



# **Palliative Care Service Delivery Framework and Funding Model Review**

## **Work Plan**

17 October 2008

In association with



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# 1 Introduction

This work plan outlines the essential elements of a project to develop a **service delivery framework** and **funding model** for palliative services for Victoria.

The project is commissioned by the Department of Human Services and undertaken by *Aspex Consulting* in conjunction with *Health Policy Solutions*.

## 2 Project management

### 2.1 Key contacts

The key contacts for the project are shown in Figure 1.

**Figure 1: Key Project Contacts in DHS and Aspex Consulting Team**

<b>Name</b>	<b>Phone</b>	<b>Fax</b>	<b>Mobile</b>	<b>E-mail</b>
Mr Gregory Dalton	9096 1459	9096 1459	N/A	<a href="mailto:Gregory.Dalton@dhs.vic.gov.au">Gregory.Dalton@dhs.vic.gov.au</a>
Ms Jackie Kearney	9096 2143	9096 2143	0432 133 002	<a href="mailto:Jackie.Kearney@dhs.vic.gov.au">Jackie.Kearney@dhs.vic.gov.au</a>
Mr Peter Axten	9419 0002	9419 0020	0419 340 516	<a href="mailto:peter.axten@aspexconsulting.com.au">peter.axten@aspexconsulting.com.au</a>
Dr Sharon Willcox	9699 7321	9699 7321	0423 348 933	<a href="mailto:sharon@healthpolicysolutions.com.au">sharon@healthpolicysolutions.com.au</a>
Dr Peter Nagel	9419 0006	9419 0020	0400 040 728	<a href="mailto:peter.nagel@aspexconsulting.com.au">peter.nagel@aspexconsulting.com.au</a>
Ms Alice Miller	9419 0002	9419 0020	0425 756 653	<a href="mailto:alice.miller@aspexconsulting.com.au">alice.miller@aspexconsulting.com.au</a>
Mr Jim Swinden	9419 0002	9419 0020	0418 358 295	<a href="mailto:jim.swinden@aspexconsulting.com.au">jim.swinden@aspexconsulting.com.au</a>

### 2.2 Advisory group

An Advisory Group has been established to oversee and support the project. The role of the Advisory Group is to:

- Provide advice on the methods and approach used to achieve project outcomes;
- Provide feedback on draft documents that will be developed to support the project;
- Provide advice and feedback on implementation issues associated with the project; and
- Promote the project and its outcomes in a positive manner to stakeholders.

The final decisions about the outcomes of each stage of the project must nevertheless remain with the Department of Human Services

Members of the Advisory Group are provided in Figure 2.

**Figure 2: Advisory Committee Members**

<b>Name</b>	<b>Organisation</b>
Ms Jackie Kearney (Chair)	Mgr. Palliative Care, Department of Human Services
Ms Jenny Trewartha	DoN & Ops Mgr., Caritas Christi Hospice
Ms Anne Oakley	Mgr., Melbourne Citymission Palliative Care
Ms Rosemary Hogan	Exec. General Mgr, Royal District Nursing Service
Ms Kethly Fallon	Ops. Mgr. Sunshine Hospital, Western Health
Mr Kevin Larkins	CEO, Palliative Care Victoria
Dr Jane Fischer	CEO, Calvary Healthcare - Bethlehem
Ms Andrea Murphy	Exec. Mgr., Family Services, Very Special Kids
Ms Carita Potts	Exec. Officer, Ballarat Hospice Care Ltd
Mr Mark Cockayne	CEO, South East Palliative Care
Dr Brian Le	Palliative Care Physician, Royal Melbourne Hospital
Ms Carol Quayle	Mgr. Palliative Care Services, Mercy Western Palliative Care
Ms Trudy Erwin	Business Mgr., Eastern Palliative Care
Ms Julie Brophy	Mgr. Funding Policy, Department of Human Services
Mr John Bayliss-McCulloch	Mgr. Reform and Innovation, Department of Human Services
Ms Amanda Bolleter	Senior Project Officer, Cancer and Palliative Care, DHS
Ms Jo Hall	Senior Project Officer, Cancer and Palliative Care, DHS
Mr Gregory Dalton	Snr. Project Officer, Cancer and Palliative Care, DHS

Members of the Aspex Consulting team will attend meetings of the Advisory Group.

## **2.3 Project communication**

It will be the responsibility of all parties to regularly communicate. It is proposed that consultants will be regularly available to discuss issues as they arise.

Formal project management will occur through the Advisory Group meetings, which have been scheduled to coincide with the draft deliverables for each of the key stages of the project. Final deliverables from each stage will be completed following input from the Advisory Group.

Regular contact will occur between the DHS Project Manger (Gregory Dalton) and Aspex Consulting Project Manager (Peter Axten)

The proposed meeting schedule is listed in Figure 3.

**Figure 3: Advisory Group Meeting Schedule and Tasks**

<b>Meeting date</b>	<b>Stage &amp; Deliverable</b>
9 October 2008	Discussion and approval of approach and literature review
20 November 2008	Discussion of the literature review and progress on service mapping
5 February 2009	Discussion of service mapping & final consultation program
5 March 2009	Discussion of consultation outcomes
16 April 2009	Discussion of draft Service Delivery Framework
25 June 2009	Discussion and endorsement of final Service Delivery Framework
30 July 2009	Discussion of draft Funding Model
17 September 2009	Discussion and endorsement of final Funding Model

## 2.4 Consulting team

The consulting team members, together with their roles, are shown in Figure 4.

**Figure 4: Consulting Team Members and Roles**

<b>Consultant</b>	<b>Title</b>	<b>Main Focus</b>
Mr Peter Axten	Director, Aspex Consulting	Project Director. All Aspects of the project.
Dr Peter Nagel	Consultant, Aspex Consulting	Service Mapping, Consultations, Service Delivery Framework and Funding Model
Dr Sharon Willcox	Director, Health Policy Solutions	Consultations and Literature Review
Mr Jim Swinden	Director, Aspex Consulting	Service Mapping, Consultations and Funding Model.
Ms Alice Miller	Consultant, Aspex Consulting	Literature Review, Consultations and Service Delivery Framework.

## 2.5 Project timetable

The project commenced in September 2008 and is scheduled to be completed by September 2009. Figure 5 shows the indicative project timelines.

**Figure 5: Proposed Timeline**

Project Phases/Weeks	6 Oct 08	13 Oct 08	20 Oct 08	27 Oct 08	3 Nov 08	10 Nov 08	17 Nov 08	24 Nov 08	1 Dec 08	8 Dec 08	15 Dec 08	22 Dec 08	29 Dec 08	5 Jan 09	12 Jan 09	19 Jan 09	26 Jan 09	2 Feb 09	9 Feb 09	16 Feb 09	23 Feb 09	2 Mar 09	9 Mar 09	16 Mar 09	23 Mar 09	30 Mar 09
Project Establishment																										
Literature Review & Interim Report																										
Sector Workshop																										
Service Mapping Template and Testing																										
Central Data Collection, Analysis & Data Integrity																										
Service Provider Survey, Analysis & Interim Report																										
Service Provider Consultations																										
Model Criteria Development																										
Draft Service Delivery Framework Report																										
Service Provider Consultation & Interim Report																										
Final Service Delivery Model Framework																										
Develop Draft Funding Model																										
Impact Assessment of Model & Interim Report																										
Service Provider Consultations																										
Final Funding Model																										
Project Management																										

Project Phases/Weeks	30 Mar 08	6 Apr 08	13 Apr 08	20 Apr 08	27 Apr 08	4 May 08	11 May 08	18 May 08	25 May 08	1 Jun 08	8 Jun 08	15 Jun 08	22 Jun 08	29 Jun 08	6 Jul 08	13 Jul 08	20 Jul 08	27 Jul 08	3 Aug 08	10 Aug 08	17 Aug 08	24 Aug 08	31 Aug 08	7 Sep 08	14 Sep 08	21 Sep 08
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Impact Assessment of Model & Interim Report																										
Service Provider Consultations																										
Final Funding Model																										
Project Management																										

### 3 Project approach and deliverables

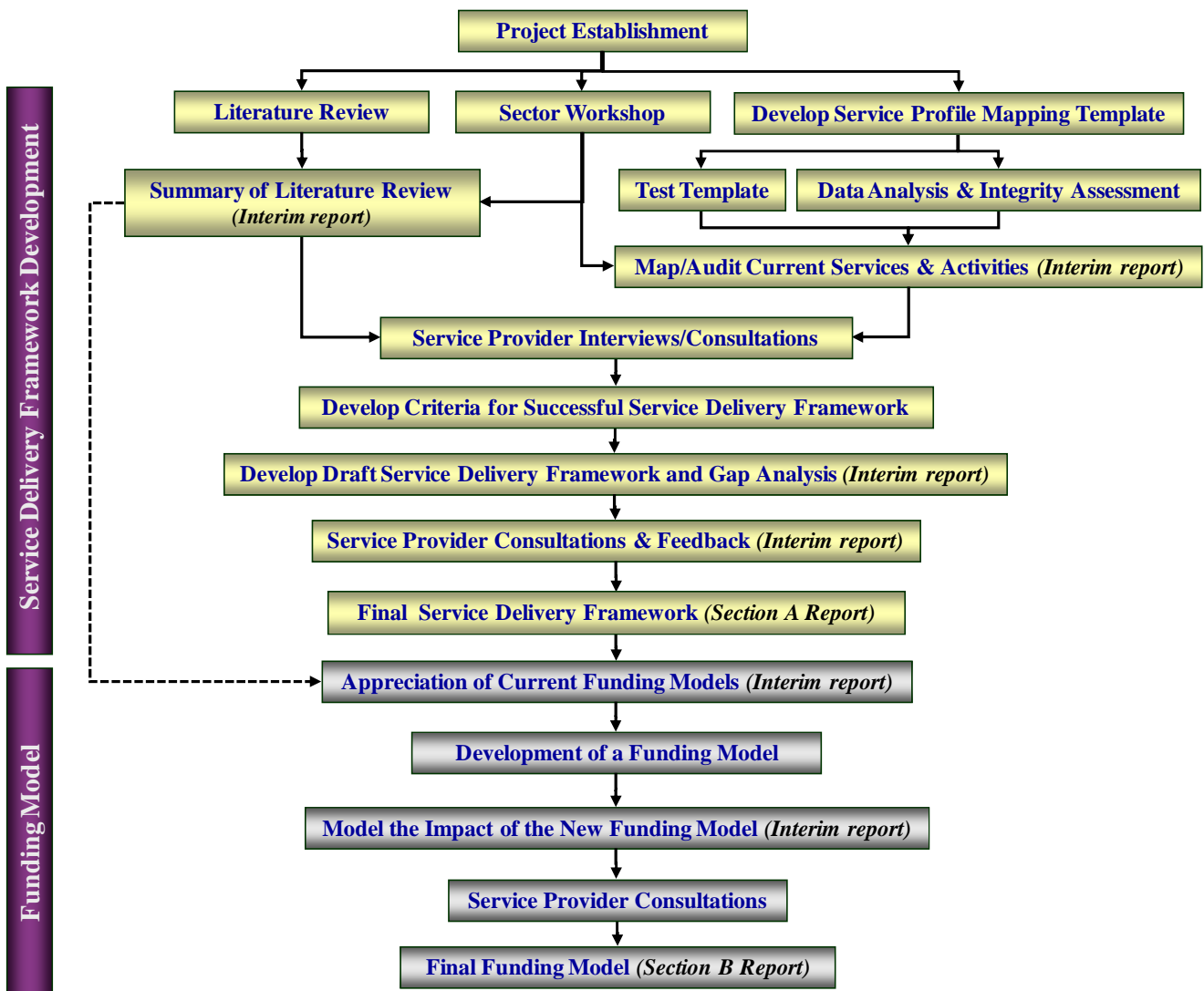
This section provides a summary of the approach and project deliverables.

The project will be undertaken in two main stages:

- The development of a **service delivery framework**; followed by
- The development of a **funding model** that is consistent with the service delivery framework.

A schematic of the general approach is provided in Figure 6.

Figure 6: Schematic of Approach



### 3.1 Project establishment and work plan

The project establishment phase includes:

- Establishment and meeting of the Advisory Group.
- Articulation or reaffirmation of the principles and goals of the palliative program and the project;
- Establishment of project management arrangements;
- Affirmation of the project methodology;
- Agree on the scope of the literature review; and
- Development of a work plan for the project.

*Outcome: Work Plan (this document)*

### 3.2 Literature review

This stage will:

- Examine and assess the current service and funding models that are operating in other jurisdictions; and
- Examine the evidence base that supports the various service models.

There are some overarching questions and parameters that are relevant to the development of both a Service Delivery Framework and a Funding Model for palliative care services. These questions will form part of the literature review and include:

- What are the objectives and goals guiding the delivery of palliative care?
- How can the goals and experiences of clients and their families and carers be incorporated?
- What criteria, indicators and outcomes can be used to assess the effectiveness of palliative care?

A detailed scoping of the literature review questions and parameters is provided as Appendix A.

*Outcome: An Interim Report relating to the literature review with a description of current frameworks.*

### 3.3 Sector Workshop

A workshop will be undertaken with selected industry stakeholders. The purpose of the workshop is for the palliative care sector to raise key issues and provide early input into the shape of the service delivery framework.

The workshop will be by invitation and for representatives of the sector (approximately 30 people) to present thought provoking ideas and discuss issues that are central to the delivery of palliative care services in the future. These presentations may be around key themes, such as models of care, service integration, role delineation etc.

The workshop will be concurrent with the literature review and service mapping.

*Outcome. Sector workshop.*

## 3.4 Service profile mapping

The purpose of this stage is to develop a shared understanding of 'what is'. It will effectively describe the current service delivery system.

### 3.4.1 Develop an information template

As a first step, a 'template' will be developed that includes the information necessary to adequately describe the current service delivery system (that is, consortia service delivery models and service models of care).

It is understood that similar service mapping may have been undertaken in some consortia and covering aspects of care. It is not the intention of this project to impose an unnecessary burden on service providers or consortia. A template will be developed that will consider current mapping approaches.

The information template will be the basis for a survey of service providers (unless the same information can be provided from alternative sources). In a broad sense, we would look to include information about the key areas that constitute a **model of care** at a (regional) **system** level.

It is likely that the following information types would potentially add to the existing understanding of the service delivery system and would be relevant for inclusion in the template:

1. Service types/settings (such as general inpatient, specialist inpatient, acute outpatient, sub-acute ambulatory, community care, home care, carers support, consultancy/advisory, social support etc);
2. Service activities, particularly key activities that characterise current service delivery;
3. Service levels (to the extent that it may relate to current perceived or designated roles within a region);
4. Patient/client characteristics (where this is not obtainable from activity data);
5. Staffing profiles;
6. Teaching, training and research;
7. Quality and effectiveness measures;

8. Patient access such as timeliness of care or support, and service locations (by type) etc; and
9. Network or coordination approaches between health services as they relate to 'system planning and development' and 'seamless patient care' services.

Not all service delivery system information is appropriate to collect from service providers. Therefore, we also propose to extract activity related data from central data repositories. Data from central repositories would include:

- *Activity data* from VAED for public and private inpatients, and VINAH/AIMS for public ambulatory services. This will include patient/client characteristics;
- *Utilisation rates* of palliative care services by SLA and region; and
- *Self-sufficiency* levels for palliative care by sub-region and region.

### 3.4.2 Test template

Given the critical nature of the service mapping, it is proposed to test the template at two to four service providers, preferably in two consortia.

The consultants propose to work closely with the service providers and consortia in completing the survey instrument.

### 3.4.3 Service provider survey

Following the testing of the survey instrument, all health services and NGOs delivering palliative care would be requested to complete the survey (unless all data can be provided through an alternative source). This can potentially be an onerous task for many smaller providers. Consequently, it will be necessary to work with almost all service providers individually in relation to the data provided in the survey.

The information from the survey and the databases will be analysed by each of the major variables indicated in section 3.4.1 above. The type of analysis may vary depending on the information provided. It will be necessary to assess the integrity and consistency of the data at an agency and system level.

The outcome of this task will be a comprehensive service audit of palliative care services across Victoria. In addition, it will provide an analysis of the service profile.

*Outcome. An Interim Report on the current service profile of palliative care services across the State.*

## 3.5 Service provider consultations

The purpose of this stage is to engage the palliative care sector to input into the service delivery framework and, to the extent that it is possible, to develop a consensus of view as to the nature of a future service delivery framework. Undertaking the consultations at this point in the project maximises the input of the sector into the service delivery framework development.

We propose to consult with specialist palliative care organisations, other relevant service providers, peak organisations and DHS.

The consultations with (specialist) palliative care organisations and service providers will incorporate:

1. Program principles and goals.
2. The findings of the literature review and environmental scan.
3. Common language and definitions.
4. The findings of the service audit and the analysis of the palliative care service profile in Victoria.
5. Consideration of criteria for a success service delivery framework.
6. Input into the structure of future service delivery, including the identification of elements of a desirable regional service delivery model and service model of care.

The main consultative approach is to:

- Conduct a full day workshop for *each consortium*, involving multiple representatives from each service provider in the consortium and other key service providers with a strong interest in palliative care (such as Integrated Cancer Services and General Practitioners) in the area.
- Workshops will be divided into three sessions:
  - An initial series of presentations relating to the literature review findings, language and definitions, and findings from the service audit & profile analysis.
  - Small group discussion regarding the validity, meaning and implications of the information presented, followed by a plenary session in relation to the outcomes of the small group discussions.
  - Further small group discussion on the many facets of a future service delivery framework, again followed by a plenary session and a summary of the findings.

We have also made provision to undertake further one-on-one consultations with stakeholders, including:

- Specialist service providers (including RDNS, Very Special Kids, Victorian Paediatric Palliative Care Program, HIV Consultancy, and Peter McCallum Cancer Institute)
- Peak bodies (including Palliative Care Victoria, Aged & Community Care Victoria, State Council of Divisions of GPs, and Motor Neurone Disease Association of Victoria; and
- DHS program and regional staff (as either three or four sessions).

### 3.6 Service delivery framework criteria

Criteria will then be developed, consistent with the palliative care goals, which will form the basis for the service delivery framework. This is a necessary step in the process as it will provide a transparent 'anchor' for the framework.

### 3.7 Draft service delivery framework

The purpose of this stage is to develop the service delivery framework.

Amongst other things, this stage will involve the identification/development of the **structure**, **operational integration**, required **competencies** and **service types**, and **service levels** necessary to operate an effective service delivery model. The building blocks for the framework are in preceding sections, and stem from the palliative care goals.

Upon these foundations, it is expected that the framework will include:

- **Service capability framework.** This would articulate the service system capability, that is, key competencies and resources. It would incorporate the concepts of role delineation and program designation. It would include such elements as the types of services available, the level and type of service networking and coordination, the level of service capability as well as a range of other potential variables such as access, quality, consultation/ advisory services, amongst others.
- **Service benchmarks.** This is to ensure equitable access to services, and optimal levels of self-sufficiency. Any baseline benchmarks would be established on the most appropriate measures of demand for palliative care and could potentially include catchment population, incidence/prevalence, utilisation rates, self-sufficiency levels or a combination of measures.
- **Service expectations.** Derived from all of the above, and the qualitative information from the consultations, it is proposed to set service expectations for each consortium catchment (or sub-catchments).

With service expectations established, it is then possible to identify the main **service gaps** or shortcoming across the system (which is a critical step in subsequently determining the funding impacts of changes to the service delivery framework). In large measure, the 'size and nature' of the gap will depend on whether the 'Service Expectations' are developed to achieve 'baseline' or minimum needs or whether they are 'aspirational' to reflect the desirable profile well into the future.

The report would be presented to the Project Advisory Group for feedback.

*Outcome. An Interim Report on the draft service delivery framework.*

### 3.8 Consultations

Consistent with the broad thrust of the project for stakeholder consultation and consensus, the purpose of this stage is to further engage service providers in the drafted service delivery framework by sharing the capability framework, service benchmarks, service expectations and the gap analysis with the field.

It is anticipated that these consultations would again be based on the consortia. In addition, there will be a presentation and briefing for DHS central and regional staff.

*Outcome. An Interim Report on the feedback from the sector in relation to the draft service delivery framework.*

### 3.9 Final service delivery framework

Following feedback from the consultation process, a final service delivery framework will be prepared.

*Outcome. A final service delivery framework. Section A Report.*

### 3.10 Appreciation of funding models

The purpose of this step is to generate a broad understanding of the current situation in relation to funding approaches, including:

- The (many and varied) bases on which current palliative care services are funded in Victoria; and
- Review of funding approaches in other jurisdictions (from the literature review). The understanding of alternative funding approaches (including outside the palliative care sector) will provide a basis for considering possible funding models for Victoria.

*Outcome. Interim report of the understanding of the current funding bases in Victoria and other jurisdictions.*

### 3.11 Develop funding model and assess implications

The purpose of this task is to draft a funding approach that facilitates the delivery of the program objectives and supports the effective implementation of the service delivery framework.

The development of the funding model will be challenging and will require a level of flexibility by all parties to generate a workable funding approach. The development of a practical funding model that is accepted by service providers will require clear (agreed) priorities and choices or trade-offs among competing objectives.

In addition, consideration will generally be required in relation to the desired funding model compared with the cost and/or effort necessary to develop robust data to support the funding components.

The funding model would have two main components.

1. The actual model would outline a set a suitable characteristics and specific elements that would constitute a funding model.

The model is likely to have the following (generic) characteristics. It would:

- Support a **patient-focused** approach.
- Support effective **service integration**.
- Support/reinforce an approach that delivers desired **service outcomes** or outputs, however defined.
- Be **simple** and **transparent**.
- Support reasonable **standards** of clinical effectiveness and support that is evidenced-based.
- Be **sustainable and efficient**.
- Not inhibit appropriate **innovation**.
- Provide an **auditable** service delivery system with adequate accountability and monitoring mechanisms.

In tailoring the funding model to support the service delivery framework, it is likely that the funding model will need to consider:

- The appropriate output measures or 'units of service', regardless of the basis of funding. Options could include anything from 'event-based' to episodic-based service units;
- The basis on which each 'unit of service' is 'priced' (and/or 'weighted' relative to each other or some other funding unit such as WIES or similar);
- The basis on which non-output driven services are funded; and
- The extent to which patient/carer co-payments are included, as well as other aspects of a funding model.

2. The funding model would have a quantitative modelling component that would indicate the projected impact on the funding of different service providers.

It will be necessary to undertake modelling of the funding approach. This means building an indicative (spreadsheet) model with all of the key variables. It will be critically important to build the model that has **dynamic variables** so that it is possible to alter the 'values' for each key variable to provide:

- **Impact analysis.** The likely funding impact that this will have on individual service providers across Victoria based on current funding (and service activities), and the implications of potential funding realignment;
- **Scenario analysis** on changes to the service profiles and service types to indicate the impact on future or prospective funding. For example, the funding implications of meeting identified service gaps, or changing the mix of service provision within known budget parameters etc). Scenario analysis may also assist in determining relative priority for future investment; and
- **Sensitivity analysis** in relation to those variables that are the most sensitive to change and that most impact on funding across the State and at individual agencies.

The modelling can only be considered indicative. Therefore, it will need to be subject to further refinement by DHS in relation to DHS-specific funding, and changes to the budget base etc.

It is proposed to present a draft funding model to the Project Advisory Group for consideration.

*Outcome: An Interim Report on the draft funding model to support the service model framework and the impact of the model on the allocation of resources/funding.*

### 3.12 Service provider consultation

Consistent with the broad thrust of the project of engagement and consensus, the purpose of this stage is to engage the service providers and specialist palliative care bodies where relevant, in the discussion of the draft funding model.

As proposed above, it is anticipated that these consultations be based on the consortia, with consultations involving a presentation and general discussion by participants.

In addition, there will be a presentation and briefing for DHS central and regional staff.

*Outcome. Completed consultation program.*

### 3.13 Final funding model report

Following consultation feedback and review by the Project Advisory Group, modifications will be made to the funding model. A final funding model and report will then be prepared.

*Outcome: A final funding mode. Section B Report.*

## Appendix A: Literature review parameters

### A.1 Scope

The literature review forms part of the early development of the project. The literature review requested by DHS covers two broad areas:

- “Description of **current/existing framework** (coordination and approaches to care) and service characteristics with peer clusters, with activities undertaken in each peer group. Summary of known outcomes and existing national and international frameworks, highlighting relevance to Victoria; and
- Currently employed and applicable **funding models** from the health, sub-acute and palliative care sectors, looking at national, international and innovative approaches to funding. Reference to the appropriateness of models to the current situation in Victoria and the available cost data. Identification of constraints/advantages within the current system that would prevent/facilitate the implementation of each funding model.”

Our proposal identified that we would examine the following sources of information:

1. Review the so-called ‘**grey**’ **literature** (mainly government reports from Australia and overseas) to identify palliative care service approaches, models, structures and funding.
2. Review **DHS internal reports** on the delivery of palliative care to the extent that these are available.
3. Review **palliative care specific studies and published material** in relation to service delivery and funding approaches in Australia and selected overseas jurisdictions. We would assess not only the structure/nature of service delivery but any basis that underpinned the service delivery system. The same applies for the structure/composition of funding and the basis that underpinned the funding model. Within this set of documents we would include:
  - The Palliative Care Australia guidelines;
  - The Centre for Palliative Care review. Palliative Care Australia;
  - The CareSearch Palliative Care Knowledge Network out of Flinders University; and
  - The Centre for Palliative Care Education and Research (St Vincent’s and University of Melbourne);
4. Review of **other health care program studies and published material** in relation to service delivery and funding approaches in Australia and selected overseas jurisdictions, which could translate to the palliative care context. This would include:
  - The King’s Fund Programme for Improving End of Life Care; and

- The US National Palliative Care Research Centre (together with the Centre to Advance Palliative Care).

## A.2 Review questions & parameters

There are some overarching questions and parameters that are relevant to the development of both a Service Delivery Framework and a Funding Model for palliative care services. These questions will form part of the literature review and include:

- What are the objectives and goals guiding the delivery of palliative care?
- How can the goals and experiences of clients and their families and carers be incorporated?
- What criteria, indicators and outcomes can be used to assess the effectiveness of palliative care?

### A.2.1 Service delivery frameworks

Questions relating to Service Delivery Frameworks include:

- Are there distinctive *models of care* evident in palliative care services in other jurisdictions?
- How are palliative care services *organised and structured* in other jurisdictions?
- What are the *components or elements*<sup>1</sup> that comprise the difference approaches to service models for palliative care?
- What are the relevant *workforce* disciplines and staff involved in the delivery of palliative care and how are they organised (e.g. multidisciplinary teams)?
- What approaches are used in *coordination*, both within palliative care services, and between palliative care services and other health, community and aged care services? For example:
  - Care pathways and guidelines?
  - Networking and referral arrangements?
  - Communication protocols?
- How are *teaching, training and education* needs integrated in palliative care service delivery models?
- How is *research* integrated in palliative care service delivery models?
- What are the *settings* in which palliative care services are provided?
- What particular resourcing, such as equipment and infrastructure, is used in different models of care for palliative care services?

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<sup>1</sup> This includes bereavement services as one element of the service model.

- How are palliative care services organised around particular *populations*?
  - How is patient eligibility determined?
  - Are there geographic patient catchments, disease or condition-specific sub-populations or some other criteria?
  - How are the needs of particular populations<sup>2</sup>, who may be disadvantaged, best met?
  - What are the patient streams by which palliative care services are organised?
  - How is patient access assured?
- How does the service delivery framework include consideration of patients', families' and carers' needs and preferences?
- Are service delivery frameworks sustainable; from the perspective of workforce, efficiency, infrastructure, amongst others? To what extent do existing service delivery frameworks reflect current workforce availability?
- How effectively do service models reflect the policy parameters within which they operate?
- What should future models of palliative care services look like? Are there innovations and new models that are more client-focussed?

## A.2.2 Funding models

Questions relating to funding models include:

- What are the existing funding models in use for palliative care?
- What are their key characteristics? What is the scope or breadth of palliative services covered by funding models (e.g. acute generalist care, specialist care, community-based palliative care)?
- What behaviour do these models drive? What is the expected impact based on the incentives included in such models?
- What are the other major ways in which funding models can be organised, based on examining the approach to funding of other health and sub-acute services?
- What are the criteria that might be used to evaluate the effectiveness of a funding model?
- What are the criteria that demonstrate a sustainable funding model?

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<sup>2</sup> This includes, for example, CALD and indigenous populations to the extent that it needs to align with other projects being undertaken within DHS.

- What are the options around a two-tiered approach to funding and purchasing of palliative care services? This goes to the issue of the potential role of purchasing intermediaries such as regions or palliative care consortia.