



SMALL RURAL HEALTH SERVICE FUNDING

—VHA BOARD ENDORSED POSITION STATEMENT—

EXECUTIVE SUMMARY

Five years after 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.

This document defines the strengths and weaknesses of this model and makes recommendations based on the experiences of those individuals working to implement the strategy.

THE HEALTH OF RURAL VICTORIANS

More than one in four (27.6%) Victorians live in a rural area (DHS. 2007). 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 (DHS. 2007).

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 (DHS. 2003).

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.

The Victorian Health Care Association

FUNDING FLEXIBILITY

While most of 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.

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.

SERVICE-WIDE FUNDING PRESSURES

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 the contracting in of professional staff represents additional inflationary factors. Other service pressures faced by SRHS's include managing the demands associated with maternity services and the provision of emergency resuscitation and stabilising facilities.

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.

REVIEWING THE MODEL

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.

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 full position statement and references are available on the VHA website: <http://www.vha.org.au>



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