

Palliative care funding model review



VICTORIA
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Services

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Foreword from the Expert Panel

The review of the palliative care funding model, commissioned by the Victorian Minister for Health, the Hon. Jill Hennessy, sought advice on the best approach to palliative care funding to meet community needs in the future.

The project was led by an expert panel (the Panel) comprising three members: Ms Patricia Faulkner AO, Ms Jennifer Williams AM and Ms Carmel Smith.

Objective

The Panel was tasked with identifying the best approach to support the access, equity and sustainability of admitted, community and consultancy palliative care services.

The Panel focused on funding reform for designated palliative care services – that is, services funded to provide specialist palliative care.

Victoria's end-of-life and palliative care framework (the framework) describes designated palliative care as the sector that provides care for people with the most complex end-of-life and palliative care needs. The framework also notes that often the most valuable role palliative care specialists can play is supporting other healthcare teams through consultation and advice.

Terms of reference

The review's terms of reference asked the Panel to:

- identify the best approach to support sustainable growth of palliative care admitted, non-admitted and consultancy services
- explore funding approaches that provide certainty and support to deliver the priority outcomes in the framework.

It is expected advice and recommendations will:

- enable flexibility for community providers to match resources (funding) to client and carer needs in the stable, unstable, deteriorating, terminal and bereavement phases of care. This will ensure resources are available to support intensive needs in the last days of life for people who wish to die at home, as well as bereavement support
- facilitate accountability for activity that is meaningful to referrers, clients and carers and providers
- enable equity of access to community palliative care for rural and regional areas
- meet community service obligations to support priority need cohorts.
- provide advice on the best approach to ensure fluctuations in the annual rebasing of the subacute weighted inlier equivalent separation (WIES) value for palliative care do not adversely impact funded services
- provide advice on a funding approach that will support hospital-based palliative care and regional consultancy teams to meet demand and build organisational capacity for high-quality end-of-life care in Victorian health services.

The review follows a series of inter-related events, including the government's passage of the Voluntary Assisted Dying legislation into law, and the announcement in November 2017 of an additional \$62 million investment (over the next five years) to increase the options for people with a terminal illness to be cared for, and die, in their place of choice.

The investment included:

- supporting home-based palliative care across regional and rural Victoria to provide care for an additional 1,215 people and their families each year
- a 24-hour expert advice line
- responding to demand and patient complexity by providing additional palliative care physician or nurse practitioner positions in regional palliative care consultancy services
- additional ancillary support services to assist people, families and carers to manage the day-to-day activities associated with caring for someone with a terminal illness at home.

The review excluded:

- the development of funding approaches to support implementation of Victoria's *Voluntary Assisted Dying Act 2017*, which comes into effect on 19 June 2019
- the work of National Independent Hospital Pricing Authority that determines the annual National Efficient Price for Australian public hospital services.

Methodology

Our recommendations are informed by a rapid and intensive review and consultation process.

In February and March 2018, we held consultations with key stakeholders and peak bodies, and hosted a sector forum attended by just under 100 health-sector personnel. The forum attendees considered a discussion paper outlining potential changes to the funding model based on allocation of care packages at service level. The consultation process enabled constructive, open and informative discussions with clinical experts, advocacy groups and health managers.

Aspex Consulting was commissioned to provide technical expertise in the analysis and evaluation of population and activity data, together with the application of funding methodologies. The 'Aspex Consulting summary' on p. 12 presents a high-level overview of these findings.

Key themes from stakeholder consultations

During the consultations, the Panel heard that the current funding model has served a worthwhile purpose over the last 15 years, but that it is now impeding, or will impede, further service reform.

Stakeholders consistently reported that the funding model requires reform to facilitate and incentivise service model development. The Panel also heard that stakeholders felt funding has not grown in line with increased demand.

Key findings relating to the current service system are discussed below. These findings assisted in the development of the Panel's recommendations for redesign.

Variable service access

There is wide variation in access to palliative care across Victoria, particularly in rural areas, due to a limited, specialised workforce, and large areas covered by individual regional and rural designated providers. This is more pronounced in after-hours support, where there is limited capacity in regional and rural areas to provide an in-home response.

The Panel heard that the lack of after-hours support has in some instances contributed to avoidable emergency department presentations and clients' prolonged pain and discomfort.

The Panel also heard that there are often insufficient resources available to support patients in the terminal phase at home.

Access for aged care residents and people with disabilities

The panel heard from stakeholders that an increasing number of aged care residents and people with disabilities may not receive sufficient access to community palliative care. This was a theme across metropolitan and rural areas.

The Panel heard that for aged care residents, the protracted assessment requirements and disparities in the Aged Care Funding Instrument for residents with multiple complexities are barriers to facilities requesting additional funding to support palliative care.

The Panel also heard that Victorians with disability, particularly those in residential facilities, have limited access to end-of-life care.

Client complexity

The Panel heard from stakeholders that client complexity is increasing. This complexity may result from:

- increased clinical interventions and options for people at the end of life
- the nature of the disease
- the characteristics of the person and/or
- psychosocial issues affecting the person.

Palliative care today has evolved significantly over the last decade. People have access to treatments that were not previously available, including immune/chemotherapies and long-term dialysis.

As a result of the successes in medical research and technological innovations, people are living longer, often with much more of a chronic disease pattern. They move between the hospital and community setting more frequently for short periods of time and often have more than one clinical team directly involved in their care.

Despite this evolution, the palliative care service system has not evolved at the same rate.

The Panel also heard about the top-up funding provided by the Motor Neurone Disease Association (Victoria) to palliative care services caring for people with MND at the end of life. This funding recognises the additional complexity and associated costs of caring for someone with MND needing palliative care.

While this approach is one method of potentially addressing the complexities associated with one disease, it does not address the overall increases in complexity of other patient cohorts identified in the consultations.

The Panel heard that a future funding model must consider and adjust for a range of complexities.

Funding model options

The Panel considered several options as the basis for the new funding model, each discussed below.

Consultancy teams

Stakeholders identified the important role of hospital-based palliative care consultancy teams in providing consultation and advice to treating teams across the hospital who are caring for people at the end of life.

The Panel heard of the potential benefits of expanding service delivery into the community setting, particularly through a rapid response for people who may benefit from community-based care.

Packages of care

Packages of care allocated at the service level were considered and tested with the palliative care sector.

Stakeholders raised concerns about funding attached to ‘packages of care’, as they saw this reducing their capacity to respond flexibly to peoples’ care needs. The term ‘packages of care’ was also associated negatively with the sector’s experience of individually allocated, client-directed aged care and disability packages.

The Panel determined that a funding model based on packages of care would not provide services with the flexibility, or the clinical care, required to respond to individual needs.

While the Panel considered funding models for community palliative care based on packages of care, the Panel does not recommend this approach.

Activity-based funding

Concerns were also raised in the consultations about community palliative care services being funded solely on an activity-based funding approach, as this was also seen to focus too strongly on rewarding activity, rather than providing appropriate care. It may also reduce community palliative care service providers’ ability to flexibly respond to client and family needs.

While the Panel is not recommending an activity-based funding approach for community palliative care, it supports the use of a standardised classification and costing system to inform the recommended funding approach.

‘Phases of care’ (stable, unstable, deteriorating and terminal) appears to be a way to potentially allocate costs associated with people’s care needs.

The Panel believes phases of care is a well-developed mechanism for allocating clinical resources based on expected need. Phases of care also provides transparency about how funding across community palliative care services is consistently allocated for the activity provided.

Block funding

While the Panel acknowledges the limitations of block funding, it is recommended that block funding be retained for community palliative care in the short and medium term.

Nevertheless, block funding will become more contemporary in its approach, with the level of funding informed by expected demand, consistent service offerings across all palliative care services, and costs of service delivery. In this way, the basis for block-grant funding becomes more transparent and equitable.

Funding will continue to enable flexibility that is important to responding to the needs of individuals and their families.

The Panel recognises that as the system becomes more sophisticated, a funding method that is based on patient outcomes is the most desirable funding approach.

Recommendations and proposed funding approach

The Panel makes seven recommendations to support the evolution of the existing palliative care funding model over the next five years. See p.18 for a full overview of the recommendations.

For community-based palliative care services

1. In the short term, enhance the existing community-based funding model to improve equity and transparency of funding.
2. Improve access to community-based palliative care services.

For service system integration

3. Drive improved integration between community and inpatient services.

4. Support more flexible service model development by hospitals.
5. Establish an innovation and development fund to deliver initiatives that develop system-wide enablers and build capacity (with the transfer of the initial investment in system development into the funding allocation of direct services after a five-year implementation period).
6. Boost system stewardship activities.

To enhance accountability to deliver care that meets the framework goals

7. Establish accountability mechanisms to incentivise good practice.

We believe that adopting the recommendations will support the palliative care framework's outcomes, improve direct access to palliative care, and drive the development of an integrated service system capable of delivering high-quality end-of-life care.

For years 1 and 2, the proposed model leaves in place the current block-funded allocation of resources to existing designated community palliative care services.

If adopted, the new funding model will require the following changes.

In years 1 and 2, the department should work with services to collect agreed outcome data, as well as activity and cost data based on phases of care. Two new components for community palliative care, the initial assessment period and post-death bereavement phase, should be included in these data collections.

This data should be used to identify and analyse variation in cost and activity. In later years, community palliative care services should use this cost data to inform how they allocate resources based on patients' phases of care and complexity. It is expected this transition would be undertaken in years 3 to 5.

Work should also progress in years 1 and 2 on developing an alternative to the Victorian palliative care weighted-population funding allocation methodology (PCRAM).

This approach forms the current basis of growth allocation for community palliative care. The review identified several limitations of this methodology in its current form, including that funding allocation is based on population, not demand for palliative care, or level of activity.

The Panel recommends the development of a needs-based allocation model that takes into account the prevalence of conditions that would benefit from access to specialist palliative care, and that incorporates patient complexity. It is expected this transition would be undertaken in years 3 to 5.

During this time, services should receive guidance on price for phases of care, and should continue to report on activity cost and outcomes to further refine the funding model. Comparative performance reports should be compiled and circulated.

The Panel believes it is imperative that the service system supports an integrated approach to palliative care that can deliver a range of services for people based on their clinical need and level of complexity. This includes support for a palliative care patient with a much longer illness trajectory than is currently being serviced.

In years 1 and 2, the proposed funding model sees the introduction of a new service component for hospital-based consultancy teams. The Panel recommends that a specified innovation grant be introduced to expand the role of hospital consultancy teams. This would aim to improve integration between community and inpatient services, and provide a rapid response to people who may benefit from community-based care. We recommend the provision of these grants for five years to support cultural change and the codesign of integrative service models, after which the specified grant should be rolled into the hospital base funding allocation.

To further support integration, the Panel recommends that existing funding streams such as Hospital In The Home (HITH) and the Health Independence Program (HIP) be reformed to facilitate patient preference to receive community-based palliative care, and to die at home. It is expected that home includes residential care for older people and people with disabilities.

The Panel is mindful that funding reform alone will not deliver the desired outcomes. As service volume and the complexity of clients increase, reporting and accountability processes must be established to ensure the safety and quality of care as well as efficiency.

Our recommendations seek to drive service quality and consistent service access through the collection and reporting of outcome measures. An accountability framework should allow monitoring of key performance indicators and tracking of key outputs at the patient, service and system-wide levels. It is recommended that outcome measures be established in years 1 and 2 with benchmarks refined over years 3 to 5.

The Panel concluded that the following outcome measures be considered and further tested:

- more people who use palliative care die in their preferred setting
- more people who use palliative care die at home.

We recommend that over the next two years the department work with palliative care services to codesign appropriate measures. The Panel specifically supports the continued collection and monitoring of measures that report the number of people who are cared for in their place of choice and who die in their place of choice.

The Panel recognises that during a person's journey to death, their preference regarding where they want to die may change. There is however substantial evidence that most people would prefer to die at home if they could.

In addition to measuring at a service level the number of patients for whom the preferred place of care and place of death is realised, we propose monitoring how the system supports an increase in the number of people dying at home.

As previously noted, this should include people in aged care and disability residential facilities, as these facilities are their home. It will be important to monitor how services work together to increase access to supports that allow people to die at home. The department may consider setting a percentage increase target or benchmark.

The Panel reviewed the *Palliative care service development guidelines* published by Palliative Care Australia in January 2018. We recommend refreshing the Victorian palliative care capability framework to drive consistency in service access and experience to complement funding reform.

The Panel notes the variation in workforce capacity and service models between metropolitan, regional and rural services, and how services across these locations may need to work together in order to meet framework requirements, as well as community expectations. The Panel recommends further work be undertaken to develop a strategy for building workforce capacity. This should support joint appointments across inpatient and community settings.

Summary

In accordance with the review's terms of reference, we have identified seven recommendations (see p. 13) to be addressed over a five-year period.

We believe these recommendations will support the Victorian Government to improve the palliative care service system to ensure it is more person-centred and more broadly integrated across the healthcare system.

We believe adopting this approach will help enable Victorians with a life-limiting illness who would benefit from palliative care to access palliative care as close to home as possible.

These proposed reforms should position Victoria's palliative care service system as an exemplar of excellence.

Our vision for the system is to be responsive, reliable, effective and accessible to everyone irrespective of ethnicity, religious beliefs, geographical location and socio-economic status.

We thank all those who contributed to this review.

Ms Patricia Faulkner AO



Ms Jennifer Williams AM



Ms Carmel Smith



About the panel

Ms Patricia Faulkner AO

Patricia Faulkner is currently the Deputy Chair of St Vincent's Health Australia. She chairs the boards of Jesuit Social Services and the Telecommunications Industry Ombudsman and is a board member of Catholic Professional Standards, Melbourne Theatre Company, the Melbourne Racing Club and Vic Super.

Patricia worked with the Victorian Public Service for more than 30 years, including as Secretary of the Department of Human Services from 2000 to 2007 and Director Consumer Affairs from 1989 to 1993. Patricia was Deputy Commissioner to the 2015 Victorian Royal Commission into Family Violence. She is a former partner of KPMG and was an expert adviser to the Prime Minister's Multi Party Climate Change Committee.

In 2017 Patricia was a member of the review panel that led the Independent Review into the Electricity and Gas Retail Markets in Victoria. Patricia has broad experience including as Chair of Peter MacCallum Cancer Centre, Super Partners and the Australian Social Inclusion Board.

Ms Jennifer Williams AM

Jennifer Williams is currently Chair of Northern Health. She has previously worked as a Chief Executive to several large healthcare organisations, including Austin Health (five years), Alfred Health (seven years) and most recently as Chief Executive of the Australian Red Cross Blood Service (seven years). Jennifer is also the Chair of Yooralla and a board member of Barwon Health, the Australia Medical Research Advisory Board, InfoXchange and the Independent Hospital Pricing Authority. She has recently completed eight years on the board of La Trobe University.

Jennifer has extensive experience in the health sector and has held many board positions.

Ms Carmel Smith

Carmel Smith is recently retired. In the immediate past, she was the Executive Manager of Goulburn Valley Hospice Care Service (a position she held for 15 years). Carmel is an experienced registered nurse who trained at St Vincent's Hospital Melbourne. She has qualifications in Cancer Nursing and

Palliative Care and was a participant of the inaugural Master Practitioner in Palliative Care Executive Program in 2009. Carmel was responsible for establishing oncology services in both Echuca Hospital and Shepparton Private Hospital, managing the latter as a sole practitioner for almost 10 years.

Carmel has received many awards during her career, the most notable being the 2004 Citizen of the Year for the City of Greater Shepparton for services to cancer sufferers in the community. She also received the Nurses Campaign Award in 2005 which allowed her to complete a study tour of hospices in England, Scotland and Wales and, in 2015, her Life Membership of Palliative Care Victoria.

Aspex Consulting summary

The vision for Victoria's end of life and palliative care framework (the framework) is that 'all Victorians and their families receive the best possible end of life care that places them at the centre where preferences, values, dignity and comfort are respected, and quality of life matters most.'

Purpose

The framework underpins the need to redesign models of service delivery, and in turn, funding approaches to support person-centre care. The review seeks to align the palliative care funding model with the overarching policy framework.

The specific objective of the project is to review the current funding model for palliative care services in Victoria for the Department of Health and Human Services (the department), and develop a funding model for community palliative care services in Victoria.

This summary:

- describes the case for change
- outlines a new funding framework for community palliative care services, and related changes to hospital-based palliative care that relate to improvements in integration between care settings
- considers some of the broader impacts of the new funding framework.

Palliative care service system

The palliative care service system is multifaceted. In 2017–18, the Victorian Government provided \$142.5 million in funding for palliative care services, through various service settings, including:

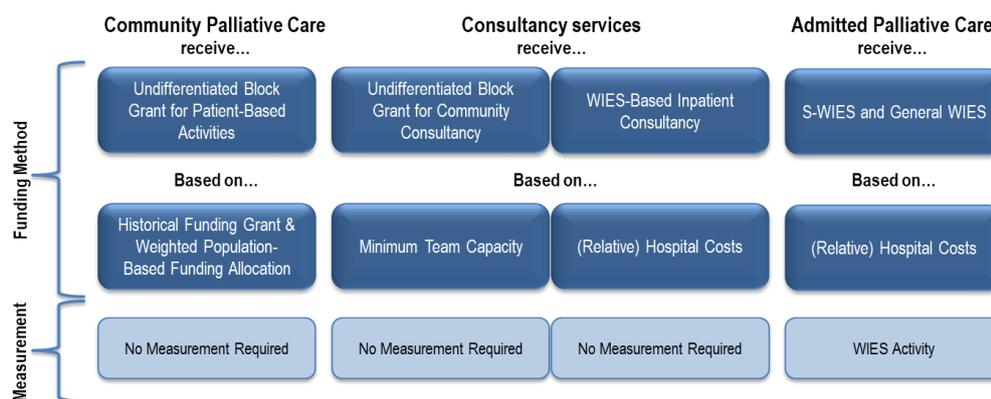
- \$63.0 million in episodic funding of 31 health services to provide admitted (inpatient) care
- \$58.7 million in block funding for 38 community palliative care services to support patients and families at their usual place of residence
- \$16.9 million in block grants for statewide and regional consultancy services to provide specialist advice and support to services.

The hospital and community-based service system is designed to provide Victorians access to a level of palliative care, irrespective of their place of residence. This may be through a general practitioner with input from a multidisciplinary regional consultancy team, or from a specialist service providing direct day-to-day care.

Funding approaches can potentially work against, or facilitate, policy directions and the service preferences of patients and their families. The current service system cannot be expected to deliver on the policy or community expectations without reform of the community palliative care funding model.

The current funding model is illustrated below. There are several methods for determining the quantum and allocation of funding across community palliative care, consultancy and admitted services. Importantly, with the exception of measuring inpatient activity by WIES, there is no 'measurement' that links the level of funding with the services that are delivered.

Figure 1: Schematic of current funding model



In conjunction with this state-based system, palliative care is also supported as part of the generic primary care service system, and residential aged care services.

The case for change

Policy changes, changing clinical service models, and the shift in community expectations means that the current service delivery system, and the accountability of the system, need to be redesigned. Perpetuating the current service system cannot deliver policy or community expectations.

A tenet of the funding model changes, including the proposals to invest in capacity building and service innovation over the next five years, is firmly grounded in the recognition that system reform is necessary. This includes supporting judicious 'experimentation' with new models of care over the next few years.

An assessment of the current community palliative care service system and funding model has identified the following needs:

Better meet growing demand

Increasing demand for palliative care services is largely attributed to the growth and ageing of Australia's population and the changing complexity of palliative care and people's preference about care

Improve integration across the service system

Stakeholders report a lack of integration of core service, with the associated difficulty for clients navigating the system. Service integration is a key weakness of the current service system. This requires integration of admitted and community services, and curative and palliative care services. Improved provision of seamless care is a necessary and fundamental response to a patient-centred palliative care system

Increase service access and consistency in service availability

Over the five-year period from 2012–13 to 2016–17, there was a 3.8 per cent per annum increase in community palliative episodes.

Many community palliative care providers are unable to meet current demand in a timely manner. In many instances, only clients who are close to death receive care, and there are relatively few patients enter care in the 'stable' phase.

Several limitations of the service system have been identified, including:

- the lack of recognition of increasing client complexity
- the inconsistency in achieving community preference to die at home

- barriers to service access for under-served populations, including people living in aged and disability residential care
- the significant inconsistency in service offering depending upon place of residence
- the inadequate timeliness of response to referrals
- the variable availability of after-hours support.

Enable effective performance monitoring and accountability

There are inconsistent measurement and reporting of service delivery and quality outcomes across Victoria. There are also insufficient requirements imposed by the funding arrangements to drive accountability of service providers to meet demand, provide value for money, or improve system efficiency.

A funding model can support more effective reporting of what services are provided and what benefit services have had on patient outcomes – that is, demonstrating benefit to the community and patients.

Funding allocation

There is currently no basis for aligning funding to meet demand, or other policy imperatives. Growth funding is distributed on a historical funding basis with some changes over time based on a weighted population approach – Palliative Care Resource Allocation Model (PCRAM).

The PCRAM provides a formula for allocation of funding based on the needs of the population within defined geographical catchment areas. Several key issues relating to the nature of funding distribution based on the PCRAM have been identified.

Funding alignment

There exists considerable variability in funding across Victoria. This has significant impact on service provision and inhibits consistent service offerings. Service provider cost data is required to drive equitable distribution of funding; and

Baseline data

There is a paucity in core data relating to costs, and phases of care that are required to drive service improvement.

Funding framework

The proposed funding framework for community-based palliative care does not seek to change the current inpatient, outpatient or emergency department funding models (although it is expected to broaden the role of consultancy teams along with additional funding).

The framework relates to community-based palliative care, and the interface between community and inpatient services to better enable care integrations. The framework has two main components:

Patient and family related care, treatment and support

These are direct provision of services to patients and their family/carers. This core component of the funding model has the following characteristics:

- Consistent with the principles of flexible funding, and delivering patient-centred care and support, the department would provide a block grant. The level of grant will be informed by service costs, expected service offerings and expected demand. Services will be delivered and reported based on phases of care. The well-established patient phases of care include stable, unstable, deteriorating and terminal

care, in addition to proposed new elements that recognise costs associated with initial contact and assessment, and post-death bereavement support.

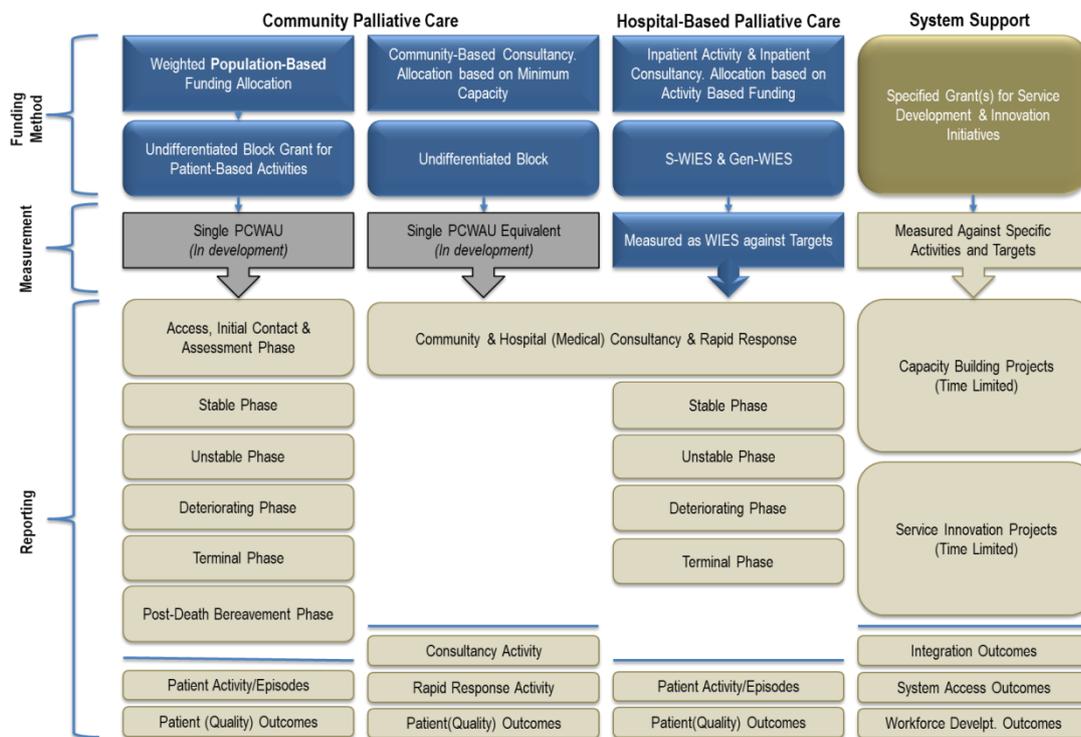
- Each funding element would have a notional price that reflects the weighted average costs for the respective phases of care.
- The block grant funding would remain a prospective payment (monthly in advance), and providers would retain the flexibility to dedicate resources based on individual need.

Service system support

These services, by definition, are not direct services to patients or family/carers. The critical support structures that enable an effective and efficient community palliative care service system to evolve/transition include: specialist medical consultancy and rapid response capacity; system wide enablers and capacity building and service innovation; and system stewardship initiatives.

The proposed short-term funding model is illustrated below. All of the components of the funding framework that are not identified as blue are newly proposed.

Figure 2: Schematic of short-term funding model for years 1 and 2



*PCWAU is a Palliative Care Weighted Activity Unit, or a common unit of measure across all types of palliative care service delivered.

The interim funding model pictured above is intended to apply for the first two years. The key actions for the department to implement the short-term model are:

- apply the general funding allocation mechanism to a weighted population (status quo)
- develop and implement effective performance reporting and accountability mechanisms
- seek accurate reporting of service delivery and cost information, by phase of care, from a representative sample of community service providers
- invest in system integration through specified grant funding of hospital consultancy teams to provide outreach into community-based services

- invest in system development including capacity building and service innovation initiatives through specified grants.

The key components of the medium-term (years 3 to 5) funding model include:

- an enhancement of the funding method by moving from a population-based approach to a needs-based funding approach.

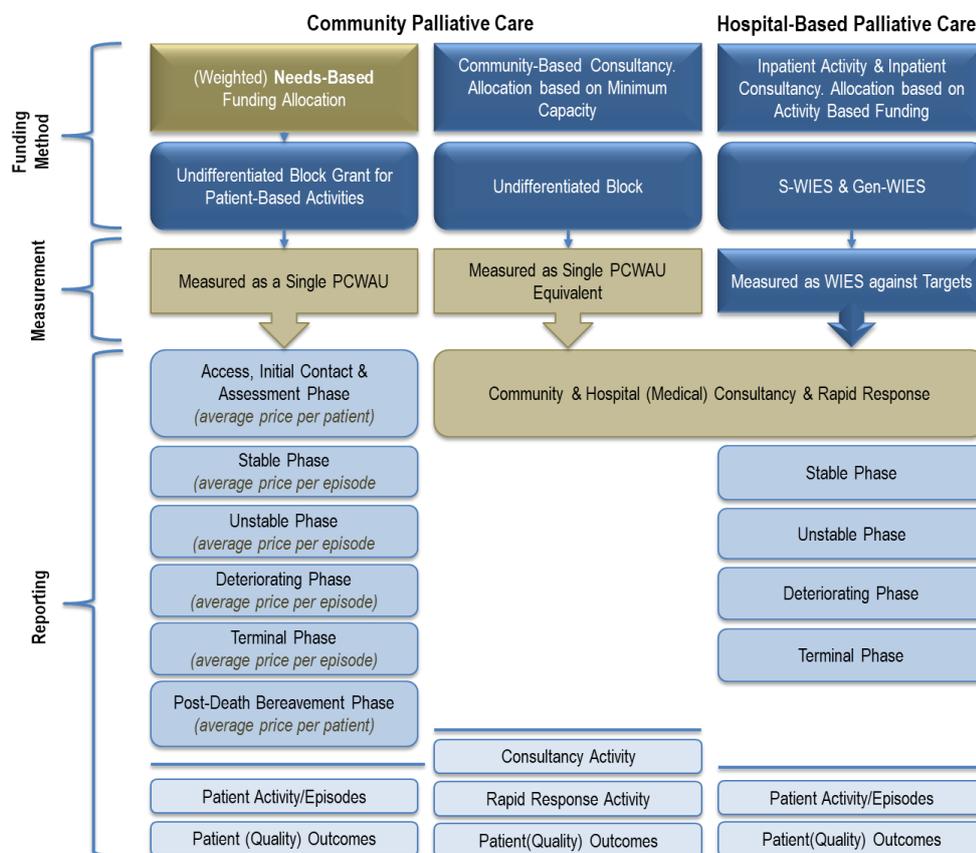
A needs-based method offers a more direct link with demand for community palliative care, and could be underpinned by, say, a prevalence rate for palliative care using the proportion of patients who would benefit from specialist palliative care, relative to all deaths.

While further work is required to operationalise this model, the approach is expected to further reduce funding inequities, support an expected service mix across all phases of care, and increase transparency. The development of a needs-based approach then provides the department with a funding model that can potentially combine inpatient and community palliative care in the future to maximise patient-centred integrated care

- development of a common unit of measure to support system transparency
- introduction of incentives or disincentives for identifiable patient cohorts or targeted phases of care. This may include normative pricing, which provides policy makers with a tool to influence market behaviour
- transfer the initial investment in system development into direct services funding.

The proposed medium-term funding model is illustrated below. The gold components will be developed and refined over years 1 to 2, with implementation and monitoring from year 3 onwards.

Figure 3: Schematic of medium-term funding model, years 3 to 5



Next steps

The proposed funding framework needs to be transitioned into a funding model that the department can use to enhance the provision of palliative care services across Victoria.

To assist this process, the critical shortcomings require:

- a more comprehensive cross-sectional sampling of community-based palliative care costs as a basis for establishing prices (priority consideration)
- testing and refining the framework for patient/family services and for system-wide support services. This supports an element of codesign
- shadowing/trialling the current framework until relevant and current costing data can be compiled
- establishing a more robust stewardship model of reporting, and monitoring.

The two key stages are outlined below. They reflect a desire to cause minimum dislocation and disruption of services.

Years 1–2: Enhanced reporting and accountability for community-based care

The first stage retains the current catchment based weighted population (PCRAM) system, in combination with a block grant approach to funding. However, the basis for determining the level of funding would be more appropriately based on expected demand, a consistent suite of services across the state, and related to expected costs.

These changes would also encompass:

- increased accountability through provision for an expected overall level of activity
- reporting of service costs on a consistent basis
- establishing activity measures relating to phases of care along with the consistent definitions of activity, consistent reporting of activity, and consistent reporting of service costs.

The changes to reporting and accountability are a necessary first step to consistent and fair funding and a better understanding of services delivered.

Years 3–5: Needs-based funding allocation for community-based and inpatient care

A second stage is to codesign a needs-based funding method that may have at least the following characteristics:

- expressed demand (by phases of care) for community palliative care, relative to the total palliative care services. This includes bed-based and other hospital palliative care services (and potentially private services)
- total expected demand (hospital and community-based). Expected demand is the sum of expressed demand and latent demand
- expected demand would be estimated based on palliative care prevalence. Prevalence is best developed transparently. It can be narrowly focused or broadly developed depending on perceptions of the (potential) benefit that can be derived from palliative care using the total number of deaths in the population as a denominator
- expected demand would then be broadly developed by service type or phase of care and setting for the care.

Overview of the Panel's recommendations

The review has provided an assessment of the current community palliative care funding model and described a redesigned model that will support the sustainable growth of admitted, community and consultancy palliative care services to meet community need and drive the framework outcomes.

The Panel's recommendations seek to align the funding model with, as well as utilise the funding model to, achieve the policy objective of access to quality services for all Victorians who may benefit from palliative care.

For community-based palliative care services

1. **In the short term, enhance the existing community-based funding model to improve equity and transparency of funding** by:
 - (a) maintaining some elements of the current model in the short term (years 1–2), including undifferentiated block grant funding and the use of PCRAM for growth funding allocation. The block grant funding would remain a prospective payment, and providers would retain the flexibility to dedicate resources based on individual need
 - (b) enhancing the requirements/expectations that services will be costed, delivered and reported based on the well-established phases of care – stable, unstable, deteriorating, terminal and bereavement
 - (c) introducing a new element for reporting that recognises the costs associated with initial contact and assessment. This links the client and carer with community-based services that will follow them through their end of life trajectory
 - (d) seeking detailed service-provider cost data by late 2018 or early 2019. This will enable the department, in consultation with providers, to more accurately derive the costs per phase of care, and examine the different service profiles and their associated costs
 - (e) with improved availability of sector cost and phase of care data, the department is to:
 - specify a notional price that captures direct, indirect and corporate costs, for each phase of care. Typically, the price would reflect average costs for the respective phases of care
 - develop a common unit of measure to establish price equivalence between different types of services, each with different service models and different intensity of need
 - (f) developing a needs-based funding approach that would apply from year 3. This needs-based model is to include weightings relating to the service delivery location and patient complexity (by phase of care)
 - (g) reviewing, with the intention of removing, all specified grants that relate to direct service provision, and instead address patient complexity through cost weights.
2. **Improve access to community-based palliative care services** by
 - (a) seeking increased activity for targeted patient cohorts or phases of care
 - (b) considering an added incentive to deliver a level of service above expected demand thresholds using funding incentives similar to other health sectors.

For service system integration

3. **Drive improved integration between community and inpatient services** by:
 - (a) providing specified grant funding to the hospital-based consultancy teams with clear expectations of the level and type of services to be delivered, including a demonstration of

integrated care and provision of a rapid response service. As these services become 'business as usual', funding is to be rolled into the base funding allocation

- (b) providing consideration of workforce models to support joint appointments and credentialing across the inpatient and community settings
 - (c) providing consideration to the longer-term application of a needs-based allocation approach capable of being applied across both inpatient and community palliative care to maximise patient-centred integrated care (long-term objective).
4. **Support more flexible service model development by hospitals** – including substitution and diversion programs – to improve integration and care continuity that enables more people to die at home. This includes:
- (a) Hospital in the Home (HITH). This initiative will require a palliative care category in HITH, or changes to the functional definition and business rules to enable the use of HITH
 - (b) Health Independence Program (HIP). This initiative will require converting inpatient funding and HIP allocations to palliative care, irrespective of service setting
 - (c) providing consideration to innovative projects for palliative care.

To support service system transition and culture change

5. **Establish an innovation and development fund** to deliver initiatives that develop system-wide enablers and build capacity (with the transfer of the initial investment in system development into the funding allocation of direct services after a five-year implementation period). Targeted initiatives may include, but are not limited to:
- (a) supporting initiatives that facilitate the accurate recording and systematic reporting of service activity, costs, and patient outcomes (priority development)
 - (b) supporting system-wide improvements in after-hours access, building on the (in development) system-wide advice line (priority development)
 - (c) supporting service model development targeted at enhancing the safety and quality of palliative care service delivery
 - (d) supporting priority need cohorts through identification of barriers to service access and where necessary, providing increased funding towards the costs of service delivery for complex patients
 - (e) supporting ICT projects that better integrate patient care, and patient care reporting
 - (f) investing in consumer and clinical education. Capacity building activities are to focus on health literacy for health professionals and community and support culture change in both the acute and community setting
 - (g) enhancing volunteer development, respite and related services.
6. **Boost system stewardship activities**, including:
- (a) building workforce capacity. This will require a workforce audit that identifies the current capacity and service gaps and sets out mechanisms to align workforce capacity and community need
 - (b) service planning, audits, research and evaluation
 - (c) refreshing the palliative care capability framework and establish expectations relating to core service components

- (d) collaborating with the Palliative Care Clinical Network (PCCN) to provide advice on consistent admission and discharge criteria and evidence-based assessment tools
- (e) assessing mechanisms to drive critical mass and system-wide efficiencies.

To enhance accountability to deliver care that meets the framework goals

7. Establish accountability mechanisms to incentivise good practice, by:

- (a) linking funding with accountability mechanisms through implementation of an accountability and performance monitoring framework that provides measures of:
 - person-centred quality outcomes
 - system access
 - system integration
 - program, process or activity outputs
 - system and service provider efficiency and effectiveness
- (b) staging the implementation of the accountability framework as data collection capabilities increase. Proposed measures are to be refined through co-design with the sector.
- (c) mandating reporting requirements to ensure consistent statewide reporting. This is to include facilitating cooperation between regional and rural providers to provide the necessary resources and support to meet reporting requirements
- (d) strengthening patient-level data linkages between datasets to inform the evolution of future funding and service models through the Victorian Agency for Health Information (VAHI).

Appendix 1: Text-equivalent descriptions of figures

Figure 1: Schematic of current funding model

The schematic shows three vertical columns. The first is headed 'Community palliative care', with the funding method 'Undifferentiated block grant for patient-based activities' based on 'Historical funding grant and weighted population-based funding allocation'. There is no measurement required.

The second column is headed 'Consultancy services', with the funding method 'Undifferentiated block grant for community consultancy' based on 'Minimum team capacity'; and 'WIES-based inpatient consultancy' based on '(Relative) hospital costs'. There is no measurement required for either of these.

The final column is headed 'Admitted palliative care', with the funding method 'S-WIES and general WIES' based on '(Relative) hospital costs'. The measurement is WIES activity.

Figure 2: Schematic of short-term funding model for years 1 and 2

The figure contains four horizontal columns. The first column is headed 'Community palliative care'. The funding method is 'Weighted population-based funding allocation' and 'Undifferentiated block grant for patient-based activities'. Newly proposed measurement is by 'Single Palliative Care Weight Activity Unit (in development)'. Newly proposed reporting includes: access, initial contact and assessment phase; stable phase; unstable phase; deteriorating phase; terminal phase and post-death bereavement phase. It also includes patient activity/episodes; and patient (quality) outcomes.

The second column is also headed 'Community palliative care'. The funding method is 'Community-based consultancy allocation based on minimum capacity' and 'Undifferentiated block'. Newly proposed measurement is by 'Single Palliative Care Weight Activity Unit Equivalent (in development)'. Newly proposed reporting is by 'Community and hospital (medical) consultancy and rapid response'. It also includes consultancy activity; rapid response activity; and patient (quality) outcomes.

The third column is headed 'Hospital-based palliative care'. The funding method is 'Inpatient activity and inpatient consultancy. Allocation based on activity-based funding'; 'S-WIED and Gen-WIES'; and 'Measured as WIES against targets'. Newly proposed reporting is by 'Community and hospital (medical) consultancy and rapid response', which stretches across from the previous column. It includes: stable phase; unstable phase; deteriorating phase; terminal phase. It also includes patient activity/episodes; and patient (quality) outcomes.

The fourth column is headed 'System support', and it is all newly proposed. Funding is by specified grants for service development and innovation initiatives, and it is measured against specific activities and targets. Reporting includes capacity building projects (time limited) and service innovation projects (time limited). It also includes integration outcomes; system access outcomes; and workforce development outcomes.

Figure 3: Schematic of medium-term funding model, years 3 to 5

The figure has three vertical columns. The first is headed 'Community palliative care'. Funding method is (newly proposed) '(Weighted) needs-based funding allocation' and 'Undifferentiated block grant for patient-based activities'. Measurement (newly proposed) is as a Single Palliative Care Weight Activity Unit. Reporting includes access, initial contact and assessment phase (average price per patient); stable phase (average price per episode); unstable phase (average price per episode); deteriorating phase

(average price per episode); terminal phase (average price per episode); post-death bereavement phase (average price per episode). It also includes patient activity/episodes and patient (quality) outcomes.

The second column is also headed 'Community palliative care'. Funding method is 'Community-based consultancy allocation based on minimum capacity' and 'undifferentiated block'. Measurement (newly proposed) is as a Single Palliative Care Weight Activity Unit equivalent. Reporting (newly proposed) is 'Community and hospital (medical) consultancy and rapid response'. It also includes consultancy activity; rapid response activity; and patient (quality) outcomes.

The third column is headed 'Hospital-based palliative care'. Funding method is 'Inpatient activity and inpatient consultancy. Allocation based on activity-based funding'; and 'S-WIES and Gen-WIES'. It is measured as WIES against targets. Reporting is by (newly proposed) 'Community and hospital (medical) consultancy and rapid response' which stretches across from the previous column. It includes stable phase; unstable phase; deteriorating phase; and terminal phase. It also includes patient activity/episodes and patient (quality) outcomes.