



**IHACPA**

# **Pricing Framework for Australian Public Hospital Services 2026–27**

December 2025

Independent Health and Aged Care Pricing Authority

## **Pricing Framework for Australian Public Hospital Services 2026–27 — December 2025**

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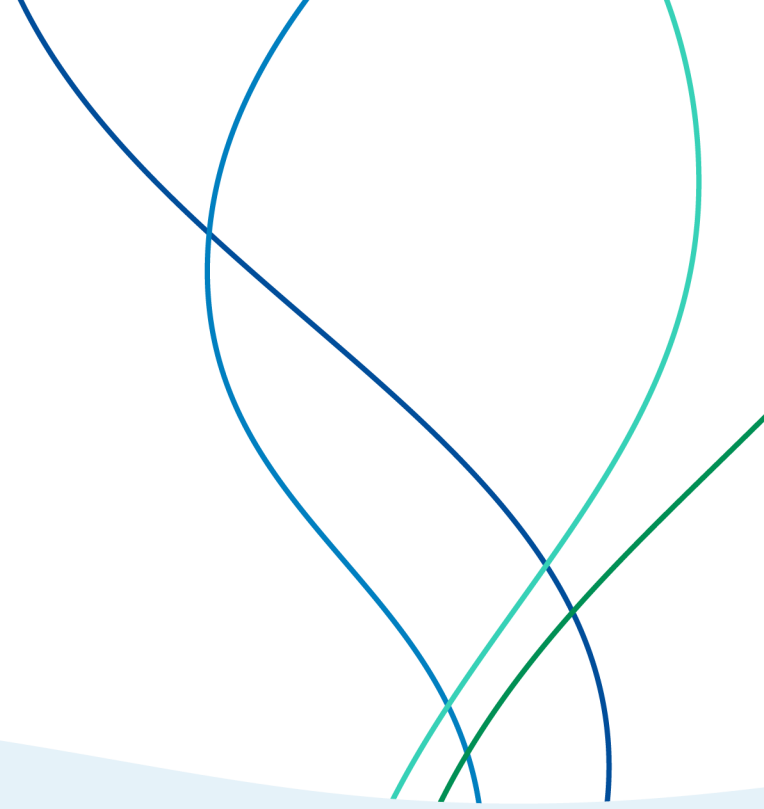
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# Abbreviations

Abbreviation	
<b>ABF</b>	Activity based funding
<b>ACHI</b>	Australian Classification of Health Interventions
<b>ACS</b>	Australian Coding Standards
<b>ADRG</b>	Adjacent Diagnosis Related Group
<b>AECC</b>	Australian Emergency Care Classification
<b>AHR</b>	Avoidable hospital readmission
<b>AMHCC</b>	Australian Mental Health Care Classification
<b>ANAPP</b>	Australian Non-Admitted Patient Classification Project
<b>AN-SNAP</b>	Australian National Subacute and Non-Acute Patient Classification
<b>AR-DRG</b>	Australian Refined Diagnosis Related Group
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>ACSQHC</b>	Australian Commission on Safety and Quality in Health Care
<b>COVID-19</b>	Coronavirus disease 2019
<b>CALD</b>	Culturally and linguistically diverse
<b>DRS</b>	Data request specifications
<b>ED</b>	Emergency department
<b>eMR</b>	Electronic medical record
<b>EVC</b>	Emergency virtual care
<b>HAC</b>	Hospital acquired complication
<b>HDU</b>	High-dependency units
<b>HoNOS</b>	Health of the Nation Outcome Scales
<b>HST</b>	Highly specialised therapy

<b>ICD-10-AM</b>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
<b>ICU</b>	Intensive care unit
<b>IHACPA</b>	Independent Health and Aged Care Pricing Authority
<b>LHN</b>	Local hospital network
<b>MDC</b>	Major Diagnostic Category
<b>NDIS</b>	National Disability Insurance Scheme
<b>NMDS</b>	National Minimum Data Set
<b>NEC</b>	National efficient cost
<b>NEP</b>	National efficient price
<b>NHCDC</b>	National Hospital Cost Data Collection
<b>NHRA</b>	National Health Reform Agreement
<b>NWAU</b>	National weighted activity unit
<b>PBS</b>	Pharmaceutical Benefits Scheme
<b>The addendum</b>	Addendum to the National Health Reform Agreement 2020–26
<b>The Commission</b>	Australian Commission on Safety and Quality in Health Care
<b>The mid-term review</b>	Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report
<b>Tier 2</b>	Tier 2 Non-Admitted Services Classification
<b>UDG</b>	Urgency Disposition Group
<b>VAD</b>	Voluntary assisted dying

**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* 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 2026–27](#) for a 30-day public consultation period on 14 May 2025. The consultation paper set 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 30 submissions to the consultation paper. The submissions from respondents who gave permission for publication are available on the [IHACPA Engagement Hub](#). A [consultation report](#) that includes commentary on how IHACPA reached its decisions for 2026–27 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, 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 [IHACPA Work Program and Corporate Plan 2025–26](#), and IHACPA's broader vision for the future and the steps that will be taken to achieve its goals and objectives are outlined in the [IHACPA Strategic Plan 2025–30](#).

## **Addendum to NHRA 2020–26**

IHACPA notes that the current Addendum to the NHRA 2020–25 has been amended and extended by Schedule K. The addendum was signed by Australian governments in February 2025 for the period 1 July 2025 to 30 June 2026. This pricing framework refers to the addendum and subsequent Schedule K extension as the Addendum to the NHRA 2020–26.

This pricing framework has been developed within this legislated context and will focus on the issues pertinent to the development of the NEP Determination 2026–27 (NEP26) and NEC Determination 2026–27 (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.

# 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.

In 2025, IHACPA published the [Virtual Care Project – Final Report](#), with stakeholders consulted throughout the project. Chapter 6 of this pricing framework provides further detail regarding its key findings and recommendations.

While several existing Pricing Guidelines are particularly relevant to pricing virtual care, 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. To strengthen the Pricing Guidelines, IHACPA proposed to explicitly state within the promoting harmonisation guideline that pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities.

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27, stakeholders broadly supported the proposed revision to the promoting harmonisation Pricing Guideline, noting this change would reflect the benefits of enabling virtual care provision across appropriate settings, support innovation and promote equity. Further detail on this feedback is provided in the consultation report.



#### **IHACPA's decision**

IHACPA has revised the promoting harmonisation Pricing Guideline to: “Promoting harmonisation: Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities”.



#### **Next steps and future work**

Once the next addendum to the NHRA is finalised, IHACPA will undertake a comprehensive review of its Pricing Guidelines.

**Figure 1: The Pricing Guidelines**

<p><b>Overarching Guidelines</b> that articulate the policy intent behind the introduction of funding reform for public hospital services comprising activity based funding (ABF) and block grant funding:</p> <ul style="list-style-type: none"> <li>• <b>Timely-quality care:</b> 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.</li> <li>• <b>Efficiency:</b> ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.</li> <li>• <b>Fairness:</b> 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.</li> <li>• <b>Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:</b> Funding design should recognise the complementary responsibilities of each level of government in funding health services.</li> </ul> <p><b>Process Guidelines</b> to guide the implementation of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none"> <li>• <b>Transparency:</b> All steps in the determination of ABF and block grant funding should be clear and transparent.</li> <li>• <b>Administrative ease:</b> Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.</li> <li>• <b>Stability:</b> The payment relativities for ABF are consistent over time.</li> <li>• <b>Evidence-based:</b> Funding should be based on the best available information, that is both nationally applicable and consistently reported.</li> </ul>	<p><b>System Design Guidelines</b> to inform the options for design of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none"> <li>• <b>Fostering clinical innovation:</b> 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.</li> <li>• <b>Promoting value:</b> Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.</li> <li>• <b>Promoting harmonisation:</b> Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities.</li> <li>• <b>Minimising undesirable and inadvertent consequences:</b> Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.</li> <li>• <b>Using ABF where practicable and appropriate:</b> ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.</li> <li>• <b>Single unit of measure and price equivalence:</b> 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.</li> <li>• <b>Patient-based:</b> Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.</li> <li>• <b>Public-private neutrality:</b> 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.</li> </ul>
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# 3

**Classifications used to  
describe and price public  
hospital services**

# 3. Classifications used to describe and price public hospital services

## 3.1 Overview

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 that 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.

## 3.2 Admitted acute care

The Australian Refined Diagnosis Related Groups (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. 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 was implemented on 1 July 2025, with education available through [IHACPA Learn](#).

## AR-DRG Version 12.0

AR-DRG Version 12.0 was released in July 2025. AR-DRG Version 12.0 was 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 working groups and advisory committees in its development.

Significant changes for AR-DRG Version 12.0 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 Adjacent Diagnosis Related Group (ADRG) O66 *Antenatal and other admissions related to pregnancy, childbirth and the puerperium*. Consequently, this 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.

In response to the consultation paper, most stakeholders did not identify any barriers to the implementation of AR-DRG Version 12.0 without a shadow pricing period based on minimal structural changes and alignment with past practices. Some stakeholders recommended shadow pricing to mitigate risks that come from changes in clinical coding practices, ensure data stability and minimise variances that may impact NEP Determination 2026–27 (NEP26). Further detail on this feedback is provided in the consultation report.

IHACPA notes the classification does not contain major structural changes or the introduction of new data elements. The approach to not shadow price aligns with IHACPA's [National Pricing Model Consultation Policy](#) and [Shadow Pricing Guidelines](#), and is consistent with the implementation of previous versions of AR-DRGs, which have also not been shadow priced.



### IHACPA's decision

IHACPA will price admitted acute episodes of care using AR-DRG Version 12.0 without a shadow pricing period for NEP26. IHACPA will continue to reallocate posthumous organ procurement costs to transplant episodes for NEP26.



### Next steps and future work

Impact analysis has been developed to enable jurisdictions to understand and anticipate pricing changes between AR-DRG Version 11.0 and Version 12.0. AR-DRG Version 12.0 education is available through [IHACPA Learn](#). 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 in consultation with IHACPA's advisory committees.

### 3.3 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 NEP Determination 2024–25 (NEP24).

Following stakeholder feedback, IHACPA is investigating several refinement areas including frailty and patients awaiting aged care or National Disability Insurance Scheme (NDIS) support. In response to the consultation paper, New South Wales (NSW) and South Australia (SA) provided support for refining these areas of the classification.



#### **IHACPA's decision**

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



#### **Next steps and future work**

IHACPA will continue the refinement of AN-SNAP, including a review of frailty measures and treatment of maintenance care patients awaiting aged care or NDIS support.

### 3.4 Emergency care

#### **Australian Emergency Care Classification (AECC)**

The AECC Version 1.1 was implemented from 1 July 2025 following consultation with its working groups and advisory committees. Consistent with all classifications, the AECC will undergo a regular cycle of refinement in the future.



#### **IHACPA's decision**

For NEP26, IHACPA will continue to price emergency department (ED) activities using the AECC Version 1.1.

#### **Pricing emergency services**

Urgency Disposition Groups (UDGs) are used to group emergency service presentations using aggregate level data, namely: type of visit, episode end status and triage. Even though the AECC has become the primary method for classifying ED presentations, UDGs are still used in specific situations within the Australian hospital pricing system. UDGs are mainly applied when emergency care is delivered outside of traditional ED settings, such as in urgent care clinics or smaller facilities, where the AECC may not be suitable. Additionally, UDGs remain in use at facilities that have not yet transitioned to the AECC system. They also serve as a fallback classification when episodes contain missing or invalid data, which would prevent accurate AECC grouping.



#### **IHACPA's decision**

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

## **3.5 Non-admitted care**

The Tier 2 Non-Admitted Services Classification (Tier 2) is the existing classification system used to price non-admitted patient services. Tier 2 Version 9.1 was implemented from 1 July 2025.

IHACPA undertakes an ongoing classification refinement program for Tier 2 to ensure its relevancy for ABF purposes. In response to the consultation paper, stakeholders proposed a range of refinement areas to Tier 2. These included new or revised Tier 2 classes, support for innovative or multidisciplinary models, adjustments for complexity and setting, and definition and structural improvements. Further information is available in the consultation report.

In response to the consultation paper, stakeholders provided general support for the proposed introduction and pricing of Tier 2 classes for hospital based voluntary assisted dying (VAD) services. They outlined several key considerations to inform their development. These included the specialised, resource intensive and multidisciplinary nature of VAD services, the legislative context, the importance of data privacy, differences across states, and overlap with palliative care. Further information is available in the consultation report.



#### **IHACPA's decision**

For NEP26, IHACPA will introduce 2 new classes for hospital based non-admitted VAD services, which will result in the development of Tier 2 Version 10.0. The 2 new classes are:

- 20.59 *Voluntary assisted dying* (for service events in clinics led by a medical practitioner and/or nurse practitioner)
- 40.69 *Voluntary assisted dying* (for service events in clinics led by an allied health and/or clinical nurse specialist and/or clinical pharmacist).

IHACPA will use Tier 2 Version 10.0 to price non-admitted patient services for NEP26.

### **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 patient care classification using health information available within state and territory electronic medical record (eMR) systems. 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. Stakeholder feedback to the consultation paper stressed the importance of working closely with key stakeholders to progress this work on a broader scale.



#### **Next steps and future work**

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 Stage 3 of ANAPP.

## **3.6 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 that 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.

In response to the consultation paper, stakeholders supported the continued refinement of the AMHCC and highlighted key areas for future development. Further information is available in the consultation report.



#### **Next steps and future work**

The areas of refinement currently being discussed within IHACPA's working groups and committees include investigating the incorporation of age and principal diagnosis within the complexity model, same day interventions and expansion of mental health legal status.

## **3.7 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 other teaching and training activities, for which the components required for ABF are not currently available.

In response to the consultation paper, NSW and Victoria (Vic) supported continued block funding in the interim whilst developing a longer-term work plan to improve the understanding of these costs across the health system.



#### **IHACPA's decision**

IHACPA will continue block funding teaching and training activities for NEP26.

# 4

## Setting the national efficient price

# 4. Setting the national efficient price

## 4.1 Overview

The Addendum to the National Health Reform Agreement (NHRA) 2020–26 (the addendum) 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 2025–26](#). 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 the Pricing Framework for Australian Public Hospital Services 2026–27.

## 4.2 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-DRGs)
- 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 NEP Determination 2025–26 (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. Furthermore, AR-DRG Version 12.0 development incorporated data from 2018–19 to 2021–22 and the classification includes symptomatic COVID-19 in its complexity model. This means the activity, costs and changes to models of care associated with the pandemic response will be reflected in the data and classification underpinning NEP26. IHACPA also intends to incorporate COVID-19 as a risk factor in

statistically relevant hospital acquired complication (HAC) and avoidable hospital readmission (AHR) categories for NEP26. Therefore, there is likely to be a decreased need for the continuation of the temporary measures.

IHACPA has also received advice through its advisory 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.

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27, Queensland (Qld), the Northern Territory (NT), and other stakeholders supported removing the remaining temporary COVID-19 measures for NEP26. However, some stakeholders raised concerns around the removal of the remaining temporary measures, including the ongoing impact of COVID-19 across the health system, potential volatility in the pricing model, and risk of future spikes in COVID-19 activity. Further information is available in the consultation report.



#### **IHACPA's decision**

IHACPA intends to remove the COVID-19 treatment and ICU adjustments and the safety and quality adjustment exemptions for NEP26, as these temporary pricing adjustments are no longer required to account for the impact of COVID-19 on service delivery. In ceasing the suspension of safety and quality adjustments for COVID-19 episodes, IHACPA intends to test and incorporate COVID-19 as a risk adjustment in statistically relevant HAC and AHR categories.

## **4.3 Adjustments to the national efficient price**

Section 131(1)(d) of the *National Health Reform Act 2011* 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 that affect the costs of service delivery such as:

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

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 in the national pricing model is available in the [NEP25](#) 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.

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.

In response to the consultation paper, 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.

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. Bundling these ICU costs into the AR-DRG price weight would effectively spread the ICU costs between ICU and non-ICU episodes in each AR-DRG and across all hospitals, allowing for greater flexibility in care delivery.

In response to the consultation paper, stakeholders expressed broad opposition to bundling ICU costs, with concerns about the potential negative impacts. Concerns centred on the risk of masking important cost variations, particularly for referral hospitals treating complex patients, and the potential disadvantage to rural and regional hospitals or high-dependency units (HDUs) not formally designated as ICUs. The Australian Capital Territory (ACT) was the only stakeholder open to bundling provided it did not increase the financial risk carried by hospitals. Further information is available in the consultation report.

IHACPA emphasises that bundling ICU costs would benefit rural and regional hospitals or HDUs not formally designated as ICUs as the bundled AR-DRG price would be higher than the unbundled price. However, the outcomes of the ICU review to date indicate that existing data collections do not support substantial changes to the existing ICU adjustment methodology for NEP26.



#### **IHACPA's decision**

IHACPA will retain the existing ICU adjustment for NEP26.



#### **Next steps and future work**

The ICU review is ongoing. IHACPA will progress updates to activity data specifications to improve the quality and coverage of ICU data collection and work with jurisdictions to improve the consistency of costing practices. Updates to data collections will enable further review and testing of more significant changes beyond 2026–27. The outcomes of the review are also likely to inform any subsequent review of the paediatric adjustment and its eligibility criteria.

### **Multidisciplinary clinic adjustment**

Since the National Efficient Price Determination 2015–16, IHACPA has applied a 'multidisciplinary clinic adjustment' in the non-admitted pricing model. This adjustment applies to non-admitted patient service events where 3 or more healthcare providers (each of a different speciality) are present, as identified using the non-admitted 'multiple healthcare provider indicator.' The adjustment does not apply to Tier 2 classes that, by definition, are multidisciplinary:

- 20.48 *Multidisciplinary burns clinic*
- 20.56 *Multidisciplinary case conference - patient not present*
- 40.62 *Multidisciplinary case conference - patient not present.*

In 2025, IHACPA received advice from its Clinical Advisory Committee that most Tier 2 Non-Admitted Services Classification 10 series procedure classes are inherently likely to involve multidisciplinary care. Other classes, such as those for home delivered procedures and 10.21 *COVID-19 vaccination*, would rarely or never involve multidisciplinary care. Furthermore, the involvement of multiple healthcare providers, sufficient for the use of the indicator, may not reflect materially different delivery or outcomes of the procedures from the patient's perspective.



### **IHACPA's decision**

IHACPA has updated the definitions for the 10 series classes in Tier 2 Version 10.0 to reflect the involvement of multidisciplinary care.

Following consultation with jurisdictions, IHACPA intends to remove the multidisciplinary clinic adjustment for all Tier 2 10 series classes for NEP26 to ensure pricing of the 10 series classes is aligned to clinical practice, accurately reflects resource utilisation and is harmonised with similar services in the admitted setting where appropriate. This will enable the multidisciplinary clinic adjustment to better account for cost variations in other Tier 2 classes where there is variation in whether care delivery is multidisciplinary.



### **Next steps and future work**

IHACPA notes jurisdictional feedback that there may be incomplete reporting of the multiple healthcare provider indicator in the non-admitted data collections. IHACPA will work with jurisdictions in improving the consistency of reporting of the indicator and may review the pricing of these classes in future if there is a change in the evidence-base.

## **Review of pricing models and adjustments**

The Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025 (the mid-term review) made several recommendations relevant to IHACPA's pricing models and adjustments. IHACPA will lead the implementation of these recommendations through a multi-year review of the NEP and national efficient cost (NEC) in these areas.

Firstly, the mid-term review recommended a reduction in calculation complexity for the pricing adjustments. In response to the consultation paper, stakeholders outlined key principles to guide model simplification in relation to IHACPA's adjustments and pricing models. They included transparency, equity and a 'no worse off' principle, materiality, being driven by evidence, adaptability and national applicability without negatively affecting smaller states and territories.

A further recommendation of the mid-term review was a review of IHACPA's Indigenous and rural and remote pricing adjustments. In response to the consultation paper, stakeholders recommended refining funding methodologies to better reflect the true costs and health needs of First Nations peoples, including culturally safe care, geographic and clinical complexity, and state and territory variations. Stakeholders also highlighted the significant and persistent challenges faced by rural and remote health services. These challenges included workforce shortages, travel, transport and accommodation costs and digital infrastructure limitations.

Finally, the mid-term review recommended that IHACPA explore a separate and further adjustment factor for smaller states and territories to compensate for the lower scale and volume and higher disproportionate costs associated with these populations. In response to the consultation paper, stakeholders outlined some cost drivers that impact the ability of hospitals and local health networks to achieve economies of scale under the current pricing model. These cost drivers include the requirement to maintain a baseline of services, specialised and high-cost services, and higher utility, equipment and facility maintenance costs.

To inform IHACPA's review of the NEP and NEC price weights, the consultation paper asked stakeholders about evidence to suggest that the actual costs of care are not being accurately reflected in cost data collections and how IHACPA can support states and territories in reporting these. Stakeholders highlighted significant gaps in cost data accuracy due to missing service components, workforce shortages, and information and communication technology limitations. They recommended refining national pricing models, improving coding and costing workforce development, and adapting data reporting to better reflect clinical complexity, geographic variation, and evolving scopes of practice.

Further detail across all these areas is provided in the consultation report.



#### **IHACPA's decision**

For NEP26, IHACPA will maintain the current methodology for determining the Indigenous adjustment and rural and remote adjustments.



#### **Next steps and future work**

IHACPA will lead a multi-year review into the costs and pricing of care delivery to First Nations peoples and people residing in rural and remote areas and smaller states and territories. This will inform any potential changes for future determinations. IHACPA will incorporate stakeholder feedback from the consultation paper in this review. IHACPA will continue to work with its advisory committees to explore opportunities for further improvement in cost collections.

## **4.4 Supporting the pricing of community mental health care**

For NEP25, community health care began its transition from block funding to activity based funding (ABF) and was priced 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. These measures included block funding for specialised forensic community mental health care establishments and low volume rural and regional local hospital networks (LHNs), as well as a transitional composite ABF and block funding model. Both transitional measures were intended for application for one year.

In the consultation paper, IHACPA asked what, if any, further measures would be required in NEP26 to support the second year of community mental health care services transitioning to ABF. In their responses, states and territories did not indicate a strong need for the extension of the composite block funding and ABF model, although Western Australia (WA) recommended it was continued for 2026–27.

However, several states and territories, including New South Wales (NSW), WA, and NT called for continued or expanded block funding arrangements for services not viable under ABF such as specialised tertiary high-cost community mental health services. Stakeholders advocated for transitional safeguards, such as floor payments, volume caps, and risk-adjusted loadings, as well as monitoring tools, a review of state and territory data submissions and support for regional, remote and culturally diverse services. Further detail is provided in the consultation report.

IHACPA is reviewing the transitional block funding criteria for specialised forensic community mental health care establishments and low volume rural and regional LHNs as part of a broader review of the block funding criteria. As this component of the block funding review is ongoing and requires further analysis, the transitional block funding criteria will be retained for the NEC Determination 2026–27 (NEC26) and reviewed for the NEC Determination 2027–28 (NEC27).

In comparison, the transitional composite ABF and block funding model, which was implemented to mitigate short-term state and territory-level funding risks for NEC Determination 2025–26, was only designed for a one-year application. Analysis of funding estimates for 2025–26 indicates that funding risks are concentrated in only a few jurisdictions, meaning a national approach, such as extension of the composite model is unlikely to be appropriate. Not extending this model aligns with the intended transition plan communicated to jurisdictions and reflects stakeholder feedback supporting a fair and transparent approach. It ensures consistency and equity for states and territories that have completed the transition to ABF from block funding.

Furthermore, extending the model could have unintended impacts within the broader NHRA growth funding model defined in the addendum. Providing states and territories a sixth year to resolve data capture issues also risks embedding long-term distortions in the community mental health care pricing model.



#### **IHACPA's decision**

For NEP26, IHACPA will continue pricing community mental health care using AMHCC Version 1.1. IHACPA does not intend to extend the composite ABF and block funding model for community mental health care services for NEC26, which is consistent with its intended one-year application. However, IHACPA will maintain the transitional block funding criteria for NEC26, meaning specialised forensic establishments and LHNs that continue to meet the criteria will be block funded for NEC26. The criteria for both will be reviewed for NEC27.

## **4.5 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 nationally weighted activity unit (NWAU) for the given year, excluding private patient adjustments.



The sum of revenue a 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.



#### **IHACPA's decision**

For NEP26, IHACPA will continue to implement the private patient neutrality methodology as required by clause A44 of the addendum. IHACPA will review its approach to private patient neutrality if there are changes to relevant clauses in the next addendum to the NHRA.

### **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 not reporting private patient medical costs within their NHCDC submission. This led to the introduction of the private patient correction factor as an interim solution for missing private patient costs in the NHCDC to prevent potential under-pricing.

IHACPA notes the private patient correction factor will be phased out once all states and territories have advised that their NHCDC cost reporting is complete in respect to private patient costs.



#### **IHACPA's decision**

For NEP26, IHACPA will continue to evaluate the private patient correction factor and remove it where appropriate.

## **4.6 Harmonising price weights across settings**

IHACPA has continued to explore price harmonisation for dialysis and chemotherapy in conjunction with its advisory committees since 2020, and is reviewing the harmonisation of the following Tier 2 non-admitted interventions classes, which are currently harmonised against cost data from 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 currently uses admitted acute costs, drawn from episodes with equivalent Australian Classification of Health Intervention codes, rather than non-admitted costs, to set the price of the non-admitted patient service event.

IHACPA notes stakeholder responses to the consultation paper on the reasons patients may require chemotherapy, dialysis, interventional imaging or imaging gastrointestinal endoscopy in an admitted versus non-admitted setting. These included system factors such as funding rules, Pharmaceutical Benefits Scheme (PBS) limitations and logistical constraints and that some states and territories record mostly admitted episodes of care, while others record mostly non-admitted service events for the same service, such as dialysis. This suggests that the differences reflect administrative decisions rather than significant clinical differences.

During the development of NEP26, IHACPA has focused on identifying and testing alternative harmonisation methodologies to better align the prices of equivalent care across the admitted and non-admitted settings.

Despite the extensive work IHACPA has already conducted, including the investigation of alternative methodologies, IHACPA acknowledges further work and consultation are required before any changes are made to the harmonisation methodology, and therefore will not be implementing a new approach for NEP26.

IHACPA also notes particular challenges with aligning admitted acute care episodes of chemotherapy more closely with non-admitted care episodes and has been conducting significant work into understanding the unexpected differences in the distribution of services and costs across both settings. IHACPA notes that issues related to the data associated with harmonisation of chemotherapy remain and will require further consultation with stakeholders.



### **IHACPA's decision**

For NEP26, the existing harmonisation approach for interventional imaging and gastrointestinal endoscopy will remain unchanged, and IHACPA will not introduce harmonisation for dialysis and chemotherapy. While the overall concept of harmonisation remains a goal, IHACPA requires further time to develop and consult on a refined methodology and resolve data challenges.



### **Next steps and future work**

IHACPA will seek to develop an equitable harmonisation methodology that incentivises lower-cost modalities where it is clinically appropriate and maintains standards of care. This work will continue in close consultation with jurisdictions and IHACPA's advisory committees.

# 5

## **Setting the national efficient cost**

# 5. Setting the national efficient cost

## 5.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) develops 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 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’s decision**

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.

IHACPA is undertaking 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 care services. 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.

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27, stakeholders outlined several policy principles and considerations that should guide IHACPA’s workplan for the review of block funding criteria and arrangements. They included equity and access, transparency and accountability, flexibility and adaptability, support for specialised services, data quality and improvement and stakeholder engagement. Further detail is provided in the consultation report.



### **IHACPA’s decision**

IHACPA acknowledges the valuable input from stakeholders and has incorporated this feedback into the policy and analytical frameworks that will underpin the review, which will be progressed in consultation with IHACPA’s advisory committees.

Analysis to date has identified several areas requiring further investigation. Therefore, IHACPA will not revise the block funding eligibility criteria for NEC26 and will continue to review the criteria in 2026.



### **Next steps and future work**

The block funding eligibility criteria for:

- standalone hospitals providing specialist mental health services
- standalone major city hospitals providing specialist services
- other standalone hospitals
- small rural hospitals
- rural and regional local hospital networks delivering a low volume of community mental health services

will be further reviewed in 2026 and changes considered for future determinations.

## **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 (HSTs) recommended for delivery in public hospitals by the Medical Services Advisory Committee.

For 2026–27, the following high cost HSTs 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.



### **IHACPA's decision**

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

Under the current funding arrangements for high cost HSTs, 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, states and territories are required to submit activity and cost data to IHACPA, including the treatment centres and local hospital networks providing the HST. The Administrator of the National Health Funding Pool then reconciles funding to the submitted activity and cost data.

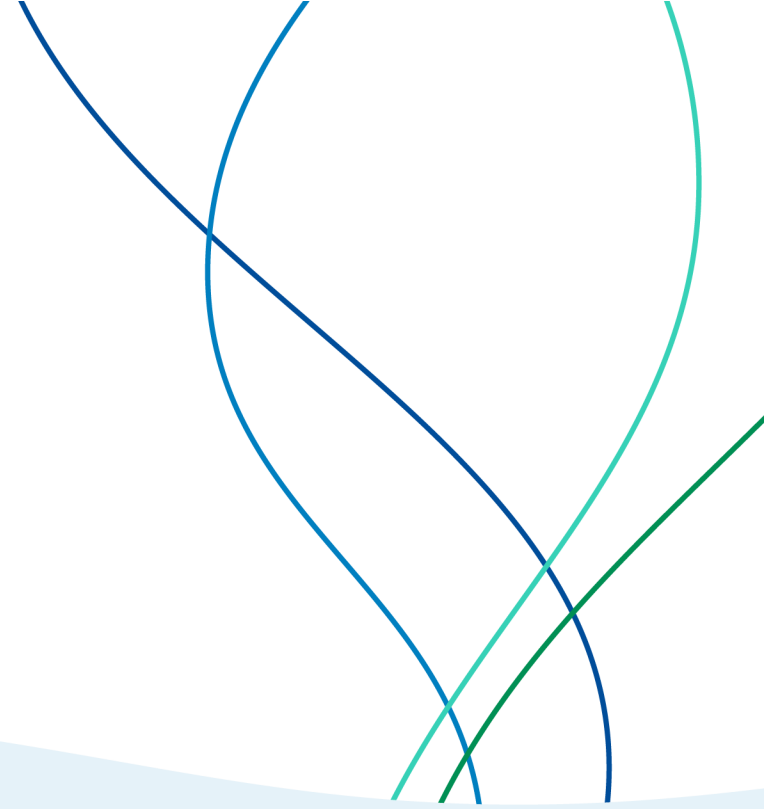
In response to the consultation paper, stakeholders indicated that the current arrangements for high cost HSTs, which have been in place since 2020, require refinement to ensure they remain fit-for-purpose, sustainable and equitable. They reported that current processes are administratively complex and burdensome, especially for reconciliation and cross-border payments. Stakeholders stressed the importance of developing pricing models for high cost HSTs that are transparent, comprehensive, and adaptable to the evolving landscape of clinical care and service delivery. Further detail is provided in the consultation report.



### **Next steps and future work**

IHACPA recognises that while the current block funding model has enabled timely access to high cost HSTs since 2020, refinements may be necessary to ensure it remains responsive to clinical and operational realities, particularly as the use of these therapies continues to grow. IHACPA will consider undertaking a more detailed review of these arrangements, based on stakeholder feedback, to inform potential changes in future determinations.

# 6



## Data collection

# 6. Data collection

## 6.1 Overview

Under the Addendum to the National Health Reform Agreement (NHRA) 2020–26 (the addendum), 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.

## 6.2 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 3 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.

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 (DRS) each year. IHACPA ensures strict procedures are followed to acquire, validate and maintain data within the IHACPA secure data management system. The Australian Hospital Patient Costing Standards provide direction for hospital patient costing through the development of standards for specific elements of the costing process and reporting requirements. 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 also works closely with the National Health Data and Information Standards Committee to agree on data definitions and appropriateness of collection. Please refer to the [Three Year Data Plan](#) and [Data Compliance Policy](#) for further information.

IHACPA collects data to develop the NEP and NEC each year. Under the addendum, jurisdictions are required to work together with the national bodies to share and work towards best practice approaches to data quality and integrity. IHACPA continues to receive cost data for over 95% of admitted patient activity nationally.

### Australian Hospital Patient Costing Standards

NEP Determination 2026–27 (NEP26) is underpinned by 2023–24 cost data. For 2023–24, National Hospital Cost Data Collection (NHCDC) submissions were guided by the [Australian Hospital Patient Costing Standards](#) Version 4.2, which included minor updates to costing guidelines related to emergency care, non-admitted care, mental health care and contracted care.

## 6.3 Assurance of cost data

In the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27, stakeholders were asked how IHACPA can ensure the data received through the NHCDC continues to be accurate, robust and fit-for-purpose. Stakeholders broadly supported enhancements to the NHCDC Dashboard and data quality processes, calling for improved transparency, consistent costing standards, and tailored support for smaller states and territories. Key concerns raised included workforce capability, the ability of states and territories to meet data submission requirements and clearer roles and responsibilities across health systems. Further detail is provided in the consultation report.

## Data Quality Framework

IHACPA developed a [Data Quality Framework](#) to enable consistent assessment, understanding, communication, and management of data quality throughout the data lifecycle. This project was developed in consultation with the jurisdictions following a recommendation from the [NHCDC Public Sector Review Report 2021–22](#). 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 includes 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.

## NHCDC Dashboard

In July 2023, IHACPA began the development of the NHCDC Dashboard to improve the timeliness of producing state and territory quality assurance and cost weight reports. The NHCDC Dashboard provides states and territories with visual summaries of their NHCDC data submission to support their review and reconciliation. A summary of their submissions, after finalisation, also assists benchmarking the cost of delivering services against the national average.

In January 2025, IHACPA released the NHCDC Dashboard to states and territories in preparation for the NHCDC 2023–24.



### IHACPA's decision

IHACPA is currently working with its advisory committees to improve the quality of IHACPA's data collections including the activity based funding (ABF) activity data and the NHCDC, ensuring data collections are robust and fit-for-purpose. Throughout 2024 and 2025 this has included:

- reviewing and refining the Data Quality Framework project
- undertaking an Independent Financial Review of the NHCDC 2023–24 to ensure the NHCDC continues to be robust and fit-for-purpose for NEP26.
- presenting quality assurance of NHCDC through a dashboard which facilitates review and quality assurance of NHCDC data on submission.

## 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 were to:

- identify and analyse the impact and materiality of variations in the use of cost centres and line items across states and territories
- 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.

The review includes 11 key recommendations to improve the consistency of use of cost centres and line items across NHCDC public and private sectors.



### Next steps and future work

IHACPA will review the recommendations from the Cost Bucket Review to develop an implementation plan in consultation with jurisdictions.

## 6.4 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 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 NEP Determination 2025–26 (NEP25) found this growth reflects 2022–23 cost increases reported across a range of areas, including workforce-associated costs.

In response to the consultation paper, stakeholders suggested that costs in categories such as labour and on-costs have increased since 2022–23 and will be reflected in future NHCDC cycles. Stakeholders advised of cost increases arising from new or updated enterprise bargaining agreements, healthcare workforce shortages and labour cost increases linked to inflationary pressures. Further detail is provided in the consultation report.



### Next steps and future work

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

In response to the consultation paper, stakeholders outlined potential areas of refinement IHACPA could consider to support the future sustainability and predictability of public hospital costs and funding. Stakeholders called for a pricing framework that better accounts for rising patient complexity, social factors that influence health, and structural cost pressures, with suggestions including pricing adjustments for culturally and linguistically diverse patients, inflation analysis, and health economic modelling. There was strong support for modernising data systems, improving cost predictability, and exploring reforms around long-stay patients. Further detail is provided in the consultation report.

IHACPA notes that its pricing models incorporate annual updates and stakeholder-driven refinements to support equitable and sustainable hospital funding. The pricing models account for patient complexity through robust and regularly updated classifications and are evolving to better reflect cost drivers such as long stay patient status. IHACPA's price indexation methodologies have also been demonstrated to have good alignment to broader price inflation and cost pressures relative to alternative methodologies.



### Next steps and future work

To ensure future NHCDC cycles remain accurate and fit-for-purpose, IHACPA will:

- Investigate the alignment of cost and expenditure data in the NHCDC and Public Hospital Establishments submissions and consider how this data reflects enterprise bargaining agreement timelines, and other workforce cost indicators.
- Consider alternative ways to improve workforce and other cost forecasting and expected impacts on the NEP.

## 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 report identified 5 key recommendations for IHACPA, in collaboration with other Australian Government agencies and health departments.

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 advisory committees and stakeholders. The results of this work will inform determinations beyond the NEP26 pricing year.

The fifth recommendation from the report was to develop a pathway to facilitate the transition of service innovations to ABF or alternative funding models that improve value. 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 emergency virtual care (EVC) activity data on a voluntary basis through the EVC DRS. The aim was to understand the scope of current virtual emergency care models within and across states and territories. 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.

In response to the consultation paper, states and territories highlighted potential barriers to submitting EVC data and suggested how IHACPA could help them to overcome these barriers. A lack of specialised data and reporting personnel and unclear data definitions were identified as major barriers to EVC data submissions, with states and territories highlighting the administrative burden and need for clearer guidance on reporting and coding. Integration challenges with existing systems and concerns over the value and alignment of EVC data collection were also raised. States and territories recommended tailored engagement with each state and territory to assess readiness and support needs.

The consultation paper also asked stakeholders about further refinement areas for the EVC DRS. States and territories emphasised the need for nationally consistent EVC definitions, clearer distinctions between virtual care models, and alignment with existing datasets to reduce duplication and improve clarity. Recommendations included capturing specific technologies used, refining data specifications and developing culturally responsive funding models to support equitable virtual care delivery.



### **Next steps and future work**

IHACPA notes stakeholder feedback around the challenges with EVC data submission and acknowledges the growing role of EVC services in public hospital systems and the importance of improving data collection to support future funding considerations.

IHACPA is contributing to the development of a nationally agreed definition of virtual care through its participation in the Australian Institute of Health and Welfare Virtual Care Working Group. Once this foundational work is complete, IHACPA will expand its efforts to align EVC definitions and datasets, ensuring consistency with national collections such as the ED National Minimum Data Set and supporting robust data capture and pricing frameworks.

# 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 (NHRA) 2020–26 requires the Independent Health and Aged Care Authority (IHACPA) to discount Commonwealth funding provided to public hospitals through programs other than the NHRA.

The 2 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 Commonwealth-funded pharmaceutical programs will also be removed prior to determining the underlying cost data for the NEP Determination 2026–27 (NEP26):

- 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.

## 7.2 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's decision**

For NEP26, IHACPA intends to implement changes to more accurately remove PBS benefits across pricing for all streams of hospital care.

# 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.

The Independent Health and Aged Care Pricing Authority (IHACPA) intends to conduct a review of its pricing approaches following the finalisation of the new multi-year National Health Reform Agreement (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 as:

- an ABF service with shadow pricing, reporting, and appropriate interim block funding arrangements for the trial period
- 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 that have been block funded through these arrangements under the national efficient cost (NEC). IHACPA will work with NSW and the Australian Government to support their review and potential transition into the national model.



### Next steps and future work

Once the next addendum to the NHRA 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. States and territories investigating alternative funding models are encouraged to approach IHACPA and the Australian Government.

# 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 3 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.

As outlined in Chapter 4 of the Pricing Framework, IHACPA intends to remove the remaining temporary coronavirus disease 2019 (COVID-19) measures for NEP Determination 2026–27 (NEP26) subject to analysis of pricing model impacts. One of these measures was the suspension of the safety and quality adjustments for episodes of care with a COVID-19 diagnosis. IHACPA proposes that the incorporation of COVID-19 as a risk factor informing the complexity scoring of HAC and AHR categories is a more appropriate method to account for current impacts of COVID-19 to the blanket exclusion of all such episodes from the safety and quality model.

## 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.



### **IHACPA's decision**

As per the addendum (clauses A165–A166) to the NHRA, IHACPA will continue to apply this funding adjustment for episodes with a sentinel event for 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](#) (NEP25) and the [National Pricing Model Technical Specifications 2025–26](#).

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



### IHACPA's decision

For NEP26, IHACPA will use [Version 3.2 of the HACs list](#) on the Commission's website to implement the HACs funding adjustment. IHACPA intends to remove the suspension of HACs from COVID-19 related episodes and incorporate COVID-19 into the risk calculations of some HAC categories.

## 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 state or territory.

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 [NEP25](#) and the [National Pricing Model Technical Specifications 2025–26](#).

The tracking of patient journeys through hospital care is a challenge and IHACPA is largely reliant on the reporting of Medicare Personal Identification Numbers for this purpose. For NEP26 IHACPA intends to investigate incorporating the Individual Healthcare Identifier and Person Identifier as alternative mechanisms. This is expected to increase the sample size of AHR and non-AHR episodes and thereby improve confidence in modelling outcomes.



### **IHACPA's decision**

For NEP26, IHACPA will use [Version 3.0 of the AHRs list](#) on the Commission's website to implement the avoidable hospital readmissions funding adjustment. IHACPA intends to remove the suspension of AHRs from COVID-19 related episodes and incorporate COVID-19 into the risk calculations of some AHR categories.

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27, stakeholders asserted that current risk adjustment models are inadequate for paediatric care, as they rely on indicators that overlook paediatric-specific conditions and social factors like culturally and linguistically diverse (CALD) status, Indigenous background, and geographic location. To improve fairness and accuracy, stakeholders argued that models should incorporate cognitive and frailty measures and pharmacy-related risks. They also stressed that models should adapt to virtual care settings, with clinical input and post-implementation reviews ensuring transparency and relevance. Further information is available in the consultation report.



### **Next steps and future work**

IHACPA acknowledges the feedback received regarding risk factors in the adjustment models for HACs and AHRs. A lack of patient level data around CALD or economic status prevents IHACPA from including these risk factors in the adjustment models for HACs and AHRs. Pharmacy related risks are outside of the current HAC and AHR categories.

While formal post-implementation reviews are not currently planned, IHACPA welcomes analysis and feedback from states and territories to inform ongoing refinement of the models.

Future work programs will explore geographic location (via remoteness), paediatric hospitals, indigenous status, cognitive considerations and frailty. Clinical engagement will continue to be a core component of model development and validation. This will be supported through IHACPA's advisory committees and in collaboration with the Commission.



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