IHACPA

Consultation paper on the Pricing Framework for Australian Public Hospital Services 2026–27

May 2025

Independent Health and Aged Care Pricing Authority

Consultation paper on the Pricing Framework for Australian Public Hospital Services 2026–27 — May 2025

Contents

Abbreviations

Abbreviation	
ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
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
DRG	Diagnosis Related Group
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 addendum	Addendum to the National Health Reform Agreement 2020–26
The commission	Australian Commission on Safety and Quality in Health Care
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. Introduction

1.1 About IHACPA

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

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

1.2 About this consultation paper

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

The Consultation Paper on the Pricing Framework for Australian Public Hospital Services is the primary mechanism for providing input to the pricing framework. The Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27 provides an opportunity for public consultation on the development and refinement of the national ABF system. This includes policy decisions, classification systems and data collection, which will underpin the NEP and NEC Determinations for 2026–27 (NEP26 and NEC26). The pricing framework benefits immensely from the contributions of jurisdictions, peak bodies, academic institutions and other stakeholders.

1.3 IHACPA's broader work program

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

This work is extensive and complex, with lead time required to implement changes to classifications and data collections that underpin refinements to the national pricing model. For this reason, this work often requires multiple years to complete and thereby impacts the development of future determinations.

The consultation paper focuses on the projects where stakeholder input is required to support the progression of specific activities for NEP26 and NEC26. It also seeks specific stakeholder input on some other areas or projects that are underway and may inform future determinations. As such, not all multi-year projects that are currently within IHACPA's broader work program are included in this consultation paper. Further information on IHACPA's key deliverables and activities is available in the annually updated IHACPA Work Program and Corporate Plan, available on the IHACPA website.

Addendum to NHRA 2020–25

IHACPA notes that the current Addendum to the NHRA 2020–25 has been amended and extended by Schedule K. The addendum has been signed by Australian governments in February 2025 for the period 1 July 2025 to 30 June 2026. Aside from extending existing policy arrangements, Schedule K provisions largely relate to funding uplifts, rather than changes to pricing arrangements, and a strengthened commitment to the National Agreement on Closing the Gap during the period 1 July 2025 – 30 June 2026. As such, this

consultation paper refers to the addendum and subsequent Schedule K extension as the Addendum to the NHRA 2020–26.

This consultation paper has been developed within this legislated context and will focus on the issues pertinent to the development of NEP26 and NEC26 that are within IHACPA's current legislated and policy remit. Once agreed, the implications of a new addendum for future determinations will be considered in consultation with stakeholders.

1.4 Supporting documents

This consultation paper builds on previous work in IHACPA's work program and should be read in conjunction with the following documents:

- Pricing Framework for Australian Public Hospital Services 2025–26
- Pricing Framework for Australian Public Hospital Services 2025–26 – Consultation Report
- National Efficient Price Determination 2025–26
- National Efficient Cost Determination 2025–26
- IHACPA Work Program and Corporate Plan 2024–25

Have your say

Submissions close at 5pm AEST on Friday 13 June 2025.
Submissions can be:

- Emailed to submissions.ihacpa@ihacpa.gov.au
- Mailed to:
  PO Box 483
  Darlinghurst NSW 1300
- Completed online via the IHACPA Engagement Hub at engage.ihacpa.gov.au

All submissions will be published on the IHACPA website unless respondents specifically identify sections that they believe should be kept confidential due to commercial or other reasons.
The Pricing Framework for Australian Public Hospital Services 2026–27 will be published in December 2025.

Enquiries

Enquiries related to this consultation process should be emailed to:
submissions.ihacpa@ihacpa.gov.au

2

Pricing Guidelines

2. Pricing Guidelines

2.1 The Pricing Guidelines

The Independent Health and Aged Care Pricing Authority (IHACPA) makes evidence-based decisions for pricing in-scope public hospital services, using the latest activity and cost data supplied by state and territory governments. 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) 2020–26. 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 as it undertakes its work. They comprise the overarching process and system design guidelines within which IHACPA makes its policy decisions.

IHACPA will continue to use the Pricing Guidelines to inform its decision making and ensure they support ongoing improvement to the efficiency and accessibility of public hospital services. The current Pricing Guidelines are reflective of the objectives in the addendum. Once a new addendum is finalised, IHACPA will undertake a comprehensive review of its Pricing Guidelines to ensure they align with the intent of the new addendum.

In 2025, IHACPA published the Virtual Care Project – Final Report, with stakeholders consulted throughout the project. Chapter 6 of this Consultation Paper provides further detail regarding the key findings and recommendations identified.

Stakeholders found these Pricing Guidelines particularly relevant to pricing virtual care:

- timely-quality care (particularly emphasising equitable access to high quality health services)
- maintaining agreed roles and responsibilities of governments determined by the NHRA
- fostering clinical innovation
- minimising undesirable and inadvertent consequences.

Recommendation 5.1 of the report suggested that IHACPA strengthen the Pricing Guidelines to support clinically appropriate care across all modalities, with stakeholders noting that pricing should be modality agnostic for equivalent care. IHACPA notes that its current Pricing Guidelines and pricing models are generally modality agnostic.

To strengthen the Pricing Guidelines, IHACPA proposes to explicitly state within the promoting harmonisation guideline that pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities. The current wording notes that pricing should facilitate best practice provision of appropriate site of care.

Consultation question
Q1. Are stakeholders supportive of revising the promoting harmonisation Pricing Guideline to: "Promoting harmonisation: Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities"?

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 payments a local hospital network (LHN) receives for a public patient should be equal to payments made for a LHN service for a private patient.

3

Classifications used to describe and price public hospital services

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.

Classifications are also used for purposes other than ABF including health service planning, benchmarking, epidemiology and research, funding agreements between private hospitals and insurers and monitoring the quality of healthcare and patient safety.

Under the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement (NHRA) 2020–26 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, Tenth Revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI); and
- Australian Coding Standards (ACS).

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

For the NEP Determination 2025–26 (NEP25) IHACPA used ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 11.0.

These classifications have been developed in accordance with the Governance Framework for the Development of the Admitted Care Classifications with relevant input from clinicians and other health sector stakeholders represented on IHACPA's advisory committees.

ICD-10-AM/ACHI/ACS Thirteenth Edition

ICD-10-AM/ACHI/ACS Thirteenth Edition will be implemented on 1 July 2025. This includes refinements to better capture complications of surgical and medical care, social and cultural determinants of health, organ, tissue and cell procurement, use of a vaping device and admissions for voluntary assisted dying. ACHI has also been updated in line with the Medicare Benefits Schedule and the Australian Dental Associations' Schedule of Dental Services and Glossary.

Other significant updates for ICD-10-AM/ACHI/ACS Thirteenth Edition include the introduction of cluster coding and standardisation of the ACS.

Cluster coding is a method that links related ICD-10-AM codes into 'clusters' by implementation of a diagnosis cluster identifier (DCID) allocated to ICD-10-AM codes. This will add to the meaningfulness of data coded using ICD-10-AM and prepare for a potential future implementation of ICD-11, where clustering is a feature.

IHACPA has standardised ACS content through the application of a new template that ensures a consistent and clear format with numbered directive statements and consistent style and language in the ACS for Thirteenth Edition.

ICD-10-AM/ACHI/ACS Thirteenth Edition education will be provided through IHACPA Learn, prior to implementation.

For NEP26, IHACPA will use ICD-10-AM/ACHI/ACS Thirteenth Edition to price admitted acute patient services.

IHACPA's framework to implement ICD-11

ICD-11 was adopted by the World Health Assembly (WHA) in 2019 and became the international standard for reporting diseases and health conditions on 1 January 2022. Recent editions of ICD-10-AM, including Thirteenth Edition, align with ICD-11, where possible.

Although Australia has adopted ICD-11, as a member state of the WHA, it is a significant undertaking to implement ICD-11 as a replacement for ICD-10-AM. IHACPA has developed a framework setting out the steps in a pathway to confirm an implementation date, alongside the steps necessary for a future implementation. It includes some work that has already been progressed in consideration of ICD-11 and has three broad categories aimed at assessing the maturity of ICD-11, development of the classification architecture required for ICD-11 and strategies related to stakeholder engagement and governance.

IHACPA will consider these requirements and consult with stakeholders when considering future ICD-10-AM/ACHI/ACS development.

AR-DRG Version 12.0

AR-DRG V12.0 has been finalised in accordance with the governance framework, which sets out policies and principles for the development of the admitted care classifications. IHACPA sought relevant input from clinicians and other health sector stakeholders represented on its technical and advisory committees in its development. AR-DRG Version 12.0 is anticipated to be released in July 2025.

Significant changes for AR-DRG V12.0 followed a review of Major Diagnostic Category (MDC) 14 *Pregnancy, childbirth and the puerperium* to improve the clinical meaningfulness and resource homogeneity within this MDC. This review found that there was significant heterogeneity among episodes grouped to ADRG O66 *Antenatal and other admissions related to pregnancy, childbirth and the puerperium*. Consequently, this Adjacent Diagnosis Related Group (ADRG) was disaggregated into 4 new medical ADRGs in MDC 14 *Pregnancy, childbirth and the puerperium* and one in MDC 19 *Mental health conditions and behavioural and neurodevelopmental disorders* to better capture postnatal depressive episodes.

AR-DRG Version 12.0 also includes a new ADRG, A16 *Posthumous organ procurement*, to facilitate more accurate capture of posthumous organ procurement activity. For NEP26, IHACPA intends to continue to reallocate posthumous organ procurement costs to transplant episodes under AR-DRG Version 12.0. IHACPA is also currently reviewing organ and tissue donation, retrieval and transplantation activity from a data capture, costing and pricing perspective. Future pricing of A16 *Posthumous organ procurement* will be informed by the findings of this project and consultation with IHACPA's advisory committees.

IHACPA notes that whilst cluster coding was implemented in NEP25 within ICD-10-AM/ACHI/ACS Thirteenth Edition, it will not impact AR-DRG Version 12.0.

For NEP26, IHACPA proposes to use AR-DRG Version 12.0 to price admitted acute patient services with no shadow pricing period as this classification does not contain major structural changes or the introduction of new data elements. This approach aligns with IHACPA's National Pricing Model Consultation Policy and Shadow Pricing Guidelines and is consistent with previous versions of AR-DRGs, which have also not been shadow priced.

Additionally, IHACPA notes the impact analysis conducted for the use of ICD-10-AM/ACHI/ACS Thirteenth Edition with AR-DRG Version 12.0 found that episode movements between AR-DRGs were small and not material to the overall performance of the AR-DRG classification.

AR DRG Version 12.0 education will be provided through IHACPA Learn in 2025.

Consultation question
Q2. What, if any, barriers are there to pricing admitted acute episodes of care using AR-DRG Version 12.0 without a shadow pricing period for NEP26?

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 has used AN-SNAP Version 5.0 to price admitted subacute and non-acute services since NEP24.

Following stakeholder feedback, IHACPA is investigating several refinement areas including frailty and patients awaiting aged care or National Disability Insurance Scheme (NDIS) support. IHACPA will continue investigations into work areas to inform the development of the future refinement of AN-SNAP.

For NEP26, IHACPA will continue pricing subacute and non-acute services using AN-SNAP Version 5.0.

3.3 Emergency care

For NEP25, IHACPA used the Australian Emergency Care Classification (AECC) Version 1.1 to price emergency department activities and Urgency Disposition Groups (UDGs) Version 1.3 to price emergency services.

Australian Emergency Care Classification

Following consultation with its working groups and advisory committees as well as implementation of AECC Version 1.1 in July 2025, IHACPA will follow a 3-year approach to review and incorporate other suggested refinement areas into the next AECC version. This will provide a predictable cycle for all stakeholders and a balance between clinical currency and administrative burden from implementing new releases of the classification.

The 3-year approach will ensure alignment with the 3-year development cycle of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Emergency Care (ICD-10-AM) Principal Diagnosis Short List (EPD Short List).

For NEP26, IHACPA will continue pricing emergency department activities using the AECC Version 1.1.

Pricing emergency services

For NEP25, IHACPA used the UDG Version 1.3 to price emergency services. UDGs are used to group emergency service presentations using aggregate level data, namely: type of visit, episode end status and triage. Stakeholder feedback has noted ongoing issues around reporting patient level data and principal diagnosis.

For NEP26, IHACPA will continue using the UDG Version 1.3 to price emergency services.

3.4 Non-admitted care

The Tier 2 Non-Admitted Services Classification (Tier 2) is the existing classification system used to price non-admitted services. IHACPA used Tier 2 Version 9.1 to price non-admitted services for NEP25.

IHACPA undertakes an ongoing classification refinement program for Tier 2 to ensure its relevancy for ABF purposes. For NEP26, IHACPA is consulting with its working groups and advisory committees on additional refinements to Tier 2. IHACPA is considering introducing a new class for hospital based non-admitted voluntary assisted dying (VAD) services and reviewing the current Tier 2 10 series classes to ensure their clinical currency and support work on price harmonisation.

IHACPA will continue using Tier 2 to price non-admitted services for NEP26. IHACPA will assess if any update is required to the classification version to incorporate new refinements.

Consultation questions
Q3. Are there any other refinement areas IHACPA should consider for the Tier 2 Non-Admitted Services Classification for NEP26?

Q4. What considerations should inform the potential introduction and pricing of a Tier 2 class for hospital-based non-admitted voluntary assisted dying (VAD) services?

The Australian Non-Admitted Patient Classification Project

In 2023, IHACPA commenced the Australian Non-Admitted Patient Classification Project (ANAPP), which explores the feasibility of developing a new non-admitted care classification using health information available within state and territory electronic medical record (eMR) systems. This approach to the classification development process aims to minimise the administrative burden on states and territories and the impact on clinical service delivery associated with a traditional costing study.

In October 2023, IHACPA completed the first stage of the project. IHACPA now has a better understanding of state and territory eMR systems, non-admitted patient service rostering, booking and costing systems.

ANAPP stage 2 is in progress and incorporates a large data extraction and costing study. IHACPA continues to consult closely with its working groups and committees on the progress of ANAPP.

3.5 Mental health care

Australian Mental Health Care Classification

In December 2023, IHACPA released the Australian Mental Health Care Classification (AMHCC) Version 1.1. This version included the recalibration of the complexity model and allowed phases with up to 2 missing Health of the Nation Outcome Scales (HoNOS) item scores to attract a valid complexity score.

During the AMHCC Version 1.1 refinement process, stakeholders provided feedback on several other areas for further refinement which would require a more substantial change to the classification structure and variables. In response, IHACPA commenced the work program for the development of AMHCC Version 2.0 in 2024. The areas of refinement currently being discussed within IHACPA's working groups and committees include the treatment of age within the AMHCC and consideration of diagnosis within the complexity score.

As part of the development of AMHCC Version 2.0, IHACPA notes that a more detailed review of the mental health legal status in the community setting, including forensic mental health care, is planned. This will determine if there is a cost differential in delivery of these services and, where possible, help IHACPA account for this differential within the classification. Other priority refinement areas include same day treatments with and without electroconvulsive therapy (ECT) and potential expansion of the Life Skills Profile (LSP-16).

3.6 Teaching and training

Teaching and training activities are 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 (embedded teaching and training), such as ward rounds, these costs are reported as part of routine care and reflected in the ABF price. However, block funding is provided for activities where the components required for ABF are not currently available.

IHACPA has previously consulted stakeholders around challenges with capturing this data in current reporting systems and the ongoing transition to new systems and collection standards.

Based on the feedback received, IHACPA will work with its advisory committees on a longer-term work plan. This work plan will help IHACPA 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.

IHACPA will continue block funding teaching and training activities for NEP26 as it is currently the most suitable model.

4

Setting the national efficient price

4. Setting the national efficient price

The Addendum to the National Health Reform Agreement (NHRA) 2020–26 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 in response to previous consultation papers, IHACPA has identified a range of potential pricing model refinements. Many of these projects 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. Updates on the progression of these deliverables will be provided in the IHACPA Work Program and Corporate Plan 2025–26, due to be released in June 2025.

Only refinements that are likely to have an impact on the development of the NEP Determination 2026–27 (NEP26), or where stakeholder input is required to progress investigation of the refinement, are included in this consultation paper.

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. IHACPA implemented a range of temporary measures to account for the impact of COVID-19 on public hospital service delivery. These included:

- application of the COVID-19 treatment adjustment to a limited number of Australian Refined Diagnosis Related Groups (AR-DRG)
- extension of the intensive care unit (ICU) adjustment to patients with a COVID-19 diagnosis but not admitted to a specified ICU
- suspension of the safety and quality adjustments for episodes of care with a COVID-19 diagnosis.

The intention of the temporary measures was to recognise the uncertainty around anticipated changes that COVID-19 would introduce to the delivery of hospital care and support healthcare delivery to COVID-19 patients in this context.

In October 2023, the Australian Government declared that COVID-19 was no longer a Communicable Disease Incident of National Significance.

For NEP25, the temporary measures noted above were retained to account for the ongoing impact of the COVID-19 pandemic response on hospital activity and cost data in 2022–23 and earlier. NEP26 will be primarily based on hospital activity and cost data from years following the initial impact of COVID-19. The activity and cost data are expected to already incorporate the impact of the pandemic, and resulting changes to models of care, on delivering hospital services. Therefore, there is likely to be a decreased need for the continuation of the temporary measures.

IHACPA has also received advice through its committees and from stakeholders that the ongoing management of COVID-19 patients is generally not significantly different to patients with other respiratory

illnesses, such as influenza. It is likely that temporary pricing adjustments are therefore no longer required to account for the impact of COVID-19 on service delivery.

For these reasons, IHACPA proposes to remove the COVID-19 temporary measures for NEP26.

Consultation questions
Q5. Are there any barriers to removing the remaining temporary measures introduced to manage the impact of COVID-19 for NEP26?

4.2 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.

Clause A47 of the addendum specifies that when making this assessment, IHACPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery such as:

- hospital and local health district type and size
- hospital location, including regional and remote status
- patient complexity, including Indigenous status, which is not captured by the classification system.

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. IHACPA considers adjustment proposals against the Pricing Guidelines, including a preference for adjustments to be based on patient-related rather than provider related characteristics wherever practicable. Adjustment proposals are not considered without sufficient evidence demonstrating that a cost variation meets the eligibility criteria.

Further information about the eligibility criteria 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 NEP Determination 2025–26 on the IHACPA website.

Intensive Care Unit adjustment

Building on the foundational work from 2023 and 2024, outlined in the respective Pricing Framework and Consultation Reports, IHACPA continues to review the ICU eligibility list and associated adjustment. In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26, stakeholders recommended the use of data in addition to mechanical ventilation hours to determine ICU complexity, and resulting eligibility, and the extension of the ICU eligibility criteria to recognise cost variation through patient and provider characteristics. IHACPA is working closely with its advisory committees to progress this piece of work.

The review focuses on 2 key questions:

- whether an ICU adjustment should only be applied to a specified list of hospitals
- whether the cost of ICU care should be bundled in the AR-DRG price for some AR-DRGs where there is a relatively consistent proportion of ICU care, rather than being removed and priced separately through the adjustment.

IHACPA notes bundling ICU costs into the AR-DRG price weight effectively spreads the ICU costs between ICU and non-ICU episodes in each AR-DRG and across all hospitals, regardless of whether they have a specified ICU. Bundling ICU costs this way allows greater flexibility in care delivery, as jurisdictions receive a

higher price weight for episodes in which patients are not admitted to ICU. Under this approach, appropriate alternative treatments can still attract a sufficient price, measured in the National Weighted Activity Unit (NWAU), to cover the cost of care, therefore removing the reliance on ICU hours.

On the other hand, bundling, in general, would be expected to under-price those episodes with more hours in a specified ICU and over-price episodes with fewer or no hours in a specified ICU. However, this effect is small as the vast majority of ICU costs can be attributed to episodes in a specified ICU.

Currently, IHACPA bundles ICU costs into the AR-DRG prices in the Major Diagnostic Category (MDC) 15 *Newborns and other neonates*, meaning they do not attract the existing ICU adjustment as all reported ICU costs are funded through the AR-DRG price weight. However, most other AR-DRGs have more limited capacity to explain variation in ICU costs for patients. Therefore, the ICU costs are removed from the base AR-DRG price weight and the ICU adjustment is applied. IHACPA is seeking stakeholder feedback on the desirability of bundling ICU costs into AR-DRG price weights where they adequately reflect the costs of care across patients and hospitals.

The outcomes of the ICU review are expected to inform determinations beyond 2026–27. However, minor changes to reporting requirements may be introduced for NEP26 to inform implementation of broader changes in future years. The outcome of the review is also likely to inform any subsequent review of the paediatric adjustment and its eligibility criteria as the paediatric adjustment interacts with the ICU adjustment and other classification systems.

Consultation question
Q6. In cases where AR-DRG price weights account for ICU cost variations, should ICU costs be bundled?

Indigenous adjustment

IHACPA has implemented an adjustment for Indigenous patients since NEP12. Based on feedback received to the 2025–26 consultation paper and through its advisory committees, IHACPA undertook preliminary analysis around alternative methodologies to calculate an Indigenous adjustment.

The analysis suggested that in the admitted acute stream, there is significant interaction between the Indigenous adjustment and other adjustments - particularly the remoteness adjustments. It also found that the sequencing of the adjustments has an impact on the resulting adjustments. Furthermore, stakeholder feedback has indicated a need to review if the pricing model could be adapted to support approaches that may reduce rates of discharge against medical advice and unplanned readmissions for First Nations peoples.

IHACPA will continue this technical review of cost and activity data under the existing policy parameters of the NHR Act and addendum. Stakeholder feedback has indicated that a broader review of policy options and consultation with appropriate representatives of the Indigenous community is required. IHACPA intends to undertake this broader investigation and consultation over coming years.

Consultation questions
Q7. In addition to reviewing the interactions underpinning the calculation of the Indigenous adjustment, are there other technical refinements to the existing pricing models that could support high-quality, culturally appropriate care for First Nations peoples?

Other adjustments and their eligibility criteria

The Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025 recommended a reduction in calculation complexity and a review of IHACPA's adjustments, including the residential and treatment remoteness adjustments, to ensure they remain fit-for-purpose and are operating as intended.

The mid-term review also suggested that the NEP may not reflect the true cost of service delivery for jurisdictions with smaller populations due to their higher cost of health service delivery, lack of scale, sparse population distribution and higher wage costs. It recommended that IHACPA explore a separate and further adjustment factor for smaller jurisdictions to compensate for the lower scale and volume and higher disproportionate costs associated with these populations.

IHACPA notes under the NHR Act it determines one national efficient price. As such, IHACPA implements a range of adjustments and measures to address these differentials nationally such as the remoteness adjustments and block funding for small rural hospitals. IHACPA will commence exploratory work to consider the impacts that economies of scale and remoteness have on the national pricing model as part of a multi-year program of work.

Consultation questions

Q8. What principles and processes could guide model simplification in relation to IHACPA's adjustments and pricing models?

Q9. After accounting for current pricing model adjustments and block funding arrangements, what are some drivers of unmet cost variation in public hospital service delivery for people residing in rural and remote areas of Australia?

Q10. After accounting for current pricing model adjustments and block funding arrangements, what are some cost drivers that impact the ability of hospitals and local health networks to achieve economies of scale under the ABF model?

Q11. What, if any, evidence is there to suggest that the actual costs of care are not being accurately reflected in cost data collections and how can IHACPA support jurisdictions in reporting these?

4.3 Supporting the pricing of mental health care

For NEP25, IHACPA priced admitted mental health care and community mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.1. This was achieved through the implementation of transitional block funding measures for community mental health care following 4 years of shadow pricing.

IHACPA intends to review the transitional block funding arrangements for community mental health care as part of a broader review of the block funding criteria.

For NEP26, IHACPA will continue pricing community mental health care using AMHCC Version 1.1.

Consultation question

Q12. What, if any, further measures are required in NEP26 to support the second year of community mental health care services transitioning to ABF?

4.4 Accounting for private patients in public hospitals

The addendum specifies 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 revenues.

In addressing clauses A13, A43 and A44 of the addendum, IHACPA developed the following definition of financial neutrality and payment parity in terms of revenue per 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.

In fulfilling its functions under clause A44 of the addendum, IHACPA intends to adopt the same methodology for NEP26.

Once the new multi-year addendum to the NHRA is finalised, IHACPA will review its approach to private patient neutrality to determine if there are changes to relevant clauses in the new addendum. If there are changes, IHACPA will consult with state and territory governments and the National Health Funding Body on the private patient adjustment methodology.

Phasing out the private patient correction factor

The reporting of private patient medical expenses has been inconsistent in the National Hospital Cost Data Collection (NHCDC), with some states and territories not reporting private patient medical costs within their NHCDC 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 NHCDC in order to prevent potential under-pricing.

The Australian Hospital Patient Costing Standards Version 4.2 provide guidance to ensure all in-scope costs are allocated to hospital activity to reflect resource utilisation in a complete and consistent manner. The standards require that jurisdictions make every effort to include all expenses incurred for products relevant to patient care in the cost ledger for submission as part of the NHCDC. IHACPA notes the private patient correction factor will be phased out once all jurisdictions have advised that their NHCDC cost reporting is complete in respect to private patient costs (admitted acute, admitted subacute and non-acute, and admitted mental health streams).

4.5 Harmonising price weights across 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 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 conjunction with its advisory committees. IHACPA signalled its intent to harmonise dialysis and chemotherapy for NEP25 in the Consultation Paper for Australian Public Hospital Services 2025–26 with consideration of local admission policies and clinical impacts. However, despite stakeholder support, data linkage challenges and unexplained differences in reported costs across settings hindered progression.

Two Tier 2 non-admitted interventions classes are currently harmonised with equivalent same-day admitted acute procedures:

- 10.02 Interventional imaging (harmonised since 2014–15)
- 10.06 Endoscopy – gastrointestinal (harmonised since 2016–17).

The harmonisation approach for both classes uses admitted acute costs drawn from episodes with equivalent Australian Classification of Health Intervention (ACHI) codes, rather than non-admitted costs, to set the price of the non-admitted service event. IHACPA intends to review this approach.

Additionally, in 2025 IHACPA noted a significant national increase in the use of the multiple healthcare provider indicator in the Tier 2 non-admitted clinic 10.06. The use of this indicator for the Tier 2 non-admitted clinic 10.02 has also grown steadily. While feedback indicates usage of the indicator is legitimate under the relevant definitions, this change in reporting suggests that the multidisciplinary clinic adjustment may incentivise the provision of services in a non-admitted rather than admitted setting, thereby contravening the concept of harmonisation.

IHACPA notes the relevance of two pricing guidelines in relation to the 10.02 and 10.06 clinics:

- 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.

However, IHACPA also acknowledges significant challenges associated with price harmonisation including:

- developing an appropriate pricing methodology based on the admitted price, non-admitted or other price or a weighted combination
- managing the risks of the pricing approach such as admitted care being under-priced and non-admitted care being over-priced based on reported cost data
- capturing the costs of all inputs to care in the harmonised price, for example where the non-admitted harmonised price weight may only reflect a portion of the admitted service
- considering the impact of jurisdictional differences in service delivery and the reasons for these variations.

For NEP26, IHACPA intends to review its price harmonisation methodology and will consult closely with jurisdictions and its advisory committees.

Consultation question
Q13. What, if any, clinical reasons are there for patients requiring chemotherapy, dialysis, interventional imaging or gastrointestinal endoscopy to be treated in an admitted versus non-admitted setting, and how could this be accounted for in a price harmonisation methodology?

5

Setting the national efficient cost

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) 2020–26. Such services include small rural hospitals, which are funded by a block allocation based on their size, location and the type of services provided.

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 eligible hospitals is based on a fixed component as well as a variable ABF-style component. Under this approach, the fixed component decreases as the variable component increases, reflecting greater volume of activity.

IHACPA will continue to use the 'fixed-plus-variable' model for the NEC Determination 2026–27 (NEC26).

5.3 Review of block funding criteria and arrangements

Clause A52 of the addendum notes that in consultation with jurisdictions, IHACPA develops the block funding criteria and identifies whether hospital services and functions are eligible for block funding only or mixed ABF and block funding.

To support the transition of community mental health from block funding to ABF for NEP25, IHACPA developed specific, time-limited block funding criteria for community mental health care services. This allowed IHACPA to extend the block funding for these services for a further year in 2025–26.

Responding to stakeholder feedback requesting review of the block funding criteria for other hospitals and services, IHACPA will undertake a broad review of the block funding criteria for small rural hospitals, standalone hospitals and rural and regional local hospital networks delivering a low volume of community mental health services for NEC26. This will form the first stage of a review of all block funding arrangements, including:

- block-funded services categories
- methods of determining block funding amounts and the processes and data that underpin these
- longer-term opportunities to support efficiency, safety and quality, value, as well as integration and flexibility of care as part of block-funded hospitals and services.

As part of the initial review of the block funding criteria for NEC26, IHACPA will consider hospitals and establishments currently listed in the NEC25 Determination and proposed by jurisdictions in the context of

factors that may impact their performance under ABF, including pricing model results, service volume, economies of scale and specialisation. It will seek to develop strengthened definitions and thresholds for concepts such as the technical requirements of ABF, standalone hospitals, low volume, low case mix diversity and skewed length of stay profiles. This intends to underpin transparent, multi-factorial criteria that go beyond volume thresholds in determining block funding eligibility.

Where evidence is available, IHACPA will also consider trends in these factors over recent years as part of the changing profile of population demographics, the organisation of services and establishments, technology and the costs of service delivery. Recent advances in IHACPA's classifications and pricing models may also support some currently block-funded hospitals to be appropriately funded under ABF.

IHACPA will draw on its Pricing Guidelines to guide the review, as well as policy principles that are particularly relevant to block funding, such as funding stability and predictability and equity of access. IHACPA is seeking input from stakeholders to guide this review, particularly on factors relevant to the review of the block funding criteria for small rural hospitals, standalone hospitals and rural and regional local hospital networks delivering a low volume of community mental health services for NEC26.

Consultation question
Q14. What policy principles and considerations should guide IHACPA's workplan for the review of the various existing block funding criteria and arrangements?

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 2026–27, the following high cost, highly specialised therapies have been recommended for delivery in public hospitals based on advice from the Australian Government:

- Kymriah® for the treatment of:
  - acute lymphoblastic leukaemia in children and young adults
  - diffuse large B-cell lymphoma
  - primary mediastinal large B-cell lymphoma
  - transformed follicular lymphoma.
- Yescarta® for the treatment of:
  - diffuse large B-cell lymphoma
  - primary mediastinal large B-cell lymphoma
  - transformed follicular lymphoma
  - relapsed or refractory large B-cell lymphoma.
- Qarziba® for the treatment of:
  - high risk neuroblastoma.
- Luxturna™ for the treatment of:
  - inherited retinal dystrophies.
- Tecartus® for the treatment of:
  - relapsed or refractory mantle cell lymphoma
  - relapsed or refractory B-precursor acute lymphoblastic leukaemia.

The indicative block-funded costs for the delivery of these high cost, highly specialised therapies based on the advice of states and territories will be included in NEC26.

Under the current funding arrangements for high cost, highly specialised therapies, after a therapy has been deemed eligible for funding under the NHRA, IHACPA includes this in the NEC and Pricing Framework for Australian Public Hospital Services. Following its delivery, jurisdictions are required to submit activity and cost data to IHACPA, including the treatment centres and local hospital networks providing the highly specialised therapy. The Administrator of the National Health Funding Pool then reconciles funding to the submitted activity and cost data.

Consultation questions

Q15. As the current arrangements for high cost, highly specialised therapies have been in place since 2020, what, if any, refinements are required to ensure they remain fit-for-purpose?

Q16. What pricing considerations are pertinent for these and other high cost, highly specialised services?

6

Data collection

6. Data collection

Under the Addendum to the National Health Reform Agreement 2020–26 the Independent Health and Aged Care Pricing Authority (IHACPA) is required to develop, refine and maintain systems as necessary 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 annually to communicate the cost and activity data reporting requirements to state and territory governments for the next three years, in accordance with clauses B66 to B83 of the addendum. The Three Year Data Plan is supported by the Data Compliance Policy, which describes the process and criteria IHACPA uses to publicly report on state and territory data submission compliance. The data requirements and data submission dates are 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. Teaching, training and research and hospital cost data, provided through the National Hospital Cost Data Collection (NHCDC), are reported on an annual basis. Quarterly 'year to date' data collection enables data from previous submissions to be corrected. It also enables monitoring of hospital activity trends following the implementation of the national efficient price each year.

Additionally, to facilitate the collection of accurate activity and cost data for the annual NEP and NEC determinations, IHACPA works with states and territories to develop and update data request specifications each year. IHACPA ensures strict procedures are followed to acquire, validate and maintain data within the IHACPA secure data management system. In developing these data specifications, IHACPA is guided by the principle of data rationalisation, including the concept of 'single provision, multiple use', as outlined in the addendum.

IHACPA collects data to develop the NEP and NEC each year, acting as an incentive for state and territory governments to report data to IHACPA. IHACPA continues to receive cost data for over 95% of admitted patient activity nationally.

Australian Hospital Patient Costing Standards

NEP26 is underpinned by 2023–24 cost data. For 2023–24, NHCDC submissions were guided by the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2, which included minor updates to emergency care, non-admitted care and contracted care.

IHACPA will continue to work closely with its advisory committees to undertake future updates to the AHPCS as required.

6.2 Assurance of cost data

For the NEP Determination 2025–26 (NEP25) IHACPA undertook quality assurance of the 2022–23 NHCDC data submissions. The process involved reviewing the NHCDC submissions and data quality statements from states and territories to ensure the NHCDC data was prepared in accordance with the AHPCS.

For NEP25, based on data submitted to the NHCDC 2022–23, IHACPA observed minor changes in the volume and quality of data submitted by state and territory governments. The outcomes and impact of the

observed changes to the data collected are discussed in detail within the NHCDC Public Sector Review Report 2022–23.

Independent Financial Review

Following changes to the quality and completeness of data submitted to the NHCDC 2022–23, IHACPA intends to engage an independent consultant to undertake an Independent Financial Review (IFR) of the NHCDC 2023–24 to ensure the NHCDC continues to be robust and fit-for-purpose for NEP26. Key considerations for this review will include:

- assessing the accuracy and completeness of hospital financial reconciliations
- determining the consistency of the application of the AHPCS Version 4.2
- reviewing the data flow from hospital general ledgers through to IHACPA publication
- a targeted assessment deep dive into Intensive Care Units (ICU), which will look at the definitions of ICU from sampled hospitals, how activity is costed for ICUs, the mapping to cost centres, and how costs are submitted to the NHCDC.

This will be facilitated by site visits (on-site and virtual), undertaking data reconciliation activities with the states and territories, and a peer review of methodologies across the states and territories.

Data Quality Framework

IHACPA is currently developing a Data Quality Framework to enable consistent assessment, understanding, communication, and management of data quality throughout the data lifecycle. This project was developed from a recommendation of the NHCDC Public Sector Review Report 2021–22, to develop an updated Data Quality Framework, in consultation with the jurisdictions. The recommendations from this project will inform future improvements to IHACPA's data collections.

The Data Quality Framework sets out to provide a systematic and methodological rigour to IHACPA's data quality processes at each stage of the data lifecycle. The framework will include clear definitions and approaches to determine data quality, enable consistency in data quality related processes, and outline what tools, systems, and stakeholders are involved in supporting data quality outcomes.

IHACPA is currently working with its advisory committees to complete this project and anticipates the framework will be published in 2025.

NHCDC Dashboard

In July 2023, IHACPA began the development of the NHCDC Dashboard to improve the timeliness of producing state and territory quality assurance (QA) and cost weight reports.

In January 2025, IHACPA released the NHCDC dashboard to the states and territories in preparation for the NHCDC 2023–24. Once NHCDC 2023–24 submissions have passed validation, and are approved for release by IHACPA, the individualised results from these submissions will be presented on the dashboard. The dashboard is versatile for data presentation, allowing the states and territories to view their data in more detail and complete extensive reconciliation. To support transition to using the new format of QA reports, IHACPA will also produce the QA reports in a spreadsheet format for each jurisdiction for NHCDC 2023–24 only.

Enhancing the accuracy and timeliness of the NHCDC assists in making the data available more robust, accurate and fit-for-purpose to inform the NEP.

Cost Bucket Review

In July 2024, IHACPA commenced the Cost Bucket Review to explore the use of cost centres and line items across the NHCDC public and private sectors.

The objectives of the Cost Bucket Review are to:

- identify and analyse the impact and materiality of variations in the use of cost centres and line items across the jurisdictions
- review the definition of all NHCDC cost centres and line items, including how they are grouped into cost centre function and cost bucket for the purpose of reporting
- provide recommendations that promote consistency in reporting to the NHCDC and the use of cost centres and line items across health services nationally.

IHACPA is working closely with its advisory committees and stakeholders on this review and anticipates its completion in 2025. IHACPA and its committees will then assess the recommendations from the review to plan the implementation stage. A further update will be provided within the Pricing Framework for Australian Public Hospital Services 2026–27.

Consultation question
Q17. Given high quality cost data is a key input to informing the NEP, how can IHACPA ensure the data received through the NHCDC continues to be accurate, robust and fit-for-purpose?

6.3 Understanding recent growth in hospital costs

One of IHACPA's legislated functions is to promote efficiency in public hospital services through setting the NEP and NEC annually. Clause A46 of the addendum notes that in determining the NEP, IHACPA must have regard to ensuring the financial sustainability of the public hospital system as well as the need for continuity and predictability in prices.

The national efficient price (NEP) was $7,258 per national weighted activity unit in 2025–26 (NWAU(25)). This is a 5.9% year-on-year increase after back casting, which is the highest increase since the introduction of national ABF. IHACPA's analysis of cost drivers for NEP25 found this growth reflects 2022–23 cost increases reported across a range of areas, including workforce-associated costs.

To promote health system efficiency, IHACPA will continue to investigate the key drivers of these increases for NEP26. Some potential avenues that warrant further analysis include increased workforce and on-costs and outcomes of employee wage agreement negotiations.

For NEP26 and future determinations, IHACPA intends to further investigate trends in the input data that inform the NEP (the activity and cost datasets). This investigation will assess whether the movement is adequately explained and the likelihood such growth will persist in future years.

Consultation questions
Q18. What potential areas of refinement could IHACPA consider to support the future sustainability and predictability of public hospital costs and funding?

Q19. What evidence, if any, is there to suggest that costs in categories such as labour and on-costs have increased since 2022–23 and will be reflected in future NHCDC cycles?

6.4 National Benchmarking Portal

In 2021, IHACPA released the National Benchmarking Portal (NBP), a secure website-based application that provides public access to aggregated data held by IHACPA, 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 (NWAU)
- hospital acquired complications (HACs)
- avoidable hospital readmissions (AHRs).

Within each dashboard the user can filter data according to their chosen state or territory, local hospital network, hospital, or hospital peer group as well as other, dashboard-specific filters.

All data is aggregated using common variables including hospitals or establishments, classification end-class, care stream and month of separation. If a user selects filters that result in a small sample size (30 records for Cost per NWAU and 20 records for HAC and AHR areas of focus), indicators and charts are masked to maintain patient confidentiality and statistical robustness.

Following stakeholder feedback, IHACPA plans to add an interface with jurisdictional log-in to present more detailed benchmarking without masking low volume selections. This will be included as part of the next iteration of the NBP.

6.5 Implementing recommendations from the Virtual Care Project

In 2025, IHACPA published the Virtual Care Project – Final Report, with stakeholders consulted throughout the project. The key findings included:

- all virtual care models identified by stakeholders that are in-scope for National Health Reform Agreement funding have existing activity based funding (ABF) or block funding arrangements
- while most models can be reported in the activity and cost data IHACPA currently collects, IHACPA may not be able to specifically identify some models under the current national reporting specifications
- there is inconsistent inclusion and allocation of the costs associated with virtual care in national costing
- broader health system challenges may be further increased by the emergence of virtual care as it breaks down the boundaries of the health system across primary care, aged care and the National Disability Insurance Scheme.

The report identified 5 key recommendations for IHACPA, in collaboration with other Australian Government agencies and health departments. The recommendations seek to improve the integration of virtual care into pricing and funding models and develop a national strategy by:

- developing a national definition and taxonomy of virtual care
- improving the visibility of virtual care in national data collections
- improving national consistency in the identification and allocation of virtual care costs
- considering supplementary collections to the NHCDC to cost service innovations, including virtual care

- developing a pathway to transition service innovations to ABF or alternative funding models that improve value.

IHACPA is developing a work plan to respond to the recommendations identified in the Virtual Care Project report. IHACPA will progress this work plan in consultation with its committees and stakeholders. The results of this work will inform determinations beyond the NEP26 pricing year.

IHACPA will seek to address the recommendation on developing a definition and taxonomy of virtual care by contributing to the work of the Australian Institute of Health and Welfare's National Health Data and Information Standards Committee Virtual Care Working Group in 2025. National agreement on a definition is considered foundational to other recommended actions, including expansion of data collection and improved costing practices for virtual care.

Additionally, the fifth recommendation relates to IHACPA's ongoing work to consider funding models for emergency virtual care (EVC) services. At present, virtual emergency department (ED) activity is not included in the national emergency care data collections and not classified and priced using the Australian Emergency Care Classification (AECC). In-scope ED videoconference services have instead been block-funded since 2022 and most states have now established these services.

In 2023, IHACPA commenced collection of EVC activity data on a voluntary basis through the EVC data request specifications. The aim was to understand the scope of current virtual emergency care models within and across jurisdictions. IHACPA is seeking to refine the EVC data collection to ensure consistency of definitions for reporting purposes and support a greater volume of submissions to build a clearer national picture of this activity. This evidence base will support the transition of ED videoconference services into appropriate long-term funding arrangements.

Consultation questions
Q20. What, if any, barriers are there to collecting EVC data submissions and how can IHACPA help jurisdictions to overcome these barriers?

Q21. What are some further refinement areas for the EVC data request specifications?

7

Treatment of other Commonwealth programs

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 2020–26 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 (NHCDC) 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.

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

- 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 benefits from the NHCDC requires linking of the payments to the corresponding hospital episodes where possible, as well as removing aggregate amounts where payments cannot be directly linked.

Pharmaceutical Benefits Scheme data linking project

IHACPA has been conducting a project to improve the linking of benefits paid under the PBS to hospital activity data to better reflect the associated PBS payments and in turn, improve the representativeness of the resulting prices. The project aims to more accurately remove PBS benefits across all streams of hospital care. IHACPA notes that in implementing changes to the linking methodology there may be impacts on all end-class price weights, particularly for chemotherapy, cystic fibrosis and multiple sclerosis.

IHACPA will continue consulting with its advisory committees on the potential impact of these differences.

8

Future funding models

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 and enabled a stable and sustainable rate of growth in public hospital costs.

IHACPA intends to conduct a review of its pricing approaches following the finalisation of the new multi-year NHRA addendum currently under negotiation.

8.2 Trialling innovative models of care

Clause A99 of the Addendum to the NHRA 2020–26 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 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.

IHACPA's role, as outlined in the addendum, is to provide advice and facilitate exploration and trial of new and innovative approaches to public hospital funding.

New South Wales (NSW) currently has several models which have been block-funded through these arrangements under the NEC. In 2025, IHACPA will work with NSW and the Commonwealth to support their review and potential transition into the national model.

IHACPA notes the new multi-year NHRA addendum has not yet been finalised and will continue to support these negotiations. Once a new addendum is finalised, IHACPA will work with the parties to the NHRA to review and implement any changes related to the trial of new and innovative approaches to public hospital funding.

In the interim, IHACPA will continue to work with jurisdictions to develop and provide advisory support for the trialling of innovative models of care. Jurisdictions investigating alternative funding models are encouraged to approach IHACPA and the Commonwealth.

9

Pricing and funding for safety and quality

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 (the Commission) follow a collaborative work program to incorporate safety and quality measures into the national efficient price (NEP), as required under the Addendum to the National Health Reform Agreement (NHRA) 2020–26.

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 (HACs) and avoidable hospital readmissions (AHRs).

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 Commission 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.

As per the addendum (clauses A165–A166), IHACPA will continue to apply this funding adjustment for episodes with a sentinel event for the NEP Determination 2026–27 (NEP26) using Version 2.0 of the Australian Sentinel Events List published on the Commission'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 2025–26 and the National Pricing Model Technical Specifications 2025–26.

For NEP26, IHACPA intends to review the risk factors adopted for each HAC in the HAC risk adjustment model outlined in Table 6 of the Risk adjustments for hospital acquired complications technical specifications 2025–26.

The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant.

For NEP26, IHACPA intends to use Version 3.1 of the HACs list on the Commission's website to implement the HACs funding adjustment.

IHACPA notes cluster coding, a feature of ICD-10-AM/ACHI/ACS Thirteenth Edition is not expected to impact the pricing approach for HACs for NEP26.

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 2025–26 and the National Pricing Model Technical Specifications 2025–26.

For NEP26, IHACPA intends to review the risk factors adopted for each readmission category in the AHR risk adjustment model outlined in Table 7 of the Risk adjustments for avoidable hospital readmissions technical specifications 2025–26.

For NEP26, IHACPA intends to use Version 2.0 of the AHRs list on the Commission's website to implement the avoidable hospital readmissions funding adjustment.

IHACPA notes cluster coding, a feature of ICD-10-AM/ACHI/ACS Thirteenth Edition is not expected to impact the pricing approach for AHRs for NEP26.

Consultation question
Q22. What, if any, are additional risk factors IHACPA should consider in the risk adjustment models for HACs and AHRs?

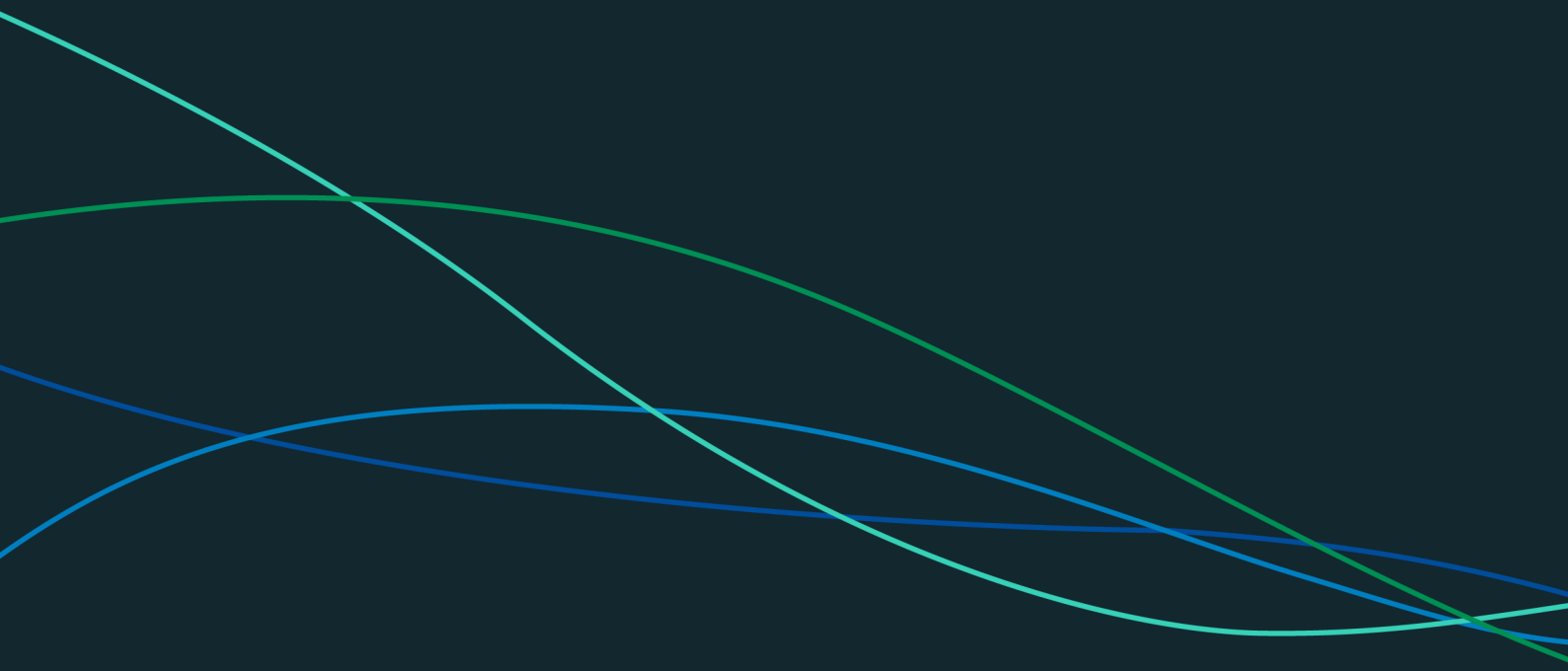
Appendix

Appendix A: Consultation questions

Question		Page
1	Are stakeholders supportive of revising the promoting harmonisation Pricing Guideline to: "Promoting harmonisation: Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities"?	10
2	What, if any, barriers are there to pricing admitted acute episodes of care using AR-DRG Version 12.0 without a shadow pricing period for NEP26?	15
3	Are there any other refinement areas IHACPA should consider for the Tier 2 Non-Admitted Services Classification for NEP26?	16
4	What considerations should inform the potential introduction and pricing of a Tier 2 class for hospital-based non-admitted voluntary assisted dying (VAD) services?	16
5	Are there any barriers to removing the remaining temporary measures introduced to manage the impact of COVID-19 for NEP26?	20
6	In cases where AR-DRG price weights account for ICU cost variations, should ICU costs be bundled?	21
7	In addition to reviewing the interactions underpinning the calculation of the Indigenous adjustment, are there other technical refinements to the existing pricing models that could support high-quality, culturally appropriate care for First Nations peoples?	21
8	What principles and processes could guide model simplification in relation to IHACPA's adjustments and pricing models?	22
9	After accounting for current pricing model adjustments and block funding arrangements, what are some drivers of unmet cost variation in public hospital service delivery for people residing in rural and remote areas of Australia?	22
10	After accounting for current pricing model adjustments and block funding arrangements, what are some cost drivers that impact the ability of hospitals and local health networks to achieve economies of scale under the ABF model?	22
11	What, if any, evidence is there to suggest that the actual costs of care are not being accurately reflected in cost data collections and how can IHACPA support jurisdictions in reporting these?	22
12	What, if any, further measures are required in NEP26 to support the second year of community mental health care services transitioning to ABF?	22
13	What, if any, clinical reasons are there for patients requiring chemotherapy, dialysis, interventional imaging or gastrointestinal endoscopy to be treated in an admitted versus non-admitted setting, and how could this be accounted for in a price harmonisation methodology?	24
14	What policy principles and considerations should guide IHACPA's workplan for the review of the various existing block funding criteria and arrangements?	27
15	As the current arrangements for high cost, highly specialised therapies have been in place since 2020, what, if any, refinements are required to ensure they remain fit-for-purpose?	28
16	What pricing considerations are pertinent for these and other high cost, highly specialised services?	28
17	Given high quality cost data is a key input to informing the NEP, how can IHACPA ensure the data received through the NHCDC continues to be accurate, robust and fit-for-purpose?	32

Appendix A: Consultation questions

18	What potential areas of refinement could IHACPA consider to support the future sustainability and predictability of public hospital costs and funding?	32
19	What evidence, if any, is there to suggest that costs in categories such as labour and on-costs have increased since 2022–23 and will be reflected in future NHCDC cycles?	32
20	What, if any, barriers are there to collecting EVC data submissions and how can IHACPA help jurisdictions to overcome these barriers?	34
21	What are some further refinement areas for the EVC data request specifications?	34
22	What, if any, are additional risk factors IHACPA should consider in the risk adjustment models for HACs and AHRs?	41



Independent Health and Aged Care Pricing Authority

Eora Nation, Level 12, 1 Oxford Street
Sydney NSW 2000

Phone 02 8215 1100
Email enquiries.ihacpa@ihacpa.gov.au

www.ihacpa.gov.au