



IHACPA

Pricing Framework for Australian Public Hospital Services 2025–26

Consultation report

December 2024

Pricing Framework for Australian Public Hospital Services 2025–26 — Consultation Report December 2024

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Abbreviations

Abbreviation	Full term
ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AHR	Avoidable hospital readmission
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
ANAPP	Australian Non-Admitted Patient Classification Project
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
APC	Admitted patient care
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
COVID-19	Coronavirus disease 2019
DCID	Diagnosis cluster identifier
DRG	Diagnosis Related Group
eMR	Electronic medical record
HAC	Hospital acquired complication
HoNOS	Health of the Nation Outcome Scales
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive care unit
IHACPA	Independent Health and Aged Care Pricing Authority
LHN	Local hospital network
NAPEDC	Non-Admitted Patient Emergency Department Care
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NMDS	National minimum data set
NWAU	National weighted activity unit
PBS	Pharmaceutical Benefits Scheme
The mid-term review	Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report
UDG	Urgency Disposition Group

1. Introduction

1.1 About IHACPA

The Independent Health and Aged Care Pricing Authority (IHACPA) was established under the *National Health Reform Act 2011* (NHR Act) to improve health outcomes for all Australians.

IHACPA enables the implementation of national activity based funding (ABF) of public hospital services through the annual determination of the national efficient price (NEP) and national efficient cost (NEC). These determinations play a crucial role in calculating the Commonwealth funding contribution to Australian public hospital services and offer a benchmark for the efficient cost of providing those services as outlined in the National Health Reform Agreement (NHRA).

1.2 About this consultation report

The Pricing Framework for Australian Public Hospital Services is one of IHACPA's key policy documents and underpins the approach adopted by IHACPA to determine the NEP and NEC for Australian public hospital services.

IHACPA conducted a public consultation on the key issues to be included in the Pricing Framework for Australian Public Hospital Services 2025–26 through the [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26](#).

The consultation period ran from 8 May 2024 to 7 June 2024. IHACPA invited submissions from the Australian Government, state and territory health departments, professional health organisations, the private health industry and other interested members of the Australian public.

IHACPA received 28 submissions to the consultation paper from a diverse range of stakeholders. Key themes arising from the consultation feedback are summarised in this report, corresponding with the chapters in the pricing framework 2025–26. This stakeholder feedback has informed the development of the pricing framework 2025–26, including the decisions that underpin the NEP and NEC Determinations 2025–26 (NEP25 and NEC25).

IHACPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. The key decisions for NEP25 are outlined in the pricing framework.

All submissions have been made available on [IHACPA's website](#), unless they were marked confidential for commercial or other reasons.

Recommendations from the Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report and development of an Addendum to the NHRA 2025–30

In December 2023, the Australian Government released the Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report. The Addendum to the NHRA 2020–25 is due to end on 30 June 2025 and negotiations to develop an Addendum to the NHRA for 2025–30 are underway. In submissions received for the consultation paper, several stakeholders highlighted the potential for future changes in the Addendum to the NHRA 2025–30 to impact the national pricing model.

IHACPA recognises that the Addendum to the NHRA 2025–30 may include changes or new provisions that would have significant implications for how the NEP and NEC are developed, and the potential development of alternate funding models for certain cohorts. As decisions regarding the development of the Addendum to the NHRA 2025–30 are yet to be finalised, the national pricing model underpinning NEP25 and NEC25 will be based on the requirements set out in the NHR Act and the Addendum to the NHRA 2020–25.

2. Pricing guidelines

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the Pricing Guidelines but received feedback from a small number of stakeholders.

Feedback received

New South Wales (NSW) recommended that IHACPA update the System Design Guideline 'Using activity based funding (ABF) where practicable and appropriate' to include a caveat that this approach should also reflect the clinical care provided. NSW noted that this proposed addition aligns with the 'Patient-based' System Design Guideline which states that 'Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable'.

The Australian College of Rural and Remote Medicine (ACRRM) noted the 'Fairness' Overarching Guideline may lead to perverse outcomes if ABF payments are based on the same price for the same service, given the differences in scale, logistics, workforce and other supporting services that impact rural hospital service delivery.

Catholic Health Australia recommended that IHACPA play a greater role in ensuring the Pricing Guidelines of efficiency, financial stability, transparency and accountability are upheld by all parties to the National Health Reform Agreement (NHRA), through increased reporting of funding spent by state and territory governments, to ensure the intent of the NHRA is met.

IHACPA's response

With respect to the feedback provided by NSW, IHACPA notes that the national pricing model is underpinned by classification systems and activity and cost data collections that are developed and updated to reflect models of clinical care provided by public hospitals. Decisions pertaining to using ABF where practicable and appropriate are informed by extensive consultation with stakeholders through IHACPA's Technical Advisory Committee, Jurisdictional Advisory Committee and Clinical Advisory Committee.

Regarding ACRRM's proposed change to the 'Fairness' Overarching Guideline, IHACPA notes the existing wording includes a caveat that ABF payments also recognise the legitimate and unavoidable cost variations faced by some providers of public hospital services and the need for appropriate pricing adjustments. Examples of these adjustments include the existing patient treatment or patient residential remoteness area adjustments.

The Pricing Guidelines outline the overarching, process and system design guidelines within which the Pricing Authority makes its policy decisions. However, the Pricing Guidelines are exclusively limited to how IHACPA fulfils its requirements under the *National Health Reform Act 2011* and the NHRA. IHACPA does not have the authority to ensure these Pricing Guidelines are applied by all parties to the NHRA.

IHACPA does not propose any changes to the Pricing Guidelines for the Pricing Framework for Australian Public Hospital Services 2025–26. Following the finalisation of the Addendum to the NHRA 2025-30, IHACPA will review the Pricing Guidelines in full, to ensure they reflect any changes in the new addendum.

3. Scope of public hospital services

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the scope of public hospital services but received some feedback on this area.

Feedback received

GPEX recommended IHACPA consider the inclusion of the shared care model on the General List of In-Scope Public Hospital Services 2025–26. This model of care provides joint responsibility and collaboration for planned care between a specialist, often hospital-based, and a general practitioner or other primary care provider. They also requested the establishment of a specific class with the Tier 2 Non-Admitted Services Classification (Tier 2) for shared care services training, accreditation and quality improvement.

IHACPA response

IHACPA notes that the Mid-Term Review of the Addendum to the National Health Reform Agreement (NHRA) 2020–25 acknowledged the increasing intersection between the hospital, aged care, disability and primary care sectors and recommended greater collaboration between the sectors to support the timely discharge of long stay patients out of hospital when clinically appropriate. The mid-term review also recommended expansion to the scope of public hospital services eligible for funding to incorporate services provided beyond the hospital door.

Services in the shared care model that are provided as part of a public hospital service, or satisfy the definition and requirements of a non-admitted service event¹, may meet the criteria for Tier 2 non-admitted service events and be considered in-scope for funding under the NHRA.

However, state and territory governments are responsible for providing submissions to the general list each year, under the General List of In-Scope Public Services Eligibility Policy. This includes proposal of innovative models of care for inclusion on the general list. IHACPA considers all submissions on an annual basis in line with the criteria and assessment process outlined in the policy, to align with the development cycle of the national efficient price and national efficient cost determinations. IHACPA is unable to consider inclusion of the shared care model on the general list for 2025–26 as the submission was not provided by a jurisdiction.

Following the finalisation of an Addendum to the NHRA 2025–30, IHACPA will review its policy to account for any changes to scope of public hospital services.

¹ A non-admitted patient service event is defined as an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record. The interaction may be for assessment, examination, consultation, treatment and/or education. Further information is available in the [Tier 2 Non-Admitted Service Compendium 2024–25](#).

4. Classifications used to describe and price public hospital services

4.1 Admitted acute care

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the acute care classifications but received feedback from a number of stakeholders on this area.

4.1.1 Cluster coding

Feedback received

The Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26 noted that IHACPA is proposing to implement cluster coding from 1 July 2025, in conjunction with the Thirteenth Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM); Australian Classification of Health Interventions (ACHI); Australian Coding Standards (ACS), collectively known as ICD-10-AM/ACHI/ACS.

Some stakeholders including New South Wales (NSW) and Austin Health raised the following concerns regarding the introduction of cluster coding:

- potentially significant burden of training and education required to support implementation
- ongoing coder workforce recruitment challenges and potential increase in queries related to correct coding practice
- changes to coding practice and advice may result in poor compliance, incorrect data and further delays in the monthly coding completion time.

The Northern Territory (NT) noted its inability to implement cluster coding prior to July 2025, and Austin Health recommended delaying implementation until the issues related to the coder workforce are addressed.

In early 2024, IHACPA undertook a pilot exercise for clinical coders to test allocation of the ACS 0004 *Diagnosis cluster identifier* (DCID), which was developed to test consistency of DCID allocation. NSW requested that the results from the pilot be circulated to jurisdictions prior to any planned implementation.

IHACPA's response

IHACPA has consulted widely in progressing its proposal to implement cluster coding, receiving in-principle support from stakeholders who acknowledge the immediate and longer term benefits of enhancing the utility of coded data. While acknowledging these benefits, particularly for safety and quality reporting, some stakeholders have also raised challenges in being able to make the necessary system changes in time to allow reporting of the DCID and potential clinical coder burden amidst ongoing workforce challenges.

IHACPA notes that all new editions of ICD-10-AM/ACHI/ACS inevitably create some burden for clinical coders, however, that burden lessens as familiarity with the new edition increases. However, based on this feedback and engagement to date, IHACPA has developed a broad range of measures to address the issues raised, particularly to minimise the burden on clinical coders and ensure consistency in reporting. For this reason, a staged implementation has been proposed with only a small number of conditions included for clustering in the initial implementation, prior to full implementation, to increase understanding and familiarity among coders.

Additionally, IHACPA has implemented the following measures to support the introduction of cluster coding and to mitigate issues raised by stakeholders:

- Development of the metadata to implement cluster coding, that is the [diagnosis array data set specification](#) that includes the DCID data element.
- Creation of a supplementary DCID value for health services or individual hospitals that are not able to report the DCID immediately. This supports the implementation of cluster coding in conjunction with ICD-10-AM/ACHI/ACS Thirteenth Edition even if the DCID does not flow through health information systems for reporting, allowing those jurisdictions that require additional time to update their systems to report DCID values.
- Development of an ACS to support national implementation – ACS 0004 *Diagnosis cluster identifier (DCID)*, that will provide guidance for clinical coders as part of ICD-10-AM/ACHI/ACS Thirteenth Edition.
- Conducting a pilot exercise to test the application of the new ACS 0004 *Diagnosis cluster identifier (DCID)* which demonstrated that allocation of the DCID using the proposed ACS was generally well understood by participants. The pilot also provided further opportunity to revise ACS 0004 prior to implementation. The Diagnosis Cluster Identifier Pilot Final Report has been distributed to jurisdictional stakeholders and published on IHACPA's website.
- Enhancements to electronic code lists for ICD-10-AM codes to support implementation by identifying codes that require clustering and enabling reporting edits to be applied.
- An industry briefing for software vendors to facilitate automation in coding software in advance of implementation.
- Development of targeted education for clinical coders and data users informed by the pilot and other feedback, which will be available through [IHACPA Learn](#).

For the NEP Determination 2025–26 (NEP25), IHACPA intends to use ICD-10-AM/ACHI/ACS Thirteenth Edition, and continue to use Australian Refined Diagnosis Related Groups Version 11.0, to price admitted acute patient services. This will include the implementation of cluster coding.

4.2 Subacute and non-acute care

IHACPA did not ask any specific consultation questions on the subacute and non-acute classifications but received feedback from a small number of stakeholders on this area.

Feedback received

Some stakeholders recommended a range of potential refinements to the next iteration of the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP), for future consideration. These included:

- consideration of an alternative complexity model that uses an overall patient complexity score
- new subclass for patient custodial status in each care type
- new models of care or pathways and how they intersect with aged care and disability sectors, such as maintenance care type for patients ready for discharge
- refinements to better identify patients who may require more complex care such as patients who are homeless, have mental health conditions, a physical or intellectual disability, patients in remote areas or those who reside in a residential aged care facility.

IHACPA's response

IHACPA will price subacute and non-acute services using AN-SNAP Version 5.0 for the NEP25.

Many of the proposed refinement areas are part of the work program for the development of future versions of AN-SNAP. IHACPA will consult with its working groups and advisory committees once the Addendum to the National Health Reform Agreement (NHRA) 2025–30 is finalised and the impact of any changes to the scope of public hospital services eligible for funding have been considered.

4.3 Emergency care



What, if any, barriers are there to pricing emergency department (ED) presentations using the Australian Emergency Care Classification (AECC) Version 1.1 without a shadow pricing period for NEP25?

Feedback received

Queensland (Qld), South Australia (SA), Western Australia (WA), Tasmania (Tas) and the NT supported IHACPA's proposal to price ED presentations using AECC Version 1.1 without shadow pricing. The NT requested the provision of a funding impact assessment prior to pricing for NEP25.

NSW noted minimal staff education and training as a barrier to pricing ED presentations using AECC Version 1.1. Victoria (Vic) noted that differences in how the point of admission is defined across jurisdictions results in costs being inconsistently allocated to emergency and admitted episodes. Vic recommended IHACPA consider providing more guidance on the point of admission.

The Queensland Nurses and Midwives' Union (QNMU) requested IHACPA provide clarification on the intended changes to AECC Version 1.1 prior to implementation.

IHACPA's response

AECC Version 1.1 was released in August 2024 and represents a modest refinement to the classification. The key refinements include updates to the complexity model based on the most recent national activity and cost data. IHACPA proposes to price ED presentations using AECC Version 1.1 for NEP25, without a shadow pricing period, given the updates included in Version 1.1 do not represent a significant structural change to the classification. This approach is aligned with IHACPA's [National Pricing Model Consultation Policy](#) and [Shadow Pricing Guidelines](#), whereby classification changes require shadow pricing where major structural changes occur or where new data elements are introduced.

To support its implementation, IHACPA will provide further detail regarding the changes included in AECC Version 1.1 including funding impacts, prior to the finalisation of NEP25. With respect to NSW's feedback regarding staff education and training as a barrier to pricing, IHACPA notes that the changes being introduced will not impact how data is collected and reported by clinicians. Therefore, the introduction of AECC Version 1.1 should not require further education or training to support its implementation.

IHACPA uses the Australian Institute of Health and Welfare's (AIHW) Metadata Online Registry Non-admitted patient emergency department care national minimum data set (NAPEDC NMDS) for the purposes of defining ED and admitted patient care (APC) data collection. The NAPEDC NMDS acknowledges that there is overlap between ED and APC data collections. Specifically, an admitted episode begins when the patient is admitted but the ED episode does not end until the patient leaves the ED. This allows states and territories to determine how emergency care is reported based on the nature of the service provided to the patient. APC data request specifications also contain line items to capture overlapping data.



Are there any other proposed refinement areas to be considered in the development of an updated version of the AECC?

Feedback received

Stakeholders, including NSW, Qld, WA, SA, NT, Tas, the Australasian College for Emergency Medicine (ACEM), the Australian Physiotherapy Association (APA) and the QNMU, proposed a range of different areas for potential refinement in the development of an updated version of the AECC. These included:

- refinements to better account for patient complexity such as patients presenting with mental health conditions, experiencing homelessness, substance use, people living with disability, psychological complexity or patients who identify as First Nations' peoples
- development of clinically relevant admission criteria for complex patients
- additional price weights for mental health patients who require additional resources and for resuscitation patients

- improvements in data capture for:
 - care performed by nurses, multidisciplinary teams and advanced practice allied health workers in the ED including assessment, investigation, intervention, and discharge
 - nursing procedural work in ED
 - resourcing for teaching and training.
- inclusion of maternity assessment centre models and the Geriatric Emergency Department Intervention model
- inclusion of safe care units as an indicator of patients presenting with addiction
- identification of flow on costs of patients presenting to EDs due to limited access to primary care services
- improved reporting of ED speciality consultations.

NSW noted that diagnosis may not always reflect complexity and raised concerns with the use of urgency as an indication of patient complexity. In some cases, low urgency patients may require more investigation and complex care compared to some higher urgency patients.

The NT recommended that IHACPA review the diagnosis modifier for homelessness on the performance of the AECC, noting that patients experiencing homelessness are likely to remain in the ED for longer and/or experience extended inpatient lengths of stay.

ACEM recommended that IHACPA conduct a costing study on the prolonged length of stay in EDs to ensure that pricing adequately reflects ED overcrowding.

IHACPA's response

IHACPA released AECC Version 1.0 in 2019 and it intended to provide a classification system for emergency care that better reflected patients' emergency care requirements and complexity. AECC Version 1.0 has been used to price ED presentations since the NEP Determination 2021–22. IHACPA continues to consult with jurisdictions and specialist stakeholders to develop future iterations of the AECC, with a view to ensure the classification remains fit for purpose and clinically relevant. IHACPA intends to review the following refinements for future versions of the AECC:

- incorporation of Emergency Care Diagnosis Groups to ensure that conditions are grouped in a clinically meaningful way, and accurately reflect the cost of patient complexity
- inclusion of complexity scores for paediatric patients, frailty in older patients and additional diagnoses codes for comorbidities and diagnostic modifiers
- inclusion of an interventions variable to capture investigations and procedures including, pathology, imaging and other diagnostic investigations, life support, respiratory and cardiology procedures, and other procedures provided by specialty consultants, nurses and allied health professionals.

IHACPA notes stakeholder concerns regarding use of principal diagnosis in the AECC. Principal diagnosis plays an important role in understanding patient complexity in the emergency care classification as it reflects the patient's reason to seek emergency care. However, principal diagnosis is not the only variable used to assign a complexity score to each presentation. Complexity levels are also calculated using the patient's type of visit, episode end status, triage category, transport mode and age.

IHACPA intends to assess urgency, ED overcrowding and performance as part of the work program for future versions of the AECC. To support this, IHACPA is currently developing a governance framework to guide the refinement of AECC in consultation with its Emergency Care Advisory Working Group. The governance framework aims to ensure that proposed changes are assessed against a consistent set of policy principles and decisions making tools.



Are there any barriers or known issues associated with reporting patient level data, specifically in relation to reporting principal diagnosis and patient's age in emergency services?

Feedback received

Stakeholders, including NSW, Vic, Qld, SA, NT, Tas, the APA and QNMU, noted the following barriers, specifically in relation to reporting principal diagnosis and patient's age in emergency services in rural, remote and smaller hospitals:

- limited capacity and workforce, particularly in rural areas
- lack of standardised education and training and the need for sufficient supporting materials to assist clinicians and clinical coders in using appropriate diagnosis codes
- lack of consistency in the coding and language used interoperability with other administration systems in smaller hospitals.

Vic noted a pilot project is underway that is exploring the feasibility of small rural health services collecting and reporting patient-level data including principal diagnosis and date of birth. The pilot project is due to conclude in September 2024.

SA noted that the AIHW currently report on patient level data and the shift to reporting patient level data would need to align with the AIHW's reporting requirements to enable a single submission to be used for multiple purposes.

SA noted that the continued roll-out of electronic medical records (eMR) will improve data collections over time. QNMU recommended consideration of using eMR systems to automatically capture principal diagnosis data and reduce the burden on health practitioners.

IHACPA's response

IHACPA notes the range of barriers to reporting principal diagnosis and will continue to work with its working groups and advisory committees to address these issues where possible within its remit. IHACPA notes the importance of minimising duplication in reporting requirements between IHACPA and the AIHW and will continue to work with stakeholders to achieve this wherever possible.

4.4 Non-admitted care



Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification (Tier 2) for NEP25?

4.4.1 Tier 2 Non-Admitted Services Classification

Feedback received

Stakeholders, including NSW, Vic, WA, and Tas, recommended the following potential refinement areas for Tier 2 for 2025–26:

- inclusion of multi-disciplinary meetings where multiple clinicians are present, including virtual meetings
- clinician discussions where a patient is not present
- diagnostic services associated with medical consultations in the 20 series
- development of a Tier 2 code specific to voluntary assisted dying due to the slowly increasing volume of this activity nationally and challenges in existing data reporting because of the confidential nature of the service
- consideration of innovative models of care and technologies or changes in models of care and technologies and nurse-led models of care
- accounting for the differences in resources required for different interventions under clinic 40.20 *Alcohol and other drugs*
- inclusion of clinic for care provided by advanced practice allied health practitioners.

Additionally, the Directors of Physiotherapy Services Queensland Health and Queensland Musculoskeletal Physiotherapy Screening Clinic and Multi-disciplinary Service Network, and the APA noted that the general physiotherapy outpatient treatment code 40.09 does not reflect the nature of advanced physiotherapy services. They recommended a specific 20 series code or to revise the 40 series code for advanced physiotherapist-led clinics to:

- reflect the range of specialty areas that these services operate in
- reflect the higher cost and value of services delivered by advanced physiotherapists
- account for pathways that combine referrals from multiple specialties
- increase sustainability of the classification to expand into new specialty areas and reflect innovative service models.

The QNMU recommended the exploration of midwifery and nurse-led models in Tier 2, including:

- enabling nurse practitioner's access to clinics within the 10 series to increase sustainability of service models
- strengthening home telehealth consultations for nurse practitioners under the 20 series
- endorsing midwives and clinical nurse specialists to align with in-person price weighting per specialty
- inclusion of patient education and monitoring of chronic conditions as activities available under the 40 series
- expansion of the list of interventions to capture services provided by nurse navigators.

The QNMU also requested clarification regarding how non-admitted service events delivered by telehealth and provided by a medical practitioner and a nurse practitioner are costed.

NSW and the Australian and New Zealand Society of Nephrology noted concern with the reductions in the price weights for Parenteral Nutrition (PN) and Home Peritoneal dialysis (HPD) between the NEP Determination 2023–24 and the NEP Determination 2024–25. They recommended that IHACPA review the costs associated with PD and HPD and make the analysis publicly available to assist hospital units and jurisdictions.

IHACPA's response

For NEP25, IHACPA consulted with its Non-Admitted Care Advisory Working Group (NACAWG) and advisory committees to support the amendments to Tier 2 classes 40.48 *Haematology and immunology* to improve data capture for nurse-led rheumatology services and 10.20 *Radiation therapy – simulation and planning* to better reflect modern clinical practice and the complexity of care provided in these clinics. Additionally, IHACPA will retire the class 40.34 *Specialist mental* to support the transition of community mental health care to ABF. The changes to the classification will result in a new version of Tier 2, Version 9.1.

In response to a new class for voluntary assisted dying, IHACPA will work with its working groups and advisory committees to assess and review this proposal for NEP Determination 2026–27.

IHACPA considered the introduction of a new class for advanced practice physiotherapy through NACAWG in 2023. Based on state and territory feedback and the preference for Tier 2 refinement to focus on classes that group activity on patient and clinical factors rather than provider groups, IHACPA proposed not to proceed with the new class.

IHACPA intends to consider improvements to capturing patient complexity, treatment of multiple healthcare providers, innovative models of care and services provided or led by advanced practice physiotherapists as part of the development of a new non-admitted classification through the Australian Non-Admitted Patient Classification Project (ANAPP).

In response to feedback received from the QNMU, IHACPA notes that the 10 series procedural classes in Tier 2 are provider agnostic and focus on the activity rather than who provides the service, as outlined in the [Tier 2 Non-Admitted Services Definition Manual](#). In response to home telehealth consultations under the 20 series, these are equivalent to an in-person consultation. Additionally, patient education and monitoring of chronic conditions is included in a number of 40 series classes. Where activity meets the definition of a non-admitted patient service event², this activity can be reported to the most relevant Tier 2 class.

² A non-admitted patient service event is defined as an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record. The interaction may be for assessment, examination, consultation, treatment and/or education. Further information is available in the [Tier 2 Non-Admitted Service Compendium 2024–25](#).

The Tier 2 price weights are also location agnostic and do not vary for services delivered in-person or via telehealth as the classification focuses on patient and clinical factors, rather than the provider. IHACPA is investigating improvements to capture virtual care to ensure that the NEP and the national efficient cost determination remains reflective of changing models of care and cost profiles of health care delivery over time.

IHACPA acknowledges the concerns raised around accurate pricing for the delivery of PN and HPD. However, price weight changes have resulted from an annual and ongoing program of work to refine the national pricing model, based on data driven, evidence-based methodologies, and in consultation with jurisdictions and clinical stakeholders. Specifically, the transition to using actual activity and cost data reported by states and territories through the National Hospital Cost Data Collection (NHCDC) for these classes. These changes were made after rigorous analysis and consultation with state and territory governments, and have meant that pricing is reflective and more responsive to changes in the actual costs associated with the delivery of this service over time. IHACPA does not intend to undertake further work to investigate these changes at this stage however the price weights will be reviewed as part of IHACPA's annual review of Tier 2 price weights in the development of the NEP25.

4.4.2 Tier 2 Non-Admitted Services Classification – documentation

Feedback received

NSW, Vic, and WA requested the following updates to Tier 2 documentation:

- alignment between the Compendium, Definitions Manual and the Metadata Online Registry resources regarding both multidisciplinary clinics and multidisciplinary case conferences
- clarification of definitions for specialties and professions and what comprises a unique service
- update to the Definitions Manual to separate community and primary care from non-admitted care provided at hospitals
- update to the name of 'Subcutaneous Immunoglobulin home delivered' to 'Subcutaneous Immunoglobulin home administered'
- clarification around the Tier 2 classes 40.07 *Pre-admission and pre-anaesthesia* and 40.59 *Postacute care*.

IHACPA's response

IHACPA will retain the title for 10.22 *Subcutaneous Immunoglobulin (SCIg) infusion therapy - home delivered* to ensure consistency with other home delivered classes in the 10 series. IHACPA notes that the [Tier 2 Non-Admitted Services Definitions Manual](#) provides information on the definition of service and activity related to class 10.22.

IHACPA intends to update the Tier 2 Compendium and Definitions Manual in line with any refinements made to the classification for NEP25. IHACPA will consider the other feedback provided in making these updates, in consultation with NACAWG and its advisory committees.

4.4.3 A new non-admitted care classification

Feedback received

Qld, SA, WA, Catholic Health Australia (CHA), QNMU and Medtronic indicated support for the commencement of the ANAPP.

CHA recommended private hospital involvement in ANAPP and specialised training on the implementation of the classification in private hospitals. QNMU suggested consideration be given to how data will be captured in settings that do not use eMR as part of the ANAPP.

IHACPA's response

IHACPA is currently in the second stage of the ANAPP that focuses on the development of a data model and methodological processes to test whether the data extracted from state and territory eMR systems can be transformed into a useful format for classification development. The outcomes from Stage 2 will inform how later stages will be implemented including, the collection of data from state and territory eMR systems and cost data from established sites, and the development of a final activity and cost data set. IHACPA will continue to consult NACAWG and its other advisory committees throughout the ANAPP.

IHACPA will publicly consult with stakeholders on the structure and characteristics of a new non-admitted care classification during a later stage of the ANAPP. ANAPP does not include the implementation of the new classification. This will be a separate project once the classification is developed and will include the development of educational materials to support the consistent application of the new classification.

4.5 Mental health care

4.5.1 Refinements to the Australian Mental Health Care Classification

Feedback received

NSW requested a review of the AMHCC and proposed the following refinements for consideration for Version 1.1:

- treatment of age within the complexity score
- extension of legal status across age groups
- inclusion of diagnosis within the complexity score
- inclusion of a same-day end class for eating disorders
- consideration of short stay classes where the National Outcomes and Casemix Collection does not require outcome measures to be undertaken
- recognition of mental health legal status by way of an additional price weight to remunerate these classes
- services for managing mental health consumers in an ambulatory setting.

The QNMU recommended the following areas for refinement of the AMHCC Version 2.0:

- development of a governance and accountability framework
- public reporting on performance and outcomes
- consideration of complexity and variability of mental health services
- coordination of mental health and National Disability Insurance Scheme (NDIS) systems.

IHACPA's response

The development cycle and work program for AMHCC Version 1.1 was finalised in December 2023. IHACPA will investigate incorporating the proposed refinements as part of its future work program for AMHCC.

IHACPA has commenced development of the AMHCC Version 2.0 work program that includes refinement to treatment of age, same-day treatments and diagnosis within the complexity model, expansion of age grouping, Abbreviated Life Skills Profile-16 across settings, age and phases. The priority refinement areas being assessed based on the [Governance Framework for the Development of the Australian Mental Health Care Classification](#) and supporting data analysis. As part of the AMHCC Version 2.0 refinement work program, IHACPA is undertaking a broader review of the various forms of legal status and current reporting in the community setting. This will include an investigation into forensic mental health to determine if there is a cost differential in delivering these services. IHACPA is reviewing any cost differentials as part of the development of the cost model for NEP25, where forensic mental health services can be identified in reported data and may inform the development of any transitional pricing arrangement for these services if significant discrepancy in the cost differentials is found.

IHACPA is not considering the inclusion of residential mental health services during the development of AMHCC due to the insufficient cost and activity data available for these services. IHACPA encourages state and territory governments to submit cost and activity data to enable development of a residential mental health care classification.

IHACPA will continue to consult IHACPA's Mental Health Working Group and its advisory committees on the development of AMHCC Version 2.0.

4.5.2 Pricing admitted and community mental health care using the Australian Mental Health Care Classification Version 1.1



What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification (AMHCC) Version 1.1 for NEP25?

Feedback received

States and territories provided a range of feedback in regard to the proposal to price admitted and community mental health care services using AMHCC Version 1.1 for NEP25. Specifically:

- NSW identified a range of reporting, implementation and classification related barriers in using AMHCC Version 1.1 to transition community mental health care services from block funding to activity based funding (ABF). These included the refinements to the classification to allow for anonymous services, concurrent episodes for different settings, and variability in data provision between states and territories.
- Vic identified a range of classification and pricing related barriers, including higher price weights for Unknown Health of the Nation Outcome Scales (HoNOS) end classes and requirements for consistent HoNOS scores across age ranges, not allowing concurrent community mental health episodes and limitations in the pricing of forensic mental health services.
- Qld did not support pricing admitted or community mental health care services using AMHCC Version 1.1 for NEP25 and recommended an additional year of shadow pricing, due to the classification update being based on coronavirus disease 2019 (COVID-19) impacted data. However, they noted that Qld will be transitioning its community mental health services to ABF in 2024–25 through the Qld ABF model.
- WA did not identify any barriers to pricing admitted and community mental health care services using AMHCC Version 1.1 for NEP25.
- Tas noted concern that the end classes within the community setting of the AMHCC may not reflect resource homogenous groups, particularly where multiple clinicians may be involved in a single consumer contact.
- NT noted concern with AMHCC Version 1.1 not reflecting the costs of delivering community mental health services in remote off-campus locations.
- SA supported the changes in AMHCC Version 1.1 and did not note any barriers to its use to price admitted mental health care services for NEP25. SA also provided in-principle support for pricing community mental health care services using AMHCC Version 1.1, however it noted potential limitations in the quality of the community mental health data collected and its reliability to accurately reflect the costs of providing these services. SA requested continuation of work to explore residential mental health and other areas of mental health in the classification.

The AMA noted concerns about the appropriateness of transitioning community mental health care services to ABF, noting challenges with capturing the breadth and complexity of services provided and the need to balance efficiency with ensuring the provision of preventative care.

The Royal Melbourne Hospital noted limitations to reporting and data collection systems, along with challenges in implementation across states and territories and in rural and remote areas, as the primary barriers to pricing admitted and community mental health using AMHCC Version 1.1 for NEP25.

IHACPA's response

Transition from block funding to activity based funding

Clause A3 of the Addendum to the NHRA 2020–25 and the pricing guidelines outline that Commonwealth funding is to be provided on the basis of ABF except where it is neither practicable nor appropriate. Since 2012, IHACPA has worked to develop the AMHCC, with a view to transition community mental health care services to ABF in line with the intent of the NHRA and to improve transparency by enabling funding to be based directly on the volume, type and complexity of care provided to consumers. In April 2024, IHACPA set out the requirements and expectations of the state and territory governments to facilitate the transition of community mental health care to ABF for NEP25. Throughout 2024, IHACPA has been working closely with jurisdictions through bilateral meetings, working groups and advisory committees to address the concerns raised.

IHACPA has developed a number of short term transitional pricing measures that are considered to be within its remit, to mitigate any potential risks associated with the transition of community mental health care to ABF. This has included the consideration of options for transitional arrangements to support funding stability year-on-year such as block funding for rural local hospital networks (LHNs) delivering a low volume of community mental health services and specialised standalone establishments delivering specialised forensic mental health services. IHACPA has also developed a proposed composite ABF and block funding approach for services that would otherwise be subject to ABF based on the activity reported by each state or territory to mitigate significant funding disruptions. Further information about the block funding approaches for the National Efficient Cost Determination 2025–26 is outlined in Chapter 5 of the pricing framework.

For NEP25, IHACPA intends to price admitted and community mental health care using AMHCC Version 1.1, without a shadow pricing period, as the updates included in Version 1.1 do not represent a significant change to the classification structure and do not include new data elements. This approach aligns with IHACPA's [National Pricing Model Consultation Policy](#) and [Shadow Pricing Guidelines](#), whereby classification changes only require shadow pricing where major structural changes occur or where new data elements are introduced.

IHACPA notes it shadow priced community mental health care services using AMHCC Version 1.0 for 4 years. The proposed approach to use AMHCC Version 1.1 seeks to align the pricing of both admitted and community mental health care services by using the same classification version, and incorporate the benefits of using an updated classification for pricing.

Data quality and reporting issues

IHACPA has worked closely with jurisdictions to support the implementation of AMHCC Version 1.1, including providing guidance on reporting of particular services within the classification.

IHACPA is also providing advice on how anonymous services or innovative models of care where consumers are required to be de-identified, can be appropriately classified using AMHCC Version 1.1, where such services are in-scope and meet the mental health care type. IHACPA notes stakeholder feedback around the potential incentives arising from the shadow price weights for Unknown HoNOS and Unknown Mental Health Phase of Care and intends to impose price caps, where appropriate, to support accurate data reporting.

With respect to the use of COVID-19 impacted data, during classification development for AMHCC Version 1.1, IHACPA provided analysis to its Mental Health Working Group (MHWG), Technical Advisory Committee (TAC) and Jurisdictional Advisory Committee (JAC) to examine the impact of the pandemic on data collected. Agreement was received from the MHWG, TAC and JAC for COVID-19 impacted data to remain in the dataset for AMHCC Version 1.1 development as it had minimal impacts on the average phase cost observed.

IHACPA will consider the classification-related issues identified by stakeholders as part of the AMHCC Version 2.0 refinement work program, including a broader review of the various forms of legal status and current reporting in the community setting.

4.6 Teaching and training



- Are there any persisting barriers to collecting activity data following the COVID-19 pandemic response? If so, what potential strategies could IHACPA use to support states and territories overcoming these barriers?
- What data-driven processes can be used to determine the efficient cost of teaching and training services to improve the transparency of block funded amounts provided for these services, ahead of a potential longer-term transition to ABF?

Feedback received

A range of stakeholders including NSW, Qld, WA, the Australian College of Rural and Remote Medicine (ACRRM), AMA, and the Directors of Physiotherapy Services Queensland Health and Queensland Musculoskeletal Physiotherapy Screening Clinic and Multi-disciplinary Service Network noted the following barriers to collecting teaching and training activity data:

- resourcing issues to implement changes to classifications
- lower volume of hospital-based placements
- elementary digital systems for data collection
- lack of measurement capability to reflect the additional time to provide care by students compared with clinicians and supervisory time.

SA and the NT noted concerns regarding the appropriateness of the Australian Teaching and Training Classification (ATTC) for the pricing of teaching and training services due to the complexities in collecting and preparing teaching and training data and recommended IHACPA conduct a cost benefit analysis to determine the value of the ATTC.

Stakeholders such as the Office of the National Rural Health Commissioner (ONRHC) and Universities of Australia also proposed the following strategies to support state and territory governments in collecting teaching and training data:

- public health alerts and/or flags to identify activity and impacts of a pandemic or other infectious diseases
- development of a national data collection platform, integrated workflows with eMRs, or expanded roll out of electronic learning management systems
- introduction of a requirement to provide data as a condition for receiving block funding.

Stakeholders, such as Qld, Vic, WA, the College of Intensive Care Medicine of Australia and New Zealand and the ONRHC, noted that teaching and training data is currently collected manually, which creates challenges in the consistency of data collected. Stakeholders recommended the following data-driven processes to determine the efficient cost of teaching and training services:

- using unique student identifiers to understand cumulative costs, placement locations, length of training and speciality pathways across all medical workforce training
- intersections of different Australian Government funded programs such as the Rural Health Multidisciplinary Training Program and other recruitment programs in rural and remote communities
- collecting data through a survey or interview.

ACRRM and the ONRHC noted the importance of dedicated teaching and training funding to support tertiary health education programs, including the Rural Generalist pathway. They recommended that IHACPA engage with the Australian Government Department of Education and the Department of Health and Aged Care to understand placement requirements, costs and payments to public hospitals.

Stakeholders recommended IHACPA consider the following refinements to the ATTC:

- enable flexible and coordinated funding models for teaching and training
- promotion of rurally relevant research, data collection and benchmarking
- representation from rural generalists in discussions related to rural teaching and training
- inclusion of online training activities where appropriate and exploring alternative methods to conduct research, particularly around the adoption of artificial intelligence

- streamline business rules relating to data collection.

IHACPA's response

IHACPA recognises the challenges in collecting teaching and training data particularly in rural areas and the costs associated with data collection for the purposes of ABF. IHACPA intends to work with its advisory committees to develop a workplan to gain a clearer understanding of the composition of existing block-funded amounts for teaching and training and how this funding is distributed across states and territories. Greater transparency in the distribution of these block-funded amounts is essential prior to exploring whether teaching and training activities can be transitioned to ABF, or alternative funding models, or whether block funding amounts can be calculated and determined using a different methodology.

However, IHACPA understands that achieving this, including the analysis to determine whether these activities are suitable for transitioning from block funding to either ABF or an alternative funding model, will require an extended period of time. This process will also need to consider the impact of any new provisions resulting from the implementation of the Addendum to the NHRA 2025–30. In the interim, IHACPA expects teaching, training and research services to continue being block funded as IHACPA consults with state and territory governments to gain a clearer understanding of the composition of existing block funded amounts for these activities.

5. Setting the national efficient price

5.1 Impact of COVID-19



What evidence can stakeholders provide that demonstrates the costs and changes to models of care associated with the coronavirus disease 2019 (COVID-19) pandemic response have persisted into 2022–23, or changed over time?

Feedback received

Stakeholders, such as South Australia (SA), the Australian College of Rural and Remote Medicine (ACRRM) and Queensland Nursing and Midwives' Union (QNMU), noted the following changes to models of care and demand associated with the COVID-19 pandemic response:

- increase in virtual care services including telehealth
- integration of Long COVID-19 clinics within existing clinics
- increase in nursing and midwifery-led models of care including hospital in the home and nurse-led clinics
- increases in length of stay, the need for mental health services, elective surgery waiting lists and treatment of complex patients and changes in patient mix.

Stakeholders, such as New South Wales (NSW), Victoria (Vic) and Queensland (Qld), noted the following changes to costs associated with the COVID-19 pandemic response:

- implementation of new infection protocols, including personal protective equipment, isolation of COVID-19 positive patients in intensive care units (ICU) and disaster and emergency management
- increased workforce costs including leave, wage, recruitment and insurance costs
- flow on costs associated with COVID-19 outbreak responses.

Vic, SA and Western Australia (WA) noted the inflationary pressures associated with the COVID-19 pandemic response.

Additionally, NSW, ACRRM, Catholic Healthcare Australia (CHA), the College of Intensive Care Medicine of Australia and New Zealand (CICM), and the Royal Australasian College of Physicians (RACP) recommended a review of the impact of the COVID-19 pandemic response for the National Efficient Price (NEP) Determination 2025–26 (NEP25). Specifically, stakeholders recommended reviewing the following:

- impact on emergency department presentations and elective surgery admissions
- influenza cases
- implications of Long COVID-19
- public health physician and other non-procedural subspecialty activity during and beyond COVID-19.

Qld and SA expressed support for the continuation of the COVID-19 treatment adjustment. WA noted that as of October 2022, the WA Department of Health requested that health service providers no longer report and identify COVID-19-specific costs separately. Hence the visibility of costs has diminished during 2022–23 as the expectation was for providers to absorb COVID-19 related costs.

IHACPA's response

The Independent Health and Aged Care Pricing Authority (IHACPA) notes that many of the proposed enduring costs or impacts from the COVID-19 pandemic response reflect feedback received in previous years in response to the Consultation Paper on the Pricing framework for Australian Public Hospital Services. IHACPA also notes that states and territories are increasingly incorporating such costs into their ongoing service delivery costs and as such, these costs become difficult to isolate as an impact specifically resulting from the pandemic.

The development of NEP25 uses 2022–23 costed activity data. IHACPA has undertaken analysis to determine whether the impact of the COVID-19 pandemic response endured into 2022–23 and if the measures implemented for the NEP Determination 2024–25 continue to be required for NEP25. The analysis indicated that a COVID-19 diagnosis may continue to be a relevant risk factor in predicting some hospital acquired complications and avoidable hospital readmission categories. Additionally, the analysis indicated that the cost of treating patients with a COVID-19 diagnosis has continued to be substantially higher when compared to patients without a COVID-19 diagnosis patients in a limited number of AR-DRGs, and that these AR-DRGs report high proportions of such patients.

The current pricing model does not fully account for these cost differences through its existing length of stay price structure and the ICU adjustment. Without a further adjustment, there is a risk of under-pricing the treatment of COVID-19 patients and over pricing non-COVID-19 patients.

For NEP25, IHACPA will retain the implement the following temporary measures to account for the ongoing impact of the COVID-19 pandemic response on hospital activity and cost data in the 2022–23 financial year:

- application of the COVID-19 treatment adjustment in a limited number of clinically relevant AR-DRGs
- application of the ICU adjustment to patients with a COVID-19 diagnosis
- exemption of the safety and quality adjustments for episodes of care with a COVID-19 diagnosis.

IHACPA will review the requirements for these temporary measures including the COVID-19 treatment adjustment during the development of the NEP Determination 2026–27 (NEP26).

5.1.1 Preparedness for future disruptions



What principles and processes could guide an appropriate pricing response to significant disruptions to the health system, including natural disasters and epidemics?

Feedback received

Stakeholders supported IHACPA's work plan to investigate a pricing response to significant disruptions to the health system in response to the Mid-Term Review of the Addendum to the National Health Reform Agreement (NHRA) 2020–25 and recommended the following principles and processes to guide the investigation.

Stakeholders suggested a policy-based process, including the introduction of a normalisation policy, national agreement on the timing of financial assistance and a national definition of significant disruption. They also recommended the use of first responder networks, standardised equipment and resources in disaster and resilience planning and the identification of the disproportionate impact of health system disruptions in regional, rural and remote locations to guide pricing responses to significant disruptions to the health system.

Stakeholders also proposed specific changes to the national pricing model to prepare for future disruption including impact analysis of legitimate and unavoidable cost variations when delivering services to complex outpatient appointments and implementation of classification codes and fixed-plus-variable cost structure and reporting.

Lastly, stakeholders proposed broader changes to allocation funding such as the creation of a dedicated cost centre to quarantine identifiable costs, and consideration of providing funding in the same year of disruption and inclusion of capital costs and virtual care delivered by multidisciplinary teams.

Vic noted that they do not support IHACPA's approach to normalisation and recommended consultation with state and territory governments prior to the implementation of pricing model responses to disruptions to the health system.

IHACPA's response

IHACPA notes that the Addendum to the NHRA 2025–30 is yet to be finalised and that it may include specific provisions resulting from the learnings from the COVID-19 pandemic response. Therefore, IHACPA will consider these suggestions in light of any new provisions that result from the implementation of the Addendum to the NHRA 2025–30.

Additionally, IHACPA notes that the [National Pricing Model Stability Policy](#) was updated in June 2024 to broaden its coverage to apply to system impacts affecting the overall year-to-year stability of national pricing model, not just year-to-year changes in the prices for specific end-classes. This update was made to address the request from state and territory governments for IHACPA to develop a normalisation policy to provide a clear basis for conditions under which normalisation is enacted.

5.2 Adjustments to the national efficient price

5.2.1 Intensive care unit adjustment



Should the ICU adjustment be restricted to a list of eligible hospitals? If so, what factors should be considered in determining the level of ICU complexity, required to be eligible to receive the ICU adjustment, noting that individual units cannot be identified in the current national data collections?

Feedback received

Vic, Qld, SA, WA, the CICM, the Australian and New Zealand Intensive Care Society (ANZICS) and the QNMU supported the review of the ICU adjustment and its eligibility criteria.

NSW, Vic and Qld noted that the eligibility for the ICU adjustment should not be restricted to a list of designated hospitals. Vic and Qld requested that all health services that provide ICU services should receive an ICU adjustment.

Vic noted concerns that the implementation of changes would not be possible for NEP25. They recommended that jurisdictions prospectively designate their ICU services prior to the NEP determination each year. SA noted it allocates different funding to types of critical care wards depending on the type of care provided compared to level 3 ICUs.

NSW and ANZICS raised the following factors for consideration in determining the level of ICU complexity that would be required to be eligible to receive the ICU adjustment:

- range, availability and frequency of advanced therapies and other services offered
- patient acuity levels derived from standardised scores
- technological capability such as that for continuous monitoring and support systems
- hospital size, geographical and population considerations particularly in rural and remote areas
- inclusion of surgical neonatal ICUs.

IHACPA's response

IHACPA noted stakeholder views regarding whether the ICU adjustment should be restricted to a list of eligible ICUs and considerations in determining the level of ICU complexity eligible for an adjustment.

In 2023, IHACPA commenced the review of the ICU adjustment and its eligibility criteria. This included examining the reporting of ICU hours and costs, the impact of the ICU adjustment on the acute cost model under current arrangements, and impact analysis of options to alter the ICU eligibility criteria.

Building on the foundational work undertaken in 2023, IHACPA has developed an analytical plan to provide a cohesive way to investigate these options. This approach allows sufficient time to conduct rigorous analysis, propose definitive changes to the adjustment, and consult with IHACPA's advisory committees on any proposed changes prior to implementation.

As part of this plan, IHACPA is investigating where there is a reasonably predictable pattern that patients in most episodes within certain AR-DRGs enter an ICU for an extended period of time and whether the cost of ICU services could be bundled within these AR-DRGs. Additionally, IHACPA is reviewing if there is evidence of variations in the cost of ICU services based on patient and provider characteristics, this includes the suggestions from stakeholders like the patient's acuity and hospital geographical location.

For NEP25, IHACPA will maintain the existing eligibility criteria for the ICU adjustment and continue to undertake its review based on the analytical plan developed, in consultation with its advisory committees. IHACPA anticipates that the ICU adjustment review will conclude in 2025 with recommendations due to be implemented in alignment with the development of NEP26. For this reason, IHACPA does not seek to implement an interim measure for the ICU adjustment for NEP25 given any such changes will likely require revision the following year.



Are there any barriers to a tiered adjustment that would allow for different ICU adjustment prices to apply, based on the characteristics of eligible hospitals or episodes of care within those hospitals?

Feedback received

NSW, Vic, Qld, SA, ANZICS, and the QNMU supported a tiered adjustment to account for differences in ICU resource intensity and raised the following barriers to determining the adjustment:

- achieving data quality and uniformity across health services
- defining ICU complexity including types of services provided, patient acuity, technological availability and treatments used
- administrative and operational burden and implementation costs
- potential to incentivise types of care or inequalities in care provision that receive more funding.

Stakeholders also recommended that IHACPA provide guiding eligibility principles to the Jurisdictional Advisory Committee based on the characteristics of larger and more complex ICU hospitals, as informed by the ANZICS.

Vic noted that the current approach for retrospective application for recognition as an eligible ICU does not align with the timing of investment decisions, nor does it account for decisions pertaining to system preparedness and responsiveness.

IHACPA's response

IHACPA notes the barriers raised in developing a tiered ICU adjustment. IHACPA will consider this feedback in carrying out the analytical plan for the ICU adjustment review to determine whether the ICU adjustment should be a single adjustment or tiered based on patient or hospital characteristics. This includes consulting with IHACPA's advisory committees on the range of options and if the current data collections are adequate to address the current suggestions.



Are there any barriers to including a fixed national weighted activity unit (NWAU) adjustment for eligible hospitals, regardless of activity levels?

Feedback received

Vic supported the inclusion of a fixed NWAU adjustment for eligible hospitals, regardless of activity levels. SA did not support the inclusion of a fixed NMAU adjustment for eligible hospitals and noted concern regarding the potential to impact the NWAUs required to meet the Commonwealth funding cap.

NSW, SA, WA and ANZICS noted the following concerns to including a fixed NWAU adjustment for eligible hospitals:

- potential to disincentivise efficiency if funding is assured, regardless of volume
- inconsistency with how NWAU is calculated elsewhere in the national pricing model
- challenges with allocating resources across health care systems with varying demands and the risk of leading to undersupply in higher demand areas
- potential impact on small or rural hospitals and funding cap limitations
- responsiveness to changes
- complexity in setting and seeking consensus on rates.

Additionally, ANZICS requested to collaborate with IHACPA to effectively identify and address potential barriers to data access and support the development of nuanced and contextually appropriate funding strategies for ICUs.

IHACPA's response

IHACPA notes the barriers to including a fixed NWAU adjustment for eligible hospitals regardless of activity, particularly the concerns around meeting the funding cap requirements. This feedback will be considered as part of the analytical plan for the ICU adjustment review in consultation with IHACPA's advisory committees.

5.2.2 Indigenous adjustment



To support IHACPA's investigation, what factors may help explain the reduction in the Indigenous adjustment, observed in recent years? Additionally, what factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public hospital services for First Nations' peoples across Australia?

Feedback received

Stakeholders noted the following factors may help explain the observed reduction in the Indigenous adjustment:

- statistical or data quality issues, such as the interaction with other adjustments and higher likelihood of being high, outlier patients
- local system data collection issues such as poor collection in electronic medical records and under reporting of Indigenous status because patients feel culturally unsafe
- First Nations' patients are more likely to:
 - present with a greater rate of comorbidities and as such, cost per separation, cost per bed day, NWAU per separation, and average length of stay are consistently higher for Indigenous patients or non-reporting patients
 - receive care through First Nations run initiatives that provide culturally appropriate care
 - be under-represented in Diagnosis Related Groups (DRG) that have higher funding to cost recovery rate and thus may not be accurately accounted for in the national pricing model
- increased proportion of people identifying as a First Nations person who have a lower burden of disease, as reflected in the reduction in the total cost pool of Indigenous patients reported in the Australian Bureau of Statistics (ABS) national census
- changes in a person's identification as a First Nations person over the period of their lifetime due to a shift in social, personal or external policy circumstances
- costs allocated across health care episodes.

NSW noted that costs associated with First Nations' patients have been increasing over the last 3 years, indicating that there has been significant decline in one or more other jurisdictions which has impacted the calculation of the adjustment.

The NT noted that it is imperative to ensure that the changing demographic makeup resulting from the increase in self-identification as Indigenous should not inadvertently undermine the purpose of the Indigenous adjustment, to account for the higher costs of providing services to a cohort experiencing severe disadvantage. The NT requested IHACPA review the criteria and basis for calculation of the Indigenous adjustment in order to develop a more effective method that reflects the following factors related to the costs of providing culturally appropriate and secure hospital care, particularly in the NT:

- homelessness, noting First Nations people residing in the NT have the highest homelessness rates in Australia, mainly as a result of overcrowded housing
- burden of disease, barriers to care and cross-cultural complexities that affect hospital service delivery
- remoteness, noting the NT's First Nations population is substantially more concentrated in remote and very remote areas than other jurisdictions
- language, as 58% of First Nations people in the NT speak a local Indigenous language as their first language, compared with 9.5% nationally.

Vic, the Centre for Indigenous Policy Research (CIPR) and the National Health Leadership Forum (NHLF) noted concern that the current model appears to over-penalise patients that are flagged as having Indigenous status.

NSW, Vic, WA, the NT, CIPR and NHLF provided a range of considerations to refine the calculation and application of the Indigenous adjustment. These include the following:

- review the criteria and basis of the calculation of the Indigenous adjustment including changes in reporting and interactions between other adjustments, complexity scores, remoteness and homelessness
- conduct a costing study or investigation into whether the Indigenous adjustment is meeting the requirements of Closing the Gap Agreement
- consideration for clinical yarning as part of the therapeutic treatment in the actual cost for delivering public hospital service
- calculating the Indigenous adjustment at the state and territory level.

Vic recommended IHACPA block fund actual expenditure and the development of a policy-based adjustment separate to the cost data based on the relative weighting of culturally appropriate care. Statistical adjustments in the NWAU model will still be based on the cost data but calibrated to take into account this policy position.

WA and the NT recommended review of the patient residential remoteness adjustment to consider a multiplication factor that includes the distance of the patient's admission treatment location from their residential address and presence of comorbidities, which all contribute to delayed discharge.

CIPR and NHLF recommended IHACPA develop a needs-based adjustment for First Nations' patients rather than the current cost-based adjustment. They also noted the continued absence of First Nations' representation in the Pricing Authority and IHACPA's broader advisory committees, and a lack of tailored consultation that accounts for cultural protocols. They also recommended IHACPA articulate a clear vision for the inclusion of organisations and researchers involved in the delivery of public hospital services to First Nations peoples in the development, implementation, and monitoring of IHACPA's functions.

IHACPA's response

Based on the feedback received, IHACPA has undertaken preliminary analysis to test alternative methodologies to calculate the Indigenous adjustment. This includes the recommendation to isolate the impact of the Indigenous adjustment from other adjustments. The preliminary analysis suggests that, in the admitted acute stream, there is notable interaction between the Indigenous adjustment and other adjustments, particularly the remoteness adjustments. Depending on the sequencing of the adjustments, these interactions will have differing impacts on the value of the Indigenous adjustment, especially in remote and very remote areas, and opposing impacts on other adjustments. Extensive statistical analysis on multiple years of data is required to assess the stability of these interactions and identify suitable changes to the adjustment's calculation including potential impact on other adjustments and streams.

IHACPA notes that the policy intent of the Indigenous adjustment is to reflect legitimate and unavoidable variations that affect the costs of service delivery for First Nations peoples, as provided for under Section 131(1)(d) of the *National Health Reform Act 2011* (the NHR Act). This is separate from the development of a needs-based adjustment and broader government policies to address unmet needs, such as the Closing the Gap Agreement.

IHACPA recognises that further analysis and engagement with First Nations peoples' representatives is required to explore whether the adjustment is achieving its policy aims. IHACPA anticipates that the implementation of the Addendum to the NHRA 2025–30 will provide further directives to guide the policy aspects of the Indigenous adjustment review. For example, IHACPA notes that the development of a First Nations' Schedule, as recommended by the mid-term review, is likely to include new provisions to promote greater engagement with First Nations' peoples in the development of pricing approaches. Once the Addendum to the NHRA 2025–30 is finalised, IHACPA will also review opportunities to improve consultation and communications processes to incorporate input from First Nations peoples or organisations representing their interests in the health sector, to inform its implementation.

In relation to First Nations' representation in the Pricing Authority and IHACPA's advisory committees, IHACPA notes it is important to have diverse capabilities and experience to inform its work, including representation from First Nations' peoples. IHACPA's remit to appoint members to the Pricing Authority, the Jurisdictional Advisory Committee and Clinical Advisory Committee is limited, as per the requirements set out in the NHR Act. Nevertheless, IHACPA will continue to work within its remit to identify and engage with people and health care organisations that represent the views of First Nations' peoples to inform its work, particularly in regard to specific refinements that affect this population cohort such as the review of the Indigenous adjustment.

Given the anticipated changes in the Addendum to the NHRA 2025–30, the need for broader consultation, and the potentially significant impact on the national pricing model should an alternative methodology be applied, the pricing framework states that for NEP25, IHACPA will maintain the current methodology for determining the Indigenous adjustment.

5.2.3 Interfaces between hospitals and aged care

Feedback received

WA and the NT requested IHACPA investigate the interface between public hospitals and residential aged care services, including modifying the national pricing model for long-stay older patients who have received an assessment from an Aged Care Assessment Team and are deemed ready for discharge.

IHACPA's response

IHACPA commissioned research to investigate the increasing number of older, medically fit patients in public hospitals who are waiting for aged care services. Findings indicated that while there has been a significant growth in older patients waiting for aged care services in public hospitals, less than half are discharged directly into residential aged care. Due to the increasing focus on this area in the health system, IHACPA will work with jurisdictions and key stakeholders to investigate the impact and occurrence of long-stay patients in public hospitals as outlined in the [IHACPA Work Program and Corporate Plan 2024–25](#).

5.2.4 Accounting for costs associated with treating patients in remote areas

Feedback received

The NT noted that remote and very remote patients stayed in hospitals in Darwin for 40% longer than expected due to the following characteristics associated with this cohort:

- lower likelihood of returning to hospital due to distance and limited subacute and step-down care in remote communities
- high cost of outreach services which may also be impacted by seasonal weather conditions
- proactive testing due to the prevalence of comorbidity and chronic conditions to identify and treat undiagnosed complications
- risk of deterioration or re-infection for certain medical conditions if prematurely discharged due to overcrowding in housing.

IHACPA's response

IHACPA notes the geographic and demographic differences in the NT and will consider this following the outcome of the Indigenous adjustment review, which has a close interaction with the remoteness adjustments. IHACPA determines the patient residential remoteness adjustment is based on postcode or the ABS Statistical Area category data. As such, the detail provided is not sufficient for the calculation of a multiplicative factor.

5.2.5 Other pricing related refinements

Feedback received

Stakeholders including NSW, WA, NT, ACRRM, Catholic Healthcare Australia, CICM, the RACP and the National Centre of Excellence in Intellectual Disability Health (NCEIDH) supported IHACPA's work plan to investigate refinements to the national pricing model and recommended the following:

- an interim small jurisdiction adjustment for NEP25 prior to assessing viability of ongoing adjustments to the pricing model and review IHACPA's materiality threshold criteria to support a relevant price signal for small jurisdictions
- review of the patient treatment remoteness adjustment for non-admitted care to better account for outreach services using a combination of data elements

- development of a pricing adjustment for homelessness
- application of a multiplier to all DRGs for people with an intellectual disability to account for the additional resources to provide high quality care.

The NCEIDH noted that the complex needs of people with intellectual disability are not currently supported by the national pricing model nor routinely collected in hospital morbidity datasets at a national level. The NCEIDH recommend IHACPA develop a complexity adjustment for people with intellectual disability to recognise the additional complexity encountered during admission and discharge with the aim of reducing readmission and improving health outcomes for this cohort.

WA recommended the use of contemporary data and the removal of the 3-year time lag when determining the NEP and the national efficient cost (NEC) to align with the actual cost of service delivery. Related to this, the Australian Medical Association noted concern that the NEP indexation rate has not kept up with the rate of inflation or public hospital expenditure increases and recommends significant increase in the NEP indexation to align with inflation rates nationally.

The Royal Australasian College of Medical Administrators requested IHACPA make the tools it produces such as NWAU calculators more accessible and device-agnostic for clinicians and clinical educators, and noted limitations in using Microsoft Excel tools on web-based or MacOS-based platforms.

NSW noted that the average length of stay listed for the DRGs related to drug and alcohol (V60A to V62A) are significantly shorter than expected and that this results in under-valuing of those price weights.

IHACPA's response

IHACPA notes that the NHR Act requires IHACPA to set the efficient price for public hospital services on a national basis, however, it includes provisions for adjustments to account for legitimate and unavoidable cost variations. To support the development of an adjustment, evidence is required to demonstrate that this variation in costs is directly related to characteristics unique to smaller jurisdictions such as a lack of economies of scale, rather than inefficiency. IHACPA is undertaking analysis to identify the policy basis and the data required to implement a refinement to the national pricing model to address the concerns raised.

Based on the evidence available to IHACPA currently, IHACPA does not intend to introduce a new adjustment for smaller jurisdictions for NEP25. However, IHACPA will continue to work with the Australian Government and state and territory governments to investigate the underlying drivers of cost variation that differ between smaller and larger states and territories, and the possible ways to address this, within IHACPA's existing legislative remit. This will also provide time to examine any changes that result from the finalisation of the Addendum to the NHRA 2025–30.

In relation to the feedback from the NCEIDH, the national pricing model incorporates the in-scope cost of providing hospital care for all patients. IHACPA acknowledges that there is limited ability in the current data to identify patients with intellectual disabilities. However, existing mechanisms in the pricing model may overlap and account for some of the issues identified, including higher price weights for more complex episodes and adjustments for longer lengths of stay. Additionally, intellectual disability is classifiable both when it meets the criteria as a principal or additional diagnosis and also when it doesn't meet these criteria in the ICD-10-AM/ACHI/ACS Thirteenth Edition code U79.4 *Disorder of intellectual development* as part of the supplementary codes for chronic conditions. The Thirteenth Edition of ICD-10-AM/ACHI/ACS includes new codes for waiting periods related to arrangement of disability services, including patients with an intellectual disability. This is an important step to being able to identify patients who have a longer length of stay in hospitals and further investigate the drivers contributing to this.

With respect to other adjustments proposed, IHACPA will develop a broader work plan to review a number of areas in the national pricing model and ensure they remain fit-for-purpose, reflecting current clinical practice and service delivery models. The scope and timeframes for the reviews will be developed in consultation with IHACPA's working groups, advisory committees and key stakeholders as outlined in the IHACPA Work Program and Corporate Plan 2025–26.

Regarding the use of more contemporary data to inform determinations, IHACPA's remit under the NHR Act specifies that the NEP must be based on empirical analysis of actual activity and cost data from public hospitals. This analysis considers any time lags. Additionally, clauses A33-44 of the Addendum to the NHRA 2020–25 sets out the ABF calculation that IHACPA is required to adhere to in developing the national pricing model. Combined, the implementation of these requirements results in a 3-year time lag. IHACPA may only reduce this gap once all jurisdictions develop the capability to report activity and cost data over shorter timeframes in a sustainable manner.

Additionally, in 2023, IHACPA undertook a review of the indexation methodology that highlighted that alternative indexation options do not have a clear advantage over the existing indexation methods in terms of predictive accuracy in forecasting inflation. IHACPA intends to maintain the existing indexation methodology for NEP25.

With respect to the format of publicly available NWAU calculators, IHACPA notes that Microsoft Excel is used as it is accessible in most hospitals and health services. IHACPA notes that the cost of creating a device-agnostic platform may not be justified given that most health services use local systems to calculate NWAU. It is unlikely that IHACPA will change to a different platform in the foreseeable future.

Regarding NSW's query on the length of stay for drug and alcohol services, IHACPA notes that for the NEP Determination 2022–23, admitted mental health care was separated into its own stream. Since then, the average length of stay for DRGs related to drug and alcohol are reported as part of the NEP Determinations for 2022–23, 2023–24 and 2024–25. During this time, the length of stay for these DRGs has remained stable.

5.3 Accounting for private patients in public hospitals

IHACPA did not ask any specific consultation questions on accounting for private patients in public hospitals but received feedback from a small number of stakeholders on this area.

Feedback received

NSW and CHA requested a review into private patient neutrality and recommended that IHACPA consult with public and not-for-profit hospital operators when conducting this work, particularly in rural and regional areas.

Vic did not support the private funding neutrality adjustment due to a lack of effective policy mechanisms for states and territories to mitigate the financial risk of a retrospective funding adjustment and the unpredictable nature of the calculation, which makes it difficult to control.

IHACPA's response

IHACPA determines the private patient adjustment methodology as required in clauses A13, A43 and A44 of the Addendum to the NHRA 2020–25. The mid-term review recommended that IHACPA undertake a review regarding the requirements and implementation of the arrangements for determining funding neutrality for private patients in public hospitals. Once the Addendum to the NHRA 2025–30 is finalised, IHACPA will consult with state and territory governments and the National Health Funding Body and undertake a review of its approach to private patient neutrality if relevant clauses are changed.

5.4 Harmonising price weights across care settings

IHACPA did not ask any specific consultation questions on harmonisation of price weights across settings but received feedback from a small number of stakeholders on this area.

Feedback received

NSW, Vic and the NT supported the progression of price harmonisation and recommended the following:

- review and understanding of the clinical factors and system level impacts, including potential impact on national reporting and the ability for specialist hospitals to safely deliver chemotherapy services
- applying transitional arrangements and price stabilisation in circumstances where price harmonisation is deemed appropriate.

NSW requested visibility of analysis of 2021–22 data and noted delays in the completion of this work.

IHACPA's response

Data linkage challenges and unexplained differences in reported costs across settings have hindered progression of price harmonisation for chemotherapy and dialysis in past years, despite stakeholder support and feedback recommending harmonisation of these services. In 2024, IHACPA has been conducting a project to improve the linking of benefits paid under the Pharmaceutical Benefits Scheme (PBS) to hospital activity data to improve the development of the NEP. The completion of this project will potentially impact end-class price weights and thus is a prerequisite for harmonising.

IHACPA has also conducted analysis into the costs of these services which highlighted notable differences across identified admitted acute and non-admitted dialysis and chemotherapy services. The preliminary findings indicated that further assessment was required, in consultation with its advisory committees, prior to progression with price harmonisation to better understand the potential financial impact and resulting incentives of such a change.

IHACPA will continue to conduct analysis on available data and consult with its advisory committees to ensure the appropriateness of these services for price harmonisation.

5.5 Unqualified newborns

Feedback received

The QNMU supported IHACPA's analysis of costs associated with unqualified newborns and recommended a review of the current funding structures for maternity care with consideration of the following:

- bundled pricing model for maternity care
- implementation of recommendations from the Strengthening Medicare Taskforce Report 2022 and the Medicare Benefits Schedule (MBS) Participating Midwives Reference Group Report 2021
- publicly funding midwife-led sexual and reproductive healthcare services.

IHACPA's response

IHACPA continues to consult with jurisdictions and clinical experts, while also conducting analysis to determine whether the concerns raised are supported by existing activity and cost data, as well as national clinical best practice standards. This exploration includes consideration of the policy and data collection implications for treating both unqualified and qualified newborns as admitted acute episodes of care. IHACPA will consider the recommendations of the Strengthening Medicare Taskforce Report 2022 and the MBS Participating Midwives Reference Group Report 2021 as part of its review.

Additionally, the mid-term review made specific recommendations around further investigation into bundled pricing, including for maternity care. IHACPA will consider this following the finalisation of the Addendum to the NHRA 2025–30.

6. Setting the national efficient cost

6.1. The fixed-plus-variable model

Feedback received

New South Wales (NSW) and the Australian College of Rural and Remote Medicine noted concerns that actual costs of delivering care in rural areas has been higher than the estimated costs provided in the national efficient cost (NEC), particularly due to the volume of services and workforce constraints.

NSW noted that under the small hospitals methodology within the NEC Determination, there is no provision to revise or update calculated cost to reflect current levels. NSW requested that the Independent Health and Aged Care Pricing Authority (IHACPA) review the funding model for small hospitals in a post coronavirus disease 2019 (COVID-19) climate.

IHACPA's response

The Local hospital networks/Public hospital establishments national minimum data set is one of the primary data sources available to IHACPA to determine the NEC for block-funded services. This information is supplemented by the introduction of a separate data request specification for IHACPA to develop a list of establishment identifiers and hospitals, based on submissions received from jurisdictions. Combined, this information represents the best available and nationally consistent data for the purposes of developing block-funded amounts for small hospitals as part of the NEC Determination each year. All costs reported through these mechanisms are accounted for in the development of the pricing model for small hospitals.

In 2023, IHACPA undertook a review of the NEC indexation methodology. This review tested a range of proposed options, both individually and in combination, and in both stable and volatile inflationary environments. The goal was to analyse the accuracy of their predictions and compare these to the existing indexation methodology. The outcomes highlighted that alternative indexation options did not have a clear advantage over the existing indexation methods in terms of predictive accuracy in forecasting inflation. However, the review recommended that some options are worthy of future testing once more data becomes available. Additionally, IHACPA notes that all cost data collected is used in the modelling and development of the NEC, despite the level of cost growth.

IHACPA intends to maintain the existing indexation methodology for the NEC Determination 2025–26 (NEC25) and will consult with its advisory committees as it undertakes further testing of options identified in the review.

6.2 Standalone hospitals providing specialist mental health services and residential mental health care services

Feedback received

NSW recommended that funding for standalone hospitals providing specialist mental health services and residential health services remain block funded to account for low activity volume.

Victoria (Vic) recommended consideration of specialist forensic mental health services as standalone hospitals providing specialist mental health care services under the NEC for future determination. Vic requested that IHACPA consider the appropriateness of classifying mental health secure extended care units as in-scope for activity based funding (ABF), given that admitted episodes in these settings may span significantly extended periods of time, and whether block funding is more appropriate for these services for future NEC determinations.

IHACPA's response

In response to the feedback provided by NSW, IHACPA notes that standalone hospitals providing specialist mental health services and residential mental health services will remain block funded for NEC25.

As part of the planned transition of community mental health care services from block funding to ABF, IHACPA has worked with stakeholders to develop appropriate block funding criteria for these establishments.

For NEC25, IHACPA intends to continue to work with jurisdictions in finalising the application of its block funding criteria for community mental health establishments within the following categories:

- rural LHNs delivering a low volume of community mental health services
- standalone establishments delivering specialised forensic community mental health services.

The final block funding criteria will be published in the NEC Determination 2025–26 and will be reviewed in the development of the NEC Determination 2026–27 following an anticipated uplift in data reported for community mental health care services following its transition to ABF.

Further information is available in Chapter 5 of the Pricing Framework for Australian Public Hospital Services 2025–26.

7. Data collection

7.1 Cost and activity data collection



- How should the Independent Health and Aged Care Pricing Authority (IHACPA) account for the changes in data reporting when developing a costed dataset?
- How can IHACPA ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity?

Feedback received

Stakeholders including New South Wales (NSW), Victoria, Queensland (Qld), South Australia (SA), Western Australia (WA), and Tasmania recommended the following changes to data reporting methods when developing a costed dataset, to ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity:

- allow for additional time for reporting and quality assurance
- streamline collection mechanisms to reduce administrative burden, including different potentially limited data reporting requirements for smaller states and territories
- the ability to submit smaller, representative datasets and exclude services based on consideration of the data's materiality and quality and for this information to be included in the data quality statement
- improved guidelines, standardised data quality measures, education and training in addition to regular monitoring and auditing
- undertaking an audit on a random sample of a fixed proportion of data
- analysis on the impact of a reduced data set on pricing adjustments
- back-casting for prior years using the costed dataset
- investigation of different models of care that will impact activity and cost data results.

The Australian College of Rural and Remote Medicine (ACRRM) noted concerns that cost data collections underestimate costs associated with rural and remote services, the transfer of costs to patients due to a lack of accessible services and the higher cost of operations in these areas.

IHACPA's response

IHACPA is developing a Data Quality Framework that will set out a consistent approach to monitor and measure data quality. The purpose of the Data Quality Framework will be to improve the integrity of data and measure conformance with national data development principles and practices including promoting good data governance and management. The Data Quality Framework will also allow IHACPA to implement a uniform approach to quality assurance to assess what would be considered an appropriate and representative sample of data required to deliver IHACPA's legislated functions. IHACPA is currently consulting with jurisdictions and intends to complete the Data Quality Framework by July 2025.

Additionally, IHACPA notes that it does not have the authority nor capability to audit data submissions received from states and territories, based on provisions in the Addendum to the National Health Reform Agreement (NHRA) 2020–25. Rather, the addendum sets out the requirement for jurisdictions to submit data to IHACPA as per the provisions in the IHACPA Three Year Data Plan, and a statement of assurance on the completeness and accuracy of approved data submissions. Nevertheless, IHACPA has provided material to support national consistency in reporting of cost data.

For the National Efficient Price (NEP) Determination 2025–26 (NEP25), IHACPA will continue to implement the requirements outlined in the [IHACPA Three Year Data Plan](#) and [Data Compliance Policy](#). These require states and territories to provide sufficient data for IHACPA to have confidence that the data reflects the actual cost of delivering public hospital services from as wide a range of hospitals as practicable.

7.2 Assurance of cost data



What quality assurance approaches are being implemented at the hospital or state and territory level that should be considered by IHACPA to apply to national data collections?

Feedback received

NSW, Qld, SA and WA identified the following quality assurance approaches that are being implemented at the hospital or state and territory level, that should be considered by IHACPA to apply to national data collections:

- end-to-end cost and activity reconciliation
- data quality programs to flag data entry errors and data quality adjusters to penalise services that do not submit quality data
- jurisdictions to access the IHACPA validated data and quality reports
- tiered approach to data compliance, including system validation, data analytics and clinical auditing
- using dashboards to manage data quality.

NSW and the Queensland Nurses and Midwives' Union (QNMU) supported IHACPA's intention to undertake a quality assurance review of the National Hospital Cost Data Collection (NHCDC) 2022–23 for NEP25 and recommended the involvement of IHACPA's advisory committees in the review.

IHACPA's response

IHACPA is currently undertaking a quality assurance project, similar to that conducted on the 2021–22 cost data, in consultation with state and territory governments. This process, in place of an Independent Financial Review, is intended to provide assurance that the NHCDC 2022–23 Public Sector data is complete for the purposes of pricing for NEP25. This includes the reconciliation of state and territory government data quality statements against to the Australian Hospital Patient Costing Standards.

Separately, IHACPA is finalising the development of a quality assurance report dashboard and a new NHCDC data portal that will both be available by the end of 2024. Together, the NHCDC dashboard and data portal aim to provide streamlined, flexible and near instantaneous data insights to state and territory governments regarding their NHCDC submission.

7.3 National Benchmarking Portal



What changes would enhance the user experience and functionality of the National Benchmarking Portal (NBP) to inform improvements in public hospitals and policy making?

Feedback received

Stakeholders recommended the following changes to enhance the user experience and functionality of the NBP to inform improvements in public hospitals and policy making:

Hospital Acquired Complications (HAC) specific refinements:

- inclusion of HAC data preceding 2017–18 to observe trends
- broader data manipulation and visualisation functionality such as:
 - the ability to select 2 or more HAC groups
 - summary data on the 14 HAC groups
 - display observed and expected number of HACs for each discrete HAC sub-classification
 - filter by the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification level rates within each HAC group

- observe HAC activity according to individual local hospital networks when 2 or more local health networks are selected
- ability to extract record level data across a particular diagnosis related group (DRG) and peer group sites
- addition of a new visual or calculation, where appropriate, that divides the state or territory HAC ratio by the national HAC ratio.

Software refinements:

- improving user functionality by enabling multiple year selection, filters for principal intervention, additional interventions and additional diagnoses, with the flexibility to make multiple selections and detailed demographic and mobility information
- improving the recency of data available including the date of the last update to the NBP
- greater flexibility in comparing peers, for example the ability to pick top 10 performers for a particular DRG
- introduce predictive technology to have new queries displayed visually.

The Centre for Indigenous Policy Research and the National Health Leadership Forum recommended the disaggregation of HAC and avoidable hospital readmissions (AHR) data to separate patients who have identify as First Nations' peoples to enable greater public scrutiny of trends in relation to HACs and AHRs in relation to this cohort.

The QNMU recommended the inclusion of the following measures in the NBP:

- patient reported outcome measures (PROMs)
- patient reported experience measures (PREMs)
- average length of stay and readmission rates
- costs to patients for health services
- post-surgical mortality rates
- adverse events
- healthcare-associated infections
- presentations to emergency departments (ED)
- waiting and treatment times in emergency as well as the proportion of patients staying for 4 hours or less
- elective surgery waiting and treatment times
- perinatal indicators such as premature births, planned and unplanned caesarean sections, breastfeeding and access to continuity models of care.

IHACPA's response

IHACPA notes that information on readmission rates in the form of AHRs, healthcare associated infections in the HAC and presentations to ED is currently available in the NBP. Additionally, AHR and HAC dashboards may provide a proxy for adverse events.

The data in the NBP depends on its availability and quality. IHACPA is unable to include HAC data preceding 2017–18 due to differences in data quality submitted prior to that year. Additionally, IHACPA does not collect data related to patient expenditure, post-surgical mortality rates or on perinatal indicators such as premature births and breastfeeding, PREMS or PROMS. Therefore, IHACPA is unable to display patient level information in the NBP for these measures.

IHACPA is in the final stages of updating the NBP and expects 2021–22 data to become available by the end of 2024. As such, IHACPA will consider the proposals to improve the NBP's data manipulation, visualisation and functionality as part of the next tranche of the NBP. IHACPA will also consider including information on waiting and treatment times in EDs and for elective surgery in future tranches. Separately, IHACPA intends to undertake a comprehensive review of the NBP to improve its usability and functionality and will consider the recommended changes in consultation with its advisory committees during that time. This includes exploring the addition of filters to replicate pricing functionality like the removal of blood and Pharmaceutical Benefit Scheme costs from the calculation of total cost. IHACPA is also exploring the addition of small rural hospitals to the current hospital list within the NBP. IHACPA notes that it is not possible to publish disaggregated HAC and AHR data related to First Nations' patients at this stage, due to privacy considerations arising from smaller sample sizes.

8. Future funding models

8.1 Trialling of innovative models of care

Feedback received

New South Wales (NSW) noted the challenges of implementing a bilateral agreement between a state or territory and the Australian Government as required under clause A97 of the Addendum to the National Health Reform Agreement (NHRA) 2020–25, and the lack of annual review and implementation of trials of innovative models of care between state and territory governments.

The Australian College of Rural and Remote Medicine (ACRRM) recommended that it is important for the rural and remote sector to be represented in policy discussions regarding new and innovative models of care and funding. Future funding models should incentivise approaches to rural health resourcing which will deliver robust rural health services, sustainable over the long term. This includes directing rural funding to staff and resources that are based in rural areas.

IHACPA's response

The Independent Health and Aged Care Pricing Authority (IHACPA) understands and agrees that the current approach to the integration of innovative models of care into the national pricing model is challenging due to the limitations in the Addendum to the NHRA 2020–25. IHACPA has raised these concerns in negotiations for the development of the Addendum to the NHRA 2025–30. IHACPA notes that the development of the Addendum to the NHRA 2025–30 is likely to include new provisions relating to innovative models of care, given its focus in the Mid-Term Review of the Addendum to the NHRA 2020–25. However, until the Addendum to the NHRA 2025–30 is implemented, trials of innovative models of care require approval under a bilateral agreement between a state or territory government and the Australian Government. IHACPA will commence work with NSW to explore the translation of trials to the national pricing model as well as developing processes and frameworks at the national level.

With respect to the feedback provided by ACRRM, IHACPA notes that responsibility for policy development of models of care for health care delivery in rural areas is shared between the state and territory governments and the Australian Government. IHACPA encourages jurisdictions to propose innovative models of care for inclusion on the General List of In-Scope Public Hospital Services, including those tailored to the unique conditions in rural and remote areas. As recognised in ACRRM's submission, the mid-term review included a focus on rural and remote service delivery. Following the finalisation of an Addendum to the NHRA 2025–30, IHACPA will review any new or changed provisions with respect to how equity considerations may be managed within the limitations of a national pricing model.

8.2 Virtual models of care

Feedback received

Stakeholders supported IHACPA's investigation into virtual models of care and provided a range of examples of different settings or services where virtual care has been provided. This included non-admitted settings for chronic disease management, general practice settings, emergency care, satellite hospitals and rural areas. Stakeholders also noted consideration of technological support or small devices required to support implementation of virtual care.

NSW recommended consideration of the impact of virtual care for both entities receiving and providing this care, and the importance of accounting for the benefits of virtual care in the national pricing model, for both health services and patients. NSW also noted challenges in reporting the delivery of virtual care for opioid treatment programs across local health districts, including those that involve teaching and training.

The Australian Medical Association recommended that funding for digital models of care should be incentivised, primarily in regional and rural areas where access to in-person healthcare is less accessible. They also emphasised that virtual care delivery should not become the preferred model of care despite upfront efficiency gains.

Queensland noted that due to the increase in new models of virtual care, which may impact pricing, new data collection that is more flexible and adaptable to these emerging models – whether considered admitted or non-admitted – may be required.

IHACPA's response

IHACPA notes the increasing range of settings where virtual care may be provided, a trend that has accelerated following the onset of the coronavirus disease 2019. IHACPA has been progressing a comprehensive program of work to gain a better understanding of virtual care activity, costs, modes of service delivery and models of care in Australia, including variations across states and territories. To date, this has included extensive consultation with jurisdictions and broader stakeholders and a desktop review of virtual care delivery – both domestically and internationally – which has considered many of the examples provided.

IHACPA plans to finalise this horizon scan by January 2025, to facilitate the development of a national strategy for improved integration of virtual care into the pricing and funding of public hospital services. IHACPA will work with all jurisdictions to develop an implementation plan based on the outcomes and recommendations of the project.

With respect to reporting for the delivery of virtual care for opioid treatment programs, these services are in-scope and captured within the Tier 2 Non-Admitted Classification.

Currently, the national pricing model is agnostic to in-person and virtual modalities, with the exception of emergency department video conferencing which receives block funding, to ensure there are no undue incentives regarding the use of clinically appropriate modalities. IHACPA recognises the importance of maintaining clinical appropriateness of care, including appropriate use of in-person and virtual modalities for different patients and components of care. This will be considered as part of the implementation of any future changes to the national pricing model.

9. Pricing and funding for safety and quality

9.1 Evaluation of safety and quality measures



What impact has the introduction of the pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions had on public hospital service delivery?

Feedback received

Queensland (Qld), Western Australia (WA) and the College for Intensive Care Medicine Australia and New Zealand (CICM) supported the pricing approaches to safety and quality and have noted the following impacts on service delivery:

- decrease in sentinel event notification reporting
- increased costs of implementing safety and quality mechanisms
- ability to report on price impact and volume.

New South Wales (NSW) and the Northern Territory (NT) recommended a review of safety and quality approaches and reducing the penalties associated with the following complications:

- hypoglycaemia due to expected blood sugar decrease in patients fasting for surgery
- renal failure due to the volume of cardiac and lung transplant patients experiencing acute renal failure
- cardiac complications including arrhythmias and cardiac arrest where successful resuscitation is penalised.

NSW noted the challenges with balancing the provision of quality care and resources required to meet the policy objectives.

Victoria (Vic) noted insufficient information to estimate the impact that hospital acquired complication (HAC) and avoidable hospital readmission (AHR) funding rules have on public hospital service delivery. Vic also noted the following considerations around pricing approaches for safety and quality:

- lack of consideration of the broader admission context and the fact that potential data gaps may limit the accuracy of the risk adjusted rate measures.
- concerns around whether risk-adjusted rate measures appropriately account for specialist health services that manage patients with a higher risk profile for the onset of HACs, including healthcare-associated infections (HAC03) among specialist cancer health services managing immunocompromised patients and in maternity care where there are higher rates of persistent incontinence (HAC12).

Vic recommended a review of the risk-adjusted model to ensure it accurately reflects the risk profile of specialist services and to inform refinement of the HAC adjustment to ensure appropriate funding.

The NT provided a range of considerations to inform the review including assessment of improved patient outcomes, decreases in AHRs, clinician awareness of penalties, and changes in data quality and existing processes or programs implemented by states and territories to improve quality and safety.

The Queensland Nurses and Midwives' Union noted that they did not support a reduction for sentinel events due to concerns that this will not improve patient outcomes.

IHACPA's response

The Independent Health and Aged Care Pricing Authority (IHACPA) notes the considerations provided by stakeholders. The pricing approach for HACs is risk-adjusted to consider each patient's risk profile – that is, their likelihood of experiencing a HAC – based on a series of risk factors for each HAC group. The funding adjustment for HACs is split into low, moderate and high risk categories for each HAC group, such that patients with a higher risk of experiencing a particular HAC receive a lower HAC funding adjustment. IHACPA also monitors the statistical significance of risk factors for each HAC category as part of each NEP cycle.

As part of the joint advice provided to health ministers in October 2021, IHACPA, the Australian Commission on Safety and Quality in Health Care and the Administrator of the National Health Funding Pool investigated options for reducing avoidable and preventable hospitalisations, with a focus on patients with chronic and complex conditions.

IHACPA will consider any new provisions related to safety and quality once the Addendum to the NHRA 2025–30 is finalised to ensure that any new provisions are included in the evaluation.

9.2 Exploration of pricing related approaches to reward high quality care



To inform the further development of safety and quality measures, are there other pricing-related approaches that could be used to reward high quality care? How can IHACPA identify such care in national data collections?

Feedback received

Stakeholders including NSW, Vic and Qld, proposed examples of different measures or methods to identify high quality care in the health system, as a means of then developing pricing approaches to reward such care. Examples provided included:

- identifying and rewarding health services that report positive patient and staff experience including high staff engagement, high safety cultures and high leadership quality
- linking patient reported outcome measures and patient reported experience measures to activity and cost data
- identifying whether care was in alignment with the Australian Commission on Safety and Quality in Healthcare standards
- utilising care quality registry data or identifying models of care that have high quality outcomes
- identifying episodes where there is a lower length of stay compared to national or state averages.

Stakeholders including Vic, South Australia, Tasmania, the Australian Physiotherapy Association and the Royal Australasian College of Physicians, noted a range of factors that IHACPA could consider in developing pricing approaches for services in providing high quality care. These factors included:

- developing a definition of what constitutes high-quality care, including consultation with clinicians
- recognising limited state and territory resources available to implement incentives to reward high-quality care
- approaches to rewarding high-quality care in addition to the existing safety and quality measures may create a wider funding gap
- accounting for models of care across different streams or settings including innovative or integrated models of care or new technologies
- accounting for nurse-to-patient and midwife-to-patient ratios in all public hospitals
- approaches to incentivise clinician in-reach and outreach services, especially in rural and remote areas and hospital-in-the-home programs
- ensuring increased support for underperforming health services based on contemporary HAC or AHR data to ensure they receive sufficient funding to enhance patient outcomes and overall safety.

The Centre for Indigenous Policy Research (CIPR) noted concern around the lack of focus on quality and safety measures for First Nations peoples. CIPR noted that the lack of First Nations perspectives in the development process may have resulted in safety and quality reforms that have the potential to further embed the inequities of health outcomes between First Nations and non-Indigenous peoples. Additionally, CIPR recommended that the sentinel events, HACs and AHR lists alongside the risk-adjustment model should all be reviewed from a First Nations peoples and equity lens, and that IHACPA should engage directly with First Nations communities, organisations and experts in undertaking such a review.

IHACPA's response

IHACPA notes that developing pricing approaches for high-quality care would provide complex challenges. These include interactions with existing safety and quality measures, other adjustments and the potential for unintended consequences. Based on the provisions in the Addendum for 2025–30, IHACPA will investigate options for the development of pricing approaches for high-quality care in consultation with the Australian Commission on Safety and Quality in Health Care and jurisdictions to ensure the risks identified are managed. Given the recommendation in the Mid-Term Review of the Addendum to the NHRA 2020–25 to develop pricing approaches to incentivise high value care and disincentivise low value care, IHACPA anticipates that the Addendum for 2025–30 is likely to include provisions that will have significant implications on how IHACPA undertakes this exploratory work. Therefore, IHACPA will progress this work following the finalisation of the Addendum to the NHRA 2025–30 to ensure that any new provisions are considered included in pricing approaches for high-quality care.

IHACPA acknowledges the potential for biases to emerge in data driven responses to safety and quality, particularly when limited data is available on the provision of care to First Nations peoples and communities. IHACPA notes that activity based funding and the Indigenous adjustment are intended to provide appropriate price signals that support the provision of care to First Nations peoples in line with these government commitments, where data is available in national collections. Once the Addendum to the NHRA 2025–30 is finalised, IHACPA will review opportunities to improve consultation and communications processes to incorporate input from First Nations peoples or organisations representing their interests in the health sector, including how safety and quality measures are reported and reflected in the national pricing model.

Appendix A: List of stakeholders

The stakeholders that made submissions in response to the [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26](#) have been outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Abbreviation
Jurisdictions	
New South Wales Health	NSW
Victorian Department of Health	Vic
Queensland Health	Qld
South Australian Department for Health and Wellbeing	SA
Western Australian Department of Health	WA
Tasmanian Department of Health	Tas
Northern Territory Department of Health	NT
Organisations	
Austin Health	Austin Health
Australian and New Zealand Intensive Care Society	ANZICS
Australian and New Zealand Society of Nephrology	ANZSN
Australian College of Rural and Remote Medicine	ACRRM
Australasian College of Emergency Medicine	ACEM
Australian Medical Association	AMA
Australian Physiotherapy Association	APA
Catholic Healthcare Australia	CHA
Centre for Indigenous Policy Research, Australian National University	CIPR
College of Intensive Care Medicine of Australia and New Zealand	CICM
Directors of Physiotherapy Services Queensland Health and Queensland Musculoskeletal Physiotherapy Screening Clinic and Multi-disciplinary Service Network	N/A
GPEX	GPEX
National Centre of Excellence in Intellectual Disability Health	NCEIDH
National Health Leadership Forum	NHLF
Office of the National Rural Health Commissioner	ONRHC
Queensland Nurses and Midwives' Union	QNMU
Royal Australasian College of Physicians	RACP
Royal Australasian College of Medical Administrators	RCMA
Royal Melbourne Hospital	RMH
Universities Australia	Universities Australia



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