Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26

May 2024

Independent Health and Aged Care Pricing Authority

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26 – May 2024

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Abbreviations

Abbreviations	Full term
ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AHR	Avoidable hospital readmission
AMHCC	Australian Mental Health Care Classification
ANAPP	Australian Non-Admitted Patient Classification Project
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
COVID-19	Coronavirus disease 2019
DRG	Diagnosis Related Group
eMR	Electronic medical record
HAC	Hospital acquired complication
HoNOS	Health of the Nation Outcome Scales
HMM	Health Ministers' Meetings
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive care unit
IHACPA	Independent Health and Aged Care Pricing Authority
LHN	Local hospital network
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NWAU	National weighted activity unit
PBS	Pharmaceutical Benefits Scheme
The addendum	Addendum to the National Health Reform Agreement 2020–25
The commission	Australian Commission on Safety and Quality in Health Care
The mid-term review	Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report
UDG	Urgency Disposition Group
WHO	World Health Organization

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Introduction

1. Introduction

1.1 About IHACPA

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

IHACPA enables the implementation of national activity based funding (ABF) of public hospital services through the annual determination of the national efficient price (NEP) and national efficient cost (NEC). These determinations play a crucial role in calculating the Commonwealth funding contribution to Australian public hospital services and offer a benchmark for the efficient cost of providing those services as outlined in the National Health Reform Agreement (NHRA).

1.2 About this consultation paper

The Pricing Framework for Australian Public Hospital Services is one of IHACPA's key policy documents and underpins 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 is the primary mechanism for providing input to the pricing framework. The Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26 provides an opportunity for public consultation on the development and refinement of the national ABF system. This includes policy decisions, classification systems and data collection, which will underpin the NEP and NEC Determinations for 2025–26 (NEP25 and NEC25). The pricing framework benefits immensely from the contributions of states and territories, academic institutions, and other stakeholders.

1.3 IHACPA's broader work program

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

Due to the volume and complexity of this work, and the lead time to implement changes to classifications and data collections that underpin refinements to the national pricing model, this work often requires multiple years to complete, thus impacting the development of future determinations.

The consultation paper focuses on the projects where stakeholder input is required to support progression of specific activities for NEP25 and NEC25. It also seeks specific stakeholder input on areas or projects that are underway and may inform future determinations. As such, not all of the multi-year projects that are currently within IHACPA's broader work program is included in this consultation paper. Further information on IHACPA's key deliverables and activities is available in the annually updated IHACPA Work Program and Corporate Plan, available on the IHACPA website.

Recommendations from the Mid-Term Review of the NHRA Addendum 2020-2025 – Final Report

In December 2023, the Australian Government released the Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report. As decisions regarding the implementation of the recommendations are yet to be finalised, the consultation paper will primarily focus on the issues pertinent to the development of NEP25 and NEC25. The consultation paper may include references to outcomes from the mid-term review where relevant to the development of the national pricing model, or to support future implementation of the recommendations.

1.4 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 2024–25
- Pricing Framework for Australian Public Hospital Services 2024–25 – Consultation Report
- National Efficient Price Determination 2024–25
- National Efficient Cost Determination 2024–25
- IHACPA Work Program and Corporate Plan 2023–24.

Have your say

- Submissions close at 5pm AEST on Friday 7 June 2024.
- Submissions can be:
  - Emailed to 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 2025–26 will be published in December 2024.

Enquiries

- Enquiries related to this consultation process should be emailed to: submissions.ihacpa@ihacpa.gov.au

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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 state and territory governments. In making these decisions, IHACPA balances a range of policy objectives provided by the *National Health Reform Act 2011* and the Addendum to the National Health Reform Agreement 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. They comprise the overarching process and system design guidelines within which IHACPA makes its policy decisions.

In response to stakeholder feedback on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25, IHACPA updated the 'Time-quality care' overarching guideline to include considerations of equity of access and outcomes for all Australians, especially Aboriginal and Torres Strait Islander peoples. This approach aligns with the intent of the principles for reform and IHACPA's remit as outlined in the addendum.

IHACPA will continue to use the Pricing Guidelines to inform its decision making and ensure they support ongoing improvement of the efficiency and accessibility of public hospital services. The current Pricing Guidelines are reflective of the objectives in the addendum. Once a new addendum is finalised, IHACPA will undertake a comprehensive review of its Pricing Guidelines to ensure they align with the intent of a new addendum.

Figure 1: The Pricing Guidelines

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

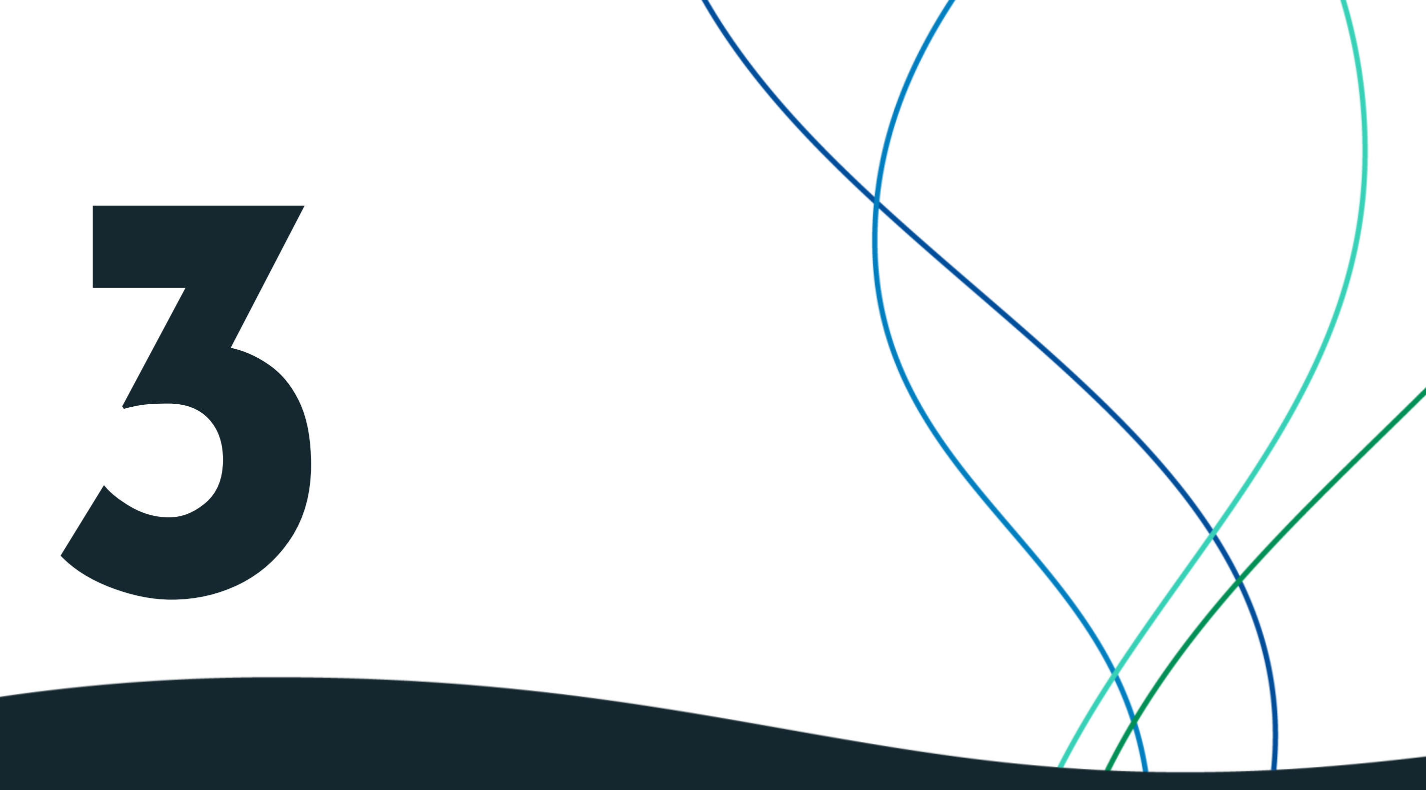
- **Timely-quality care**: Funding should support timely and equitable access to high quality health services and reduce disadvantage for all Australians, especially for Aboriginal and Torres Strait Islander peoples.
- **Efficiency**: ABF should improve the value of the public investment in hospital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

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

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

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

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve 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 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 6 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 include the:

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

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

For the NEP Determination 2024–25 (NEP24) IHACPA used ICD-10-AM/ACHI/ACS Twelfth Edition and AR-DRG Version 11.0.

Both classification systems have a 3-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 with relevant input from clinicians and other health sector stakeholders represented on IHACPA's advisory committees.

For NEP25, IHACPA proposes to use ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 11.0 to price admitted acute patient services.

3.1.1 ICD-10-AM/ACHI/ACS Thirteenth Edition

The Thirteenth Edition of ICD-10-AM/ACHI/ACS will be released from March 2025 and proposed for implementation on 1 July 2025.

ICD-10-AM is based on, and historically updated in line with, the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). However, the WHO's International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11) is the new international standard for international disease reporting, having been adopted by the 72nd World Health Assembly in 2019 and came into effect on 1 January 2022. ICD-10 is no longer being updated, with the last of its updates having been incorporated into ICD-10-AM Twelfth Edition, implemented in Australia from 1 July 2022. Updates to ICD-10-AM

Thirteenth Edition now align with ICD-11, where possible, as a potential future transition to ICD-11 is considered.

ACHI is based on and updated in line with the Medicare Benefits Schedule and the Australian Dental Associations' Schedule of Dental Services and Glossary.

Additional refinements are based on stakeholder submissions or have been progressed by IHACPA to ensure the currency and usability of the classifications. Major updates proposed for ICD-10-AM/ACHI/ACS Thirteenth Edition are detailed in the public consultation paper published on the IHACPA website.

Education material for ICD-10-AM/ACHI/ACS Thirteenth Edition will be provided through IHACPA Learn ahead of proposed implementation on 1 July 2025.

3.1.2 Cluster coding

IHACPA is proposing to implement cluster coding from 1 July 2025 in conjunction with ICD-10-AM/ACHI/ACS Thirteenth Edition. Cluster coding is a mechanism of linking related diagnosis codes through use of a Diagnosis cluster identifier. Codes are considered 'related' when they connect the circumstances of an event or certain other code relationships together.

Clustering will increase the understanding and context of coded activity data in both the short and longer term by:

- identifying relationships between codes
- enhancing safety and quality reporting
- enhancing reporting of chronic conditions
- reducing assumptions when interpreting data
- eliminating the need to review episodes of care to establish relationships between codes
- preparing for a potential future ICD-11 implementation, where clustering is a feature.

Education material for cluster coding will also be provided as part of the ICD-10-AM/ACHI/ACS Thirteenth Edition education program through IHACPA Learn.

3.1.3 AR-DRG Version 12.0

AR-DRG Version 12.0 has been updated to maintain clinical currency and cost homogeneity and has been further revised following consideration of submissions from stakeholders. The consultation paper on the Development of ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 was released in November 2023. The public consultation paper and the submissions received are available on the IHACPA website.

AR-DRG Version 12.0 is anticipated to be used to price admitted acute patient services for the NEP Determination 2026–27. Education material for AR-DRG Version 12.0 will be provided through IHACPA Learn.

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. IHACPA used AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP24 following two years of shadow pricing.

For NEP25, IHACPA will continue to price subacute and non-acute services using AN-SNAP Version 5.0.

3.3 Emergency care

For NEP24, 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.

3.3.1 Australian Emergency Care Classification Version 1.1

Since 2021, IHACPA has consulted with its working groups and advisory committees to develop an updated version of AECC Version 1.0. AECC Version 1.1 represents a modest refinement to the classification. The key refinements include updates to the complexity model based on the most recent national activity and cost data. IHACPA intends to release AECC Version 1.1 by mid-2024, for implementation from 1 July 2025.

For NEP25, IHACPA intends to price emergency department services using AECC Version 1.1 without a shadow pricing period as the updates included in Version 1.1 do not represent a significant structural change to the classification. This approach is aligned with IHACPA's National Pricing Model Consultation Policy and Shadow Pricing Guidelines, whereby classification changes only require shadow pricing where major structural changes occur.

Consultation question

- What, if any, barriers are there to pricing emergency department services using the Australian Emergency Care Classification Version 1.1 without a shadow pricing period for NEP25?

3.3.2 Refinements to the Australian Emergency Care Classification

During the AECC Version 1.1 development process, stakeholders identified additional areas of refinement. The proposed refinements would require significant changes to the structure of the classification or additional data items. These include reviewing the complexity of paediatric patients and possible inclusion of interventions variables to capture investigations and procedures within the classification. IHACPA commenced the work program for the development of an updated AECC version in early 2024.

Additionally, since 2019, IHACPA has been progressing the collection of patient level activity data in emergency services with support from the states and territories. This is intended to facilitate an uplift in data to support the future transition of emergency service presentations to be priced using AECC, in place of UDGs.

Consultation questions

- Are there any other proposed refinement areas to be considered in the development of an updated version of the Australian Emergency Care Classification?
- Are there any barriers or known issues associated with reporting patient level data, specifically in relation to reporting principal diagnosis and patient's age in emergency services?

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 9.0 to price non-admitted services for NEP24. Tier 2 Version 9.0 included 2 new classes to allow for the collection of activity and cost data to inform pricing refinement and enable more accurate capture of the costs associated with service provision:

- *10.22 Subcutaneous immunoglobulin (SCIg) infusion therapy – home delivered*
- *40.68 Supervised administration of opioid substitution therapy*

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 NEP25, IHACPA is consulting with its working groups and advisory committees on additional refinements to Tier 2. These include proposals to capture patient complexity, treatment of multiple healthcare providers, and innovative models of care.

IHACPA will continue using Tier 2 to price non-admitted services for NEP25. IHACPA will assess whether the incorporation of any proposed refinements require an update to the classification version.

Consultation question

Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification for NEP25?

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.

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

In October 2023, IHACPA completed Stage One: Investigation and consultation to better understand state and territory eMR systems, non-admitted patient service rostering, booking and costing systems.

IHACPA has commenced Stage Two: Proof-of-concept of the ANAPP which focuses on the development of a data model and methodological processes to conduct a technical proof-of-concept to extract data from state and territory eMR systems. This includes transforming unstructured data into a format that can be utilised for classification development.

IHACPA intends for ANAPP to be completed by 2025, which will inform the development of a new classification for non-admitted services.

3.5 Mental health care

3.5.1 Australian Mental Health Care Classification

IHACPA released the Australian Mental Health Care Classification (AMHCC) Version 1.1 in December 2023. AMHCC Version 1.1 is a modest refinement of the classification structure. The key changes include the recalibration of the complexity model by updating Health of the Nation Outcome Scale (HoNOS) weights and thresholds, and Abbreviated Life Skills Profile thresholds. These changes have been both informed and strongly supported by IHACPA's jurisdictional and clinical stakeholders.

During the AMHCC Version 1.1 refinement process, stakeholders provided feedback on several other areas for further refinement which would require a more substantial change to the classification structure and variables. In response, IHACPA commenced the work program for the development of AMHCC Version 2.0 in early 2024.

3.5.2 Admitted mental health care

For NEP24, IHACPA priced admitted mental health care using AMHCC Version 1.0.

For NEP25, IHACPA intends to price admitted mental health care using AMHCC Version 1.1 without a shadow pricing period given updates included in this version do not represent a significant change to the classification structure. This approach is aligned with IHACPA's National Pricing Model Consultation Policy and Shadow Pricing Guidelines, whereby classification changes only require shadow pricing where major structural changes occur.

3.5.3 Community mental health care

Clause A3 of the Addendum to the National Health Reform Agreement 2020–25 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 (NEC) 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 with 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 Determinations for 2021–22, 2022–23, 2023–24 and NEP24.

Jurisdictional feedback in the development of NEP24 indicated significant concerns with funding continuity and the lack of funding transition arrangements between state and territory governments and the Australian Government. As such, the Pricing Authority approved a fourth and final year of shadow pricing community mental health care services using AMHCC Version 1.0, and continued block funding for community mental health under the NEC Determination 2024–25.

In 2024, IHACPA will work closely with state and territory governments to address the local system and data reporting issues, and assessment and mitigation of expected funding impacts.

As such, for NEP25, IHACPA intends to price community mental health care services using AMHCC Version 1.1, following 4 years of shadow pricing.

Consultation question

- What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification Version 1.1 for NEP25?

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. 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. However, block funding is provided for activities where the components required for ABF are not currently available to enable these activities to be priced.

IHACPA 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.

IHACPA has previously consulted with stakeholders on how states and territories can be supported to improve the volume and quality of data reported against the ATTC. The key issues raised included challenges with capturing this data in current reporting systems and the ongoing transition to new systems and collection standards, after the coronavirus disease 2019 (COVID-19) pandemic response.

The Mid-Term Review of the NHRA Addendum 2020–25 recommended greater transparency in funding and investment in teaching and training functions with a particular focus on the equitable distribution of funding for teaching, training and research in regional and rural hospitals.

In the long-term, IHACPA intends to transition teaching and training from block funding to ABF using the ATTC. In order to facilitate analysis and reporting on the potential impact of such a transition, IHACPA requires a clearer understanding of the composition of existing block-funded amounts and how this funding is distributed across the states and territories. IHACPA intends to work with the states and territories to understand the reporting and distribution of block-funded amounts for teaching and training across the states and territories.

As outlined in the draft IHACPA Work Program and Corporate Plan 2024–25, research is not incorporated into the ATTC and IHACPA is not proposing any further work to develop a research classification.

Consultation questions

- Are there any persisting barriers to collecting activity data following theCOVID-19 pandemic response? If so, what potential strategies could IHACPA use to support states and territories in overcoming these barriers?
- What data-driven processes can be used to determine the efficient cost of teaching and training services to improve the transparency of block-funded amounts provided for these services, ahead of a potential longer-term transition to ABF?

4

Setting the national efficient price

4. Setting the national efficient price

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

IHACPA uses a data-driven approach to continually refine the national pricing model each year. This includes reviewing and using actual activity and cost data, to ensure it is fit for the purpose of pricing and developing the NEP.

As a result of this analysis, and stakeholder feedback in response to previous consultation papers, IHACPA has identified a range of potential pricing model refinements. Many of these projects are complex and have a longer-term development and implementation horizon.

An overview of these activities and their delivery timeframes is outlined in the IHACPA Work Program and Corporate Plan 2023–24. Updates on the progression of these deliverables will be provided in the IHACPA Work Program and Corporate Plan 2024–25, due to be released in June 2024.

Only refinements that are likely to have an impact on the development of the NEP Determination 2025–26 (NEP25), or where stakeholder input is required to progress investigation of the refinement, are included in this consultation paper.

In addition, some state and territory governments have identified specific factors associated with service delivery in smaller jurisdictions, that result in higher costs per capita to deliver care. IHACPA will work with jurisdictions on the negotiations for a new addendum to the NHRA to better understand the drivers of increased cost in smaller jurisdictions, and the impact on, and their relevance to, pricing model development. Following finalisation of a new addendum, IHACPA will develop a more detailed work plan to investigate and provide options to address these cost drivers.

4.1 Impact of COVID-19

The coronavirus disease 2019 (COVID-19) pandemic response resulted in significant changes to models of care and service delivery in Australian public hospitals.

To account for the impact of the COVID-19 pandemic response in the NEP Determination 2024–25 (NEP24), IHACPA adopted the following measures:

- modification of admitted acute activity data nationally in 2021–22
- continuation of the COVID-19 treatment adjustment for patients being treated for COVID-19 in a limited number of Australian Refined Diagnosis Related Groups (AR-DRGs).
- continuation of the temporary measures:
  - application of the intensive care unit (ICU) adjustment to patients with a COVID-19 diagnosis
  - exemption of the safety and quality adjustments for episodes of care with a COVID-19 diagnosis.

IHACPA will continue to monitor the impact of the COVID-19 pandemic response on the latest available data, as well as seek clinical advice on the current management and effects of COVID-19 to determine whether such measures are required for the development of NEP25.

4.1.1 Preparedness for future disruptions

The Mid-Term Review of the NHRA Addendum 2020–25 – Final Report contained recommendations specifically relating to addressing the ongoing impact of the COVID-19 pandemic response and the need to prepare for future system disruptions as part of a new addendum.

For NEP25, IHACPA's data analysis is intended to determine whether the initial costs and changes to service delivery and models of care associated with the COVID-19 pandemic response have endured or

changed over time. IHACPA seeks stakeholder input on evidence that demonstrates any impact on public hospital costs and service delivery, directly related to the onset of the COVID-19 pandemic response, in order to adequately account for it in the national pricing model.

Additionally, the mid-term review noted that a new addendum should be more responsive to system disruptions and recommended the establishment of pre-agreed principles and processes for time-limited funding arrangements to respond to short term emergencies. This could contribute to a more resilient health system that is better prepared for future disruptions, can minimise the potential negative consequences resulting from it, and recover quickly.

To prepare for the implementation of a new addendum, IHACPA seeks stakeholder input on the types of principles and processes to prepare for significant and unforeseen disruptions to the health system, including natural disasters and epidemics. Specifically, processes in relation to nationally consistent data reporting and modifications to the national pricing model, to ensure it remains responsive to such disruption.

IHACPA aims to balance the responsiveness and longer-term stability of the national pricing model and alignment with broader pricing policy objectives.

Consultation questions

- What evidence can stakeholders provide that demonstrates the costs and changes to models of care associated with the COVID-19 pandemic response have persisted into 2022–23, or changed over time?
- What principles and processes could guide an appropriate pricing response to significant disruptions to the health system, including natural disasters and epidemics?

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 and local health district 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. 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 adjustment requests for investigation.

Further information about the eligibility criteria is provided in the Assessment of Adjustments to the National Pricing Model Policy available on IHACPA's website. A list of all the adjustments IHACPA applies to the national pricing model is available in the NEP Determination 2024–25 on the IHACPA website.

4.2.1 Intensive Care Unit adjustment

Since the NEP Determination 2012–13 (NEP12), IHACPA has applied an ICU adjustment for specified ICUs. 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 development.

Currently, hospitals that consistently report more than 24,000 ICU hours and have more than 20% of those hours reported with the use of mechanical ventilation on an annual basis 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.

In 2023, IHACPA commenced a program of work to ensure the ICU adjustment reflects current practice and remains appropriate. In response to the

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25, stakeholders supported prioritisation of the review of the ICU adjustment and eligibility criteria for specialised ICUs. Stakeholders noted the shift away from mechanical ventilation in many ICUs and suggested that IHACPA consider broadening the definition of ICUs eligible for the adjustment to include neonatal or regional ICUs.

The current specified ICU list is defined at the hospital level, as individual units within a hospital cannot be identified in existing data collections, and therefore cannot be adjusted for separately. IHACPA acknowledges this approach may not account for ICU activity in non-specified hospitals or where 'complex' ICUs are staffed and available, but may not receive the throughput necessary to be recognised on the specialised ICU list. IHACPA is seeking stakeholder feedback on the following proposed options for specifying an ICU list:

- refinement of the existing hospital-based list, by changing thresholds, or casemix requirements
- reliance on external sources, such as the College of Intensive Care Medicine or the Australian and New Zealand Intensive Care Society
- listing of specific kinds of ICUs eligible within a hospital rather than the hospital itself
- consideration of hospital size and location.

Additionally, stakeholders have recommended that IHACPA consider separate rates for different cohorts of patients should be considered. Currently, episodes in specified ICUs receive an hourly rate for the time spent in an ICU. This is a weighted average of adult level 3 and paediatric ICU costs per hour for eligible episodes of care. Alternative approaches to this may be using multiple or tiered ICU rates, depending on unit type or patient criteria, or inclusion of a fixed component of the adjustment to recognise the baseline costs associated with staffing and operating an ICU.

IHACPA will continue working with its advisory committees to progress the ICU review. IHACPA will consider the Pricing Guidelines and the Assessment of Adjustments to the National Pricing Model Policy in undertaking its review. The outcomes of the review are expected to inform determinations beyond 2025–26.

Consultation questions

- Should the ICU adjustment be restricted to a list of eligible hospitals? If so, what factors should be considered in determining the level of ICU complexity required to be eligible for the ICU adjustment, noting that individual units cannot be identified in the current national data collections?
- Are there any barriers to a tiered adjustment that would allow for different ICU adjustment prices to apply, based on the characteristics of eligible hospitals or episodes of care within those hospitals?
- Are there any barriers to including a fixed national weighted activity unit (NWAU) adjustment for eligible hospitals, regardless of activity levels?

4.2.2 Other adjustments and their eligibility criteria

Since NEP12, IHACPA has applied a paediatric adjustment to reflect the legitimate and unavoidable costs associated with treating patients who are 17 years of age or less that are treated in a specialised children's hospital. 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.

During 2025–26, IHACPA will commence a review of the paediatric adjustment and its respective eligibility criteria, based on the outcomes of the ICU review. The paediatric adjustment interacts with both the ICU adjustment and other classification systems. Therefore, the scope of this review may include consideration of how legitimate and unavoidable cost variations associated with paediatric care may be addressed through other classification or pricing-related approaches.

Similar to the paediatric adjustment, IHACPA has implemented the Indigenous adjustment since NEP12. For NEP24, the empirical value of the adjustment for the admitted acute stream dropped from its historical level. However, the actual stabilised value published in the NEP24 Determination was unchanged from the NEP Determination 2023–24. IHACPA will examine the available data with the aim of identifying the drivers of the change for NEP25.

The draft IHACPA Work Program and Corporate Plan 2024–25 provides further information on the proposed review of specific adjustments and their approximate timeframes.

Consultation question

- To support IHACPA's investigation, what factors may help explain the reduction, in the Indigenous adjustment observed in recent years? Additionally, what factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public hospital services for Aboriginal and Torres Strait Islander peoples across Australia?

4.3 Accounting for private patients in public hospitals

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

In addressing clauses A13, A43 and A44 of the addendum, IHACPA developed the following definition of financial neutrality and payment parity in terms of revenue per 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 NEP25.

The mid-term review recommended IHACPA undertake a review, in consultation with jurisdictions and the National Health Funding Body, regarding the requirements and implementation of the arrangements for determining funding neutrality for private patients in public hospitals. Once a new addendum is finalised, IHACPA will undertake review of its approach to private patient neutrality as required.

4.3.1 Phasing out the private patient correction factor

The reporting of private patient medical expenses has previously been inconsistent in the National Hospital Cost Data Collection (NHCDC), with some states and territories not reporting private patient medical costs within their NHCDC submission. This led to the introduction of the private patient correction factor imputing costs 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. IHACPA will assess the 2022–23 NHCDC submissions to determine if there has been a change in the reporting of costs associated with the medical treatment of private patients. IHACPA will then determine if the private patient correction factor is still required.

4.4 Harmonising price weights across care settings

The 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 and noted that analysis is required to support progression of price harmonisation of chemotherapy.

For NEP25, IHACPA will further investigate opportunities for price harmonisation, commencing with chemotherapy, with consideration of local admission policies and clinical impacts. IHACPA will be analysing available data and seeking to ensure that equivalent services relating to chemotherapy are appropriately aligned.

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. 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 2025–26 (NEC25).

5.3 Standalone hospitals providing specialist mental health services and residential mental health care 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 has priced admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0 since the National Efficient Price (NEP) Determination 2022–23. In 2021–22, 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.

Additionally, in the NEC Determination 2024–25 (NEC24), a separate block-funded services category was created for residential mental health care services. Residential mental health care services are eligible for block funding if they meet the criteria outlined in the General List of In-Scope Public Hospital Services Eligibility Policy. IHACPA intends to maintain this new category for residential mental health care services for NEC25.

IHACPA will work with state and territory governments to review activity and cost data from standalone hospitals providing specialist mental health services that received block funding in NEC24. This will involve ongoing block funding categorisation of the admitted and community mental health care services being delivered by standalone hospitals and determining if they continue to meet the 'low-volume' threshold.

IHACPA will work with state and territory governments to investigate the feasibility of transitioning these services to ABF in the development of NEC25. IHACPA will also consider whether more data-driven approaches can be applied to the determination of the efficient cost of services that continue to receive block funding.

5.4 High cost, highly specialised therapies

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

For 2025–26, the following high cost, highly specialised therapies have been recommended for delivery in public hospitals based on advice from the Australian Government:

- Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
- 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 and B-precursor acute lymphoblastic leukemia.

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 NEC25.

Additionally, the Mid-Term Review of the NHRA Addendum 2020–25 – Final Report recommended the development of a nationally consistent approach to undertaking health technology assessment for high-cost, highly specialised therapies which are likely to increase in both number and diversity. It also recommended a structured horizon scanning process should be established for high-cost, highly specialised therapies, with the involvement of all jurisdictions, and with input from relevant stakeholders, including but not limited to the National Blood Authority, Organ and Tissue Donation Authority, Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee to support forward planning and priority setting.

IHACPA will engage with the Australian Government to assess whether any changes resulting from these processes might have implications for the national pricing model.

Data collection

6. Data collection

Under the Addendum to the National Health Reform Agreement 2020–25, the Independent Health and Aged Care Pricing Authority (IHACPA) is required to develop, refine and maintain systems as necessary to determine the national efficient price (NEP) and national efficient cost (NEC), including classifications, costing methodologies and data collections.

6.1 Cost and activity data collection

IHACPA develops the Three Year Data Plan every year to communicate cost and activity data reporting requirements to state and territory governments for the next three years, in accordance with clauses B66 to B83 of the addendum. The Three Year Data Plan is supported by the Data Compliance Policy, which describes the process and criteria by which IHACPA will publicly report on compliance by state and territory governments with the data requirements and data submission dates specified in the Three Year Data Plan.

State and territory governments are required to report hospital activity data on a quarterly 'year to date' basis to IHACPA, while teaching, training and research and hospital cost data provided through the National Hospital Cost Data Collection (NHCDC) is reported on an annual basis. Quarterly 'year to date' data collection enables data from previous submissions to be corrected. For example, the end of year submission would be considered final, allowing for any missing or erroneous data in the third quarter submission to be corrected.

Additionally, 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 and update appropriate data request specifications each year. IHACPA also works with stakeholders 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 addendum.

The data collected by IHACPA is used to develop the NEP and NEC each year. This acts as an incentive for state and territory governments to report data to IHACPA. The NHCDC is a voluntary collection with an understanding that the submission of all activity and cost data is not possible in every context. Nevertheless, IHACPA continues to collect cost data for over 95% of admitted patient activity nationally.

Recently, IHACPA observed changes in the volume and quality of data submitted by state and territory governments. Stakeholders noted the reasons for the variation are due to changes to data collection systems, the limited resources available to collect data, and noted that a less extensive subset of cost data could be of higher quality than the complete data submission. IHACPA is in the process of determining the impact of the observed changes to the collected data. This has involved determining if the data collected is sufficient in ensuring IHACPA is guided by the 'evidence-based' Pricing Guideline, including the concept that 'funding should be based on the best available information that is both nationally applicable and consistently reported'.

Consultation questions

- How should IHACPA account for the changes in data reporting when developing a costed dataset?
- How can IHACPA ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity?

6.2 Assurance of cost data

For the NEP Determination 2024–25 (NEP24,) IHACPA undertook quality assurance of the 2021–22 NHCDC data submissions and NHCDC data quality statements through bilateral meetings with each state and territory. The process involved reviewing the NHCDC submissions to understand how the NHCDC data has been prepared and if it is consistent with the Australian Hospital Patient Costing Standards (AHPCS).

The review identified that there were no significant anomalies identified in the data however recommended that IHACPA:

- discontinue the current annual independent financial review
- investigate cost variations across the states and territories through selected focus areas
- develop a data quality framework to improve the cost and activity data collections.

The NHCDC Public Sector Review 2021–22 will be published in May 2024.

For NEP25, IHACPA will implement a similar process to review the NHCDC 2022–23. IHACPA will continue to work with stakeholders to address the changes to data reporting and use this information to develop an NHCDC Data Quality Framework to improve the cost and activity data collections.

Consultation question

- What quality assurance approaches are being implemented at the hospital or state and territory level that should be considered by IHACPA to apply to national data collections?

6.3 National Benchmarking Portal

In 2021, IHACPA released the National Benchmarking Portal (NBP), a secure website-based application that provides public access to aggregated data held by IHACPA, to enable informed policy decisions, to support health services research and to improve health system performance.

The NBP contains three areas of focus:

- cost per national weighted activity unit (NWAU)
- hospital acquired complications (HACs)
- avoidable hospital readmissions (AHRs).

Within each dashboard the user can filter data according to their chosen state or territory, local hospital network, hospital, or hospital peer group as well as other, dashboard-specific filters.

All data is aggregated using common variables including but not limited to hospitals or establishments, classification end-class, care stream and month of separation. If a user selects filters that result in a sufficiently small sample size, indicators and charts are masked in order to maintain patient confidentiality and statistical robustness.

As part of the next iteration of the NBP, IHACPA is considering the development of updates to improve the NBP's functionality and user experience. This includes potential updates to its filters, aggregation and usability to maximise utility for a range of audiences.

Consultation question

- What changes would enhance the user experience and functionality of the National Benchmarking Portal to inform improvements in public hospitals, and policy making?

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 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 Australian Government 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.

IHACPA has commenced 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.

As reiterated in the Mid-Term Review of the National Health Reform Agreement (NHRA) Addendum 2020–25 – Final Report, ABF continues 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.

8.2 Trialling of innovative models of care

Clause A99 of the Addendum to the NHRA 2020–25 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.

Trials of innovative models of care may only occur through a bilateral agreement between the Australian Government and a state or territory, for a fixed period of time under clause A97 of the addendum.

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

The mid-term review noted that a new addendum should prioritise the development of optimal models of care that deliver end-to-end integrated care, using agreed innovative financing mechanisms, and pricing approaches that reward high value care. It recommended the establishment of a National Innovation and Reform Agency, an Innovation Fund and Innovation Pathway designed to develop and transition innovative models of care from seed funding to operation at scale.

IHACPA will continue to support NHRA negotiations in line with the recommendations made in the mid-term review. In the interim, 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 Australian Government. Once a new addendum is finalised, IHACPA will work with the parties to the NHRA to review and implement any changes related to the trial of new and innovative approaches to public hospital funding.

8.3 Virtual models of care

In response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services for 2023–24 and 2024–25, stakeholders provided feedback demonstrating the diversity of activities related to virtual care. The feedback received reflects IHACPA's understanding that there is significant variation in the delivery of virtual care across the states and territories, and a lack of national consistency in the definition and scope of virtual care services in Australia, and the way these services are being captured in the existing activity and cost data collections.

In January 2024, IHACPA commenced a program of work to address these inconsistencies, improve data collections and support the improved integration of virtual care into the national pricing and funding model. The project encompasses a horizon scan of virtual care activity, costs, modes of service delivery and models of care in Australia, including variations across the states and territories, and virtual care funding arrangements in similar international health systems.

The horizon scan, alongside consultation with relevant bodies in the Australian virtual care space, will inform the development of recommendations for a national strategy for the treatment and improved integration of virtual care into the pricing and funding for public hospital services. This may involve refinements to existing ABF arrangements or consideration of alternative models that may better facilitate value-based funding for services involving virtual care delivery. The development of a work plan to address the outcomes of this project will also consider interactions with the objectives outlined in a new addendum.

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 (NHRA) 2020–25.

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 (AHRs).

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

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 2025–26 (NEP25) 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 2024–25 and the National Pricing Model Technical Specifications 2024–25.

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

For NEP25, 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 AHR occurs when a patient who has been discharged from hospital (the index admission) is admitted again within a certain time interval (the readmission), and the readmission is:

- clinically related to the index admission; and

- has the potential to be avoided through either, or both, improved clinical management and appropriate discharge planning in the index admission.

From 1 July 2021, IHACPA has implemented a funding adjustment for AHRs. It involves applying a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode. This applies where there is a readmission to any hospital within the same 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 2024–25 and the National Pricing Model Technical Specifications 2024–25.

For NEP25, IHACPA will use Version 2.0 of the AHRs list on the Commission's website to implement the avoidable hospital readmissions funding adjustment.

9.5 Evaluation of safety and quality measures

Under the addendum, IHACPA is required to monitor the effectiveness of strategies to address safety and quality in the national pricing model and their impact on patient outcomes.

IHACPA led the development of a proposed approach to evaluate the implemented safety and quality reforms for sentinel events, HACs and AHRs. This was provided to the Health Ministers' Meetings (HMM) for consideration in October 2021 as part of the joint advice from the national bodies.

The Mid-Term Review of the NHRA Addendum 2020–25 – Final Report noted that the current safety and quality adjustments in the national pricing model may result in the following unintended outcomes:

- changes to clinical practice is limited due to a lack of visibility of safety and quality adjustments at the local health network level
- that the base plus growth funding model and back-casting methodology may mute the effect of the quality and safety adjustments.

For these reasons, the mid-term review recommended that safety and quality measures are further developed, strengthened and enhanced in line with the NHRA. This included continued scrutiny of the specific adjustments and their application to ensure they remain fit-for-purpose and are achieving their intended objectives.

Additionally, the mid-term review reiterated the current addendum's focus on patient outcomes and rewarding best practice clinical care, as a means of shaping outcomes and improving system sustainability. The mid-term review recommended the development and implementation of pricing approaches that reward high value care and penalise low value care providing incentives to accelerate changes in clinical practice and manage introduction of new technologies, and remove services that are identified as low value from the scope of public hospital services eligible for Commonwealth funding under the NHRA. Examples provided in the review included financial incentives through the funding model for those pathways that are best practice or ensure price signals are applied consistently to remove incentives for low value care.

Based on these recommendations, IHACPA intends to undertake preparatory work to inform future refinements to the safety and quality measures. This includes exploring whether the current safety and quality adjustments in the national pricing model are meeting their policy objectives of improving safety and quality in hospital care. IHACPA will consider any new provisions related to safety and quality once a new addendum is finalised, in consultation with state and territory governments and the Australian Government.

Consultation questions

- What impact has the introduction of the pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions had on public hospital service delivery?
- To inform the further development of safety and quality measures, are there other pricing-related approaches that could be used to reward high quality care? How can IHACPA identify such care in national data collections?

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