



**IHACPA**

# **Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25**

June 2023

## Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25 – June 2023

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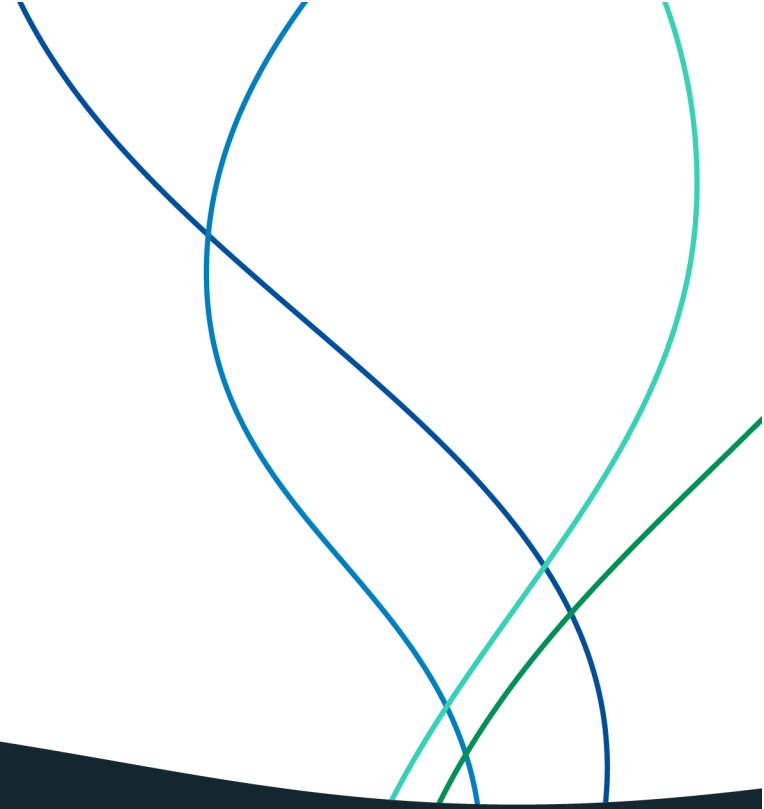
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# Abbreviations

Abbreviations	Full term
<b>ABF</b>	Activity based funding
<b>ACE</b>	Australian Classification Exchange
<b>ACHI</b>	Australian Classification of Health Interventions
<b>ACS</b>	Australian Coding Standards
<b>AECC</b>	Australian Emergency Care Classification
<b>AHR</b>	Avoidable hospital readmission
<b>AMHCC</b>	Australian Mental Health Care Classification
<b>AN-SNAP</b>	Australian National Subacute and Non-Acute Patient Classification
<b>APACHE</b>	Acute Physiology and Chronic Health Evaluation
<b>AR-DRG</b>	Australian Refined Diagnosis Related Group
<b>ATTC</b>	Australian Teaching and Training Classification
<b>COVID-19</b>	Coronavirus disease 2019
<b>DRG</b>	Diagnosis Related Group
<b>eMR</b>	Electronic medical record
<b>HAC</b>	Hospital acquired complication
<b>HoNOS</b>	Health of the Nation Outcome Scales
<b>HMM</b>	Health Ministers' Meetings
<b>ICD-10-AM</b>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
<b>ICD-11</b>	International Classification of Diseases 11th Revision
<b>ICU</b>	Intensive care unit
<b>IHACPA</b>	Independent Health and Aged Care Pricing Authority
<b>LHN</b>	Local hospital network
<b>MHPoC</b>	Mental Health Phase of Care
<b>NBEDS</b>	National best endeavours data set
<b>NEC</b>	National efficient cost
<b>NEP</b>	National efficient price
<b>NHCDC</b>	National Hospital Cost Data Collection
<b>NHRA</b>	National Health Reform Agreement
<b>NMDS</b>	National Minimum Data Set
<b>NPA</b>	National Partnership on COVID-19 Response Agreement
<b>NWAU</b>	National weighted activity unit
<b>The Addendum</b>	Addendum to the National Health Reform Agreement 2020–25
<b>The Commission</b>	Australian Commission on Safety and Quality in Health Care
<b>UDG</b>	Urgency Disposition Group

**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.

## 1.2 About this Consultation Paper

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

The Consultation Paper on the Pricing Framework for Australian Public Hospital Services (the Consultation Paper) is the primary mechanism for providing input to the Pricing Framework. The Consultation Paper 2024–25 provides an opportunity for public consultation on the development and refinement of the national ABF system, including policy decisions, classification systems and data collection, which will underpin the NEP and NEC Determinations for 2024–25 (NEP24 and NEC24). The Pricing Framework benefits immensely from the contributions of states and territories, academic institutions, and other stakeholders.

This Consultation Paper will only apply to developing the NEP and NEC Determinations for Australian public hospital services. The Pricing Framework for Australian Residential Aged Care Services 2023–24 was released in May 2023. Separate consultation papers to inform the development of pricing advice for Australian residential and in-home aged care services will be released in due course.

## 1.3 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 2023–24\*](#)
- [\*Pricing Framework for Australian Public Hospital Services 2023–24 – Consultation Report\*](#)
- [\*National Efficient Price Determination 2023–24\*](#)
- [\*National Efficient Cost Determination 2023–24\*](#)

### **Have your say**

- Submissions close at 5pm AEST on Friday 14 July 2023.
- Submissions can be:
  - Emailed to [submissions.ihacpa@ihacpa.gov.au](mailto:submissions.ihacpa@ihacpa.gov.au)
  - Mailed to:  
PO Box 483  
Darlinghurst NSW 1300
- All submissions will be published on the [IHACPA website](#) unless respondents specifically identify sections that they believe should be kept confidential due to commercial or other reasons.
- The *Pricing Framework for Australian Public Hospital Services 2024–25* will be published in December 2023.

### **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 The Pricing Guidelines

The decisions made by the Independent Health and Aged Care Pricing Authority (IHACPA) in pricing in-scope public hospital services are evidence-based and use the latest activity and cost data supplied to IHACPA by the states and territories. In making these decisions, IHACPA balances a range of policy objectives provided by the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement 2020–2025. These objectives include, but are not limited to, improving the efficiency and accessibility of public hospital services.

The Pricing Guidelines outlined in Figure 1, signal IHACPA's commitment to transparency and accountability as it undertakes its work and comprise the overarching, process and system design guidelines within which IHACPA makes its policy decisions.

In 2022, IHACPA reviewed the Pricing Guidelines and made minor amendments to the 'Activity based funding (ABF) pre-eminence' pricing guideline, updating it to 'Using ABF where practical and appropriate'.

IHACPA has reviewed the Pricing Guidelines in 2023 and is proposing minor amendments to the 'Evidence-based' Process Guideline, based on stakeholder feedback to the National Efficient Price Determination 2023–24.

**Figure 1: The Pricing Guidelines**

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

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

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

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

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

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

# 3

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

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

Classifications aim to facilitate a nationally consistent method of classifying patients, their treatments and associated costs in order to provide better management and funding of high quality and efficient health care services.

Effective classifications ensure that hospital data is grouped into appropriate classes, which contributes to the determination of a national efficient price (NEP) for public hospital services and allows Australian governments to provide funding to public hospitals based on the activity based funding (ABF) mechanism.

The Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for reviewing and updating existing classifications, as well as introducing new classifications.

There are currently six public hospital service categories in Australia which have classifications in use or in development:

- admitted acute care
- subacute and non-acute care
- emergency care
- non-admitted care
- mental health care
- teaching and training.

## 3.1 Admitted acute care

The Australian Refined Diagnosis Related Group (AR-DRG) classification is used to price admitted acute patient services. AR-DRGs are underpinned by a set of classifications and standards used to collect activity data for admitted care, which includes:

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

- Australian Coding Standards (ACS).

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

The AR-DRG and ICD-10-AM/ACHI/ACS classification systems have a three-year development cycle, to balance currency against the need for stability and to reduce the burden of implementation for stakeholders. These classifications have been developed in accordance with the [Governance Framework for the Development of the Admitted Care Classifications](#) (the Governance Framework) with relevant input from clinicians and other health sector stakeholders represented on IHACPA's advisory committees.

For the *NEP Determination 2023–24* (NEP23) IHACPA used ICD-10-AM/ACHI/ACS Twelfth Edition and AR-DRG Version 11.0. For the *NEP Determination 2024–25* (NEP24), IHACPA proposes to continue to use AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition to price admitted acute patient services.

### 3.1.1 ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0

IHACPA commenced the development of ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 in 2022.

The work program for the development of these classifications is informed by the Governance Framework and developed in consultation with stakeholders, working groups and advisory committees.

Major planned refinements for AR-DRG Version 12.0 include:

- review of care types used in the development of AR-DRGs

- review of the potential impact of coronavirus disease 2019 (COVID-19) on Version 12.0 development
- review of General Interventions to better define interventions that inform the Intervention Partition
- review of poorly performing Major Diagnostic Categories
- review of Adjacent Diagnosis Related Group O66 *Antenatal and Other Admissions related to Pregnancy, Childbirth and the Puerperium*.

Major planned refinements for ICD-10-AM/ACHI/ACS Thirteenth Edition include:

- development of a cluster identifier, a new piece of metadata to be reported alongside ICD-10-AM codes to indicate the relationship between codes
- the second stage of a major review to standardise the format and content of the ACS
- review of the ACS and classification development for procedural complications, organ procurement, anticoagulant use and subacute care
- inclusion of some disease and/or health problems currently not classifiable in ICD-10-AM
- development to further enhance the classification of social factors and other social determinants of health
- updates to incorporate recent Medicare Benefits Schedule and Australian Schedule of Dental Services and Glossary updates.

### 3.1.2 ICD-11 readiness project

The [11th Revision of the International Classification of Diseases](#) (ICD-11) was released by the World Health Organization (WHO) in June 2018 and came into effect as the international standard for recording and reporting of causes of illness, death and other health-related episodes in February 2022.

In response to the *Consultation Paper on Australian Public Hospital Services 2023–24*, stakeholders indicated their support for IHACPA’s proposal to prepare for the implementation of ICD-11 by refocussing resources to ICD-11 ‘readiness’ projects.

In 2023, IHACPA commenced a project to map ICD-10-AM to ICD-11. It is anticipated this will provide insights into not only the gaps between ICD-10-AM and ICD-11 but identify the additional features that ICD-11 has to offer for the Australian setting, to inform future decisions about implementation. IHACPA will work with the

Australian ICD-11 Taskforce to inform a decision on a potential implementation of ICD-11 in Australia. IHACPA will also work with WHO’s Family of International Classifications network in progressing this work and to share outcomes and findings with other countries undertaking similar projects.

## 3.2 Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services.

For the *NEP Determination 2022–23* (NEP22) and the NEP23, IHACPA used AN-SNAP Version 4.0 to price admitted subacute and non-acute services and AN-SNAP Version 5.0 to shadow price admitted subacute and non-acute services.

### 3.2.1 AN-SNAP Version 5.0

AN-SNAP Version 5.0 was released in December 2021 and has been developed through extensive statistical analysis and consultation with jurisdictions, clinicians and other experts.

AN-SNAP Version 5.0 represents a modest refinement of AN-SNAP Version 4.0 with no major structural changes. The most significant refinement is the recognition of frailty as a cost driver which has received support from clinicians and broader stakeholders.

IHACPA shadow priced admitted subacute and non-acute services using AN-SNAP Version 5.0 for NEP22 and NEP23. IHACPA’s analysis indicates there was minimal difference in cost model results, data collection compliance and funding impact between AN-SNAP Versions 4.0 and 5.0.

For NEP24, IHACPA proposes to progress to pricing admitted subacute and non-acute services using AN-SNAP Version 5.0, following two years of shadow pricing.

#### Consultation questions

- Are there any significant barriers to pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for NEP24?

## 3.3 Emergency care

IHACPA used the Australian Emergency Care Classification (AECC) Version 1.0 to price emergency department activities and Urgency Disposition Groups (UDGs) Version 1.3 to price emergency services for NEP23. IHACPA will continue to adopt this approach for NEP24.

### 3.3.1 Refinement of the AECC and the Emergency Care Principal Diagnosis Short List

IHACPA is currently investigating several areas for refinement within the AECC, in consultation with its Emergency Care Advisory Working Group. These include updates to the complexity model based on the most recent national activity and cost data, and incorporation of investigations and procedures, paediatric complexity and Emergency Care Diagnosis Groups into the refinement work program.

IHACPA released the Emergency Care Principal Diagnosis Short List (EPD Short List) Twelfth Edition in May 2023, which was updated to align with ICD-10-AM Twelfth Edition.

In 2023, IHACPA will commence development of the EPD Short List Thirteenth Edition.

### 3.3.2 Considering the use of AECC for emergency services

In 2022–23, the Emergency service care national best endeavours data set was updated to include refinements that will enable more detailed patient level activity data collection.

IHACPA intends to review the first completed year of more detailed data collection prior to commencing analysis to assess the appropriateness of pricing emergency services using the AECC in the future.

#### ? Consultation questions

- Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?
- What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition?

## 3.4 Non-admitted care

### 3.4.1 Tier 2 Non-Admitted Services Classification

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

IHACPA used Tier 2 Version 8.0 to price non-admitted services for NEP23. Tier 2 Version 8.0 included the following new classes to better account for the activity being reported against existing Tier 2 classes and to collect applicable activity and cost data to inform price weight refinement:

- 20.58 Long COVID
- 40.65 Violence, abuse, and neglect services
- 40.66 Genetic counselling
- 40.67 Long COVID.

IHACPA undertakes an ongoing program of classification refinement to ensure the relevancy of Tier 2 for ABF purposes, while a new non-admitted care classification is developed.

For NEP24, IHACPA has consulted with its advisory committees and working groups on additional refinements that could be made to Tier 2. These include potential refinements relating to the supervised administration of opioid agonist treatment and home-based subcutaneous immunoglobulin infusion treatment.

IHACPA is also working with jurisdictions to investigate whether refinements to Tier 2 are required to better capture the activity being delivered by innovative models of care developed by jurisdictions.

For NEP24, IHACPA will continue using Tier 2 to price non-admitted services. The incorporation of any proposed refinements may result in an update to a new version of Tier 2.

IHACPA will consider the suitability of pricing or shadow pricing any new classes in Tier 2 in the development of NEP24.

### 3.4.2 A new non-admitted care classification

IHACPA is developing a new non-admitted care classification to better describe patient characteristics and care complexity, and more accurately reflect the costs of non-admitted services. The new non-admitted care classification will also better account for changes in care delivery and models of care as services transition to the non-admitted setting.

To inform the development of the new classification, IHACPA commenced a national costing study in 2018, which was suspended in 2020 due to the impact of COVID-19.

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

As part of the first stage of the project, IHACPA has commenced a series of consultations with state and territory health departments and other relevant stakeholders to better understand eMR and other systems, the data elements available and the feasibility of utilising information from these systems to inform classification development.

#### Consultation questions

- Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25?

## 3.5 Mental health care

### 3.5.1 Admitted mental health care

For NEP23, IHACPA priced admitted mental health care using the Australia Mental Health Care Classification (AMHCC) Version 1.0.

As part of the work program for the development of AMHCC Version 1.1, IHACPA has undertaken analysis to inform updates to the Health of the Nation Outcome Scales (HoNOS) weights and thresholds and Life Skills Profile thresholds using updated national mental health care activity and cost data collections. IHACPA is also proposing to allow phases with up to two missing HoNOS item scores to attract a valid complexity score and a high or moderate HoNOS complexity grouping, in line with the National Outcomes and Casemix Collection rules.

IHACPA will consult with stakeholders through its advisory committees and working groups to finalise AMHCC Version 1.1 and to determine the refinement plan for AMHCC Version 2.0.

For NEP24, IHACPA will continue using AMHCC Version 1.0 to price admitted mental health care services.

### 3.5.2 Community mental health care

Clause A3 of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) and the Pricing Guidelines outline that Commonwealth funding is to be provided on the basis of ABF except where it is neither practicable nor appropriate.

Community mental health care is currently block funded as part of the National Efficient Cost Determination, with jurisdictions advising IHACPA of their community mental health care expenditure each year. Introducing ABF for community mental health care aims to improve the transparency of funding and alignment to the Pricing Guidelines by enabling funding to be based directly on the volume and type of care provided to consumers.

IHACPA shadow priced community mental health care services using AMHCC Version 1.0 as part of the NEP Determination 2021–22 and NEP22.

IHACPA undertook a third year of shadow pricing for community mental health care for NEP23 to better understand the composition of current community mental health care block funding amounts and to accurately assess the funding impact of transitioning from block funding to ABF.

This information will enable IHACPA to compare block funding and ABF outcomes more directly and facilitate the refinement of arrangements to support the transition to ABF and promote funding stability.

IHACPA will consult with jurisdictions, the National Health Funding Body and the Administrator of the National Health Funding Pool to develop arrangements to support the transition from block funding to ABF for community mental health care services, including strategies to mitigate any identified funding risks.

Based on this transition plan, IHACPA proposes to price community mental health care services using AMHCC Version 1.0 for NEP24, following three years of shadow pricing.

#### Consultation questions

- Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?
- Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

## 3.6 Teaching and training

Teaching and training activities represent an important aspect of the public hospital system alongside the provision of care to patients. However, the components required for ABF are not currently available to enable these activities to be priced. As a result, these activities are currently block funded, except where teaching and training is delivered in conjunction with patient care (embedded teaching and training), such as ward rounds. These costs are reported as part of routine care and the costs are reflected in the ABF price.

IHACPA has developed the Australian Teaching and Training Classification (ATTC) as a national classification for teaching and training activities that occur in public hospitals. The ATTC aims to provide a nationally consistent approach to how teaching and training activities are classified, counted and costed.

For NEP24, IHACPA will continue to determine block funding amounts for teaching, training and research activity based on advice from states and territories and will continue to work with stakeholders to improve the volume and quality of activity and cost data being reported.



# 4

Setting the  
national  
efficient price

# 4. Setting the national efficient price

The Addendum to the National Health Reform Agreement 2020–25 (the Addendum) specifies that one of the Independent Health and Aged Care Pricing Authority's (IHACPA's) primary functions is to determine the national efficient price (NEP) for services provided on an activity basis in Australian public hospitals.

Coronavirus disease 2019 (COVID-19) has resulted in significant changes to models of care and service delivery in Australian public hospitals. The *Pricing Framework for Australian Public Hospital Services 2023–24* noted that due to instability introduced into activity and cost data during 2019–20, 2020–21 and 2021–22 as a result of the COVID-19 pandemic response, IHACPA deferred further consideration of developing new adjustments or reviewing existing adjustments to future NEP Determinations and prioritised the investigation of refinements to the pricing model to account for COVID-19 in the development of the *NEP Determination 2023–24* (NEP23).

For the development of the NEP Determination 2024–25 (NEP24), assessment of the impact of COVID-19 on activity and cost data and any sustained changes in service delivery and models of care is important, to ensure such changes are adequately accounted for in the national pricing model.

## 4.1 Impact of COVID-19

### 4.1.1 Impact of COVID-19 on NEP23

The data underpinning a NEP Determination has a three-year time lag. NEP23 used costed activity data from 2020–21 which was the first full financial year of data impacted by the COVID-19 pandemic response.

IHACPA's analysis indicated that at a national level in 2020–21, activity across all care streams except for the admitted acute stream returned to a level that was not significantly different from pre-COVID-19 trends. However, at the jurisdictional level, activity in Victoria in the admitted acute stream was below trend, with substantially higher costs in 2020–21 in comparison to historical trends.

IHACPA also acknowledged that, due to its evolving nature, it was not possible to definitively account for the ongoing impact that COVID-19 may have on hospital service delivery and costs in 2023–24.

Based on these considerations, IHACPA undertook the following approach to account for the impact of COVID-19 in developing NEP23:

- modification of admitted acute activity and cost data in Victoria during the lockdown period from August to October 2020 to approximate the volume of services that would have been delivered without the impact of COVID-19
- application of a set of assumptions underpinning NEP23
- exemption of three end-classes from the [National Pricing Model Stability Policy](#)
- development and application of the COVID-19 treatment adjustment to address the legitimate and unavoidable cost variations associated with treating patients for COVID-19.

### 4.1.2 Plan to assess the impact of COVID-19 on NEP24

The development of the NEP24 will use 2021–22 costed activity data, which will also represent a full financial year of activity that has been impacted by the COVID-19 pandemic response.

IHACPA intends to analyse the impact of COVID-19 on the available data to determine whether modification of data impacted by the COVID-19 pandemic response, development of assumptions or retention of the COVID-19 treatment adjustment are required for the development of NEP24.

IHACPA also intends to monitor the backlog of elective surgery and other deferred care to understand the impacts of these changes on activity and cost data.

### 4.1.3 Review of the COVID-19 treatment adjustment

In response to the observed clinical impacts of COVID-19 on cost and activity data, IHACPA introduced a COVID-19 treatment adjustment in NEP23. This adjustment aimed to recognise and account for the increased length of stay and associated cost of care for COVID-19 patients within certain AR-DRGs, compared to patients who did not have COVID-19. A list of these AR-DRGs is available in Appendix P of the [NEP Determination 2023–24](#).

For NEP24, IHACPA will review the cost and activity data for 2021–22, as well as clinical advice on the current management and effects of COVID-19 on care and length of stay, to investigate whether the COVID-19 treatment adjustment is still required.

### 4.1.4 Review of the COVID-19 Response – Costing and Pricing Guidelines

In 2020, IHACPA published the [COVID-19 Response – Costing and Pricing Guidelines](#), to specify IHACPA's process for the costing and pricing of activity for the duration of the *National Partnership on COVID-19 Response Agreement* (the NPA). The NPA provided financial assistance from the Commonwealth to states and territories for the additional costs incurred by health services in responding to the COVID-19 pandemic.

The *COVID-19 Response – Costing and Pricing Guidelines* includes the following measures that were reflected in the national pricing model:

- for the purpose of COVID-19 activity funded through the NPA, the intensive care unit (ICU) loading will apply to any patient with a COVID-19 diagnosis code and ICU hours reported in the admitted patient care activity data set

- the hospital acquired complications (HAC) adjustment and the avoidable hospital readmissions (AHR) adjustment<sup>1</sup> will not be applied to activity with a COVID-19 diagnosis.

These measures were implemented in the development of the NEP Determinations for 2021–22, 2022–23 and 2023–24. They were designed to be temporary arrangements to address significant uncertainty in the early stages of the pandemic around the clinical management of COVID-19 and its impact on ICU capacity for the duration of the NPA.

Given funding provided under the NPA expired in December 2023, for NEP24, IHACPA intends to review the temporary pricing measures outlined in the *COVID-19 Response – Costing and Pricing Guidelines*: the applicability of the ICU loading to patients with a COVID-19 diagnosis and withholding the HAC and AHR adjustments to activity with a COVID-19 diagnosis.

#### Consultation questions

- How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?
- For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis, including patients in an ICU, to support retention of the:
  - COVID-19 treatment adjustment
  - temporary ICU measure for COVID-19 patients
  - temporary HAC and AHR measures for COVID-19 patients?

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<sup>1</sup> The avoidable hospital readmissions adjustment was introduced in the *NEP Determination 2021–22* (NEP21). Whilst not explicitly included in the *COVID-19 Response – Costing and Pricing Guidelines*, as part of its introduction in NEP21, the decision was made that the avoidable hospital admissions adjustment would also not be applied to activity with a COVID-19 diagnosis.

## 4.2 Adjustments to the national efficient price

Section 131(1)(d) of the *National Health Reform Act 2011* (the NHR Act) allows IHACPA to determine 'loadings' or adjustments to the NEP to reflect legitimate and unavoidable cost variations in the delivery of public hospital services.

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

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

Development and application of adjustments to the NEP is the method that IHACPA applies to address legitimate and unavoidable cost variations in the delivery of public hospital services.

A list of all the adjustments IHACPA applies to the national pricing model is available in the [NEP Determination 2023–24](#) on IHACPA's website.

### 4.2.1 Assessment of adjustment proposals

Each year, IHACPA investigates adjustments that are either proposed by jurisdictions or stakeholders through IHACPA's consultative mechanisms or identified by IHACPA through its review of the data and model performance. In order for IHACPA to assess adjustment proposals, stakeholders must outline the evidence or best available information to support both of the following eligibility criteria:

1. that a material difference in costs (between patients or provider groups) can legitimately be demonstrated; and
2. those differences in costs are unavoidable.

As part of the assessment process, IHACPA considers adjustment proposals against the Pricing Guidelines, including a preference for adjustments to be based on patient-related rather than provider-related characteristics wherever practicable.

Without sufficient evidence reflecting how a cost variation meets the eligibility criteria, IHACPA is unable to progress requests for investigation.

Further information about the eligibility criteria is provided in the [Adjustments to the National Efficient Price Policy](#) available on IHACPA's website.

### 4.2.2 Intensive Care Unit adjustment

Since the *NEP Determination 2012–13* (NEP12), IHACPA has applied an ICU adjustment for specified ICUs, listed in Appendix D of the NEP Determination each year.

The ICU adjustment was introduced to address legitimate and unavoidable cost variations associated with treating patients in specified ICUs compared to other admitted patients which was not reflected in patient casemix or characteristics in data collections and could not otherwise be adequately addressed through classification.

When introduced in 2012–13, the ICU adjustment was applied to patients within a Diagnosis Related Group (DRG) where most patients do not normally receive treatment in an ICU. At the time, ICUs eligible for the loading included ICUs listed as level 3 or above by the Australian and New Zealand Intensive Care Society or considered to meet that level by jurisdictions. From 2014–15 onwards, only ICUs recognised as level 3 or equivalent by an independent external body were eligible for the ICU loading.

Currently, hospitals that consistently report more than 24,000 ICU hours and have more than 20 per cent of those hours reported with the use of mechanical ventilation are generally considered to be eligible for the ICU adjustment. However, IHACPA and jurisdictions work together when determining whether a hospital meets the eligibility criteria for inclusion or exclusion from the ICU adjustment.

Previously, IHACPA outlined its intention to review the eligibility criteria for the ICU adjustment for the *NEP Determination 2022–23*, however this work was delayed due to the impact of COVID-19.

In response to the *Consultation Paper on Australian Public Hospital Services 2023–24* (the Consultation Paper), stakeholders supported prioritisation of the review of the eligibility criteria for the ICU adjustment. In particular, stakeholders suggested that IHACPA reconsider the reliance on using mechanical ventilation hours thresholds in its eligibility criteria and consider broadening the criteria to include other ICU services or high-cost treatments provided in the ICU, to reflect contemporary clinical practice.

Other data items and measures that have been suggested for consideration include:

- clinically relevant Australian Classification of Health Interventions (ACHI) codes or Adjacent DRGs, such as for non-invasive ventilation and/or continuous renal replacement therapy
- non-invasive ventilation hours
- Acute Physiology and Chronic Health Evaluation (APACHE) scores.

For NEP24, IHACPA will review the ICU adjustment including the eligibility criteria to be listed as a specified ICU, the underlying drivers of cost variation across different types of ICUs, the materiality of the variation and whether it is unavoidable. IHACPA will also consider the Pricing Guidelines, [Adjustments to the National Efficient Price Policy](#) and [National Pricing Model Materiality Policy](#) in undertaking its review.

### 4.2.3 Paediatric adjustment and eligibility criteria for specialised children's hospitals

Since NEP12, IHACPA has also applied a paediatric adjustment to reflect the legitimate and unavoidable cost variations associated with treating patients who are 17 years of age or less that are treated in a specialised children's hospital, as specified in Appendix E of the [NEP Determination 2023–24](#). Hospitals with a Level 3 ICU or Paediatric ICU that undertake a substantial number of mechanical ventilation procedures on paediatric patients (on average, greater than one patient per week) are deemed as specialised children's hospitals, in consultation with states and territories.

In response to the Consultation Paper, stakeholders supported IHACPA's proposed review of the eligibility criteria for specialised children's hospitals to better account for the cost variations of delivering services in these hospitals.

For NEP24, IHACPA will review the eligibility criteria for specialised children's hospitals that underpins the paediatric adjustment, including the underlying drivers of cost variation between specialised and non-specialised children's hospitals, the materiality of the variation and whether it is unavoidable. IHACPA will also consider the Pricing Guidelines, [Adjustments to the National Efficient Price Policy](#) and [National Pricing Model Materiality Policy](#) in undertaking its review.

### ? Consultation questions

- To inform the review of the ICU adjustment:
  - what available evidence demonstrates the underlying drivers of cost variation for complex ICUs?
  - what additional or alternative measures, other than mechanical ventilation hours, should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?
- To inform the review of the paediatric adjustment:
  - what available evidence demonstrates the underlying drivers of cost variation between specialised and non-specialised children's hospitals?
  - what additional or alternative measures should IHACPA consider for inclusion in the eligibility criteria for a specialised children's hospital?

## 4.3 NEP indexation methodology

The data underpinning a NEP Determination has a three-year time lag. As part of the NEP development, IHACPA indexes costs from the latest available data to estimate those in the year of the pricing model. IHACPA uses the five most recent years of available patient costed admitted acute activity data to calculate an indexation rate.

In response to the Consultation Paper, stakeholders claimed a range of economic indicators were suggestive of input costs increasing at a faster rate than what is reflected in the available historical cost data captured in the National Hospital Cost Data Collection (NHCDC). Examples of costs drivers identified by stakeholders included staff wage increases, and increased costs associated with commodity and utility prices due to inflation and supply chain disruption.

For NEP24, IHACPA will review the NEP indexation methodology in consultation with jurisdictions. The review will include testing alternative indexation methodologies and modelling techniques, exploring the appropriateness of using hospital cost data from other care streams, using other available price indices that demonstrate growth in specific cost components such as labour costs, or using more granular cost data for the purposes of calculating NEP indexation rates.

IHACPA will consider the suitability for shadow pricing any changes to the indexation methodology in the development of NEP24, as required in the Addendum.

#### ? Consultation questions

- To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

## 4.4 Harmonising price weights across care settings

IHACPA's Pricing Guidelines include an objective for price harmonisation whereby pricing should facilitate best practice provision of appropriate site of care.

Price harmonisation is a method to reduce and eliminate financial incentives for hospitals to admit patients that could otherwise be treated on a non-admitted basis due to a higher price for the same services.

In response to the Consultation Paper, stakeholders supported IHACPA undertaking work to harmonise price weights across care settings.

IHACPA notes that progressing price harmonisation requires further analysis of the stability of the underlying data, the suitability of services for harmonisation and the potential unintended consequences of pursuing price harmonisation. In particular, data linkage challenges and unexplained differences in reported costs across settings have hindered progression of price harmonisation for chemotherapy and dialysis in past years, despite stakeholder support and feedback recommending harmonisation of these services.

For these reasons IHACPA will consider opportunities to harmonise prices for similar services across settings for future Determinations.

#### ? Consultation questions

- What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?
- Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

## 4.5 Unqualified newborns

In response to the Consultation Paper, stakeholders supported prioritisation of the proposed investigation into how costs for unqualified newborns are accounted for in the national pricing model and assessing whether methodology changes are required.

At present, a newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is considered qualified if the infant meets at least one of the following criteria<sup>2</sup>:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care
- is admitted to or remains in hospital without its mother.

<sup>2</sup> Newborn qualification status. Available at: <https://meteor.aihw.gov.au/content/index.phtml/itemId/327254>

A newborn patient day is considered unqualified if the infant does not meet any of the above criteria. Unqualified newborns are therefore not considered in-scope for admitted patient data collections for activity based funding (ABF). Their costs are assigned to the mother's episode and included in the DRG price for the delivery.

Previously, stakeholders noted that the current approach to pricing newborn episodes of care does not reflect the increased care being provided to newborns outside of the ICU setting, and that bundling of unqualified newborns within the maternal DRG may not adequately reflect the cost of care. Stakeholders recommended costs associated with both qualified and unqualified newborns should be assigned to separate DRG prices, independent of the mother's admitted episode. Stakeholders also recommended reviewing the definitions and business rules for unqualified newborns.

On the basis of this feedback, IHACPA will commence a review of the pricing methodology for unqualified newborns in 2023–24 with a view to remove any unintended pricing incentives that may affect service delivery and care decisions. IHACPA notes available cost data is limited and changes may be required to jurisdictional costing practices to support refinements to the methodology. As such, changes resulting from this review will require sufficient lead time and would likely be considered for implementation in future Determinations.

In addition, IHACPA notes that the criteria for determining qualification status, which is set out in legislation, is out-of-scope for this review. IHACPA's review of the pricing methodology will focus on any changes that can be considered within the current legislative framework and IHACPA's remit under the *National Health Reform Act 2011*.

## 4.6 Setting the national efficient price for private patients in public hospitals

The Addendum specifies that IHACPA will adjust the price for privately insured patients in public hospitals to the extent required to achieve overall payment parity between public and private patients in the relevant state or territory, taking into account all hospital revenues.

In addressing clauses A13, A43 and A44 of the Addendum, IHACPA developed the following definition of financial neutrality and payment parity in terms of revenue per national weighted activity unit (NWAU) for the given year, excluding private patient adjustments.

The sum of revenue a local hospital network (LHN) receives for public patient NWAU (Commonwealth and state or territory ABF payments) should be equal to payments made for a LHN service for private patient NWAU (Commonwealth and state or territory ABF payments, insurer payments and Medicare Benefit Schedule payments).

IHACPA determines a private patient adjustment methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public. Stakeholders provided feedback regarding the limits and consistency of data used in the methodology, and the methodology's potential impact on the growth of public NWAU.

In fulfilling its functions under clause A44 of the Addendum, IHACPA intends to adopt the same methodology for NEP24.

### 4.6.1 Phasing out the private patient correction factor

The collection of private patient medical expenses has previously been problematic in the NHCDC, which led to the introduction of the private patient correction factor as an interim solution for the issue of missing private patient costs in the NHCDC.

The implementation of the Australian Hospital Patient Costing Standards Version 4.0 aimed to address the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required.

At present, the private patient correction 'adds back' costs of private patients which are met through alternative funding sources, for example, where a jurisdiction does not report private patient costs within their NHDC submissions. IHACPA will assess 2021–22 cost data and continue to consult with jurisdictions on phasing out the private patient correction factor.



# 5

**Setting the national  
efficient cost**

# 5. Setting the national efficient cost

## 5.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) developed the national efficient cost (NEC) for services that are not suitable for activity based funding (ABF), as provided by the Addendum to the National Health Reform Agreement (NHRA) 2020–25 (the Addendum). Such services include small rural hospitals, which are funded by a block allocation based on their size, location and the type of services provided.

A low volume threshold is used to determine whether a public hospital is eligible to receive block funding. All hospital activity is included in assessing the hospital against the low volume threshold. This includes admitted acute and subacute, non-admitted and emergency department activity.

## 5.2. The 'fixed-plus-variable' model

Both ABF and block-funding approaches cover services that are within the scope of the NHRA. The key difference is that the ABF model calculates an efficient price per episode of care, while the block funded model calculates an efficient cost for the hospital.

Since the *NEC Determination 2020–21*, IHACPA has used a 'fixed-plus-variable' model where the total modelled cost of each hospital is based on a fixed component as well as a variable ABF style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.

IHACPA will continue to use the 'fixed-plus-variable' model for the NEC Determination 2024–25 (NEC24).

## 5.3 Standalone hospitals providing specialist mental health services

Other block funded hospitals such as standalone hospitals providing specialist mental health services (for example, psychiatric hospitals) are treated separately from the 'fixed-plus-variable' cost model.

The efficient cost of these hospitals is currently determined in consultation with the relevant state or territory with reference to their total in-scope reported expenditure.

IHACPA priced admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0 for the National Efficient Price (NEP) Determinations for 2022–23 and 2023–24. In the 2021–22 financial year, some standalone hospitals providing specialist mental health services reported admitted mental health care activity as part of the Activity based funding Mental health care national best endeavours data set.

IHACPA will work with jurisdictions to review activity and cost data from standalone hospitals providing specialist mental health services that received block funding in the NEC Determination 2023–24 to determine if they continue to meet the 'low-volume' threshold and if not, investigate the feasibility of transitioning them to ABF in the development of NEC24.

## 5.4 NEC indexation methodology

In response to the *Consultation Paper on Australian Public Hospital Services 2023–24* (the Consultation Paper), stakeholders advised of a range of ongoing cost pressures for regional or remote hospitals that may not be reflected in the cost data such as costs associated with rural workforce shortages, and regional and remote specific costs, including patient transport costs.

Similar to the NEP indexation methodology, the NEC indexation methodology is based on historical data, however it is developed using expenditure data that incorporates both costs and volumes of activity. The purpose of the NEC indexation rate is to also account for growth in volume and growth in unit costs.

For NEC24, IHACPA will review the NEC indexation methodology in consultation with jurisdictions. The review will include testing alternative indexation methodologies and modelling techniques and exploring the appropriateness of using hospital cost data from other care streams or using more granular cost data for the purposes of calculating NEC indexation rates. IHACPA will consider the suitability for shadow pricing any changes to the indexation methodology in the development of NEC24, as required in the Addendum.

### Consultation questions

- To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?

## 5.5 Quality assurance of public health expenditure data

IHACPA uses public hospital expenditure as reported in the National Public Hospital Establishments Database to determine the NEC for block funded hospitals.

In the Consultation Paper, IHACPA noted that it is exploring the development of an independent quality assurance process for the public health expenditure included in Local Hospital Networks and Public hospital establishments national minimum data set.

This process will help to ensure high quality input data for cost modelling for the NEC Determination is maintained and aligns with the quality assurance process adopted to inform the NEP Determinations.

Following consultation with the Australian Institute of Health and Welfare, IHACPA has implemented a series of additional internal data validation and quality checks of the public health expenditure data as part of the model development underpinning the NEC Determination.

## 5.6 New high cost, highly specialised therapies

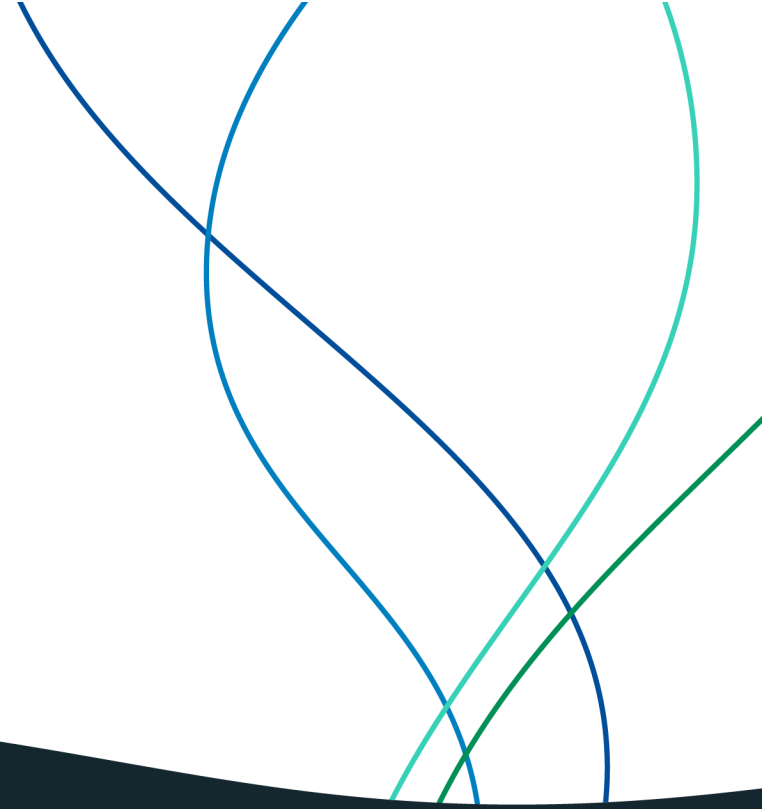
The annual NEC Determination includes block funded costs for the delivery of high cost, highly specialised therapies, as provided by clauses C11–C12 of the Addendum. These clauses contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee.

For 2024–25, the following high cost, highly specialised therapies have been recommended for delivery in public hospitals based on advice from the Commonwealth:

- 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
- 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.

The indicative block funded costs for the delivery of these high cost, highly specialised therapies based on the advice of states and territories will be included in NEC24.

# 6



## Data collection

# 6. Data collection

Under the Addendum to the National Health Reform Agreement 2020–25 (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.

To facilitate the collection of accurate activity, cost and expenditure data for the annual NEP and NEC determinations, IHACPA works with states and territories to develop appropriate data specifications and to acquire, validate and maintain data within the IHACPA information technology environment.

In developing these data specifications, IHACPA is guided by the principle of data rationalisation, including the concept of 'single provision, multiple use', as outlined in the Addendum.

## 6.1 Assurance of cost data

Each year, IHACPA commissions an independent financial review (IFR) of the National Hospital Cost Data Collection (NHCDC) to ensure that the quality of NHCDC data is robust, fit-for-purpose, and includes in-scope costs in accordance with the Australian Hospital Patient Costing Standards (AHPCS).

Stakeholder feedback suggested that the current NHCDC quality assurance activities and the IFR process results in the duplication of some information submitted by states and territories. IHACPA's review of all information collected through the NHCDC quality assurance activities and the IFR confirmed this and identified some variation in relation to whether information is collected at the jurisdiction, health network or hospital level.

IHACPA will not undertake the IFR on the 2021–22 NHCDC data. Instead, IHACPA will hold bilateral meetings with each jurisdiction to review their NHCDC submission and data quality statement to understand how the NHCDC data has been prepared and if it is consistent with the AHPCS.

IHACPA will publish a report including information collected and opinions developed through this assurance process.

### ? Consultation questions

- What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

## 6.2 Virtual models of care

In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, IHACPA outlined its intention to investigate innovative models of care and services related to virtual care, with an initial focus on virtual care delivered by emergency departments.

Stakeholders indicated support for this investigation and provided feedback demonstrating the diversity of virtual care services, models of service delivery and settings where virtual care services are being provided. IHACPA is working with other government agencies and jurisdictions to develop a staged approach to facilitate the inclusion of virtual care in national data collections, with a view to minimising the implementation burden for jurisdictions.

For 2023–24, IHACPA has developed data request specifications in consultation with jurisdictions for the collection of emergency virtual care activity data from 1 July 2023 as part of an initial project to collect virtual care data to inform future data collection refinements.

### ? Consultation questions

- Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?
- Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?

## 6.3 Organ donation, retrieval and transplantation

In 2018, the *Review of the Australian organ donation, retrieval and transplantation system – Final Report* made two recommendations for IHACPA to conduct a costing study and classification review of organ donation, retrieval and transplantation and of non-admitted pre and post organ transplantation care.

IHACPA is developing a project plan outlining the scope, timeframes and proposed approach to undertaking this investigation, in consultation with its advisory committees, jurisdictions, and the Australian Institute of Health and Welfare (AIHW).

In addition, IHACPA will commence work to investigate the development of a posthumous organ procurement National Best Endeavours Data Set in 2024–25, or an appropriate alternative data collection, in consultation with the Commonwealth Department of Health and Aged Care and the AIHW.

# 7

## Treatment of other Commonwealth Programs

# 7. Treatment of other Commonwealth programs

## 7.1 Overview

To prevent a public hospital service being funded more than once, the Addendum to the National Health Reform Agreement 2020–25 (the Addendum) requires the Independent Health and Aged Care Authority (IHACPA) to discount Commonwealth funding provided to public hospitals through programs other than the National Health Reform Agreement.

The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs.

Consistent with clauses A9 and A46(e) of the Addendum, blood expenditure that has been reported in the National Hospital Cost Data Collection (NHCDC) by states and territories will be removed in determining the national efficient price (NEP), as Commonwealth funding for this program is provided directly to the National Blood Authority.

The following Commonwealth funded pharmaceutical programs will also be removed prior to determining the underlying cost data for the NEP determination given that they are already funded separately:

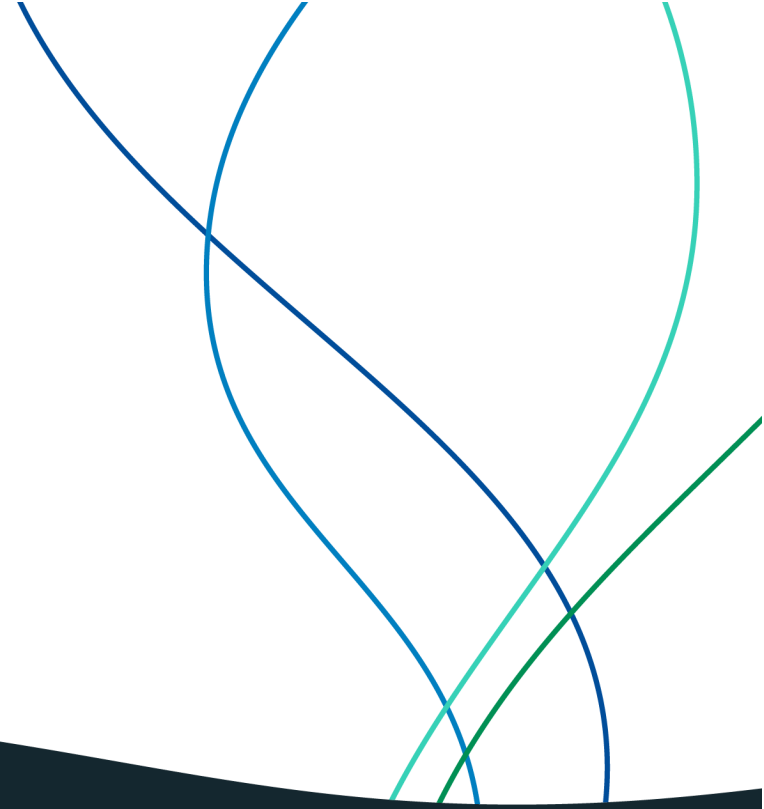
- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme (PBS) Access Program
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding).

IHACPA's process to remove PBS payments from the NHCDC involves linking the benefits to the corresponding hospital episodes where possible, as well as removing aggregate amounts where payments cannot be linked.

In 2023–24, IHACPA intends to commence a review of this linking process and explore potential process improvements to ensure the amounts deducted from individual hospital episodes better reflect the associated PBS payments and in turn, improve the representativeness of resulting prices.



# 8



## Future funding models

# 8. Future funding models

## 8.1 Overview

Activity based funding (ABF) has been an effective funding mechanism since it was introduced to Australian public hospitals in 2012. By setting a national efficient price (NEP) for each ABF hospital service, it has contributed to creating a more equitable and transparent system of hospital funding across Australia and enabled a stable and sustainable rate of growth in public hospital costs.

ABF will continue to be the best pricing and funding mechanism for many hospital services, however, the existing ABF system could benefit from the incorporation of alternate funding models that have the potential to create better incentives for improved continuity of care, use of evidence-based care pathways and substitution of the most effective service response. This is consistent with the move towards value-based care and a focus on outcomes over volume of services.

The Addendum to the National Health Reform Agreement 2020–25 (the Addendum) stipulates that the Independent Health and Aged Care Pricing Authority (IHACPA) will support the exploration and trial of new and innovative approaches to public hospital funding through:

- developing a funding methodology for approval from the Health Ministers' Meetings (HMM)<sup>3</sup> that does not penalise states and territories undertaking trials of innovative models of care
- advising the Commonwealth and states and territories on the application of the aforementioned methodology and on any issues it foresees with the proposed trial, with regard to the national funding model
- providing advice to HMM on any proposal to translate an innovative funding model to the national funding model, to inform consideration on the matter.

## 8.2 Trialling of innovative models of care

Clause A99 of the Addendum stipulates that states and territories can seek to trial innovative models of care, either:

- as an ABF service with shadow pricing, reporting, and appropriate interim block funding arrangements for the trial period; or
- as a block funded service, with reporting against the national model and program outcomes for the innovative funding model.

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

As part of the *Update to the National Efficient Cost Supplementary Determination 2022–23*, IHACPA included block-funded expenditure amounts for the following four innovative models of care proposed by New South Wales (NSW), based on a pending interim agreement with the Commonwealth to trial these models under clause A97 of the Addendum:

- Northern Sydney Local Health District Frail Aged – a program that aims to deliver proactive and timely community care for people at high-risk of an unplanned hospital admission
- Royal Prince Alfred Virtual Hospital – a program that aims to improve patient outcomes and experiences, accommodate increasing demand, enhance access to a specialised workforce and ensure sustainability of services through virtual service provision
- Telestroke – a program that aims to connect emergency department doctors to stroke specialists via video consultation

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<sup>3</sup> The Council of Australian Governments has been dissolved. The Health Ministers' Meeting, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies.

- Virtual Clinical Care Centre - a secondary triage program targeted at decreasing transfers for low acuity patients from Residential Aged Care Facilities to hospital via ambulance and in turn reducing increased demand for ambulance services.

IHACPA will continue to work with jurisdictions to develop and provide advisory support for the trialling of innovative models of care, under bilateral agreements between states and territories and the Commonwealth.

# 9

**Pricing and funding  
for safety and  
quality**

# 9. Pricing and funding for safety and quality

## 9.1 Overview

The Independent Health and Aged Care Pricing Authority (IHACPA) and the Australian Commission on Safety and Quality in Health Care (the Commission) follow a collaborative work program to incorporate safety and quality measures into determining the national efficient price (NEP), as required under the Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

Under the Addendum, IHACPA is required to incorporate safety and quality into the pricing and funding of public hospital services to improve patient outcomes across three key areas: sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions.

The funding adjustments applied as part of the safety and quality reforms not only act as a price signal, but also aim to improve awareness of areas that clinicians and hospital managers can work on to address and improve patient care.

## 9.2 Sentinel events

Sentinel events are defined by the Commission as a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

Since 1 July 2017, IHACPA has specified that an episode of care including a sentinel event will be assigned a national weighted activity unit (NWAU) of zero. This approach is applied to all hospitals, whether funded on an activity or block funded basis.

As per the Addendum (clauses A165–A166), IHACPA will continue to apply this funding adjustment for episodes with a sentinel event for the NEP Determination 2024–25 (NEP24) using Version 2.0 of the [Australian Sentinel Events List](#) published on the Commission's website.

## 9.3 Hospital acquired complications

A HAC is a complication that occurs during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

The funding adjustment for HACs reduces funding for any episode of admitted acute care where a HAC occurs. This approach incorporates a risk adjustment model and recognises that the presence of a HAC increases the complexity of an episode of care or the length of stay, driving an increase in the cost of care.

Further information on the HACs funding approach is included in the [NEP Determination 2023–24](#) and the [National Pricing Model Technical Specifications 2023–24](#).

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

For NEP24, IHACPA will use Version 3.1 of the [HACs list](#) on the Commission's website to implement the HACs funding adjustment.

## 9.4 Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission.

An avoidable hospital readmission (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 improved clinical management and/or appropriate discharge planning in the index admission.

From 1 July 2021, IHACPA has implemented a funding adjustment for AHRs and involves the application of a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode, to apply 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 2023–24](#), and the [National Pricing Model Technical Specifications 2023–24](#).

For NEP24, IHACPA will use Version 1.0 of the [AHRs list](#) on the Commission's website to implement the avoidable hospital readmissions funding adjustment.



# Appendix

# Appendix A: Consultation questions

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6	Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?	14
7	How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?	17
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9	To inform the review of the ICU adjustment: <ul style="list-style-type: none"> <li>○ what available evidence demonstrates the underlying drivers of cost variation for complex ICUs?</li> <li>○ what additional or alternative measures, other than mechanical ventilation hours, should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?</li> </ul>	19
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11	To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?	20



12	What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?	20
13	Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?	20
14	To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?	25
15	What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?	27
16	Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?	28
17	Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?	28
18	Do you have any further comments to inform the development of the NEP and NEC Determinations for 2024–25?	39



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