



# Rural and Remote Service Delivery Models

## Resource Sheet

*Developed by ACSA's Rural and Remote Working Group, this Resource Sheet is a response to concern about Multipurpose Service (MPS) models being forced on communities without adequate consultation and consideration of their effects on local service delivery. The material presented here is intended to give providers direction, positions, information and arguments to use in negotiations if a MPS or Regional Health Service (RHS) is likely to proceed in their local community.*

## Introduction

- In recent years, governments have been aware of limited access to a range of health and community services and viability issues faced by providers in rural and remote communities.
- A range of models such as Multipurpose Centres, Multipurpose Services and Regional Health Services have been implemented since the 1980s with the aim of improving access and maintaining local service infrastructure.
- This Resource Sheet provides background and information to support aged and community care providers to determine whether their needs and those of the broader community are best served by entering into a mixed service model.

## Multipurpose Services

### Background

- Multipurpose Services (MPS) are flexible service models that provide a range of integrated health services to rural and remote communities. Some of the services that a MPS may provide include residential aged care, hospital care, other health care services, home and community care services, palliative care and paramedical services.
- The MPS Program enables communities to pool Commonwealth and State Government funds from community health services, hospitals, home care services and residential aged care. Their aim is to allow selected rural and remote communities to determine and prioritise their specific needs and to allocate resources accordingly.
- As of 31 August 2001, there were 56 operational Multipurpose Services with 1,233 flexible places.

## **History of Multipurpose Services**

- In the 1989 federal budget, the Government announced funding for Multipurpose Centres (MPC). The aim of the MPCs was to assist in the delivery of a variety of health and welfare services in rural and remote areas. MPCs were developed as an initial response to the special needs of rural and remote communities where some health services were in jeopardy because of their small scale operation.
- The MPCs aimed to support shared administrative structures for services in order to ensure that they were more viable. There was no single model adhered to - rather, the composition of services was to be appropriate to the specific needs of the individual community.
- In 1992/1993, a pilot of the Multipurpose Service Program was implemented with the support and cooperation of the Commonwealth and State Governments. The MPS Program was designed to address a variety of problems that are characteristic of rural and remote communities including:
  - a lack of residential and community aged care services;
  - isolation from mainstream services;
  - cost ineffective delivery of discrete services to small populations;
  - difficulty in recruiting and retaining staff and GP's;
  - duplication of resources and infrastructure and;
  - inflexible funding arrangements.
- Under a MPS, health and aged care funding is combined in order to provide cost effective, flexible and coordinated service delivery under a single management structure.
- The Rural Multipurpose Health and Family Services Network, initiated in the 1998-1999 federal budget, increased the capacity for MPSs to provide a greater range of services. Under the Network, extra funding for aged care places, planning and quality assurance was provided.

## **The Development of a Multipurpose Service**

- The development of a MPS requires the approval of both State and Commonwealth Ministers. Comprehensive community and service provider consultation is undertaken and submissions from rural and remote communities for a MPS are considered.
- The formation of a MPS requires all or most Commonwealth and State funded health and aged care services in a given area to integrate. In some States the MPS cannot proceed unless all services are willing to participate.
- A MPS does not require services to co-locate. Rather, the aim is to allow a variety of services to operate flexibly and in a coordinated way, under one administration system.
- Auspice arrangements for a MPS vary from State to State.

## **Issues for Consideration in the Formation of a Multipurpose Service**

The following issues have been identified as those which aged care providers and local communities need to consider in the formation of a MPS:

- Local communities may have legitimate concerns when a MPS is being forced as a solution to a particular problem eg lack of acute services or acute services at risk. The creation of a MPS should take a holistic approach with regards to the needs of the whole community.

- The creation of a MPS requires extensive consultation with key stakeholders, including the local community. MPSs should take into consideration the characteristics of the local community and should enable the retention of at least some local community ownership. There should be a cooperative approach between the local community, service providers and relevant Government Departments.
- Before creating a MPS there must be a guarantee of local input. Some form of ownership by the local community ensures that the MPS is community based and driven, and also assists to secure an essential volunteer component of a MPS.
- There should be evidence of long-term viability both in terms of the MPS and the local community itself.
- The existing management committee(s) or representatives thereof, should continue to play a role in the governance of the MPS.
- Aged care services should ensure that their capacity to respond to needs of the community will not be diminished by the formation of a MPS.
- The creation of a MPS requires extensive consultation with and agreement between all key stakeholders and as such there is the potential for the process to become protracted. There have been instances where the time elapsed has resulted in the gradual withdrawal of local health services and subsequent reductions in State funding. This needs to be monitored in local processes to ensure services are not disadvantaged if the MPS does not proceed.
- It is recommended that a MPS have on-going/fixed bed based services with flexible places to 'top up' the mix.
- The current emphasis on maintaining acute service delivery at the expense of or in preference to, other services such as residential aged care places requires further attention/review. There should be guaranteed funding for aged care and/or there should be funding protection to ensure that the needs of older people in the community are able to be met at any given point in time.
- Comprehensive program guidelines should be developed for the implementation of a MPS.
- Consistent program accountability arrangements should be implemented to minimise unnecessary overlap with regards to the incorporation of program and pooled funding models.
- There should be agreement to one accreditation system governing all components of the service.
- One of the advantages of having a MPS is that it provides Aged Care services to areas that previously didn't have such services as there is a requirement for a MPS to provide residential care. However, unlike funding for Regional Health Services, funding for residential care is averaged out - that is, all high level care places are funded at RCS Level 3 and low level care places at RCS Level 7. This funding arrangement can place limitations on the level of care provided. As MPSs are locked into 3 year funding arrangements/budgets, the flexibility of service provision is arguable.
- The pooled funding arrangement for MPSs can also mean that residential care may sometimes 'prop up' acute services. This may be due to the non-disclosure of hospital funding before the MPS is formed.

- Aged care services should ensure that they do not become medicalised if they join a MPS. As MPSs tend to operate under a medical model, ageing itself may be medicalised, rather than there being a focus on community care or home-like settings.

## Regional Health Services Program

### Background and History

- In the 1999-2000 Federal Budget, the Commonwealth Government provided funding for the Regional Health Services Program which incorporated the previously separately administered programs of the MPCs, MPSs, the Rural Multipurpose Health and Family Services Network and Regional Health Services.
- The establishment of the RHS Program in 1999-2000 provided for new funding of \$42.8 million over four years nationally. In the 2000/2001 budget, additional funding of \$68.9 million over four years was announced to establish a further 85 Regional Health Services (RHSs) nationally.
- This Program aims to foster locally based solutions to local health problems, flexibility, innovation and integration across health programs and improve access to a broad range of primary health and community services.
- RHSs deliver primary health care to communities through a flexible mix and range services. Such services may include rural health promotion, GP services, women's health, illness and injury prevention, aged care, mental health, podiatry, radiology, immunisation, public health and allied health.
- Communities with a population of approximately 5,000 people that can identify a need for a particular health service can apply for Regional Health Services funding.

### Issues for Consideration in the Formation of Regional Health Service Centres

- Regional Health Service Centres (RHSs) are governed by the Aged Care Act (Cth) 1997. They have access to a broader range of Commonwealth funds than MPSs (eg primary health care funding.) RHSs are Commonwealth only funded.
- Under RHSs, there is no specified model of care. There is also no requirement to restructure into a single management structure.
- Unlike MPSs, funding for aged care under a RHS is allocated at required RCS Levels. RHSs are not necessarily locked into the same 3 year funding arrangements as MPSs although the Commonwealth may choose to lock into a longer agreement.
- There is no pooled funding system under a RHS.
- Under the RHS Program, acute care is not eligible for Commonwealth funding.

## Conclusion

- The information presented here highlights issues surrounding mixed services and is intended to promote further discussion and consideration for providers considering either integrating with a MPS or forming a RHS. ACSA intends that these concerns be raised and discussed further with the National Rural Health Alliance and the Minister for Ageing.