

Rural and Regional Health and Aged Care Services Division

Small Rural Health Services Guide 2003–04

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Foreword

The creation of the Rural and Regional Health and Aged Care Services Division in late 2001 aimed to increase the focus on rural health and aged care service delivery issues and to support an accessible, high quality and effective health system for all rural Victorians. From the outset, the division has sought to engage with rural areas to understand the range of health challenges and solutions that exist in rural Victoria. Visits to services and analyses of service delivery and financial performance information during 2002 highlighted the need to think differently about the department's approach to funding health and aged care services in small rural towns.

From 2003–04 the department is therefore introducing new funding and accountability arrangements for Small Rural Health Services. These new arrangements will be available to 67 such services in the first year of implementation.

The new approach will promote a focus on local needs and a sustainable, locally determined service mix. Simplified departmental funding and accountability will support this flexible, local service response. The new approach will also seek to achieve a more strategic and interactive relationship between Small Rural Health Services and the department (through its regional offices).

The new funding and accountability arrangements contribute to achieving the division's priorities of making a positive difference in rural Victoria and achieving greater service integration across program boundaries.

The new approach will be implemented incrementally over the next two to three years. The development and change process aims to take realistic steps towards reform, considering and monitoring the extent and pace of change as we move forward together. I look forward to working with Small Rural Health Services and rural communities on research, development and implementation of these new arrangements.



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Part 1: Approach to reform

Policy objectives

- Improve the health status of Victorians living in small rural communities
- Support a sustainable configuration of health and aged care services in these communities that is responsive to local needs
- Facilitate delivery of a locally determined mix of services, with an emphasis on those which are community-based and in-home

The three policy objectives provide the context and the drivers for the new funding and accountability arrangements for Small Rural Health Services (SRHSs). They set the broad directions for the first year of implementation and will continue to guide further development work over the next two to three years.

The three related policy objectives operate at different levels and in different timeframes:

- health status: whole population, long term
- sustainable configuration of services: local community, facility types and locations, medium to long term
- mix of services: local community, service types, short to medium term.

The new funding and accountability approach will contribute to the achievement of these objectives by reducing procedural barriers to provision of an integrated, locally determined mix of services. However, while offering greater opportunity to use some existing funding differently, the new arrangements retain an emphasis on financially sustainable service provision within existing budget. In addition, due to the developmental nature of the new funding and accountability approach there will be some limitations on the level of funding flexibility available to SRHSs, particularly in 2003–04, the first year of implementation (see Part 3 for details).

The developmental nature of the approach also acknowledges that the ‘best possible’ service mix for any community and agency may change over time. However, in future this mix will be driven increasingly by local strategic objectives and evidence based planning, rather than departmental program distinctions and detailed funding and accountability rules.

In 2003–04 the new SRHS approach will be available to 67 agencies across rural Victoria that deliver a range of health and aged care services and have all sites/campuses located in towns with a population of less than 5,000. More information on the 67 SRHSs is provided in Part 2 and Appendix 1.

Change at a realistic pace

- Signalling medium to long term directions from the start
- Incremental change and development over two to three years
- Change as and when the local community and the agency are ready
- Some important changes for 2003–04

Having set broad policy objectives, it is important that each Small Rural Health Service (SRHS) and the department (each region and each central office program) can move towards these goals at a sensible pace. For example, in several instances, the department's funding and accountability policies are governed by Commonwealth–State agreements or broader Whole of Victorian Government policies, and change will need to be negotiated over time. For SRHS agencies, it will be important to take account of local community views and draw on relevant population projections and service provision data. SRHSs will also need to consider carefully what opportunities and constraints exist based on current and projected agency finances, facilities and staffing.

The new funding and accountability arrangements for 2003–04 represent the start not the end of the change process; they are based on the research and development that has been undertaken to June 2003. There will be many opportunities for the department and SRHSs to work together on further development of various aspects of the overall approach during the next two to three years.

Some significant changes will, however, already occur in the first year of implementation (see Part 3 for more details). For example:

- Once an SRHS's 2003–04 health and aged care budget has been set, there will be increased flexibility in the use of that budget.
- SRHSs in receipt of acute health funding will no longer be subject to WIES targets or be required to go through a formal WIES conversion process.
- The working relationship between the department and SRHSs will move towards a more strategic basis.

Recognising similarities and differences

- Small rural communities with some shared characteristics and health needs
- Services with several similarities but different labels and funding approaches
 - D hospital, E hospital, Bush Nursing Centre, Community Health Service, Healthstreams, Multi-Purpose Service
- A variety of needs and a variety of responses – now and in the future

Under the new Small Rural Health Service (SRHS) approach, the department recognises that small rural towns (population less than 5,000) and their health and aged care services have many features in common, and that a broad statewide policy approach to funding these agencies can bring benefits to rural communities over time.

This new approach will build on the best features of existing flexible models such as Multi-Purpose Services and Healthstreams. The agencies that have already operated under these funding approaches are already well advanced in applying a flexible funding model. Through the creation of the SRHS group, it is expected that some artificial distinctions between similar agencies due to different departmental funding policies (rather than real differences in service delivery goals and practice) will disappear.

The extent of change in the first year of implementation (2003–04) and in subsequent years will vary from agency to agency. For example:

- Some SRHSs may have made major changes recently and see little scope in the near future for further change.
- Other SRHSs may be completing an extensive service development or strategic planning process and be able to take advantage of funding flexibility in implementing change.
- Some SRHSs may see little opportunity for change in the short term but could take advantage of the new arrangements in future years.

Regardless of the extent or pace of change for each local community and each SRHS, a key goal in making new, more flexible funding and accountability arrangements available to these 67 agencies is to stimulate debate and thinking, rather than assuming that historical funded service delivery patterns must continue. The new arrangements offer opportunities for SRHSs; each SRHS will need to consider how and when it takes advantage of this increased flexibility.

Part 2: Overview of Small Rural Health Services

Scope and coverage (2003–04)

- 67 agencies
- 94 towns
- Approximately \$162 million in total
- All health and aged care funding for these agencies via RRHACS and MHACS (Public Health, Mental Health on a case-by-case basis only)

Agencies in scope

In the first year of implementation the new, more flexible funding and accountability arrangements will be available to 67 Small Rural Health Services (SRHSs) across rural Victoria that deliver a range of health and aged care services and have all sites/campuses located in towns with a population of less than 5,000. The agencies that fall into this category are primarily Group D and E Hospitals (including Multi-Purpose Services and Healthstreams) and Bush Nursing Centres, plus a small number of stand-alone community health services.

The new arrangements will not apply to 'sites' or 'campuses' of larger agencies such as Group C hospitals in 2003–04. However, additional agencies or campuses that have similar characteristics to SRHSs may be considered for inclusion in future years as the approach is developed further.

Appendix 1 contains a full list of SRHSs, and a map showing their location.

Funding in scope

The new funding and accountability approach covers the health and aged care funding SRHSs receive through the Rural and Regional Health and Aged Care Services Division (RRHACS) and the Metropolitan Health and Aged Care Services Division (MHACS). Very few SRHSs receive Public Health or Mental Health funding and the inclusion of any of these funds in the new funding and accountability arrangements will be decided on a case-by-case (agency-by-agency) basis.

In this first year of implementation, funds provided by the Community Care, Disability and Housing Divisions of the department will not be incorporated within the SRHS funding and accountability approach. These funds may be considered for inclusion in future years.

In terms of funding (based on 2002–03 data):

- Of the total budget for SRHSs, 68.3% is Acute Health Services (acute and sub-acute) funding, and 23.5% of funds are allocated under the Aged and Home Care Output Group.
- The total SRHS budget for Primary Health represents 9.4% of the statewide Output Group budget; for Aged and Home Care the proportion is 8.6%.
- Of the 67 SRHSs, 64 receive Aged and Home Care funding.
- Most SRHSs (54 of 67) receive funding under more than one RRHACS and/or MHACS Output Group.
- Several SRHSs (20 of 67) are also funded under other departmental Output Groups.

More details about the funding for the SRHS group of agencies can be found in Appendix 1.

Part 3: The new funding and accountability arrangements

A locally driven approach

- Focus on best possible service mix aligned with local needs
- Greater agency decision-making and flexibility in use of funds
- Improved information sharing between the agency and the department

A fundamental principle of the new funding and accountability arrangements for Small Rural Health Services (SRHSs) is that changes to service configuration or service mix will be determined at the local level, with collaborative input from the SRHS management and board, the department's regional office and members of the local community. Changes will focus on the local community's needs but also take account of wider area-based planning and health status goals. The new SRHS approach will build on the advances in local collaborative planning and service integration and coordination occurring as part of primary health care reforms through the Primary Care Partnership Strategy. As indicated in Part 1, decisions about the extent and pace of any changes will need to be made within agency budgets and take account of current and future staffing and facilities requirements.

SRHSs will be able to make more choices about the use of departmental funding across a range of health and aged care services. They will have greater flexibility in determining service type and volume, and therefore more opportunity to tailor service responses to local community need. However, this increased local discretion brings with it the expectation that agencies will adopt a strategic approach and communicate regularly with the department's regional office about local needs and local service provision. More information about this changing relationship between SRHSs and the department is contained in the following section.

Department–SRHS working arrangements

- A strategic, interactive relationship
- Collaborative discussion and development
- Regular communication and support
- Links to local and area-based service planning
- Regional Agency Relationship Manager as key agency contact

A shift in emphasis

Under the new funding and accountability approach, the working arrangements between the department and Small Rural Health Services (SRHSs) will move from a focus on very detailed program-specific funding and target issues to a much broader discussion about service mix, local needs and local health planning and health outcomes. There will be less time spent on formal approval processes and more emphasis on an open exchange of views about the realities of service delivery. In many instances, regions and SRHSs will bring different local perspectives together to plan for changes to the agency service profile.

Developing and strengthening this SRHS–department relationship is a key aspect of the new approach. It is expected that the SRHS and the regional Agency Relationship Manager will maintain close contact throughout the year to discuss local health status and needs as well as a range of relevant agency operational issues including management arrangements, governance and financial viability.

To support these working arrangements, the department will provide information resources to SRHSs. For example, the Service Profile proforma will be an important tool that can help shape and guide discussions (see Part 4 for more information about resource materials).

This change in roles will start in 2003–04 and proceed gradually as the new, more flexible arrangements are further developed over the next two to three years.

SRHS roles

SRHS agencies will be responsible for:

- short, medium and long term service planning for local needs that reflects regional and area-based planning priorities and is informed by relevant demographic and service provision data
- consultation with the community and other stakeholders such as other local health and aged care services on opportunities for change
- decisions about the best possible service mix and service configuration
- operational management of the agency
- service delivery.

Departmental roles

The regional offices of the department will provide:

- a regional and area-based service planning perspective
- simplified, flexible approaches to service funding and monitoring
- regular opportunities to discuss health needs and service options
- regular opportunities to discuss the implementation and further development of the new funding and accountability arrangements.

The central office of the department will provide:

- overarching policy directions, planning frameworks, funding and accountability parameters
- supporting documentation (see Part 4 for some examples)
- regular opportunities to discuss the implementation and further development of the new funding and accountability arrangements
- practical assistance to regions and SRHSs to explore opportunities for change.

Agency Relationship Manager

In order to strengthen the capacity for collaborative debate and planning, it is the intention under the new SRHS approach that the department's regional offices will nominate a regional Agency Relationship Manager for each SRHS. This departmental representative will:

- develop and maintain a strategic overview of health and aged care needs in the local community and the services provided by the SRHS
- work with the SRHS to explore opportunities to take advantage of the new, flexible funding and accountability arrangements
- be able to consider the long term planning implications and the potential impact on service configuration.

The way regions give effect to this role may vary, but in all instances the emphasis will be on a strong, local relationship that brings a strategic perspective to bear on discussions between the department and the SRHS.

Development of 2003–04 agency budgets

- Three-year service agreements
- Three-year base budgets (July 2003)
- 2003–04 budgets and targets (October 2003)

Three-year service agreements

As part of the department's partnership approach to working with funded agencies delivering human services, three-year service agreements are being introduced from 2003–04. Three-year agreements aim to provide greater certainty about budget and the service delivery environment, emphasise value added work, and support improved collaborative local planning and problem solving. These aims are complementary to the objectives of the new Small Rural Health Service (SRHS) approach.

Budgets

For all programs except acute health the budget contained in the initial service agreement provided to SRHSs by mid July 2003 is the base budget for the three years of the agreement (2003–04 to 2005–06). The base budget comprises the recurrent funding the agency received from the department for health and aged care service delivery and wage-related increases paid during 2002–2003, all calculated to full year effect.

The base budget will be adjusted for 2003–04 (and each subsequent year) to take account of indexation, wage-related increases, savings requirements including productivity improvements, and the impact of annual State and Commonwealth Budget decisions (see the *Rural and Regional Health and Aged Care Services Division Policy and Funding Plan 2003–04 to 2005–06* for more information). The 2003–04 budget for each agency will be finalised by the end of the first official service agreement variation period on 31 October 2003.

Acute health budgets

Where SRHSs receive funding from the acute health program (including sub-acute health), this budget contained in the initial service agreement in July 2003 is the initial 2003–04 'modelled budget'. It already includes the effect of indexation, wage-related increases, and other 2003–04 State Budget decisions.

The following principles underpin the development of acute health budgets for SRHSs:

- During August and September the department will carry out trend analysis of each agency's performance and conversion history over the last three financial years in relation to previous variable payments (WIES, NHT) that will now be part of the global, flexible acute health budget. Modelled budgets may be adjusted to reflect the findings of this analysis. Analysis over a three-year period aims to avoid any artificial gains or losses that might occur if budgets were based on data from the most recent financial year only.
- Specified grants will form part of SRHS budgets on a similar basis to previous years, that is, either as a direct allocation included in the initial modelled budget or via applications or submissions during the year.
- As in previous years, figures for DVA and TAC funding are notional.

The intention of this approach to acute health funding for SRHSs is to ensure that a fair budget is established for SRHS agencies at the start of the new approach, while also recognising that the SRHS approach must operate within the total acute health budget available.

After this 2003–04 acute health budget for each SRHS has been established (by 31 October 2003 at the latest), for the remainder of the financial year there will be:

- no funding recall or additional payments based on actual WIES or NHT related performance
- increases where successful applications are made for additional specified grant funding
- adjustments as necessary based on actual DVA and TAC performance.

Documentation

In addition to the budget and target information contained in the service agreement each SRHS will receive:

- a Baseline Information document containing information about the agency's budget and targets across all services funded by the department as at end 2002–03
- a Budget Statement containing an overview of the agency's total health and aged care budget from the department for 2003–04, and indicating the level of flexibility for different funds under the new SRHS approach.

Part 4 contains more information about these documents.

Flexible use of funds

Extent of flexibility	Funding type
Agency discretion <ul style="list-style-type: none"> • Discuss with Department of Human Services region as part of ongoing communication about service mix 	Acute health Sub-acute health Primary health
Limited agency discretion <ul style="list-style-type: none"> • Reach agreement with regional office (in consultation with central office) 	Aged care including HACC Drugs services Mental health
No discretion <ul style="list-style-type: none"> • Funds to be used for specified purpose/s only 	DVA, TAC One-off specific purpose funding (generally submission-based)

Making decisions about budget and service mix

From 2003–04 onwards, Small Rural Health Services (SRHSs) can make decisions, within their agency budget, about the mix of services that will best meet the needs of their local community, subject to the parameters set out below. Some of these parameters are determined by Commonwealth–State funding agreements.

Decisions to change the service mix in the short or medium term are expected to:

- draw on service development and service planning work undertaken at a local, sub-regional or regional level, and the agency’s own strategic plan and/or business plan
- avoid adverse effects on other health and aged care services in the local area
- increase the proportion of community-based service provision where this represents the most appropriate care in response to local needs.

In making decisions about service mix, SRHSs must meet all statutory obligations and other accountability requirements (see p 13 for more information).

Agency discretion

Where agency discretion exists to make decisions about use of budget, it is expected that changes to funded service types will be discussed with the regional office, in particular, with the Agency Relationship Manager. However, these changes will not involve an approval process or service agreement variation. Innovative approaches will be encouraged.

A shift from acute health to primary health and other community-based primary care services such as mental health and drugs services is one of the main opportunities for change in the first year of the new funding and accountability model.

Acute and sub-acute health

Funding that has previously been used to provide a range of acute health and sub-acute health services can now be used flexibly across the full range of health and aged care services. Acute and sub-acute health services must be provided in accordance with the *Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2003–2004*.

Primary health

Primary health funding can be used flexibly across the full range of health and aged care services.

In making decisions about service mix under the new SRHS approach, several SRHSs have an opportunity to extend the strategic thinking about primary health care that they have engaged in as members of a Primary Care Partnership, and as individual agencies during the first year of implementation of the new Primary Health Funding Approach (PHFA) in 2002–03. SRHSs should use the PHFA as a starting point when considering options for financially sustainable primary health service provision. Primary health services must be provided in accordance with the *Community and Women's Health Program Guidelines 2003–2006*.

Limited agency discretion

Where there is limited agency discretion to use funds flexibly, changes to service mix can only be made with the agreement of the department, and in line with relevant program funding processes. The SRHS and the regional office may reach agreement to use funds more flexibly following discussion of the SRHS proposal between the region and the central office program. Services must be provided in accordance with the relevant program guidelines.

HACC

Home and Community Care (HACC) funding must be allocated to a set range of service types provided to the HACC target group, as agreed between the Commonwealth and State Governments. In 2003–04, agencies are expected to allocate and expend funds in accordance with this Commonwealth–State agreement and in line with the new HACC planning and funds allocation process. As an appendix to the agency service agreement, each SRHS will negotiate a detailed breakdown of its intended use of HACC funds and associated service delivery targets across the various HACC service types. This is required to calculate the minor capital grant for each agency, as well as to meet agreed Commonwealth reporting requirements.

Residential aged care

The bulk of funding that SRHSs receive for residential aged care is subject to Commonwealth legislative and funding requirements. Any changes SRHSs wish to propose to their residential aged care service provision will need to be endorsed by the Department of Human Services and approved by the Commonwealth. The department will work with SRHSs on a case-by-case basis to develop proposals that meet changing community need.

Public health, mental health, drugs services

Only a very small number of SRHSs receive specific public health, mental health or drugs services funding. Inclusion of public health or mental health funds in the new SRHS approach will be determined on a case-by-case (agency-by-agency) basis. In the case of drugs services some funding is subject to court orders and/or Commonwealth requirements and cannot be redirected to other clients and service types.

In considering the needs of the local community, SRHSs are encouraged to explore options for flexible use of other funds (for example, acute health or primary health funds) to provide an enhanced package of services to vulnerable clients including those supported by the drugs services and mental health programs.

No discretion

Some funds can only be used for the original purpose as set out below. SRHSs are expected to adhere to these funding policies.

DVA

Commonwealth funds provided for the treatment and care of Department of Veterans Affairs (DVA) clients can only be used for this target group. In line with Commonwealth–State funding agreements, DVA funds in the agency’s budget indicate notional amounts only. DVA funding is adjusted in arrears for the exact number of DVA clients, recorded in line with Commonwealth guidelines, who received a service. Note that special arrangements apply for the community-based Veterans Care program that provides planned activity groups and delivered meals to eligible veterans.

More information about DVA funding can be found in the *Rural and Regional Health and Aged Care Services Division Policy and Funding Plan 2003–04 to 2005–06* and the *Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2003–2004*.

TAC

Transport Accident Commission (TAC) funding is allocated for specific clients and cannot be used for other purposes. More information about TAC funding can be found in the *Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2003–2004*.

Submission-based funding

During the year, non-recurrent grants may be provided to agencies for specific purposes, often in response to submissions from agencies. These one-off grants are to be used for the agreed purposes only.

Simplifying accountability

- Two performance measures
 - Provide agreed overall range and level of services
 - Develop service profile (explore changes to service mix)
- Comply with relevant legislation, service standards and guidelines
- Complete all existing program activity reports on services delivered
- Streamlined reporting in future – pilot with 3–5 SRHSs during 2003–04

Under the new Small Rural Health Service (SRHS) approach there are two broad performance measures. Regular payments under the service agreement will flow automatically regardless of service mix changes, as long as SRHSs comply with these two performance measures and meet statutory requirements and other key standards.

SRHSs are expected to report comprehensively ‘after the event’ on funded services actually delivered, using existing reporting mechanisms. While some of this data will help monitor compliance with the first performance measure, the main purpose of this detailed information is to help SRHSs and the department monitor the impact of the new approach and plan for future years. In some instances, these details are also required to meet the department’s Commonwealth or State reporting obligations.

Options for streamlining data collection and reporting while retaining essential service delivery and service planning information will be explored during 2003–04.

Performance measures and targets

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:

- ‘delivery of a range of health and aged care services as per agreed Service Profile and business rules’ (unit of measure: Rural Health Service Unit – see p 14), that is, SRHSs are expected to maintain an agreed overall effort in health and aged care service delivery and to deliver these services in line with the parameters set out in this Guide and other relevant policy documents
- ‘development of Service Profile’, that is, SRHSs should use the Service Profile proforma to discuss and document ideas about service mix with the regional Agency Relationship Manager (see Part 4 for more information about the Service Profile).

Note that different performance measures apply to a small number of SRHS activities (HACC DVA funding, annual provisions funding, mental health funding).

Rural Health Service Unit

The 2003–04 SRHS agency service agreements reflect these new measures and contain new Rural Health Service Unit (RHSU) targets against most measures. This RHSU is a notional unit of measure, and agencies will not be expected to calculate or report RHSUs. Any calculations or conversions, if required, will be done by the department. A brief overview of the methodology used to calculate RHSUs in agency service agreements is contained in Appendix 3.

Service standards and reporting

For SRHSs, the guidelines, standards, legislation and reports that apply in 2003–04 will reflect the service type actually delivered. For example, if an SRHS decides to provide additional primary health services using funds originally sourced from acute health, these primary health services must be delivered and reported in accordance with the *Community and Women’s Health Program Guidelines 2003–2006*.

There is no change to program data collection and reporting requirements in 2003–04 as a result of the new SRHS approach. SRHSs are required to report all service delivery activity according to the relevant existing departmental data collection and reporting requirements, including financial reporting requirements. Provision of these reports remains a crucial part of agencies’ and the department’s accountability for the use of public funds. During 2003–04, a pilot project will commence with a small number of SRHSs to test the feasibility of streamlined data collection and reporting arrangements.

SRHSs are also required to adhere to all departmental program service standards and guidelines and State and Commonwealth legislative requirements that apply to the health and aged care services they provide.

More information

More information about SRHS performance measures, data collection and reporting requirements, and service standards and guidelines can be found in the *Rural and Regional Health and Aged Care Services Division Policy and Funding Plan 2003–04 to 2005–06*.

Part 4: Key documents

Small Rural Health Services Guide 2003–04

- The key reference document and information resource

Supporting documentation

- Baseline Information (for each SRHS)
- Budget Statement (for each SRHS)
- Service Profile (proforma, available on website)
- Questions and Answers (available on website)

Baseline Information

The Baseline Information document will detail the budgets and targets for each funded service type provided by Small Rural Health Services (SRHSs) as recorded on departmental databases at the end of the 2002–03 financial year, that is, prior to the commencement of the new funding and accountability arrangements. This document will provide the SRHS and the department with a baseline reference about the service mix that has been provided to date, before any changes proposed under the new approach are made. It will inform the ongoing discussions between the agency and the region, and assist in monitoring the impact of the new approach over time. It is anticipated that this document will be issued in late August 2003.

An example of the Baseline Information document is contained in Appendix 2.

Budget Statement

The Budget Statement will provide a consolidated overview of each SRHS's budget for all services funded via the RRHACS and MHACS Divisions. It will be derived from the agency's service agreement and additional data drawn from the Baseline Information document. It will also indicate the extent of funding flexibility for each budget line. The confirmed 2003–04 Budget Statement will be issued by 31 October 2003.

Service Profile

The Service Profile proforma is intended for use by SRHS agencies and regional staff as a working document that records any proposed changes to the agency service mix and/or any planned developmental work to explore opportunities for change in the future. The net effect of changes is to be cost-neutral, that is, an SRHS must accommodate any changes within its existing agency budget.

An example of a completed Service Profile is contained in Appendix 2. The proforma and example are also available on the RRHACS website at dhs.vic.gov.au/rrhacs.

Each SRHS's Service Profile document will contain very brief information describing why changes are proposed and the anticipated impacts of the changes. Where relevant, the Service Profile will contain cross-references to the Baseline Information or the Budget Statement, as well as to local planning documents, for example, the Primary Care Partnership Community Health Plan and HACC Regional Plans, but it will not replicate material contained in these documents.

The Service Profile is primarily intended to reflect anticipated changes to service mix.

In addition, some SRHSs may choose to use the Service Profile proforma to:

- record existing key features of their service delivery that are not adequately described in the Baseline Information document
- indicate that scope for any change in future years will be explored during 2003–04
- highlight any development and planning strategies in place for 2003–04.

Development of the Service Profile is one of two key performance measures for SRHSs. However, the Service Profile document is not an end in itself. A pivotal feature of the new funding and accountability arrangements is meetings between the SRHS and the regional Agency Relationship Manager to discuss strategic directions for the agency, including changes to service mix (see Part 3). The Service Profile simply serves as a brief record of those discussions.

It is expected that initial discussions about possible changes to the agency's service mix will have taken place and been recorded in the first version of the Service Profile by 31 October 2003.

Questions and Answers

The Questions and Answers document is available on the RRHACS website at dhs.vic.gov.au/rrhacs. The first version of this document was posted on the website in June 2003. The Questions and Answers document will be updated regularly to provide SRHSs and departmental staff with news about the ongoing development of the SRHS approach and answers to specific questions that have been raised.

Appendix 1: Profile of the SRHS group

Agencies in scope

Table 1 provides an overview of the number of Small Rural Health Services (SRHSs) per (lead) departmental region.

Table 1: SRHSs by Lead Region

Region	Barwon-South Western	Gippsland	Grampians	Hume	Loddon Mallee	Total
No. of SRHSs	11	13	10	17	16	67

Table 2 provides an overview of SRHSs by notional agency type based on historical funding arrangements.

Table 2: SRHSs by Agency Type

SRHS Type	No. of SRHSs
Group E Hospital	17
Bush Nursing Centre	14
Healthstreams	10
Group D Hospital	9
Community Health Service*	9
Multi-Purpose Service	7
Other	1
Total	67

* Receives Community Health Program funding, does not fall under any other agency type

A listing and map of all SRHS sites/campuses, and the towns where they are located, are presented on the following pages.

Small Rural Health Services – agencies in scope for 2003–04

Map ID	SAMS Agency Name	Locality	Population ERP 2001	Agency Type	Region of Location
1	Alexandra District Hospital	Alexandra	2234	D	Hume
2	Alpine Health	Bright	1861	MPS	Hume
3	Alpine Health	Mount Beauty	1596	MPS	Hume
4	Alpine Health	Myrtleford	2695	MPS	Hume
5	Balmoral Bush Nursing Centre Inc	Balmoral	217	BNC	Barwon-SW
6	Beaufort & Skipton Health Service	Beaufort	1072	Healthstreams	Grampians
7	Beaufort & Skipton Health Service	Skipton	491	Healthstreams	Grampians
8	Beechworth Health Service	Beechworth	2905	D	Hume
9A	Boort District Hospital	Boort	804	E	Loddon Mallee
10	Cann Valley Bush Nursing Centre Inc	Cann River	229	BNC	Gippsland
11	Casterton Memorial Hospital	Casterton	1738	D	Barwon-SW
12A	Cobaw Community Health Service Inc	Kyneton	4385	CHS	Loddon Mallee
13	Cobaw Community Health Service Inc	Woodend	3164	CHS	Loddon Mallee
14	Cobram District Hospital	Cobram	4834	D	Hume
15A	Cohuna District Hospital	Cohuna	2069	D	Loddon Mallee
16	Coleraine District Health Services	Coleraine	1059	Healthstreams	Barwon-SW
17	Coleraine District Health Services	Merino	232	Healthstreams	Barwon-SW
18	Dargo Bush Nursing Centre Inc	Dargo	200	BNC	Gippsland
19	Dartmoor & District Bush Nursing Centre Inc	Dartmoor	259	BNC	Barwon-SW
20	Dingee Bush Nursing Centre Inc	Dingee	200	BNC	Loddon Mallee
21	Dunmunkle Health Services	Minyip	481	E	Grampians
22	Dunmunkle Health Services	Murtoa	832	E	Grampians
23	Dunmunkle Health Services	Rupanyup	438	E	Grampians
24	East Wimmera Health Service	St Arnaud	2547	D	Grampians
25	East Wimmera Health Service	Birchip	716	D	Loddon Mallee*
26	East Wimmera Health Service	Charlton	1039	D	Loddon Mallee*
27	East Wimmera Health Service	Donald	1444	D	Loddon Mallee*
28	East Wimmera Health Service	Wycheproof	723	D	Loddon Mallee*
29	Edenhope & District Memorial Hospital	Edenhope	841	D	Grampians
30	Elmhurst Bush Nursing Centre Inc	Elmhurst	200	BNC	Grampians
31	Ensay Community Health Centre Inc	Ensay	200	CHS	Gippsland
32	Gelantipy District Bush Nursing Centre Inc	Gelantipy	200	BNC	Gippsland
33	Gisborne and District Community Health and Hospital Board Inc	Gisborne	4629	CHS	Loddon Mallee
34	Glenview Community Care Inc	Rutherglen	1200	CHS	Hume
35	Harrow Bush Nursing Centre Inc	Harrow	200	BNC	Grampians
36	Hepburn Health Service	Clunes	1092	D	Grampians
37	Hepburn Health Service	Creswick	2571	D	Grampians
38	Hepburn Health Service	Daylesford	3418	D	Grampians
39	Hepburn Health Service	Trentham	737	D	Grampians
40	Hesse Rural Health Services	Beeac	220	Healthstreams	Barwon-SW
41	Hesse Rural Health Services	Rokewood	240	Healthstreams	Barwon-SW
42	Hesse Rural Health Services	Winchelsea	1173	Healthstreams	Barwon-SW
43	Heywood Rural Health	Heywood	1322	Healthstreams	Barwon-SW

continues

Small Rural Health Services – agencies in scope for 2003–04 (cont.)

Map ID	SAMS Agency Name	Locality	Population ERP 2001	Agency Type	Region of Location
44	Inglewood & Districts Health Service	Inglewood	726	E	Loddon Mallee
45	Inglewood & Districts Health Service	Wedderburn	687	E	Loddon Mallee
46A	Kerang District Health	Kerang	3971	Healthstreams	Loddon Mallee
47	Kilmore & District Hospital	Kilmore	3633	D	Hume
12B	Kyneton District Health Service	Kyneton	4385	D	Loddon Mallee
48	Lake Bolac Bush Nursing Centre Inc	Lake Bolac	200	BNC	Grampians
49	Lockington & District Bush Nursing Centre Inc	Lockington	200	BNC	Loddon Mallee
50	Lorne Community Hospital	Lorne	1090	Healthstreams	Barwon-SW
51	Maldon Hospital	Maldon	1214	E	Loddon Mallee
52	Mallacoota District Health & Support Service Inc	Mallacoota	200	Other	Gippsland
53	Mallee Track Health and Community Service	Murrayville	252	MPS	Loddon Mallee
54	Mallee Track Health and Community Service	Ouyen	1187	MPS	Loddon Mallee
55	Mallee Track Health and Community Service	Patchewollock	200	MPS	Loddon Mallee
56	Mallee Track Health and Community Service	Underbool	245	MPS	Loddon Mallee
57	Manangatang & District Hospital	Manangatang	289	E	Loddon Mallee
58	Mansfield District Hospital	Mansfield	2702	D	Hume
59	Mclvor Health and Community Services	Heathcote	1677	E	Loddon Mallee
60	Mitchell Community Health Services Inc	Broadford	2844	CHS	Hume
61A	Mitchell Community Health Services Inc	Seymour	6702	CHS	Hume
62	Mitchell Community Health Services Inc	Wallan	4166	CHS	Hume
63	Moyne Health Services	Port Fairy	2582	Healthstreams	Barwon-SW
64	Murrindindi Community Health Service Inc	Eildon	739	CHS	Hume
65	Murrindindi Community Health Service Inc	Marysville	540	CHS	Hume
66	Nathalia District Hospital	Nathalia	1545	Healthstreams	Hume
9B	Northern District Community Health Service Inc	Boort	804	CHS	Loddon Mallee
15B	Northern District Community Health Service Inc	Cohuna	2069	CHS	Loddon Mallee
46B	Northern District Community Health Service Inc	Kerang	3971	CHS	Loddon Mallee
67	Northern District Community Health Service Inc	Pyramid Hill	525	CHS	Loddon Mallee
68	Northern District Community Health Service Inc	Quambatook	261	CHS	Loddon Mallee
69	Nowa Nowa Community Health Centre Inc	Nowa Nowa	200	CHS	Gippsland
70	Numurkah District Health Service	Numurkah	3540	D	Hume
71	Omeo District Hospital	Omeo	251	E	Gippsland
72	Orbost Regional Health	Orbost	2220	MPS	Gippsland
73	Otway Health & Community Services	Apollo Bay	1301	MPS	Barwon-SW
74	Robinvale District Health Services	Robinvale	2152	MPS	Loddon Mallee
75	Rochester and Elmore District Health Service	Elmore	713	D	Loddon Mallee
76	Rochester and Elmore District Health Service	Rochester	2828	D	Loddon Mallee
77	Rural Northwest Health	Beulah	217	D	Grampians
78	Rural Northwest Health	Hopetoun	669	D	Grampians
79	Rural Northwest Health	Warracknabeal	2647	D	Grampians
80	San Remo & District Community Health Centre Inc	Corinella	506	CHS	Gippsland
81	San Remo & District Community Health Centre Inc	San Remo	965	CHS	Gippsland
61B	Seymour District Memorial Hospital	Seymour	6702	D	Hume

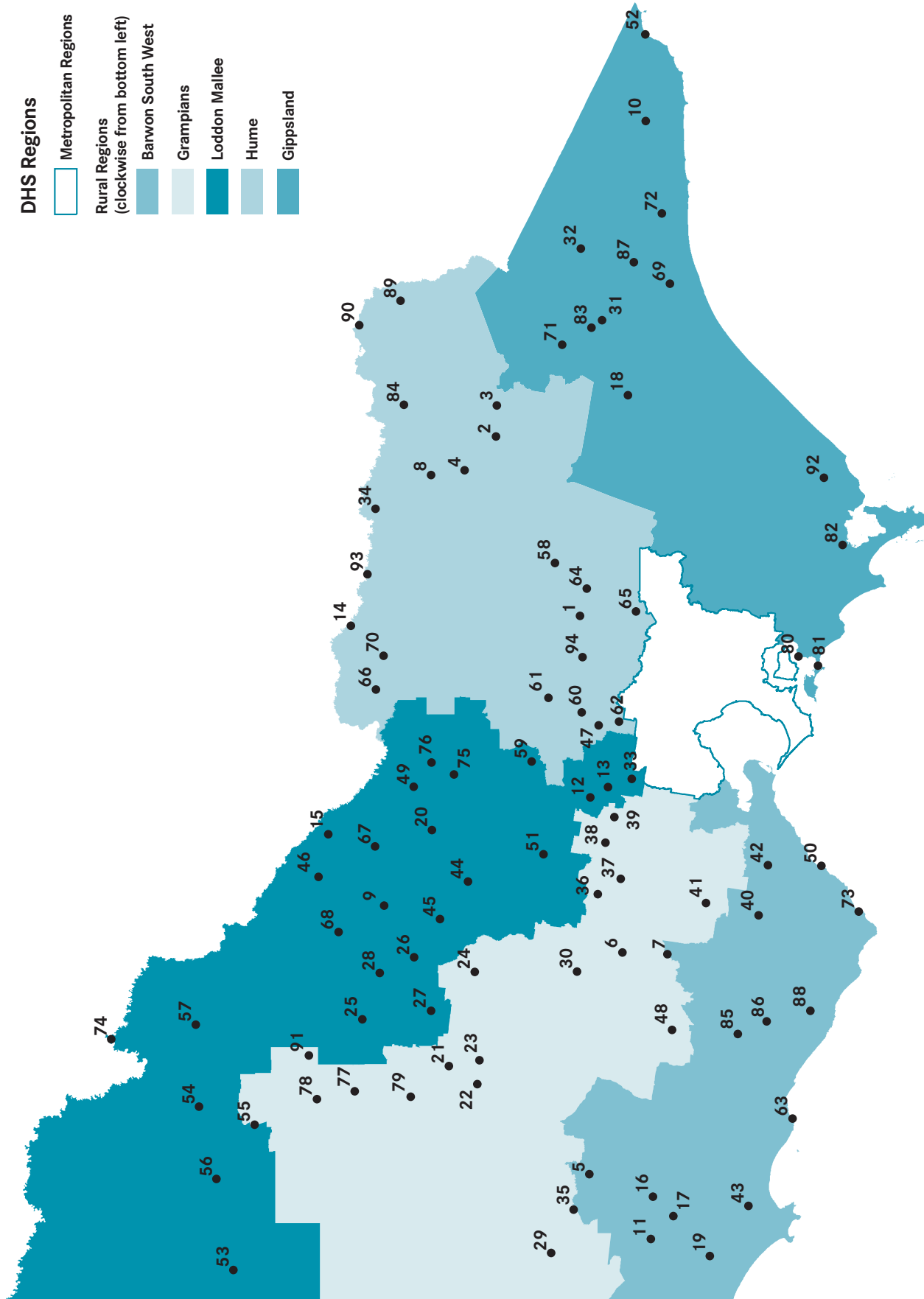
continues

Small Rural Health Services – agencies in scope for 2003–04 (cont.)

Map ID	SAMS Agency Name	Locality	Population ERP 2001	Agency Type	Region of Location
82	South Gippsland Hospital	Foster	1055	E	Gippsland
83	Swifts Creek Bush Nursing Centre Inc	Swifts Creek	200	BNC	Gippsland
84	Tallangatta Health Service	Tallangatta	983	Healthstreams	Hume
85	Terang and Mortlake Health Service	Mortlake	1029	D	Barwon-SW
86	Terang and Mortlake Health Service	Terang	1948	D	Barwon-SW
87	The Buchan Bush Nursing Association Inc	Buchan	200	BNC	Gippsland
88	Timboon and District Healthcare Service	Timboon	871	MPS	Barwon-SW
89	Upper Murray Health and Community Services	Corryong	1225	MPS	Hume
90	Walwa Bush Nursing Hospital Inc	Walwa	200	BNC	Hume
91	Woomelang & District Bush Nursing Centre Inc	Woomelang	224	BNC	Grampians
92	Yarram & District Health Service	Yarram	1843	Healthstreams	Gippsland
93	Yarrawonga District Health Service	Yarrawonga	4241	D	Hume
94	Yea & District Memorial Hospital	Yea	1080	E	Hume

* Grampians = lead region

Location of Small Rural Health Services



Numbers 1-94 refer to SRHS towns. See Map ID column in SRHS list on pp 18-20 for details of sites/campuses.

Funding in scope

Total budget for Small Rural Health Services

Table 3 shows the SRHS budget breakdown for RRHACS and MHACS Output Groups based on 2002–03 agency budget data as at May 2003. The table also shows the percentage of the total SRHS budget that each Output Group budget represents, as well as the proportion of the statewide Output Group budget that SRHSs represent. The 2002–03 figures are presented here to give an indication of total budget in scope; these figures will be updated in line with 2003–04 budgets.

Table 3: Total SRHS Budget by Output Group (2002–03 Funding as at May 2003)

Output Group	Budget for SRHSs (million)*	Percentage of Total SRHS Budget*	SRHS Budget as Proportion of Statewide Output Group Budget
Acute Health Services	\$110.8	68.3%	3.0%
Aged and Home Care	\$38.1	23.5%	8.6%
Primary Health	\$9.4	5.8%	9.4%
Mental Health	\$2.9	1.8%	0.6%
Public Health and Drugs [†]	\$1.0	0.6%	0.5%
TOTAL	\$162.2	100%	N/A

* SRHS budget from RRHACS and MHACS Divisions (does not include other departmental funding).

[†] In 2002–03 Drugs Services and Public Health funding fell under the one Public Health and Drugs Output Group; from 2003–04 these are separated into two Output Groups.

Diversity of funding sources

SRHSs provide a range of services and receive funding under multiple Department of Human Services Output Groups.

Table 4 shows the number of SRHS agencies funded under each RRHACS and MHACS Output Group based on 2002–03 budget data. There may be some minor changes to this distribution in 2003–04.

Table 4: Number of SRHSs Funded per Output Group (as at May 2003)

Output Group	No. of SRHSs (Total = 67)	Percentage of all SRHSs
Aged and Home Care	64	96%
Acute Health Services	49	73%
Primary Health	39	58%
Drugs Services*	8	12%
Mental Health	3	4%
Public Health*	1	1%

* In 2002–03 Drugs Services and Public Health funding fell under the one Public Health and Drugs Output Group; from 2003–04 there are two separate Output Groups.

Most SRHSs are funded under more than one of these RRHACS and MHACS Output Groups.

- Just 13 agencies are funded from one of these Output Groups only.
- In addition, 20 SRHSs (approximately 30 per cent of total) receive funding from the department under other Output Groups that are not in scope for the new funding and accountability arrangements.

A more detailed breakdown shows:

- Of the 64 SRHSs funded under the Aged and Home Care Output Group, all receive HACC funding, making the HACC program the most frequently represented funding source amongst the SRHSs. In addition, 44 of these 64 SRHSs are funded for residential aged care.
- Of the 49 SRHSs receiving Acute Health Services funding, 2002–03 data shows that 48 were funded for Admitted Patients, 43 for Non Admitted Patients, and 10 for Emergency Services.

Appendix 2: Sample documentation

Baseline Information: sample

Agency (Name): Utopian District Hospital

Output Group	Output	Activity (Number-Name)	Service Name/Grant Description	Unit of Measure	Recurrent \$	Non-Recurrent \$	Budget \$	Targets	
Acute Health Services	Admitted Patients	11008 – Admitted Patients	AMA Rural Enhancement Package	N/A	\$31,330	\$0	\$31,330	0	
			ANF Enterprise Bargaining Agreement	N/A	\$31,200	\$0	\$31,200	0	
			Biomedical Engineers Award	N/A	\$0	\$196	\$0	\$196	0
			Conversion Stabilisation Reserve	N/A	\$0	\$90,160	\$0	\$90,160	0
			DVA WIES Target – Rural Group D,E	WIES	\$476,580	\$0	\$476,580	\$0	174
			Embedded Tax Savings	N/A	-\$17,290	\$0	-\$17,290	\$0	0
			Equipment & Infrastructure Maintenance Grant	N/A	\$30,772	\$0	\$30,772	\$0	0
			HDMS – Bonus Funding (Non ESIS)	N/A	\$7,540	\$0	\$7,540	\$0	0
			Health Maintenance Workers	N/A	\$0	\$882	\$0	\$882	0
			Health Super Defined Benefits Scheme Funding (Notional)	N/A	\$0	\$0	\$0	\$0	0
			Historical Superannuation Adjustment	N/A	\$43,810	\$0	\$43,810	\$0	0
			Infection Control	N/A	\$0	\$0	\$0	\$0	0
			Inpatient Revenue	N/A	-\$234,780	\$0	-\$234,780	\$0	0
			Pharmacy Department Improvement	N/A	\$0	\$25,480	\$0	\$25,480	0
			Price Maintenance	N/A	\$63,180	\$0	\$63,180	\$0	0
			Private WIES – Target B	WIES	\$0	\$0	\$0	\$0	0
			Private WIES Target – Rural Group D,E	WIES	\$159,250	\$0	\$159,250	\$0	73
			Public WIES – Target B	WIES	\$0	\$0	\$0	\$0	0
			Public WIES Target – Rural Group D,E	WIES	\$2,920,970	\$0	\$2,920,970	\$0	1099
			PYA 01 /02 Financial Year	N/A	\$0	\$0	\$0	\$0	0
			Quality Framework	N/A	\$68,120	\$0	\$68,120	\$0	0
			Rural/Isolated Payment – Rural		\$23,010	\$0	\$23,010	\$0	1357
					WIES Loading Rural/Isolated				
		Small Rural Productivity Savings etc Compensation Grant	N/A	\$0	\$43,120	\$0	\$43,120	0	
		TAC WIES Target – Rural Group D,E	WIES	\$25,610	\$0	\$25,610	12		
		WorkCover Premium – Advance	N/A	\$0	\$0	\$0	0		
		Trauma Appropriate Payment	N/A	\$0	\$0	\$0	0		
		Trauma Equipment	N/A	\$0	\$0	\$0	0		
		Trauma Service – Data & Education	N/A	\$0	\$0	\$0	0		
		Highly Specialised Drugs	N/A	\$0	\$2,059	\$0	\$2,059	0	
		Outpatients – Non VACS Funded	N/A	\$404,300	\$0	\$404,300	0		
		Outpatients Revenue	N/A	-\$30,550	\$0	-\$30,550	0		
		NHT Days – Non DVA	Bed Days	\$236,080	\$0	\$236,080	1533		
		Continuing Medical Education	N/A	\$0	\$196	\$0	\$196	0	
		Division 2 Nurse Paid Study Leave Program	N/A	\$0	\$4,116	\$0	\$4,116	0	
		HSUA No 3 Study Leave	N/A	\$0	\$1,274	\$0	\$1,274	0	
		Nurse Back Injury Prevention Project	N/A	\$0	\$0	\$0	\$0	0	
		T&D Allied Health – Allied Health Undergraduate Allowance	N/A	\$2,275	\$0	\$2,275	0		
		T&D Nursing – Continuing Nurse Education	N/A	\$10,400	\$0	\$10,400	0		
Acute Health Services Total					\$4,221,035	\$198,255	\$4,419,290		

continues

Baseline Information: sample (cont.)

Output Group	Output	Activity (Number-Name)	Service Name/Grant Description	Unit of Measure	Recurrent \$	Non-Recurrent \$	Budget \$	Targets	
Aged and Home Care	Aged Residential Care	13031 – Nursing Home State Support	AMA / HSUA No. 1 EBA Small Rural – Funding for all Output Groups	N/A	\$99,450	\$0	\$99,450	0	
			Annual Leave Liability – Small Rurals – for all Output Groups	N/A	\$0	\$6,664	\$6,664	0	
			HealthSuper DBS – Small Rurals – Funding for all Output Groups	N/A	\$0	\$20,090	\$20,090	0	
			HSUA No 5 – Small Rurals – Funding for All Output Groups	N/A	\$0	\$7,154	\$7,154	0	
			Nurses EBA	Projects	\$32,760	\$0	\$32,760	0	
Aged and Home Care Total					\$242,333	\$35,087	\$277,421		
	Primary Health	Community Health Care	28001 – Community Health – Health Promotion	Community Health Care	Hours	\$10,277	\$0	\$10,277	202
			28011 – Allied Health – Physiotherapy	Community Health Care	Hours	\$39,845	\$0	\$39,845	712
		Primary Health Service	28033 – Annual Provisions Minor Works	Primary Health Development & Resourcing	Dollars	\$565	\$0	\$565	0
		System Dev & Resourcing	28043 – Workforce Development	Primary Health Development & Resourcing	N/A	\$1,222	\$0	\$1,222	0
			28049 – Primary Health Development & Resourcing	Primary Health Development & Resourcing	N/A	\$9,976	\$0	\$9,976	0
						\$61,885	\$0	\$61,885	
					\$4,525,254	\$233,342	\$4,758,596		
Grand Total									

Service Profile: completed example

SRHS Service Profile: Change in Service Mix 2003–04

Name of SRHS: Zen Health Service

Contact Details:

Denise Plum, Executive Director
 Hospital Rd
 Zen, Vic, 3333
 2233 2233

Working Draft	SRHS Representative		DHS Representative	
	Name	Initial	Name	Initial
Version and Date	Denise Plum	DP	J Smith	JS
1. 15 August 2003				
2.				
3.				

Summary Information

Local Government Area: East Gippsland	Division of GP: East Gippsland
Name of PCP Alliance: East Gippsland PCP	

Other Reference Documents

- SRHS Baseline Information 2003–2004
- Community Health Plan 2003
- Zen Service Plan 2003–2006
- Municipal Public Health Plan 2003
- HACC Regional Plan

continues

Service Profile: completed example (cont.)

Services Type	Proposal	Rationale	Anticipated Impact	Reporting Method	Cost	Stakeholder Engagement	Comments
Acute Inpatient Rehabilitation	Provide an additional 320 Rehabilitation bed days per annum	A review of Acute service provision from November 2002 indicates a need for an inpatient rehabilitation program. The aim of the program is to reduce the need for patients to be transferred.	Average length of stay will reduce by 6%. Performance against clinical indicators will be maintained.	VAED	\$104,400	Ongoing 3 monthly meetings with Yang Community Health Service have been introduced.	This service change is to be reviewed and evaluated in December 2003.
Primary Health Social Support Program	Provide a social support program to include men's, women's and youth health education.	Drought and increased unemployment (<i>Pg 36 CHP</i>) have impacted significantly on the catchment of Zen Health Service. Community consultation (<i>Service Plan pg 6</i>) indicates support for these services. There is currently no social support available in the catchment district of Zen.	Early discharge or the prevention of admission where psychosocial factors are negatively impacting on client health.	AIMS/SWITCH	\$58,300	Ongoing 3 monthly meetings with Yang Community Health Service have been introduced. Yang Community Health Service supports this program. Advised potential difficulty in recruiting a Social Worker.	To be evaluated and reviewed in 3 months recognising possible difficulty in recruitment of a Social Worker.
Primary Care Integrated Healthcare model	An integrated healthcare model is to be piloted between Zen and Zen Medical Centre, involving provision of coordinated primary care services through an integrated community based model of care.	This model is supported by a data review of client referral patterns. Zen has struggled to retain GPs longer than 18 months. The model is intended to support GPs and streamline referral processes.	Improved access to GPs throughout catchment. Improved access to other services stemming from improved referral and integration.	2 monthly reviews of referral processes. Progress reports via PCP Service Coordination reporting requirements	\$65,137	Yin Health Service has piloted a similar model with great success. Yin is very supportive of this pilot.	As this is a pilot, evaluation and review to occur every 3 months.

continues

Service Profile: completed example (cont.)

Services Type	Proposal	Rationale	Anticipated Impact	Reporting Method	Cost	Stakeholder Engagement	Comments
Acute Health Non-admitted Patients Services	Reduction in after hours service in the acute setting. Estimated reduction on non-admitted presentation of 500 people per annum.	Analysis of non-admitted presentations over the last 2 years shows that the vast majority of clients reflect demand for primary care, rather than acute level services. The development of the above primary care services, which are to include on-call after hours access, will meet the needs of these clients.	Similar level of service to Zen community. Demand for most non-admitted services to be met through alternative service models and setting.	AIMS	(\$167,837)	Monthly meetings will be conducted with Yin Health Service and Ambulance Services to monitor whether this reduction has an impact on each of the services listed above. A community education program is planned to ensure that clients are aware of alternative arrangements.	To be reviewed over the next 12 months.
Other	Outsourcing of meals provision.	Analysis of bed occupancy over 3 years shows that on-site meal preparation is no longer required. Contract has been entered into with local provider commencing July 1 for preparation and delivery of required meals.	Quality and timeliness of meals maintained.	Ongoing monitoring of meals expenditure	(\$60,000)	Quality of meals to be monitored through existing patient satisfaction surveys.	Savings represent 1 EFT (imminent retirement) and some savings in maintenance, cleaning and utility costs.
				Net budget impact	\$0		

Appendix 3: Unit of measure – Rural Health Service Unit

Generic units have been introduced in various RRHACS Output Groups over the last few years. The main driver for introducing these units as a way of describing volume of service delivery activity has been the need for greater flexibility during the year in service delivery and therefore in resource allocation, while maintaining accountability for the total quantum of funds and a certain overall level of activity.

The Rural Health Service Unit (RHSU) is a notional unit only that facilitates the provision of a flexible service mix while maintaining an agreed overall level of service. In 2003–04, the notional value of the RHSU is \$66.84; this value is derived from the average primary health unit price (with some adjustments).

SRHSs will be expected to report actual service delivery activity in line with their usual program reporting requirements and systems; they will not need to do any calculations using RHSUs. The RHSU is for Department of Human Services use only and the department's central office will perform most calculations, where necessary, including any conversion of reported performance actuals if required.

The RHSU formula is applied at the service agreement Activity level as follows:
 recurrent budget ÷ \$66.84 = number of RHSUs.

Table 5 shows how the conversion formula was applied, based on one agency's hypothetical 2002–03 funded activities, in setting up agency service agreements for 2003–04 and beyond.

Table 5: RHSUs in Service Agreements – Example

Activity No. (2002–03)	Activity Name (2002–03)	Recurrent Budget (2002–03) (\$)	No. of RHSUs
13097	HACC – Delivered Meals	\$12,700	190
28001	Community Health – Health Promotion	\$171,395	2,564
28011	Allied Health – Physiotherapy	\$49,913	747
11008	Admitted Patients	\$1,250,750	18,713
Total		\$1,484,758	22,214