College Submission

July 2025

Pricing Framework for Australian Public Hospital Services 2026-27

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

ACRRM's vision is ***healthy rural, remote and First Nations communities through excellence, social accountability and innovation***.

The College works to define, promote and deliver quality standards of medical practice for rural, remote and First Nations communities through a skilled and dedicated Rural Generalist profession. We provide a quality Fellowship program including training, professional development, and clinical practice standards; and support advocacy services for rural doctors and the communities they serve.

ACRRM has more than 5000 rural doctor members including some 1200 registrars, who live and work in rural, remote, and First Nations 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 the Royal Flying Doctor Service (RFDS) and the Australian Antarctic Division.

Initial Comments

ACRRM appreciates the opportunity to submit feedback to this consultation. The college supports a framework that continues to protect the viability of small rural hospitals and the broad-scope, flexible work of Rural Generalists (RGs). Funding should support integrated, place-based care, not fragment services or incentivise urban transfers.

At the process level, the College would emphasise the importance that the RG perspective to be represented at all levels of decision making for the pricing framework.

The College would like to also acknowledge its appreciation to the IHACPA for the feedback that was received in response to our 2024 submission.

About Rural Generalist Medicine

Rural Generalist Medicine (RGM) is a distinctive model of care that equips practitioners to provide broad and integrated medical services in rural and remote areas, including comprehensive primary care, hospital and emergency care, and advanced specialised services to meet local needs. It also emphasises population

health and involves collaboration within multi-professional teams to deliver services within a cohesive and community-responsive system of care.[1]

ACRRM Fellows are specialist general practitioners with the training and experience to provide skilled services working to the RG scope. The College is hopeful that in accordance with the recommendations of the Medical Board of Australia, this scope will be recognised in the national law as a specialist field within the next 12 months.

Rural and Remote Contexts

Recent national data from 2023–24 highlights that Australians living in rural and remote regions continue to experience the highest rates of hospitalisation.[2] First Nations Australians are particularly affected, with significantly higher rates of same-day acute hospitalisations for dialysis—407 per 1,000 population—and nearly double the rate of overnight acute hospital admissions compared to non-Indigenous Australians. [3]

People living in 'remote', and 'very remote' locations face additional challenges. These populations experience potentially preventable hospitalisations at roughly twice the rate of those in major cities. They also report notably higher rates of lower urgency emergency department (ED) visits—1.8 and 1.6 times higher than those in inner and outer regional areas, respectively, and more than three times the rate of city dwellers.

Several factors contribute to these disparities. In many rural and remote communities, limited access to general practitioners often leads to delays in seeking care. As a result, individuals may present with more advanced or complex health conditions, increasing the likelihood of hospital admission. Geographic isolation compounds these issues, with patients frequently needing to travel hundreds of kilometres to access hospital services. These difficulties are further intensified by persistent workforce shortages, higher operational costs, and limited economies of scale, all of which place additional strain on health service delivery in rural and remote areas.

The College welcomes the recognition of these issues in the National Health Reform Agreement Mid-Term Review and emphasises the importance of aligning with the recommended approach:

"The NHRA should establish a coordinated national approach to address health disparities in rural and remote communities, that encompass models of care able to function where workforce and infrastructure is limited, with health providers operating at a full scope of practice, and greater integration across sectors to get the most from available resources.

A shared plan of action focused on equity of access in rural and remote areas should form a Schedule of a new Agreement with priority actions and milestone, national datasets and minimum access standards, appropriate regionality weightings in funding formulae and equitable distribution of Teaching, Training and Research (TTR) funds. Some of the current mechanisms to improve access to services such as the Single Employer Model and access to the Medicare Benefits Schedule (MBS) by State and Territory managed

[1] Cairns Consensus, International Statement on Rural Generalist Medicine, 2014.
[2] Australian Institute of Health and Welfare (2024) Retrieved from Patient demographics - Hospitals - AIHW
[3] Australian Institute of Health and Welfare. (2025). *Use of emergency departments for lower urgency care 2017–18 to 2022–23.* Retrieved from https://www.aihw.gov.au/reports/primary-health-care/use-of-eds-lower-urgency-care-2017-18-to-2022-23

services through section 19(2) Health Insurance Act 1973 exemptions should be made more widely available across rural and remote settings and where 'thin markets' emerge."[4]

Teaching and Training

The College welcomes the inclusion of Recommendation 36 in the NHRA Mid-Term Review, which calls for priority actions to improve equitable access to healthcare in rural and remote areas – specifically "*Ensuring an accountable and equitable distribution of the TTR funding pool to regional and rural hospitals to underpin sustainable health workforce training."*[5]

As previously advised, rural training has been evidenced to be a determining factor in whether medical students and junior doctors pursue rural careers. A central element of the National Rural Generalist Pathway is a coordinated training pathway that provides a seamless transition from medical school through to Fellowship.

RGs meet community needs by working flexibly across hospitals, GP clinics, and other settings. This versatility creates unique training and funding challenges, including navigating multiple employment systems, training across specialty areas, and acquiring skills typically delivered in urban tertiary settings. These cross-cutting issues must be considered in hospital planning and funding frameworks.

Addressing this requires adequate and flexible funding models that support both hospital and community-based training, provide strong support for trainees and supervisors, enable cross-disciplinary collaboration, and are responsive to local health service needs.

While the College supports the general principles outlined on teaching and training, we emphasise the importance of block funding as a transparent and effective mechanism to support teaching and training in rural and remote areas. We would also welcome formal recognition of the RG workforce within funding frameworks. In line with the Medical Board of Australia's advice, we hope the RG workforce will soon be formally recognised in the National Law as a specialist field, which will assist in this process.

Addressing Complexity in Health Needs Through Funding Reform

ACRRM supports the proposed revisions aimed at harmonising best-practice provision of equivalent care across diverse settings, sites, and modalities. However, concerns remain that the current funding model insufficiently addresses the increasing complexity of health needs in our ageing population, particularly in rural and remote communities.

This is especially evident in areas such as emergency and mental health care. As outlined in the IHACPA Consultation Paper, in 2022-23, mental health services recorded 729,422 phases of care, costing $1.7 billion nationally—a 31% increase in activity and a 10% rise in costs from the previous year. Notably, $612.9 million in community mental health expenditure could not be attributed to a valid phase-end classification under the Australian Mental Health Care Classification (AMHCC), pointing to significant gaps in data capture and classification.

[4] National Rural Health Agreement Mid-Term Review Final Report October 2023 https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf
[5] National Rural Health Agreement Mid-Term Review Final Report October 2023 https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf

For rural and remote areas, the College acknowledges that these gaps are particularly problematic. It is also noted that in these settings emergency and mental health services may appear less costly due to underreporting or incomplete data capture. As a result, hospitals serving rural communities can be mischaracterised as low-cost providers, leading to the erroneous assumption that they do not require additional funding. This misconception further exacerbates resource constraints in already stretched services—despite the reality that rural providers often face higher per-patient costs due to workforce shortages, limited-service access, and greater coordination demands.

The College recommends implementing mechanisms to improve the accuracy of data capture and to ensure that funding models fully account for service complexity. Additionally, simplification efforts must consider the unique challenges faced by small rural hospitals and the health professionals delivering care in these settings. Funding models should not be based on assumptions derived from high-volume, urban environments, as staff—including RGs—operate across both admitted and non-admitted care in low-volume settings.

Recognising Rural Hospitals in Tier Classifications

ACRRM supports the use of tier classifications as a tool to inform equitable funding and service planning. However, the College remains concerned that the current tier structures are primarily based on metropolitan hospital service volumes and profiles, and therefore do not adequately account for the operational realities of rural and remote facilities.

Rural hospitals frequently operate under markedly different conditions—facing higher patient acuity, greater geographic isolation, persistent workforce shortages, and constrained infrastructure. Despite these challenges, they are often grouped with urban hospitals in the same tier, resulting in comparable funding allocations that do not reflect the true complexity or cost of care delivery in rural settings. This misalignment can contribute to systemic under-recognition and underfunding, placing at risk the sustainability and responsiveness of these essential services.

ACRRM recommends that the tier classification framework be revised to include more nuanced and context-sensitive definitions. These should capture the breadth of services rural hospitals provide, the additional costs associated with delivering care in low-volume, high-need settings, and the critical role these facilities play in ensuring timely, local access to healthcare for rural and remote communities.

Improving Data Accuracy and Funding Equity

RGs play a vital role in bridging gaps in physical and mental healthcare across rural and remote Australia. These practitioners often deliver care across a wide scope in community and hospital settings. However, current funding and data models risk fragmenting this care by failing to explicitly recognise and support the integrated nature of RG services.

The College is particularly concerned that persistent gaps in outpatient services in rural areas lead to unnecessary hospital admissions for care that could otherwise be delivered in an ambulatory setting—such as chemotherapy, dialysis, and mental health support. This drives up costs and places additional strain on rural hospitals and emergency departments, while forcing patients to travel long distances for care that should be available locally

Efforts to harmonise health data and pricing structures must reflect the realities of rural practice and patient preferences for local treatment. ACRRM recommends targeted audits or case studies within rural hospitals to more accurately reflect the true costs of integrated, place-based care models. While rural hospital data may be lower in volume, it is critical to understanding the unique service delivery context and to informing sustainable funding models.

Limitations in the IHACPA Data Framework and the National Benchmarking Portal

ACRRM welcomes the transparency efforts reflected in IHACPA's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26* and its sibling portal the *National Benchmarking Portal (NBP).* *However*, the College remains concerned that these tools do not adequately represent healthcare delivery in Modified Monash (MM) regions, particularly MM6 and MM7. While the NBP does capture Local Hospital Network (LHN) data, which may provide an opportunity to capture the initial scope of the situation, the comparability of LHNs varies significantly. This limits the portal's ability to capture the scope and constraints of rural hospitals operating in highly remote settings. ACRRM recommends a data collection framework that more directly captures MM-level data, including RG-led emergency and procedural services.

For example, Tennant Creek Hospital (MM7) in the Northern Territory operates at nearly $1,000 below the national average for NWAU21. In contrast, major metropolitan hospitals such as the Queensland Children's Hospital operate over $1,000 above the national average.[6] Without contextual information, these data points may be misinterpreted. Lower-than-average costs in remote hospitals may indicate efficient use of limited resources, or they may reflect constrained service availability and access, with significant implications for patient outcomes.

Addressing Cost Allocation and National Hospital Cost Data Collection (NHCDC) Limitations

The College recognises that the NHCDC does not fully reflect how hospital size and remoteness influence the range and cost of services provided. Smaller and remote hospitals frequently carry fixed costs for essential services despite lower volumes, leading to distorted national cost averages and inefficient allocation through cost buckets.

ACRRM recommends that IHACPA review the structure of cost buckets to compare how resources are used across different geographic and service contexts. In particular, the College advocates for analysis by remoteness area (e.g., MM category) and year-on-year cost variation. This would provide clearer insight into how funding models need to adapt to regional resource access, service limitations, and local health priorities.

Ensuring Sustainable Funding for Rural Health Services

ACRRM advocates for the continuation of stable and flexible block funding to support the viability of small rural and remote hospitals. These hospitals are often the only source of healthcare for their communities, yet they operate under significant financial pressure due to workforce shortages, low service volumes, and geographic isolation.

[6] National Benchmarking Portal | IHACPA

To more accurately reflect rural healthcare delivery, ACRRM recommends that funding frameworks incorporate rural loadings or targeted adjustments. This is particularly essential for services with high coordination costs, such as mental health, emergency care, and maternity. These areas demand additional staffing and infrastructure that are not adequately accounted for in activity-based models.

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; and strong collaboration with other services such as allied health, pharmacy, and nursing. These models are most effective when programs can be tailored to the needs and circumstances of communities and the healthcare facilities within those communities. Such flexibility is critical to ensuring that the rural workforce is both well-supported and well-distributed, with sustainable pathways that reflect the full scope of RG practice.

Cost pressures across the healthcare system continue to rise, further straining rural services. For example, according to IHACPA:

- Admitted acute care recorded **6.5 million separations** in 2022–23 at a total cost of **$40.6 billion**—a **5% increase** from the previous year and 12% over 2021–22. The **average cost per separation** rose to **$6,239.**
- The admitted subacute and non-acute stream incurred **$3.8 billion** for **164,415 episodes**, with an average cost of **$23,356—a 9% increase.**
- Emergency department services had **8.6 million presentations** in 2022–23 at a cost of **$8.4 billion**, with the average cost per presentation increasing **10%** to **$980.**
- The non-admitted stream saw a **14% reduction** in volume, yet average cost per service rose 24% to **$404.**[7]

These figures highlight that average costs continue to rise regardless of service volume, placing additional pressure on rural providers already working with fewer resources and greater logistical challenges. If funding models fail to evolve, they risk undermining equity and sustainability in rural care delivery.

Additionally, varying hospital funding and pricing structures across states compound these issues, especially for remote hospitals subject to state-specific constraints.

In light of these pressures, ACRRM urges that funding models be revised to support flexibility, equity, and responsiveness—with tailored provisions that reflect the true cost and value of rural health services.

Indigenous Health Considerations

ACRRM supports the continued review and refinement of the Indigenous adjustment to ensure it adequately captures the complexity of care for Aboriginal and Torres Strait Islander peoples, particularly in rural and remote settings. This includes addressing systemic challenges such as higher rates of unplanned readmissions and discharges against medical advice.

Indigenous patients face unique cultural, geographic, and socio-economic barriers to care, requiring tailored policy interventions and funding mechanisms. These should enable culturally safe, community-

[7] Independent Health and Aged Care Pricing Authority. *Consultation paper on the Pricing Framework for Australian Public Hospital Services 2025–26*. Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27.

based, and flexible service models that improve access and outcomes for Aboriginal and Torres Strait Islander communities.

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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.