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**Submission to the Independent Health and Aged Care Pricing Authority**
**Consultation Paper: Pricing Framework for Australian Public Hospital Services 2027–28**

Dear ~~Professor Pervan,~~ Michael

The National Rural Health Alliance (the Alliance) welcomes the opportunity to comment on IHACPA's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2027–28* (Consultation Paper), with a focus on emphasising equity, service viability, and the need for pricing arrangements that reflect the true cost of delivering care outside metropolitan centres.

The Alliance represents organisations and individuals committed to improving the health and wellbeing of people living in rural, regional and remote Australia (hereafter rural Australia). The Alliance comprises 56 member organisations which include healthcare, disability and ageing professionals, service providers, health and medical educators and trainers, researchers, medical and health practitioner students, the Aboriginal / Torres Strait Islander health sector and organisations that deliver care for rural and remote Australians.

Consistent with our submission to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27 (2026-27 Submission) and broader health reform consultations, the Alliance's focus is on equity of access, viability of services in thin markets and pricing arrangements that reflect the real cost of delivering safe, high-quality care outside metropolitan centres. The challenges raised by our members and stakeholders that were outlined in the 2026-27 Submission are enduring concerns, indeed are worsening in rural Australia, and are reiterated in this submission.

That is, in comparison to cities, rural Australia faces numerous challenges, including but not limited to higher operating costs to deliver services, limited economies of scale, higher rates of chronic disease and disability, earlier deaths and digital and physical infrastructure constraints.

Moreover, due to workforce shortages, there is a high reliance on a rotation of locums working in rural hospitals. This places significant financial pressure on services due to the need to pay extremely high fees and shoulder retention whilst there is a disparity between payments to local clinicians versus locum staff. In addition, services carry the burden of costs related to relocation and accommodation for health professionals. The Alliance has heard stakeholder feedback that locum staff alone can cost from $2,000 (and up to $4000) a day, and their use is increasing, yet the support and assistance to keep local clinicians is not. In smaller and more remote hospitals, reliance on locums can become a major cost pressure, reflecting structural workforce shortages, inflexible engagement and employment structures and the absence of sustainable local staffing models (e.g. New South Wales, Western Australia).[1]

[1] ABC News, WA's regional health system 'reliant' on expensive locum doctors, 23 December 2024

As part of the Alliance's advocacy to highlight health access and equity issues in rural Australia, the Alliance published The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia (The Forgotten Health Spend Report, NOUS Group), which we referred to in our response to the *Consultation Paper on the Pricing Framework for Australian Support at Home Aged Care Services 2027-28* (2027-28 Support at Home Submission). The Forgotten Health Spend Report provides an updated analysis of government health expenditure and access across rural Australia for 2023-24, covering, but not limited to, public and private hospitals, ambulance, Aboriginal and Torres Strait Islander primary care, Medicare Benefits Schedule (MBS), pharmaceuticals, aged care, and the NDIS.

To reiterate points raised in the 2027-28 Support at Home Submission, the Forgotten Health Spend Report found that the expenditure gap between urban and non-urban populations was $8.35 billion in 2023-24, equating to an average of $1,090.47 per person per year – an increase from the $848.00 gap per person per year (or $6.55 billion per annum) reported for 2020-21.

Concerningly, the Forgotten Health Spend Report highlights that the underspend is most pronounced in rural to very remote areas (MMM 5–7), where the annual per capita expenditure is now $4,701 lower than in metropolitan areas. This large expenditure gap **is driven in part by public hospitals, with the differential driven by shortfalls in medium and small regional towns**. The Report indicates that, **in aggregate, public hospitals in small rural towns (MMM 5) receive 70% less public funding per person in metropolitan areas**,[2] (refer to table below). This is despite the fact that they are Australian and have a right to receive equitable and flexible healthcare, no matter where they live.

**Public hospital expenditure by MMM area, FY2023-24**

| | MMM 1 | MMM 2 | MMM 3 | MMM 4 | MMM 5 | MMM 6 | MMM 7 |
|---|---|---|---|---|---|---|---|
| Total expenditure ($M) | $72,353 | $11,778 | $8,740 | $3,205 | $3,012 | $2,139 | $1,614 |
| Expenditure per capita ($) | $4,086 | $4,562 | $5,850 | $3,947 | $1,383 | $6,203 | $6,468 |
| Expenditure per capita ($, age standardised) | $4,198 | $4,554 | $5,361 | $3,493 | $1,239 | $6,166 | $7,247 |
| Indexed at Metropolitan Areas (MMM 1) | 1.00 | 1.08 | 1.28 | 0.83 | 0.30 | 1.47 | 1.73 |

(Source: The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia, Table 7, page 22.)

The Alliance is currently working to update the analysis of government health expenditure and access across rural Australia with 2024-25 data, with the next report anticipated to be released in July 2026.

## Pricing framework to actively support equity

The Alliance supports IHACPA's evidence-based transparency approach to pricing in-scope public hospital services, including its commitment to accountability of taxpayer's money through the Pricing Guidelines.

We also note that IHACPA's Pricing Framework for Australian Public Hospital Services (Pricing Framework) plays a central role in operationalising the Addendum to the National Health Reform Agreement 2026–31 (NHRA Addendum), which seeks a healthcare system that is person-centred, equitable, responsive, and sustainable[3] and a simpler, more equitable public hospital and health services funding model.[4]

[2] The Forgotten Health Spend Report, section 5.1 Public hospital expenditure, page 22
[3] Addendum to the National Health Reform Agreement 2026–31 (NHRA Addendum), Vision, p. 7
[4] NHRA Addendum, Objectives and outcomes, p. 8

The Alliance, in particular, strongly supports inclusion of Schedule F - *Better Health Equity for Rural and Remote Communities* in the NHRA Addendum which outlines reforms that all Australian governments have agreed upon to help achieve equitable health outcomes and access to health services for people living in rural and remote Australia.[5] Indeed, we strongly support the access and equity tenets enshrined in Schedule F which will **prioritise rural towns and remote communities, according to relevant geographical classifications that have inequities in health outcomes and health service access compared to metropolitan areas**.[6]

The Alliance welcomes IHACPA's recognition in the Consultation Paper that there are multi-faceted and complex issues that affect equity of access and fairness of funding for health services delivered to the 3 focus areas (First Nations peoples, people residing or receiving care in rural and remote areas and smaller states and territories).

The Pricing Framework must **actively support equity** via taxpayer's funding for these 3 focus areas by accounting for factors such as service sustainability and scale, geographic location/tyranny of distance, health need and early death rates, thin markets or areas with no market, workforce shortages, digital and physical infrastructure constraints and inflexibility of policies and funding. As per the Alliance's 2026-27 Submission, rural hospitals face higher overheads including significantly higher costs for transport, freight, fuel, energy and telecommunications, which are not adequately covered by standard pricing.

The Alliance is of the strong view that *Activity Based Funding (ABF) - Principles for determining the National Efficient Price* outlined in the NHRA Addendum presents an opportunity to reconsider the national funding model which relies heavily on the ABF. Small rural hospitals have high fixed costs as noted above, but low patient volumes and are penalised by the ABF due to being unable to generate the volume required to make services financially sustainable.

This creates the Hospital Avoidance Paradox, that is, while governments seek to reduce hospital stays, the funding model often incentivises keeping people in hospital beds. In instances where a rural hospital successfully runs a "hospital avoidance" program (e.g. in-home care) to decrease their activities, they may lose or receive less Commonwealth funding, creating a financial penalty for efficiency. This is a perverse outcome of the funding model which **rewards activity-based services rather than value (better patient outcomes and efficiency) - and is not inefficiency.**

Clause A59 lists a range of factors that IHACPA must consider in relation to the National Pricing Model, including having regard to **reasonable access to public hospital and health services** (for all Australians not just those who live in cities)**, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system**.[7] In addition, there are factors that are often not considered, such as population health status of the community, the tyranny of distance for workforce, lack of public transport and local sustainability.

In the Alliance's 2026-27 Pre-Budget Submission, Defining Optimal Levels of Access to Primary Health Care in Rural and Remote Australia (Defining Optimal Levels of Access) we note that "reasonable" access is context-dependent and not readily defined. While this proposal was developed with primary health care in mind, the principle of reasonable access equally applies to rural hospitals.
That is, while optimal levels often reflect what is feasible within existing resources, **reasonable access considers what is necessary for equitable** (equity in terms of what urban people can access, is funded via taxpayers' funds)**, effective** (accessible, flexible, culturally appropriate) **and parity** (cost, distance, socio-economic status, public transport, health or disability need), **in health care**.

[5] NHRA Addendum, Schedule F, cl. F1, p. 125
[6] NHRA Addendum, Schedule F, cl. F5, p. 125
[7] NHRA Addendum, cl. A59, p. 32

## Pricing Guidelines and 'value' (Questions 1-3 and Questions 5-8)

The Alliance supports the inclusion of value as a core consideration in transparent pricing, consistent with the NHRA Addendum's requirement to consider outcomes relative to cost - with some additional considerations outlined below. We also support the definition of value to reflect "a system wide policy intent to better align incentives across patients, providers, and governments to achieve improved outcomes from public investment in health care" (in particular rural people), as stated in the IHACPA Consultation Paper.

We recommend that geographic equity be **explicitly embedded within the concept of value**, as outcomes cannot be meaningfully interpreted without considering **access constraints.** Patients living in rural areas face additional burdens (travel, service gaps, systems that are not flexible to suit certain communities, delayed or no care). Equal pricing does not deliver equal outcomes or parity in disparate environments; therefore, **value should consider patient outcomes - adjusted for access, equity, population health need, earlier deaths and service delivery context, relative to the cost of delivery**.

Value must also recognise the **rural service delivery context**. Pricing must account for additional inputs required for services to deliver the same outcomes in rural contexts; as noted above these include but are not limited to outreach, transport and cost of goods, workforce support and costs, locum costs.

Our member organisation, the Australian College of Rural and Remote Medicine, points out that there is a potential significant challenge with the introduction of "value" with the definition as provided, i.e. *'maximising patient experience and outcomes, improving population health and high quality, evidence based clinical care, **relative to the cost of delivery**'*, given the key argument that there are often higher costs to deliver rural services. There is an inherent tension between the introduction of this definition of value and the overarching objectives of the universal access principle, the NHRA Addendum and Schedule F, specifically clauses F1, F3, F5, F6, F8, F9, F10 and F11. Therefore, **recognition of this challenge must also be noted in the definition of value**.

In terms of metrics or proxies to support consideration of value beyond the cost of delivery (Question 7), the Alliance supports the use of proxies such as avoidable hospitalisations, delayed presentations, and access-related indicators (e.g. workforce distribution and capacity, travel distances, remoteness classification). These metrics reflect the health system context, not just clinical outcomes. Avoidable admission and delayed presentation often occur when patients cannot access care when needed and therefore align with IHACPA's requirement to ensure reasonable access to services. These proxies also reflect travel barriers, such as travel time, availability of transport (whether public or private), and lack of diagnostic services– factors that constrain economies of scale and increase costs per unit of activity[8].

## Pricing stability and mitigating unintended volatility (Questions 9-13)

The Alliance supports IHACPA's focus on balancing cost responsiveness and stability in pricing outcomes to ensure predictable funding and stability to support the workforce, infrastructure and service planning. The Consultation Paper notes that one of the options for mitigating unintended volatility is to sample cost data from a subset of hospitals to provide more contemporaneous information about cost movements within the hospital sector.

The risks with this approach include under-representation of rural and remote hospitals and bias toward larger, metropolitan facilities. In addition, it does not reflect the cost shifting that might be occurring, at the expense of rural people. Sampling must therefore include **representative rural and remote facilities and individuals.**

[8] National Rural Health Alliance 2026. Submission to the Independent Health and Aged Care Pricing Authority Draft Work Program 2026-27.

## Block funding and National Efficient Cost

In line with our feedback on IHACPA's Draft Work Program 2026-27, the Alliance welcomes the multi-year review of block or blended funding arrangements for small rural hospitals and other standalone, specialised hospitals as part of developing, indeed reforming, the National Efficient Cost. However, this should not be at an impost or at increased red tape.

The Alliance has heard stakeholder feedback that the National Efficient Cost used for block-funding small rural hospitals often fails to meet the true cost of operating in remote areas. While small rural hospitals receive block funding, **this often does not reflect the need for, and the cost to maintain, 24/7 emergency readiness**. Considering that fires, floods, droughts and other emergencies significantly hit rural and remote communities, true costs must be supported, rather than place another barrier for communities to overcome for emergency readiness.

Added to this pressure, rural hospitals often become the default option for primary care and shoulder the increased reliance on emergency departments for non-urgent health needs in rural settings.[9] Yet they are not funded for this increased burden.

Inadequate funding and workforce shortages also contribute to the closure and downgrading of essential services in rural and remote areas, including maternity care, reducing access to local services and increasing risk for communities.[10]

Accordingly, the multi-year reviews will be essential for addressing structural inequities faced by rural health services and **must consider the full scope of additional costs associated with geography and thin markets that reflect the unavoidable cost of service delivery in sparse populations**. Suggestions for improvement include **adjusted National Efficient Cost benchmarks and hybrid funding models that combine guaranteed baseline funding with activity-based payments**.

## Adjustments to the National Efficient Price

As you will be aware, clause A60 of the NHRA Addendum indicates IHACPA must have regard to factors that affect cost of service delivery. These include hospital type and size, hospital location including remoteness, patient complexity, Indigenous status and smaller jurisdictions.[11]

The Alliance encourages IHACPA to determine 'loadings' or adjustments to the National Efficient Price to take these factors into account.

In addition, the Alliance is particularly interested to know IHACPA's assessment of the extent to which the National Efficient Price and the National Efficient Cost price weights and the national pricing model are operating as intended. As outlined in this submission, funding models and ABF weightings in rural areas do not capture the true cost of delivery of services. Examples are maternity, antenatal, and birthing where costs to deliver these services are much higher than the funding received.

As noted by our member organisation, the Royal Australasian College of Surgeons, "applying a rural lens to policy initiatives can ensure that decision making does not create unintended consequences for rural, regional and remote communities. The requirement for a rural stress testing must consider the complex clinical needs of the community, access to health services (physical facility and telehealth), workforce configuration, financial sustainability of practices and the impact on whole-of-system."[12]

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[9] Australian College of Rural and Remote Medicine 2024. Pricing Framework for Australian Public Hospital Services 2025-26.
[10] National Rural Health Alliance, The Future of Rural and Remote Maternity: a Framework for Success, 24 June 2025; Australian College of Midwives, 2023
[11] NHRA Addendum, cl. A60, p. 32
[12] Royal Australasian College of Surgeons (RACS) Rural Surgery Committee Submission to the inquiry into Rural, regional and remote Medicare Access and Funding (page 4).

## Conclusion

The Alliance supports IHACPA's continued development of an evidence-based Pricing Framework aligned with the NHRA Addendum. Achieving the Addendum's vision of a person-centred, equitable, responsive, and sustainable healthcare system requires explicit integration of **rural and remote equity** into pricing decisions.

As outlined in this submission, there must be recognition that **equal prices do not produce equal outcomes** in disparate contexts, and that adjustments, data and funding models must reflect **real-world service delivery.** We already see this in government figures which reflect underfunding and under access by rural people.

The ripple effects of not making changes are enormous to the health and wellbeing of rural Australians and economic wealth of Australia. Fair and transparent pricing that reflects rural realities is essential to ensure that ALL Australians can access safe, high-quality hospital care, regardless of where they live.

The Alliance welcomes the opportunity to engage further with IHACPA to support its role in implementing the NHRA Addendum.

Yours sincerely,

**Susi Tegen**
Chief Executive