Agenda:

9:30 – 10:00  WELCOME AND INTRODUCTIONS
Maureen O’Neil, President and CEO, CHSRF
Barbara Drew, Acting Secretary General and CEO, CMA
Glenn Brimacombe, President and CEO, ACAHO

10:00 – Noon  PANEL DISCUSSION
Moderator: Terry Sullivan
Speakers: Tim Doran, Arnold Epstein, and Alan Hudson

High Stakes Performance Measurement, Public Reporting and Pay for Performance

The panel moderator will launch the day's discussions by delineating the context and rationale for injecting payment for performance in the health system. Participants will then engage with three panellists who will draw from their own evidence and experience regarding the effectiveness of pay-for-performance and service-based funding policies. The presentations will provide a comparative perspective on intended and unintended consequences, across three different health system settings. Significant time will be allocated for open discussion by CEOs and fellows.

12:00 – 13:30  LUNCH BREAK
13:30 – 16:30  PANEL DISCUSSION

Moderator: Lorne Tyrrell
Speakers: Robert Bell, Brian Day, Les Vertesi, and Glenda Yeates

Coping with the Change in Canada: Best and Emerging Practice

This panel discussion will begin with an overview of the data gathered reflecting the progress and challenges of pay-for-performance and service-based funding policies in Canada. The panellists will then respond to the morning discussions and offer personal reflections on how they coped (or are coping) with the introduction of these policies in their health systems.

16:30 – 17:00  BREAK

17:00 – 19:00  DINNER / EVENING SESSION FOR CEOS

Moderator: Terry Sullivan

Service-based Funding: Passing Fad, or Wave of the Future?

Following dinner, Terry Sullivan will reflect on the day’s discussions and will pose a provocative question(s) for discussion by the group. These discussions will be recorded by a professional writer, and will form a significant basis of the final report to be produced from the workshop.

The Forum will be conducted in English and simultaneous interpretation into French will be provided.
Objectives:

1. To provide healthcare leaders, particularly those affiliated with the Executive Training for Research Application program, with an opportunity to discuss the practical application of evidence to an emerging issue in healthcare leadership.

2. To create an opportunity for exchange of information between fellows, CEOs, and national/international experts.

Background:

Since 2006, the Executive Training for Research Application program (EXTRA) has held an in-camera event for CEOs during the program’s final learning module. The EXTRA CEO Forum allows chief executives and deputy ministers from sponsoring organizations take part in a session to discuss and debate emerging health policy and management issues with prominent leaders in the field.

Partners, 2009:

* Association of Canadian Academic Healthcare Organizations
* Canadian Health Services Research Foundation
* Canadian Medical Association
Chief Executive
Royal Brompton & Harefield
NHS Trust

Bob is the Chief Executive of the Royal Brompton & Harefield NHS Trust, a specialist teaching and research hospital in London. The Trust is Europe’s largest, cardio-thoracic centre and has been designated as a Biomedical Research Unit by the National Institute for Health Research. Prior to coming to the U.K., Bob was the CEO of William Osler Health Centre in Toronto. He started his career at the Hospital for Sick Children, Toronto and for many years was the Partner leading the healthcare and public sector practices at Ernst & Young and KPMG in Canada. He has also served with the Ontario Ministry of Health and the Management Board of Cabinet. Bob is a graduate of the University of Toronto and Queen’s University. He has lived and worked in the U.K., Canada, Saudi Arabia and Lebanon.

Brian Day
Past President
Canadian Medical Association

Dr. Brian Day obtained medical and postgraduate qualifications in Britain before completing orthopaedic training at UBC. He is a Fellow of the Royal Colleges of Surgeons of Canada and England and the American Academy of Orthopaedic Surgeons. He holds a M.Sc. degree from UBC and in 1979 received the Canadian Orthopaedic Association’s Samson Award, for outstanding orthopaedic research in Canada. He is a past President of the Arthroscopy Association of North America; former Vice-President of the Canadian Orthopaedic Foundation; Director of the Canadian Orthopaedic Association; and past Chair of the Royal College of Surgeons of Canada Test Committee in Orthopaedics. Dr. Day is Associate Professor in orthopaedics at the University of British Columbia. In addition to lecturing world-wide in his area of specialization, he often speaks on issues of health economics and policy. He is the President and CEO of Cambie Surgeries Corporation,
a private company that developed the first private health care facility of its type in Canada. In August 2007, he became the first orthopaedic surgeon to assume the role of President at the Canadian Medical Association.

Tim Doran
Clinical Research Fellow in Public Health
National Primary Care Research and Development Centre
University of Manchester

Tim Doran is a Clinical Research Fellow at the National Primary Care Research & Development Centre (www.npcrdc.ac.uk) based at the University of Manchester, and a member of the Faculty of Public Health of the Royal College of Physicians. He holds degrees in biochemistry and medicine from Edinburgh University, and a master’s degree in public health and a doctorate from Liverpool University. He conducts research on the impact of health and social policy on health inequalities and on the effectiveness of interventions to improve the quality and equity of health care. He also advises the U.K. Department of Health on financial incentives for health care providers, in particular their effect on population health and health inequalities.

Arnold M. Epstein
Chairman of the Department of Health Policy and Management
and John H. Foster Professor
School of Public Health
Harvard University

Arnold M. Epstein, M.D., M.A., is Chairman of the Department of Health Policy and Management and the John H. Foster Professor at the Harvard University School of Public Health. Dr. Epstein’s research interests focus on quality of care and access to care. He has published nearly 200 articles on these and other topics. His book, *Falling Through the Safety Net, Insurance Status and Access to Health Care*, won the Kulp Wright Award presented by the American Risk and Insurance Association in 1994 for the best new book
on life and health insurance. From 1993-1994, Dr. Epstein worked in the White House where he had staff responsibility for policy issues related to the health care delivery system, especially quality management. He was Vice-Chair of the Institute of Medicine Committee on Developing a National Report on Health Care Quality, and Co-Chair of the Performance Measurement Coordinating Committee of the Joint Commission, the National Committee on Quality Assurance and the American Medical Association. He has served as Chairman of the Board of AcademyHealth and is on the Board of the Center for Health Care Strategies. He has been elected to the American Society for Clinical Investigation and the American Association of Professors. He is currently Associate Editor for Health Policy at the *New England Journal of Medicine* and a member of the Institute of Medicine.

Alan R. Hudson, OC, FRCSC
Lead, Access to Services and Wait Time Strategy
Health Results Team for the Province of Ontario

On September 29, 2008 Dr. Alan Hudson was appointed Chair, eHealthOntario by the Minister of Health and Long-Term Care. In September 2004 he was appointed Lead, Access to Services and Wait Time Strategy, Health Results Team for the Province of Ontario by the Minister of Health and was appointed President and CEO of Cancer Care Ontario as of April 1, 2002. From 1991 to 2000, Dr. Hudson was President and Chief Executive Officer of Toronto’s University Health Network. Prior to this appointment, Dr. Hudson served as McCutcheon Chair and Surgeon in Chief at Toronto Hospital from 1989-1991, and from 1970 to 1989 was Chairman of Neurosurgery at the University of Toronto.
Terrence Sullivan
President and Chief Executive Officer
Cancer Care Ontario

Dr. Sullivan is President and Chief Executive Officer of Cancer Care Ontario. He joined the provincial cancer agency in 2001 and occupied successively responsible positions in preventive oncology/research. From 1993-2001, Dr. Sullivan held the position of President of the Institute for Work & Health (IWH), a private not-for-profit institute affiliated with University of Toronto, which he developed into North America’s leading research center on work-related injury. Dr. Sullivan has held senior roles in the Ontario Ministries of Health, Intergovernmental Affairs and Cabinet Office. He served two successive First Ministers of Ontario as Executive Director of the Premier’s Council on Health Strategy, including a period of time as Deputy Minister. Dr. Sullivan is an active behavioral scientist with research and practice interests in cancer prevention and health system performance. He holds faculty appointments in the Departments of Health Policy, Management and Evaluation and Public Health Sciences at the University of Toronto. Among his voluntary commitments, he is Vice Chair of the Ontario Agency for Health Protection and Promotion and he chairs the Performance Committee of the Canadian Partnership Against Cancer.

D. Lorne Tyrrell, OC, AOE, MD, PhD, FRCP, FRSC
Professor and CIHR/GSK Chair in Virology
Department of Medical Microbiology and Immunology
University of Alberta

Since Dr. Tyrrell’s first academic appointment in 1975, he has served as chair of Medical Microbiology and Infectious Diseases from 1986-1994 and as Dean of the Faculty of Medicine and Dentistry from 1994-2004. He holds the CIHR/GSK Chair in Virology in the Department of Medical Microbiology and Immunology at the University of Alberta. His work on the development of antiviral therapy
resulted in the licensing of the first oral antiviral agent to treat chronic hepatitis B infection – lamivudine – in 1998. Dr. Tyrrell has recently taken on a number of important positions in healthcare in Alberta. These include the Chair of the Board of the Institute of Health Economics and the Chair of the Board of the Health Quality Council of Alberta. He was recently appointed to produce a report for the Alberta Health Services outlining the working relationship between Alberta Health Services and Academic Health Centres in support of health research.

Les Vertesi
Institute for Research in Mathematics and Computing Science (IRMACS)
Simon Fraser University

Les Vertesi is a career physician with over 30 years’ experience in major trauma referral hospitals. He was the founder of the Advanced Life Support paramedic ambulance program of the BC Ambulance service (1975-1985), and the founding chairman of the Canadian Medical Association’s accreditation committee on Accreditation of EMS training. In addition to his specialty certificate in Emergency Medicine, he earned a Master’s Degree in Health Sciences and Clinical Epidemiology in 1989 from UBC. He currently holds an academic appointment at Simon Fraser University’s Institute for Research in Mathematics and Computing Science (IRMACS), within the Faculty of Health Sciences working on health facility modeling and waitlist research. He is the architect and a central figure in Vancouver Coastal Health Authority’s pay-for-performance project at four Emergency Departments. Some of his career appointments include: Head of the Department of Emergency Medicine at Royal Columbian Hospital (New Westminster, BC, 1989-2001); member of the advisory panel for the Senate Report on Canadian health care (2002); and BC’s representative to the Health Council of Canada. Les Vertesi still maintains a part-time clinical practice in the Emergency Department of a major trauma referral hospital near Vancouver.
Glenda Yeates is the President and Chief Executive Officer of the Canadian Institute for Health Information (CIHI). Previously, she served as the Deputy Minister of Health in Saskatchewan for five years (1999 to 2004), and as Deputy Minister of Social Services. She was an assistant deputy minister of Health in Saskatchewan for seven years and held a number of senior posts in the Saskatchewan Department of Finance. Glenda has served in the past as chair of the Federal/Provincial/Territorial Advisory Committee on Health Services, as co-chair of the National Children’s Agenda and as a member of the Health Council of Canada and the Board of Trustees of the Canadian Health Services Research Foundation. She is currently a member of the Board of Governors of Carleton University, The Change Foundation and IDÉES (Institut d’évaluation en Santé de l’université de Montréal).
Service-Based Funding and Paying for Performance – A Briefing

3rd Annual EXTRA CEO Forum
February 16, 2009

This briefing was prepared for the 3rd Annual EXTRA CEO Forum, “Service-Based Funding and Paying for Performance: Experience, Evidence and Future Prospects,” taking place in Kananaskis, Alberta on February 16, 2009. It presents an overview of service-based funding and pay-for-performance of Canadian healthcare institutions and providers, with specific emphasis on background, perspectives, and future prospects. As this briefing is not exhaustive, references are provided.

Background – How are Canadian hospitals chiefly financed?
The vast majority of hospital revenues come from taxes levied by the federal and provincial/territorial governments. While it’s often conceived that these revenues are channelled to health services organizations across Canada via block funding schemes, there are, in fact, a variety of approaches in use. Jurisdictions often rely on more than one approach to distribute funds to their hospitals: a primary funding approach to allocate the majority of funds, and secondary methods to allocate lesser amounts. This is particularly the case for hospital operating costs, which are most commonly funded through population-based, ministerial discretion or global budgeting approaches. (See Canadian hospital funding approaches by jurisdiction, page 19, for a complete list of budgeting methods by province, as well as a related glossary.) Alternatively, funds for capital projects – for example, hospital construction and equipment purchases – are generally allocated with a project-based model of financing.

1This briefing was prepared by Knowledge Summaries staff at the Canadian Health Services Research Foundation and made available only after expert review.
Across jurisdictions, there is a desire to consider financial mechanisms that may improve efficiency and quality of care, particularly in hospital and medical services. Among many possible solutions, two strategies consistently emerge: service-based funding and pay-for-performance.

What is service-based funding? And what is pay-for-performance? Service-based funding (SBF) has been described as a means for financially reimbursing hospitals based on the episodes of care for which patients are admitted and on the type of services or procedures performed.ii Described elsewhere, the approach is said to rely on the number of cases carried out – for example, the number of hip replacements – to estimate the cost to sustain a specified profile of service volumes in the future.i Applying the strategy effectively requires a solid understanding of what constitutes a case and how cases may be grouped in a way that makes sense clinically and in terms of relative resource use. In most cases where this method is employed, it is based on Diagnosis-Related Groups (DRGs), which identify a number of case types that are expected to draw on a similar amount of hospital services.

There are a number of terms to describe SBF or variations of the strategy. For example, the 2002 Kirby report relied on two terms, service-based funding and case-mix funding.ii Since then, the Canadian Medical Association has coined the term patient-focused funding, arguing the approach allows the funding to follow the patient.iii The Canadian Doctors for Medicare and their Quebec counterparts, Médecins canadiens pour le régime public, prefer the term activity-based funding, countering that “the focus is not necessarily on the patient, but rather on the type and volume of service delivered.”iv Meanwhile, in the United Kingdom, the term payment-by-results is preferred, while in the United States, prospective payment system is favoured. Payment-for-volume or volume-based funding are also used internationally. Some critics argue that these terms are not interchangeable and reflect different strategies. These purists argue that in the strictest sense, SBF involves any attempt to link payment to incremental volumes or efficiency ratios. For the purpose of this briefing, though, we use the term broadly, encompassing patient-based payment schemes as well as service-based ones.
At times, SBF has been confused with *pay-for-performance* (often abbreviated P4P). Not surprisingly, there is a strong overlap between these two types of policy. Both types require unit of service level measurement and judgments. Both typically involve public reporting and standardization of data collection, and many begin with a *pay-for-reporting* approach, too. Likewise, many P4P programs have, at least, some criteria related to service volumes or timeliness. Still, the terms are quite distinct: *pay-for-performance* involves a direct link between providers’ or institutions’ performance (how well they perform) and their compensation, while SBF involves a direct link between an institution’s volume of activity (how many services are performed) and its financing. More specifically, *pay-for-performance* is an incentive program that involves compensating hospitals that reach efficiency targets or physicians whose patients achieve health outcome goals. Many P4P models rely on quality bonuses, performance fee schedules or increased reimbursement rates for higher-quality providers. A P4P may be a bonus paid to a physician if a certain percentage of their eligible patient population is immunized against or screened for a particular disease, for example. In other P4P models, a portion of compensation may be placed at risk, contingent upon achieving quality targets.

**What examples exist in Canada?**

While there are limited examples of SBF for hospital funding in Canada, there are some noteworthy experiences. According to the Kirby report, Ontario was the first Canadian jurisdiction to experiment with a service-based funding method for financing selected hospital services. In 2001, Ontario used its *Integrated Population Based Allocation* formula to distribute $95-million in additional lump-sum funding across hospitals based on their service volumes. The new funding methodology was developed by the Ontario Joint Policy and Planning Committee (JPPC), which recommended a plan to progressively extend the formula over three years and monitor the impact.

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2 Some jurisdictions are using this approach for home care and other types of care, however.
3 CMA (2007) provides an overview of the Canadian experience.
4 JPPC is a partnership through the Ontario Ministry of Health and Long-Term Care and the Ontario Hospital Association. More recently, Ontario’s 14 Local Health Integration Networks have begun to participate fully at all levels of the JPPC.
In April 2008, British Columbia’s two largest health authorities, Fraser Health and Vancouver Coastal Health, partnered in a government-funded initiative to “encourage new patient-focused funding models that will support patient access.” The Lower Mainland Innovation and Integration Fund ($75-million) – a key initiative of the 2008 throne speech and launched by the B.C. Minister of Health Services, Hon. George Abbott – aims to encourage closer ties between the two health authorities, but is chiefly focused on improving efficiency and effectiveness of care. Already the fund has led to strategic investments – for example, to improve operating room capacities as well as surgical and diagnostic volumes.

Some would argue that neither the Ontario nor B.C. examples constitute true SBF, which entails reimbursing providers at a fixed rate for individual services delivered. Arguably, few hospitals would have the financial management systems in place to make such service-based allocations possible.

Meanwhile, with no clear consensus on how to operationalize P4P and other incentive structures, Canada remain slow to join, with few examples. In particular, Ontario and B.C. appear to be moving quite aggressively on introducing P4P in primary care, while Alberta recently negotiated its own fund.

What are the claims and criticisms?
One of the strongest calls for SBF in Canada came from the 2002 Kirby report. The report recommended that jurisdictions replace their existing methods of remunerating hospitals – those based on funding inputs rather than final outcomes – with a method that focuses on “performance in delivering hospital services.” Specifically, the report recommended that jurisdictions adopt SBF.

Since Kirby, the Canadian Medical Association (CMA) has emerged as a strong proponent for an SBF approach. This approach was a key topic at the CMA’s annual meeting last year, with presentations from Robert J. Bell, Chief Executive of the Royal Brompton and Harefield National Health Service Trust in London, on the U.K. experience, and President and CEO of Vancouver Coastal Health, Ida Goodreau, on the
case that is developing in B.C. Coming out of the CMA’s annual meeting in 2008, president Dr. Robert Ouellet resolved that the CMA would develop “a blueprint and timeline for transformational change in Canadian healthcare to bring about patient-focused care.”

Several reviews of SBF exist. The Kirby report explored the experiences of the U.S., the U.K., France, Denmark, and Norway, concluding that SBF can achieve a number of objectives, including: measuring in an appropriate manner the cost of specific hospital services; improving overall hospital efficiency; enabling the public to compare hospitals based on their performance; enhancing hospital accountability; fostering competition among hospitals; reducing waiting lists; and encouraging the further development of centres of specialization. In addition, the report noted that the SBF approach appears to enable more equitable hospital funding than other methods, and encourages efficiency and performance. More recently, an OECD (Organization for Economic Cooperation and Development) report posited that “[m]arket-oriented mechanisms can help to reduce costs of provision of hospital services, even in hospitals that are primarily government-operated, under a number of conditions.” Among the conditions are that “financial support for a hospital is related to the number of patients treated and their treatments, so that hospitals have an incentive to seek to treat more patients” and that “sufficient information is collected to judge exactly what services are provided by hospitals, ideally, including indicators of quality of care.”

In 2006, Pink et al. carried out an extensive review of P4P, drawing a few main conclusions. First, evidence from the U.S., the U.K. and Australia shows a lack of consensus on the design of government-sponsored P4P programs, despite their having similar goals of realizing significant improvements in quality of care through performance rewards. Second, little is known about the effects of P4P; however, available evidence supports the effectiveness of financial and reputation incentives in improving quality, with some caution around compensating individuals. And third, despite a lack of substantial evidence, P4P of publicly funded healthcare is being implemented in the U.S., the U.K. and Australia, mostly as a direct result of pressures on healthcare delivery and finance, which are said to be augmented by an aging and empowered patient population.
Despite its alleged benefits, SBF has spurred a number of critics, who are likely to continue as vocal opponents. In its 2002 submission to the Kirby committee, the Canadian Healthcare Association, which represents hospitals and other institutions, raised a concern that SBF might lead to “procedure-driven” healthcare rather than comprehensive and integrated care. At the same time, and in its own submission to Kirby, the Association of Canadian Academic Healthcare Organizations argued that SBF, as a competitive funding model, is inconsistent with the fact that teaching centres generally do not compete with other service providers. Furthermore, an SBF approach could pose a challenge for teaching centres that would be in line to receive the same province-wide fee for a given service – notwithstanding their requirements in teaching, education and research.

Following B.C.’s announcement of a new fund to support patient-focused funding, and as part of its Profit is Not the Cure campaign, the Council of Canadians (Canada’s largest citizens’ organization) released the briefing “Why patient-focused funding doesn’t work.” Adding their voice to the debate, Canadian Doctors for Medicare have also criticized the claims about patient-focused funding. In addition to likening the funding method to an “à la carte” or “fee-for-service” funding approach, the member-based organization argues that proponents of SBF also advocate for increasing the number of private for-profit clinics that would “compete” with hospitals for government activity-based funding. This free-market competition, so the argument goes, would force hospitals to improve their productivity. Further, in their review of SBF in seven countries (Australia, Denmark, England, France, Sweden, Norway and the U.S.), they concluded: “At best, data from other countries are unclear because [service-based funding] has largely been part of a potpourri of interventions aimed at improving health. We don’t yet know, for example, whether SBF improves quality, reduces (or at least stabilizes) overall health system costs, or ensures equitable care — and equal access to that care — across the population.” That said, advocates of Medicare support an experiment to study SBF, but only under strict conditions; namely, “to learn whether this approach to hospital funding is any more successful than other funding mechanisms currently in use.”
While the discussion of SBF can be heated at times, discussions of P4P are far less so, likely because P4P, as it is currently conceived, involves supplying additional funding to organizations or physicians. It is, in effect, a bonus scheme.

**What do we see in the way of future prospects?**

The future of SBF in Canada is unclear. It remains to be seen whether pilot projects, such as those underway in B.C., will be transformational in terms of allowing increased efficiency and cost-effectiveness in care delivery. Change will be hard to measure, as many hospitals in Canada lack sufficient infrastructure or expertise to know, with any degree of precision, what their unit costs are for any procedure.

 Meanwhile, P4P is best viewed as an extension of the movement toward more performance information and greater accountability in healthcare in Canada. More and more examples of P4P are underway in Canada, although it is probably too early to conduct a thorough evaluation of these. As the international community sets new standards for both quality and productivity in healthcare, jurisdictions may find it increasingly difficult to stick to existing funding mechanisms.
References


## Canadian hospital funding approaches by province/territory

*Primary and secondary hospital funding approaches by province/territory*

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* Updated and adapted from McKillop et al. (2001), Tables 3.3 and 3.5 (pp. 50 and 53, respectively).

** In April 2008, the Government of British Columbia announced $75-million fund to encourage patient-focused funding models.
Descriptions of Canadian hospital funding approaches*

* Adapted from McKillop et al. (2001), Tables 2.4 (p. 18).

**Case Mix-based (also known as Service-based)**
Uses a profile of cases and/or service volumes previously provided (such as number of knee replacements, number of dialysis procedures) to estimate the cost to sustain a specified profile of cases and/or service volumes in the future.

**Facility-based**
Uses characteristics of the organization providing care (such as size of organization, type of organization, geographic isolation, occupancy rate) to estimate the cost of operating a health service organization.

**Global**
Applies a factor to a previous spending figure (or to a forecast spending figure) to derive a predicted spending level for an upcoming period.

**Line-by-line**
Applies factors on an individual basis to previous cost experiences (or to forecasted costs) to derive a proposed funding level for each line item (such as housekeeping, inpatient nursing, etc.) for an upcoming period.

**Ministerial discretion**
The Minister of Health decides on the specific dollar amounts to flow to health service organizations.

**Project-based**
Flows funds to a single health service organization in response to evaluating a proposal from that organization for one-time funding, often for a major expenditure.

**Policy-based**
Directs spending to address specific policy initiatives of the Department or Ministry of Health. These policy initiatives affect the operation of multiple organizations within the jurisdiction.

**Population-based**
Uses demographics or other characteristics of the population (such as age, gender, socio-economic status, etc.) to determine the relative propensity of different population groups to seek health services.