Local Government and Multi Purpose Services in Non-Metropolitan Areas

Report by the National Rural Health Alliance
for the
Australian Local Government Association's
Project on

'The Role of Local Government in Health and Community Services'

Canberra

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EXECUTIVE SUMMARY

This Report is provided to the Australian Local Government Association (ALGA) as part of its work on "defining the best role that Local Government can play in promoting the health of people at a community level" (Draft ALGA Position Paper, October 1996).

Multi-Purpose Services (MPSs) exist in small country communities and it is expected that there will be an increase in their number (in whatever form and known by whatever name) because the model underlying the MPS meets some of the requirements of service delivery to small populations. The key characteristics of the model are the pooling of funds and the financial and managerial flexibility in a successful MPS, which overcome the 'threshold issue' for services provided singly and separately. In a community where there are insufficient clients to justify a range of separate health and aged care services, an MPS enables the provision of all of them, perhaps in modified from, through the pooling of funds, the sharing of infrastructure, and revised methods of accountability to the agencies providing the funds.

The services provided in an MPS usually include aged care, acute health care (hospital type services), and a range of other services such as home help, Meals on Wheels, and child and family health programs.

Given this common range of services, the MPS model requires co-operation between the three levels of government for the release of funds, and local collaboration between service providers. The difficulties experienced in the establishment of MPSs include the need for local organisations to 'let go' of some of their traditional territory, and for local health and community service professionals to change their patterns of work and engage with others in close collaboration.

There are several roles for local authorities in MPSs. In some areas and States local authorities themselves have traditionally been the service provider in one or more of the functional areas which may be combined in an MPS. The LGA and its staff may therefore be among those which have to demonstrate the co-operation and new ways which contribute to the success of an MPS. Other roles of the LGA stem from its presence as a local leader, and as the potential provider of infrastructure or other resources to be added to the shared pool.

From a cursory examination of the small number of MPSs that are operational, it seems that the LGA has not been the critical player. This is mainly because the bulk of the resources to be pooled are those of the State (eg those for acute hospital services) or the Commonwealth (eg those for aged care).

In almost all of the Multi Purpose Services in operation the local authority is a player and represented on the local Management Board or Committee of the MPS.

As well as providing a limited volume of resources, there is some evidence that the LGA has been critical in helping to lead the local interest groups to the collaborative positions required.

In some States there is currently concern being expressed by Councils in areas which are “being considered” for nomination as an MPS site. In NSW, for example, Councils understand that control over expenditures by the MPS will be through the new Area Health Authority, which (it is asserted) will also select the Manager of the local MPS Management Committee. Whether these fears are based on misinformation or not, they illustrate the importance of full consultation with local people and the importance of giving ownership and control to local agencies, notwithstanding the need for those local agencies to be accountable to the State and Commonwealth bodies whose funds are to be pooled.

As the MPS model becomes more widely adopted in various forms there will be scope for more local authorities to become involved. The experiences from areas where there has been early establishment of MPSs could encourage LGAs in these other areas to play a more significant role.

This is because it is clear that MPSs can provide workable solutions to service delivery challenges which are serious for small country towns. It is likely that these challenges will become even more serious and urgent as the ‘rationalisation’ and rationing of health and community services continue.

Local government should be encouraged by the fact that the MPS provides a forum in which its local leadership capacities can be exercised to good effect. The MPS also provides a means through which the limited volume of resources the local authority has or is prepared to allocate to health and community services can be put to effective use through their combination with resources for related purposes from State and Federal Governments.

Local government should be represented in both the central and local consultations relating to the further development of the Multi Purpose Service Program.

ACKNOWLEDGMENTS and DISCLAIMER

Work on the preparation of this Report benefited from the contributions of a number of agencies and individuals. Members of the Forum of Rural Health Policy Units provided up-to-date information and views on the status of MPSs and related policies in their respective State and Territory jurisdictions. Staff of the Aged and Community Care Division of the Federal Department of Health and Family Services also provided valuable information and views. The Managers of seven of the sixteen operational MPSs completed and returned the brief questionnaire used for this work. On behalf of the Council and Members of the National Rural Health Alliance, thanks to all those people for their contributions.

Responsibility for the interpretation of the information received, and errors of omission and commission, remain the responsibility of the Executive Director of the NRHA.

26 November 1996

Local Government and Multi Purpose Services in Non-Metropolitan Areas

1. Definition

The Multi Purpose Service (MPS) Program, through the pooling of State and Commonwealth funds, allows an incorporated auspicing body to provide a range of health, aged care and other community services to a small rural community.

The specific services provided vary from one MPS to another. They may include nursing home and/or aged hostel accommodation, acute care hospital beds, some community health services, home help, neighbourhood houses, meals-on-wheels and other community services. In the MPS based on the Nganampa Health Service in the Pitjantjatjara Lands of South Australia the MPS became involved in fundamental activity such as the collection of firewood.

> *" - - if we do sign up as an MPS, all our recurrent funds are pooled - we lose a lot of the bureaucratic restrictions and line budgets, and we can redraw our budget to meet the health needs of Anangu [the Pitjantjatjara word for 'person'] as agreed between the communities, Nganampa Health, and funding bodies."* (1)

Many of the services provided by an MPS stand alone in larger centres where each one has a significant number of clients. In these larger centres the specific services have separate budget and management structures.

The aim of the MPS Program is to meet more closely, in a flexible fashion, the health and community service needs of people in small rural communities.

2. Introduction

The general difficulties of providing a comprehensive range of health and community services in rural areas are well known.

Over the past twenty years the problem has become greater because the expectations of rural people have increased at the same time as services have been rationalised. This rationalisation has been caused by pressure to reduce total government expenditures on health and community services, and has affected country areas in particular because the population of many of those areas has continued to fall.

Recent work by the National Farmers' Federation suggests that the situation for country towns as far as health services are concerned varies markedly from place to place (NFF, personal communication).

That work also shows that, despite an overall rise in community expectations due to common understanding of what is possible in health services and what is available in the best and largest hospitals, many country people appear to accept that their local health services are bound to be limited.

The work of the National Rural Health Alliance is aimed at, among other things, ensuring that country people do not have and do not have to accept a second-rate health and community service system. Equality for rural people (and in particular for remote people) is obviously not possible but access to services which can provide equivalent outcomes to health services in the cities is a fundamental right and a central part of the notions of social justice and equity.

As far as health and aged care services are concerned, local authorities have, in general, had a very minor role compared with State and Commonwealth governments. As the work project undertaken by the ALGA, of which this Report is a part, has already shown, the direct contribution of local authorities to health and community services varies markedly both between and within States.

The erosion of services in rural and remote areas has accelerated as governments providing them have sought to secure economies of size and scale. The establishment of Multi Purpose Centres (MPCs) and Multi Purpose Services (MPSs) in a small number of places has provided examples of a successful means for halting this erosion of services.

As for other mainstream health and community services, the direct contributions of the State and Federal Governments to the MPCs and the MPSs outweigh those of local authorities. Despite the fact that local government is 'closest to the people', its capacity to be involved in these new models has been limited. The main reason for this is that the bulk of the funds used by MPCs and MPSs are in the hands of those other two levels of government.

At the local level there has frequently been a vested interest built up by a particular sector of the aged and health care delivery system. The establishment of a successful MPC or MPS requires these local vested interests and power holders to co-operate in order to pool their funds and collaborate in the new service model.

Local government also has limited financial capacity to become directly involved in health and community services.

It also has limited confidence about the wisdom of becoming heavily involved in this sector. This lack of confidence is due to a history, experienced locally or witnessed in other areas, of local authorities accepting responsibility for a particular service together with funds from the State or the Commonwealth, only to find that after a limited period the funds are withdrawn while local expectation and responsibility for the service remain.

The available evidence shows that successful MPSs require a substantial amount of local trust, collaboration and flexibility. This positive situation will normally be reflected in a Management Committee for the MPS which is broad-based and includes the willing contribution of all of those stakeholders involved in the original service structures.

The local Council(s) have the potential to be key stakeholders but the willingness of Council to be involved, its capacity to contribute resources, and its effectiveness as a leader and peacemaker obviously varies from case to case.

Where an MPS is not totally successful it may be due in part to a lack of trust and consultation among local groups. At the 3rd National Rural Health Conference, some Aboriginal delegates expressed opposition to the establishment of MPSs because of an experience where the new organisation had the potential to lead to a loss of Aboriginal control over their local health services.

On the other hand the MPS at Belyuen, the first Aboriginal MPS and the only one so far in the Northern Territory, and the one at the Nganampa Health Service in South Australia, demonstrate that these issues do not always arise.

Where problems do occur, the local authority could be able to play a leadership role to smooth the process. However, there may be local vested interests of equivalent strength to that of the local authority and in such a situation such a leadership task may be difficult.

3. The Multi Purpose Services Pilot Program

The Pilot Program for MPSs was approved in the 1992-93 Budget as a joint Commonwealth/State initiative in concert with relevant State and Territory authorities.

> *"The MPS Program is a national response to problems of providing health services to rural and remote communities. These problems include:*
>
> - *isolation from mainstream services;*
> - *cost-effective delivery of discrete services to small populations;*
> - *high infrastructure and support service costs;*
> - *difficulties in staffing;*
> - *uncertainty relating to the role of small rural hospitals;*
> - *lack of local residential and community aged services;*
> - *involvement of different tiers of government; and*
> - *duplicated and inconsistent accountability requirements.*

> *The aim of the MPS Program is to improve provision of services in small rural and remote areas by simplifying funding and accountability mechanisms and by providing a more flexible, coordinated and cost-effective framework for service delivery. The concept involves pooling of State and Commonwealth program funds for health services. This allows a community to reconfigure services to better meet health needs and allocate staff with a degree of flexibility across a range of services."*[2]

Not only does an MPS provide the means for pooling existing funds. There is also the attraction that the new service, once it demonstrates that it is targeting local needs effectively, may be able to attract additional funds.

Guidelines for the establishment and operation of MPSs were developed jointly by the States and the Commonwealth. Before the agreed guidelines were put in place they were endorsed by the Commonwealth, State and Territory Health Ministers.

The Commonwealth agency involved in this joint Commonwealth-State initiative is the Aged and Community Care Division of the Commonwealth Department of Health and Family Services.

Variants of the agreed guidelines are used in all States and the Northern Territory. A comprehensive version of these guidelines has been produced and formally published by the Victorian Department of Human Services. The publication is entitled 'Multi Purpose Services: Development and Design Guidelines - Health and Aged Care in Rural Communities'.

The following quotation is from the introduction to that Victorian document:

> *"In line with the Department of Human Services' focus on 'People First', the aim is to provide the highest quality, most effective and cost efficient health and aged care services.*
>
> *"To achieve this, each MPS must have a comprehensive understanding of its community's health service needs. Each MPS will then be able to plan how improved health services can best be delivered, in an environment which optimises its operational and capital resources.*
>
> *"MPS agencies are encouraged to be innovative in their delivery of a range of services and to be flexible in adapting to the future needs of their communities."*[3]

Attachment 2 to this Report for the Australian Local Government Association (ALGA) is an extract from that Victorian document which describes some of the changes to rural hospitals and other trends which have led to the need for and establishment of the MPS Program. That Attachment details the historical background to the MPS Program and lists the wide range of services which may be offered by an MPS. These services range from dental and psychiatric care, through neighbourhood houses and day centres, to speech pathology and acute hospital beds.

The Victorian guidelines also give explicit and implicit recognition to the potential role of local authorities. Local Government funding may be part of the total pool of funds used by an MPS and Local Government "should be involved" in the new service. "This depends to some extent upon local circumstances, which service provider is currently responsible for certain services and whether one or more towns are involved" (page 7 of the Victorian Guidelines Document).

4. Multi Purpose Centres

The Multi Purpose Centre (MPC) Program was the precursor of the MPS Program. The MPC approach now co-exists with the MPS Program.

The main purpose of the Multi Purpose Centre model was to encourage State and Federal Programs to co-locate at a single site. It was intended that this would result in so-called 'one-stop shops' for local services.

Although the main thrust of MPCs was not for the pooling of funds from various sources, in some areas they did result in the pooling of a variety of State (but not Commonwealth) monies.

The MPC model, with a number of services co-located and managed on one site, improved the ability to manage funds efficiently and effectively, and helped to identify local needs and re-prioritise funds to address them.

> *"Tasmania has MPCs at Dover, Oatlands, Flinders Island and King Island. All sites provide much-needed residential aged care in their local communities as well as minimal hospital services and an extensive range of community based services. Local Government was involved in the development of all MPC sites and in the case of Oatlands they manage the site. For Dover and King Island, Local Government employs the Community Development Officer. On Flinders Island there is no significant Local Government involvement.*
>
> *"On a per capita basis Tasmania had a greater uptake rate of the MPC Model, which addressed a number of issues in rural communities of need. Consequently the MPS Model has not progressed as quickly (in Tasmania as in other States)."*[4]

5. The Current Distribution of Multi Purpose Services

The following table shows that, at November 1996, there were 24 approved MPSs in the seven State/Territory health jurisdictions [5].

STATE	**OPERATIONAL(*) and NEWLY-APPROVED FACILITIES**	**STATUS AND POPULATION ACCORDING TO THE RURAL, REMOTE AND METROPOLITAN AREAS CLASSIFICATION (1994)**
NSW	Braidwood* Barradine* Urana* Urbenville* Dorrigo Delegate Tumbarumba Warren	- - Other Rural (1613) - - - Other Rural (3686) Other Rural (3543)
VIC	Corryong* Orbost* Apollo Bay* Mallee Track Alpine (Bright, Mt Beauty, Myrtleford and smaller towns)	- Other Remote (6484) - -
QLD	Clermont* Cooktown*	- -
WA	Dalwallinu* Boyup Brook* Northampton/Kalbarri* Leonora/Laverton/ Merredin Katanning	Other Remote (1660) Other Rural (1744) Other Remote (2694 - N) Other Remote (7790) Other Rural (4663)
SA	Ceduna (inc Yalata/Oak Valley)* Streaky Bay/ Elliston/Wudinna* Nganampa (Pitjantjatjara Lands)*	- Other Remote (1892 - SB, 1255 - E) -
TAS	Beaconsfield (Tamar Valley)	Large Rural/Other Rural (c. 7000)
NT	Belyuen*	-

Total Allocated: 35. Total Approved: 24. Total Operational: 16

In addition to the operational and newly-approved facilities listed in the table, there are proposed new facilities at Cobden/Timboon (in Victoria) and East Arnhem Land (in the Northern Territory).

Following a call in July 1996 in Western Australia for expressions of interest for further sites, the West Australian MPS Steering Committee received 34 applications [6]. These were from a wide range of communities and proposed a range of structures from single community sites to sites which would service the whole of a Health District. Several of these sites have started work towards integration of services and see their formal identification as an MPS as the next step towards completion of that process.

This situation in Western Australia reflects the national scene. There is an increasing demand from small rural communities to participate in the MPS Program. In NSW, for example, over 40 communities have expressed an interest in participating in the Program.

The large number of communities seeking nomination as an MPS is due largely to pressure on small rural hospitals, residential aged care services and other local community services.

Small rural hospitals have experienced low levels of bed utilisation but a significant increase in the number of Nursing Home Type Patients occupying acute care beds. They also experience the effects of demographic change in rural areas, including the difficulty of maintaining existing clinical practices and in attracting and retaining skilled health professionals. The introduction of Casemix and purchase/provider arrangements has focussed attention on services which are relatively inefficient or heavily subsidised, many of which are in smaller hospitals.

At the same time there is widespread community resistance to the closure of hospitals. This is due to the desire of local people to have acute care services close by and also to the fact that the hospitals are major employers and a key part of the fabric of country communities.

Similar pressures are experienced by residential aged care services. To be viable, a stand-alone nursing home needs at least thirty beds. This is beyond the requirement of many rural communities. Frail older people in such communities are therefore faced with the choice of leaving friends and family to access nursing home care or entering the local hospital as a Nursing Home Type Patient. However, a hospital bed is neither an appropriate nor cost-effective form of residential accommodation for the elderly.

6. What Works Well and Why

The following description from Dalwallinu in Western Australia provides a clear indication of the importance of flexibility in the roles of individuals within the health and aged care system. Flexibility among the traditional local service providers and their staff is required as well as the funding flexibility allowed by the State and Commonwealth through the MPS Program.

> *"A Brief Background Of How We Came To Be Involved In The MPS*
>
> *"It is something which evolved over several years from dealing with a few functional factors such as the low numbers of patients attending for all types of health services, coupled with the requests from people in the community who were asking for a wider range of health services. At the same time there was a change of GPs in the town and the usual small town practice and belief that the past is better than the present; and that services elsewhere were better than those available locally. The resulting effect was a dramatic fall in the numbers using the services currently available. It was then that the Hospital Board decided that we needed to ask our community what their expectation of their hospital was and what services they needed - including those currently being provided and others not then available.*
>
> *In conjunction with community representatives, hospital staff and Board members, a questionnaire was developed and circulated to all households within the district so that they could tell us their thoughts on the present system and what they wanted for the future. This Health Needs Analysis of the Shire was conducted in early 1992 with the formal results published later that year.*
>
> *The point of greatest interest in the responses was the consistent concern regarding the need for disease control along with health prevention & education. The second point of significance was the over-riding concern with lifestyle conditions. Stress was identified as being the single most important health problem, followed by alcohol, tobacco and drugs (substance abuse), along with the need for more services available to the ever-increasing number of elderly residents.*
>
> *It was from these initial responses that a health promotion program was developed.*
>
> *Every respondent replied that they wanted the Hospital be there when it was needed and that the district must retain a Doctor.*

The Hospital in 1992 provided a full range of acute care services - a 24 hour accident and emergency centre, general medical, obstetrics, radiology, physiotherapy, extended care, home nursing and home help services, anti-natal classes and palliative care. All were available then and are still available today.

The formal agreement on the MPS was signed in January 1994.

Where Are We At Today?

Outwardly to the casual visitor nothing seems much different to the usual small country hospital - nurses on duty, patients in beds, administration functioning in the usual busy paper warfare way. You have to look beyond the surface to see that everyone is much more motivated. There is a lot more happening.

Nursing staff have the ability to perform more roles than nursing the in-patient and assisting the Doctor with procedural services. Cleaners are carers, gardeners are handymen, orderlies are gardeners, nurses are child and school health nurses and Board and staff members are co-ordinators and leaders of specific interest areas. All are part of the multi-skilled team that makes up a successful MPS, delivering to the community health services that they have designed and requested for themselves. A great deal of the activity is now taking place out in the community away from the traditional hospital, taking the hospital to the community, where the hospital is seen as a place of wellness, not just a curative institution.

In other words we now have community owned, designed and driven health service."[7]

In South Australia the guidelines for MPSs are the same as the Commonwealth's. Local authorities in South Australia have a very low level of involvement in community services. It has frequently been difficult to get LGAs to take up Home And Community Care (HACC) grants for such things as stairs and grab-rails for the elderly and disabled.

State and local government authorities find it difficult to match funds provided for programs like HACC. As in other States this has resulted in a number of non-government organisations, such as religious bodies, putting in the matching money and running HACC programs.

Some local authorities in South Australia run senior citizens' clubs but these are only in the larger towns. Even in these locations some such clubs had to be taken over by the health and community services Department due to local financial difficulties. Some local authorities ran hostels and, again, some of those had to be taken over due to financial problem. A greater number of local authorities have homemaker services and are involved in elements of public and environmental health.

In South Australia, as in other States, amalgamation of local authorities is in train and some Councils will be forced to amalgamate.

Given this historical and current situation there is little capacity and enthusiasm within local government for Multi Purpose Services in that State.

However the capacity and willingness of local authorities to be involved in health and community services vary substantially both between and within States. In the main local authorities in rural Western Australia have been willing to contribute capital and other resources. Experience in that State shows that the local Council is usually the next port of call, after the hospital, for involvement in the establishment and operation of an MPS.

Councils in Western Australia, as elsewhere, have contributed significantly towards the provision of infrastructure, such as housing and other incentives, to help attract and retain a doctor to particular communities.

The National Rural Health Alliance received a strong representation earlier in 1996 on local health services from the Shire of Broome, which it had also sent to the State Minister and other parties. This illustrates the fact that the local authority can be one of the first and strongest advocates for improved health and community services.

7. Survey Information

At the end of September 1996 a simple one-page questionnaire was sent to the Managers of thirteen of the sixteen operational MPSs. Contacts for the two in Queensland were not obtained and the questionnaire was not sent to the Nganampa MPS in the Pitjantjatjara Lands of South Australia.

Seven responses were received.

The first question asked how many local authorities areas are covered by or involved with the MPS. In six cases the MPS covered a single Shire, in the seventh two Shires.

The second question asked for a description of the role the local authority had in the initial establishment of the MPS and whether it had been a key player and supporter in the process of establishment. The responses included the following:

> "They were supportive. Homecare and maternal and childcare which had been auspiced by the Shire was transferred to the MPS."

> "Only in representation of the local community and their need - the LGA was fairly supportive."

"The Council had a representative on the initial Steering Committee and was a key stakeholder. It provided secretarial support and supported our establishment. There were no major problems."

"Council had equal representation on the initial Steering Committee. There were no problems initially until Commissioners replaced the Council."

"Council had one member on the Steering Committee. Council's role was slight but it was a key supporter."

"The Council auspiced a frail aged hostel. The transfer of the hostel to the MPS was planned from the beginning. The hospital worked closely with the hostel (staffing, meals, supplies and other services). The transfer took place with the blessing of the LGA. There were minor problems only."

The third question asked for a description of the current situation regarding the involvement of the local Council in the MPS:

"Council records immunisation data. The maternal and child health nurse is involved in giving injections."

"Representation on our Advisory Committee but no involvement in the management and function of the MPS."

"There is a Councillor on the Management Committee. It is providing $160,000 towards capital works program (building a nursing home wing). Aged care lodge (hostel) is on Shire land and Shire holds the deeds. Provided office space for HACC and child health clinic."

"Little involvement for first year of operation. HACC services and funding to shift to MPS soon!"

"One member from Council on MPS Board."

"Involved in some minor projects all initiated by the MPS. Our LGA does not see itself as a major player in health care services. MPS and Council have a good relationship."

"Formally none. Only involvement is with things like getting a footpath at the front and usual Council activity."

The fourth question asked whether Council has a formal representative on the MPS Management Committee:

> "Initially - since amalgamation they have withdrawn."
>
> "Yes."
>
> "Yes - the Committee has to have a Shire rep. - in fact our Committee has two Shire Councillors on it."
>
> "Yes and no." (sic)
>
> "One member on the Steering Committee."
>
> "Originally yes - now the position is not formal but a Councillor has been on the Committee since the beginning."
>
> "No."

The fifth question asked for a note on the current contribution of the local authority to health and community services and how it compares with the situation before the establishment of the local MPS:

> "No health and community services provided by the LGA. MPS does this."
>
> "No really significant contribution; situation unchanged since becoming MPS."
>
> "Limited contribution now and the same pre-MPS. Council has a part-time environmental health officer."
>
> "As stated above the appointment of Commissioners resulted in the LGA turning its back on agreements previously struck with former Councillors."
>
> "Very little involvement and no change since MPS."
>
> "No real change. Our LGA has not really been involved in health and community care. The hospital auspiced HACC services because LGA did not want to. LGA only became involved in hostel services because the Commonwealth could not give the funding to the hospital."
>
> "LGA contribution to health is not affected by the establishment of MPS. No information on LGA health initiatives."

The sixth and last question sought any other comments on the involvement of the local Council in health and community services:

> "We are now in [amalgamated] Council who are looking to restructure the remaining maternal and child health (immunisation) service auspiced by [the local] Community Health Centre. The amalgamated Council has transferred the remaining HACC services (not MPS run) to the Community Health Centre."
>
> "They need to become more involved and recognise the importance of representing community needs."
>
> "Without Shire backing we would have experienced problems raising the capital for our building project."
>
> "We look forward to improved co-operation on the issue of service delivery within the MPS model."
>
> "At present Council seems to leave this to the MPS to manage but it assists if necessary."
>
> "It is part of the health services philosophy to work closely with local government. Local government does not at this time appear interested. Our MPS committee has written to Council requesting time to discuss MPS services with Council. Council has politely declined."
>
> "No problems in getting Council to do work in usual role."

8. Some Specific Dangers

It is clear from this simple survey and other anecdotal evidence that things can go wrong if active collaboration between local health and community service bodies is lacking, or if there is a failure of State or Commonwealth agencies to consult and inform local Councils and other bodies.

At the time of writing, a number of Councils in NSW are seeking accurate information from the Local Government and Shires Associations about the way the MPS Program in that State is to be further developed.

In the absence of such information Councils are frustrated and even fearful about what might happen to their local services. They understand that dealings about a local Multi Purpose Service will be under the control of the Chief Executive Director of the new Area Health Authority and that the local Management Committee of the MPS will only have the right to make recommendations to that CEO.

> *"Under the current legislative arrangements, MPS Committees are part of their respective Rural Area Health Services, which have the necessary structure and resources for administration and employment of staff. It is therefore not possible for an MPS to employ a Manager directly. They will be appointed by the Area Health Service - - -"*[8]

There is an additional fear that the person appointed as Manager will have to have a nursing background. This is reported here, true or false, because it illustrates the extreme importance of involving local communities (including their Councils) at every step in a process which has the capacity to change the structure and availability of services which local people identify as being essential, and which can only be completely successful if there is a strong sense of local ownership and control.

The uncertainty in NSW is further reflected by the fact that the Local; Government and Shires Associations know 'officially' of four MPSs in the State which are operational, four which are "being targeted" (the phrase illustrates a degree of suspicion) and eight others "which are being looked at". However a list is said to exist which includes 53 Councils whose local areas are being considered for MPS status.[9]

It is very damaging that a Program that has so much to offer small rural communities is viewed in such a way, that uppermost in the minds of some Councils is a potential loss of local control, and that the Shire Council in the town of Tenterfield - recently deleted from the list of proposed MPS sites - should be reported as "celebrating its reprieve".

There are also questions being asked about the future funding for and quality of aged care accommodation if it is integrated with an MPS. Small country towns already feel the pinch because of the shortage of local capital for the refurbishing or expansion of aged care accommodation. There is a fear that this will become worse should the funding of aged care facilities pass to the States.

As for the quality of aged care facilities within an MPS:

> "*It is not clear if hostels which are part of an MPS will have to meet the same standards as others. They apparently will not have to provide overnight respite care and will have different outcomes standards to meet. Does this mean they will be a lower standard than other hostels?"*[9]

The effect of the establishment of new MPSs on existing services is also an issue to be considered. Currently certain services, such as those under the Home and Community Care (HACC) Program, are funded on a sub-regional or district basis, covering a number of local authorities, allowing for economies of scale and enabling flexible service to be developed.

If some of the funding from these district services is redirected to an MPS within the district and effectively quarantined from the services for the larger area, there is a chance that the remaining towns and their LGAs will be left with smaller or even non-viable services.

Another case concerns the relationship between a new MPS and a pre-existing Aboriginal Medical Service (AMS).

The services and reputation of the AMS in this case were of such a high order that it was used by the local non-Aboriginal population as well as local indigenous people. The local authority, comprised of non-Aboriginal people, applied for MPS status and set about the business of establishing the range of services normally associated with an MPS. They did this with only token consultation with the Aboriginal community and the AMS, which upset many people and resulted in what was regarded locally as a substantial waste of resources.

Some new health and community services were established by the non-Aboriginal interest groups but they were widely regarded as inferior to the pre-existing services of the same type which the AMS had provided. For this reason the new services failed to cater for all people in the same way that the services of the AMS had previously done.

9. Steps in Establishing an MPS

"Once a community is informed about the MPS Program and decides to proceed with its implementation, it must gather support and commitment from the wider community and all of the health and aged care service providers to pool funds, relinquish their separate management authority and join the Multi Purpose Service.

Once an MPS site has been agreed upon, several steps then follow:

Step 1: The community determines an appropriate incorporated body to oversee the Multi-Purpose Service and its development.

Step 2: A health and aged care needs assessment is undertaken with full participation from community representatives and assistance from State and Commonwealth officials. This approach ensures the analysis includes community views about what is needed as well as current statistical data from Commonwealth and State Departments' information systems and local demographic details. The needs assessment becomes the foundation for future developments and directions under the MPS.

It is especially important in gathering community input that is informed input. This means that information on demographics, local health trends and epidemiological information and service utilisation needs to be taken into consideration.

Such an assessment can empower communities and give them a clearer understanding of their local aged care and health needs.

Step 3: Following the needs assessment a plan is developed to demonstrate how services could be delivered to better match health and aged care needs in the community using the flexibility available under the MPS model.

Step 4: An appropriate level of funding is determined for the community, based on consideration of such factors as existing aged care services/funding, existing health programs/funding, population characteristics and the outcomes of the needs assessment.

The Program has the capacity to allow pooling of a wide range of grant funds, such as Rural Health Support, Education and a Training (RHSET) Grants and General Practice Grants. In fact, there is very little that cannot, potentially, be pooled.

[Note: the main Commonwealth funds eligible for the pool are for aged care; the rest may come as add-ons, assuming joint Ministerial approval when necessary. At least one of the NRHA's correspondents would prefer to see funds from RHSET and the General Practice Strategy quarantined from 'standard' local services, in which category they include the MPSs, and used only for the selected innovative proposals and service models to which those monies are targeted.]

Step 5: The final step involves a contract covering a 3 year period. This outlines the State and Commonwealth contributions and the range of planned services to be undertaken by the MPS, in accordance with its identified needs.

The contract is signed by the MPS entity plus State and Federal Ministerial delegates.

The contract also specifies reporting arrangements, indemnity provisions and other contractual obligations of the parties.[(10)]

10. What's In A Name?

There is a view, shared by some members of the National Rural Health Alliance, that the term 'Multi Purpose Service' is not best suited for the integrated service regarded with such optimism by many rural advocates.

The reservations about the suitability of the name rest largely on the fact that it does not include a number of words which are attractive to rural people and which connote the characteristics of services which are regarded as important. These 'missing' words include 'local', 'community', 'health' and 'hospital'.

At its meeting in Dubbo in October 1996 the Rural and Isolated Pharmacists Association, an organisation with close links to the NRHA, proposed the name 'Local Health Co-operative' instead of Multi Purpose Service.

There is substantial importance attached to this question of the name, given the need to have local people recognise the new structure for what it is and to relate with empathy to its establishment and operation.

11. Conclusion

It is clear that the Multi Purpose Service model provides a very useful means for the flexible and effective use of health and community service funds in small communities.

Given the desirable level of co-operation between Federal, State and Local Governments (a substantial part of which is allowed for in the standard form of agreement between the Commonwealth and the States) funds from a variety of sources may be pooled for an MPS. These monies include those from health and community service grant programs, as long as its use for the purpose is approved by the granting body and is likely to be beneficial to local clients.

As with all other areas of local government's involvement in health and community services, the current situation in the few places where there are already operational MPSs varies substantially from one to another.

Local authorities have key roles to play in the establishment of a successful MPS but mainly in areas other than direct provision of resources. Their role is likely to be most important as a direct collaborator and as a facilitator of collaboration between other local parties.

This sort of role will therefore provide a challenge to the leadership abilities of local Councils.

It is certain that the number and importance of Multi Purpose Services in rural areas will grow in the near future. At the time of writing the date for the next meeting of the MPS Contact Group is approaching. It is possible that this meeting may result in a significant number of additional places being nominated as official MPS sites.

Given a broad definition of ‘health and community services’ local authorities have a significant role to play in them. Local Councils are in a good position to know or to find out exactly what the local circumstances and needs are. This should give Councils an advantage over other levels of government in contributions to the planning and evaluation of local community services in general.

Given the nature of the MPS model, there are significant roles for local authorities to play in their establishment and operation. There are certain to be more MPSs established.

However local government is not currently at the table in relation to decisions being made about Multi Purpose Services. It ought to be.

References:

(1) "Nganampa Health Council as a Multi Purpose Service", John Lawrence and Mandy Pusmucans, in The Politics of Rural Health: How Far Have We Come?, Proceedings of the 3rd National Rural Health Conference, NRHA, Canberra, May 1995.

(2) Report of the National Evaluation of the MPS Program, Commonwealth Department of Human Services and Health, Canberra, December 1995.

(3) Multi Purpose Services - Development and Design Guidelines, Health and Aged Care in Rural Communities, Department of Human Services, Victoria, August 1996.

(4) Personal communication from Phillipa Leedham, Manager, Planning and Development, Northern Region, Community and Health Services, Tasmania; 27 September 1996.

(5) Information in the Table provided by the Federal Department of Health and Family Services.

(6) The information on WA in this section is based on a report from the Rural Health Development Unit of the Health Department of Western Australia.

(7) "The Dalwallinu Multi-Purpose Service: One Year On", Irene Mills; in The Politics of Rural Health: How Far Have We Come?, Proceedings of the 3rd National Rural Health Conference, NRHA, Canberra, May 1995.

(8) Joint Position Paper from the NSW Department of Health and the Commonwealth Department of Health and Family Services on the Aged Services Association Amendments to the Multi Purpose Services Model; page 2.

(9) Personal communication from the NSW Local Government and Shires Associations, 26/11/96.

(10) Guide to Assist Communities With Expressions of Interest for the Multi-Purpose Service Program, Section 5, Rural Health Department, Perth, July 1996.