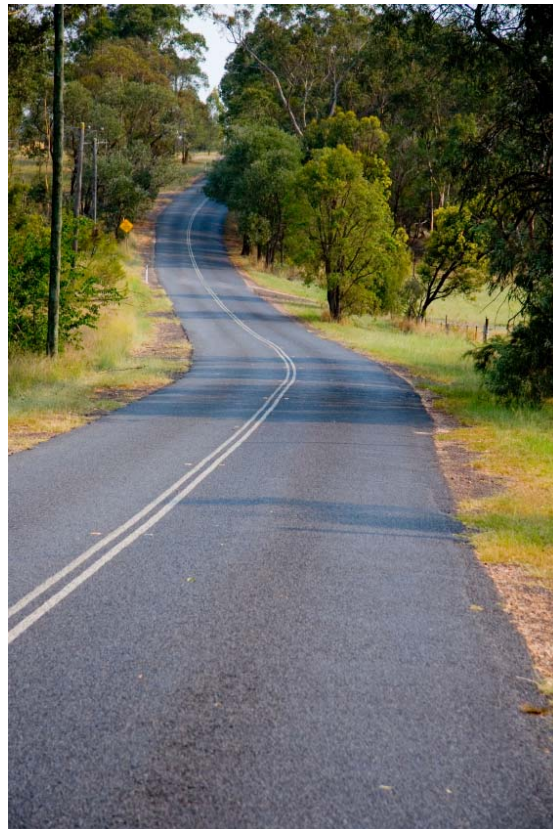




Victorian Healthcare Association

*Building better health policy for all Victorians*



## SMALL RURAL HEALTH SERVICE FUNDING

*—VHA BOARD ENDORSED POSITION STATEMENT 200803—*

**The Victorian Health Care Association**

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VHA Board Endorsed Position Statement 200803

## Executive Summary

Five years since rural health services first transitioned into the Small Rural Health Service (SRHS) funding model in Victoria, the Victorian Healthcare Association (VHA) has explored the funding model comparing its original intent with the day-to-day impact of implementing it across Victoria.

Health services remain supportive of the funding model's intent – a focus on local needs and a sustainable, locally determined service mix. For some SRHSs the model works in their best interests providing increased security of funding, greater community accountability and increased flexibility. But for many, the SRHS funding model has been plagued by the absence of growth funding, a lack of clarity in both the structure and release of funding and led to an inability to cope with population growth and changing population needs.

The reduced government input inherent in the SRHS model has resulted in many services feeling forgotten by the Department of Human Services (DHS). Indeed, many services wouldn't choose to transition to the SRHS funding model in its current format, if the opportunity presented itself again.



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## Recommendations

- 1** Services must be supported to balance community need with community wishes. This should include regional level planning, educated by population health data, supported by policy and assisted by the DHS Regional Offices
- 2** Government must undertake a campaign to educate Victorian communities about their health systems and what services they can expect to receive
- 3** That DHS partner SRHSs in an audit three years after transitioning into the model to ensure no disparity exists between funded and actual outcomes
- 4** That DHS review the SRHS funding model in the immediate future to ensure it still meets the original intent of the model and remains achievable for services trying to implement it

## The VHA's Position

Local solutions for local needs are vitally important to the health of rural Victorians. The VHA supports funding models and service structures that allow our members to deliver services that best meet the needs of the communities they serve. The VHA believes the SRHS funding model should continue but it must be reviewed to ensure it continues to meet the original objectives.

## The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities.

## The Health of Rural Victorians

More than one in four (27.6%) Victorians live in a rural area<sup>1</sup>. These Victorians face deprivation of health services related to access, availability, affordability and appropriateness as a feature of where they choose to reside. People living in rural Victoria have lower standards of health and lower socio-economic status than their metropolitan counterparts<sup>1</sup>.

Even when socio-economic status is accounted for, the health status of rural Victorians is significantly lower than metropolitan Victorians. Rates of hospitalisation for preventable chronic diseases are higher in rural Victoria as are avoidable mortality rates for cardiovascular disease, cancer and road traffic injury<sup>1</sup>. Some of this can be attributed to the distance to definitive care experienced by rural people. However, many of these rates can be reduced through the provision of community-based public health prevention measures<sup>1 2</sup>.

## Small Rural Health Service Funding

The Small Rural Health Service (SRHS) funding model was instigated in the 2003-04 financial year. The model was available to 67 agencies across rural Victoria delivering health and aged care services in towns with a population less than 5000. These services ranged from Category D & E hospitals, Multi Purpose Services (MPSs), Bush Nursing Centres, Community Health Services and Healthstreams<sup>3</sup>.

The SRHS model was designed to provide a focus on local needs and a sustainable, locally determined service mix taking into account the best features of the MPS and Healthstream models and removing departmental funding distinctions. Through transitioning to this model SRHSs were promised:

- Increased flexibility in the use of their budget from 2003-04 onwards
- No requirement to meet WIES (weighted inlier equivalent separations) targets or go through a formal WIES conversion process
- A strategic relationship between SRHSs and DHS into the future<sup>3</sup>.

Since services first transitioned to this model in 2003 significant changes have occurred in health policy in Victoria including the publication of:

- Healthy Horizons: outlook 2003-07 (2003)
- Rural Directions for a better State of Health [Rural Directions] (2005)
- Growing Victoria Together (2005)
- A Fairer Victoria (2005)
- Care in Your Community (2006)



The only SRHS publications from the DHS since the 2003 SRHS guide was a 2004 update and the Stage One report on the SRHS Data collection and reporting project (released in 2005). Despite this the VHA's rural members continue to implement a funding model designed with good intentions, but perceived to not be meeting the needs of rural Victoria.

The VHA undertook a survey and interview methodology to ascertain the strengths and weaknesses of the SRHS model and make some clear, achievable recommendations to improve service delivery. The results of this work will be built into advocacy our activities in the future.

## Clarity of the Model

Throughout the sector and the DHS there is little clarity about what constitutes a SRHS.

**"I agree we should move towards community-based service delivery. But funders don't have to live in a town when you cut back chemotherapy... or surgery... or maternity services. I have to see the people in the supermarket or at the school gate".**

Often, category D&E hospitals are uniformly termed Small Rural Health Services, while other agencies or individuals define SRHS under the

provisions of the 2003 guide (category D & E hospitals, Multi Purpose Services (MPSs), Bush Nursing Centres, Community Health Services and Healthstreams). This is a particular issue for some MPSs who are grouped with SRHS by the DHS despite having very different funding and accountability requirements and service agreements clearly identifies them as MPSs.

The VHA believes a SRHS is any service funded under the provisions of the 2003-04 guide, whose service agreement stipulates them as a SRHS. The DHS needs to provide a clear official definition of the term SRHS to improve sector wide clarity and understanding.

## Funding Flexibility

While most the VHA members surveyed felt

there was adequate flexibility in their abilities to allocate funding; very few believed that this flexibility extended to being able to instigate major service change. Encumbering this is an inability to shift from acute service provision as the SRHS model intends. This is due to community expectation, the expectations of visiting medical officers or the pressure provided by the DHS to maintain acute services for rural communities. The nurse:patient ratio requirement also means that substantial change is required to free up funding when incremental change is often all that is required. This creates a strategic conflict that can result in no change at all.

For services providing care to shrinking rural populations, the SRHS model does allow service restructuring and redevelopment to meet community needs. However, for many small hospitals their workload is on the increase making service redevelopment impossible. The current mode of funding does not adequately account for increases in patient separations.

In theory, the SRHS model in theory allows services to allocate funding to meet local needs. The missing link is that with local needs, come local expectations. Rural Directions and other government policies demonstrate a committed intent by government to move away from bed-based models of service delivery to population health and community-based approaches.

Rural Victorians expect (and are entitled to) equitable access to the health services delivered in metropolitan areas. Altering the service mix in a small rural town may run counter to the wishes of the local community, despite being in their best interests. As one SRHS CEO recounted:

*"I agree we should move towards community-based service delivery. But funders don't have to live in a town when you cut back chemotherapy... or surgery... or maternity services. I have to see the people in the supermarket or at the school gate".*

**Recommendation One**  
**Services must be supported to balance community need with community wishes. This should include regional level planning, informed by population health data, supported by policy and assisted by DHS Regional Offices.**

**Recommendation Two**  
**Government must undertake a campaign to educate Victorian communities about their health systems and what services they can expect to receive.**

Small Health Services are in a unique position to deliver one-off funded services like the Hospital Admission Risk Programme because of their links to the local community. Many health services perceive that one-off funding is not accessible to SRHSs with funding often going to regional and sub-regional providers.

Shifting funding from acute services to primary care is hampered by factors such as the Nursing Enterprise Bargaining Agreement (EBA). The nurse:patient ratios in the EBA have to be kept at a constant level without regard to patient occupancy. This factor alone makes redirecting funding to primary care difficult without radical change.

**Growth Funding**  
A particular frustration of health services is the lack of growth funding applied to SRHSs. In 2007, three SRHS were in receipt of growth funding, while many others have not received growth funding since transitioning to the SRHS model in 2003. The VHA understands that growth funding is applied from a restricted pool of funding. What remains unclear to the sector and the VHA is how services are selected to receive growth funding and how the final value of growth funding for each service is calculated.

In rural communities with a constant or increasing population base; health services are unable to extend or grow their services because of the shift away from WIES based funding. As services no longer have to meet WIES targets, it is hard in growing populations to demonstrate the need for more WIES-equivalence in the future.

To assist with acute service provision in growing communities, the VHA suggests a base level of occupancy is established for health services with a sliding scale for occupancy rates above that level. This rate could be audited against WIES to ensure consistency.

### Recommendation Three

**That DHS partner SRHSs in an audit three years after transitioning into the model to ensure no disparity exists between funded and actual outcomes.**

#### Service-Wide Funding Pressures

A variety of overhead costs impact on SRHSs. This further obstructs a SRHS's ability to provide flexible services for their local community. The higher fixed costs associated with running a small health service is recognised by government in the higher WIES payments paid to non-metropolitan health services<sup>4</sup>.

In recent times Consumer Price Index Increases, the revised funding model for the regional IT alliances, ambulance transfers, the implementation of HealthSmart Patient and Client Management System and the Financial and Supply Management Information System have all increased the overhead costs of SRHSs. Current pressure from escalating fuel costs, and pressures associated with contracting in of professional staff represents additional inflationary factors.

SRHSs must also provide emergency resuscitation and stabilisation facilities for their community under the provisions of the Rural Emergency Health Services Planning Framework<sup>5</sup>. With the decreasing availability of after hours general practitioners, and increasing rural tourism, emergency presentations at rural hospitals are rapidly increasing. Health services are not compensated under the Nursing EBA for the increased staffing needed when nurses have to leave acute wards to treat emergency presentations. More information regarding emergency services is covered in the soon to be released VHA Rural Emergency Services Position Statement.

The management of long service leave in SRHSs remains a pressure. Long service leave is notionally accrued through WIES payments but with a shift in service delivery to primary and community based services; the formula for calculating long service leave remains unclear to the VHA and agencies within this model.

Another area of growth confronting SRHSs is in maternity services. This is particularly relevant in Victoria's rural and regional growth corridors and for some SRHSs where neighbouring maternity services have closed. A cost weight



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review for maternity services has been repeatedly promised to SRHSs, but is yet to eventuate. While most of these patients can be managed by the SRHS, on occasion they must be evacuated for more advanced care. For one service in the north of the state it costs \$1200 to transport a patient in an ambulance to the nearest regional hospital. This cost increases to \$6000 if the patient requires transport to Melbourne. This cost is borne by the SRHS that initiates the transfer.

Rural communities and SRHS's alike are indebted to Visiting Medical Officers (VMOs) who provide necessary care both in the hospital and external to it. However, because fee for service payments made to VMOs are not governed by an employment award, indexation of rapidly increasing fees that have to be negotiated with VMOs to retain their services is not possible.

The assuredness of DHS funding in the SRHS model is highly valued by the VHA's members. In contrast to this is the recouping of funding by the Department of Veteran's Affairs (DVA) and the Transport Accident

Commission (TAC) when expected targets are not met. While sound financial planning can ameliorate this to some degree; the recall of DVA and TAC payments is made more difficult by the three to four month lag time between the end of the financial year and funding recall.

All of these factors serve only to evidence the need for a systemic review of the SRHS funding model in the immediate future.

#### **Recommendation Four**

**That DHS review the SRHS funding model in the immediate future to ensure it is still meeting the original intent of the model and is still achievable for services trying to implement it.**

## **Conclusion**

Grass roots motivations are the best solutions for local problems. Five years ago, the SRHS funding model was a clear step by the DHS to improve the funding and accountability arrangements for small health service agencies in rural Victoria. While this model is well received by some agencies, the majority of services are struggling to implement the model as it was intended. The VHA believes that this funding model should be reviewed extensively. The DHS must support services to meet their communities needs through locally delivered health service provision.

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