

SMALL RURAL HEALTH SERVICES (SRHSs) FUNDING AND ACCOUNTABILITY APPROACH

QUESTIONS AND ANSWERS

1. How are SRHSs being supported in this first year of implementation?

SRHSs receive ongoing support from regional offices, and they are also encouraged to make use of documentation and other resources available - see below and at the end of this bulletin.

Some strategies are specific to the SRHS approach, for example, holding six-monthly statewide SRHS forums for all 67 SRHSs to facilitate exchange of ideas - the first to be held in early 2004.

SRHSs are also encouraged to take advantage of broader departmental initiatives, such as:

- Rural Health Boards of Management Training and Development Program
- assistance available to support service development and service planning
- access to the Hospital Costing Bureau Service's cost data (mainly for acute and sub-acute services)
- primary health pilot project providing training in Leadership in Population Health and Health Promotion in Rural Services.

2. How might my relationship with the regional office change?

In some regions there will be little need for this relationship to change. Where a change in the relationship does occur, it will typically be focussed on the position of the Agency Relationship Manager, whose role will be to provide a single point of contact for the agency in dealing with the regional office on all DHS-related matters of concern.

Regular communication and information sharing between the SRHS and the regional office (particularly through the Agency Relationship Manager) will continue to include discussions of local health status and needs as well as a range of relevant agency operational issues. Owing to the nature of the new funding and accountability arrangements, discussions with the regional office will not need to cover detailed service delivery targets or, in the case of (ex) group D and E hospitals, WIES conversion proposals.

3. What are the accountability arrangements for SRHSs?

There are no *new* data collection or reporting arrangements for SRHSs as a requirement of this approach in 2003-04 (as outlined in the *Small Rural Health Services Guide 2003-04*, page 13). SRHSs are expected to report comprehensively 'after the event' on funded services actually delivered, using existing reporting mechanisms.

In relation to their total budget for RRHACS and MHACS funded health and aged care services, SRHS agencies are expected to meet two key performance measures:

- maintenance of an agreed overall effort in health and aged care service delivery and delivery of these services in line with the parameters set out in the SRHS Guide and other relevant policy documents.
- utilisation of a Service Profile proforma to discuss and document ideas about service mix with the regional Agency Relationship Manager.

Note that SRHSs in receipt of acute health funding will no longer be subject to WIES targets or be required to go through a WIES conversion process.

4. What further development is taking place during 2003-04?

2003-04 represents the starting point for the new approach and there will be a two to three year implementation horizon. In order to understand the overall progress of the new approach and prepare for the second phase in 2004-05, the following tasks and projects will be undertaken this year:

- investigation of possible changes to data collection and reporting requirements via a pilot project
- development of a method for benchmarking aspects of SRHS operations to promote efficient and effective use of resources
- exploration of ways to help SRHSs access assistance available to support service development

- monitoring of agency service delivery to assess the impact of the new approach
- exploration of options for expanding the scope of the SRHS approach.

5. How will service agreements work?

Across the department, three-year service agreements were introduced on 1 July 2003, with aims that are complementary to the new SRHS approach. SRHSs operate within this departmental framework.

As outlined in the SRHS Guide (p 10-12), in 2003-04 the SRHS approach offers funding flexibility at agency discretion for acute, sub-acute and primary health funding. For some other programs where there is limited discretion about funding flexibility any changes to service mix need to be agreed by regions (in consultation with central office) on a case-by-case basis.

A service agreement variation is not required where there is a change in service mix in line with these parameters.

A variation is required for any changes to an SRHS's total budget, including to facilitate payment of standard adjustments such as price indexation and wage-related increases.

The department recognises that due to the developmental nature of the SRHS approach, there may need to be some scope for variations to be executed outside the standard variation periods.

6. What expectation does the department have of SRHSs regarding planning?

A fundamental principle of the new funding and accountability arrangements for SRHSs is that any changes to service configuration or service mix will be determined at the local level, with collaborative input from the SRHS management, staff and board, the department's regional office and members of the local community. The SRHS approach does not require a new planning approach; rather, it draws on existing planning frameworks and uses increased funding flexibility to help facilitate any locally determined changes.

Planning will focus on the local community's needs but also take account of wider area-based planning and health status goals, relevant population projections and service provision data. The new SRHS approach will build on the advances in local collaborative planning and service integration and

coordination occurring through the Primary Care Partnership Strategy and draw on the outcomes of any existing service planning processes.

SRHSs will need to consider the impact of any proposed service mix changes on other health services in their area. Regional offices will be able to contribute to this thinking with their knowledge of the regional service system.

7. How can MPSs and BNCs participate in the approach to their advantage in the current year?

For both Bush Nursing Centres (BNCs) and Multipurpose Services (MPSs), the SRHS approach provides the opportunity to be part of a larger group of funded agencies exploring ways to achieve more flexible, local service responses. They will now be able to share their experiences with others and draw on a broader pool of ideas and expertise.

BNCs

In 2003-04, BNCs have the opportunity to discuss and document (via the SRHS Service Profile) the actual range of services they provide, which the department recognises does not always correspond exactly to the types of activities for which they are funded. This will provide a more realistic understanding of the current funding and accountability arrangements and facilitate discussions about possible future service enhancements.

An important benefit for BNCs in 2003-04 is that they will be able to foreshadow and discuss with regions any proposed changes to future service provision and therefore begin to establish the change process in their services.

MPSs

Victorian MPSs already have significant flexibility across their health, aged care and community-based programs that enables them to shape the services they offer in response to the needs of their communities.

All Victorian MPSs are required to prepare a service plan that clearly describes their service mix and any proposed changes over a three-year period. Over the life of the plan, regions regularly communicate with MPSs on the range of services they provide and any changes that are proposed. The SRHS Service Profile will be the working document that records the key points of these discussions.

In addition, for some time there have been some concerns about MPS service activity

reporting. The SRHS data collection and reporting pilot will attempt to address this key issue. An MPS (Otway Health and Community Services) is one of the six SRHSs participating in this pilot.

8. What role does DHS see for SRHSs in procedural medicine?

DHS wants to see quality health services, relevant to need, provided to people in rural communities. Procedural services, including low risk obstetric and surgical services, are essential in maintaining a sustainable configuration of health and aged care services in small rural communities that is responsive to local needs. DHS does not support change for its own sake, but recognises that, because of demographic, clinical practice, workforce and technological changes, small hospitals sometimes need to review and adjust their service mix.

DHS continues to provide financial and other support to promote local procedural services in SRHSs. This support includes workforce development programs and capital funding to assist SRHSs in the maintenance of buildings and equipment.

Some examples of workforce development programs include the Extended Skills for GPs program (\$380,000 annually), the Continuing Professional Development for Rural GPs subsidy program (\$200,000 annually), the Rural Clinical Schools Initiative (\$9 million over three years), and the Rural Country Education Program (\$140,000 annually).

In 2002-03, capital works funding for SRHSs included up to \$1 million for Targeted Equipment Program funding (medical equipment), approximately \$18 million to support procedural work for services like Omeo, Hopetoun and Beechworth Hospitals. The most recent DHS funded theatre upgrade in an SRHS was a \$500,000 grant for East Wimmera Health Service at St Arnaud.

The SRHS approach provides SRHSs with the autonomy to make informed decisions about the type of health services they should provide to their communities. The approach does not advocate change where it is not necessary or beneficial to the community, but the SRHS is no longer obliged simply by virtue of the rules of the funding system to engage in activity that is not the highest priority for its community.

An example of the proposed DHS approach to procedural services can be found in the Rural and Regional Health Services Branch discussion paper entitled *Rural Birthing Services*. Comment and feedback on the discussion paper is welcome. Further information on the paper can be obtained by contacting Maureen Robinson (9616 2007; maureen.robinson@dhs.vic.gov.au). You can obtain a copy of the paper from the DHS website at:

<http://www.dhs.vic.gov.au/rrhacs/ruralbranch.htm>

SRHS Documentation

The *Small Rural Health Services Guide 2003-04* is the key reference document and information resource for the new approach and includes brief overview information about other resources available:

- Baseline Information to provide a reference point about the pre-SRHS situation
- Budget Statement for RRHACS and MHACS funding indicating extent of flexibility
- Service Profile proforma to help shape and guide discussions and document ideas about service change.

The Service Profile was made available in July 2003. There have been some delays in finalising the content of the Baseline Information and Budget Statement documents. At this stage, it is still the intention to issue these documents during 2003.