Fact Sheet: Small Rural Health Services Funding under National Reform

health

• Costing • Counting • Classification • Transparency

Block Funding for Small Rural Health Services

Under the National Health Reform Agreement (NHRA), health services are Activity Based Funded (ABF) 'wherever practicable'; however, the NHRA recognises that some hospital services may be 'better funded through block grants, including relevant services in rural and regional communities'.

This is similar to the Victorian Small Rural Health Service (SRHS) funding model, adopted in 1995 due to concerns regarding the financial viability of SRHS under the Casemix funding system. The model applies to 43 SRHS that deliver public hospital services.

The SRHS model was developed to enable SRHS to flexibly meet the changing needs of rural communities.

Block funding Criteria

The Independent Hospital Pricing Authority (IHPA) has developed the following block funding criteria that can be used to determine which public hospital services are eligible for block funding. The criteria have been submitted to the Council of Australian Governments (COAG) for endorsement:

- Block funding will be required when it is not technically possible to use activity based funding (ABF); or
- When there is an absence of economies of scale that mean some services would not be financially viable under ABF[1].

The IHPA has determined 'low volume' thresholds for use in 2013–14. Under these thresholds, hospitals may be eligible for block funding if they are:

- in a metropolitan area, and provide ≤ 1,800 acute inpatient National Weighted Activity Units (NWAU)[2] per annum; or
- in a rural area and provide ≤ 3,500 acute inpatient NWAU per annum.

The IHPA has applied these criteria in developing the National Costing Model, and the National Efficient Cost (NEC13) Determination for 2013–14 that applies to block funded services.

As system manager the Victorian Government provides advice to the IHPA on which services meet the criteria to be block funded. Services currently funded through the SRHS model will continue to be block funded; those currently receiving output funding through the casemix model will be subject to ABF.

Scope

Eligible facilities in scope for block funding are Local Hospital Networks (LHNs) that meet the block funding criteria, as discussed above. States are required to provide advice to the IHPA on which hospitals meet the

[1] Economies of scale are the cost advantages that Health Services obtain due to size, because the cost per unit of output generally decreases with increasing scale of Health Services as fixed costs are spread out over more units of output.

[2] The NWAU is the 'currency' that is used to express the price weights for all services that are funded on an activity basis. It does not replace the classifications that are used to describe activity (such as URGs, UDGs or AR-DRGs).

block funding criteria on an annual basis. For SRHS, this advice can be provided once every six years, or more frequently at the discretion of the State.

Public and private patients are in scope for block funding, compensable patients are out of scope (for example, funding for eligible veterans will continue to be subject to funding arrangements by the Department of Veterans Affairs (DVA)).

NEC for 2013–14

The NEC in 2013–14 (NEC13); is $4.738 million; this represents the average cost of a block funded hospital in Australia.

The NEC13 was derived from in-scope expenditure data for 2010–11, that is reported to the National Public Hospital Establishment Database (NPHED).

IHPA's SRHS Block Funding Model in 2013–14

The IHPA engaged a consortium of consultants to identify the design of block funding arrangements for SRHS. The IHPA model incorporates two components, an availability payment and a service capability payment.

Availability Payment

- This component recognise that block funded hospitals have significant fixed costs by calculating fixed availability payments for all block funded hospitals.
- Availability payments are determined on the basis of total reported NWAU activity, and ASGC Remoteness[3]. The grouping of small rural hospitals by size and location is provided in Table 1 of the NEC Determination.

Service Capability Payment

- This payment recognises the costs related to the level of service provision. Hospitals in Groups F and G will receive an additional Service Capability payment of $498 per NWAU.

The efficient cost of a hospital campus is determined by multiplying the cost weight of the relevant cell within the categorisation by the NEC13 ($4.738 million).

The following table provides the categorisation of small rural hospitals by size and location:

	Service Volume Grouping (Total NWAU)						
ASGC Remoteness Classification	Group A 0-199.9	Group B 200-374.9	Group C 375-674.9	Group D 675-1049.9	Group E 1050-1499.9	Group F 1500-2649.9	Group G 2650+
Major Cities	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inner Regional	0.329	0.629	0.677	1.012	1.221	1.829	2.995
Outer Regional	0.346	0.454	0.699	0.908	1.469	1.923	3.382
Remote	0.25	0.436	0.605	0.923	1.98	N/A	3.823
Very Remote	0.237	0.454	0.737	1.154	1.95	N/A	4.328

Source: Table 1 of the NEC Determination.

[3] Australian Standard Geographical Classification – Remoteness Classification.

Victoria's SRHS Funding Model in 2013–14

The NEC as determined by the IHPA is a national benchmark set to determine the Commonwealth component of funding. As system manager, Victoria will continue to set the budget for all Health Services.

The IHPA SRHS model funds at the campus level. Victoria will continue to set budgets for Health Services at the LHN level.

Further Information

The IHPA's final NEC Determination 2013–14 provides further details about the national approach to funding SRHS.

Updated on 23 March 2013.