



Pricing Framework for Australian Public Hospital Services 2025–26

December 2024

Pricing Framework for Australian Public Hospital Services 2025–26 — 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
AMHCC	Australian Mental Health Care Classification
ANAPP	Australian Non-Admitted Patient Classification Project
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
COVID-19	Coronavirus disease 2019
eMR	Electronic medical record
HAC	Hospital acquired complication
HoNOS	Health of the Nation Outcome Scales
HMM	Health Ministers' Meetings
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
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
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
WHO	World Health Organization

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 pricing framework

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.

The pricing framework is published prior to the release of the NEP and NEC determinations in early March each year. This provides an additional layer of transparency and accountability by making available the principles, decisions and approach used by IHACPA to inform the determinations.

IHACPA released the [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26](#) for a 30-day public consultation period on 8 May 2024. The consultation paper sets out the major policy issues for the development and refinement of the national ABF system, including policy decisions, classification systems and data collection. The pricing framework benefits immensely from the contributions of jurisdictions, academic institutions and other stakeholders to the consultation paper.

This year, IHACPA received 28 submissions to the consultation paper. These submissions are available on the [IHACPA website](#). A consultation report that includes commentary on how IHACPA reached its decisions for 2025–26 is also available.

1.3 IHACPA's broader work program

IHACPA undertakes an extensive and complex program of work to refine its classification systems and the national pricing model to ensure they remain fit for purpose. This includes reviewing its classification systems and data collections, as well as undertaking data and trend analysis and stakeholder consultation across all its functions.

Given the volume and complexity of this work, along with the lead time to implement changes to classifications and data collections that underpin refinements to the national pricing model, this work often takes multiple years to complete, thus impacting the development of future determinations. Consequently, not all multi-year projects currently within IHACPA's broader work program are included in this pricing framework. Further information on IHACPA's key deliverables and activities is available in the annually updated [IHACPA Work Program and Corporate Plan 2024–25](#), available on the IHACPA website.

Recommendations from the Mid-Term Review of the Addendum to the NHRA 2020–2025 – Final Report and development of the 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. Consequently, negotiations to develop the addendum to the NHRA 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 a new addendum may include changes or new provisions that 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 the NEP and NEC Determinations for 2025–26 will be based on the requirements set out in the NHR Act and the Addendum to the NHRA 2020–25.

2. Pricing guidelines

2.1 The Pricing Guidelines

The decisions made by the Independent Health and Aged Care Pricing Authority (IHACPA) in pricing in-scope public hospital services are evidence-based and use the latest activity and cost data supplied to IHACPA by jurisdictions. In making these decisions, IHACPA balances a range of policy objectives provided by the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement (NHRA) 2020–2025. These objectives include, but are not limited to, improving the efficiency and accessibility of public hospital services.

The Pricing Guidelines outlined in Figure 1 signal IHACPA's commitment to transparency and accountability in its work. They encompass the overarching process and system design guidelines within which IHACPA makes its policy decisions.

In response to the consultation paper, New South Wales recommended that IHACPA update the System Design Guideline 'Using activity based funding where practicable and appropriate' to include a caveat that this approach should also reflect the clinical care provided. Some stakeholders also recommended refinements to the 'Fairness' Overarching Guideline to account for differences in operating costs and models in rural areas and ensure transparency of hospital funding decision processes.

Further detail on this feedback is provided in the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26.



IHACPA's decision

IHACPA considers the existing Pricing Guidelines sufficiently account for these issues raised and does not propose any changes to the Pricing Guidelines.



Next steps and future work

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.

Figure 1: The Pricing Guidelines

Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising activity based funding (ABF) and block grant funding:

- **Timely-quality care:** Funding should support timely and equitable access to high-quality health services and reduce disadvantage for all Australians, especially for Aboriginal and Torres Strait Islander peoples.
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

Process Guidelines to guide the implementation of ABF and block grant funding arrangements:

- **Transparency:** All steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Stability:** The payment relativities for ABF are consistent over time.
- **Evidence-based:** Funding should be based on the best available information, that is both nationally applicable and consistently reported.

System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Promoting value:** Pricing supports innovative and alternative funding solutions that deliver efficient, high-quality, patient-centred care.
- **Promoting harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **Using ABF where practicable and appropriate:** ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.
- **Single unit of measure and price equivalence:** ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Patient-based:** Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.
- **Public-private neutrality:** ABF pricing should ensure that the payments a local hospital network (LHN) receives for a public patient should be equal to the payments made for a LHN service for a private patient.

3. Classifications used to describe and price public hospital services

Classifications aim to facilitate a nationally consistent method of classifying patients, their treatments and associated costs to provide better management and funding of high-quality and efficient health care services.

Effective classifications ensure that hospital data is grouped into appropriate classes, which contributes to the determination of a national efficient price (NEP) for public hospital services and allows Australian governments to provide funding to public hospitals based on the activity based funding (ABF) mechanism.

The Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for reviewing and updating existing classifications, as well as introducing new classifications.

There are currently 6 public hospital service categories in Australia which have classifications in use or in development:

- admitted acute care
- subacute and non-acute care
- emergency care
- non-admitted care
- mental health care
- teaching and training.

3.1 Admitted acute care

The Australian Refined Diagnosis Related Group (AR-DRG) classification is used to price admitted acute patient services. AR-DRGs are underpinned by a set of classifications and standards used to collect activity data for admitted care, which include the:

- International Statistical Classification of Diseases and Related Health Problems (ICD), Tenth Revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI)
- Australian Coding Standards (ACS).

These are collectively known as ICD-10-AM/ACHI/ACS.

3.1.1 ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0

The AR-DRG and ICD-10-AM/ACHI/ACS classification systems have a 3-year development cycle to balance currency against the need for stability and to reduce the burden of implementation for stakeholders. These classifications have been developed in consultation with stakeholders represented on IHACPA's clinical and technical advisory groups and in accordance with the [Governance Framework for the Development of the Admitted Care Classifications](#).

IHACPA commenced the development of ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 in 2022 with a work program informed by the governance framework. The [Consultation Paper on the Development of ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0](#) was released in November 2023, which details the major refinements proposed to the classifications.

The Thirteenth Edition of ICD-10-AM/ACHI/ACS will be released in March 2025 and is proposed for implementation on 1 July 2025. AR-DRG Version 12.0 will be released in 2025 and used to price admitted acute patient services for the NEP Determination 2026–27.



IHACPA's decision

For the NEP Determination 2025–26 (NEP25), IHACPA will use ICD-10-AM/ACHI/ACS Thirteenth Edition, and continue to use AR-DRG Version 11.0, to price admitted acute patient services.

3.1.2 Cluster coding

IHACPA is proposing to implement cluster coding from 1 July 2025 in conjunction with the introduction of ICD-10-AM/ACHI/ACS Thirteenth Edition. Cluster coding is a mechanism for linking related diagnosis codes using a diagnosis cluster identifier. Codes are considered related when they connect the circumstances of an event or other specific code relationships together.

Clustering will increase the understanding and context of coded activity data in both the short and long term by:

- identifying relationships between codes
- enhancing safety and quality reporting
- enhancing reporting of chronic conditions
- reducing assumptions when interpreting data
- eliminating the need to review episodes of care to establish relationships between codes
- preparing for a potential future ICD Eleventh Revision implementation, where clustering is a feature.

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26, stakeholders noted potential challenges to the introduction of cluster coding. These challenges were associated with clinical coder recruitment and training, and the possibility that changes to coding practice and advice may result in data compliance issues.

IHACPA consulted widely throughout the development of cluster coding to ensure its development and implementation was well-supported by the sector, and to mitigate any issues raised by stakeholders. Throughout this consultation IHACPA has received in-principle support from stakeholders for its implementation. Many have acknowledged its immediate and longer term benefits in enhancing data collections, particularly for safety and quality reporting.

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. IHACPA has proposed a staged approach to implementing cluster coding, including undertaking a pilot exercise in March 2024, to increase understanding and familiarity among coders, prior to its full implementation. IHACPA will also be developing extensive education materials to support clinical coders and data users, which will be provided as part of the ICD-10-AM/ACHI/ACS Thirteenth Edition education program through [IHACPA Learn](#).

Further information on the implementation of cluster coding and the feedback received is available in the on the Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report.

3.2 Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services. IHACPA used AN-SNAP Version 5.0 to price admitted subacute and non-acute services for the NEP Determination 2024–25 (NEP24).

In response to the consultation paper, stakeholders proposed a range of future refinements to AN-SNAP to better account for patient complexity and the intersections of care pathways between the hospital, aged care and disability sectors. Further information is available in the consultation report.



IHACPA's decision

IHACPA will continue to use AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP25.



Next steps and future work

IHACPA notes that many of the proposed refinement areas are part of the work program for the development of future versions of AN-SNAP. This work will also be reviewed in consultation with IHACPA's 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 has been considered.

3.3 Emergency care

For NEP24, IHACPA used the Australian Emergency Care Classification (AECC) Version 1.0 to price emergency department (ED) presentations and the Urgency Disposition Groups (UDG) Version 1.3 to price emergency service presentations.

3.3.1 Australian Emergency Care Classification Version 1.1

Since 2021, IHACPA has consulted with its working groups and advisory committees to develop an updated version of the AECC Version 1.0. 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.

In response to the consultation paper, stakeholders supported using AECC Version 1.1 to price ED presentations for NEP25 without a shadow pricing period.

Stakeholders also proposed a number of refinements to the AECC to better account for patient complexity and the inclusion of interventions, variables to capture investigations and procedures within the classification. IHACPA will consider these as part of the broader work program for the development of future versions of the AECC.



IHACPA's decision

For NEP25, IHACPA will price ED presentations using AECC Version 1.1 without a shadow pricing period, as the updates 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 or where new data elements are introduced.

3.3.2 Pricing emergency services

Since 2019, IHACPA has been progressing the collection of patient level activity data in emergency services with support from the states and territories. This is intended to facilitate an uplift in data to support the consideration of whether a future transition to price emergency services using the AECC in place of UDGs may be feasible.

In response to the consultation paper, stakeholders noted workforce, education and data collection issues, as barriers in reporting principal diagnosis, particularly for emergency services in rural and remote locations. Further information is available in the consultation report.



IHACPA's decision

For NEP25, IHACPA will continue to use UDG Version 1.3 to price emergency services. IHACPA will work with the state and territory governments, within the limitations of its remit, to address issues related to reporting patient level data for emergency services.

3.4 Non-admitted care

3.4.1 Tier 2 Non-Admitted Services Classification

The Tier 2 Non-Admitted Services Classification (Tier 2) is the existing classification system used to price non-admitted services.

IHACPA undertakes an ongoing program of classification refinement to ensure the relevancy of Tier 2 for ABF purposes, while a new non-admitted care classification is developed. For NEP25, IHACPA consulted with its working groups and advisory committees on additional refinements to Tier 2. These include:

- amendments to the class 40.48 *Haematology and immunology*, to improve data capture for nurse-led rheumatology services
- amendments to the class 10.20 *Radiation therapy – simulation and planning* to better reflect modern clinical practice and the complexity of care provided in these clinics
- retirement of the class 40.34 *Specialist mental health* 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 the consultation paper, stakeholders proposed a range of refinement areas for Tier 2 including the development of codes specific to voluntary assisted dying and services provided by advance practice allied health workers, including physiotherapists, to reflect the resources used to deliver services provided by these professions.

Further information is available in the consultation report.



IHACPA's decision

For NEP25, IHACPA will use Tier 2 Version 9.1 to price non-admitted services.



Next steps and future work

IHACPA will continue working with its working groups and advisory committees to assess the feasibility of other proposed refinement areas for future versions of Tier 2.

3.4.2 A new non-admitted care classification

IHACPA is developing a new non-admitted care classification to better describe patient characteristics and care complexity and more accurately reflect the costs of non-admitted services. The new non-admitted care classification will also better account for changes in care delivery and models of care as services transition to the non-admitted setting.

In 2023, IHACPA commenced the Australian Non-Admitted Patient Classification Project (ANAPP) to explore the feasibility of developing a new non-admitted care classification through the utilisation of the health information available within state and territory electronic medical record (eMR) systems. This aims to minimise the administrative burden on clinicians and hospitals and the impact on clinical service delivery associated with additional data collection through utilisation of existing data generated from clinical care.

In response to the consultation paper, several stakeholders indicated support for the commencement of the ANAPP.

3.5 Mental health care

3.5.1 Australian Mental Health Care Classification Version 1.1

IHACPA released the Australian Mental Health Care Classification (AMHCC) Version 1.1 in December 2023. AMHCC Version 1.1 is a modest refinement of the classification with key changes including the recalibration of the complexity model by updating Health of the Nation Outcome Scales (HoNOS) weights and thresholds and Abbreviated Life Skills Profile thresholds. In addition, phases with up to 2 missing HoNOS items attract a valid complexity score in AMHCC Version 1.1. These changes have been both informed and strongly supported by IHACPA's jurisdictional and clinical stakeholders.

In response to the consultation paper, stakeholders proposed a range of areas for refinement in future iterations of the AMHCC including the consideration of age, legal status and diagnosis in the complexity score to account for variability of mental health services. Further information is available in the consultation report.



Next steps and future work

IHACPA will continue to consult with its working groups and advisory committees to assess the feasibility of incorporating the proposed refinements as part of the classification development work program for AMHCC Version 2.0, based on supporting data analysis.

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

For NEP24, IHACPA priced admitted mental health care using AMHCC Version 1.0. The consultation paper signalled IHACPA's intention to price admitted mental health care services using AMHCC Version 1.1 for NEP25, without a shadow pricing period.

Community mental health care is currently block funded as part of the national efficient cost (NEC) determination, with state and territory governments advising IHACPA of their community mental health care expenditure each year. IHACPA shadow priced community mental health care services using AMHCC Version 1.0 as part of the NEP Determinations for 2021–22, 2022–23, 2023–24 and NEP24. Due to jurisdictional feedback regarding funding transition risks, the Pricing Authority approved a fourth and final year of shadow pricing for 2024–25 and continued block funding for community mental health under the NEC Determination 2024–25.

The consultation paper signalled IHACPA's intention to transition community mental health care services from block funding to ABF for NEP25 following 4 years of shadow pricing using AMHCC Version 1.0. Introducing ABF for community mental health care aims to improve the transparency of funding and alignment with the Pricing Guidelines by enabling funding to be based directly on the volume and type of care provided to consumers.

In response to the consultation paper, stakeholders identified the following barriers to pricing community mental health services using AMHCC Version 1.1:

- reporting and implementation barriers including variability in data collection between states and territories and challenges to data collection in rural and remote areas
- classification and data quality-related barriers such as the current treatment of age in the AMHCC.

Further information on stakeholder feedback is available in the consultation report.

In 2024, IHACPA continued working closely with jurisdictions through bilateral meetings, working groups and advisory committees and the National Health Funding Body (NHFB) 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 delivering a low volume of community mental health services and specialised establishments such as specialised forensic establishments. Further information about block funding arrangements is available in Chapter 5.



IHACPA's decision

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 that 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.



Next steps and future work

IHACPA will continue to engage with all jurisdictions and the NHFB during the refinement and implementation of transitional measures to support the transition of community mental health care services from block funding to ABF for NEP25 and to mitigate any associated reporting and implementation issues identified.

3.6 Teaching and training

Teaching and training activities represent an important aspect of the public hospital system alongside the provision of care to patients. Where teaching and training is delivered in conjunction with patient care, including embedded teaching and training, such as ward rounds, these costs are reported as part of routine care and the costs are reflected in the ABF price. However, block funding is provided for activities where the components required for ABF are not currently available to enable these activities to be priced.

IHACPA developed the Australian Teaching and Training Classification (ATTC) as a national classification for teaching and training activities that occur in public hospitals. The ATTC aims to provide a nationally consistent approach to how teaching and training activities are classified, counted and costed. As outlined in the [IHACPA Work Program and Corporate Plan 2024–25](#), research is not incorporated into the ATTC and IHACPA is not proposing any further work to develop a research classification.

The Mid-Term Review of the NHRA Addendum 2020–25 – Final Report recommended greater transparency in funding and investment in teaching and training functions with a particular focus on the equitable distribution of funding for teaching, training and research in regional and rural hospitals.

In response to the consultation paper, stakeholders noted teaching and training data is currently manually collected and this has impacted the quality and consistency of the data. Stakeholders also proposed various strategies to support state and territory governments in collecting teaching and training data, including streamlining eMR systems and data collection platforms and creating mandatory requirements for gathering ATTC data for hospitals that currently receive block funding for these services.

Additionally, to improve the transparency around the block funded amounts provided for teaching and training services, stakeholders recommended using unique student identifiers to understand the costs of training to assist in determining the efficient cost of teaching and training services. Some stakeholders also suggested that IHACPA engage with the Australian Government Departments of Education and Health and Aged Care on current funding arrangements, costs and payment systems for tertiary education in rural and remote areas. Further information is available in the consultation report.



IHACPA's decision

For the NEC Determination 2025–26, IHACPA will continue to determine block funding amounts for teaching, training and research activity based on advice from states and territories.



Next steps and future work

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 the states and territories. Greater transparency in how these block-funded amounts is distributed is essential prior to exploring whether teaching and training activities can be transitioned to ABF, alternate funding models or whether block funding amounts can be calculated and determined using a different methodology. However, IHACPA understands that achieving this, including analysis to identify whether these activities are suitable to transition from block funding to either ABF or an alternate funding model, will require an extended period of time and consideration of the impact of any new provisions resulting from the implementation of the Addendum to the NHRA 2025–30. As such, IHACPA expects teaching and training activities to continue being block funded in the interim.

4. Setting the national efficient price

The Addendum to the National Health Reform Agreement (NHRA) 2020–25 specifies that one of the Independent Health and Aged Care Pricing Authority's (IHACPA) primary functions is to determine the national efficient price (NEP) for services provided on an activity basis in Australian public hospitals.

IHACPA uses a data driven approach to continually refine the national pricing model each year. This includes reviewing and using actual activity and cost data to ensure it is fit for the purpose of pricing and developing the NEP.

As a result of this analysis and stakeholder feedback to previous consultation papers, IHACPA has identified a range of potential pricing model refinements. Many of these are complex and have a longer term development and implementation horizon. An overview of these activities and their delivery timeframes is outlined in the [IHACPA Work Program and Corporate Plan 2024–25](#). Only refinements that are likely to have an impact on the development of the NEP Determination 2025–26 (NEP25), or where stakeholder input is required to progress investigation of the refinement, are included in the Pricing Framework for Australian Public Hospital Services 2025–26.

4.1 Impact of COVID-19

The coronavirus disease 2019 (COVID-19) pandemic response resulted in significant changes to models of care and service delivery in Australian public hospitals.

To account for the impact of the COVID-19 pandemic response in the NEP Determinations for 2022–23, 2023–24 (NEP23) and 2024–25 (NEP24), IHACPA made a number of changes to the national pricing model. Specifically for NEP24, IHACPA adopted the following measures:

- modification of admitted acute activity data nationally in 2021–22
- continuation of the COVID-19 treatment adjustment for patients being treated for COVID-19 in a limited number of Australian Refined Diagnosis Related Groups (AR-DRG)
- exemption of specific end-classes from the National Pricing Model Stability Policy where there was a legitimate change in the costs of care, for example, changes in models of care due to the COVID-19 pandemic response
- continuation of the temporary measures:
 - application of the intensive care unit (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.

The development of NEP25 uses 2022–23 costed activity data. IHACPA has undertaken analysis to understand whether the impact of the COVID-19 pandemic response endured into 2022–23 and if the measures implemented in previous years are required for NEP25. The analysis indicated that modification of the admitted acute activity applied for NEP24 is no longer required for NEP25 as the 2022–23 hospital activity reflects the data trends prior to the COVID-19 pandemic response.

However, the analysis also indicated that a COVID-19 diagnosis may continue to be a relevant risk factor in predicting some hospital acquired complications (HAC) and avoidable hospital readmission (AHR) categories. Additionally, 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 the same 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 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.

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26, stakeholders identified costs associated with infection prevention and control, workforce-related capacity constraints and increased lengths of stay and elective surgery wait lists as enduring costs in the 2022–23 financial year. Further information is available in the Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report.



IHACPA's decision

For NEP25, IHACPA will retain 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 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).

4.1.1 Preparedness for future disruptions

The Mid-Term Review of the NHRA Addendum 2020–25 – Final Report recommended that the Addendum to the NHRA 2025–30 should be more responsive to system disruptions. This includes establishing pre-agreed principles and processes for time-limited funding arrangements to respond to short-term emergencies. This could contribute to a more resilient health system that is better prepared for future disruptions, can minimise the potential negative consequences resulting from it and recover quickly.

In response to the consultation paper, stakeholders recommended a variety of methods to prepare for significant and unforeseen disruptions to the health system. This included changes related to policy-based processes, the national pricing model and funding allocation such as national agreement on when financial assistance is provided and a national definition of 'significant disruption'. Further detail on the principles and processes proposed by stakeholders is available in the consultation report.



Next steps and future work

IHACPA notes that the Addendum to the NHRA 2025–30 will be finalised for implementation from 1 July 2025 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 resulting from the implementation of the Addendum to the NHRA 2025–30.

4.2 Accounting for changes in cost data submissions

Recently, some state and territory governments have not supplied the same level of cost data to support the development of the NEP Determination, compared to previous years. The reasons noted for the variation include changes to data collection systems, the increasing burden of data collection and limited resources available to collect data. In response to the consultation paper, some jurisdictions claimed that a smaller subset of cost data could be of higher quality than the complete data submission.

IHACPA considers that the exclusion of activity or cost data from national data collections should only occur in specific and limited circumstances, and in consultation with IHACPA, to ensure the data remains fit for the purposes of pricing and achievement of the outcomes of the NHRA, as outlined in IHACPA's Data Compliance Policy. This is because a nationally representative activity and cost data collection is an essential foundation for determining the NEP and national efficient cost (NEC) each year. Accurate data reporting is also essential for benchmarking between hospitals or establishments, and classification refinement to ensure that classification systems remain clinically appropriate. A nationally complete data collection provides greater transparency in the allocation of ensure resources across jurisdictions and enables the resulting pricing models to better reflect the cost of care being delivered in public hospitals.

IHACPA intends to review the impact of the observed changes to the collected data, guided by the 'Evidence-based' Process Guideline, which specifies that funding should be based on the best available information that is both nationally applicable and consistently reported. IHACPA is working with all jurisdictions to ensure the data is fit for purpose for the development of NEP25 and the NEC Determination for 2025–26, including potential measures to enhance the cost data available for pricing and implement necessary remediation measures.

4.3 Adjustments to the national efficient price

Section 131(1)(d) of the *National Health Reform Act 2011* (the NHR Act) allows IHACPA to determine loadings or adjustments to the NEP to reflect legitimate and unavoidable cost variations in the delivery of public hospital services. Development and application of adjustments to the NEP is the method that IHACPA applies to address legitimate and unavoidable cost variations in the delivery of public hospital services.

Further information about the development of adjustments to the NEP is provided in the [Assessment of Adjustments to the National Pricing Model Policy](#) available on IHACPA's website. A list of all the adjustments IHACPA applies to the national pricing model is available in the [NEP24](#) on the IHACPA website.

4.3.1 Intensive care unit adjustment

Since the NEP Determination 2012–13 (NEP12), IHACPA has applied an intensive care unit (ICU) adjustment for specified ICUs. The ICU adjustment was introduced to address legitimate and unavoidable cost variations associated with treating patients in specified ICUs compared to other admitted patients. These variations were not reflected in patient casemix or characteristics in data collections and at that time, could not be adequately addressed through classification development.

Currently, hospitals that consistently report more than 24,000 ICU hours and have more than 20% of those hours reported with the use of mechanical ventilation on an annual basis are generally considered to be eligible for the ICU adjustment. However, IHACPA and jurisdictions work together when determining whether a hospital meets the eligibility criteria for inclusion or exclusion from the ICU adjustment.

The current specified ICU list is defined at the hospital level, as individual units within a hospital cannot be identified in existing data collections and therefore cannot be adjusted for separately. IHACPA acknowledges that this approach may not account for ICU activity in non-specified hospitals or in complex ICUs that are staffed and available but do not receive the throughput necessary to be recognised on the specialised ICU list.

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

In response to the consultation paper, jurisdictions recommended that the eligibility criteria for ICUs not be restricted to a list of designated hospitals. Additionally, stakeholders raised the following factors for consideration in determining the level of ICU complexity, 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.

Building on the foundational work undertaken in 2023, IHACPA is investigating how separate rates for different cohorts of patients could be considered such as using multiple or tiered ICU rates, depending on unit type or patient criteria. In response to the consultation paper, stakeholders identified challenges in data quality and uniformity and the potential to create inequalities by incentivising different types of care as potential issues in implementing this approach.

Another approach proposed in the consultation paper was the inclusion of a fixed component of the adjustment to recognise the baseline costs associated with staffing and operating an ICU. Stakeholders noted that there may be challenges in representing the complexity of care and allocating resources across the healthcare system and the potential risk of causing undersupply in high demand areas. Stakeholders also noted the potential to disincentivise efficiency if funding is assured regardless of volume. Further information is available in the consultation report.

Based on the feedback provided and the significant range of considerations proposed, in 2024, IHACPA has developed an analytical plan for the review, in consultation with IHACPA's advisory committees. The plan provides a cohesive methodology to investigate the diverse range of options proposed and test the suitability of different potential adjustment options. This approach allows sufficient time to conduct rigorous analysis, propose definitive changes to the adjustment, and consult on any proposed changes prior to implementation. IHACPA anticipates that the ICU adjustment review will be completed in 2025 and that the outcome of this review will also guide the review of the paediatric adjustment and its eligibility criteria, due to the close interaction between the 2 adjustments' calculation methodologies.



IHACPA's decision

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 the NEP26.

4.3.2 Indigenous adjustment

IHACPA has implemented the Indigenous adjustment since NEP12. The Indigenous adjustment was introduced to reflect legitimate and unavoidable variations in the cost of delivering health care services to First Nations peoples.

For NEP24, the empirical value of the adjustment continued a long-term decreasing trend for the admitted acute stream. However, the stabilised value published in NEP24 remained unchanged from the NEP Determination 2023–24.

In response to the consultation paper, stakeholders identified the following factors that may explain the reduction in the Indigenous adjustment observed in recent years:

- statistical issues, such as the interaction between other adjustments
- local system data collection issues and under-reporting of Indigenous status because patients feel culturally unsafe
- changing health profile of people identifying as First Nations' peoples such the increase in people identifying as Aboriginal and Torres Strait Islander who have a lower burden of disease
- the higher likelihood that Aboriginal and Torres Strait Islander peoples receive care through First Nations run initiatives such as Aboriginal Community Controlled Organisations.

Additionally, stakeholders recommended direct engagement with First Nations communities and organisations and further analysis into changes in reporting, complexity scores, remoteness and homelessness and interactions between the Indigenous adjustment and other adjustments. Further information on the feedback received is available in the consultation report.

Based on the feedback received, IHACPA has undertaken preliminary analysis to test alternative methodologies to calculate an Indigenous adjustment. This included the recommendation to isolate the impact of the Indigenous adjustment from other adjustments. The analysis suggests that, in the admitted acute stream, there is significant interaction between the Indigenous adjustment and other adjustments, particularly the remoteness adjustments. Depending on the sequencing of the adjustments, these interactions have differing impacts on the nominal value of the Indigenous adjustment which are then potentially countered by opposing changes in other adjustments. Extensive statistical analysis on multiple years of data is required to assess the consistency of these findings and more carefully examine the methodology of the adjustment's calculation and its 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 the NHR Act. This is separate from the concept of a needs-based adjustment and broader government policies to address unmet need under 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 accurately and appropriately reflecting the legitimate and unavoidable cost variations in the delivery of care to First Nations peoples. 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.



IHACPA's decision

For NEP25, IHACPA will maintain the current methodology for determining the Indigenous adjustment. IHACPA will undertake analysis and consult with its advisory committees, First Nations' representatives on refinements to its calculation.



Next steps and future work

Following the finalisation of the Addendum to the NHRA 2025–30, IHACPA will conduct a larger program of work to consider any new provisions related to health care delivery for First Nations' peoples, the policy basis of the Indigenous adjustment and potential changes to ensure it meets its aims. This approach will also provide sufficient time for consultation with all jurisdictions and First Nations' peoples.

4.3.3 Small jurisdictions adjustment

In 2024, Tasmania, the Northern Territory (NT), and the Australian Capital Territory identified specific factors associated with service delivery in smaller jurisdictions that result in higher costs per capita to deliver care. In response to the consultation paper, the NT proposed that IHACPA develop an interim small jurisdiction adjustment for NEP25 prior to assessing viability of ongoing adjustments to the pricing model and to review IHACPA's materiality threshold criteria to support a relevant price signal for small jurisdictions.

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. For example, IHACPA introduced the patient residential remoteness and treatment remoteness adjustments to account for legitimate and unavoidable variations in cost across different geographic regions.

IHACPA is considering the development of pricing approaches in future determinations based on evidence that demonstrates there are material drivers of costs directly related to characteristics unique to smaller jurisdictions, such as a lack of economies of scale. To address the concerns raised, IHACPA is investigating possible ways to address the cost variations between smaller and larger jurisdictions within IHACPA's legislative remit and the data required to implement a refinement to the national pricing model.



IHACPA's decision

Based on the evidence currently available, IHACPA does not intend to introduce a new adjustment for smaller jurisdictions for NEP25. IHACPA will continue to work with all jurisdictions to investigate underlying drivers of cost variation that differ between smaller and larger states and territories, and the possible ways to address this, in light of any changes that result from the implementation of the Addendum to the NHRA 2025–30.

4.4 Accounting for private patients in public hospitals

Clauses A13, A43 and A44 of the Addendum to the NHRA 2020–25 specify that IHACPA will adjust the price for privately insured patients in public hospitals, to the extent required, to achieve overall payment parity between public and private patients in the relevant state or territory, taking into account all hospital–I revenues. IHACPA developed the following definition of financial neutrality and payment parity in terms of revenue per national weighted activity unit (NWAU) for the given year, excluding private patient adjustments.



The sum of revenue a local hospital network (LHN) receives for public patient NWAU (Commonwealth and state or territory ABF payments) should be equal to payments made for a LHN service for private patient NWAU (Commonwealth and state or territory ABF payments, insurer payments and Medicare Benefit Schedule payments).

IHACPA determines a private patient adjustment methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public. Stakeholders provided feedback regarding the limits and consistency of data used in the methodology and the methodology's potential impact on the growth of public NWAU.

The mid-term review recommended that IHACPA, in consultation with jurisdictions and the National Health Funding Body, undertake a review regarding the requirements and implementation of the arrangements for determining funding neutrality for private patients in public hospitals.



IHACPA's decision

For NEP25, IHACPA will continue to implement the private patient neutrality methodology as required by clause A44 of the Addendum to the NHRA 2020–25. Once the Addendum to the NHRA 2025–30 is finalised, IHACPA will undertake review of its approach to private patient neutrality if relevant clauses are changed.

4.4.1 Phasing out the private patient correction factor

The reporting of private patient medical expenses has previously been inconsistent in the National Hospital Cost Data Collection (NHDCDC), with some states and territories not reporting private patient medical costs within their NHDCDC submission. This led to the introduction of the private patient correction factor imputing costs as an interim solution for the issue of missing private patient costs in the NHDCDC.

The implementation of the Australian Hospital Patient Costing Standards Version 4.0 aimed to address the issue of missing costs in the NHDCDC, meaning the private patient correction factor is no longer required. IHACPA will assess the 2022–23 NHDCDC submissions to determine if there has been a change in the reporting of costs associated with the medical treatment of private patients. IHACPA will then determine if the private patient correction factor is still required.



IHACPA's decision

For NEP25, IHACPA will continue to evaluate the private patient correction factor and remove it where appropriate.

4.5 Harmonising price weights across care settings

The Pricing Guidelines include an objective for price harmonisation whereby pricing should facilitate best practice provision of appropriate site of care.



Price harmonisation is a method to reduce and eliminate financial incentives for hospitals to admit patients that could otherwise be treated on a non-admitted basis due to a higher price for the same services.

Since 2020, IHACPA has explored price harmonisation for dialysis and chemotherapy, in consultation with IHACPA's advisory committees.

In response to the consultation paper, state and territory governments supported the further investigation of the price harmonisation for specific services including chemotherapy and dialysis. Stakeholders recommended that IHACPA review the clinical and system level impacts of price harmonisation on chemotherapy services and apply transitional arrangements and price stabilisation in circumstances where price harmonisation is deemed appropriate. Additionally, jurisdictional feedback noted that further consideration of the impact of differing models of care and administrative arrangements for chemotherapy is required prior to harmonising these services. Further information on the feedback received is available in the consultation report.

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 more accurately remove PBS costs from relevant end-classes in admitted, emergency and non-admitted streams. The identification and removal of these costs will potentially impact end-class price weights and is a prerequisite for harmonising price weights across settings.

IHACPA also conducted parallel analysis of both the methodology for linking PBS claims to hospital activity and cost data, and the costs of chemotherapy and dialysis services. The analysis highlighted notable differences across admitted and non-admitted dialysis and chemotherapy services. IHACPA considers that further assessment is required, in consultation with its advisory committees, prior to progression with price harmonisation of these services, to better understand the potential financial impact and resulting incentives of such a change.



Next steps and future work

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.

4.6 Unqualified newborns

At present, the costs associated with the care for unqualified newborns¹, that is newborns cared for at the mother's bedside and not admitted to a specialised ICU or special care nursery, are bundled with the mother's episode of care for the purposes of pricing.

Over a number of years, stakeholders have noted that changes in clinical best practice recommend newborns receive care at the mother's bedside where possible. Therefore, newborns with higher care needs are increasingly being cared for outside of a specialised ICU or special care nursery setting. According to stakeholders, this shift has resulted in underpricing of newborn care due to the perception that bundling of newborn costs with the mother's episode of care does not account for this increase in care and associated costs. Stakeholders noted that this may incentivise care practices that do not align with clinical best practice.

IHACPA notes that all care provided to newborns – whether at the mother's bedside or in a special care nursery or specialised ICU – is captured and reflected in data collections and prices. Episodes of care for unqualified newborns are coded and assigned diagnosis and intervention codes. IHACPA then bundles the costs associated with the unqualified newborn episode of care with the mother's episode of care so that the costs of both are bundled into the price for the AR-DRG of the mother's episode of care. Some states and territories also report costs that are already bundled with the mother's episode of care in the National Hospital Cost Data Collection.

Further investigation, into the policy basis and feasibility to separate the funding for episodes of care for unqualified newborns from the mother's episode of care, is required. Importantly, such separation may require significant system changes that may improve transparency but without a change in overall funding. IHACPA is consulting with the jurisdictions and clinical experts, as well as conducting analysis to understand whether the concerns raised are supported by existing activity and cost data and national clinical best practice standards. This will inform IHACPA's assessment to whether healthy newborns should be treated as admitted patients in their own right in the national pricing model.



IHACPA's decision

IHACPA will continue to consult with its advisory committees and clinical experts on whether there is a policy basis to separate unqualified newborn episodes of care from the mother's episode of care, including consideration of the policy and data collection implications for doing so.

¹ The newborn qualification status outlined by the Australian Institute of Health and Welfare notes that the criteria for qualification is only applied when the baby is 9 days old or less. Available at: <https://meteor.aihw.gov.au/content/index.phtml/itemId/327254>

5. Setting the national efficient cost

5.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) developed the national efficient cost (NEC) for services that are not suitable for activity based funding (ABF), as provided by the Addendum to the National Health Reform Agreement (NHRA) 2020–25. Such services include small rural hospitals, which are funded by a block allocation based on their size, location and the type of services provided.

As part of the NEC determination each year, IHACPA publishes eligibility criteria for block-funded hospitals. A low volume threshold is used to determine whether a public hospital is eligible to receive block funding. All hospital activity is included in assessing the hospital against the low volume threshold. This includes admitted acute and subacute, non-admitted and emergency department activity.

5.2. The ‘fixed-plus-variable’ model

Both ABF and block funding approaches cover services that are within the scope of the NHRA. The key difference is that the ABF model calculates an efficient price per episode of care, while the block funded model calculates an efficient cost for the hospital.

Since the NEC Determination 2020–21, IHACPA has used a fixed-plus-variable model where the total modelled cost of each hospital is based on a fixed component as well as a variable ABF style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.



IHACPA’s decision

IHACPA will continue to use the fixed-plus-variable model for the NEC Determination 2025–26 (NEC25).

5.3 Block funding criteria for community mental health establishments

The existing block funding criteria are not considered appropriate to be applied to community mental health establishments, as the activity profile of community mental health establishments is sufficiently different to hospitals. 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 the NEC25. The 2 block funding arrangements for community mental health establishments for 2025–26 are intended to apply to:

- rural local hospital networks (LHN) delivering a low volume of community mental health services
- standalone establishments delivering specialised forensic community mental health services.

5.3.1 Rural local health networks delivering a low volume of community mental health services

IHACPA recognises there is a different cost profile for low volume, rural health service delivery, including through the fixed-plus-variable model that applies to small rural hospitals. Block funding for rural LHNs delivering a low volume of community mental health services seeks to address the potentially higher costs associated with rural service delivery combined with funding volatility and reduced economies of scale associated with ensuring access in areas with low and dispersed populations.

The average population and geographical catchment area of LHNs in each jurisdiction varies significantly. Therefore, IHACPA is considering adoption of different volume thresholds for each jurisdiction based on the average geographical area of rural LHNs in the jurisdiction. This is to address the risk of diseconomies of scale for jurisdictions with LHNs with a larger geographical area, when delivering community mental health services.

5.3.2 Standalone establishments delivering specialised services

Other block-funded hospitals such as standalone hospitals providing specialist mental health services are treated separately from the fixed-plus-variable cost model. The efficient cost of these hospitals is currently determined in consultation with the relevant state or territory with reference to their total in-scope reported expenditure.

In response to the consultation paper, state and territory governments recommended that standalone hospitals providing specialist mental health services remain block funded for NEC25 until the transition to pricing using the Australian Mental Health Care Classification Version 1.1, including impacts on costs and funding, have stabilised. Some state and territory governments recommended IHACPA consider specialist forensic mental health services providing specialist mental health care services as standalone hospitals under the NEC for future determinations. Further information on the feedback received is available in the Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report.

IHACPA recognises that in many cases, such forensic community health services are provided as part of broader establishments. However, for establishments reporting a higher volume of forensic community mental health activity, cost variations for forensic services may not be balanced out as part of the establishment's overall service delivery. Therefore, IHACPA is working with stakeholders to identify a suitable threshold for establishments providing a high volume of forensic community mental health services to be considered eligible for block funding as a standalone establishment delivering specialised services.



IHACPA's decision

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 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.

5.4 High cost, highly specialised therapies

The annual NEC determination includes block funded costs for the delivery of high cost, highly specialised therapies, as provided by clauses C11–C12 of the addendum. These clauses contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee.

For 2025–26, the following high cost, highly specialised therapies have been recommended for delivery in public hospitals based on advice from the Australian Government:

- Carvykti® – for refractory or relapsed multiple myeloma in adults²
- Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah® or Yescarta® – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Luxturna™ – for the treatment of inherited retinal dystrophies
- Qarziba® – for the treatment of high-risk neuroblastoma

² These high cost, highly specialised therapies will only be included in the NEC Determination once a deed of agreement is finalised by the Australian Government.

- Tecartus® – for the treatment of relapsed or refractory mantle cell lymphoma and B-precursor acute lymphoblastic leukemia
- Yescarta® – for relapsed or refractory large B-cell lymphoma².

Additionally, the Mid-Term Review of the NHRA Addendum 2020–25 – Final Report recommended the development of a nationally consistent approach to undertaking health technology assessment for high-cost, highly specialised therapies which are likely to increase in both number and diversity. It also recommended establishing a structured horizon scanning process for high-cost, highly specialised therapies. This process should involve all jurisdictions and include input from relevant stakeholders, such as the National Blood Authority, Organ and Tissue Donation Authority, Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee to support forward planning and priority setting.



IHACPA's decision

For NEC25, IHACPA will continue to include the indicative block-funded costs for the delivery of these high cost, highly specialised therapies based on the advice of states and territories.

6. Data collection

Under the Addendum to the National Health Reform Agreement (NHRA) 2020–25, the Independent Health and Aged Care Pricing Authority (IHACPA) is required to develop, refine and maintain systems to determine the national efficient price (NEP) and national efficient cost (NEC), including classifications, costing methodologies and data collections.

6.1 Cost and activity data collection

IHACPA develops the [Three Year Data Plan](#) every year to communicate cost and activity data reporting requirements to state and territory governments for the next 3 years, in accordance with clauses B66 to B83 of the Addendum to the NHRA 2020–25. The Three Year Data Plan is supported by the [Data Compliance Policy](#), which describes the process and criteria by which IHACPA will publicly report on compliance by state and territory governments with the data requirements and data submission dates specified in the Three Year Data Plan.

State and territory governments are required to report hospital activity data on a quarterly year to date basis to IHACPA. While teaching, training and research and hospital cost data provided through the National Hospital Cost Data Collection (NHCDC) is reported on an annual basis. The NHCDC is a voluntary collection with an understanding that the submission of all activity and cost data is not possible in every context. Nevertheless, IHACPA continues to collect cost data for over 95% of admitted patient activity nationally.

In response to changes observed in the volume and quality of data submitted by state and territory governments, IHACPA sought feedback in the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26 about how to account for the changes in data reporting when developing a costed dataset. Stakeholders provided limited recommendations in response to this, but recommended the following methods to ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity:

- sufficient time to allow for data collection and quality assurance processes to be undertaken
- improved guidelines and standardised data quality measures
- ability to submit smaller, representative datasets and exclude services based on consideration of the materiality and quality of the data.

Further information on the feedback received is available in the Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report.

IHACPA is developing a Data Quality Framework that will set out a consistent approach to monitor and measure data quality in consultation with its advisory committees. The purpose of the Data Quality Framework will be to improve the integrity of the data and measure conformance against 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's decision

For the NEP Determination 2025–26 (NEP25), IHACPA will continue to implement the requirements outlined in its 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.



Next steps and future work

IHACPA is currently consulting with state and territory governments and its advisory committees and intends to complete the Data Quality Framework by July 2025.

6.2 Assurance of cost data

For the NEP Determination 2024–25, IHACPA undertook quality assurance of the 2021–22 NHCDC data submissions and NHCDC data quality statements through bilateral meetings with each state and territory. This process involved reviewing the NHCDC submissions to understand how the NHCDC data was prepared to ensure its consistency with the Australian Hospital Patient Costing Standards (AHPCS).

The [NHCDC 2021–22 Public Sector Review Report](#) identified that there were no significant anomalies in the data, however, it recommended that IHACPA:

- discontinue the current annual independent financial review
- investigate cost variations across the states and territories through selected focus areas
- develop a data quality framework to improve the cost and activity data collections.

In response to the consultation paper, stakeholders identified several quality assurance approaches that are being implemented at the hospital or state and territory level. These should be considered by IHACPA to apply to national data collections:

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

Further information on the feedback received is available in the consultation report.



IHACPA's decision

For NEP25, IHACPA is implementing a quality assurance process 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 APHCS.



Next steps and future work

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

6.3 National Benchmarking Portal

In 2021, IHACPA released the [National Benchmarking Portal](#) (NBP), a secure web-based application that provides public access to aggregated data held by IHACPA. This portal aims to enable informed policy decisions, support health services research and improve health system performance.

The NBP contains three areas of focus:

- cost per national weighted activity unit
- hospital acquired complications (HAC)
- avoidable hospital readmissions.

In response to the consultation paper, stakeholders recommended several specific HAC visualisation improvements including updates the broader data manipulation and visualisation functionality. Stakeholders also requested the inclusion of HAC data preceding 2017–18 to allow for the observation of longer term trends. IHACPA notes that due to differences in data quality submitted prior to 2017–18, this data cannot be included in the NBP.

Stakeholders also recommended a number of software refinements to improve user functionality and the ability to compare data elements. Further information on the feedback received is available in the consultation report.

IHACPA is in the final stages of updating the NBP and expects 2021–22 data to become available by the end of 2024. Additionally, 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 existing dashboards and the potential of adding small rural hospitals to the current hospital list available on the NBP. Further information on the feedback received is available in the consultation report.



Next steps and future work

As part of the next iteration of the NBP, IHACPA will consider proposals to improve the NBP's data manipulation, visualisation and functionality.

7. Treatment of other Commonwealth programs

7.1 Overview

To prevent a public hospital service being funded more than once, the Addendum to the National Health Reform Agreement 2020–25 requires the Independent Health and Aged Care Authority (IHACPA) to discount Commonwealth funding provided to public hospitals through programs other than the National Health Reform Agreement.

The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs.

Consistent with clauses A9 and A46(e) of the addendum, blood expenditure that has been reported in the National Hospital Cost Data Collection (NHDC) by states and territories will be removed in determining the national efficient price (NEP), as Commonwealth funding for this program is provided directly to the National Blood Authority.

The following Australian Government funded pharmaceutical programs will also be removed prior to determining the underlying cost data for the NEP determination given that they are already funded separately:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme (PBS) Access Program
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding).

IHACPA's process to remove PBS payments from the NHDC involves linking the benefits to the corresponding hospital episodes where possible, as well as removing aggregate amounts where payments cannot be linked.

Currently, there is no direct linking key that would connect individual PBS benefits to their corresponding hospital stay. This results in most benefits being removed through aggregate allocation rather than assigned to individual episodes of care. IHACPA has consulted with clinicians to gain a contemporary understanding of how pharmaceuticals are prescribed within hospital settings and how cost data for them is captured within the NHDC. This has informed the PBS data linking project, which aims to explore potential process improvements while accepting the limitations of currently available data. The goal is to ensure that the amounts deducted from individual hospital episodes better reflect the associated PBS claims, thereby improving the representativeness of resulting prices.

8. Future funding models

8.1 Overview

Activity based funding (ABF) has been an effective funding mechanism since it was introduced to Australian public hospitals in 2012. By setting a national efficient price (NEP) for each ABF hospital service, it has contributed to creating a more equitable and transparent system of hospital funding across Australia. This has also enabled a stable and sustainable rate of growth in public hospital costs.

As reiterated in the Mid-Term Review of the National Health Reform Agreement (NHRA) Addendum 2020–25 – Final Report, ABF continues to be the best pricing and funding mechanism for many hospital services. However, the existing ABF system could benefit from the incorporation of alternate funding models that have the potential to create better incentives for improved continuity of care, use of evidence-based care pathways and substitution of the most effective service response. This is consistent with the move towards value-based care and a focus on outcomes over volume of services.

8.2 Trialling of innovative models of care

Clause A99 of the Addendum to the NHRA 2020–25 stipulates that states and territories can seek to trial innovative models of care, either:

- as an ABF service with shadow pricing, reporting, and appropriate interim block funding arrangements for the trial period; or
- as a block funded service, with reporting against the national model and program outcomes for the innovative funding model.

Trials of innovative models of care may only occur through a bilateral agreement between the Australian Government and a state or territory, for a fixed period of time, under clause A97 of the Addendum to the NHRA 2020–25. In response to the Consultation paper on the Pricing Framework for Australian Public Hospital Services 2025–26, New South Wales noted concerns with the current implementation of these arrangements and recommended a review of the current process.

The Independent Health and Aged Care Pricing Authority's (IHACPA) role as outlined in the Addendum to the NHRA 2020–25 is to provide advice and facilitate exploration and trial of new and innovative approaches to public hospital funding. As such, it is limited in its authority to review or improve the current process which includes a requirement for a bilateral agreement between a state or territory and the Australian Government.

However, IHACPA notes that the mid-term review recommended that the Addendum to the NHRA 2025–30 should prioritise the development of optimal models of care that deliver end-to-end integrated care, using agreed innovative financing mechanisms and pricing approaches that reward high value care. It recommended the establishment of a National Innovation and Reform Agency, an Innovation Fund and Innovation Pathway designed to develop and transition innovative models of care from seed funding to operation at scale. Thus, the development of the Addendum to the NHRA 2025–30 is likely to include new provisions related to innovative models of care, given its focus in the mid-term review.



Next steps and future work

IHACPA will continue to work with state and territory governments to develop and provide advisory support for the trialling of innovative models of care, under bilateral agreements between states and territories and the Australian Government, as required under the current addendum. Once the Addendum to the NHRA 2025–30 is finalised, IHACPA will work with all jurisdictions to review and implement any changes related to the trial of new and innovative approaches to public hospital funding.

8.3 Virtual models of care

In January 2024, IHACPA commenced a program to improve data collections and support the improved integration of virtual care into the national pricing and funding model. This comes following stakeholder feedback noting the significant variation in the delivery of virtual care across the states and territories and a lack of national consistency in the definition and scope of virtual care services in Australia. The project encompasses a horizon scan of virtual care activity, costs, modes of service delivery and models of care in Australia, including variations across the states and territories, and virtual care funding arrangements in similar international health systems.

To date, this has included extensive consultation with jurisdictions and broader stakeholders and a desktop review of virtual care delivery, both domestically and internationally.

In response to the consultation paper, state and territory governments and 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. Further information is available in the Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report.



Next steps and future work

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

9. Pricing and funding for safety and quality

9.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) and the Australian Commission on Safety and Quality in Health Care follow a collaborative work program to incorporate safety and quality measures into determining the national efficient price (NEP), as required under the Addendum to the National Health Reform Agreement (NHRA) 2020–25.

Under the addendum, IHACPA is required to incorporate safety and quality into the pricing and funding of public hospital services to improve patient outcomes across three key areas: sentinel events, hospital acquired complications (HAC) and avoidable hospital readmissions (AHR).

The funding adjustments applied as part of the safety and quality reforms not only act as a price signal, but also aim to improve awareness of areas that clinicians and hospital managers can work on to address and improve patient care.

9.2 Sentinel events

Sentinel events are defined by the Australian Commission on Safety and Quality in Health Care as a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

Since 1 July 2017, IHACPA has specified that an episode of care including a sentinel event will be assigned a national weighted activity unit (NWAU) of zero. This approach is applied to all hospitals, whether funded on an activity or block funded basis.

Victoria provided feedback in response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26, noting that there may be variability in the interpretation of definitions in the Australian Sentinel Events List. It was recommended that IHACPA work with the Australian Commission on Safety and Quality in Health Care to clarify definitions and categorising events. IHACPA will work with the Australian Commission on Safety and Quality in Health Care and broader stakeholders to consider these issues as part of the evaluation of safety and quality measures and in light of any changes resulting from the Addendum to the NHRA 2025–30.



IHACPA's decision

As per the Addendum to the NHRA 2020–25 (clauses A165–A166), IHACPA will continue to assign an NWAU of zero for episodes with a sentinel event for the NEP Determination 2025–26 (NEP25) using Version 2.0 of the [Australian Sentinel Events List](#) published on the Australian Commission on Safety and Quality in Health Care's website.

9.3 Hospital acquired complications

A HAC is a complication that occurs during a hospital stay and for which clinical risk mitigation strategies may reduce, but not necessarily eliminate, the risk of that complication occurring.

The funding adjustment for HACs reduces funding for any episode of admitted acute care where a HAC occurs. This approach incorporates a risk adjustment model and recognises that the presence of a HAC increases the complexity of an episode of care or the length of stay, driving an increase in the cost of care.

Further information on the HACs funding approach is included in the [NEP Determination 2024–25](#) and the [National Pricing Model Technical Specifications 2024–25](#).

The Australian Commission on Safety and Quality in Health Care is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant.

In response to the consultation paper, some state and territory governments recommended IHACPA review the risk-adjusted rate measures to minimise penalties associated with specialist health services that manage patients with a higher risk profile for the onset of HACs. Related to this, New South Wales also recommended a review of HAC definitions and Diagnosis Related Groups to minimise penalties where there are expected to be complications. IHACPA will work with the Australian Commission on Safety and Quality in Health Care and broader stakeholders to consider these issues as part of the evaluation of safety and quality measures and in light of any changes resulting from the Addendum to the NHRA 2025–30.

Additional information is available in the Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report.



IHACPA's decision

For NEP25, IHACPA will use Version 3.1³ of the [HACs list](#) on the Australian Commission on Safety and Quality in Health Care's website to implement the HACs funding adjustment.

9.4 Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission.

An AHR occurs when a patient who has been discharged from hospital (the index admission) is admitted again within a certain time interval (the readmission), and the readmission is:

- clinically related to the index admission; and
- has the potential to be avoided through either, or both, improved clinical management and appropriate discharge planning in the index admission.

From 1 July 2021, IHACPA has implemented a funding adjustment for AHRs. It involves applying a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode. This applies where there is a readmission to any hospital within the same jurisdiction.

IHACPA developed a discrete risk adjustment model for each readmission condition, which assigns the risk of being readmitted for each episode of care.

Further information on the AHRs funding approach is included in the [NEP Determination 2024–25](#) and the [National Pricing Model Technical Specifications 2024–25](#).



IHACPA's decision

For NEP25, IHACPA will use Version 2.0² of the [AHRs list](#) on the Australian Commission on Safety and Quality in Health Care's website to implement the AHR funding adjustment.

³ The Australian Commission on Safety and Quality in Health Care may update the HACs and AHRs lists in conjunction with the introduction of International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, the Australian Classification of Health Interventions and the Australian Coding Standards (ICD-10-AM/ACHI/ACS) Thirteenth Edition from 1 July 2025.

9.5 Evaluation of safety and quality measures

Under the Addendum to the NHRA 2020–25, IHACPA is required to monitor the effectiveness of strategies to address safety and quality in the national pricing model and their impact on patient outcomes. IHACPA led the development of a proposed approach to evaluate the implemented safety and quality reforms for sentinel events, HACs and AHRs. This was provided to the Health Ministers' Meeting (HMM) for consideration in October 2021 as part of the joint advice from the national bodies.

The Mid-Term Review of the NHRA Addendum 2020–25 – Final Report recommended that safety and quality measures be further developed and strengthened to ensure they remain fit for purpose and achieve their intended objectives.

In response to the consultation paper, some stakeholders supported the pricing approaches to safety and quality and noted a decrease in sentinel event notification reporting. Other stakeholders noted that there is insufficient information available to estimate the impact of HACs and AHRs on public hospital services delivery. They noted that while there have been changes in the prevalence of sentinel events, HACs and AHRs, such changes may be the result of changes in reporting rather than underlying outcomes.



Next steps and future work

IHACPA will consider any new provisions related to safety and quality once the Addendum to the NHRA 2025–30 is finalised. Therefore, IHACPA will progress this work following the implementation of the Addendum to the NHRA 2025–30 to ensure that any new provisions are included in the evaluation.

9.6 Pricing approaches for high quality care

The mid-term review reiterated the current addendum's focus on patient outcomes and rewarding best practice clinical care as a means of shaping outcomes and improving system sustainability. It recommended the development and implementation of pricing approaches that reward high value care and penalise low value care, providing incentives to accelerate changes in clinical practice, manage the introduction of new technologies and remove services that are identified as low value from the scope of public hospital services eligible for Commonwealth funding under the NHRA. Examples provided in the review included financial incentives through the funding model for those pathways that are best practice or ensure price signals are applied consistently to remove incentives for low value care.

Stakeholders supported the development of pricing related approaches to reward high value care, noting the anticipated introduction of the Addendum to the NHRA 2025–30. They recommended the following measures to identify such care in national data collections:

- positive patient and staff experience including high staff engagement, high safety cultures and high leadership quality
- patient reported outcome measures and patient reported experience measures
- alignment with the Australian Commission regarding Healthcare standards and the Australian Atlas of Healthcare Variation
- utilise care quality registry data or identifying models of care that have high quality outcomes.

Additional detail on the proposed approaches is available in the consultation report.



Next steps and future work

Given the recommendation in the mid-term review to develop pricing approaches to incentivise high value care and disincentivise low value care, IHACPA anticipates that the Addendum to the NHRA 2025–30 is likely to include provisions that will have significant implications for how IHACPA undertakes this exploratory work. Therefore, IHACPA will progress this work following the implementation of the Addendum to the NHRA 2025–30 to ensure that any new provisions are included in pricing approaches to high quality care.



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