Independent Hospital Pricing Authority

General List of In-Scope Public Hospital Services Eligibility Policy

July 2021

General List of In-Scope Public Hospital Services Eligibility Policy – Version 6.0 July 2021

Table of contents

Acronyms and abbreviations

Category A	Category A of the General List of In-Scope Public Hospital Services
Category B	Category B of the General List of In-Scope Public Hospital Services
CHC	Council of Australian Governments Health Council
ED	Emergency department
IHPA	Independent Hospital Pricing Authority
General List	General List of In-Scope Public Hospital Services
NEP	National efficient price
Pricing Framework	*Pricing Framework for Australian Public Hospital Services*
The Act	*National Health Reform Act 2011* (Cwlth)
The Addendum	Addendum to the National Health Reform Agreement 2020–25
The Administrator	Administrator of the National Health Funding Pool

Definitions

Activity based funding

Refers to a system for funding public hospital services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Hospital Pricing Authority (IHPA), as outlined in the Addendum to the National Health Reform Agreement 2020–25 (the Addendum).

An activity based funding activity may take the form of a separation, presentation or service event.

Category A

Refers to Category A of the General List of In-Scope Public Hospital Services (see definition of the General List of In-Scope Public Hospital Services).

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30 that were reported as a public hospital service in the 2010 Public Hospital Establishments Collection in terms of their activity, expenditure or staffing. The exception is the General practice and primary care (20.06) clinic, which is considered by the Pricing Authority to be ineligible for Commonwealth funding as a public hospital service.

Category B

Refers to Category B of the General List of In-Scope Public Hospital Services (see definition of the General List of In-Scope Public Hospital Services).

This comprises Other Non-Admitted Patient Services and Non-Medical Specialist Outpatient Clinics and class 40 of the Tier 2 Non-Admitted Services (except Aged care assessment (40.02), Family planning (40.27), General counselling (40.33) and Primary health care (40.08)).

To be eligible for Commonwealth funding as an Other Non-Admitted Patient Service and Non-Medical Specialist Outpatient Clinics or a class 40 Tier 2 Non-Admitted Service, a service must be:

- directly related to an inpatient admission or an emergency department attendance; or
- intended to substitute directly for an inpatient admission or emergency department attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

Eligibility criteria and interpretive guidelines

IHPA developed the eligibility criteria and interpretive guidelines in close consultation with the jurisdictions in late 2012 to provide a basis for determining which services would be included on the General List of In-Scope Public Hospital Services. These eligibility criteria and interpretive guidelines have been designed to include contemporary models of clinical care within the General List of In-Scope Public Hospital Services.

Eligibility criteria and interpretive guidelines are published as part of the *Pricing Framework for Australian Public Hospital Services* available on IHPA's website.

General List of In-Scope Public Hospital Services

In accordance with section 131(f) of the *National Health Reform Act 2011* (Cwlth) and clauses A9–A17 of the NHRA, the scope of "Public Hospital Services" eligible for Commonwealth funding under the agreement are[1, 2]:

- All admitted programs, including hospital in the home programs (forensic mental health inpatient services are included)
- All emergency department services
- Non-admitted services. There are two broad categories of in-scope, public hospital non-admitted services[3]:
    - Category A: Specialist Outpatient Clinic Services (See definition of Category A)
    - Category B: Other Non-Admitted Patient Services and Non-Medical Specialist Outpatient Clinics (See definition of Category B).

Pricing Authority

The governing body of IHPA established under the *National Health Reform Act 2011* (Cwlth).

[1] In August 2011, Governments agreed to be jointly responsible for funding growth in 'public hospital services'. But, as there is no standard definition or listing of public hospital services, Governments gave IHPA the task of deciding which services will be ruled 'in scope' as public hospital services, and so eligible for Commonwealth funding under the Addendum.

[2] With regards to IHPA's role in defining the scope of public hospital services, refer to the Addendum clauses A16–A32.

[3] Non-admitted services must be public hospital services that are provided in a community setting that are designed to prevent or shorten hospital admission.

Tier 2 Non-Admitted Services classification

The Tier 2 Non-Admitted Services classification provides a consistent framework for counting non-admitted service events.

The clinics are grouped into a number of categories that reflect the type of service provided and the clinicians who typically provide the service. The clinics are grouped into four categories, as follows:

Table 1: Categories of Tier 2 Clinics

Category	Description	Range of Clinics
Procedures	Procedures provided by a surgeon or other medical specialist.	10.01 – 10.20
Medical Consultation	Medical consultations provided by a medical or nurse practitioner.	20.01 – 20.55
Stand-alone Diagnostic	Diagnostic services, within a specific field of medicine or condition (e.g. epilepsy).	30.01 – 30.08
Allied Health and/or Clinical Nurse Specialist Intervention	Services provided by an allied health professional or Clinical Nurse Specialist.	40.01 – 40.61

For more information, please consult the following documentation available on IHPA's website:

- Tier 2 Non-Admitted Services definitions manual
- Activity based funding: non-admitted patient care data set specifications
- Tier 2 Non-Admitted Services compendium
- Tier 2 Non-Admitted Services national index.

1. Executive summary

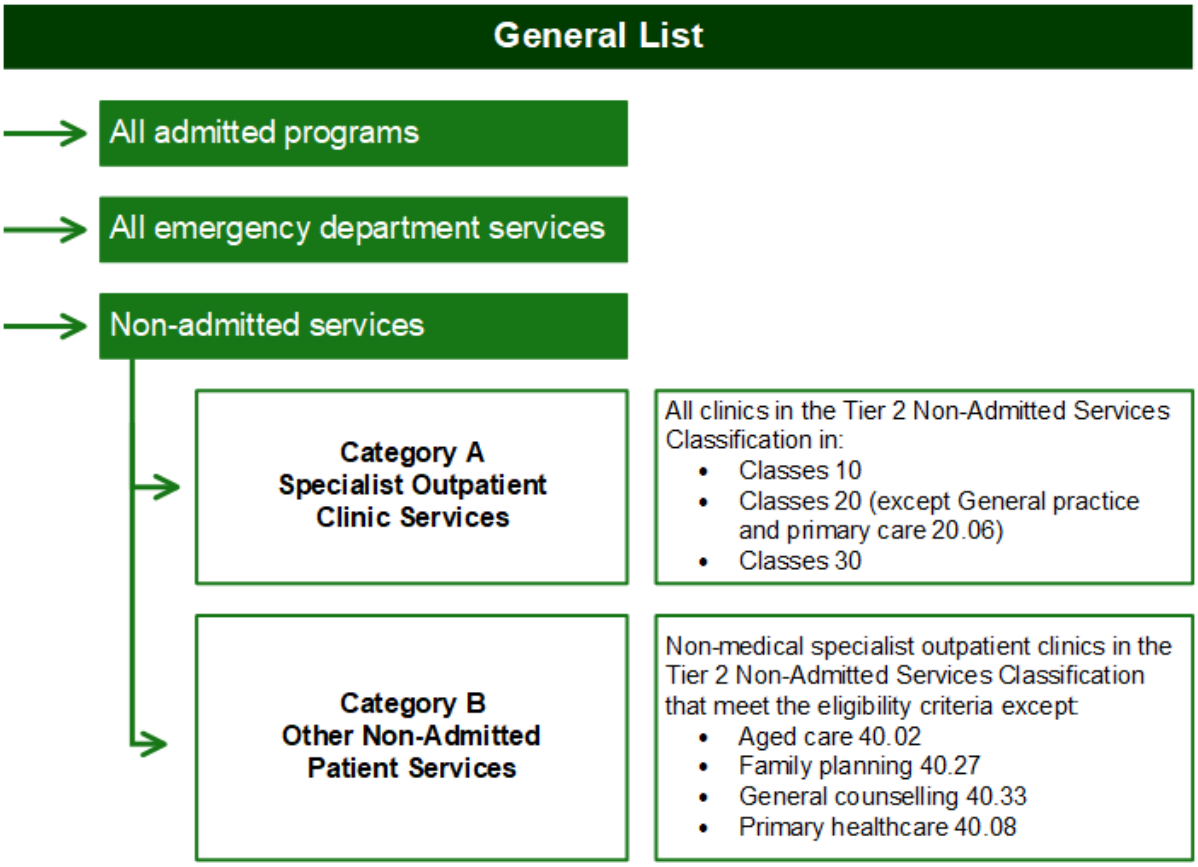
1.1 Background

The *National Health Reform Act 2011* (Cwlth) (the Act), section 131(1)(f), prescribes that the Independent Hospital Pricing Authority (IHPA) will determine the public hospital functions in the states and territories that are to be funded by the Commonwealth, except where otherwise agreed between the Commonwealth and a state or territory.

In accordance with clause A17 of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), the scope of public hospital services eligible for a Commonwealth funding contribution under the Addendum and therefore included on the General List of In-Scope Public Hospital Services (the General List) is described in Figure 1.

The Commonwealth, states and territories (jurisdictions) are able to apply to have services included or excluded from the General List. In accordance with clause A31 of the Addendum, IHPA will conduct an analysis of each application to determine if services are transferred from the community to public hospitals for the dominant purpose of making services eligible for Commonwealth funding.

Figure 1. Scope of public hospital services eligible for a Commonwealth funding contribution under the Addendum



1.2 Purpose

The General List of In-Scope Public Hospital Services Eligibility Policy (the Policy) outlines the public hospital services that form the General List. It provides guidance for jurisdictions on the process for having a service added or removed from the General List by the Pricing Authority, the eligibility criteria those services must meet and the evidence required.

1.3 Review

The Pricing Authority and Chief Executive Officer of IHPA will review this Policy, including associated documentation, annually or as required.

The Policy was reviewed in July 2021.

2. Eligibility criteria

2.1 IHPA General List of In-Scope Public Hospital Services

Guidance on the process to determine the scope of public hospital services that are eligible for Commonwealth funding on an activity or block grant basis is described in clauses A17–A26 of the Addendum.

Clause A19 of the Addendum provides that IHPA will:

- maintain and publish criteria for assessing services for inclusion on a General List of hospital services eligible for Commonwealth growth funding
- consider each state's and territory's recommendations against the published criteria
- publicly release its determination and its rationale if it considers the service should continue to be included or excluded
- establish a General List of other services eligible for Commonwealth funding.

As per clause A21 of the Addendum, IHPA may update the eligibility criteria or the interpretive guidelines, and will update the General List based on any updated eligibility criteria, or as required to reflect innovations in clinical pathways.

IHPA may also be requested by the Council of Australian Governments Health Council (CHC) to update the eligibility criteria, the interpretive guidelines or the General List.

2.2 Overall scope

In accordance with clause A17 of the Addendum, the scope of public hospital services eligible for a Commonwealth funding contribution under the Addendum is as follows:

a. All admitted programs, including hospital in the home programs (forensic mental health inpatient services are included)
b. All emergency department (ED) services
c. Other non-admitted services (see Section 2.3).

Clause A17 of the National Health Reform Agreement provided a form of "grand parenting" in that a service not already captured within the General List and which is not eligible for Commonwealth funding under clause A10 of the National Health Reform Agreement will be eligible for Commonwealth funding for a specific hospital if that service was purchased or provided by that hospital during 2010. This is referred to as the A17 List.

IHPA has determined that the inclusion of a service in the Public Hospital Establishments Collection in 2010 is sufficient evidence that a service was provided by a hospital in 2010.

2.3 Non-admitted services

The listing of in-scope non-admitted services is independent of the service setting in which the service is provided. This means that in-scope services can be provided on an outreach basis.

To be included as an in-scope non-admitted service, the service must meet the definition of a Service Event. This is "an interaction between one or more healthcare provider(s) with one

non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record."

As depicted in Figure 1, IHPA has determined that there are two broad categories of in-scope public hospital non-admitted services – 'Specialist Outpatient Clinic Services (Category A) and 'Other Non-Admitted Patient Services and Non-Medical Specialist Outpatient Clinics' (Category B).

Category A

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30 with the exception of the General practice and primary care (20.06) clinic, which is considered by the Pricing Authority to be ineligible for Commonwealth funding as a public hospital service.

Category B

To be eligible for Commonwealth funding under Category B: Other Non-Admitted Patient Services, a service must be:

- closely related to an inpatient admission or an ED service attendance; or
- intended to substitute for an inpatient admission or ED service attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

Out-of-scope services

IHPA has determined that the following clinics are not eligible for Commonwealth funding as a public hospital service under Category A or B:

- General practice and primary care (20.06)
- Aged care assessment (40.02)
- Family planning (40.27)
- General counselling (40.33)
- Primary health care (40.08).

IHPA has determined that certain non-admitted services are not in-scope for Commonwealth funding, on the basis that they do not meet the eligibility criteria for inclusion on Category B of the General List.

These non-eligible services include certain mental health services such as:

- psychosocial rehabilitation programs where the primary purpose of the service is to meet the social needs of consumers living in the community rather than hospital avoidance
- prevention and early intervention services, which in many cases are already funded by the Commonwealth Government and community based programs where the primary focus is on the ongoing management of stable patients.

2.4 Innovative models of care

Clauses A96–A101 of the Addendum provide that IHPA facilitate the exploration and trial of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes. To support the trialling of innovative models of care and services, IHPA is required to develop a funding methodology for CHC approval by April 2021 that does not penalise jurisdictions for

undertaking such trials. IHPA must also advise the Commonwealth and states and territories on the application of the trial methodology and provide advice to CHC on any proposal to translate an innovative funding model to the national funding model.

Schedule C of the Addendum contains clauses relating to the goals and principles around long-term reforms to the health system, in particular the direction for 'Paying for value and outcomes'. Clause C19 of the Addendum provides that this reform will explore funding and payment mechanisms to create stronger incentives for providers to:

a. focus on the outcomes that matter to patients, including through the utilisation of Patient Reported Measures;
b. improve patient equity, namely inequities in health care provision, access to health care, and health outcomes;
c. improve clinical outcomes, including the outcomes that matter to patients, and experiences of health care;
d. deliver best-practice clinical care; and
e. focus on the entire patient journey, not just individual parts of it.

To support the proposed health reform objectives and facilitate the trial of innovative funding models, IHPA will consider trials of innovative models of care and services for inclusion on the General List, using the interpretive guidelines outlined in Chapter 3.

The interpretive guidelines do not preclude trials of innovative models of care where all or most aspects of the innovative model of care is delivered beyond the hospital setting or where the Commonwealth and a state or territory have agreed to trial an innovative model of care through a bilateral agreement, as per clause A97 of the Addendum.

3. Interpretive guidelines

3.1 Key attributes of eligible health services

In line with the eligibility criteria, community mental health, physical chronic disease management, community based allied health programs and innovative models of care and services considered in-scope will be required to be:

- closely related to an inpatient admission or an ED service attendance; or
- intended to substitute for an inpatient admission or ED service attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

These eligible services may include:

- rehabilitation services incorporating clinician outreach and non-clinical support
- hospital avoidance programs and services incorporating community health providers, chronic care patient programs, patient medication programs and other home-based treatment programs
- those provided through contract arrangements.

Eligible health services will be assessed on the following attributes:

- be closely linked to the clinical services and clinical governance structures of a public hospital (for example, integrated area mental health services, step-up/step-down mental health services and crisis assessment teams)
- target patients with severe disease profiles, including chronic conditions
- demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum)
- demonstrate the operation of formal discharge protocols within the program
- demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

In addition to the above requirements, trials of eligible innovative models of care and services will be required to have all or most of the following attributes:

- be delivered as a hospital service
- demonstrate a set of established eligibility criteria for the nominated patient cohort
- demonstrate effective ICT systems and adequate data linkage to provide IHPA with patient-level activity and cost data for the service on a regular basis
- demonstrate sound program methodology, including risk adjustment and an established governance structure across care settings and funders
- demonstrate potential to be replicated or scaled up in a jurisdiction-wide or national-wide capacity

- allow for evaluation of measurable patient outcomes to determine the effectiveness of the innovative funding model.

3.2 Evidence to support assessment against eligibility criteria

The jurisdiction must outline the evidence or best available information to support the eligibility criteria. Jurisdictions should aim to provide the following supporting information:

- the cost of delivering the program/service across the jurisdiction
- clinical service plans or service level agreements that demonstrate links to the clinical or governance structure of public hospitals
- information on the proportion of patients who are referred following an admission, readmission or ED presentation
- data that supports the patient cohort of the service have a history of frequent hospital admission or ED presentation
- any evaluation demonstrating the program or similar programs has an impact on admission rates (e.g. the number of prevented ED services presentations/hospital admissions, the type of patients the preventative group is dealing with, the number of patients seen in the community and their admission rates per year)
- arrangements such as service level agreements that demonstrate key performance indicators in reducing hospital admission rates
- data that supports the service provides regular and intensive contact with the target group
- clinical service plans or protocols that demonstrate the discharge pathway for patients from the service.

In addition to meeting the eligibility criteria specified above, a service must be operational in order to be considered in-scope for the purposes of inclusion on the General List. However, for new programs, evidence can include data from similar programs in other locations or evidence based research outcomes.

3.3 Evaluating applications

In undertaking its assessment of a request for inclusion on, or exclusion from, the General List, IHPA will assess the proposed non-admitted service according to if:

- the proposed service meets the definition of a Service Event
- the service is already captured by clause A17(a) (all admitted services including hospital in the home programs) and clause A17(b) (all emergency department services provided by a recognised emergency department service) of the Addendum
- the evidence supports that the service is closely related to the non-admitted service, an inpatient admission or an ED service attendance or is intended to substitute for an inpatient admission or ED service attendance
- the patient/target groups have a history of frequent hospital attendance or admission
- the service is operational at the time of the application
- services are being transferred from the community to public hospitals for the dominant purpose of making services eligible for Commonwealth funding.

For the purposes of clarity, the following definitions apply when determining alignment with the General List eligibility criteria:

- hospital avoidance program: comprehensive clinical assessment, risk screening and review of care generally targeted at people with chronic health and/or mental health conditions at risk of unplanned hospital presentations. This will generally include the provision of time limited goal orientated care planning in an ambulatory setting to reduce unplanned admissions or readmissions to hospital and would usually include timely referral to specialist services and care coordination
- ‘patients with severe disease profiles’ may include managing patients with severe physical chronic disease or chronic conditions.

4. Assessment against the eligibility criteria

The key stages in the IHPA assessment process for inclusion or exclusion of services from the General List are outlined below.

Table 1. Overview of assessment process

Stage	Process Details
Stage 1: **Request for assessment**	(1a) Jurisdiction determines that it meets the eligibility criteria for assessment
	(1b) Jurisdiction requests an assessment by IHPA by completing and submitting the application form at Appendix A no later than 31 May in a given year
Stage 2: **Assessment**	(2a) IHPA reviews the request and evidence provided
	(2b) IHPA provides notification of the request to all jurisdictions and invites written submissions to be made to IHPA within 28 days
	(2c) IHPA undertakes the assessment. Further information may be requested from jurisdictions with a 14-day consultation period
Stage 3: **Draft decision**	(3a) IHPA determines the decision
	(3b) IHPA drafts the decision and provides to jurisdictions for a 14-day consultation period
	(3c) IHPA reviews the written comments by the jurisdictions with regard to the draft decision. If further clarifications are needed they will be sought within 7 days
Stage 4: **Final decision**	(4a) IHPA drafts the final decision and provides to the jurisdictions
	(4b) IHPA refines the General List (if applicable)

Stage 1: Request for assessment

(1a) Jurisdiction determines that it meets the eligibility criteria for assessment

A jurisdiction may request IHPA consider services to be included or excluded from the General List.

The jurisdiction must provide evidence that the proposed service for inclusion meets one or more of the eligibility criteria and is in line with the interpretive guidelines where possible. If the request

for assessment is to request an exclusion of a service from the General List, the jurisdiction must provide evidence that the service does not meet any of the above eligibility criteria.

(1b) Jurisdiction requests an assessment by IHPA

The jurisdiction's request must be in writing and accompanied by a written submission in support of the request, in line with the application form provided at Appendix A.

Stage 2: Assessment

(2a) IHPA reviews the request and evidence provided

IHPA will assess the submission against the eligibility criteria. IHPA will only proceed to undertake an assessment where the jurisdiction outlines the evidence or best available information to support those eligibility criteria. If IHPA is not satisfied that these eligibility criteria have been met, the request will be referred back to the jurisdiction:

- explaining that insufficient information has been provided to enable IHPA to undertake an assessment of whether the non-admitted service should be included or excluded from the General List
- seeking additional information to enable IHPA to make this assessment.

IHPA will not take further action until the jurisdiction provides additional information that enables IHPA to undertake an assessment against the eligibility criteria.

(2b) IHPA provides notification of the request to all jurisdictions

As the request for assessment may impact other jurisdictions, IHPA will provide all jurisdictions with:

- the request for assessment received from the jurisdiction, including a copy of the written submission that accompanied the request
- an invitation to make a written submission to IHPA within 28 days about the proposed inclusion or exclusion from the General List.

(2c) IHPA undertakes the assessment

In undertaking the assessment, IHPA will consider the submissions received from all jurisdictions. Where required, IHPA will:

- request additional evidence from jurisdictions (e.g. data, information, agreements) to clarify information in the assessment process
- consult further with jurisdictions where required
- seek expert input/advice.

To support the timeliness of the investigation, additional information will generally be requested within 14 days after receiving the written request.

Stage 3: Draft decision

(3a) IHPA determines the decision

IHPA will only determine that adjustments should be made to the General List to include or exclude a non-admitted service where there is demonstrable evidence to support this amendment.

(3b) IHPA drafts the decision and provides to all jurisdictions

Following the assessment process, IHPA will:

- prepare a draft decision and obtain endorsement from the Pricing Authority
- provide the draft decision to all jurisdictions
- invite the jurisdictions to give IHPA written comments on the draft decision within 14 days of receiving them.

Neither the Act nor the Addendum prescribe any timeframes in relation to IHPA conducting the assessment. However, subject to adequate evidence to support IHPA in undertaking a timely investigation, it is generally expected that IHPA will be able to provide the draft decision to the jurisdictions within three months of receiving the request.

The draft decision will include the following:

- summary of the request
- overview of the evidence examined and analysis undertaken
- any limitations to the scope of the assessment
- IHPA's decision as a result of the assessment
- reasons supporting the decision including whether the service is in-scope, or out-of-scope as it does not meet the eligibility criteria or out-of-scope due to insufficient supporting evidence.

(3c) IHPA reviews the written comments by the jurisdictions with regards to the draft decision

IHPA will review the comments received by the jurisdiction(s) with regards to the draft decision.

IHPA may seek explanation or clarification of issues or statements that appear in the submissions. IHPA will request this in writing from the relevant jurisdiction(s). To support the timeliness of the final decision, this response will be requested to be provided within seven days after receiving the request for clarification.

Stage 4: Final decision

(4a) IHPA drafts the final decision and provides to all jurisdictions

IHPA will prepare a final decision and obtain endorsement from the Pricing Authority. The final decision will be provided to all jurisdictions.

(4b) IHPA refines the General List (if applicable)

Following the release of the final decision, IHPA will update the General List to reflect the addition or removal of a service, if required.

Following an update to the General List being approved, details of the policy decision will be outlined in the Pricing Framework (Note: depending on the timing of the approval, this may be the next calendar year).

5. Verification of compliance

5.1 Certification that services reported are true and correct

IHPA will require that the Chief Executive Officer of the relevant Health Department certify that:

- public hospital services reported to IHPA are true and correct in-scope public hospital services eligible for Commonwealth funding as determined by IHPA and the services are consistent with the information provided to IHPA at the time that application for inclusion on, or exclusion from, the General List was made
- information provided to IHPA to support claims regarding the eligibility of a service for a Commonwealth funding contribution is true and correct.

This will be requested by IHPA in writing on an annual basis.

5.2 Procedures to be used by IHPA to assist the Administrator to reconcile reported activity against approved in-scope public hospital services

IHPA will use the following process for ensuring only approved services receive Commonwealth funding under the Addendum:

- IHPA will provide a detailed listing of in-scope services by Local Hospital Network to the Administrator of the National Health Funding Pool (the Administrator) on an annual basis
- If in performing reconciliations the Administrator suspects non in-scope activity is being reported and the Administrator is unable to resolve this with the jurisdiction in question, the Administrator will request IHPA to review the data
- IHPA will consult with the relevant jurisdiction and advise the Administrator of the outcome of that process. IHPA may require evidence from the relevant jurisdiction that its services reconcile with the approved in-scope services previously determined by the Pricing Authority.

Appendix A: Application form for inclusion of new services on the General List

Contact Details	
Name	
Position	
Organisation	
Email address	
Phone number	
Contact person for further information	

Prior to completing this application form, please ensure you have reviewed the *General List of In-Scope Public Hospital Services Eligibility Policy*, available at www.ihpa.gov.au. This application form is intended as a guide only. An editable PDF version of this form is now available on IHPA's website.

The General List is published in March every year as part of the IHPA national efficient price (NEP) Determination. For services to be considered for inclusion or exclusion from the General List, the request for assessment must be received by IHPA by no later than 31 May each year.

Requests sent after that date will be considered for inclusion in the following NEP Determination.

Application Details

Assessment against the General List eligibility criteria and interpretive guidelines:

This application form has been developed to assist jurisdictions in providing information that clearly demonstrates how the service or program meets one or more of the eligibility criteria outlined below:

- Closely related to an inpatient admission or an emergency department (ED) service attendance provided by a recognised ED service
- Intended to substitute for an inpatient admission or ED attendance provided by a recognised ED service
- Expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission

1. Service description, including (but not limited to): - Name of service - Local Hospital Network where the service is provided - Geographic location (i.e. is it based on hospital grounds or elsewhere) - Composition of staff by profession (e.g. number of nurses, number of doctors etc.) - Objective of care - Commencement date of program/service - Evidence of innovations in clinical pathways - After hours services - Evidence that the service is closely linked to a clinical service or governance structure - Similarity to existing in-scope public hospital programs or services (e.g. Tier 2 classes)
2. Patient profile, including (but not limited to): - Diagnosis / presenting problems - Age group, sex and other relevant patient characteristics - Proportion of patients who were referred following an admission, readmission or ED presentation - Median and average time per patient between hospital stay - Information on the length of time patients are enrolled - Average number of service events per enrolled patient and total number of service events - Evidence of formal discharge protocols

3. Current program expenditure, including (but not limited to): - The cost of delivering the program across the jurisdiction (e.g. annual expenditure, expenditure per patient) - Proportion of expenditure which is potentially in-scope (e.g. the treatment of patients for primary care in the program or by the service would be excluded as well as treatment of private patients) - How the jurisdiction proposes to report the program or service (e.g. block funded through the non-admitted mental health category in the national efficient cost Determination or through a Tier 2 class)
4. Documentation/evidence to support the assessment against the General List eligibility criteria and interpretive guidelines including (but not limited to): - Any evaluation demonstrating the program or similar programs has an impact on admission rates (e.g. the number of prevented ED service presentations/hospital admissions, the type of patients the preventative group is dealing with, the number of patients seen in the community and their admission rates per year) - Quantitative evaluations of the program or similar programs which demonstrate that it has an impact on admission rates (e.g. number of prevented presentations or admissions) - Qualitative studies around clinical governance (e.g. relationship between non-government organisations and hospitals) - Surveys demonstrating that the service supports hospital avoidance - Longitudinal or linked data analyses of participating patients - Additional statistical information
Please attach as Word, PDF or Excel

Declaration by applicant

I make this application on the basis that the details in this form are true and accurate.

Applicant name, position and signature	**Date**

Independent Hospital Pricing Authority

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IHPA