IHACPA

Development of IHACPA Classifications

Volume 7 Tier 2

Version 1.0
October 2026



Acknowledgement of Country

We respect and acknowledge the Traditional Owners and Custodians throughout Australia and recognise their continuing connection to land, sky, waters and culture. We pay our respect to people, communities and Elders today and those who walk in spirit.

Artwork by Chern'ee Sutton

Development of IHACPA Classifications – Volume 7 Tier 2 – Version 1.0

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Contents

Contents 4

Abbreviations 5

1. Purpose 6

2. Tier 2 Non-Admitted Services Classification 7

3. The development process 8

3.1 Stages of the development cycle 8

3.2 Principle-based development 10

4. Work program establishment 11

4.1 Work program establishment principles 11

5. Tier 2 development 14

5.1 Tier 2 development principles 14

6. Resources 17

6.1 Classification resources 17

7. Tier 2 timelines and milestones 18

Abbreviations

Abbreviations	Full term
ABF	Activity-based funding
CAC	Clinical Advisory Committee
IHACPA	Independent Health and Aged Care Pricing Authority
NACAWG	Non-Admitted Care Advisory Working Group
NHRA	National Health Reform Agreement
Tier 2	Tier 2 Non-Admitted Services Classification

1. Purpose

The **Development of IHACPA Classifications – Volume 1 Governance Framework** provides the overarching structure for creating, maintaining and updating IHACPA classifications ensuring they remain accurate, clinically relevant and fit for purpose across the healthcare system. It sets out a unified and standardised approach to classification development that aligns with the IHACPA Strategic Plan 2025–30.

The Development of IHACPA classifications – Volume 7 Tier 2 builds on the foundations established in Volume 1 and provides detailed guidance for developing the Tier 2 Non-Admitted Services Classification (Tier 2). It outlines the key development principles and work program establishment principles, scope and prioritisation criteria, technical development principles and the classification resources produced.



Volume 7 Tier 2
This volume should be read together with **Volume 1 Governance Framework**. Together, volumes 1 and 7 comprise the full governance framework for the development of **Tier 2**.

2. Tier 2 Non-Admitted Services Classification

Tier 2 categorises non-admitted services into classes based on the predominant nature of the service provided and the type of healthcare provider delivering the service.

Tier 2 is built around the concept of clinics. Clinics are classified into groups based on the predominant nature of the service provided, including:

- procedures (10 series)
- medical consultation services (20 series)
- diagnostic services (30 series)
- allied health or clinical nurse specialist intervention services (40 series).

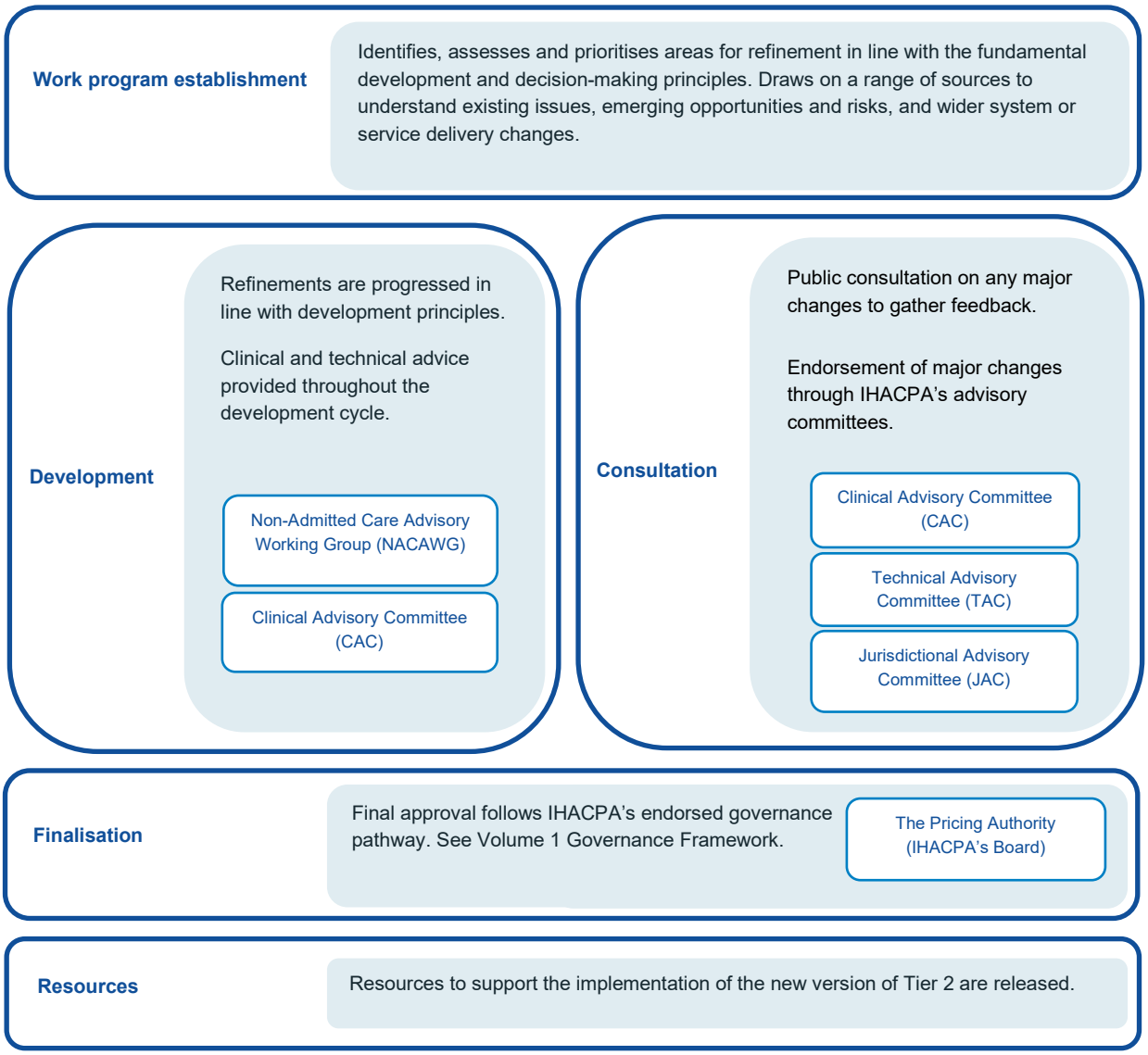
Tier 2 classifies a non-admitted clinic to a single class. All non-admitted patient service events provided by that clinic are then classified to that Tier 2 class. Non-admitted clinics are allocated to Tier 2 classes based on their predominant specialisation, which may be formed around the clinician, patient condition, patient population group or type of care.

3. The development process

3.1 Stages of the development cycle

The development of Tier 2 is a 5-stage process (Figure 1). This approach, outlined in **Volume 1 Governance Framework**, supports consistent decision making, transparency and accountability, while ensuring the classifications remain stable and current.

Figure 1: The stages of the Tier 2 development cycle



Tier 2 operates on a 3-year development cycle. It begins with broad evidence identification and priority setting as part of the establishment of the work program. Then it progresses through detailed development, analysis and consultation, before concluding with validation, approval and publication.

Stakeholder engagement is integrated across all stages of the classification development process, reflecting a collaborative and transparent approach to refinement and decision-making. Stakeholder perspectives are incorporated through structured consultation and advisory mechanisms. Their influence is balanced alongside clinical, analytical and implementation considerations.

3.1.1 Advisory groups

The Non-Admitted Care Advisory Working Group (NACAWG) and their broader networks provide expert input into the Tier 2, as summarised in Table 1.

Table 1: Role of advisory groups during development

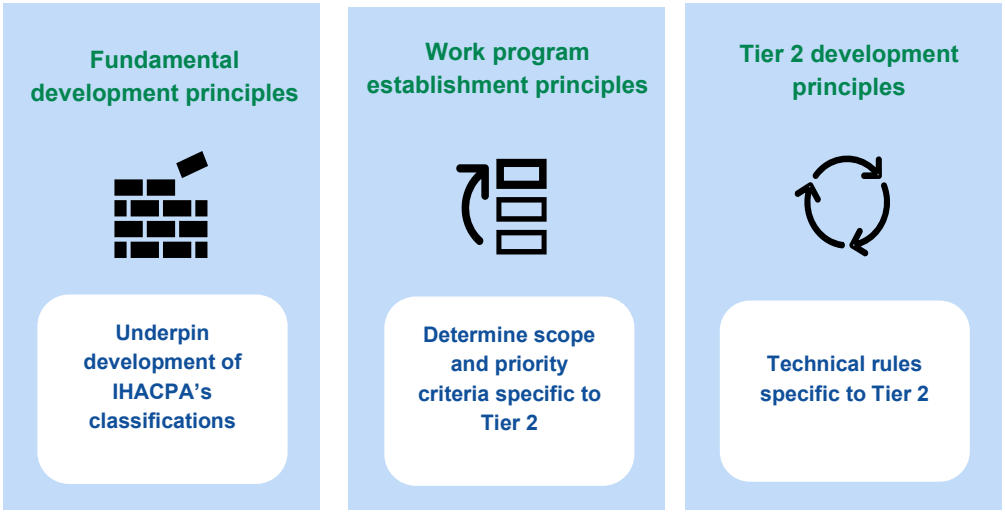
Group	Description
Non-Admitted Care Advisory Working Group (NACAWG)	Provides expert advice on the development, refinement and implementation of nationally consistent classification and pricing approaches for non-admitted care. The group operates in an advisory capacity and does not have decision-making authority. Membership is structured to ensure balanced jurisdictional, clinical and sector representation. It includes one representative from each Australian jurisdiction, members from the Clinical Advisory Committee (CAC) and representatives from key professional and industry bodies, including nursing, allied health, medical colleges and the private health sector.
CAC	The CAC provide high-level technical and clinical advice on a range of issues such as activity-based funding, classification development and policy development. Members are appointed by the Minister for Health and Ageing and are drawn from a range of clinical specialties and backgrounds ensuring the committee represents a wide range of clinical expertise. Further information on CAC is available on our website.

We may consult other relevant clinical bodies to seek further advice that require clinical input, as required.

3.2 Principle-based development

The Tier 2 is developed using a principles-based approach. These principles are applied throughout the development cycle with their application at different levels, to ensure the classification system remains fit for purpose. These principles are organised into 3 categories, as shown in Figure 2.

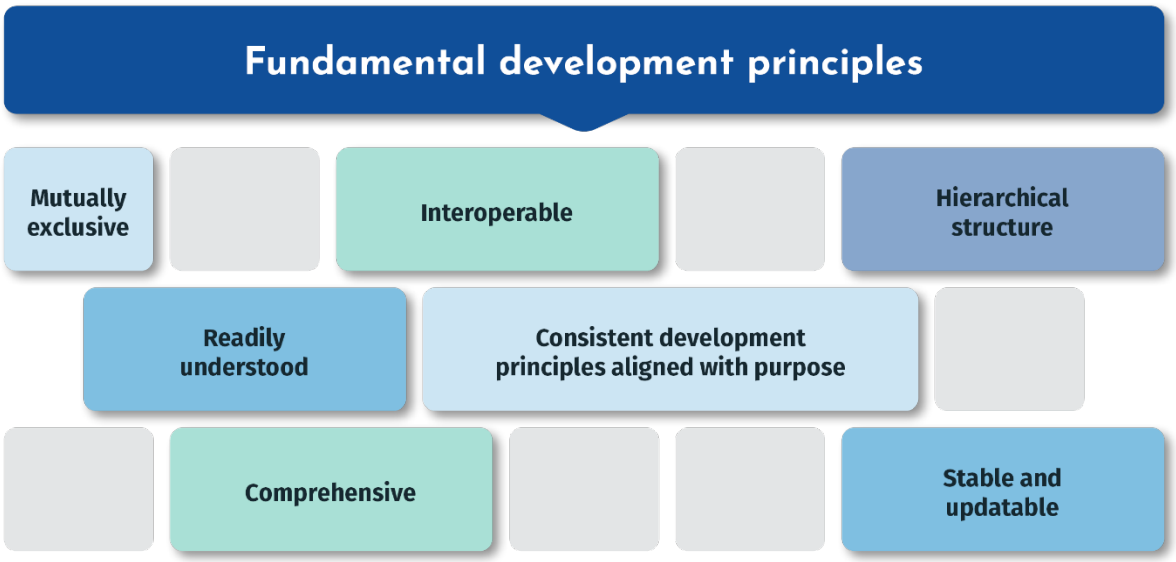
Figure 2: The 3 categories of principle-based development



3.2.1 Fundamental development principles

The fundamental development principles are set out in in **Volume 1 Governance Framework** and are illustrated in Figure 3.

Figure 3: Fundamental development principles



4. Work program establishment

Refinements to Tier 2 are assessed against the work program establishment principles to determine whether they are within scope and, if so, their priority. Higher priority submissions inform the work program. However, not all high-priority submissions may be progressed in each development cycle, and some may need to be deferred for future consideration.

4.1 Work program establishment principles

The work program establishment principles are informed by, and build on, the fundamental development principles (Figure 3):

- stable and updatable – balance needs to incorporate new clinical knowledge, technology, service models and activity patterns, while maintaining conceptual consistency and stakeholder understanding over time.
- consistent development principles aligned with purpose – the rules and decision criteria are applied systematically and transparently.
- interoperable across care settings – the classification must remain meaningful and consistent across care settings where possible, enabling consistent data capture and harmonisation where appropriate.

4.1.1 Scope principles

A refinement is within scope for Tier 2 if it relates to services delivered in non-admitted care settings in Australian public hospitals. When assessing potential refinements, we may consider factors such as the clinical rationale, affected services or patient cohorts, impact on classification performance, activity and cost evidence, stakeholder feedback, implementation considerations, and available data sources.

Refinements are considered out of scope for Tier 2 where they:

- lack clinical relevance
- are differentiated primarily by organisational or funding arrangements rather than a difference in the clinical purpose or nature of the service provided
- lack sufficient evidence, including analysis of available activity, cost or other relevant data to support assessment and implementation
- introduce additional complexity without clear analytical, clinical or policy benefit

- reduce comparability over time without strong supporting evidence
- are outside our remit
- relate to policies that do not apply nationally. For example, admission policies.

Issues identified as out of scope for Tier 2 may reflect broader system matters. These matters may be more appropriately addressed through other mechanisms to Tier 2, including other IHACPA classifications, pricing or policy development, guidance to improve data collection and coding practices, enhancements to costing methodologies, or targeted pricing adjustments.

4.1.2 Prioritisation principles

We apply a structured and evidence-informed approach to prioritising Tier 2 refinements. This approach acknowledges that one source of data may not completely represent the challenges, opportunities and requirements for refinements in non-admitted care.

To develop a list of potential refinement priorities, areas are identified through quantitative analysis, stakeholder engagement, expert advice and literature review. These are then assessed through a process of evidence triangulation, with greater weight given to areas where multiple sources consistently indicate a gap in the current classification. The potential refinement areas are then prioritised using priority criteria in Table 2. A submission will be assigned a priority level if it meets at least one of the criteria defined within that priority level. If a submission meets criteria across multiple levels, it is assigned the highest applicable priority level. Final prioritisation decisions are made through the governance processes.

Table 2: Priority criteria for Tier 2 development tasks

Priority	Criteria for priority level
High priority	• strong and consistent evidence across multiple sources • high materiality, including evidence of significant activity, cost impact, or growth • clear risks of non-action • demonstrable improvement in clinical coherence, resource homogeneity, comprehensiveness and/or comparability • availability of nationally consistent and robust data

Priority	Criteria for priority level
	• alignment with broader strategic priorities, including consistency across classifications and NHRA-related initiatives • identified issues requiring correction or refinement
Medium priority	• evidence is present across multiple sources but not yet sufficiently consistent or compelling, and materiality or system impact may still be developing • benefits to classification performance are plausible but not yet clearly demonstrated • data availability is improving but not completely established, and implementation effort is moderate • clinical service models are still evolving, limiting the readiness for stable and nationally consistent refinement • addresses known limitations in Tier 2 and reflects changes in clinical practice and technology • changes are incremental in nature, including minor structural or definitional improvements • updates support maintenance activities (for example, retirement or consolidation of classes, minor documentation improvements)
Low priority	• evidence is limited, inconsistent, or not supported by reliable data, and materiality and system impact are low • limited expected improvement to classification integrity, performance or comparability, or risk of introducing unnecessary complexity • data limitations constrain evaluation, and implementation effort outweighs potential benefits • potential to undermine comparability, stability, or alignment with immature or insufficiently established service models

5. Tier 2 development

Tier 2 updates are developed in line with the fundamental development principles. Throughout this stage, we seek expert technical and clinical advice from our advisory groups to ensure the updates are appropriate, reflect the intended classification logic and are fit for purpose.

5.1 Tier 2 development principles

The Tier 2 development principles outline the rules applied during classification design and refinement (Table 3). These principles are informed by the fundamental classification development principles set out in the **Volume 1 Governance Framework** and are applied in the context of non-admitted care (Figure 3).

Principles for the development of the Tier 2 Non-Admitted Services Definitions Manual are outlined in Table 4.

Development is informed by the most recently available activity and cost data at the start of the development cycle.

Table 3: Development principles for the Tier 2 Non-Admitted Services

Principle	Description

Clinical coherence	• clinics within a class share similar clinical purposes and service characteristics, including patient condition or population, clinician type and type of care delivered
	• classification reflects the functional role of the clinic in the patient pathway, including:
	  • procedures (10 series)
	  • medical consultation services (20 series)
	  • diagnostic services (30 series)
	  • allied health or clinical nurse specialist intervention services (40 series)
	• clinics are classified based on what they primarily provide, not the full range of services offered

	• classification prioritises the nature of the service delivered, rather than the clinician's professional title
Resource homogeneity	• clinics within a group share similar service delivery models and resource characteristics • variation between groups is driven by different types of care and substantial resource differences
Stability	• the classification remains sufficiently stable over time to support longitudinal analysis and national comparability • updates are made when evidence indicates they will improve classification performance and reflect changes in clinical practice, service delivery and patterns of activity and cost • existing classes are retained unless there is a clear and material change in service profile
Evidence-based decision making	• refinements are supported by analysis of activity and cost data, stakeholder engagement and other available evidence • proposed changes must demonstrate a clear, evidence-based rationale and expected benefit to classification performance • evidence and demonstration of a material difference in cost that justifies refinement
Interoperable	• Tier 2 is designed to remain meaningful and consistent when considered alongside other classifications • the work program prioritises refinements that enhance interoperability across care pathways, including consistent terminology and alignment across settings, providers and jurisdictions

Table 4: Development principles for the Tier 2 Non-Admitted Services Definitions Manual

Convention	Principles
Class code format	• numeric identifier XX.XX • first two digits shall correspond to the group Each class code shall be unique and will not be reused for another class with a different meaning.
Standardised definition structure	Each class definition follows a consistent template that includes identifying attributes, definition of service, guide for use and administrative attributes.

Definition of service	The definition of service describes the overarching services delivered by the clinic and reflect the intended scope and purpose of the class.
Formatting rules for Definitions Manual	• fixed field labels used consistently in each definition table (number, name, category, definition of service, activity, conditions, constraints) • identifying and administrative attributes presented in tables • content separated: identifying attributes, definition, guidance and administrative metadata not intermingled • class numbering and titles formatted consistently (XX.XX + class name) • activities, inclusions and exclusions formatted as bullet lists • inclusions listed before exclusions under activity • avoid multi-level lists where possible, use simple bullet hierarchy • consistent clinical and service terminology applied. Standard medical and scientific terms are preferred • consistent phrasing and level of detail across all definitions • sentence case used for content and headings (except proper nouns and acronyms • consistent ordering, granularity and structure maintained across all class definitions
Inclusions and exclusions	Inclusions describe typical clinic activities within a class. Exclusions indicate where another class may be more appropriate. Lists are non-exhaustive and support, not replace, classification judgement.
Clarity of classification boundaries	Definitions maintain clear boundaries between classes, supported by inclusions, exclusions and constraints.
Usual provider information	Where included, usual provider information will be used as guidance only and shall not determine classification.
Administrative completeness	Definitions include administrative attributes, such as source, dates and update history, to support traceability and transparency.
Non-exhaustive guidance	Supporting content within definitions provide representative examples and is not intended to capture all possible clinic activities.
Stability and version control	Definitions are maintained in a controlled manner to preserve stability over time while incorporating approved updates to classification content.

6. Resources

When finalising a new version of Tier 2, we provide a range of resources to support implementation. Major changes will be reflected in a new version (for example, Version 2), while minor changes will be reflected in an incremental update (for example, Version 1.1).

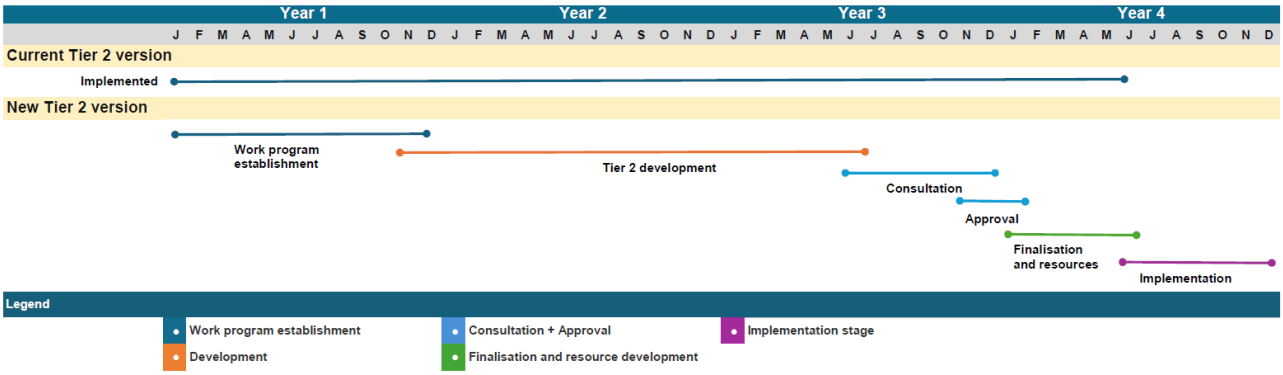
6.1 Classification resources

Tier 2 Non-Admitted Services Compendium	This document provides guidance on the counting rules associated with Tier 2 for activity-based funding purposes. It provides business rules and examples to assist with consistent counting, classification and reporting of non-admitted activity data at a national level.
Tier 2 Non-Admitted Services Definitions Manual	This is the classification manual for Tier 2. It provides further information on each Tier 2 class, including: • definitions • usual provider • affected body system • guides for use • inclusion criteria • exclusion criteria • administrative information.
Tier 2 Non-Admitted Services National Index	The National Index is a reference document that supports the mapping of non-admitted care clinics to the Tier 2 class. It provides a consistent basis for jurisdictions to classify clinics to the appropriate Tier 2 class.

7. Tier 2 timelines and milestones

The development cycle of Tier 2 operates across a 3-year cycle. Figure 4 illustrates the 3-year development cycle for Tier 2 irrespective of version.

Figure 4: Anticipated development timeline for Tier 2



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