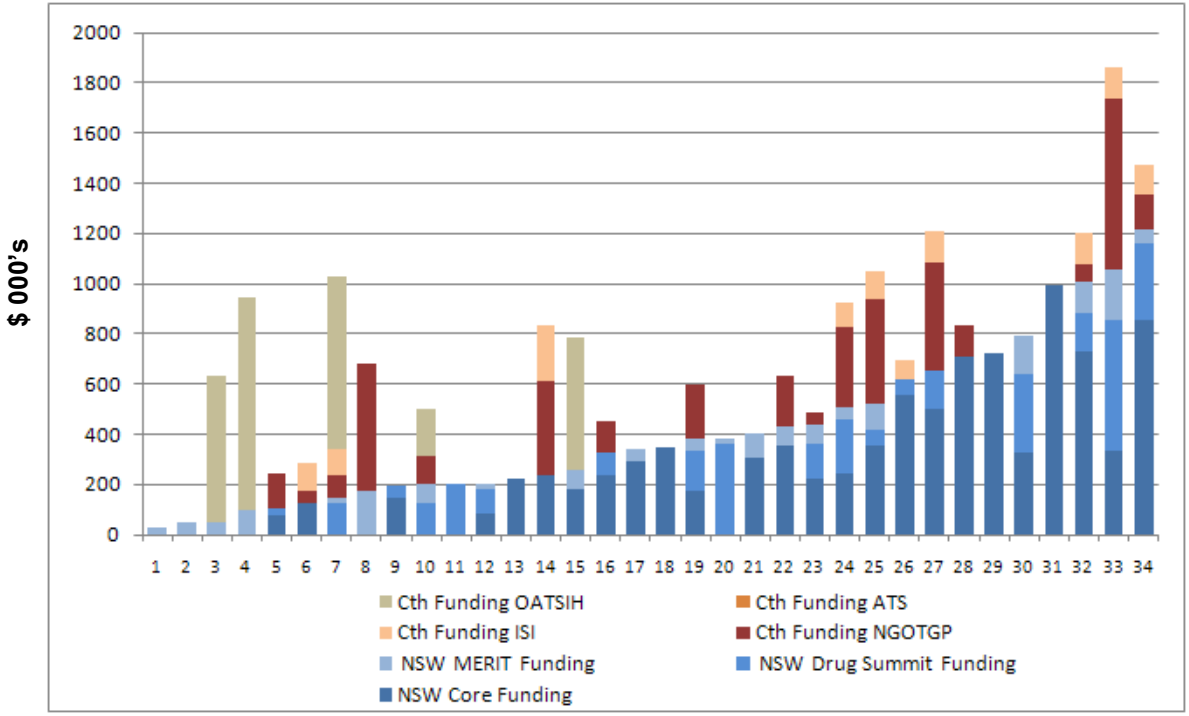
- The actual costs of delivering residential rehabilitation services were estimated in the costing study in 2004.
- In 2003-04, it was estimated the mean expenditure per client day was $117 (median $107).
- The mean cost per closed episode was $6,995 (median $7,206).
- On average services received $83 in government funding per day (median $101) and $4,960 per closed episode (median $4,442).

Overview of residential rehabilitation services -previous costing study

- The costing study found considerable variation around these averages. Some issues that need to be considered in the development of a funding model include:
  - the nature of the program being offered
  - on average female clients are more expensive
  - services that take children into residence are more costly
  - some evidence suggests that services located in Sydney are more costly
  - certain service characteristics impact on costs i.e. Whether an organisations owns their own building or pays rent, whether full commercial rent or peppercorn rents.

Challenges with current arrangements -DoHA and NSW Health funding

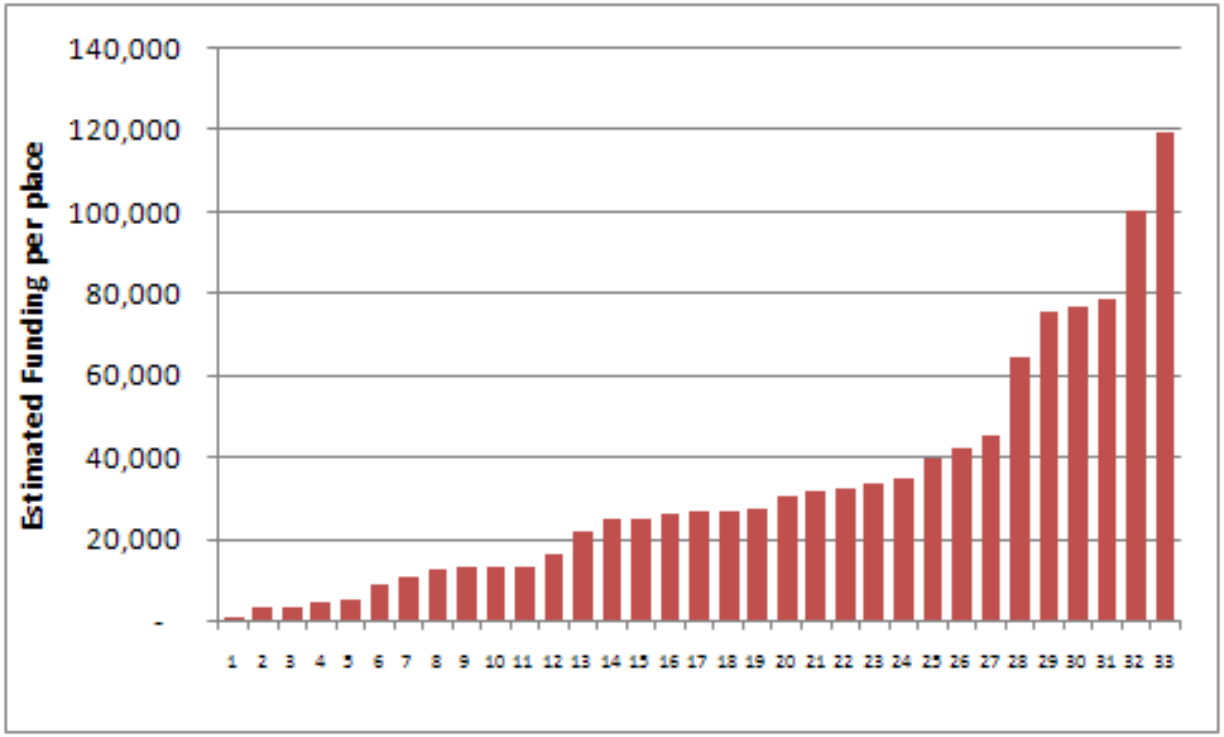
Figure 4.2: Levels of Commonwealth and State funding for residential rehabilitation Services, 2007-08



- Figure 4.2 shows the level of funding provided to residential rehabilitation services in 2007-08 by the source of funding.
- Access to various funding sources varies significantly across NGOs

Challenges with current arrangements -funding and service size

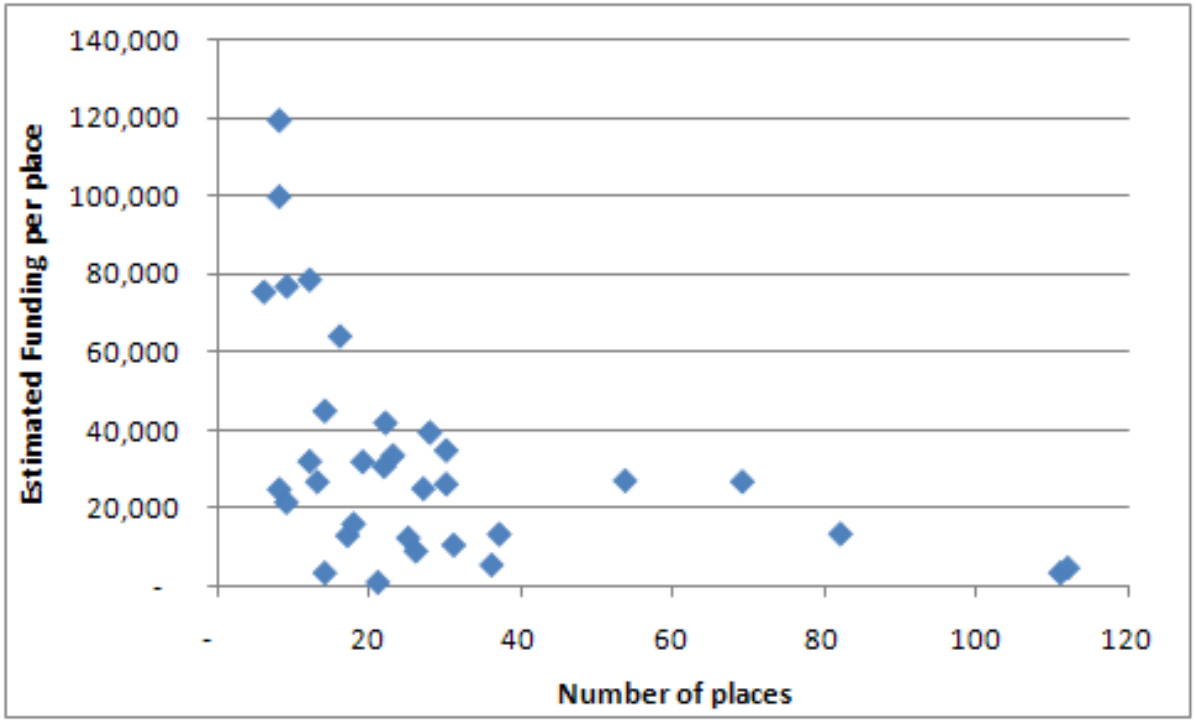
Figure 4.3: Estimated Commonwealth and State contribution per residential rehabilitation place, 2007-08



- Figure 4.3 shows the total level of funding contribution per residential rehabilitation place
- Government funding contributions range from $1,200 per place to $120,000 per place. Most services are in a narrower range of $11,000 to $35,000 per place

Challenges with current arrangements -funding and service size

Figure 4.4: Estimated Commonwealth and State funding contribution per residential rehabilitation place by the number of places, 2007-08



Challenges with current arrangements -funding and service size

- The lack of clarity and consistency in current funding creates several challenges. These include:
  - Difficulties in justifying continued or expanded investment in residential rehabilitation, particularly given the push for ‘activity based funding’
  - No clear basis for funding negotiations between Governments and NGOs
  - Inequities between providers in level of funding provided for equivalent services;
  - Limited incentives for providing efficient services
  - Absence of a consistent basis on which NGOs can be accountable for funding provided.

Residential rehabilitation services - funding options

Option A:

- **Maintenance of current arrangements**

Residential rehabilitation services - funding options

Option B:

- **Benchmark price for rehabilitation places (an input based model)**
  - Separate prices would be set for:
    - Residential rehabilitation services, supported accommodation services and detoxification services.
  - Other modifying factors would be considered and negotiated including:
    - Services that cater for children and babies in residence
    - Services that target young people
    - Specific arrangements for the property from which the service operates
    - The size of the service.
  - Funding would be supplied whether or not a residential care place is occupied.

Residential rehabilitation services -funding options

Table 4.3: Illustration of how Option B would work

	Service Type	Numer of Places	Benchmark Rate	Base Funding	Additional factors	Additional Factor Funding	Non-residential services funding	Total Funding
		A	B	C=A*B	D	E=A*D	F	G=C+E+F
			$ per place	$	$ per place	$	$	$
Service A	Residential Rehabilitation	20	28,000	560,000	-	-		560,000
Service B	Residential Rehabilitation	20	28,000	560,000	1,000	20,000	50,000	630,000
Service C	Residential Rehabilitation	10	28,000	280,000	1,000	10,000		290,000
Service D	Supported Accommodation	10	10,000	100,000	-	-		100,000

- The values presented are for illustration only.

Residential rehabilitation services - funding options

Option B:

- Implementation:
  - Adjust number of places funded for services in which current funding if below the benchmark rate;
  - Period of transition for services in which current funding is greater than the proposed benchmark rate. Transition could involve: increasing numbers of places actually provided or alternative reductions in funding provided; and
  - Coordination with Commonwealth funding arrangements.
- Review process to include review of numbers of clients treated (completed episodes) and associated characteristics.

Residential rehabilitation services - funding options

Option C:

- **Benchmark price for rehabilitation days (an output based model)**
  - Separate prices would be set for:
    - Residential rehabilitation services, supported accommodation services and detoxification services.
  - Other modifying factors (as discussed under the previous options)
  - Target funding rates would be set to reflect planned level of activity.
  - A tolerance band would be established around the target number of bed days.
  - Similar issues and approaches in relation to implementation.

Residential rehabilitation services -funding options

Table 4.6: Illustration of how Option C would work

	Service Type	Numer of Bed Days	Benchmark Rate	Base Funding	Additional factors	Additional Factor Funding	Non-residential services funding	Total Funding
		A	B	C=A*B	D	E=A*D	F	G=C+E+F
			$ per bed day	$	$ per bed day	$	$	$
Service A	Residential Rehabilitation	8,111	85	689,444	-	-		689,444
Service B	Residential Rehabilitation	8,111	85	689,444	10	81,111	50,000	820,556
Service C	Residential Rehabilitation	4,056	85	344,722	10	40,556		385,278
Service D	Supported Accommodation	4,056	30	121,667	-	-		121,667

- The values presented are for illustration only.

Residential rehabilitation services - funding options

Option D:

- **Benchmark rate for number of completed episodes (an output based model – similar to Victoria).**
  - Separate prices would be set for:
    - Residential rehabilitation services, supported accommodation services and detoxification services.
  - Other modifying factors (as discussed under the previous options)
  - Target funding rates would be set to reflect planned level of activity.
  - A tolerance band would be established around the target number of completed episodes
  - The option requires attention to the business rules governing how 'client episodes' are reported
  - Similar issues and approaches in relation to implementation.

Residential rehabilitation services -funding options

Table 4.7: Illustration of how Option D would work

	Service Type	Numer of Completed Episodes	Benchmark Rate	Base Funding	Additional factors	Additional Factor Funding	Non-residential services funding	Total Funding
		A	B	C=A*B	D	E=A*D	F	G=C+E+F
			$ per completed episode	$	$ per completed episode	$	$	$
Service A	Residential Rehabilitation	90	8,500	765,000	-	-		765,000
Service B	Residential Rehabilitation	90	8,500	765,000	100	9,000	50,000	824,000
Service C	Residential Rehabilitation	40	8,500	340,000	100	4,000		344,000
Service D	Supported Accommodation	40	4,000	160,000	-	-		160,000

- The values presented are for illustration only.

Residential rehabilitation services - funding options

Option D:

- **Benchmark rate for number of completed episodes (an output based model – similar to Victoria).**

  - Implementation:
    - Adjust number of closed episodes funded for services in which current funding if below the benchmark rate
    - Period of transition for services in which current funding is greater than the proposed benchmark rate. Transition could involve: increasing numbers of places actually provided or alternative reductions in funding provided
    - Coordination with Commonwealth funding arrangements.

Residential rehabilitation services -funding options

Table 4.8: Illustration of how Option D would work

	Service Type	Numer of Completed Episodes	Benchmark Rate	Base Funding	Additional factors	Additional Factor Funding	Non-residential services funding	Total Funding
		A	B	C=A*B	D	E=A*D	F	G=C+E+F
			$ per completed episode	$	$ per completed episode	$	$	$
Service A	Residential Rehabilitation	90	8,500	765,000	-	-		765,000
Service B	Residential Rehabilitation	90	8,500	765,000	100	9,000	50,000	824,000
Service C	Residential Rehabilitation	40	8,500	340,000	100	4,000		344,000
Service D	Supported Accommodation	40	4,000	160,000	-	-		160,000

Residential rehabilitation services -funding options

Option E:

- **Blended Model**
  - Under this model funding would be broken into two components:
    - A fixed 'base' grant; and
    - An 'activity' grant which would be related to a measure of the level of activity performed by a service. The activity grant would be linked to number of places, beds days or closed episodes
  - A benchmark price would be developed for the activity grants. The prices would be determined in the same manner as described in Options B, C and D, but with a reduction reflecting the base grant, the separate benchmark price would be set for:
    - Residential rehabilitation services, supported accommodation services and detoxification services.
  - Other modifying factors (as discussed under the previous options)
  - Target funding rates would be set to reflect planned level of activity.
  - Similar issues and approaches in relation to implementation.

Residential rehabilitation services -funding options

Table 4.9: Illustration of how Option E would work

	Service Type	Numer of Bed Days	Base Grant	Activity Grant:				Non-residential services funding	Total Funding
				Benchmark Rate	Funding	Additional factors	Additional Factor Funding		
		A	B	C	D=A*B	E	F=A*E	G	G=B+D+E+G
				$ per bed day	$	$ per bed day	$	$	$
Service A	Residential Rehabilitation	8,111	200,000	40	324,444	-	-		524,444
Service B	Residential Rehabilitation	8,111	200,000	40	324,444	10	81,111	50,000	655,556
Service C	Residential Rehabilitation	4,056	200,000	40	162,222	10	40,556		402,778
Service D	Supported Accommodation	4,056	200,000	10	40,556	-	-		240,556

- The values presented are for illustration only.

Residential rehabilitation services -funding options

Table 4.10: Illustration of how and alternative Option E would work

	Service Type	Number of Places	Numer of Bed Days	Base Grant	Activity Grant:				Non-residential services funding	Total Funding
					Benchmark Rate	Funding	Additional factors	Additional Factor Funding		
		A	B	C	D	E=B*D	F	G=B*F	H	I=C+E+G+H
					$ per bed day	$	$ per bed day	$	$	$
Service E	Residential Rehabilitation	50	15,000	300,000	40	600,000	-	-		900,000
Service F	Residential Rehabilitation	20	8,111	200,000	40	324,444	10	81,111	50,000	655,556
Service G	Residential Rehabilitation	10	4,056	100,000	40	162,222	10	40,556		302,778
Service H	Supported Accommodation	10	4,056	100,000	10	40,556	-	-		140,556

- The values presented are for illustration only
- The alternative is that the base grant increases in a series of steps as the size of the service increases

Residential rehabilitation services - assessment of options

	Option A	Option B	Option C	Option D	Option E
Supports the goals of the funding body	?	✓	✓	✓	✓
Results-focussed rather than input focussed	✗	✓	✓	✓✓	✓
Maintains or enhances quality of services delivered	?	?	?	?	?
Promotes equity between providers	✗	✓	✓	✓	✓
Is technically robust yet easy to understand	✗	✓✓	✓	✓	✓
Is simple to administer	✓	✓	✗	✗	?

Conclusion

- Pure application of any funding model would create significant reallocation of funds across providers assuming the total funding available for distribution remains constant.
- Phased implementation using transition grants appears the only logical approach to implementing any of the funding models except historical grants (Option A).
- Blended model (Option E) is most attractive because it recognises the need to fund a base level of infrastructure in a service while retaining the incentives associated with output based funding.
- Blended model will however be complicated to implement.
- Significant issues to be resolved in respect of data collection.