IHACPA

Understanding the NEP and NEC Determinations 2026–27

March 2026

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1. Introduction

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

IHACPA enables the implementation of national activity-based funding (ABF) for Australian 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 Australian Government funding contribution to Australian public hospital services and offer a benchmark for the efficient cost of providing these services, as outlined in the NHRA.

The NEP underpins ABF across Australia for public hospital services. ABF is a way of funding hospitals whereby they are paid for the number and mix of patients they treat. ABF is intended to improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.

The NEC is used to determine the Australian Government funding contribution to local hospital networks (LHNs) for public hospital services that are not suitable for ABF, such as for small rural hospitals.

IHACPA annually develops and publishes the Pricing Framework for Australian Public Hospital Services (Pricing Framework), which outlines the principles and policies adopted by IHACPA to determine the NEP and NEC for that financial year.

IHACPA consults with all stakeholders, including the Australian Government, state and territory governments and the general public, prior to finalising the Pricing Framework each year.

The Pricing Framework is released ahead of the NEP and NEC Determinations to provide transparency and accountability by making available the key principles and policies adopted by IHACPA to inform the NEP and NEC Determinations.

In February 2026, all Australian governments signed the Addendum to the NHRA 2026–31, effective for public hospital financing arrangements in the NHRA from 1 July 2026 to 30 June 2031. Any changes arising from the addendum will be considered in future NEP and NEC determinations in accordance with clause A63 of the addendum.

1.1 About the national efficient price

The NEP is based on the average cost of an admitted acute episode of care provided in public hospitals during a financial year. Each episode of patient care is allocated a national weighted activity unit (NWAU).

The NWAU is a measure of hospital activity expressed as a common unit, against which the NEP is paid.

It is a point of relativity for the pricing of public hospital services, which are weighted for clinical complexity. The 'average' hospital service is worth one NWAU. More complex and expensive activities are worth multiple NWAUs, and simpler and less expensive activities are worth fractions of an NWAU.

The price of each public hospital service is calculated by multiplying the NWAU allocated to that service by the NEP. For example:

- A tonsillectomy has a weight of 0.7417 NWAU, which equates to $5,502.
- A coronary bypass (minor complexity) has a weight of 5.7850 NWAU, which equates to $42,913.
- A hip replacement (minor complexity) has a weight of 3.8021 NWAU, which equates to $28,204.

The NEP has 2 key purposes:

1. To determine the amount of Australian Government funding for public hospital services.
2. To provide a price signal or benchmark about the efficient cost of providing public hospital services.

Each NEP Determination includes the scope of public hospital services eligible for Australian Government funding on an activity basis as per the General List of In-Scope Public Hospital Services. It also includes loadings ('adjustments') to the price to reflect legitimate and unavoidable variations in the cost of delivering health care services, including patient factors such as patient complexity, residence and treatment location, and hospital factors such as hospital type, size, and location.

Approximately 484 public hospitals nationwide, including all large metropolitan hospitals, receive funding based on their activity levels.

The NEP is used by jurisdictions as an independent benchmarking tool to measure the efficiency of public hospital services in their state or territory. For instance, it is possible to compare the cost of a hip replacement in 2 different hospitals, which may assist jurisdictions to identify best practice and make funding decisions.

1.2 About the national efficient cost

The NEC is used when activity levels are not suitable for funding based on activity, such as for small rural hospitals. In these cases, hospitals are funded by a block allocation based on size, location and the type of services they provide. This type of funding applies to 364 small rural hospitals. Some of these hospitals may operate with a mix of block funding and ABF.

The NEC also applies to public hospital services or functions that are not yet able to be described in terms of 'activity', such as teaching, training and research.

The NEC Determination outlines the efficient cost of a small rural hospital, which is the sum of the fixed component and a variable cost component.

IHACPA works closely with its Small Rural Hospitals Working Group, which includes representatives from the states and territories, small rural hospitals and peak healthcare bodies and associations. The working group provides vital guidance and advice to IHACPA about setting the efficient cost of a small rural hospital.

2. Summary of key changes

Based on the principles and policies in the Pricing Framework for Australian Public Hospital Services 2026–27 (Pricing Framework), the Independent Health and Aged Care Pricing Authority (IHACPA) has determined the national efficient price (NEP) and national efficient cost (NEC) for 2026–27.

2.1 National Efficient Price Determination 2026–27

The NEP for 2026–27 (NEP26) is $7,418 per national weighted activity unit (NWAU).

Some of the key changes and policy considerations for the NEP Determination 2026–27 (NEP26 Determination) are outlined below.

Classification system updates

For the NEP26 Determination, IHACPA will use the Australian Refined Diagnosis Related Groups Version 12.0 (AR-DRG V12.0), along with the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), the Australian Classification of Health Interventions (ACHI) and the Australian Coding Standards (ACS), collectively known as ICD-10-AM/ACHI/ACS Thirteenth Edition to price admitted acute episodes of care.

The AR-DRG classification is refined over a 3-year development cycle, to balance currency against the need for stability and to reduce the burden of implementation for stakeholders. AR-DRG V12.0 improves the clinical coherence of the classification, particularly in relation to pregnancy and childbirth episodes, and improves capture of posthumous organ procurement activity.

IHACPA will use the Tier 2 Non-Admitted Services Classification (Tier 2) Version 10.0 to price non-admitted services for the NEP26 Determination. Tier 2 Version 10.0 includes 2 new classes 20.59 *Voluntary assisted dying* and 40.69 *Voluntary assisted dying* to capture non-admitted activity for hospital-based voluntary assisted dying (VAD).

For the NEP26 Determination, IHACPA has removed the multidisciplinary clinic (MDC) adjustment for all Tier 2 procedure classes (10 series). This will ensure that pricing of Tier 2 10 series classes is aligned to clinical practice, accurately reflects resource utilisation and is harmonised with similar services in the admitted setting where appropriate. Further information on 10 series classes that are not eligible for the MDC adjustment can be found at Appendix Q in the NEP26 Determination.

Pricing model refinements

In developing the NEP26 Determination, IHACPA reviewed the impact of the coronavirus disease 2019 (COVID-19) on the 2023–24 year of activity and cost data (used for pricing in the NEP26 Determination). The analysis indicated that COVID-19 costs are being accounted

for through alternative measures, including the AR-DRG V12.0 classification, and the incorporation of COVID-19 as a risk factor in statistically relevant hospital acquired complications and avoidable hospital readmissions categories.

As a result, IHACPA has removed the following temporary measures that were introduced in response to the COVID-19 pandemic:

- application of a COVID-19 treatment adjustment in a limited number of AR-DRGs
- extending the intensive care unit (ICU) adjustment to episodes of care involving a COVID-19 diagnosis in any ICU
- suspension of the safety and quality adjustments for episodes of care with a COVID-19 diagnosis.

The removal of these temporary measures is in line with clinical advice that the treatment of COVID-19 is no longer significantly different to other respiratory illnesses.

IHACPA has also updated its methodology to remove pharmaceutical benefits scheme (PBS) benefits across all streams of hospital care. Removal of PBS benefits from the cost data across all streams of hospital care used in the calculation of the NEP is required under clause A59 of the Addendum to the National Health Reform Agreement 2026–31 to prevent duplication of funding.

2.2 National Efficient Cost Determination 2026–27

The NEC Determination 2026–27 (NEC26 Determination) uses a ‘fixed-plus-variable’ model, where the total modelled cost of a small rural hospital is the sum of the fixed cost component and the variable cost component.

For 2026–27, the fixed cost is $3.127 million and the variable cost is $8,003 per NWAU. An additional loading of 18.1% is applied for ‘very remote’ hospitals.

For the NEC26 Determination, IHACPA has determined an indexation rate of 8.4%, which includes an allowance to account for increases in the minimum superannuation guarantee between 2023–24 and 2025–26.

In addition, the Pricing Authority determines the efficient cost of some services in public hospitals that do not meet the technical requirements for applying ABF. Usually this means that they cannot be counted and/or costed. For example, teaching, training and research services are instead provided a block-funding amount.

IHACPA recognises that service delivery models are not static, and innovative models of care offer the potential to provide more efficient health services. The Pricing Guidelines in the Pricing Framework outline the policy objectives to guide IHACPA’s work, with reference to fostering clinical innovation whereby the pricing of public hospital services responds in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.

With this in mind, IHACPA will continue to block-fund public hospital programs that have been approved by the Pricing Authority for inclusion on the General List of In-Scope Public Hospital Services.

The Addendum contains provisions around specific arrangements for high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee. In 2026–27, the following high cost, highly specialised therapies are recommended for delivery, based on advice received from the Australian Government:

- Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah® or Yescarta® – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Yescarta® – for the treatment of 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 and relapsed or refractory B-precursor acute lymphoblastic leukaemia.

Community mental health care - transitional funding

For 2026–27, the transitional block funding criteria will continue for:

- specialised forensic establishments, and
- rural and remote local hospital networks delivering low-volume community mental health services.

The transitional composite ABF and block funding model used in NEC25 to support the first year of transition is not included in NEC26, as it was designed for use in the transition year only.

3. More information

For more information about the Independent Health and Aged Care Pricing Authority, activity-based funding and the National Efficient Price and National Efficient Cost Determinations for 2026–27, please visit www.ihacpa.gov.au or contact enquiries.ihacpa@ihacpa.gov.au.

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