Catholic Health Australia – Pricing Framework for Australian Public Hospital Services 2026-27 Submission

June 2025

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Executive summary

Catholic Health Australia (CHA) is the nation's largest non-government provider of health, aged, and community care services. Its members deliver more than 15 per cent of all hospital-based care in Australia, operating hospitals in every state and the Australian Capital Territory. They provide around 30 per cent of private hospital care, 5 per cent of public hospital care, and a wide range of community and residential aged care services. Catholic hospital providers have a vital interest in working with the Independent Health and Aged Care Pricing Authority (IHACPA) to ensure the sustainable provision of health care services for all Australians to meet community expectations of safe and quality care.

CHA appreciates the opportunity to provide input into the consultation on the *Pricing Framework for Australian Public Hospital Services 2026–2027* (Pricing Framework). We look forward to working with IHACPA during the consultation process to ensure the Pricing Framework achieves its intended outcomes. Our goal is to ensure it fully supports a high-quality and safe hospital system for all Australians irrespective of their wealth or geography.

Overall, CHA welcomes the progress IHACPA has made in highlighting key issues through the Consultation Paper and is encouraged by the depth of stakeholder engagement to date. This submission focuses on key questions raised in the Consultation Paper on the *Pricing Framework* for Australian Public Hospital Services 2026–2027 and is not an exhaustive response to each issue raised in the Consultation Paper.

Key observations and issues related to the *Pricing Framework* articulated in our submission include:

1. **Recognition of the true cost of multidisciplinary care in pricing structures:** To ensure sustainable and high-quality care for individuals with complex needs, pricing models must explicitly account for the multidisciplinary nature of service delivery. This includes recognising the coordinated contributions of nurses, allied health professionals, care workers, and other specialists. Embedding this recognition in pricing frameworks is essential to reflect the real cost of delivering integrated, person-centred care.
2. **Incorporating continuous improvement through refined data collection frameworks:** Sustained improvement in IHACPA's cost collections and pricing advice depends on robust, flexible data systems that can adapt to the evolving needs of the hospital sector. This requires refining data collection frameworks and principles by drawing on insights from past submission processes. Establishing a continuous feedback loop will enhance data quality, reduce administrative burden, and support more accurate and responsive policy and funding decisions. In addition, introducing mechanisms that improve transparency, accountability, and public confidence are essential, including data governance processes and mechanisms to compare how health funding is allocated.
3. **Embedding flexibility and future focus in pricing advice to reflect evolving care models:** As models of care shift to meet the needs of an ageing population with increasing complexity and comorbidities, pricing advice must be equally adaptive and forward-looking. IHACPA's pricing frameworks should support innovation in care delivery by accommodating integrated, multidisciplinary approaches and enabling sustainable funding for emerging models. A strategic, flexible approach to pricing will ensure the system remains responsive to demographic trends and evolving clinical realities.

4. **Embedding equity and access into pricing design:** There is a need to embed equity and access into pricing design, particularly by addressing the distinct needs of rural and remote hospitals, smaller local health networks, and Aboriginal and Torres Strait Islander peoples. Achieving this requires culturally safe roles to be factored into cost models, adjustments for outcomes like discharge against medical advice (DAMA), and recognition of the unique financial and operational challenges faced by hospitals in geographically and socially complex areas. A more tailored funding model that moves beyond current activity-based funding and partial block grants is needed to ensure fair and sustainable access to care across all settings.
5. **Promotion of system efficiency and best practice through integrated and harmonised care**: Pricing models should support the provision of equivalent care across settings and modalities, reflect clinical differences between admitted and non-admitted care, and ensure complexity is appropriately recognised. Simplification of pricing models is seen as a necessary but delicate task, requiring a phased, evidence-informed process that preserves transparency, equity, and relevance.
6. **Stakeholder engagement and co-design:** It is important to involve a broad range of stakeholders, including private hospitals, clinicians, local health districts, and jurisdictional health departments throughout the development, consultation, and implementation phases of pricing reforms. Engagement with the private hospital sector is particularly important when refining classifications that may eventually apply across both public and private settings. Deeper clinical engagement is also critical, especially in refining activity-based funding models for complex areas such as mental health, chronic disease management, and culturally safe care for Aboriginal and Torres Strait Islander peoples.

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Our list of recommendations

CHA makes the following recommendations to IHACPA for amendments to *Pricing Framework for Australian Public Hospitals 2026-27*:

Recommendation 1: Expand on the proposed wording under subheading: 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 and be used to drive required improvements in system efficiency and supporting measures to enable long-term financial sustainability of the Australian public hospital system."

Recommendation 2: Define "transparency" within the Pricing Guidelines and explicitly include the public's ability to compare how state and territory governments allocate health funding—particularly the proportion spent on administration and overheads.

Recommendation 3: Revise the focus area of 'Promoting harmonisation' in the Pricing Guidelines to explicitly refer to "best practice provision of equivalent care across appropriate settings, sites and modalities."

Recommendation 4: As part of the process to refine classifications used to describe and price public hospital services, ensure that the private hospital sector is also consulted around the applicability (present or future) of new classifications, given that public hospitals exist and operate within a broader health care ecosystem.

Recommendation 5: Concurrently release a comprehensive explanation of the pricing changes for admitted acute episodes of care with the launch of AR-DRG Version 12 in July 2025. This should be accompanied by targeted educational content through IHACPA Learn to ensure stakeholders are well-equipped to understand, interpret, and implement the changes effectively.

Recommendation 6: Specific refinement areas for Tier 2 have been summarised below:

- Expand the Allied Health and/or Clinical Nurse Specialist Intervention Services (40 series) to enable more accurate representation of the care delivered by allied health professionals and nurses within non-admitted settings.
- Consider incorporating other factors that better adjust for patient complexity, particularly in the context of chronic disease management.
- Continue review and refinement of the approach to capture ICT-delivered service events as part of broader work plans to ensure that funding and reporting mechanisms are aligned with patient-centred outcomes instead of just service volume.

Recommendation 7: Consider the resource pressures for individual services created by the VAD system including relevant nuances applicable to each jurisdiction, and account for these pressures as part of the design of a Tier 2 class for VAD services.

Recommendation 8: Ensure that the designed Tier 2 class is piloted in a range of hospital settings, including participants and non-participants in VAD, as well as private hospital settings.

Recommendation 9: While the technical rationale for removing COVID-19 temporary measures in NEP26 is sound, several barriers remain. These include incomplete cost reflection of ongoing care changes, jurisdictional variability, lingering complexity in some patient cohorts, risk of unintended financial disincentives, and the need to maintain system confidence through careful, data-informed transitions. Addressing these challenges through robust consultation, clear transition planning, and targeted monitoring of post-adjustment impacts will be essential to ensuring a stable and equitable pricing environment beyond COVID-19.

Recommendation 10: IHACPA maintain unbundled ICU pricing with a separate adjustment reflecting actual resource use, as bundling ICU costs into AR-DRG price weights risks masking important cost variation driven by factors beyond AR-DRG classification, such as patient complexity and procedural differences.

Recommendation 11: While reviewing the sequencing and interaction of the Indigenous and remoteness adjustments is a necessary first step, broader technical refinements are both feasible and necessary. Embedding culturally safe roles into cost models, adjusting for culturally mediated outcomes like DAMA and readmission, incorporating social and cultural complexity, refining geographic adjustments, and respecting Indigenous data governance all offer promising avenues to reshape the pricing system in service of equity. As IHACPA continues its technical review and embarks on broader consultations, these refinements should form part of a deliberate and respectful process to ensure the pricing system actively supports culturally safe, high-quality care for First Nations peoples.

Recommendation 12: Simplifying IHACPA's pricing and adjustment models is a necessary but delicate task. Guided by the principles of transparency, equity, materiality, and evidence-based design, and implemented through a phased and inclusive process, simplification can improve the usability and coherence of the national pricing system without compromising its core purpose—to fund public hospital services in a way that reflects cost, supports access, and promotes efficiency. As IHACPA embarks on a multi-year program of review, its approach must ensure that simplification enhances, rather than diminishes, the model's ability to serve Australia's diverse hospital system and its communities.

Recommendation 13: To address persistent and structurally driven cost variation in rural and remote hospitals, pricing and funding models must be revised to more accurately reflect the full cost of sustaining safe, equitable, and accessible care in these settings. This includes accounting for the high fixed costs of low-volume service delivery, the premium labour and incentive costs required to maintain a skilled workforce, and the additional resource intensity arising from limited access to diagnostics, allied health, and specialist support. Further adjustments are needed to capture the compounded impact of socioeconomic disadvantage, cultural and geographic complexity, and the reliance on generalist models of care. Capital and infrastructure costs, including digital limitations, should also be better recognised, along with the essential "insurance costs" associated with maintaining regional emergency and disaster response capabilities. A more comprehensive funding approach, beyond current activity-based pricing and partial block grants, is necessary to support the sustainability of rural and remote health services and ensure equitable access for all Australians.

Recommendation 14: To enhance equity and sustainability under the ABF model, national pricing and funding mechanisms must better reflect the structural cost barriers that prevent smaller hospitals and LHNs from achieving economies of scale. These barriers include the need to maintain 24/7 service capability regardless of demand, rigid workforce requirements that limit scalability, and the duplication of services across geographically dispersed sites. Facilities with specialised mandates or complex case-mix profiles also face high fixed costs

that are not fully offset by existing pricing adjustments. Further challenges arise from low digital maturity, which hampers efficiency gains, and from local cost variations in wages, logistics, and procurement that are not adequately captured in national benchmarks. Additionally, hospitals are increasingly required to compensate for systemic gaps in aged care, mental health, and primary care, leading to inefficiencies not aligned with ABF incentives. A more tailored funding model — one that accounts for structural inefficiencies, local cost differentials, and service obligations beyond direct activity — is essential to support the viability of diverse health services and ensure funding fairness across all settings.

Recommendation 15: To support the second year of ABF implementation for community mental health services under NEP26, IHACPA should strengthen data quality, deepen clinical engagement, and tailor support for regional and remote services. This includes investing in data infrastructure and training, establishing a readiness assessment framework, and refining the AMHCC based on emerging trends and clinical input. Co-designed monitoring tools should track access, quality, and outcomes without creating excessive burden. Transitional safeguards — such as floor payments and risk-adjusted loadings — are also needed to ensure funding stability and service continuity during the transition.

Recommendation 16: To support appropriate care and equitable pricing, IHACPA should adopt a price harmonisation approach that accounts for clinical reasons behind admitted versus non-admitted care in procedures such as chemotherapy, dialysis, interventional imaging, and gastrointestinal endoscopy. These decisions are driven by patient complexity, treatment intensity, and the need for monitoring or supportive care. A harmonised pricing model should include adjustment factors or risk stratification that reflect clinical severity and resource use, ensuring funding aligns with care complexity while maintaining incentives to treat patients in the most suitable setting.

Recommendation 17: To ensure the proposed review is aligned with the evolving public health funding landscape, adopt the following policy principles and considerations:

- **Embed transparency** by adopting a clear, evidence-informed approach that explicitly demonstrates how data informs the development of revised block funding criteria;
- **Emphasise the need for integrated care** by embedding incentives that actively promote integrated models of care into a revised block funding criteria and arrangements;
- **Account for workforce pressures** by recognising the costs associated with implementation of innovative workforce models.

Recommendation 18: To ensure current funding arrangements remain fit-for-purpose, it is essential that the process for determining a therapy's eligibility for high-cost funding is made clear, consistent, and publicly accessible. Additionally, how a therapy is transitioned from high-cost funding arrangements to standard activity-based funding should also be clear and transparent. Embedding stakeholder consultation and regular review mechanisms into the transition process would further support its responsiveness to the evolving nature of specialised therapies and ensure that funding models remain sustainable, fair, and fit-for-purpose.

Recommendation 19: Key pricing considerations pertinent for these and other high cost, highly specialised services include, but are not limited to, the following:

- Clear articulation of the full spectrum of costs associated with delivering high-cost therapies, which may include consumables, infrastructure, direct care delivery, procurement or acquisition of the intervention, and other implementation-related expenses.
- Clearly stated cost drivers and unbundled pricing approach should be incorporated as key considerations to ensure that the pricing model becomes more transparent, accountable, and adaptable to changes in context.
- Differentiated pricing between upfront and ongoing costs for these and other highly specialised services.
- Potential adoption of financial risk sharing approaches to pricing, where payment is aligned with the value and/or outcomes of care, as opposed to volume alone.

Recommendation 20: Ensuring that ongoing data collection is accurate, robust, and fit for purpose is essential for effective policy development, service planning, and performance monitoring. As such, it is important that the following is considered in future NHCDC data submissions:

- **Embedding monitoring and evaluation activities** as part of ongoing quality improvement processes to ensure that data is accurate, robust and fit for purpose.
- **Refining feedback loops and ensuring transparency** through sharing of data insights with contributing services and/or jurisdictions, and in particular, the use of platforms such as the NHCDC Dashboard to enhance the timeliness and transparency of state and territory quality assurance and cost weight reporting.
- **Clear and collaborative articulation of roles and responsibilities** is critical to the success of any data collection initiative involving jurisdictions, LHDs, and individual hospitals. Mechanisms such as timely processes and controls, dedicated feedback channels, and IHACPA-facilitated troubleshooting between LHDs and jurisdictions can support continuity and responsiveness.

Recommendation 21: There are several areas of refinement that could support the future sustainability and predictability of public hospital costs and funding. These include, but are not limited to, the following:

- Strategic and coordinated investment in innovative models of care supported by interoperable digital infrastructure is essential to expand Australia's digital health and data-sharing capabilities.
- Contribute towards work designed to better manage regulatory variation between the public hospital sector and other parts of the care economy, including cost implications associated with system inefficiencies.
- Modernise data request specifications to better align with the evolving landscape of public hospital care and the recent growth in hospital costs.
- Update data collection frameworks to better capture the realities of innovative, patient-centred models of care that are increasingly becoming standard practice.
- Align public hospital cost and funding data with other nationally collected datasets.

- Leverage insights from previous NHCDC cycles identify priority areas for targeted pilot projects, helping to test and refine new data strategies.

Recommendation 22: Specific evidence of workforce cost increases includes, but is not limited to, the 3.5% increase in minimum wages as recently announced by the Fair Work Commission (FWC) that will come into effect 1 July 2025. Additionally, IHACPA should work in partnership with leading agencies that routinely collect and analyse workforce and skills data to contribute towards the evidence-base associated with increased workforce costs.

Recommendation 23: Potential barriers to participation that should be considered in planning and implementation of future data submissions have been identified below:

- **Resource availability:** Tailored engagement with each jurisdiction to assess their specific resource needs in meeting the EVC data request specifications should be prioritised for future data collections. As part of this process, consider the provision of targeted grant funding to enable jurisdictions to contract the necessary technical expertise to complete the data submission.
- **Alignment between data request specifications and local EVC model of care:** To address potential misalignments between data request specifications and local models of care, consider incorporation of a targeted analysis of data gaps identified during the EVC Data Submission project, and use findings to inform future data submissions. Aggregated insights could then be shared with jurisdictions to encourage engagement in future submissions, as well as improving knowledge-sharing.

Recommendation 24: Provide guidance to support consistent application of EVC data request specifications for future data collections. As part, ensure that information about specific technologies used during virtual consultations can be recorded in the data collection so that the specifications remain future-proof and adaptable to evolving technologies.

Recommendation 25: There are a range of additional risk factors that IHACPA should consider as part of the revised risk adjustment models for HACs and AHRs. These include:

- **Social determinants of health**, including, but is not limited to a person's cultural and linguistic diversity (CALD) status, Indigenous status, socioeconomic background, geographic location, and access to support networks.
- A broader category of **cognitive conditions** and/or spectrum disorders that may contribute to hospital-associated deconditioning and immobility-related complications.
- **Clinical frailty measures**, such as the Clinical Frailty Scale (CFS), that are being increasingly recognised for their utility in risk stratification should also be considered as part of the revised model.

Recommendation 26: Conduct a comparative analysis of the feasibility and equity of implementing the HAC adjustment between tertiary and non-tertiary hospitals, ensuring that facilities treating higher-risk patient populations are not disadvantaged relative to those treating lower-risk cohorts.

Submission

This submission focuses on key questions raised in the Consultation Paper on the *Pricing Framework for Australian Public Hospital Services 2026-2027* and is not an exhaustive response to each issue raised in the Consultation Paper.

Chapter 2: Pricing Guidelines

Public hospitals receive funding from state and territory governments. This funding is underpinned by a significant contribution from the Commonwealth Government under the National Health Reform Agreement (NHRA). CHA has previously emphasised the importance of IHACPA taking a more active role in upholding the standards for data reporting, activity calculation, and funding under the National Health Reform Agreement (NHRA) given its expertise and capabilities. This includes driving improvements in system efficiency and supporting measures that ensure the long-term financial sustainability of the public hospital system, with accountability shared across all relevant parties to the NHRA.

Recommendation 1: Expand on the proposed wording under subheading: *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 **and be used to drive required improvements in system efficiency and supporting measures to enable long-term financial sustainability of the Australian public hospital system.**"

With regard to operationalising the proposed revision to the Pricing Guidelines, CHA recommends that IHACPA begin reporting specifically on any gap between the Commonwealth funding given to states and territories provided under the national funding model and the funds provided to hospitals to provision services. This is aligned with the principle of Transparency, as stated in the Pricing Guidelines, which maintains that "all steps in the determination of ABF and block grant funding should be clear and transparent." CHA proposes that IHACPA explicitly defines what transparency should look like within context of these Guidelines. It is the view of CHA and its members that transparency requires that the Australian public be able to readily compare the performance of state and territory governments in keeping the proportion of the health budget spent on administration and other overheads at reasonable levels.

Recommendation 2: Define "transparency" within the Pricing Guidelines and explicitly include the public's ability to compare how state and territory governments allocate health funding—particularly the proportion spent on administration and overheads.

Q1. Are stakeholders supportive of revising the promoting harmonisation Pricing Guideline to: "Promoting harmonisation: Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities"?

CHA and its members are supportive of the proposed wording in the pricing framework to reflect the best practice provision of equivalent care across appropriate settings, sites and modalities. CHA supports the adoption of a modality-agnostic pricing model, as it would foster fairness, flexibility, and innovation in care delivery—particularly in the context of virtual care. By aligning pricing with care outcomes rather than modes of delivery, this approach shifts the focus to the value and effectiveness of care provided. A harmonised pricing framework would also help to overcome existing barriers between care settings, enabling more integrated and coordinated models of care. Ultimately, this would contribute to the foundations for a more sustainable, efficient, and responsive public hospital system.

Recommendation 3: Revise the focus area of 'Promoting harmonisation' in the Pricing Guidelines to explicitly refer to "best practice provision of equivalent care across appropriate settings, sites and modalities."

Chapter 3: Classifications used to describe and price public hospital services

When developing classifications, it is important to recognise that Australian public hospitals do not exist in a vacuum, but as part of a system that includes primary care and a significant private hospital market (providing two thirds of planned surgeries and catering to a significant volume of ED presentations and other hospital admissions).

Often, components of classifications developed for the Australian public hospital system are adopted by the private hospital sector. As such, it is appropriate that IHACPA conduct some consultation with the private hospital sector around the applicability (present or future) of new classifications. One example is the new Non-Admitted Care Classification. CHA acknowledges IHACPA's important work as part of the Non-Admitted Patient Classification Project (ANAPP). IHACPA's pragmatic approach to long-term integration with state and territory eMR systems is welcome. However, it is important that CHA conducts, at a minimum, broad education accessible to the private hospital sector on opportunities for it to utilise the ANAPP. This may help inform the private sectors' decisions around its own eMR development and procurement.

Recommendation 4: As part of the process to refine classifications used to describe and price public hospital services, ensure that the private hospital sector is also consulted around the applicability (present or future) of new classifications, given that public hospitals exist and operate within a broader health care ecosystem.

Q2. What, if any, barriers are there to pricing admitted acute episodes of care using AR-DRG Version 12.0 without a shadow pricing period for NEP26?

While the consultation paper notes that there are minimal episode movements between AR-DRGs, which do not present as material impact to the overall performance of the AR-DRG classification, it is important to consider the following risks to its implementation without a shadow pricing period.

- Timing of release of AR-DRG version 12 and its implementation in July 2026. Public hospitals may experience unanticipated funding shifts due to the reclassification of episodes of care without sufficient time to adjust systems and processes accordingly. Particularly given the context of the one-year extension to the National Health Reform Agreement (NHRA), relevant stakeholders may also experience reform fatigue and other funding shifts in conjunction with the proposed changes in AR-DRG version 12.
- Pricing changes may disproportionately impact services that care for more complex and/or chronically-ill patients. Public hospitals that service populations experiencing a higher social disadvantage or other vulnerable communities may often see more complex cases. Without a shadow pricing period to model the financial impact of the changes, these services may face unexpected budget shortfalls, affecting their ability to deliver care as part of usual business operations. Based on this context, hospitals may also be required to address any potential risks in real-time, which could compromise care delivery.

CHA members remain hesitant about not having a shadow pricing period as the new classification version 12.0 has not been released or reviewed. Therefore, it is imperative that specific change management activities are undertaken to ensure the above risks are addressed if AR-DRG version 12.0 is implemented without a shadow pricing period.

Recommendation 5: Concurrently release a comprehensive explanation of the pricing changes for admitted acute episodes of care with the launch of AR-DRG Version 12 in July 2025. This should be accompanied by targeted educational content through IHACPA Learn to ensure stakeholders are well-equipped to understand, interpret, and implement the changes effectively.

Q3. Are there any other refinement areas IHACPA should consider for the Tier 2 Non-Admitted Services Classification for NEP26?

While the Tier 2 Non-Admitted Services Classification (Tier 2) provides a structured and clinically detailed approach to classifying service events, the system is fundamentally medically driven, focusing on the type of clinician and clinical intervention rather than the holistic needs or experiences of the patient. This approach has naturally led to a prioritisation on provider-centric metrics over patient-centred care models, limiting its ability to fully capture the value of multidisciplinary, preventive, and person-focused interventions – particularly those delivered by professions such as nursing and allied health, whose contributions often extend beyond traditional clinical classifications.

As part of its ongoing efforts to enhance Tier 2, IHACPA could explore expanding the Allied Health and/or Clinical Nurse Specialist Intervention Services (40 series). This would enable more accurate representation of the care delivered by allied health professionals and nurses within non-admitted settings. Such an expansion aligns with broader health system priorities to strengthen the role of allied health across the care continuum—particularly through the development of tailored, meaningful funding mechanisms that support their integration into multidisciplinary healthcare teams.

It is understanding of CHA that Tier 2 does not adequately adjust for patient complexity, particularly in the context of chronic disease management. This limitation risks undervaluing the intensity, coordination, and continuity of care required to effectively support complex patients. While the Tier 2 compendium outlines specific methods for counting non-admitted service events, it may not fully capture the shared contributions of multidisciplinary teams. As a result, its utility in informing appropriate funding models that support integrated, team-based care may be constrained.

Australia's health system is increasingly focused on value-based care, preventive health, and chronic disease management. A more nuanced Tier 2 classification would support these goals by ensuring that funding and reporting mechanisms are aligned with patient-centred outcomes rather than just service volume. As an example, this may include breaking down Tier 2, 20.01 by the different transplant types to better reflect the different costs that are incurred by each transplant type. Furthermore, CHA supports the counting rules and definition of telehealth models of care outlined in the current Tier 2 classification. The compendium notes that: "Consultations delivered via information and communication technology (ICT) must be equivalent to a face to face consultation to be counted as a non-admitted patient service event." However, in light of the rapid evolution of virtual care models, CHA recommends that IHACPA continue to review and refine its approach to capturing ICT-delivered service events. This will help ensure the classification remains fit-for-purpose, contemporary, and reflective of the diverse modalities through which non-admitted care is now delivered.

Recommendation 6: Specific refinement areas for Tier 2 have been summarised below:

- Expand the Allied Health and/or Clinical Nurse Specialist Intervention Services (40 series) to enable more accurate representation of the care delivered by allied health professionals and nurses within non-admitted settings.
- Consider incorporating other factors that better adjust for patient complexity, particularly in the context of chronic disease management.
- Continue review and refinement of the approach to capture ICT-delivered service events as part of broader work plans to ensure that funding and reporting mechanisms are aligned with patient-centred outcomes instead of just service volume.

Q4. What considerations should inform the potential introduction and pricing of a Tier 2 class for hospital-based non-admitted voluntary assisted dying (VAD) services?

CHA supports a review of the current Tier 2 Non-Admitted Services Classification 10-series classes to ensure their clinical currency, as well as in support of the broader work being done on price harmonisation. CHA and its members have observed maintaining high-quality routine care for patients or residents, while simultaneously addressing the complexities and

sensitivities associated with Voluntary Assisted Dying (VAD), requires significant resourcing to meet the associated service demands.

In principle, CHA supports the proposed efforts to assess the feasibility of introducing and pricing a Tier 2 classification for hospital-based, non-admitted VAD services. It is important that the interpretation and use of the Tier 2 classification for VAD services is broad. Specific considerations have been outlined below.

- Applicability of Tier 2 classification for VAD services. There are costs related to servicing requirements around VAD regardless of whether the organisation is a direct participant or non-participants in VAD. It is important for the proposed Tier 2 class for VAD services to be applicable to both direct participants in VAD, as well as non-participants that wish to respond well to the choices made by individuals in this context.
- Adhering to jurisdictional nuances. Effectively capturing jurisdictional differences in approaches to VAD within a unified classification system requires a nuanced understanding of local legislation and the ability to translate these legal distinctions into a coherent, adaptable framework. This task is further complicated by the dynamic nature of VAD laws, which continue to evolve across regions. Public hospitals are therefore required to maintain flexibility in their clinical practices to ensure alignment with current legal standards and to provide care that is both compliant and contextually appropriate.
- Pricing should reflect the costs incurred to service requirements around VAD. While CHA member organisations are non-participants in VAD, examples of costs incurred that have been unfunded include the amount spent on upskilling of the whole workforce, advanced skills in end-of-life discussions and care provision among some staff, and the availability of a support structure to enhance complex decision-making that is aligned with the ethics of care relevant to the hospital service, if required. Despite the relatively low number of individuals seeking VAD, the time and workload burden created by the legislation for organisations which seek to respond to it well is significant.[1] For instance, to the best of our knowledge, no organisation in Victoria receives funding to support this response to VAD, despite its relevance for all health services.

As such, CHA recommends that the proposed Tier 2 class considers the resource pressures for individual services created by the VAD system including relevant nuances applicable to each jurisdiction, and accounts for these pressures as part of the pricing. As part of this, CHA also recommends that IHACPA pilots the use and feasibility of the proposed Tier 2 class in a range of hospital settings to ensure its relevance, accuracy and feasibility for scaled implementation. This may include piloting the proposed Tier 2 class with both participants and non-participants in VAD, as well as in private hospital settings.

Recommendation 7: Consider the resource pressures for individual services created by the VAD system including relevant nuances applicable to each jurisdiction, and account for these pressures as part of the design of a Tier 2 class for VAD services.
Recommendation 8: Ensure that the designed Tier 2 class is piloted in a range of hospital settings, including participants and non-participants in VAD, as well as private hospital settings.

[1] Hudson et al. (2024). What are the cost and resource implications of voluntary assisted dying and euthanasia? - PubMed

Chapter 4: Setting the national efficient price

Q5. Are there any barriers to removing the remaining temporary measures introduced to manage the impact of COVID-19 for NEP26?

The removal of the remaining temporary pricing measures introduced to manage the impact of COVID-19 for NEP26 is a logical step in the progression toward normalising public hospital funding settings. However, several barriers may complicate or delay this transition. While hospital activity and cost data from more recent years may reflect a return to stable patterns of care, the pandemic has left a residual impact on hospital systems, service models, and patient complexity that may not be fully accounted for in the current dataset. One significant barrier is the potential lag in cost data capturing the true operational impacts of sustained changes to hospital care delivery introduced during the pandemic. These include heightened infection prevention and control protocols, ongoing workforce challenges, and the integration of telehealth and other virtual care modalities, which may not yet be adequately embedded in the cost weights or DRG structures.

Another barrier is the persistent variability across jurisdictions and individual hospitals in how COVID-19 care has been absorbed into routine service delivery. While IHACPA has received advice that COVID-19 is now managed similarly to other respiratory conditions, this may not universally reflect the experience of hospitals with higher volumes of immunocompromised patients, limited ICU capacity, or ongoing challenges in managing long COVID presentations. For such services, the removal of the ICU adjustment or other temporary pricing mechanisms may expose them to financial risk or disincentivise the provision of care for patients who still require more intensive or prolonged support.

Additionally, the withdrawal of temporary adjustments — such as the suspension of safety and quality penalties for episodes with a COVID-19 diagnosis — may reintroduce financial penalties in cases where care delivery continues to be complicated by COVID-related factors, including delayed presentations, prolonged admissions, or comorbid complications. Without clear mechanisms to differentiate between avoidable and unavoidable quality outcomes in this context, reintroducing these adjustments may unfairly penalise providers still grappling with the aftershocks of the pandemic.

Stakeholder confidence and system stability are also important considerations. The rapid shift from temporary to permanent pricing structures without a phased or clearly communicated transition may unsettle hospital executives and clinicians who are still adapting to post-pandemic models of care. Ensuring transparency in how COVID-era costs have been normalised into the NEP26 price will be crucial to maintaining trust and engagement with the national pricing framework.

Finally, the broader health system continues to experience strain from cumulative pandemic impacts, including workforce burnout, surgical backlogs, and capacity pressures. While these are not COVID-specific, they are part of the system-wide legacy of the pandemic response and may interact with pricing settings in ways that are not yet fully understood.

Recommendation 9: While the technical rationale for removing COVID-19 temporary measures in NEP26 is sound, several barriers remain. These include incomplete cost reflection of ongoing care changes, jurisdictional variability, lingering complexity in some patient cohorts, risk of unintended financial disincentives, and the need to maintain system confidence through careful, data-informed transitions. Addressing these challenges through robust consultation, clear transition planning, and targeted monitoring of post-adjustment impacts will be essential to ensuring a stable and equitable pricing environment beyond COVID-19.

Q6. In cases where AR-DRG price weights account for ICU cost variations, should ICU costs be bundled?

While bundling ICU costs into the AR-DRG price weight may appear logical in theory, particularly where AR-DRG classifications align closely with ICU resource use, this approach is not supported. In practice, ICU cost variation is not fully captured by AR-DRG assignment alone but is significantly influenced by other factors, including patient comorbidities, procedural complexity, and the nature of care required. As a result, bundling risks masking clinically meaningful variation and could lead to systemic underfunding of high-acuity episodes and overfunding of lower-acuity ones. This is particularly concerning for referral and tertiary hospitals, which manage more complex patient cohorts and typically have higher ICU utilisation. Applying a bundled model in such settings would unfairly disadvantage these providers and may erode the financial signal necessary to sustain high-cost, high-intensity care.

In addition, applying a uniform bundled ICU price across hospitals, regardless of ICU designation or case mix, could exacerbate funding inequities — particularly for smaller or regional hospitals that refer patients for critical care or provide equivalent services in alternative units not formally designated as ICUs. Therefore, it is recommended that IHACPA continue the use of unbundled ICU pricing, where a separate ICU adjustment reflects actual resource use. In limited circumstances, a hybrid or conditional approach may be appropriate, for example where robust evidence shows that ICU utilisation is consistent across hospitals within an AR-DRG, but only with clear designation criteria and reporting thresholds. Importantly, any changes to the ICU pricing model must be accompanied by rigorous modelling and transparency, particularly regarding interactions with other price adjustments such as those for paediatrics and remoteness.

Recommendation 10: IHACPA maintain unbundled ICU pricing with a separate adjustment reflecting actual resource use, as bundling ICU costs into AR-DRG price weights risks masking important cost variation driven by factors beyond AR-DRG classification, such as patient complexity and procedural differences.

Q7. In addition to reviewing the interactions underpinning the calculation of the Indigenous adjustment, are there other technical refinements to the existing pricing models that could support high-quality, culturally appropriate care for First Nations peoples?

In addition to reviewing the interactions underpinning the calculation of the Indigenous adjustment, IHACPA could consider several technical refinements to the existing pricing models to better support high-quality, culturally appropriate care for First Nations peoples.

One potential refinement is to incorporate ABF incentives that explicitly recognise and reward the provision of culturally safe care. This could be achieved by developing and pricing specific “cultural liaison” or “cultural care coordination” activities into existing care pathways. For instance, where hospitals employ Aboriginal Liaison Officers (ALOs) or embed First Nations health workers into multidisciplinary teams, these roles could be recognised as separate costed components, similar to how allied health services are accounted for within broader AR-DRG structures. Recognising the cost and value of these roles in hospital pricing would send a strong signal about their importance, support workforce growth, and enable better resourcing of culturally tailored care.

In addition, refinement of the current models to account for preventable hospital readmissions and discharges against medical advice (DAMA) is warranted. These outcomes are disproportionately experienced by Aboriginal and Torres Strait Islander patients and are often linked to experiences of cultural insecurity or miscommunication. While the NEP currently includes adjustments for complexity and comorbidities, it does not systematically account for cultural or systemic barriers to safe discharge and continuity of care. IHACPA could explore the use of risk-adjusted outcome indicators tied to ABF, such as readmission rates stratified by Indigenous status, to identify where additional funding or bundled payments might support hospitals to implement continuity-of-care initiatives, including culturally informed discharge planning and follow-up with community-controlled health services.

Another refinement lies in the way complexity is defined and measured within the pricing model. Currently, complexity is largely clinical and biomedical in nature. However, First Nations peoples often face overlapping social, cultural, and structural complexities that influence both the care provided and the resources required to deliver it. Expanding the complexity adjustment to include recognised social determinants — such as housing insecurity, intergenerational trauma, or access to culturally safe primary care — could create a more accurate and equitable reflection of hospital resource use for First Nations patients.

There is also scope for more sophisticated geographic modelling. While the remoteness adjustment accounts for certain cost pressures, it does not always align with the actual distribution of First Nations populations, who may reside in urban or regional areas with poor access to culturally appropriate care. Introducing a “First Nations population density” or “cultural access gap” index — layered onto existing geographic adjustments — could allow the pricing model to more directly respond to the needs of Aboriginal and Torres Strait Islander communities regardless of location.

Finally, technical enhancements must be underpinned by data governance principles that reflect Indigenous data sovereignty. The refinement of pricing models requires access to robust, disaggregated data, but also mandates culturally appropriate data collection, linkage, and interpretation practices. Partnering with Indigenous-led organisations and researchers in the design, analysis, and translation of pricing data is essential to ensure any refinements are informed by lived experience and community priorities.

Recommendation 11: While reviewing the sequencing and interaction of the Indigenous and remoteness adjustments is a necessary first step, broader technical refinements are both feasible and necessary. Embedding culturally safe roles into cost models, adjusting for culturally mediated outcomes like DAMA and readmission, incorporating social and cultural complexity, refining geographic adjustments, and respecting Indigenous data governance all offer promising avenues to reshape the pricing system in service of equity. As IHACPA continues its technical review and embarks on broader consultations, these refinements should form part of a deliberate and respectful process to ensure the pricing system actively supports culturally safe, high-quality care for First Nations peoples.

Q8. What principles and processes could guide model simplification in relation to IHACPA's adjustments and pricing models?

Simplification must not come at the expense of fairness, transparency, or the model's ability to reflect legitimate cost variation across Australia's diverse hospital system. The following guiding principles are recommended:

- **Transparency and understandability:** Simplification must enhance the model's transparency for stakeholders. Pricing rules, adjustment factors, and underlying rationales should be easily understood by policy makers, funders, and providers. A simplified model should reduce reliance on technical interpretation while maintaining a clear and defensible link between pricing components and actual cost drivers.
- **Equity and fairness:** Any reduction in complexity must not erode the model's capacity to recognise and fund legitimate differences in the cost of delivering care — particularly in smaller jurisdictions, rural and remote areas, and facilities serving populations with high health needs.
- **Materiality and impact:** The principle of materiality should guide the retention or removal of adjustment factors. Adjustments that have minimal impact on funding distribution or price signal should be candidates for consolidation or removal. Conversely, high-impact adjustments, such as those for remoteness or complexity, should be retained and potentially refined rather than removed.
- **Data integrity and evidence-based design:** Adjustments must continue to be grounded in robust cost and activity data. Simplification should not compromise the empirical foundation of the pricing model. Where simplification is pursued, the process should prioritise adjustments that are difficult to validate, unstable across time, or disproportionately burdensome to report.
- **Flexibility and future adaptability:** A simplified model should remain adaptable to evolving service models, technology, and population health needs. This includes enabling the future incorporation of refined adjustments — such as those related to economies of scale or new patient complexity metrics — without needing to rebuild the entire model.
- **Consistency with the National Health Reform Agreement:** Under the National Health Reform Agreement, IHACPA is required to determine a single national efficient price. Simplification efforts must operate within this legislative constraint while ensuring the equitable distribution of funding across jurisdictions through block funding, price adjustments, or other mechanisms.

The following processes are recommended:

- **Adjustment mapping and classification:** IHACPA could begin by categorising existing adjustments according to their policy objective (e.g. cost reflection, access equity, efficiency incentives), materiality, data requirements, and sensitivity to change. This mapping provides a foundation for prioritising which adjustments to simplify, consolidate, or retain.
- **Stakeholder engagement and co-design:** Jurisdictions, health services, and clinicians must be closely involved in the simplification process to ensure changes reflect operational realities and do not produce unintended consequences. Structured engagement via advisory committees, technical working groups, and public consultation can help build consensus and flag potential risks early.
- **Scenario testing and modelling:** Before removing or modifying adjustments, IHACPA should undertake modelling to test their impact on funding distribution across states, hospital peer groups, and geographic areas. This will help assess whether simplification would produce funding distortions or compromise access and service sustainability.
- **Consolidation of related adjustments:** Where possible, overlapping or closely related adjustments could be consolidated into a single, more intuitive adjustment. Similarly, low-impact adjustments might be absorbed into broader structural factors.
- **Incorporation of scale and economies-based adjustments:** As recommended by the Mid-Term Review, IHACPA could explore the creation of a scale adjustment for smaller jurisdictions or hospitals with structurally higher costs due to low volume and sparse population coverage. This adjustment would need to be tightly defined, empirically validated, and designed to complement rather than duplicate existing block funding mechanisms.
- **Phased implementation and change management:** Given the technical and funding implications, simplification should occur in phases, with appropriate transition arrangements and reporting guidance. Minor changes could be introduced in NEP26 reporting, with more substantial reforms targeted for post-2026–27 determinations, aligning with the next iteration of the NHRA.

Recommendation 12: Simplifying IHACPA's pricing and adjustment models is a necessary but delicate task. Guided by the principles of transparency, equity, materiality, and evidence-based design, and implemented through a phased and inclusive process, simplification can improve the usability and coherence of the national pricing system without compromising its core purpose—to fund public hospital services in a way that reflects cost, supports access, and promotes efficiency. As IHACPA embarks on a multi-year program of review, its approach must ensure that simplification enhances, rather than diminishes, the model's ability to serve Australia's diverse hospital system and its communities.

Q9. After accounting for current pricing model adjustments and block funding arrangements, what are some drivers of unmet cost variation in public hospital service delivery for people residing in rural and remote areas of Australia?

A primary driver of unmet cost variation is the structural inefficiency associated with small, low-volume services. Rural and remote hospitals must maintain a broad range of capabilities despite low and unpredictable throughput, resulting in high fixed costs per episode of care. These facilities are often required to operate 24/7 emergency departments, maternity units,

and inpatient wards with minimum staffing levels, even if patient volumes are insufficient to achieve economies of scale. Current pricing and block funding models only partially address this issue; they do not always account for the full spectrum of services that must be sustained, nor the resource intensity required to deliver safe care in such settings.

Workforce availability is also a critical factor that drives cost variation. Rural and remote hospitals face persistent challenges in recruiting and retaining skilled clinical staff, often resulting in a reliance on locum or agency workers at significantly higher rates. These premium labour costs — frequently required to maintain baseline service access — are not fully captured in the national pricing model. In addition, the need to offer incentives such as housing, travel, or additional leave further elevates personnel costs in rural areas, adding to the gap between actual expenditure and priced funding.

Hospitals in rural and remote settings often operate with constrained access to diagnostic, allied health, mental health, and specialist services. This can lead to higher lengths of stay, increased interhospital transfers, and greater resource consumption per patient episode, particularly for patients with complex or chronic conditions. Additionally, transport between metropolitan and rural or remote areas may require more expensive types of transportation, such as aircrafts. The current adjustments do not fully reflect the higher per-episode cost associated with compensating for these systemic gaps, nor the increased burden on staff who must provide broader, generalist care without the usual level of multidisciplinary support.

Rural and remote populations often experience higher rates of comorbidities, socioeconomic disadvantage, and poorer health outcomes, particularly among Aboriginal and Torres Strait Islander peoples. These factors contribute to more complex presentations and higher care needs, including greater time spent on care coordination, discharge planning, and cultural safety measures. While IHACPA's pricing model includes adjustments for clinical complexity, it does not fully address the cumulative impact of geographic, cultural, and social complexity on the cost of delivering appropriate care in remote contexts.

In addition, older infrastructure, higher maintenance costs, and limited access to digital systems also contribute to unmet cost variation in rural and remote hospitals. Many facilities face higher capital expenditure needs due to remoteness, logistics, and transport costs, which are not factored into activity-based pricing. Additionally, while metropolitan hospitals increasingly leverage technology and centralised support services to drive efficiency, rural sites may struggle to adopt these innovations due to connectivity issues or upfront investment requirements, further entrenching cost differentials.

Finally, rural hospitals are often the only healthcare provider within vast catchment areas and must retain capabilities for emergency and disaster response. This necessity for built-in redundancy — staff, beds, equipment — incurs costs that may rarely be drawn upon but are essential for regional health security. These "insurance costs" are not easily incorporated into the NEP or block funding mechanisms, yet they are vital to maintaining baseline access and public trust.

Recommendation 13: To address persistent and structurally driven cost variation in rural and remote hospitals, pricing and funding models must be revised to more accurately reflect the full cost of sustaining safe, equitable, and accessible care in these settings. This includes accounting for the high fixed costs of low-volume service delivery, the premium labour and incentive costs required to maintain a skilled workforce, and the additional resource intensity arising from limited access to diagnostics, allied health, and specialist support. Further adjustments are needed to capture the compounded impact of socioeconomic disadvantage, cultural and geographic complexity, and the reliance on generalist models of care. Capital and infrastructure costs, including digital limitations, should also be better recognised, along with the essential "insurance costs" associated with maintaining regional emergency and disaster response capabilities. A more comprehensive funding approach, beyond current activity-based pricing and partial block grants, is necessary to support the sustainability of rural and remote health services and ensure equitable access for all Australians.

Q10. After accounting for current pricing model adjustments and block funding arrangements, what are some cost drivers that impact the ability of hospitals and local health networks to achieve economies of scale under the ABF model?

While current pricing model adjustments and block funding arrangements help to account for variation in remoteness, service capability, and patient complexity, there remain significant cost drivers that impede hospitals and local health networks (LHNs) from achieving economies of scale under the ABF model. These drivers are particularly pronounced in smaller facilities, regional networks, and hospitals with specific service mandates, and they pose challenges for equitable and sustainable service delivery.

Hospitals and LHNs are often required to maintain a baseline suite of services irrespective of demand or throughput. Emergency care, maternity services, mental health support, diagnostic imaging, and surgery must often be available 24/7, even in settings with limited population catchment or unpredictable demand. This results in high fixed costs relative to activity levels, particularly in rural and regional hospitals where the volume of separations and procedures is insufficient to dilute overheads. While block funding offsets some of this burden, it does not fully compensate for the inefficiencies inherent in maintaining comprehensive capability without the volume to support cost-effective delivery.

Staffing requirements set by clinical safety, industrial agreements, and accreditation standards often prevent hospitals from scaling their workforce in line with activity. For example, minimum nurse-to-patient ratios, on-call rosters, and the need for specialist availability create a cost floor that cannot be adjusted downward even when activity is low. Conversely, in high-demand periods, a lack of staffing flexibility or availability can constrain service expansion. In both cases, hospitals are unable to fully realise scale efficiencies due to workforce rigidity and the fixed nature of clinical labour costs.

Many LHNs manage multiple hospital sites across a geographic region, particularly in regional and remote areas. The need to duplicate services, systems, and infrastructure across these sites leads to fragmented delivery and limits opportunities to centralise functions and consolidate care. Shared services (such as pathology, radiology, or administrative support) are often constrained by geography, technology limitations, and community expectations around local service access. As a result, LHNs incur higher per-unit costs and are unable to leverage the scale efficiencies available to larger, centralised health services.

In addition, hospitals with specialised roles such as paediatric centres, trauma units, or facilities with high volumes of chronic or complex patients face structural barriers to achieving economies of scale due to the nature of their case-mix. These hospitals may deliver high-cost, low-volume services that require significant infrastructure, high-cost consumables, and highly trained staff. While pricing model adjustments (e.g., for paediatrics or complexity) provide some compensation, they may not fully reflect the service intensity or capital and labour costs associated with specialised care. Moreover, the need to retain specialised service capacity, even when not fully utilised, constrains efficiency.

Furthermore, hospitals that lack digital maturity often face duplicated manual processes, reduced clinical productivity, and limited integration with other parts of the health system. Transitioning to digital health infrastructure requires significant upfront investment and change management, which smaller services or cash-constrained LHNs may struggle to absorb. This limits their ability to streamline processes, automate administrative tasks, and share data, which are key levers for achieving scale efficiencies under the ABF model. In contrast, large metropolitan hospitals with advanced digital systems are better positioned to realise economies of scale through technology-enabled care.

Local input costs such as wages, utilities, maintenance, and procurement also vary significantly between jurisdictions and between urban and rural contexts. In remote and regional areas, higher freight charges, contractor premiums, and facility upkeep costs inflate baseline operating expenditure. These local cost structures are not always proportionately recognised in national pricing benchmarks, especially when the model assumes some degree of national price convergence. As a result, some hospitals are structurally disadvantaged in their ability to achieve scale efficiencies compared to metropolitan counterparts.

Finally, hospitals frequently absorb costs associated with system gaps in aged care, mental health, primary care, and disability support — particularly in areas with limited community-based alternatives. Extended lengths of stay, avoidable readmissions, and ‘bed block’ from patients requiring non-acute services all distort activity levels and reduce operational efficiency. These pressures undermine the alignment between ABF pricing and actual service delivery, as the hospital is funded for activity but not for the broader system inefficiencies that drive that activity.

Recommendation 14: To enhance equity and sustainability under the ABF model, national pricing and funding mechanisms must better reflect the structural cost barriers that prevent smaller hospitals and LHNs from achieving economies of scale. These barriers include the need to maintain 24/7 service capability regardless of demand, rigid workforce requirements that limit scalability, and the duplication of services across geographically dispersed sites. Facilities with specialised mandates or complex case-mix profiles also face high fixed costs that are not fully offset by existing pricing adjustments. Further challenges arise from low digital maturity, which hampers efficiency gains, and from local cost variations in wages, logistics, and procurement that are not adequately captured in national benchmarks. Additionally, hospitals are increasingly required to compensate for systemic gaps in aged care, mental health, and primary care, leading to inefficiencies not aligned with ABF incentives. A more tailored funding model — one that accounts for structural inefficiencies, local cost differentials, and service obligations beyond direct activity — is essential to support the viability of diverse health services and ensure funding fairness across all settings.

Q11. What, if any, evidence is there to suggest that the actual costs of care are not being accurately reflected in cost data collections and how can IHACPA support jurisdictions in reporting these?

One significant issue is the time lag between the incurrence of costs and their reflection in data collections. For instance, workforce expenses, which constitute a substantial portion of operational costs, may not be promptly captured, leading to outdated cost representations. This delay could increase financial risks for providers, especially when wages rise but are not immediately reflected in funding models. It is the experience of CHA and its members that there are variations in how senior medical staff are paid across Australia. For example, in NSW, this variation is based on whether doctors are paid by a salary or are contracted. Salary variations are based on whether the specialist elects to undertake their rights of private practice and the level or percentage of income they retain. As at time of writing, there are no clear guidelines as to how these costs should be managed within the national costing standards.

In addition, IHACPA's costing guidelines allow for flexibility in allocating expenses, such as using relative value units or informed decision-making based on service activity. While this flexibility accommodates diverse healthcare settings, it can lead to inconsistencies in how costs are reported across institutions, potentially affecting the accuracy of the aggregated data. While IHACPA performs quality assurance checks on submitted data to ensure accuracy and suitability, the reliance on self-reported data from various jurisdictions and private hospitals introduces the possibility of discrepancies. Differences in data collection practices and interpretations of costing guidelines can result in variations that may not accurately reflect the true costs incurred.

Furthermore, IHACPA's initial forays into aged care costing, including the Residential Aged Care Costing Pilot Study and the subsequent 2023 Costing Study, acknowledged the need for foundational work to support robust and mature cost collections. These studies aimed to understand and analyse cost and activity data, but the evolving nature of aged care services and data collection methods suggests that current cost data may not yet fully capture the actual costs of care delivery. For example, there are substantial variations in costs incurred in the delivery of residential aged care services in certain geographic areas. The experience of our members is that the costing study and associated advice provided to Government does not adequately account for the cost differentiation of delivering services in these areas under the Modified Monash Model (MMM) classification. This results in providers incurring significant losses in delivering services in regional, rural and remote areas. In addition, the aged care sector has undergone significant reform over the past three years. While this reform is focused on improving the quality and safety of care to older people, the regulatory changes have a significant administrative and therefore financial impact on providers. It is the experience of CHA members that these costs are not accounted for due to costing studies using historical data. These lessons learnt from costing studies undertaken in health-adjacent sectors should be considered in designing specific supports for jurisdictions to better report the actual costs of care.

Finally, NHCDC has been recognized as a valuable tool for collating health system costs at a product level. However, as healthcare services evolve, the data collection frameworks must adapt to capture new models of care and associated costs accurately. Ongoing strategic reviews and updates to the NHCDC aim to address these challenges, but during periods of transition, the cost data may not fully represent current care delivery expenses.

Q12. What, if any, further measures are required in NEP26 to support the second year of community mental health care services transitioning to ABF?

To effectively support the second year of the transition to ABF for community mental health care services under NEP26, IHACPA should implement a suite of additional measures beyond the existing transitional composite funding model. These measures are critical to address persistent data quality issues, clinical engagement challenges, and the complexities of service delivery in diverse settings.

While community mental health services have made progress in capturing the necessary data for the Australian Mental Health Care Classification (AMHCC) Version 1.1, significant variation remains in the completeness and consistency of data submissions across jurisdictions. Investment in data infrastructure and workforce capability is needed to ensure reliable collection of key variables such as the Health of the Nation Outcome Scales (HoNOS), Life Skills Profile-16 (LSP-16), phase of care, and legal status. Training programs for clinicians and administrative staff on the importance and use of these data items in funding determinations will help improve data quality and clinical buy-in.

In addition, IHACPA should deepen its engagement with service providers, particularly in regional, rural, and remote areas where community mental health care often faces resource constraints and geographical barriers. These areas may not meet ABF volume thresholds and may require tailored support to transition effectively. Targeted consultations, technical assistance, and mechanisms for local adaptation of funding models can help ensure these services are not disadvantaged. A regional readiness assessment framework could also help LHNs evaluate their preparedness for ABF and identify gaps needing support.

Furthermore, IHACPA should establish a formal review and refinement mechanism for the AMHCC, informed by emerging data trends and frontline clinical feedback. As the classification is still relatively new, some groupers may not yet fully reflect the diversity of community mental health presentations, particularly for complex psychosocial cases or culturally appropriate care models for Aboriginal and Torres Strait Islander peoples. As there will be continual improvements in the grouping rates within hospitals and jurisdictions, there is a likelihood that there will be an inconsistency between costs and price weights for the classes within the new classification system. A dedicated advisory group or working party involving clinicians, consumers, data analysts, and system managers could play a valuable role in shaping iterative improvements to the classification. These improvements may include continued training and clarification on how the required documentation and data elements are used in the grouping mechanism.

Implementation of benchmarking and monitoring tools will be necessary to track the impact of ABF on service delivery, access, and outcomes. These tools should be co-designed with the sector to ensure they are fit for purpose and not overly burdensome. Transparent reporting on service activity, funding flows, and outcome measures can also support accountability and continuous improvement.

Finally, IHACPA should explore transitional incentives or safeguard mechanisms to protect services during the early years of ABF implementation. This could include floor payments, volume caps, or risk-adjusted transitional loadings to ensure funding stability while services adapt to the new model. These mechanisms will be particularly important to maintain service continuity for vulnerable populations during this period of structural change.

Recommendation 15: To support the second year of ABF implementation for community mental health services under NEP26, IHACPA should strengthen data quality, deepen clinical engagement, and tailor support for regional and remote services. This includes investing in data infrastructure and training, establishing a readiness assessment framework, and refining the AMHCC based on emerging trends and clinical input. Co-designed monitoring tools should track access, quality, and outcomes without creating excessive burden. Transitional safeguards — such as floor payments and risk-adjusted loadings — are also needed to ensure funding stability and service continuity during the transition.

Q13. What, if any, clinical reasons are there for patients requiring chemotherapy, dialysis, interventional imaging or gastrointestinal endoscopy to be treated in an admitted versus non-admitted setting, and how could this be accounted for in a price harmonisation methodology?

Clinical reasons for treating patients in an admitted versus non-admitted setting for chemotherapy, dialysis, interventional imaging, or gastrointestinal endoscopy largely hinge on patient complexity, treatment intensity, comorbidities, and the need for close monitoring or supportive care. Other clinical reasons may include: risk of the patient for experiencing severe side effects, airway management, dehydration, or the need for overnight monitoring for complications.

- For chemotherapy, admitted care is typically required for patients who need intensive regimens, management of severe side effects such as neutropenic fever, or complications requiring inpatient observation and intervention. In contrast, many chemotherapy treatments, especially those that are less intensive or part of maintenance protocols, can be safely delivered in non-admitted outpatient settings, improving patient convenience and reducing costs.
- Dialysis patients may require admission when there are acute complications such as fluid overload, infection, or vascular access issues necessitating intensive management, whereas stable chronic dialysis treatments are predominantly delivered in outpatient or ambulatory settings.
- Interventional imaging procedures performed in admitted settings are often linked to higher-risk cases where patients need sedation, anaesthesia, or complex intervention, necessitating inpatient monitoring, while routine diagnostic imaging or minimally invasive procedures may be safely done in non-admitted environments.
- Gastrointestinal endoscopy in admitted patients is generally reserved for those needing therapeutic interventions, complex polypectomy, or with comorbidities requiring anaesthesia and post-procedure observation, whereas straightforward diagnostic endoscopies are commonly outpatient procedures.

A price harmonisation methodology could account for these clinical distinctions by incorporating adjustment factors that reflect the intensity and complexity of care required in admitted settings, potentially through risk stratification or weighting systems that differentiate patient cohorts based on clinical severity, anticipated resource utilisation, and care complexity. This approach would support equitable pricing that reflects true resource consumption while preserving incentives for delivering care in the most appropriate setting based on clinical needs.

Recommendation 16: To support appropriate care and equitable pricing, IHACPA should adopt a price harmonisation approach that accounts for clinical reasons behind admitted versus non-admitted care in procedures such as chemotherapy, dialysis, interventional imaging, and gastrointestinal endoscopy. These decisions are driven by patient complexity, treatment intensity, and the need for monitoring or supportive care. A harmonised pricing model should include adjustment factors or risk stratification that reflect clinical severity and resource use, ensuring funding aligns with care complexity while maintaining incentives to treat patients in the most suitable setting.

Chapter 5: Setting the national efficient cost

Q14. What policy principles and considerations should guide IHACPA's workplan for the review of the various existing block funding criteria and arrangements?

Australia's public health funding models should focus on encouraging ongoing improvement in performance, with additional funding available to public hospitals that improve outcomes. With a growing and aging population, increasing chronic disease, and increasing costs of delivering care, the pressure on public hospitals is only expected to increase. One of the most significant challenges is that the current funding formula for public hospitals is failing to meet the growing demands of the population. This funding shortfall has led to overcrowded emergency departments, longer waiting times for elective surgeries, and a general strain on hospital resources, which disproportionately affects regional, rural and remote communities.

CHA and its members welcome IHACPA's proposed approach to undertake an initial review of the block funding criteria for National Efficient Cost (NEC) 26. CHA understands that only small rural hospitals, standalone hospitals, and rural and regional local hospital networks that deliver a low volume of community mental health services, are in scope of the review. To ensure the proposed review is aligned with the evolving public health funding landscape, CHA recommends that IHACPA adopt the following policy principles and considerations to guide its approach.

Embedding transparency

The Commonwealth Government contributes significantly to the funding of public hospitals through the National Health Reform Agreement (NHRA). Despite this, in many cases how these funds are utilised is unclear. This lack of transparency makes it difficult to assess whether the funds are being used efficiently and effectively to meet the needs of the population. It also hinders the ability of stakeholders to hold the system accountable for its performance.

In light of these concerns, and as part of the current review of block funding criteria and arrangements, CHA recommends that IHACPA embed transparency at every stage of the review process. A clear, evidence-informed approach should be adopted to demonstrate how data contributes to the development of the revised criteria for block funding. To support this, IHACPA could implement a tailored, participatory stakeholder engagement process that is culturally sensitive to the needs of regional, rural, and remote communities. This would not only improve clarity around funding decisions but also help address knowledge gaps among frontline service staff and ensure that those most affected by NEC decisions are meaningfully involved.

Emphasise the need for integrated care

CHA believes that the current NHRA does not adequately support the integration of hospitals with primary, aged, and disability care systems. This fragmentation across sectors undermines the development of a seamless continuum of care—an essential foundation for improving patient outcomes and reducing avoidable hospital admissions. When care is not coordinated across settings, individuals are more likely to experience gaps in service, delayed interventions, and unnecessary hospitalisations that could have been prevented through earlier, community-based support.

The current review of block funding criteria presents a timely and strategic opportunity to address this gap. While resolving technical issues such as the low-volume threshold is important, the review should also take a broader, system-wide perspective by embedding incentives that actively promote integrated models of care. These models are particularly vital for people with complex, chronic, or overlapping health and social needs—many of whom rely on services across multiple sectors.

To support the implementation of integrated care, the review should consider the introduction of modernised funding approaches that enable flexibility and responsiveness at the local level. This includes funding mechanisms that support cross-sector collaboration, pooled resources, and shared service delivery. In parallel, strengthened governance structures and mechanisms for shared accountability are essential to ensure that all partners—hospitals, primary care providers, aged care services, and disability supports—are working toward common goals and outcomes.

By embedding these elements into the revised block funding framework, IHACPA can help create the conditions for more connected, person-centred care. This not only improves the efficiency and sustainability of the health system but also ensures that care is delivered in the right place, at the right time, and by the right provider.

Accounting for workforce pressures

Workforce shortages across the health, aged care, and disability sectors are significantly impacting the efficiency and effectiveness of essential services. These sectors are not only competing with each other for the same workforce but also with other countries facing similar challenges. These shortages exist for a variety of reasons, which are exacerbated by regional and rural geographic influences.

Many regions struggle to attract and retain healthcare professionals. The escalating cost of housing is a significant barrier to attracting and retaining staff, with nurses and other healthcare professionals often finding it challenging to afford housing near their workplaces, leading to long commutes or the need to relocate to more affordable areas. This issue is not confined to major cities but has spread to regional and rural areas, exacerbating the shortage of healthcare workers in these communities. Additionally, despite the rising cost of living, wages in many sectors have not kept pace. This wage stagnation makes it difficult for employees to meet their financial needs, leading to dissatisfaction and higher turnover rates.

The costs associated with implementing innovative workforce models—essential for maintaining safe and high-quality care in public hospitals—should be appropriately recognised in the review of current block funding criteria. To ensure these costs are accurately reflected, IHACPA should consider tailored engagement with workforce planning teams or expert advisors. This would support the development of robust, fit-for-purpose indicators that capture the true resource requirements of evolving workforce strategies.

Recommendation 17: To ensure the proposed review is aligned with the evolving public health funding landscape, adopt the following policy principles and considerations:

- **Embed transparency** by adopting a clear, evidence-informed approach that explicitly demonstrates how data informs the development of revised block funding criteria;
- **Emphasise the need for integrated care** by embedding incentives that actively promote integrated models of care into a revised block funding criteria and arrangements;
- **Account for workforce pressures** by recognising the costs associated with implementation of innovative workforce models.

Q15. As the current arrangements for high cost, highly specialised therapies have been in place since 2020, what, if any, refinements are required to ensure they remain fit-for-purpose?

CHA welcomes the continued inclusion of block-funded costs for the delivery of high-cost, highly specialised therapies as part of the annual NEC determination. This approach plays a critical role in supporting their accessibility and delivery within public hospital settings.

The Australian healthcare system is experiencing rapid growth in specialised therapies and personalised medicine, driven by advances in genomics, biotechnology, and targeted treatments. Advancement in research enables the development of tailored interventions and government investment facilitates greater accessibility to personalised approaches,[2] leading to a shift towards precision healthcare that is more effective, preventive, and patient-specific.

To ensure current funding arrangements remain fit-for-purpose, it is essential that the process for determining a therapy's eligibility for high-cost funding is made clear, consistent, and publicly accessible. Transparency in this process enables stakeholders to better understand the criteria, engage meaningfully with the system, and provide informed feedback. To support continuous improvement, regular reviews of the key indicators and decision-making criteria should be undertaken. Insights from these reviews should be used to evaluate and refine the broader funding framework, ensuring it remains responsive to the ongoing evolution of specialised and personalised therapies.

Similarly, there is a need for greater clarity and transparency around the process that determines when and how a therapy transitions from high-cost funding arrangements to standard activity-based funding. Without a clearly defined and publicly communicated transition framework, there is a risk of inconsistency, uncertainty, and misalignment between funding mechanisms and clinical practice. The framework and transition process should be informed by clinical evidence, utilisation trends, and existing data collections on its cost-effectiveness. This would enable providers to plan appropriately, ensure continuity of care, and maintain access for patients. Embedding stakeholder consultation and regular review mechanisms into the transition process would further support its responsiveness to the evolving nature of specialised therapies and ensure that funding models remain sustainable, fair, and fit-for-purpose.

[2] SMART move: UQ to host national push for next-gen therapy manufacturing

Recommendation 18: To ensure current funding arrangements remain fit-for-purpose, it is essential that the process for determining a therapy's eligibility for high-cost funding is made clear, consistent, and publicly accessible. Additionally, how a therapy is transitioned from high-cost funding arrangements to standard activity-based funding should also be clear and transparent. Embedding stakeholder consultation and regular review mechanisms into the transition process would further support its responsiveness to the evolving nature of specialised therapies and ensure that funding models remain sustainable, fair, and fit-for-purpose.

Q16. What pricing considerations are pertinent for these and other high cost, highly specialised services?

In line with emerging trends in specialised therapies and personalised medicine, current funding arrangements should transparently account for the full spectrum of costs associated with delivering high-cost therapies. These costs may include consumables, infrastructure, direct care delivery, procurement or acquisition of the intervention, and other implementation-related expenses. It is essential that all components of the care pathway are reflected in the pricing structure—particularly in determining a therapy's eligibility for high-cost funding. Embedding transparency in pricing ensures that hospitals are not left to absorb these substantial costs, thereby removing financial barriers that could otherwise limit patient access to these advanced therapies.

Additionally, pricing of these and other high cost, highly specialised services should be unbundled and clearly state the relevant cost drivers.[3] By explicitly identifying and reporting these cost drivers, the pricing model becomes more transparent, accountable, and adaptable. It allows funders, providers, and policymakers to better understand where resources are being allocated, identify opportunities for efficiency, and ensure that funding reflects the true cost of delivering care. Moreover, unbundled pricing supports comparative analysis across services and settings, facilitates more accurate forecasting and budgeting, and strengthens the case for sustained investment in emerging therapies. It also provides a foundation for dynamic pricing models that can evolve in response to changes in clinical practice, technology, and patient needs – ensuring that it is aligned with future models of care.

Pricing should differentiate between upfront and ongoing costs for these and other highly specialised services. For example, personalised cancer treatment may involve upfront costs that include the manufacture and procurement of the therapy, as well as infrastructure upgrades to deliver the treatment safely (i.e., specialised infusion facilities and staff training). In contract, ongoing costs may include follow-up care, monitoring for adverse effects post-treatment, other forms of supportive therapies, and involvement in data collection to assess long-term outcomes. As part of these ongoing costs, pricing should also account for the fixed costs of maintaining the readiness and capability to deliver these services.[4] This may include maintenance costs of infrastructure and/or staff training to ensure that services can be services can be delivered safely, efficiently, and at a consistently high standard. Recognising and incorporating these fixed costs into pricing models is critical to supporting service

[3] Kasztura, M., Richard, A., Bempong, N. E., Loncar, D., & Flahault, A. (2019). Cost-effectiveness of precision medicine: a scoping review. *International journal of public health*, *64*(9), 1261–1271. https://doi.org/10.1007/s00038-019-01298-x

[4] ANZCA. (2025). NSW Special Commission of Inquiry into Healthcare Funding. Accessed at: https://www.health.nsw.gov.au/Reports/Pages/special-commission-inquiry-funding.aspx

sustainability, particularly in regional or lower-volume settings, and helps ensure that access to advanced therapies is not compromised by financial or operational constraints.

IHACPA could also explore adoption of financial risk sharing approaches to pricing, where payment is aligned with the value and/or outcomes of care, as opposed to volume alone[5]. These models may include outcome-based payments, in which reimbursement is tied to the achievement of specific clinical or patient-reported outcomes, ensuring that the service provided delivers measurable benefits. Alternatively, IHACPA could consider pricing models involving staged payments, where funding is distributed across different phases of treatment—such as initiation, monitoring, and follow-up—based on performance or continued effectiveness. These models could be adopted to manage uncertainty with determining the value of high cost, highly specialised therapies, promote shared accountability for the quality and safe provision of care, while encouraging continuous improvement in care delivery.

Recommendation 19: Key pricing considerations pertinent for these and other high cost, highly specialised services include, but are not limited to, the following:

- Clear articulation of the full spectrum of costs associated with delivering high-cost therapies, which may include consumables, infrastructure, direct care delivery, procurement or acquisition of the intervention, and other implementation-related expenses.
- Clearly stated cost drivers and unbundled pricing approach should be incorporated as key considerations to ensure that the pricing model becomes more transparent, accountable, and adaptable to changes in context.
- Differentiated pricing between upfront and ongoing costs for these and other highly specialised services.
- Potential adoption of financial risk sharing approaches to pricing, where payment is aligned with the value and/or outcomes of care, as opposed to volume alone.

Chapter 6: Data Collection

Q17. Given high quality cost data is a key input to informing the NEP, how can IHACPA ensure the data received through the NHCDC continues to be accurate, robust and fit-for-purpose?

CHA commends IHACPA for undertaking quality assurance of the 2022–23 NHCDC data submissions as part of the NEP Determination 2025-26. Ensuring that ongoing data collection is accurate, robust, and fit for purpose is essential for effective policy development, service planning, and performance monitoring.

Monitoring and evaluation

There is a need for embedded monitoring and evaluation activities as part of ongoing quality improvement processes to ensure that data is accurate, robust and fit for purpose. Established data governance structures is essential to provide oversight of data quality and relevance over time. While most jurisdictions have a quality assurance system in place, IHACPA should consider the provision of dedicated resources to streamline the data

[5] Centre for the Health Economy. (2019). *The use and usefulness of outcomes-based funding for hospitals*. Accessed at: https://researchers.mq.edu.au/en/publications/the-use-and-usefulness-of-outcomes-based-funding-for-hospitals

collection and quality assurance processes at the LHN (or equivalent) level. This may include:

- Contracting technical staff to support the LHN in completing the data request specifications as part of the NHCDC process.
- Allocating an independent data quality assurance manager to provide local support and oversight in the NHCDC process.
- Piloting digital tools and approaches to improve efficiencies in data reporting and quality assurance, ensuring that appropriate ethical considerations and safeguards are in place.

As part of these activities outlined above, CHA welcomes IHACPA's work on developing a Data Quality Framework in consultation with the jurisdictions, and looks forward to reviewing the framework upon its completion.

Refining feedback loops and transparency

Given the volume of data submissions received through the NHCDC process, embedding processes for sharing data insights with contributing services will support continuous improvement. Building on from the existing NHCDC Public Sector reports, a tailored version of data insights for each jurisdiction that made a submission would be valuable to inform policy-making and guide investment decisions at the jurisdiction level. Where appropriate, data insights disaggregated by LHD (or equivalent) could provide meaningful insights into areas requiring targeted allocation of resources to improve patient outcomes, relative to expenditure.

As such, CHA welcomes the development of the NHCDC Dashboard as a valuable tool to enhance the timeliness and transparency of state and territory quality assurance and cost weight reporting. By enabling jurisdictions to access and analyse their submitted data in greater detail, the dashboard supports more thorough reconciliation and data validation processes. To maximise its impact, CHA encourages the integration of ongoing quality improvement initiatives to regularly assess the dashboard's relevance, usability, and effectiveness. This will help ensure that the data collected through the NHCDC remains robust, fit for purpose, and responsive to the evolving needs of the health system.

Articulating the need for collaboration

Clear and collaborative articulation of roles and responsibilities is critical to the success of any data collection initiative involving jurisdictions, LHDs, and individual hospitals. Without a shared understanding of responsibilities—ranging from data entry and validation to reporting and governance—there is a heightened risk of duplication, data gaps, and inconsistencies that can compromise the quality and reliability of the data. Establishing clear lines of accountability not only supports more accurate and timely data collection but also fosters trust, coordination, and shared ownership across all levels of the system.

The creation of timely processes and controls to the jurisdictions submitting to the NHCDC will also ensure that the results are consistent and accurate. These governance processes and controls should be made available to all employees involved in the processing of patient-level costing data within the jurisdiction. This will allow for any errors or inconsistencies to be corrected prior to the NHCDC submission.

To further strengthen this collaborative approach, timely and tailored stakeholder engagement—underpinned by clear governance structures—is essential. This can help mitigate risks such as staff turnover, which may otherwise lead to disruptions in the NHCDC

process. Mechanisms such as dedicated feedback channels and IHACPA-facilitated troubleshooting between LHDs and jurisdictions can support continuity and responsiveness. Additionally, ongoing investment in workforce training and education is vital to ensure that updated, evidence-informed practices for maintaining data quality are consistently understood and applied across the system.

Recommendation 20: Ensuring that ongoing data collection is accurate, robust, and fit for purpose is essential for effective policy development, service planning, and performance monitoring. As such, it is important that the following is considered in future NHCDC data submissions:

- **Embedding monitoring and evaluation activities** as part of ongoing quality improvement processes to ensure that data is accurate, robust and fit for purpose.
- **Refining feedback loops and ensuring transparency** through sharing of data insights with contributing services and/or jurisdictions, and in particular, the use of platforms such as the NHCDC Dashboard to enhance the timeliness and transparency of state and territory quality assurance and cost weight reporting.
- **Clear and collaborative articulation of roles and responsibilities** is critical to the success of any data collection initiative involving jurisdictions, LHDs, and individual hospitals. Mechanisms such as timely processes and controls, dedicated feedback channels and IHACPA-facilitated troubleshooting between LHDs and jurisdictions can support continuity and responsiveness.

Q18. What potential areas of refinement could IHACPA consider to support the future sustainability and predictability of public hospital costs and funding?

With an ageing population, increasing rates of chronic and complex conditions, and evolving expectations around care, there is a need to reimagine how the hospital sector delivers high-quality, person-centred services. Strategic and coordinated investment in innovative models of care supported by interoperable digital infrastructure is essential to expand Australia's digital health and data-sharing capabilities. However, regulatory variation can suppress innovation and slow down the implementation of new models of care. Providers wishing to introduce digital tools, shared care arrangements, or cross-sector collaboration may find themselves hampered by inconsistent data-sharing laws, incompatible safety standards, or differing interpretations of scope-of-practice rules for health professionals.

The cost implications of these regulatory differences are not just financial — they also affect workforce morale, system sustainability, and patient outcomes. Staff burnout can be exacerbated by compliance burdens and the stress of working within rigid or conflicting regulatory frameworks. System inefficiencies ultimately contribute to higher costs for funders and consumers, reducing the affordability of care.

There is a valuable opportunity to modernise data request specifications to better align with the evolving landscape of public hospital care and the recent growth in hospital costs. CHA welcomes IHACPA's commitment to investigating the key drivers of these cost increases as part of NEP26, including further analysis of workforce trends, on-costs, and the outcomes of employee wage agreement negotiations. As part of this work, it is essential that data collection frameworks are updated to accurately capture the realities of innovative, patient-centred models of care that are increasingly becoming standard practice. This includes models such as shared care arrangements, integrated multidisciplinary teams, and public–private partnerships in inpatient settings. Ensuring that data indicators are clearly defined

and relevant to these contemporary care models is critical for understanding their impact on hospital costs and for supporting sustainable, evidence-based funding decisions into the future.

IHACPA has a key opportunity to strengthen the sustainability and predictability of public hospital funding by refining existing data collection and analysis approaches. One important avenue is promoting greater data linkage and integration across the broader care ecosystem—particularly between hospitals and aged care services. By aligning public hospital cost and funding data with other nationally collected datasets, IHACPA can build a more comprehensive understanding of patient journeys across the continuum of care. This integrated view would enable more accurate forecasting of service demand, resource utilisation, and cost drivers.

Additionally, insights from previous NHCDC cycles could be used to identify priority areas for targeted pilot projects, helping to test and refine new data strategies. This may involve monitoring of historical and current employee wage agreements, costs of consumables, and other key drivers of health care costs within Australia to enable a more updated predicative data model that is fit-for-purpose in estimating future costs. Through this proactive and system-wide approach, IHACPA can ensure that data collection evolves in step with changes in models of care delivery, ultimately supporting more informed, stable, and future-ready funding decisions.

Recommendation 21: There are several areas of refinement that could support the future sustainability and predictability of public hospital costs and funding. These include, but are not limited to, the following:

- **Strategic and coordinated investment in innovative models of care** supported by **interoperable digital infrastructure** is essential to expand Australia's digital health and data-sharing capabilities.
- Contribute towards work designed to **better manage regulatory variation between the public hospital sector and other parts of the care economy**, including cost implications associated with system inefficiencies.
- **Modernise data request specifications** to better align with the evolving landscape of public hospital care and the recent growth in hospital costs.
- Update **data collection frameworks** to better capture the realities of innovative, patient-centred models of care that are increasingly becoming standard practice.
- Align public hospital cost and funding data with other nationally collected datasets.
- **Leverage insights from previous NHCDC cycles** identify priority areas for targeted pilot projects, helping to test and refine new data strategies.

Q19. What evidence, if any, is there to suggest that costs in categories such as labour and on-costs have increased since 2022–23 and will be reflected in future NHCDC cycles?

A 3.5% increase in minimum wages, as recently announced by the Fair Work Commission (FWC) will directly impact on labour and on-costs for hospital providers – especially those reliant on award-covered staff. These impacts are likely to be reflected in future NHCDC cycles. As base wages rise, so too do related expenses such as superannuation, leave entitlements, and payroll tax, compounding the overall financial impact. Hospitals and health services operating under block funding or activity-based funding arrangements may face increasing financial strain if funding levels are not adjusted to keep pace with rising labour

costs. Without responsive funding models, these pressures could indirectly affect service delivery capacity or staffing levels, underscoring the need for funding mechanisms that are both sustainable and adaptable.

With respect to costs in categories such as labour and on-costs, it is important that IHACPA works in partnership with leading agencies that routinely collect and analyse workforce and skills data. One example would be Jobs and Skills Australia, which develop sector-specific reports to support workforce planning and modelling. Strategies to address increased costs should be implemented in close collaboration with relevant jurisdictional authorities to ensure cohesion and alignment with broader, longer-term approaches to workforce planning.

Recommendation 22: Specific evidence of workforce cost increases includes, but is not limited to, the 3.5% increase in minimum wages as recently announced by the Fair Work Commission (FWC) that will come into effect 1 July 2025. Additionally, IHACPA should work in partnership with leading agencies that routinely collect and analyse workforce and skills data to contribute towards the evidence-base associated with increased workforce costs.

Q20. What, if any, barriers are there to collecting emergency virtual care (EVC) data submissions and how can IHACPA help jurisdictions to overcome these barriers?

CHA welcomes the completion of the Virtual Care Project and looks forward to continuing working with IHACPA to implement the identified recommendations in consultation with the sector as funding models for virtual care develop.

It is essential that insights gained from the Emergency Virtual Care (EVC) Activity Data Submission project are used to inform and enhance future EVC data submissions. Identified below are potential barriers to participation that should be considered in planning and implementation of future data submissions.

Resource availability

CHA considers the lack of specialised resources to be a significant barrier to jurisdictional participation in EVC data submission. In line with the ABF data request specifications for EVC, personnel assigned to this task must possess a comprehensive understanding of the hospital's model of care, as well as the technical expertise to locate, interpret, and extract the required data in the specified format. Without access to such skilled resources, jurisdictions may face considerable challenges in meeting the data submission requirements.

To address this barrier, IHACPA could consider tailored engagement with each jurisdiction to assess their specific resource needs in meeting the EVC data request specifications. This may involve establishing working groups with jurisdictional data extraction teams and relevant data owners within LHDs (or their equivalents) to facilitate agreement on participation in EVC data submissions. As part of this process, IHACPA should also consider providing targeted grant funding to enable jurisdictions to contract the necessary technical expertise. This approach would support efficient data submission while minimising the impact on clinical staff time.

Alignment between data request specifications and local EVC model of care

A key barrier to jurisdictional participation in EVC data submissions is the potential misalignment between the data request specifications and the diverse models of care

emerging from the rapid development of EVC services. As hospitals adapt to evolving healthcare needs, variations in how EVC is implemented may lead to differing interpretations of the data requirements, creating challenges at the jurisdictional level in aligning local practices with IHACPA's reporting expectations.

To address potential misalignments between data request specifications and local models of care, IHACPA could incorporate a targeted analysis of data gaps identified during the EVC Data Submission project. Sharing these findings with each jurisdictional team would support a clearer understanding of reporting expectations and promote alignment with national standards. This process could also foster knowledge-sharing between jurisdictions and participating hospitals. Additionally, aggregated insights could be shared with non-participating jurisdictions to build confidence and encourage broader engagement in future submissions.

Recommendation 23: Potential barriers to participation that should be considered in planning and implementation of future data submissions have been identified below:

- **Resource availability:** Tailored engagement with each jurisdiction to assess their specific resource needs in meeting the EVC data request specifications should be prioritised for future data collections. As part of this process, consider the provision of targeted grant funding to enable jurisdictions to contract the necessary technical expertise to complete the data submission.
- **Alignment between data request specifications and local EVC model of care:** To address potential misalignments between data request specifications and local models of care, consider incorporation of a targeted analysis of data gaps identified during the EVC Data Submission project, and use findings to inform future data submissions. Aggregated insights could then be shared with jurisdictions to encourage engagement in future submissions, as well as improving knowledge-sharing.

Q21. What are some further refinement areas for the EVC data request specifications?

It is the experience of CHA and its members that the definitions used in the EVC data request specifications are not always applied consistently across jurisdictions. This inconsistency creates significant challenges in documenting, interpreting, and reporting data in line with the required specifications. To ensure data integrity and comparability, there is a clear need for nationally consistent definitions and guidance on their application. Consistency in definitions is particularly critical in a federated health system, where variability in interpretation can undermine the effectiveness of national data collections and benchmarking efforts.

Additionally, the EVC data request specifications should be designed to capture the specific technologies used during virtual consultations and ensure that the definitions and data elements are relevant across all modalities within the emergency care setting. This includes not only video and telephone consultations but also emerging platforms such as asynchronous messaging, remote monitoring tools, and integrated telehealth systems. A comprehensive and inclusive approach will support more accurate data collection, enable better evaluation of virtual care models, and ensure that the specifications remain future-proof and adaptable to evolving technologies.

Recommendation 24: Provide guidance to support consistent application of EVC data request specifications for future data collections. As part, ensure that information about specific technologies used during virtual consultations can be recorded in the data collection so that the specifications remain future-proof and adaptable to evolving technologies.

Chapter 9: Pricing and funding for safety and quality

Q22. What, if any, are additional risk factors IHACPA should consider in the risk adjustment models for HACs and AHRs?

CHA welcomes the work completed to date to incorporate factors affecting safety and quality into the pricing and funding of public hospital services to improve patient outcomes. There are a range of additional risk factors that IHACPA should consider as part of the revised risk adjustment models for HACs and AHRs.

Social determinants of health

While age is undoubtedly a key factor influencing a patient's risk profile, it is equally important to consider a broader range of demographic characteristics and social determinants of health that significantly shape health outcomes with regards to HACs and AHRs. Factors such as a person's cultural and linguistic diversity (CALD) status, Indigenous status, socioeconomic background, geographic location, and access to support networks can all contribute to their overall vulnerability and care needs. These factors may also influence their attitudes toward hospital-based care, including levels of trust, communication preferences, and willingness to engage with certain models of care. A more nuanced view of these dimensions as part of the risk adjustment model would ensure that hospitals are better equipped to respond to the diverse and complex needs of the populations they serve.

Cognitive conditions

While dementia is acknowledged in Table 6 of the Risk Adjustments for Hospital Acquired Complications Technical Specifications 2025–26, it is important to recognise that other cognitive conditions also significantly influence patient risk profiles. For instance, a broader category of cognitive spectrum disorders may contribute to hospital-associated deconditioning and immobility-related complications. These conditions can lead to a dual decline in both cognitive and physical functioning, increasing the risk of adverse outcomes such as pressure injuries and infections.

Expanding the focus beyond dementia is essential, as cognitive conditions more broadly can impair decision-making, reduce medication adherence, and compromise functional independence—especially in older adults and those with complex health needs. Recognising and addressing these conditions in risk adjustment models is critical for improving patient safety and care outcomes.

Clinical frailty

The Clinical Frailty Scale (CFS) is a judgment-based tool that assesses frailty on a scale from 1 (very fit) to 9 (terminally ill). By incorporating domains such as comorbidity, functional status, and cognition, it offers a comprehensive measure of a patient's overall vulnerability. Evidence shows that the CFS is a strong predictor of complications in hospitalised patients,

making it a valuable tool for identifying those at higher risk of hospital-acquired complications (HACs).

While tools like the CFS are not yet universally embedded in healthcare funding models, they are increasingly recognised for their utility in risk stratification. Incorporating the CFS into risk adjustment frameworks could enhance the accuracy of HAC predictions, support a more nuanced approach to value-based funding, and help identify patients who may benefit from more intensive or preventive care. Importantly, it also offers a pathway to improving equity of care for older adults and individuals with complex health needs.

There is a clear opportunity for IHACPA to consider integrating broader frailty measures—such as the CFS—into revised risk adjustment models for both HACs and AHRs.

Highly specialised procedures

It is the experience of CHA and its members that highly specialised procedures such as transplants, insertion of artificial heart devices, and trauma patients have a greater likelihood of experiencing HACs. While there is a reduction in the HAC adjustment for this cohort of patients, the current risk adjustment may not sufficiently account for the complexity of services delivered by highly specialised tertiary hospitals, particularly those that receive a high proportion of referrals from outside their local catchment. CHA supports greater transparency in the development of the 2026 – 27 HAC risk adjustment model and recommends the release of detailed information to the sector. CHA also seeks confirmation as to whether a comparison has been undertaken between tertiary and non-tertiary hospitals in the application of HAC adjustments, to ensure that hospitals treating a larger proportion of high-risk patients are not unfairly disadvantaged.

Recommendation 25: There are a range of additional risk factors that IHACPA should consider as part of the revised risk adjustment models for HACs and AHRs. These include:

- **Social determinants of health**, including, but is not limited to a person's cultural and linguistic diversity (CALD) status, Indigenous status, socioeconomic background, geographic location, and access to support networks.
- A broader category of **cognitive conditions** and/or spectrum disorders that may contribute to hospital-associated deconditioning and immobility-related complications.
- **Clinical frailty measures**, such as the Clinical Frailty Scale (CFS), that are being increasingly recognised for their utility in risk stratification should also be considered as part of the revised model.

Recommendation 26: Conduct a comparative analysis of the feasibility and equity of implementing the HAC adjustment between tertiary and non-tertiary hospitals, ensuring that facilities treating higher-risk patient populations are not disadvantaged relative to those treating lower-risk cohorts.