College Submission

June 2024

Pricing Framework for Australian Public Hospital Services 2025-26

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is **the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care**. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

It is essential that funding arrangements for rural and regional hospitals reflect the actual cost of providing services in rural hospitals, together with increased accreditation and compliance costs. Funding should not be based on past activity and must accommodate situational change and facilitate readiness to meet future trends, including increased public health demands.

Additional to covering operational costs, pricing frameworks should be cognisant of the much broader role rural and remote hospitals play in providing essential access to healthcare for people in rural and remote areas. There is comprehensive evidence that people in these areas have poorer heath status yet receive far fewer healthcare services than people in cities. This reflects among other things, their lack of easy access to the gamut of health and social services in cities. Hospitals are the key health infrastructure in place in many of these communities and it behoves them to be contributing wherever possible to addressing this inequity.

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Rural and Remote Contexts

People living in rural, remote and First Nations communities should have equitable access to high quality, safe and sustainable healthcare services. This requires funding models which properly reflect the distinctions of the rural and remote clinical context, and the cost of providing services to these communities.

It is vital that pricing frameworks enable and incentivise forward-looking resource planning committed to maintaining robust locally-based services. These should ensure that “rural” funding makes its way to “rurally-based staff and resources” and should lend confidence in their future rural and remote doctors, staff, and communities.

The College also recommends greater transparency in terms of the way in which funding for rural hospitals is determined, together with the specific allocations for these hospitals in each state and territory. ACRRM would support making funding data publicly available to support this transparency and provide accountability to communities, doctors, and patients.

It is noted that there is considerable reform work under way. Key to delivering on equitable funding to services in rural and remote areas will be the inclusion of rural perspectives at all levels of decision-making this should include as appropriate, rural, and remote hospital administrators, Rural Generalists and representation from rural, remote and First Nations communities.

Rural Generalists

Rural Generalists are specialist general practitioners who are trained for broad scope rural practice including provision of a range of advanced skilled services for hospital-based care. They are a purpose-trained and credentialled workforce operating in rural and remote hospitals across the country. They commonly provide services including inpatient, emergency, emergency mental health, obstetric, surgical, and anaesthetic care. These doctors provide a unique perspective on this model of care which should be reflected in discussions around frameworks that impact rural hospitals and health services.

General Comments

This Submission responds to the sections of the Consultation Paper pertinent to the work of the College.

Section 2 - Pricing Guidelines

The overarching pricing guidelines are stated as follows:

- **Timely-quality care**: Funding should support timely access to quality health services.
- **Efficiency**: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across public, private, or not-for-profit providers of public hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

Whilst the College fully supports the principle of timely access to quality health services for all, policy must be cognisant of the fact that attempting to apply the same price structure across the board is fundamentally flawed.

Best practice medical service delivery in the rural and remote community paradigm involves distinctive models of care. Rural and remote communities are defined by their geographic distance from a full complement of medical and other health services, resources, and specialist staff. They are often also characterised by demographic and socio-economic patterns with corresponding patterns of medical care needs. These special circumstances need to be integrated into the costing framework.

In these contexts, attempting to apply principals of fairness via a “same price for the same service” can lead to perverse consequences. Services are delivered on a much smaller scale in rural hospitals, this scale together with the logistical challenges of distance, the typically higher burden of illness, the pervasive workforce challenges, and the relative paucity of supporting local healthcare services create fundamentally different economic structures to their urban hospital counterparts. Minor changes in financing have the potential to disproportionately affect both the services viability and the provision of services for the community. In addition, rises in fuel prices, the increasing cost of food and freight and general cost of living issues combined with smaller cohorts, a considerably smaller pool of staff and resources to draw upon, and the real costs of running a viable business in rural and remote areas, make the financial imposts upon the rural hospital greater.

In terms of the agreed roles and responsibilities, including the complementary responsibilities of each level of government in funding health services, ACRRM recommends that there be greater transparency at all levels regarding the allocation and expenditure of funding. This will facilitate accountability and support funding arrangements which recognise the responsibilities of each level of government in funding health services.

Section 3 Classifications used to describe and price public hospital services

It is noted that there are currently 6 public hospital service categories in Australia which have classifications in use or in development:

- admitted acute care
- subacute and non-acute care
- emergency care
- non-admitted care
- mental health care
- teaching and training.

Discussions regarding classifications which may affect all funding arrangements to rural hospital should include representation by Rural Generalists.

Section 4 Setting the National Efficient Price

We note from the Consultation Paper that as a result of this analysis and stakeholder feedback, IHAPCA has identified a range of potential pricing model refinements, and updates on progress will be provided in the IHACPA Work Program and Corporate Plan 2024–25 (the Work Program) due to be released in June 2024.

It would have been preferable for Work Program to be finalised and released concurrently with this Consultation paper, to allow stakeholders to consider both documents in tandem. Whilst we note the

assurance that "*Only refinements that are likely to have an impact on the development of the NEP Determination 2025–26 (NEP25), or where stakeholder input is required to progress investigation of the refinement, are included in this consultation paper*"[1] the College would have preferred more transparency around this process, which could have been achieved by releasing both documents at the same time.

We also note that IHACPA will work with jurisdictions on the negotiations for a new addendum to the NHRA to better understand the drivers of increased cost in smaller jurisdictions, and the impact on, and their relevance to, pricing model development. Following finalisation of a new addendum, IHACPA will develop a more detailed work plan to investigate and provide options to address these cost drivers. It is imperative that rural and remote considerations are considered as part of the addendum and cost analysis.

Underestimating costs- rural and remote hospital funding has not been able to see the healthcare needs of the catchment communities met, nor to provide sufficient expert staff to provide their healthcare services. While allocation policies have likely contributed to these failings, the insufficiency of funding of itself remains an issue, suggesting that pricing metrics are under-estimating the costs associated with strong rural and remote services.

Transferring costs to patients - It is important that any 'costs' analysis recognises that in the rural and remote context, costs foregone by governments by 'not' providing rural hospital services, are simply transferred to people in rural and remote areas who then must finance themselves to access these services in cities (i.e., transport, accommodation, childcare, time off work, etc.), or simply go without.

Higher Cost of Operations - a complex combination of factors that occur in rural and remote contexts contribute to substantially higher operation costs, including:

- the smallness of scale
- increased operating costs
- costs of retrievals and outreach specialist services
- chronic workforce shortages and physical distance from potential relief/locums
- additional service demand arising from minimal alternative health services, and
- communities' higher burdens of illness and socio-economic disadvantage.

The Rural and Remote Underspend - a recent report from the National Rural Health Alliance (NRHA) demonstrates there is currently an estimated annual national health underspend on rural and remote Australians of around $6.5 billion arising from lack of access to services. [2] This underspend reflects the money saved through millions of health care services each year, that rural and remote people do not receive that they would be expected to receive if they lived in a city.

For people in rural and remote areas, utilisation of hospital and healthcare services does not conform to the same patterns as occur in cities. While people in these areas per capita receive more funding for their hospital care, they receive substantially less funding across virtually all other areas of healthcare services.

For example, in 2020-2021,

[1] IHACPA Consultation Paper, page 16
[2] National Rural Health Alliance (NRHA) Evidence Base for additional investment in Rural Health in Australia: June 2023 https://www.ruralhealth.org.au/document/evidence-base-additional-investment-rural-health-australia

- The per capita number of non-GP specialist services received by people in outer regional areas was 25% lower than in major cities, and 59% lower for people in remote and very remote areas. (Compared to a 9%, and 36% respectively for GP services).
- Similarly, per capita MBS funding for non-GP services declined by 16% for people in outer regional areas, and 59% for people in remote and very remote areas, compared to that spent on people in major cities. (Compared to 8%, and 28% respectively for GP services).

Figure 1: GP and Non-GP specialist MBS expenditure by geographic classification 2020-2021

	GP SERVICES			NON-GP SPECIALIST SERVICES		
	MBS funding	**Services per 100 people**	**MBS funding per 100 people**	**MBS funding**	**Services per 100 people**	**MBS funding per 100 people**
National	$8,753,453,966	666	$34,064	$2,347,556,834	102	$9,135
Major Cities	$6,458,349,941	675	$34,349	$1,787,621,659	106	$9,507
Inner Regional	$1,587,951,436	675	$34,916	$412,071,860	104	$9,061
Outer Regional	$577,054,190	613	$31,730	$127,310,635	80	$7,000
Remote/ Very Remote	$130,098,399	431	$24,619	$20,552,680	44	$3,889

- Source: AIHW. (2021). *Medicare-subsidised GP, allied health, and specialist health care across local areas: 2019–20 to 2020–21*. Retrieved from https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

The NRHA report also notes that the increased cost of service delivery in rural and remote areas can create a deceptive picture of service delivery. For example, the report details a higher per capita spend on hospitalisations with increasing remoteness, however, IHACPA weights this cost as 7% higher for remote areas and 14% higher for very remote areas showing that the increased expenditure does not result in additional activity in the same proportion:

Table 4 | Non-admitted patient care expenditure by ASGS Remoteness Area, FY2020-21

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Total expenditure ($ million)	9,217.18	2,609.42	1,304.25	214.57	212.36
Expenditure per capita ($)	515.16	563.06	560.77	669.68	1,078.55
Expenditure per capita ($, age standardised)	521.75	553.70	555.02	690.72	1,162.03
Indexed at Major Cities	1.00	1.06	1.06	1.32	2.23

Expenditure estimated using IHACPA's National Hospital Cost Data Collection Report Round 24 results on total non-admitted patient expenditure and the AIHW dataset on non-admitted patient events per remoteness (FY2020-21). Indirectly age standardised using the AIHW dataset on non-admitted patient events per remoteness (FY2020-21).

NHRA Report, section 4.2.1, page 12

Section 4.1 Impact of COVID 19 and preparedness for future disruptions

The increasing occurrence of natural disasters together with the COVID pandemic, has highlighted the importance of utilising the community knowledge, expertise and skill of rural and remote medical practitioners in disaster and emergency response and building and supporting community resilience.

Rural and remote doctors and their teams are critical players in emergency and disaster response efforts. As frontline responders they provide immediate care for their own patients and others. They are also the main providers of ongoing care following such events, including mental health services and support, and can lead or support community response and resilience initiatives.

With their connections into community, they can offer unique local insights during and in the aftermath of emergencies and disasters. They can also contribute their expertise into the operation of the health system more broadly, particularly in relation to how rural general practices and facilities can operate and integrate with secondary and tertiary care. Their skills and insights are particularly valuable, noting that support from metropolitan and regionally based emergency and retrieval services may be significantly delayed or compromised due to distance, weather, demand, or other factors.

Despite this, most States and Territories do not currently have policies and clinical management frameworks which formalise the role of the rural doctor in the pre-hospital emergency or disaster response. In some instances, the protocols instigated by centralised jurisdictional government retrieval agencies may not permit local doctors to respond to disasters in their own towns.

Australia's disaster response is characterised by siloed approaches, fragmented and inequitable funding, and convoluted arrangements, including the two-tiers of responsibility (Commonwealth and State/Territory). Poor interconnectedness, including between the Commonwealth and States/Territories; health services and social and community services; and emergency services, means that delivering the integrated responses needed during emergencies and disasters is challenging. Poor communication and mixed messages often exacerbate these challenges.

First Responder Networks - Rural doctors with current advanced skills in emergency medicine, anaesthetics, surgery, and mental health are particularly well equipped to provide emergency services in collaboration with ambulance and retrieval services. However not all practitioners are able to work at this advanced level. Initiatives such as First Responder Networks are useful in utilising volunteer RGs to

attend emergencies and provide additional support to their colleagues. These doctors are already familiar with the rural and remote context allowing them to provide effective and appropriate support.

These Networks could fill an important role at both the national and state/territory levels, particularly if consistent credentialing and ongoing upskilling were supported, and if their role was recognised and integrated in disaster and resilience planning.

Equipment and Infrastructure - The 'gold standard' for safe, quality emergency care lies at the intercept of in-time access to services and adequate resourcing (in equipment, personnel, and skills) of rural emergency departments.

ACRRM has developed minimum standards for small rural hospital emergency departments. These aim to assist small rural hospitals and relevant jurisdictions to work towards being adequately equipped and resourced to initially manage any presentation to their Emergency Department (ED), bearing in mind that many factors will influence the need for additional resources to be incorporated into the design and function.

Standardised emergency bags should also be available for the use of rural doctors who are called to attend to accidents and emergencies in the pre-hospital environment. For example, The Sandpiper Bag aims to provide a standardised set of equipment to enable a first responder to perform a limited suite of meaningful interventions on the pre-hospital scene[3]. Ideally such responses should not occur ad hoc but be part of a scheme with agreed call-out criteria, equipment, training, and clinical governance.

Section 5 Setting the National Efficient Cost

5.1 Block funding arrangements

The Independent Health and Aged Care Pricing Authority (IHACPA) developed the national efficient cost (NEC) for services that are not suitable for activity-based funding (ABF), as provided by the Addendum to the National Health Reform Agreement (NHRA) 2020–25 (the Addendum). Such services include small rural hospitals, which are funded by a block allocation based on their size, location and the type of services provided.[4]

Further to the feedback provided in Section 4 above, ACRRM reiterates that funding arrangements must keep up with the actual cost of providing services in rural hospitals, together with increased accreditation and compliance costs. They must accommodate situational change and facilitate readiness to meet future trends, including increased public health demands.

Workforce constraints in smaller regional and rural hospitals often result in the full demand for services not being met and patients either being forced to travel to other facilities, or to forgo care. This in turn means that demand is not accurately captured to inform funding. This can result in discriminatory and compromised funding models.

[3] https://sandpiperaustralia.org/index.php/sandpiper-bag-contents/
[4] IHACPA Consultation Paper, Section 5.1, page 24

Furthermore, it is likely that the budgeted costs on which block funding is calculated, do not actually reflect the true costs incurred, given that most HHSs will provide figures which reflect the budget allocation rather than the actual expenditure. This is particularly true of salary costs for Medical Officers, which may be considerably higher than the budgeted figure due to the engagement of medical locums and agency nurses. For example, medical locum costs will be up to 50% higher than budgeted salaries in many cases.

Costings for items including consumables, often do not include the cost of transportation, which can significantly increase costs for rural and remote facilities.

Place based models must be supported by equitable funding, and robust, equitable collaboration between state and territory and federal governments to address funding gaps.

Training and teaching - an increasing body of research identifies rural-and-regionally based training as a determining factor in whether a medical student/junior doctor will progress to a rural medical career; and a key component of the proposed National Rural Generalist Pathway is a coordinated training pathway with provides a seamless transition from medical school, through prevocational training and finally to Fellowship and beyond.

Rural Generalists serve communities by being able to pivot between the hospital and the GP clinic to provide services. To gain this skill set they need to transition from hospital and general practice settings over their four to five years of training; however, when trainees move between the two systems, they lose their workplace entitlements including parental leave. They also face uncertainty and lack of security as they transfer from one workplace training setting to another during their training journey. The Single Employer Model is one initiative which aims to address these issues.

Funding for, and allocation of hospital placements for RG trainees is problematic from several perspectives. Funding arrangements do not necessarily support training placements, or funding is not appropriately used for this purpose. RG trainees who require hospital placements to complete their Advanced Skills Training are often in competition with trainees from other non-GP specialities who may be funding through the Specialist Training Program or other initiatives.

RG trainees undertaking their AST terms should not be disadvantaged as is often currently the case, by a system which disproportionately advantages non-RG trainees.

The College supports flexible and coordinated funding models for teaching and training which provide strong personal and professional support for both trainees and supervisors; adequate resources to both hospital and community settings; strong collaboration between other services such as allied health, pharmacy, and nursing; and where programs can be tailored to the needs and circumstances of communities and the health care facilities within those communities.

This may include innovations such as a revised approach to 19.2 exemption arrangements so that 19.2 exemptions are tied to the registrar in rural and remote locations, rather than assigned to a specific practice or facility.

We have commented on equitable funding to promote rurally relevant research, data collection and benchmarking in our response to Section 6 below.

Section 6 Data Collection

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6.1 Cost and Activity Data Collection

It is noted that the IHACPA has recently observed changes in the volume and quality of data submitted by state and territory governments and noted stakeholder feedback for the associated reasons for these changes. The College would strongly support further consultation and research to ensure that the costings used to determine funding for rural and remote hospitals reflects the true cost of operations. This could include 'ground-truthing' and direct consultation with a range of rural and remote facility managers and consumers.

Any data collection mechanisms should be as streamlined as possible to reduce administrative imposts, which can significantly add to the already significant workloads which tend to be larger in rural and remote areas.

Section 7 Treatment of other Commonwealth programs

Nil comments.

Section 8 Future Funding Models

The College agrees that the existing Activity Based Funding (ABF) system could benefit from the incorporation of alternate funding models that have the potential to create better incentives for improved continuity of care, use of evidence-based care pathways and substitution of the most effective service response.

There is an urgent need to provide robust and equitable levels of funding to promote rurally relevant research, data collection and benchmarking, particularly with the increased recognition of rural generalism as the preferred model of service delivery in rural and remote areas. This will promote and sustain the RG model and the delivery of appropriate care to rural, remote and First Nations communities more broadly.

Initiatives which ensure an accountable, equitable distribution of the teaching, training and research funding pool to regional and rural hospitals are needed to underpin sustainable RG and GP training.

Once again, applying a rural-proofing lens to policy would reflect a broader range of settings of health care delivery, and allow for a focus on the wide range of appropriate learning experiences. Distributed teaching and research models, which are not only focused in urban centres, are required.

The development of evidence-based policy appropriate to rural community needs is not possible without an evidence base. In the absence of this, evidence of workforce models and approaches that have proved effective in urban settings is typically used as proxy evidence for programs implemented rurally often with negative outcomes. Furthermore, there is no reliable dataset to demonstrate program ineffectiveness across rural and remote communities. Appropriate national datasets should include establishment of benchmarks for minimum standards of access to primary and essential care for every Australian which could be used as a proactive planning tool to ensure maintenance of services across rural and remote Australia.

8.2 Trialling of innovative models of care

Rural health care improvements will come when funding structures facilitate the best possible models of care. Too often, the opposite has been the case and systems of care have been designed to fit the funding models.

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ACRRM contends that a fit for purpose approach to funding arrangements is required to address the complex challenges faced by non-urban communities.[5] Funding models should be tailored to the needs and challenges of rural, remote, and First Nations communities.

Given the need to tailor funding models to these unique needs and challenges, it is important that the rural and remote sector is strongly represented in policy and decision-making processes. This representation should be reflective of the wide variety of rural hospital facilities and services.

As mentioned earlier in the submission, ACRRM also recommends that a rural-proofing lens is applied to all decisions which have the potential to impact on rural hospitals.

Alongside revision of pricing metrics to ensure sufficiency of funding, funding models should be constructed to enable and incentivise approaches to rural health resourcing which will deliver robust rural health services sustainable over the long term.

These structures should:

- Incentivise future-focused expenditures that will build a strong future workforce and that signal a strong long-term commitment to maintaining rural capacity and resources. They should encourage investment in rurally-based training. They should also incentivise the building of local services sustainability. This should include preferentially funding permanent rural positions over short-term or locum appointments. Investments in appropriately trained staff that stay in rural areas and become part of the fabric of those communities, present a much greater return on investment than reliance on locums and other expensive stop gap solutions. Most critically funding structures should strongly signal to rural communities that their health services are there to stay, and that they can build their lives there, in the knowledge that they will continue to have access to care when needed.
- Direct 'rural' funding to staff and resources that are based in rural areas. Rural funding to urban-based FIFO specialists, telehealth providers, and administrators incrementally drains resourcing away from the rural point of care where it can be most effective. It also serves to undermine the fragile critical mass in each community necessary to sustain local services.
- Incentivise expenditures that invest in the models of care and resourcing that can maximise quality services within each rural context. These approaches would include training staff with an appropriate scope of practice for the rural context such as Rural Generalist doctors, and nurses and other professionals with a broad rural generalist scope. It would also involve resourcing hospitals in a manner complementary to the rural model of care.

The mid-term review noted that a new addendum should prioritise the development of optimal models of care that deliver end-to-end integrated care, using agreed innovative financing mechanisms, and pricing approaches that reward high value care. It also recommended the establishment of a National Innovation and Reform Agency; an Innovation Fund and Innovation Pathway designed to develop and transition innovative models of care from seed funding to operation at scale. It is important that our College and the experience of Rural Generalists is considered is considered in this process.

[5] NHRA Report Evidence Base for additional investment in rural health in Australia page 30

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.