

**IHACPA**

# **Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2027–28**

**May 2026**

## **Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2027–28 — May 2026**

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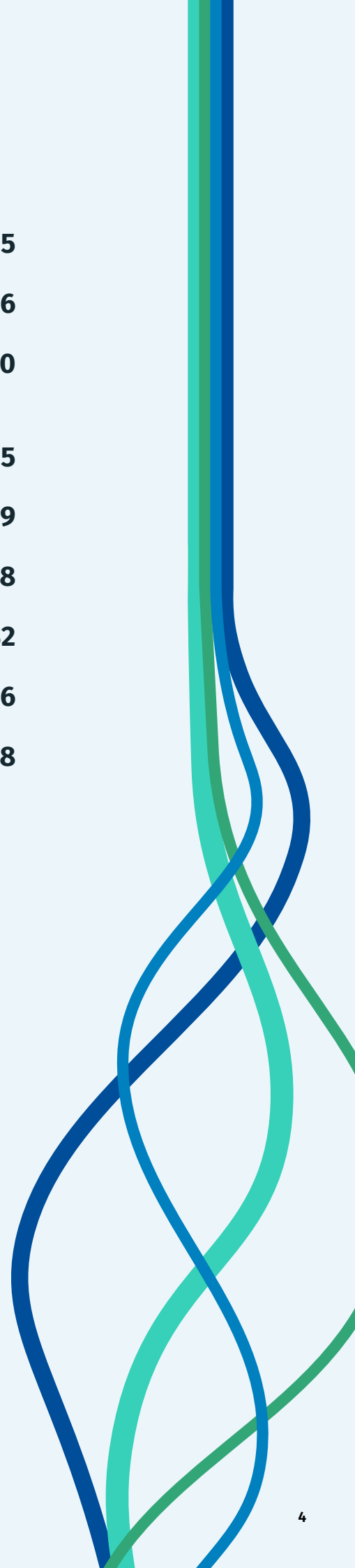
## Acknowledgement of Country

We acknowledge the Traditional Owners and Custodians of Country throughout Australia, and recognise their continuing connection to land, sky, waters and culture. We pay our respects to them, and to Elders both past and present.

Artwork by Chern'ee Sutton

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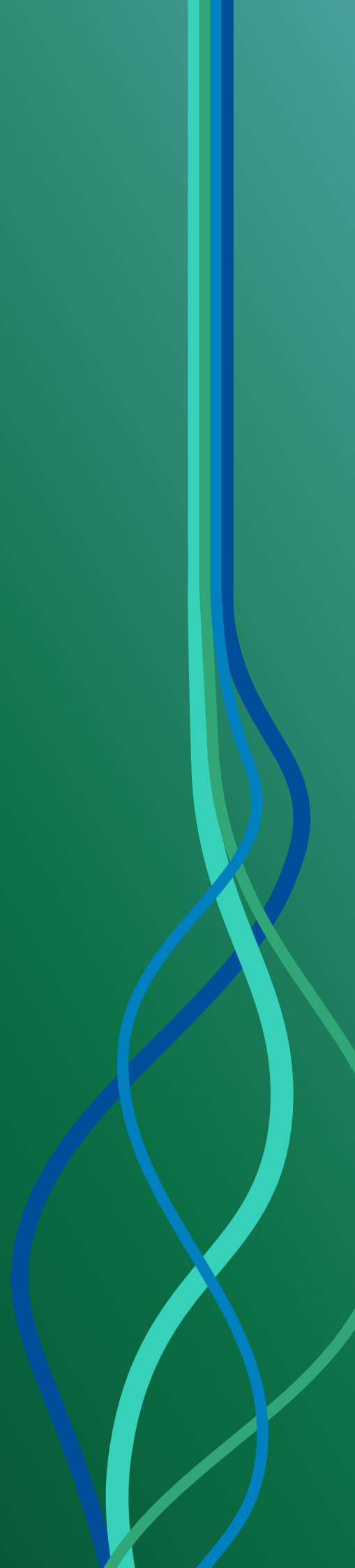


# Abbreviations

Abbreviation	Full term
<b>ABF</b>	Activity-based funding
<b>ACHI</b>	Australian Classification of Health Interventions
<b>ACS</b>	Australian Coding Standards
<b>AHR</b>	Avoidable hospital readmission
<b>AR-DRG</b>	Australian Refined Diagnosis Related Group
<b>CCR</b>	Commonwealth Contribution Rate
<b>HAC</b>	Hospital acquired complication
<b>HST</b>	High cost, highly specialised therapy
<b>ICD-10-AM</b>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
<b>IHACPA</b>	Independent Health and Aged Care Pricing Authority
<b>ICT</b>	Information and communication technology
<b>LHN</b>	Local hospital network
<b>NEC</b>	National efficient cost
<b>NEP</b>	National efficient price
<b>NHCDC</b>	National Hospital Cost Data Collection
<b>NHR</b>	National Health Reform
<b>NHRA</b>	National Health Reform Agreement
<b>NWAU</b>	National weighted activity unit
<b>The addendum</b>	Addendum to the National Health Reform Agreement 2026–31
<b>The Commission</b>	Australian Commission on Safety and Quality in Health Care

# 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 consultation paper

The Pricing Framework for Australian Public Hospital Services is one of IHACPA's key policy documents and underpins IHACPA's approach to determining the NEP and NEC for Australian public hospital services. The Consultation Paper on the Pricing Framework for Australian Public Hospital Services is the primary mechanism for providing input to the pricing framework.

The Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2027–28 provides an opportunity for public consultation on the development and refinement of the national ABF system. This includes policy decisions, classification systems, and data collection, which will underpin the NEP and NEC Determinations for 2027–28 (NEP27 and NEC27 respectively). The pricing framework benefits immensely from the contributions of jurisdictions, peak bodies, academic institutions and other stakeholders, and it is through their constructive involvement and contributions that the national agreement progresses.

## 1.3 IHACPA's broader work program

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

This work is accomplished across multiple years with lead time required to implement changes to classifications and data collections that support refinements to the national pricing model. This work requires multiple NEP and NEC cycles to complete and thereby impacts the development of future determinations.

This consultation paper focuses on the projects where stakeholder input is required to support the progression of specific activities for NEP27 and NEC27. It also seeks specific stakeholder input on other areas or projects that are underway and may inform future determinations. However, not all multi-year projects that are currently within IHACPA's broader work program are included in this consultation paper, as they are either only in their preparative stages or awaiting the completion of prerequisite steps. Further information on IHACPA's key deliverables and activities is available in the annually updated [IHACPA Work Program and Corporate Plan](#), available on the [IHACPA website](#).

## 1.4 The Addendum to the National Health Reform Agreement 2026–31

In February 2026, the Commonwealth and all state and territory governments signed the Addendum to the NHRA 2026–31 (the addendum), which amends the public hospital financing arrangements in the NHRA for the period from 1 July 2026 to 30 June 2031.

The addendum sets out a vision for an Australian healthcare system that is person-centred, equitable, responsive, and sustainable. It describes an integrated, adaptive, and efficient healthcare system that responds to the needs of people and is supported by evidence-based preventive health action.

The addendum introduces substantial reforms to national health funding, pricing, governance, and accountability arrangements. Many of these reforms directly expand IHACPA's responsibilities.

IHACPA is developing an approach to implementation, assessing the implications of the reforms from the addendum and planning pathways to their implementation, while being aware of the need for stability and predictability in outcomes for the health system. In parallel, IHACPA is progressing a review of the detailed policies that underpin its hospital pricing functions, to ensure alignment across the broader pricing framework. This includes the following policies and documents:

- Pricing Guidelines
- General List of In-scope Public Hospital Services Eligibility Policy
- National Pricing Model Stability Policy
- Assessment of Adjustments to the National Pricing Model Policy
- National Pricing Model Consultation Policy
- Shadow Pricing Guidelines
- IHACPA Three Year Data Plan 2027–28 to 2029–30.

## 1.5 Supporting documents

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

- [Pricing Framework for Australian Public Hospital Services 2026–27](#)
- [Pricing Framework for Australian Public Hospital Services 2026–27 – Consultation Report](#)
- [National Efficient Price Determination 2026–27](#)
- [National Efficient Cost Determination 2026–27](#)
- [IHACPA Work Program and Corporate Plan 2025–26](#)
- [IHACPA Strategic Plan 2025–30](#)

## 1.6 Consultation process and next steps

IHACPA is calling for submissions on this consultation paper until **12 June 2026**.

Stakeholder feedback is particularly valued on the consultation questions outlined in this paper and on matters that relate to IHACPA's pricing functions and responsibilities. Submissions are encouraged to focus on questions and issues relevant to the respondent, and submissions are not required to address every question. Where relevant, respondents are encouraged to include examples or supporting evidence for IHACPA's consideration.

Submissions will be published on the IHACPA website unless respondents specifically identify information that they believe should be treated as confidential due to commercial or other sensitivities.

To stay up to date on the latest public hospital news, alerts and consultations from IHACPA, subscribe to our [mailing list](#).



### Key dates

Release of the consultation paper	13 May 2026
Submissions close	12 June 2026
Release of the consultation report consolidating stakeholder feedback	December 2026
Release of the Pricing Framework for Australian Public Hospital Services 2027–28	December 2026



### Have your say

**Submissions close at 5pm AEST on Friday 12 June 2026.**

Submissions can be:

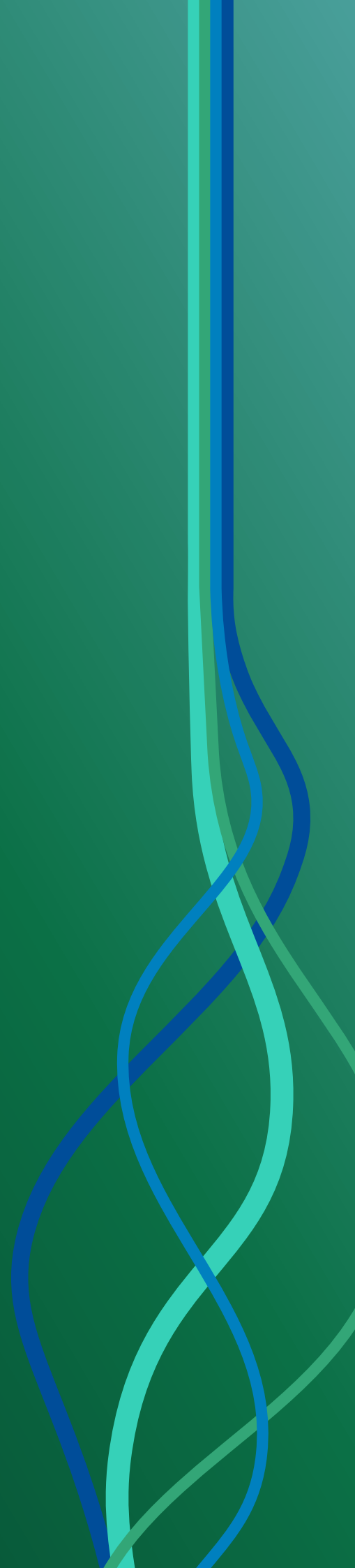
- Emailed to [submissions.ihacpa@ihacpa.gov.au](mailto:submissions.ihacpa@ihacpa.gov.au)
- Mailed to PO Box 483 Darlinghurst NSW 1300
- Completed online via the IHACPA Engagement Hub at [engage.ihacpa.gov.au](https://engage.ihacpa.gov.au)

### Enquiries

Enquiries related to this consultation process should be emailed to: [submissions.ihacpa@ihacpa.gov.au](mailto:submissions.ihacpa@ihacpa.gov.au)

# 2

## Pricing Guidelines





## 2. Pricing Guidelines

### 2.1 Overview

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 health departments. In undertaking this role, IHACPA balances a range of policy objectives provided by the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement 2026–31 (the addendum).

The Pricing Guidelines outlined in **Figure 1 (page 14)** signal IHACPA's commitment to transparency and accountability as it undertakes its work. They form the overarching process and system design guidelines within which IHACPA makes its policy decisions.

The addendum (clause A59) outlines what IHACPA must consider when determining the national efficient price (NEP). This includes to:

- ensure reasonable access to public hospital and health services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system
- consider value for patients and the system
- consider the actual cost of delivering public hospital and health services
- consider the actual and expected changes in costs
- have regard to the need for continuity and predictability in prices
- have regard to any input costs funded through other Commonwealth programs
- develop methods so the NEP can be projected
- ensure movements in weights, adjustments, and price from one year to another do not result in unintended volatility in National Health Reform funding.

### 2.2 Revising the Pricing Guidelines

#### Changes under the addendum

The addendum outlines additional considerations in determining the NEP, noting that IHACPA must have regard to developing and maintaining approaches that support safety and quality, value-based pricing and ensuring that year to year movements in weights, adjustments and price do not create unintended volatility (clause A61). These mechanisms for consideration remain high-level and require significant cross-agency preparatory work before they can be meaningfully considered in pricing implementation.

IHACPA's immediate focus is on understanding the policy intent of these provisions, identifying where and what further work is needed, and how this might be practically actioned within IHACPA's legislated remit.

IHACPA's review of the addendum and assessment of the current Pricing Guidelines (**Figure 1 (page 14)**) indicates the guidelines are still relevant and in alignment with the factors IHACPA must consider when determining the NEP. This suggests that no major changes are currently required to the Pricing Guidelines. IHACPA is instead proposing some revisions to incorporate the addendum's focus on value to patients and the system and how the issue of unintended volatility can be addressed in the pricing process.

## Proposed updates to the Pricing Guidelines

The addendum requires IHACPA to consider value for patients and the health system when determining the NEP (clause A59(b)). For the purposes of determining the NEP Determination 2027–28 (NEP27), IHACPA will apply the definition of value set out in the addendum. Further detail on how value will be considered in practice is provided in **Chapter 4**.

IHACPA's review indicates that the existing Pricing Guidelines continue to provide an appropriate framework for national pricing and do not require significant change. In particular, the guidelines relating to efficiency, safety and quality, sustainability, cost-based pricing, and stability remain fit for purpose. While the addendum introduces new funding and policy settings, it does not alter the fundamental role of the Pricing Guidelines, which is to articulate pricing principles rather than specific pricing methodologies.

The requirement to consider value for patients and the system is the primary new policy change introduced by the addendum with direct implications for the Pricing Guidelines. IHACPA therefore proposes limited and targeted updates to those guidelines where value is most directly relevant.

Consideration of unintended pricing volatility does not represent a new policy requirement. Rather, it reflects and refines IHACPA's existing commitment to maintaining stability in pricing outcomes, as set out in **section 4.4** of the consultation paper. Accordingly, this matter is proposed to be treated as a clarification of existing national pricing model policies, rather than as a substantive change to the Pricing Guidelines.

At this stage, IHACPA does not propose any changes to the stability guideline itself. The underlying principle that payment relativities should remain consistent over time continues to be appropriate and well established. While the mechanisms used to support pricing stability may evolve, this does not necessitate amendment to the guideline itself.

By contrast, the consideration of value for patients and the system represents a new requirement that IHACPA must consider when determining the NEP.

IHACPA proposes updating the promoting value principle to '**Promoting value:** Pricing supports innovative and alternative funding solutions that balance patient-centred care and outcomes with system-wide efficiency and quality, supporting the ongoing sustainability of public hospital services.' This revision is intended to explicitly reflect the requirement under the addendum to consider value at both a patient and system level, while remaining consistent with IHACPA's existing pricing principles.

IHACPA also proposes to update the fostering clinical innovation principle to '**Fostering clinical innovation**: Pricing of public hospital services should respond in a timely way to the introduction of evidence based, effective new technology and innovations in the models of care that improve outcomes and deliver value to both patients and the system.' This update clarifies that innovation supported through pricing should contribute to improved outcomes and value, consistent with the expectations of the addendum.

No other changes to the Pricing Guidelines are proposed. The Pricing Guidelines, including the revised guidelines proposed for consultation can be reviewed in **Figure 1 (page 14)**.



### Consultation questions

Q1. Does the revised Pricing Guideline 'Promoting value' appropriately capture the intent of considering value to the patient and the system?

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Q2. Does the revised Pricing Guideline 'Fostering clinical innovation' accurately reflect the need to consider value at a patient outcome level and for the health system overall?

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Q3. Are there other updates required to the Pricing Guidelines to support IHACPA's consideration of value to patients and the system?

**Figure 1: The Pricing Guidelines**

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

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

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

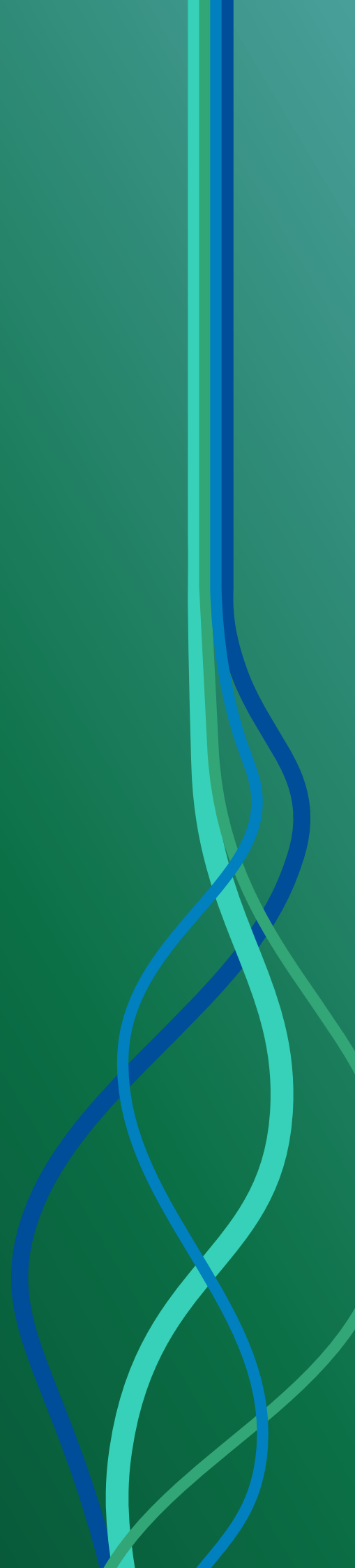
- **Transparency:** All steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Stability:** The payment relativities for ABF are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

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

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

# 3

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





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

## 3.1 Overview

Classifications aim to facilitate a nationally consistent method of classifying patients, their treatments, and associated costs to provide better transparency, management and funding of high quality and efficient health care services. In Australia there are currently 6 patient service categories used for classification purposes—admitted acute care, subacute and non-acute care, emergency care, non-admitted care, mental health care, and teaching and training.

Effective classifications ensure that hospital episodes are grouped into classes of similar or equivalent care in terms of required resources and clinical complexity. This contributes to the determination of prices that reflect the resources in delivering care and provides an evidence base for the Australian and state and territory governments to direct funding through the activity-based funding mechanism.

Classifications also facilitate health service planning, benchmarking, epidemiology and research, funding agreements between private hospitals and insurers and monitoring of healthcare quality and patient safety.

Under the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement 2026–31 (the addendum), the Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for reviewing and updating existing classifications, as well as introducing new classifications. Maintaining the clinical relevance and currency of classifications is a key component of ensuring that funding outcomes are directly linked to the clinical care provided to patients in Australian hospitals.

## 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 diagnoses and interventions data for admitted care, which include the:

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

These are collectively known as ICD-10-AM/ACHI/ACS. For the National Efficient Price (NEP) Determination 2027–28 (NEP27), IHACPA will use ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 to price admitted acute care.

### Posthumous organ procurement

IHACPA published the [Organ and Tissue Donation and Transplantation Project - Final Report](#) in April 2026. The project sought to investigate improvements in activity and cost data collections, and classification refinement for the capture of posthumous organ donation, retrieval, and transplantation costs. The final report outlines several recommendations to inform next steps for IHACPA and other key stakeholders.

Currently, IHACPA reallocates donation costs to relevant transplant episodes, such that the price for a transplant also accounts for donation costs. Recommendation 2 calls for a change to the current pricing approach, such that all donation costs incurred by the donor hospital are allocated to the consented potential donor episode and are redistributed directly to donor hospitals through the posthumous organ procurement AR-DRG.

For AR-DRG Version 12.0, IHACPA included a new Adjacent Diagnosis Related Group, A16 *Posthumous organ procurement*, to facilitate more accurate capture of posthumous organ procurement activity.

IHACPA is seeking stakeholder input on any potential barriers to pricing A16 *Posthumous organ procurement*. Other recommendations from the report will be considered for implementation in consultation with IHACPA's advisory committees and key agencies to support the provision of high quality, life-changing transplantation that is better integrated within Australia's public health ecosystem.



#### Consultation question

Q4. What, if any, barriers are there to pricing A16 *Posthumous organ procurement* for NEP27?

### 3.3 Other classifications

For NEP27, IHACPA will continue:

- pricing admitted subacute and non-acute care using the Australian National Subacute and Non-Acute Patient Classification Version 5.0.
- pricing emergency department care using the Australian Emergency Care Classification Version 1.1.
- pricing emergency services care using the Urgency Disposition Groups Version 1.3.
- pricing non-admitted patient care using the Tier 2 Non-Admitted Services Classification Version 10.0.
- pricing mental health care using the Australian Mental Health Care Classification Version 1.1.

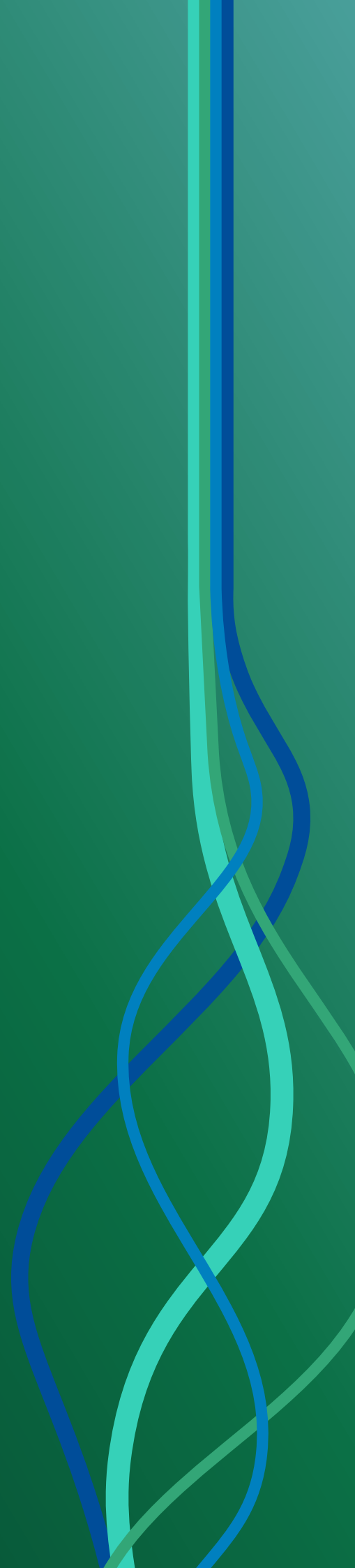
#### Teaching, training and research

The addendum introduces requirements for IHACPA to develop an approach on progressing improvements to the Australian Teaching and Training Classification, including implementation options.

These requirements will be considered by IHACPA as part of the development of a longer term implementation approach, informed by consultation and collaboration with jurisdictions, stakeholders and relevant peak bodies. However, for NEP27, IHACPA will continue to block fund teaching, training and research.

# 4

**National pricing model**





# 4. National pricing model

## 4.1 Overview

The national pricing model includes the national efficient price (NEP) and the national efficient cost (NEC) determinations, both of which support transparent, evidence-based and nationally consistent funding of public hospital services.

The NEP determines the efficient price for in-scope public hospitals funded on an activity basis, whereas the NEC determines the efficient cost for public hospital services that are not suitable for activity-based funding (ABF). Each year, the Independent Health and Aged Care Pricing Authority (IHACPA) refines the national pricing model using updated activity, cost and expenditure data collected by hospitals through submissions made by their managing jurisdictions. IHACPA regularly updates its pricing models to reflect changes to policy objectives and clinical practice.

The Addendum to the National Health Reform Agreement 2026–31 (the addendum) identifies several new requirements that IHACPA must consider in its pricing approach. These new requirements apply across the national pricing model.

## 4.2 Defining and measuring 'value'

Under the addendum, IHACPA is required to consider value for patients and the healthcare system when determining the NEP, alongside existing considerations such as efficiency, clinical safety and quality, effectiveness, and financial sustainability. This requirement expands the matters to which IHACPA must have regard to but does not replace the foundational role of ABF and block funding within the national pricing model.

Although the explicit requirement to consider value is new under the addendum, IHACPA already promotes value within its pricing of public hospital services through a range of established mechanisms that focus on efficiently pricing safe and high quality outputs. IHACPA sees any definition of value as needing to consider both the outcomes and costs of delivering care.

## NEP determinations

In setting the NEP, IHACPA establishes a nationally consistent price that reflects the efficient cost of delivering public hospital services. ABF payments are then based on the same price for the same service, promoting fairness and transparency across states and territories. This approach creates incentives for hospitals to deliver care at or below the efficient price. By aligning funding with the efficient use of resources, the NEP supports value at a system level through improved efficiency, while maintaining equity by applying a consistent national pricing model across all states and territories.

## NEC determinations

The NEC determines the efficient cost of providing services that are not suitable for ABF using a nationally consistent, evidence based cost model that recognises unavoidable differences in the cost of service delivery, including those related to scale, remoteness and service mix. By basing block funding on the efficient cost of delivering these services, the NEC helps ensure that hospitals are funded in a way that reflects the structural characteristics of their operating environment, rather than factors outside their control. This supports value for money and allocative efficiency by directing resources to sustain services that are necessary for access, particularly in rural and remote communities. Over time, this approach supports system sustainability by providing a stable funding basis for essential services, helping to maintain access while supporting efficient service delivery. Together, these outcomes support value from both an equity and a system wide perspective.

## Safety and quality adjustments

Reflecting IHACPA's view that value requires consideration of both the outcomes and costs of delivering care, IHACPA applies a range of safety and quality adjustments that link funding to the delivery of safe, high quality care. These adjustments recognise that not all activity delivers equivalent benefit, and that potentially preventable harm results in poor outcomes for patients as well as additional costs to the health system. By incorporating risk-based adjustments, these mechanisms account for clinical complexity and avoid unduly penalising hospitals treating higher-risk patients. In this way, safety and quality adjustments facilitate improved outcomes and lower costs for both patients and the system, while remaining compatible with ABF.

Collectively, these mechanisms demonstrate that national pricing already supports value through the NEP, NEC and safety and quality adjustments which promote efficiency, equity, safety, and quality. The addendum's requirement to consider value therefore builds on, rather than displaces or replaces, IHACPA's existing pricing framework.

In considering value under the addendum, IHACPA continues to be guided by the Pricing Guidelines, which set out the overarching policy intent, process principles and system design considerations that underpin national pricing. The Pricing Guidelines provide the primary framework through which value is considered when determining the NEP, and updates, as outlined in **Chapter 2**, are proposed to reflect the addendum's requirement to consider value while maintaining continuity in the pricing framework.

The addendum (Appendix A – Definitions) defines value as '*maximising patient experience and outcomes, improving population health and high quality, evidence based clinical care, relative to the cost of delivery.*' This definition reflects a system wide policy intent to better align incentives across patients, providers, and governments to achieve improved outcomes from public investment in health care.

IHACPA notes that the addendum’s definition of value encompasses a broad range of elements, including patient outcomes, patient experience, and population health. Some of these elements cannot yet be measured in a nationally consistent manner or directly reflected within the current national pricing model for public hospital services. While IHACPA can directly influence some aspects of efficiency, equity and safety and quality through pricing, other elements of value depend on broader policy levers, service design and the availability of nationally consistent data.

States and territories have adopted different value-based health care frameworks, generally focused on models of care and service redesign rather than common outcome measurement. In addition, the absence of nationally consistent outcomes reporting and the limited maturity of Individual Healthcare Identifier reporting within national health datasets significantly constrains the ability to assess value across an individual patient’s care journey.

These challenges do not limit future development but highlight the need for a phased and collaborative approach to strengthening the data and analytical foundations that support national pricing. While this work cannot be implemented for NEP Determination 2027–28 (NEP27), it is expected to support more comprehensive consideration of value over time.

IHACPA’s role is not to define clinical value or to determine high and low-value care. Responsibility for developing these national definitions and lists of high and low-value care sits with the Australian Commission on Safety and Quality in Health Care (the Commission) under clause A94 of the addendum. IHACPA intends to work closely with the Commission and other national bodies to progress this work. IHACPA’s role is predominantly to consider how value, as articulated in the addendum and ultimately defined through working with the Commission, can be reflected in the pricing decisions within the existing funding frameworks and pricing mechanisms.



### Consultation questions

Q5. To what extent is the addendum’s definition of value suitable and appropriate for IHACPA to apply when considering national pricing?

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Q6. Are there alternative or refined definitions of value that IHACPA should consider that are directly applicable for pricing purposes, noting current data and methodological constraints?

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Q7. What metrics (or proxies) could be considered within a national pricing context to support consideration of value beyond the cost of its delivery?

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Q8. Given all the factors IHACPA is required to consider when setting the NEP, alongside the addendum definition of value, are there particular factors that IHACPA should prioritise when determining value for pricing purposes?

IHACPA is seeking stakeholder feedback on the definition of value as outlined in the addendum and its suitability for application in the national pricing model and as a basis for future work on value-based approaches to pricing.

For NEP27, limitations in nationally consistent outcomes, experience and patient-level data mean that value will be reflected through existing pricing mechanisms rather than new or material changes to pricing structures. IHACPA will accordingly take a balanced and pragmatic approach when considering value alongside other statutory requirements, recognising potential trade-offs between patient-level benefits, system-wide sustainability and equity.

### 4.3 Pricing and funding for safety and quality

Safety and quality considerations form part of IHACPA's approach to pricing public hospital services and contribute to the consideration of value for patients and the health care system within the national pricing model. Consistent with the Pricing Guidelines, safety and quality are considered alongside efficiency, equity and sustainability when determining national pricing arrangements.

IHACPA and the Commission work collaboratively to incorporate safety and quality considerations into the pricing of public hospital services, consistent with IHACPA's legislated functions and the Pricing Guidelines.

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).

These pricing adjustments operate as price signals within the national pricing model. They are intended to support system wide improvements in safety and quality while recognising that not all adverse outcomes are preventable and that patient complexity varies across hospitals and service settings.

The addendum provides for an independent review of safety and quality measures to be undertaken by the Commission and completed by 30 June 2027 (clause A87). IHACPA intends to work closely with the Commission and other national bodies on this review. The review's assessment criteria and proposed scope are outlined within the addendum (clause D52):

- a) the effectiveness of existing safety and quality indicators and pricing adjustments (sentinel events, HACs and AHRs) in driving improvements
- b) how to revise and strengthen existing measures
- c) how to introduce safety and quality pricing adjustments for new payment reforms and funding streams
- d) driving improved safety and quality for patients through appropriate mechanisms that could support the reinvestment of pricing adjustments towards safety and quality improvement activities, if found to be effective
- e) whether safety, quality and/or value-based pricing mechanisms are appropriate to encourage sharing of hospital discharge summaries
- f) whether reforms are driving improvement in access and outcomes for Aboriginal and Torres Strait Islander people.

While this review is underway, absolute pricing penalties associated with HACs and AHRs will not be applied to states and territories. These pricing adjustments will continue to be shadow-priced. IHACPA may implement modifications to pricing adjustments following recommendations of the review.

## 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 basis.

As per the addendum (clauses A87–A91), IHACPA will continue to apply this funding adjustment for episodes with a sentinel event for NEP27 using Version 2.0 of the Australian Sentinel Events List published on the Commission’s website.

## 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 2026–27](#) and the [National Pricing Model Technical Specifications 2026–27](#).

Despite the implementation of safety and quality adjustments being shadowed pending completion of the review, IHACPA intends to continue its development work around risk factors for HACs in the NEP27 cycle in consultation with its advisory committees. For NEP27, IHACPA intends to use Version 3.2 of the HACs list and specifications which were released in September 2025 to shadow price the HACs funding adjustment. The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant.

## Avoidable hospital readmissions

AHRs 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.

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

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

Further information on the AHRs funding approach is included in the [NEP Determination 2026–27](#) and the [National Pricing Model Technical Specifications 2026–27](#).

Despite the implementation of safety and quality adjustments being shadowed pending completion of the review, IHACPA intends to continue its development work around risk factors for AHRs in the NEP27 cycle in consultation with its advisory committees. For NEP27, IHACPA intends to use Version 3.0 of the AHRs list, released in May 2025, to shadow price the AHRs funding adjustment.

## 4.4 Maintaining pricing stability and mitigating unintended volatility

The addendum introduces changes to the operation of Commonwealth funding arrangements, including changes to the determination of the Commonwealth Contribution Rate (CCR). In particular, the addendum no longer relies on a growth-based funding model. These changes have implications for certain technical mechanisms that were historically used to support funding calculations and comparability, while increasing the importance of ensuring that national pricing outcomes remain stable, predictable, and reflective of the underlying cost of delivering public hospital services.

### Back-casting

From NEP27, IHACPA will no longer routinely apply back-casting in its pricing models. This change does not arise from a specific requirement in the addendum to discontinue back-casting. Rather, changes to the determination of the CCR under the addendum mean that back-casting is, for the most part, no longer required.

Historically, back-casting was applied as a technical mechanism to maintain comparability between years when classification, costing or pricing model changes were introduced.

By recalculating prior-year values on a consistent basis and ensuring that changes were measured on a like-for-like basis, back-casting supported growth-based funding calculations.

### Cost-based pricing

IHACPA's national pricing model remains grounded in a cost-based approach. The NEP, price weights and adjustments are derived from cost data submitted by states and territories and are intended to reflect the efficient cost of delivering care across a wide and representative sample of public hospitals. Where the underlying costs of service delivery change over time, as observed through successive rounds of nationally consistent cost data collection, IHACPA's position is that these changes should be reflected in national prices, using the most recent, robust, representative and nationally consistent data available.

At the same time, IHACPA acknowledges that there is inherent variability in the cost and activity data used to inform national pricing. This variability reflects both the size and complexity of the Australian public hospital system and the time lag between service delivery, data submission, and price setting. Ensuring year-on-year stability in the NEP, price weights and model parameters is therefore important to support predictability in both pricing and funding outcomes.

## **IHACPA's approach to stability and unintended volatility**

IHACPA seeks to minimise the impact of statistical variation or 'noise' in the data while ensuring the national pricing model remains responsive to observed, sustained changes in hospital activity, clinical practice, and the reported costs of delivering care.

IHACPA intends to distinguish between reasonable price movements and unintended volatility. Broadly, unintended volatility could include year to year movements in prices, weights, adjustments or model outputs that arise from statistical variation, data timing effects, data quality or completeness issues, or methodological discontinuities, rather than from genuine changes in the cost of service delivery.

The objective of IHACPA's approach to support stability and mitigating unintended volatility is to limit volatility arising from data noise, while retaining movements that appropriately reflect sustained changes in costs of service delivery.

## **Measures supporting pricing stability**

IHACPA applies a range of measures to support stability in national pricing outcomes over consecutive years. These include:

- calculation of the reference cost – based on the change in the estimated cost of a hospital admission between years in the acute admitted stream. The admitted acute stream is used because it not only forms a majority of overall funding but also contains the most detailed and highest quality data
- calculation of the indexation rate – each year, the latest cost data available is used to calculate the NEP. To account for inflation and other cost changes between the year of data and the year of funding, the reference cost is indexed. The indexation rate is calculated using the most recent 5 years of data reported by jurisdictions to provide stability and a historical basis
- use of multiple years of data to boost sample size where it is naturally limited, or to facilitate calculation of averages to overcome higher year-to-year volatility that may otherwise exist
- year-on-year stability of price weights, adjustments and NEP and NEC model parameters
- other adjustments applied in the derivation of the NEP as listed in the addendum, including hospital type and size, hospital location including remoteness, patient complexity, indigenous status, and smaller jurisdictions (clause A60).

## **Options for mitigating unintended volatility**

The addendum introduces additional flexibility, including the ability to consider reasonable and likely growth in cost inputs for the NEP to be projected into the future (clause A59(g)). Considering these changes, IHACPA will explore options to further strengthen the stability of national pricing outcomes while retaining a cost-based approach.

These options may include:

- sampling cost data from a subset of hospitals, assessed as appropriate, to provide more contemporaneous information about cost movements within the hospital sector
- either partly informing the calculation or considering the outcome of the calculation, in the context of other, more recently updated data sources.

Sampling and other analytical techniques are being explored as ways to reduce volatility driven by data noise, rather than to suppress legitimate price movements. Any such approaches would be developed and applied in a transparent and targeted manner, informed by the best available evidence and in consultation with jurisdictions, consistent with [IHACPA's National Pricing Model Consultation Policy](#).



### Consultation questions

Q9. To what extent is IHACPA's definition and explanation of unintended volatility clear and appropriate?

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Q10. What other factors or mechanisms should be considered to promote pricing stability?

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Q11. In stakeholders' views, under what circumstances should IHACPA prioritise stability in national pricing outcomes over full and immediate flow-through of observed cost changes?

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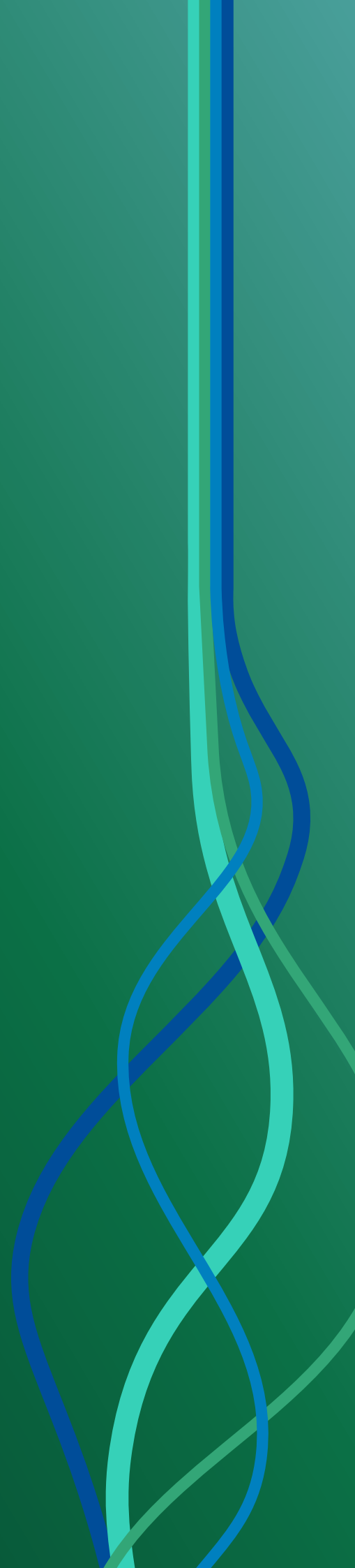
Q12. What barriers, if any, are there to sampling a subset of hospitals with high quality cost data, as a potential option to mitigate unintended volatility?

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Q13. What more current national data sources could be explored to support efforts to mitigate unintended volatility?

# 5

**Setting the national  
efficient price**





# 5. Setting the national efficient price

## 5.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) applies a data-driven approach to determining the national efficient price (NEP) each year. This approach draws on activity, cost and expenditure data reported by states and territories and supports the ongoing refinement of the national pricing model to ensure it remains fit-for-purpose for pricing public hospital services.

This chapter outlines how the Addendum to the National Health Reform Agreement 2026–31 (the addendum) affects the setting of the NEP. It should be read in conjunction with **Chapter 4**, which describes the implications on the overarching national pricing model.

## 5.2 Implications of the addendum for setting the NEP

The addendum sets out the considerations to which IHACPA must have regard to when determining the NEP, reinforcing IHACPA's role in establishing a nationally consistent and efficient price for public hospital services. These considerations include, but are not limited to, the assessment of actual and expected costs, access to services, safety and quality, continuity and predictability in prices, and value for patients and the health care system.

As outlined in **Chapter 4**, the addendum also introduces changes to Commonwealth funding arrangements, including changes to the determination of the Commonwealth Contribution Rate. Under previous arrangements, back-casting was used to support growth-based funding calculations by ensuring comparability across years where pricing or costing methodologies changed. As the addendum no longer relies on this type of growth calculation, back-casting is no longer routinely required for funding purposes. This reflects the operation of the revised funding arrangements under the addendum, rather than a change in IHACPA's approach to cost-based pricing.

In setting the NEP, IHACPA also notes that the addendum introduces a number of broader funding features, including:

- new minimum Commonwealth input contribution rates
- a revised growth funding cap; and
- replacement of the previous base plus growth funding model with a new glide path funding model.

These changes shape the funding context in which the NEP operates. However, they do not alter IHACPA's core task of determining an efficient national price based on the cost of delivering public hospital services.

## 5.3 Adjustments to the NEP

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 A60 of the addendum confirms the continued importance of these adjustments, noting that cost variations may arise from factors such as:

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

The development and application of adjustments is the primary mechanism through which IHACPA ensures that national pricing remains patient-centred, by recognising unavoidable cost differences associated with treating particular patient cohorts or delivering services in different settings. Consistent with the Pricing Guidelines, IHACPA has a strong preference for adjustments to be based on patient related rather than provider related characteristics, wherever practicable.

Adjustment proposals are only progressed where there is sufficient evidence that a cost variation is legitimate, unavoidable, and not otherwise accounted for in the pricing model. Further information about the eligibility criteria is provided in the [Assessment of Adjustments to the National Pricing Model Policy](#). A list of all the adjustments IHACPA applies to the national pricing model is available in the [NEP Determination 2026–27](#).

### Review of pricing models and adjustments

The Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025 included recommendations to simplify the calculation of the NEP, address funding challenges faced by smaller jurisdictions and ensure the Indigenous, residential, and treatment location adjustments are operating as intended.

IHACPA is leading a multi-year review into the costs and pricing of care delivered to First Nations peoples, people residing or receiving care in rural and remote areas, and smaller states and territories. The analysis, research and consultation will inform recommendations for pricing model refinements for future determinations. This work aligns with the addendum's focus on improving health outcomes for First Nations people and supporting the national Closing the Gap objectives.

IHACPA consulted extensively on factors to consider for this review through the [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27](#). IHACPA will consider all stakeholder feedback provided within this review.

The objectives of the project include:

- assessing the extent to which the NEP and national efficient cost (NEC) price weights, the national pricing model, the Indigenous, residential and treatment location adjustments are operating as intended
- assessing the extent to which the data collected is capturing all costs and covering the cost of delivering these services and the relevant cost drivers, based on current data sets and information provided to IHACPA
- developing further understanding of the multifaceted and complex issues that affect equity of access and fairness of funding for health services delivered to the 3 focus areas (First Nations peoples, people residing or receiving care in rural and remote areas and smaller states and territories) and how these are reflected in the available data
- addressing perceived funding challenges for smaller states and territories and assertions of being unable to operate at the scale and without the cost base of larger jurisdictions.

Extensive consultation will be undertaken with IHACPA's internal and external stakeholders throughout the project, including representatives from states and territories, peak bodies, First Nations peoples, and subject matter experts.

This review aligns with requirements outlined within the addendum, specifically the requirement for IHACPA to undertake a review of the NEP and NEC price weights for Indigeneity, regionality, and smaller jurisdictions (clause A64).

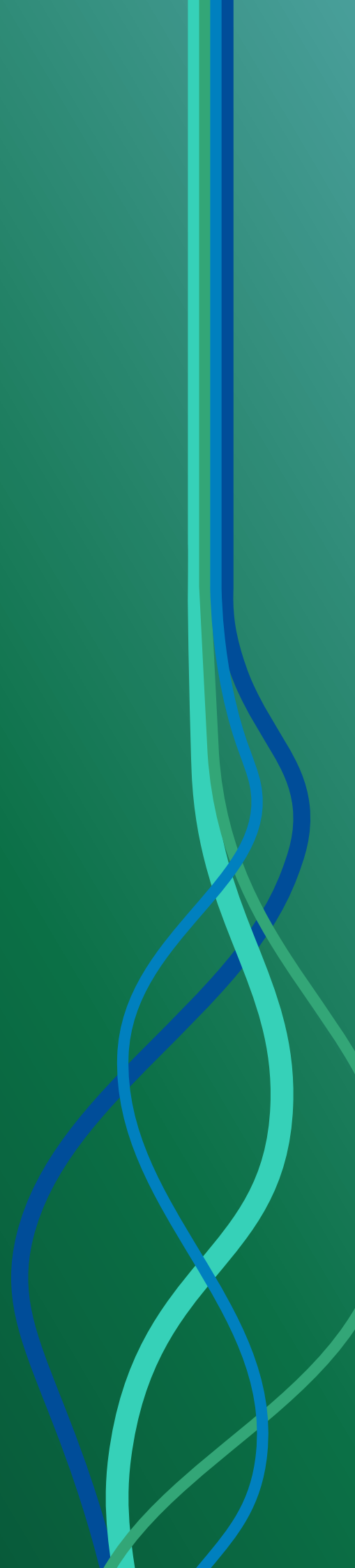
## 5.4 Accounting for private patients in public hospitals

Consistent with the [Pricing Framework for Australian Public Hospital Services 2026–27](#), IHACPA committed to a review of its approach to private patient neutrality to determine if there are changes required to reflect relevant clauses in the addendum.

The addendum outlines the scope of a planned review into the patient funding neutrality adjustment (clause A30). The intent of the review is to ensure that funding models do not incentivise public hospitals to treat private or public patients differently. The terms of reference for the review will be agreed upon at the Health Ministers' Meeting. The completed review will be provided to the Health Ministers' Meeting by December 2027 and include an assessment of the existing methodology and recommendations for alternative processes for future private patient neutrality adjustments. Until this review is completed and actioned, the existing private patient neutrality funding adjustment methodology will apply.

# 6

**Setting the national  
efficient cost**





# 6. Setting the national efficient cost

## 6.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) determines the national efficient cost (NEC) for services not suited to activity-based funding (ABF), such as small rural hospitals. These services are funded through a block allocation that reflects their size, location, and service profile. Block-funding eligibility is assessed using a low-volume threshold, incorporating admitted acute and subacute, admitted mental health, non-admitted and emergency department activity.

### The ‘fixed-plus-variable’ model

Since the NEC Determination 2020–21, IHACPA has used a ‘fixed-plus-variable’ model where the total modelled cost of eligible hospitals is based on a fixed component as well as a variable ABF-style component. Under this approach, the fixed component decreases as the variable component increases, reflecting greater volume of activity. IHACPA will continue to use the ‘fixed-plus-variable’ model for the NEC Determination 2027–28 (NEC27).

## 6.2 Review of block funding criteria and arrangements

Under the Addendum to the National Health Reform Agreement (NHRA) 2026–31 (the addendum), IHACPA is required to continue to develop eligibility criteria to determine which public hospital services are eligible for block funding (clauses A69–A75). IHACPA is undertaking a multi-year review of the block funding criteria, as outlined in the [Pricing Framework for Australian Public Hospital Services 2026–27](#). The review focuses on the block funding criteria for small rural hospitals, standalone hospitals and rural and regional local hospital networks (LHNs) delivering a low volume of community mental health care services.

IHACPA did not revise the block funding eligibility criteria for NEC Determination 2026–27 and will continue the review to inform NEC27.

IHACPA is prioritising the assessment of standalone hospitals, including standalone community mental health facilities, given their varied service profiles, governance arrangements, and cost structures. As part of this work, IHACPA is examining the characteristics and treatment of facilities that operate independently of larger hospital networks, including how their activity, costs and risk profiles are distinguished for the purposes of block funding eligibility. This analysis will inform the ongoing review of the block funding criteria.

## 6.3 High cost, highly specialised therapies

The annual NEC determination includes block-funded costs for the delivery of high cost, highly specialised therapies (HSTs), as provided by clauses A234–A241 of the addendum. These clauses set out arrangements for new HSTs recommended for delivery in public hospitals by the Medical Services Advisory Committee.

The addendum stipulates that the Health Technology and Genomics Collaboration will conduct a review of the governance process for HSTs during its term. Until the review is completed, the arrangements and processes outlined within the addendum remain in place.

For 2027–28, the following HSTs have been recommended for delivery in public hospitals based on advice from the Australian Government:

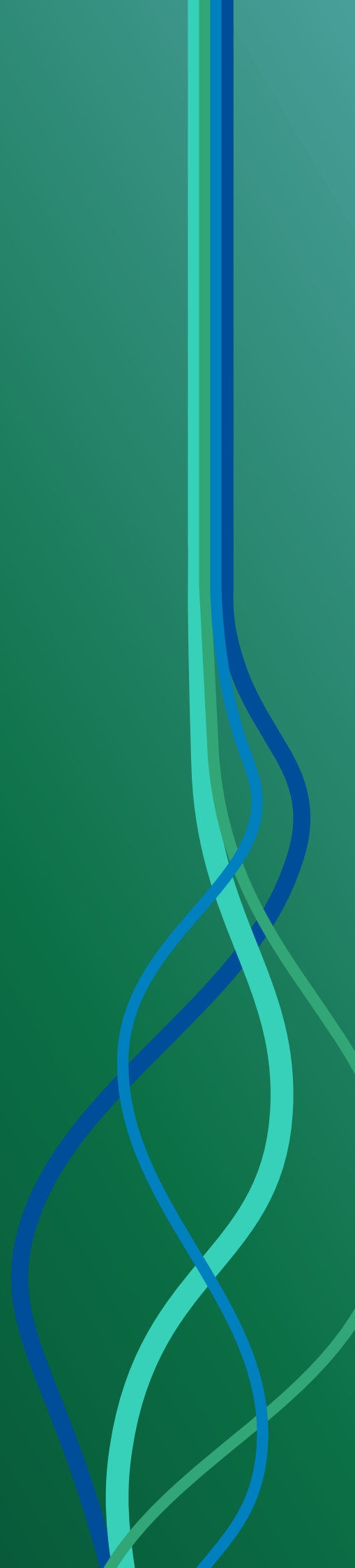
- Kymriah® for the treatment of:
  - acute lymphoblastic leukaemia in children and young adults
  - diffuse large B-cell lymphoma
  - primary mediastinal large B-cell lymphoma
  - transformed follicular lymphoma.
- Yescarta® for the treatment of:
  - diffuse large B-cell lymphoma
  - primary mediastinal large B-cell lymphoma
  - transformed follicular lymphoma
  - relapsed or refractory large B-cell lymphoma.
- Qarziba® for the treatment of:
  - high risk neuroblastoma
  - primary relapsed or refractory 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.
- Carvykti® for the treatment of:
  - relapsed or refractory multiple myeloma in adults.

The indicative block-funded costs for the delivery of these HSTs based on the advice of states and territories will be incorporated in NEC27.

Under the current funding arrangements for 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 LHNs providing the HST. The Administrator of the National Health Funding Pool then reconciles funding to the submitted activity and cost data.

# 7

**Data collection**





# 7. Data collection

## 7.1 Overview

Under the Addendum to the National Health Reform Agreement (NHRA) 2026–31 (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.

## 7.2 Monitoring information and communication technology in hospital costs

The addendum requires IHACPA to improve transparency of information and communication technology (ICT) related expenditure by establishing a distinct ledger cost category for operational ICT costs within the National Hospital Cost Data Collection (NHCDC), supported by any necessary business rules to enable consistent and accurate reporting (clause H74). This requirement is intended to improve visibility of in-scope operational ICT expenditure and support better understanding of its contribution to hospital costs and, ultimately, the NEP. Consistent with the addendum, there is no change to the scope of ICT costs eligible for Commonwealth funding, and capital ICT costs will remain out of scope (clause H75).

IHACPA intends to progress implementation of this requirement after completing consultation with jurisdictions through the Independent Financial Review 2024–25, which will examine how ICT costs are currently reported in the NHCDC. Findings from this review will inform the appropriate approach and timing for implementation, including any changes to data collection, reporting processes or business rules. Improvements in the reporting of operational ICT costs, while maintaining the exclusion of capital costs from NHRA funding, are expected to enhance transparency and support clearer assessment of which ICT expenditures are in scope for national pricing purposes.



# A

**Appendix**

# Appendix A: Consultation questions

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