Rural Funding Changes – Alliancing Overview – Q & A's

Rural funding changes and the impact on some rural practices

- Impact of rural funding changes to some rural practices.
- Plans for rural funding.
- Plans for rural after-hours and DHB after-hours funding.

In October 2013, Minister Jo Goodhew announced the Government's support for a new way of allocating rural funding through Service Level Alliances and that additional rural funding would be provided in the form of "transitional funding" and "rural practice sustainability funding."

In/Out rule criteria

The new funding approach was negotiated under the PHO Services Agreement Amendment Protocol (PSAAP).

It was agreed that from 1 July 2014 an "In/Out rule" will apply to determine a "first cut" of which communities are "rural".

This means that practices within 30kms/mins from a base hospital (level 3 ED), and a population of more than 15,000 residents, are excluded from rural funding support unless a DHB or Service Level Alliance Team (SLAT) agrees to include them in rural services and funding arrangements.

Ministry expectations for the establishment of rural SLATs have been set and have been communicated to DHBs through the DHB annual planning process for 2014/15.

Transition funding is available to support practices excluded from rural funding support from 1 July 2014.

Fifteen practices have been identified as not meeting the In/Out rule. Any practices that are excluded under the In/Out rule criteria and not subsequently included in funding arrangements by a DHB or SLAT will be transitioned out of their current level of rural funding over a two-year period from 1 July 2014, receiving current funding in 2014/15 reducing to 50% in 2015/16.

The Ministry has made transitional funding available from 1 July 2014 once a DHB has notified the Ministry of those practices requiring such support. The DHB and PHO will need to engage with the practice(s) and develop a plan to support/manage the practice(s) once the transitional funding has been made available.

Note, that in the instance where a practice, that is excluded from rural funding based on the In/Out rural criteria, is included in rural funding arrangements by a SLAT then that practice will no longer be considered eligible for transitional funding.

Rural funding

To support the funding approach, the Ministry has made all rural funding held by the Ministry available for SLAT discussions from 1 July 2014. The Ministry will initiate discussions with DHBs and PHOs to offer advice and support through this change process.

Available rural funding for SLAT discussion includes the following:

- Current funding that DHBs hold in their baselines to support rural primary health care services (nationally in 2013/14 this totaled $13.6 million).
- Current funding of $5 million per annum for rural after-hours (to be devolved from 1 July 2014). The rural after-hours funding was devolved to DHBs baseline funding as allocated in 2013/14.
- Additional new funding of $2 million per annum for DHBs who agree to establish rural Services Level Alliances to support rural primary health care service delivery.
- Transitional funding of up to $581,462 to be paid during 2014/15 reducing to $290,731 during 2015/16 to support practices excluded from rural funding support.

Q&As for rural funding

What has happened to the Rural Ranking Score tool?
The Rural Ranking Score (RRS) tool has not changed. It will be replaced with local alliancing arrangements but will continue to be used until such time as DHBs, PHOs and practices make decisions within the scope of a Rural Service Level Alliance.

What rural funding is available?

- the current rural DHB expenditure of $13.6 million per annum
- $2 million extra funding per annum
- transition funding to support any practices that are within 30kms/mins from a base hospital and have a population of more than 15,000 residents and are not included in an alliance arrangement going forward
- $5 million rural after-hours funding.

How will the additional funding be allocated to DHBs?
The $2 million new funding will be allocated to DHBs using Urban/Rural profiles from Statistics NZ population estimates, plus a deprivation weighting. This was the recommendation of the Rural Advisory Group. DHBs have been advised of their share of the funding. The funding will be distributed to DHBs via a variation to the Crown Funding Agreement from 1 July 2014. The variation will require DHBs to apply the new funding to rural primary care services. DHBs will be required to explain in their annual plans how they are establishing sustainable rural services.

The Ministry's transition funding will be used to support any practices that are excluded from a rural service level alliance arrangement. They will receive full current funding in 2014/15 reducing to 50% in 2015/16 and ceasing on 30 June 2016.

Can all DHBs expect a funding proportion will be allocated to them?
All DHBs that have rural practices will receive a proportion of the funding. The funding will be allocated to individual District Health Boards (DHBs) taking into account their population demographics, remote rural issues, and the historical share of existing rural funding allocation.

What will transition funding be used for?
The purpose of the rural transitional funding is to support those practices that are not eligible for rural funding from 1 July 2014 and that are excluded from rural SLAT discussions moving forward.

How will the after-hours funding be allocated to DHBs?
The rural after-hours funding (and the after-hours funding) will be devolved to the DHB baselines according to how it is currently allocated by the Ministry.

The Ministry and Rural Advisory Group (RAG) considered whether the rural after-hours funding should be distributed differently and expressed some preference for devolving it using Urban/Rural profiles from Statistics New Zealand population estimates. However, this methodology for allocating the rural after-hours funding creates shifts in current funding across DHBs and results in significantly reduced funding for some DHBs. Therefore, the rural after-hours funding will be devolved to DHBs baseline funding as currently allocated in 2013/14. After-hours funding of $9 million will be devolved to DHBs using the Population Based Funding Formula (PBFF).

How will the local rural service level alliance ensure that rural funding continues to support rural communities?
The RAG has developed principles to guide alliance decision-making, with an aspirational goal that people in rural areas have equitable health outcomes. The principles are around planning, service access, service capacity and capability, rural support (financial and non-financial), and monitoring.

The additional funding is to support the sustainability of rural general practice. However, if the alliance agrees, some 'rural' funding could potentially be directed towards supporting other services or providers, or access to services, that help achieve improved health outcomes for people in rural communities.

What will happen if a local rural service level alliance arrangement is not in place on 1 July 2014?
Under the PHO Services Agreement, the status quo will continue until such time as DHBs, PHOs and practices agree arrangements within the scope of a Rural Service Level Alliance. In the situation where a rural service level alliance arrangement is not in place, the following would occur:

- PHOs and practices would continue to be funded using the RRS
- PHOs and practices would continue to receive the same rural after-hours funding
- the DHB share of the $2 million additional funding would be retained by the DHB until an alliance arrangement is in place.

How do Alliances and Service Level Alliances work?
Alliancing is one approach that the New Zealand health system can use to efficiently allocate scarce resources through building communities of interest across more than one practitioner or organisation. There are core elements to alliancing that contribute to improving success.

An Alliance reflects a group of organisations agreeing to work together to achieve shared outcomes and using a shared decision-making forum, the Alliance Leadership Team (ALT). The approach provides a more 'fit for purpose' arrangement that promotes and facilitates integration, regional service planning, and alliance funding and planning. It provides a mechanism for clinical leaders to be involved in the development of health services.

Service Level Alliances are established by the ALT, as required, to implement significant service change and or specific service redesign. ALTs are decision-making forums for organising groups of related health services, including decisions on contractual mechanisms and budgets.

Who will be involved in a Rural Service Level Alliance?
DHBs, primary health organisations (PHOs) and providers will work together in a Rural Service Level Alliance. They will involve GPs and possibly other health professionals and organisations who deliver a given service. They are likely to engage with patient groups and communities. The range of participants depends on the agreed scope of the discussions.

Defining Rural

- The <15,000 population was an attempt to recognise that towns of less than 15,000 will generally have less in the way of infrastructure and support for general practice – eg pharmacy, ambulance etc.
- The population of 15,000 is somewhere between what Stats NZ define as “Minor Urban area” of over 1,000 people and “Major Urban area” with a population of more than 30,000 (see attached)
- Rural areas as described by Stats NZ as having a population of 300-999 people
- Rural areas as defined by Stats NZ are areas which are not specifically urban, so include rural centres, inlets, islands etc.
- During discussions it was felt that towns with between 1,000 and 15,000 people would have more difficulty in attracting and retaining staff for general practice.
- Using any Stats NZ units of geographic measure tends to be difficult as the units vary in size from a few square kilometres to many thousand square kilometres.
- Defining a population for the census does not give a picture of how people use services, and therefore does not help with funding allocation. For example Ohura in the King Country has a population of 129, the Otangiwai-Haeo area in which it sits has a population of 822 but the population receives primary care services in Taumarunui or perhaps New Plymouth.
- Some of the area units and mesh blocks cross the “catchment” area for a number of different rural centres. For example people living in the Matukituki mesh block may use services in Queenstown or Wanaka – and they are unlikely to use both because the Crown Range runs through the middle of the area
- Defining the town by the domicile code of people enrolled with general practice is similarly difficult. People in rural areas will commute to a town for work and enrol with a general practice in the town where they work.