



Pricing Framework for Australian Public Hospital Services 2022–23

December 2021

Independent Hospital Pricing Authority



Pricing Framework for Australian Public Hospital Services 2022–23 – December 2021

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Glossary

ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
CHC	Council of Australian Governments Health Council ¹
COVID-19	Coronavirus Disease 2019
DRG	Diagnosis Related Group
HAC	Hospital acquired complication
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11	International Classification of Diseases 11 th Revision
IHI	Individual Healthcare Identifier
IHPA	Independent Hospital Pricing Authority
LHN	Local hospital network
MHPoC	Mental Health Phase of Care
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NWAU	National weighted activity unit
PPH	Potentially preventable hospitalisation
The Addendum	Addendum to the National Health Reform Agreement 2020–25
The Commission	Australian Commission on Safety and Quality in Health Care
UDG	Urgency Disposition Group
WHO	World Health Organization

¹ The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies.



1

Introduction

1

Introduction

The Pricing Framework for Australian Public Hospital Services (the Pricing Framework) is the Independent Hospital Pricing Authority's (IHPA) key policy document and underpins the approach adopted by IHPA to determine the national efficient price (NEP) and national efficient cost (NEC) for Australian public hospital services.

The Pricing Framework is published prior to the release of the NEP and NEC Determinations in early April. This provides an additional layer of transparency and accountability by making available the principles, decisions and approach used by IHPA to inform the determinations.

IHPA released the [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23](#) (the Consultation Paper) for a 30-day public consultation period on 9 June 2021. The Consultation Paper sets out the major issues for the development and refinement of the national activity based funding system, including policy decisions, classification systems and data collection. Development of the Pricing Framework has been informed by stakeholder feedback to the Consultation Paper.

This year, IHPA received 25 submissions to the Consultation Paper, including responses from the majority of jurisdictions. These submissions are available on the [IHPA website](#). A Consultation Report outlining their content, including commentary on how IHPA reached its decisions for 2022–23, is also available.

Stakeholders provided valuable feedback regarding IHPA's proposed approach for using the 2019–20 cost and activity data to assess and account for the pricing impacts of the Coronavirus Disease 2019 (COVID-19) pandemic on the NEP Determination 2022–23 (NEP22). Areas for consideration to inform potential pricing model refinements included changes to activity levels, volume and casemix; changes to models of care and service delivery; and the ongoing and potentially long term costs associated with the COVID-19 response.

IHPA acknowledges the financial and resource impacts on jurisdictions arising from the COVID-19 response, as well as significant variations in data reporting. Ensuring that the pricing model adequately accounts for COVID-19 impacts is the highest priority. In developing NEP22, IHPA will also have consideration of the implications from the *National Partnership on COVID-19 Response* and subsequent announcements by National Cabinet concerning public hospital funding arrangements.

Stakeholders were supportive of IHPA's work to explore innovative models of care and funding approaches, as directed by the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), and the intention to trial innovative funding approaches for 2022–23. Feedback highlighted the importance of clinical involvement, flexibility in models of care across care settings, and consideration of state and territory capability and capacity.

This work is closely linked to the incorporation of further safety and quality measures into the pricing and funding of public hospital services. Under the Addendum, IHPA is required to provide advice to the Council of Australian Governments Health Council² on options for reducing avoidable and preventable hospitalisations through changes to the Addendum. Stakeholders provided feedback on considerations for investigating and developing further safety and quality reforms.

The Addendum also stipulates that IHPA will work with the jurisdictions, the national bodies and other stakeholders to establish a framework to evaluate safety and quality reforms. IHPA received feedback from stakeholders on potential evaluation measures and recommendations for undertaking the evaluation process.

IHPA continues to work with jurisdictions through its advisory committees to assess and account for the impact of COVID-19 on NEP22 and future determinations. IHPA will also undertake additional consultation to progress the trialling of innovative funding approaches, and the development and evaluation of safety and quality reforms.

² The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to the Council of Australian Governments Health Council, including matters relating to the national bodies.

A large green graphic consisting of two overlapping arrow-like shapes pointing to the right. The number '2' is centered in the leftmost shape.

2

Impact of COVID-19

Coronavirus Disease 2019 (COVID-19) has resulted in significant and potentially long lasting changes to models of care and service delivery in Australian public hospitals. It is important that the impact of COVID-19 is adequately accounted for in the national pricing model.

2.1. Impact of COVID-19 on NEP22

The Independent Hospital Pricing Authority (IHPA) is working with jurisdictions to understand the changes to, and the cost drivers of, the delivery of public hospital services as a result of the COVID-19 pandemic. Stakeholder feedback to the Consultation Paper outlined the following areas for consideration:

- changes to in-scope activity, volume and casemix (for example, reductions in elective surgery and emergency department presentations)
- changes to models of care (for example, increased use of hospital-in-the-home, telehealth and remote monitoring)
- ongoing costs related to COVID-19 (for example, additional personal protective equipment and staffing requirements).

In the Consultation Paper, IHPA proposed to identify variations in cost and activity compared to historical trends for the three month period of 2019–20 impacted by COVID-19 for the National Efficient Price Determination 2022–23 (NEP22). Stakeholders were supportive of this approach and provided recommendations including:

- use of 2018–19 data where the 2019–20 data is not robust
- undertaking separate analysis for activity based funding and block-funded facilities
- consideration of a state and territory level COVID-19 adjustment
- consideration of a separate COVID-19 back-casting multiplier
- sourcing additional data from surgery waitlists and other current records.

2.2. Impact of COVID-19 on future determinations

IHPA notes that the national pricing model will need to remain reactive in recognising the ongoing and longer term impacts of COVID-19. In response to the Consultation Paper, stakeholders outlined the following considerations for future determinations:

- address increased patient complexity stemming from delayed care
- review the new and evolving models of care developed and implemented during the pandemic
- account for increased costs due to changes in practice and protocol
- consider the yet unknown complications and chronic conditions arising from patients diagnosed with COVID-19.

IHPA's decision

IHPA is working with jurisdictions to ensure that changes in service delivery, volume, casemix and cost are taken into account in refining the national pricing model for NEP22. IHPA will also ensure that any implications from the *National Partnership on COVID-19 Response* and associated funding arrangements are considered in the context of NEP22.

Next steps and future work

IHPA will continue to work with jurisdictions to understand the ongoing impact of COVID-19 on service delivery, activity levels and models of care, noting that any changes to the national pricing model for future determinations will require accurate cost and activity data.

IHPA will monitor and assess the longer term impacts of COVID-19 as updated data becomes available.

3

The Pricing Guidelines

3.1. The Pricing Guidelines

The decisions made by the Independent Hospital Pricing Authority (IHPA) in pricing in-scope public hospital services are evidence-based and use the latest cost and activity data supplied to IHPA by the jurisdictions. In making these decisions, IHPA balances a range of policy objectives, including improving the efficiency and accessibility of public hospital services.

The Pricing Guidelines, outlined in **Figure 1**, signal IHPA's commitment to transparency and accountability in making its policy decisions. The Pricing Guidelines comprise of 'overarching', 'process' and 'system design' guidelines'.

In 2020, IHPA updated the 'activity based funding (ABF) pre-eminence', 'patient-based' and 'public-private neutrality' guidelines to reflect stakeholder feedback and changes arising from the Addendum to the National Health Reform Agreement 2020–25.

In response to the Consultation Paper, some stakeholders recommended a broader review of the role of ABF within the Pricing Guidelines to accommodate the introduction of innovative funding approaches. Requests for consideration of new Pricing Guidelines and modifications to existing Pricing Guidelines were also received. Further detail on these requests is provided in the Consultation Report.

IHPA's decision

IHPA has reviewed the feedback from stakeholders in detail, in particular, addressing the role of ABF and the incorporation of innovative funding approaches. IHPA has determined that the current Pricing Guidelines provide adequate flexibility for the adoption of new and innovative funding approaches.

IHPA considers that amendments to the Pricing Guidelines are not required at this time.

Next steps and future work

IHPA is working with jurisdictions to progress trials of innovative models of care and funding approaches. As this work evolves, IHPA will review the Pricing Guidelines to ensure that they accommodate the introduction of innovative funding approaches and fulfil the policy intent of the Addendum.

IHPA will continue to use the Pricing Guidelines to inform its decision making where it is required to exercise policy judgement in undertaking its legislated functions.

Figure 1: The Pricing Guidelines

<p>Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising ABF and block grant funding:</p> <ul style="list-style-type: none">- Timely-quality care: Funding should support timely access to quality health services.- Efficiency: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.- Fairness: ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.- Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement: Funding design should recognise the complementary responsibilities of each level of government in funding health services.	<p>System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none">- Fostering clinical innovation: Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.- Promoting value: Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.- Promoting harmonisation: Pricing should facilitate best practice provision of appropriate site of care.- Minimising undesirable and inadvertent consequences: Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.- ABF pre-eminence: ABF should be used for funding public hospital services wherever practicable and compatible with delivering value in both outcomes and cost.- Single unit of measure and price equivalence: ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.- Patient-based: Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.- Public-private neutrality: ABF pricing should ensure that payments a local hospital network (LHN) receives for a public patient should be equal to payments made for a LHN service for a private patient.
<p>Process Guidelines to guide the implementation of ABF and block grant funding arrangements:</p> <ul style="list-style-type: none">- Transparency: All steps in the determination of ABF and block grant funding should be clear and transparent.- Administrative ease: Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.- Stability: The payment relativities for ABF are consistent over time.- Evidence-based: Funding should be based on best available information.	



4

Scope of public hospital services

4

Scope of public hospital services

In August 2011, Australian governments agreed to be jointly responsible for funding efficient growth in public hospital services. The Independent Hospital Pricing Authority (IHPA) was assigned the task of determining whether a service is determined to be ‘in-scope’ as a public hospital service and therefore eligible for Commonwealth funding under the National Health Reform Agreement (NHRA).

4.1. General List of In-Scope Public Hospital Services

Each year, IHPA publishes the General List of In-Scope Public Hospital Services (the General List) as part of the national efficient price determination. The General List defines public hospital services eligible for Commonwealth funding, except where funding is otherwise agreed between the Commonwealth and a state or territory.

This model has been retained by the Addendum to the NHRA 2020–25 (the Addendum). Clause A21 of the Addendum notes that IHPA may update the criteria for inclusion on the General List to reflect innovations in clinical pathways.

Clause A17 of the Addendum and the IHPA [General List of In-Scope Public Hospital Services Eligibility Policy](#) (the General List Policy) provide that the scope of public hospital services funded on an activity or grant basis that are eligible for a Commonwealth funding contribution will include:

- all admitted services, including hospital-in-the-home programs;
- all emergency department services provided by a recognised emergency department service; and
- other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service in accordance with clauses A18–A24 of the Addendum.

The General List Policy provides that the listing of in-scope services is independent of the setting in which the service is provided. This means that in-scope services can be provided on an outreach basis, including in the community or in a person’s home.

Applications to have a service added to the General List are made as part of the annual process outlined in the General List Policy. Submissions are assessed by IHPA to determine whether specific services proposed by a state or territory are ‘in-scope’ and eligible for Commonwealth funding, based on criteria and empirical evidence provided by that state or territory. These criteria are outlined in the General List Policy.

Under the Addendum, IHPA is also required to facilitate the exploration and trial of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes.

In July 2021, IHPA finalised and published Version 6.0 of the General List Policy, which includes updates to the eligibility criteria to facilitate trials of innovative models of care and expand the scope of services eligible for inclusion on the General List.

Next steps and future work

IHPA will consider further refinements to the General List Policy as part of its annual review process.

A large teal graphic consisting of two overlapping shapes: a smaller teal shape on the left and a larger, lighter teal shape on the right, both with rounded corners. The number '5' is centered in white within the smaller shape.

5

Classifications used to describe and price public hospital services

5

Classifications used to describe and price public hospital services

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

Effective classifications contribute to the determination of a national efficient price (NEP) for public hospital services and allows Australian governments to provide funding to public hospitals based on the activity based funding (ABF) mechanism.

The Independent Hospital Pricing Authority (IHPA) is responsible for reviewing and updating existing classifications, as well as introducing new classifications. In Australia, there are currently six patient service categories which have classifications in use or in development:

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

5.1. Standard development cycles for all classifications

Under the National Health Reform Agreement, one of IHPA's determinative functions is to develop, refine and maintain the national classifications to ensure that they remain fit-for-purpose, reflect current clinical practice and facilitate continual improvement of the national pricing model.

The Consultation Paper sought feedback on the feasibility of implementing standard development cycles for all classification systems.

Standard development cycles would ensure classification currency, provide greater certainty regarding the timing of new versions and assist states and territories in planning for education programs and implementation costs.

Stakeholders were supportive of this proposal and a potential three-year standard development cycle, in line with the current development cycle length for the admitted acute care classifications.

Next steps and future work

IHPA will work with jurisdictions and key stakeholders to determine the next steps for implementing standard development cycles for all classification systems.

5.2. Admitted acute care

The Australian Refined Diagnosis Related Group (AR-DRG) classification is used for admitted acute episodes of care. AR-DRGs are underpinned by a set of classifications and standards:

- International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) to code diseases and other health problems
- Australian Classification of Health Interventions (ACHI) to code procedures and interventions
- Australian Coding Standards (ACS), a supplement to ICD-10-AM and ACHI, to assist clinical coders in using the classifications, collectively known as ICD-10-AM/ACHI/ACS.

5.2.1. AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition

For the NEP Determination 2021–22 (NEP21), IHPA used AR-DRG Version 10.0 and ICD-10-AM/ACHI/ACS Eleventh Edition to price admitted acute patient services.

New versions of these classification systems are developed on a three-year development cycle to balance currency against the need for stability and reduce the burden of implementation for stakeholders.

AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition are proposed for release from 1 July 2022.

AR-DRG Version 11.0 has been updated to maintain clinical currency and robustness, and further revised by taking into consideration submissions from stakeholders.

ICD-10-AM/ACHI/ACS Twelfth Edition has been informed by updates to the World Health Organization’s (WHO) International Statistical Classification of Diseases and Related Health Problems, Tenth Revision and updates to the Medicare Benefits Schedule.

AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition were released for public consultation in May 2021. The Consultation Paper and the submissions received are available on the [IHPA website](#).

IHPA’s decision

IHPA will use AR-DRG Version 10.0 and ICD-10-AM/ACHI/ACS Twelfth Edition to price admitted acute patient services for the National Efficient Price (NEP) Determination 2022–23 (NEP22).

Next steps and future work

Following finalisation of AR-DRG Version 11.0, IHPA plans to use this version to price admitted acute patient services for the NEP Determination 2023–24.

5.2.2. Enhancing education materials for admitted acute care classification systems

IHPA is exploring options for the development of an interactive and responsive online educational program for new versions of the admitted acute care classifications to support flexible on-demand access and self-paced learning.

IHPA is also exploring options to transition hard copies of the AR-DRGs Definitions Manual and ICD-10-AM/ACHI/ACS to electronic versions.

Next steps and future work

IHPA will continue to explore options for the development of education and training materials in consultation with jurisdictions and key stakeholders.

5.2.3. Phasing out support for older AR-DRG versions

IHPA remains committed to phasing out support for older AR-DRG versions to maintain clinical currency and ensure that the benefits of more recent AR-DRG versions are realised. IHPA will continue to work with private health sector stakeholders to progress withdrawing support for older AR-DRG versions.

Cost reports using AR-DRG Version 10.0 are available on the [IHPA website](#) and it is recommended that all new agreements between private hospitals and insurers use AR-DRG Version 10.0.

5.2.4. Release of ICD-11

The International Classification of Diseases 11th Revision (ICD-11) was released by WHO in June 2018. The Australian Institute of Health and Welfare has explored the feasibility and potential timeframe for implementation of ICD-11 in Australia, however this is still under consideration by Australian governments.

Next steps and future work

IHPA will continue to explore the feasibility of implementing ICD-11 for admitted care by undertaking a gap analysis mapping ICD-10-AM to ICD-11 and reviewing the impact of ICD-11 on the AR-DRG classification.

5.3. Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) is used to price admitted subacute and non-acute services. Admitted subacute and non-acute services not classified using AN-SNAP are classified using AR-DRGs.

For NEP21, IHPA used AN-SNAP Version 4.0 to price admitted subacute and non-acute patient services.

5.3.1. AN-SNAP Version 5.0

IHPA has developed AN-SNAP Version 5.0 through detailed statistical analysis and consultation with jurisdictions, clinical experts and other subacute care stakeholders.

AN-SNAP Version 5.0 represents a modest refinement of AN-SNAP and introduces a new variable to recognise frailty as a cost driver for geriatric evaluation and management, and non-acute episodes of care.

AN-SNAP Version 5.0 was released for public consultation in April 2021. The public consultation paper and the submissions received are available on the [IHPA website](#).

IHPA's decision

For NEP22, IHPA will price admitted subacute and non-acute care using AN-SNAP Version 4.0 and shadow price admitted subacute and non-acute care using AN-SNAP Version 5.0.

Next steps and future work

IHPA will investigate prospective measures for classifying paediatric subacute care and assessing patient frailty in subacute admitted settings.

IHPA will assess the feasibility of introducing these data elements in the Admitted Subacute and Non-Acute Hospital Care National Best Endeavours Data Set from 1 July 2023.

5.4. Emergency care

For NEP21, IHPA used the Australian Emergency Care Classification (AECC) Version 1.0 to price emergency department activities and Urgency Disposition Groups (UDGs) Version 1.3 to price emergency services.

IHPA acknowledges that there is a need for a stabilisation period following the implementation of AECC Version 1.0 and will continue to support states and territories to improve data collections.

IHPA's decision

IHPA will use AECC Version 1.0 to price emergency department activities and UDGs Version 1.3 to price emergency services for NEP22.

Next steps and future work

IHPA will investigate potential variables such as diagnosis modifiers, procedures and investigations for incorporation into future refinements of the AECC.

IHPA will continue to work with states and territories to determine the feasibility of transitioning emergency services to be priced using the AECC.

5.5. Non-admitted care

5.5.1. Tier 2 Non-Admitted Services Classification

The Tier 2 Non-Admitted Services Classification is the existing classification system used for pricing non-admitted services, while a new non-admitted classification is being developed.

For NEP21, IHPA used the Tier 2 Non-Admitted Services Classification Version 7.0 for pricing non-admitted services.

IHPA's decision

IHPA will continue to use the Tier 2 Non-Admitted Services Classification Version 7.0 for pricing non-admitted services for NEP22.

5.5.2. A new non-admitted care classification

IHPA is developing a new non-admitted care classification to better describe patient characteristics and care complexity and more accurately reflect the costs of non-admitted services.

In 2018, IHPA commenced a national costing study to collect non-admitted cost and activity data and test a shortlist of variables and potential classification hierarchies. The costing study was suspended in 2020 due to the impact of Coronavirus Disease 2019 (COVID-19).

The Consultation Paper sought feedback on state and territory readiness to recommence the non-admitted care costing study. Stakeholders welcomed the development of a new non-admitted care classification, however recommended that longer timeframes are explored due to ongoing resource and financial pressures arising from the COVID-19 pandemic.

Next steps and future work

IHPA will continue to work with jurisdictions and key stakeholders to explore readiness for undertaking the non-admitted care costing study, including consideration of whether methodology changes are required and monitoring of site and jurisdiction capacity for recommencement.

IHPA's decision

Following the completion of a two-year shadow period, assessment of the quality and coverage of admitted mental health data, and consultation with jurisdictions, IHPA will use AMHCC Version 1.0 to price admitted mental health care for NEP22.

5.6.2. Community mental health care

Community mental health care is currently block funded as part of the national efficient cost (NEC) Determination, with states and territories advising their block-funded expenditure each year.

NEP21 was the first year of shadow pricing community mental health care using AMHCC Version 1.0. Shadow price weights for 2021–22 are available on the [IHPA website](#).

The volume and coverage of community mental health data continues to improve, with four jurisdictions (New South Wales, Victoria, Queensland and Tasmania) supplying costed phase data in 2019–20.

The Consultation Paper sought feedback regarding readiness to progress to pricing using AMHCC Version 1.0 for community mental health care for NEP22. Stakeholders noted that additional time was required to implement costing systems and processes to address gaps in data collections.

IHPA's decision

For NEP22, community mental health care will continue to be block funded while a second year of shadow pricing is undertaken using AMHCC Version 1.0.

Next steps and future work

IHPA is undertaking a review of the AMHCC to identify specific areas for improvement. This work will inform the direction of future revisions to the AMHCC.

5.6. Mental health care

5.6.1. Admitted mental health care

For NEP21, IHPA used AR-DRG Version 10.0 to price admitted mental health care.

NEP21 is the second year of shadow pricing for admitted mental health care using the Australian Mental Health Care Classification (AMHCC) Version 1.0. Shadow price weights for 2020–21 are outlined in the [Australian Mental Health Care Classification Pricing Feasibility Report](#). Shadow price weights for 2021–22 are available on the [IHPA website](#).

The Consultation Paper outlined IHPA's intention to price admitted mental health care using AMHCC Version 1.0 for NEP22.

5.6.3. Mental Health Phase of Care

In July 2021, IHPA published the [*Mental Health Phase of Care Clinical Refinement Testing Project – Final Report*](#), which outlines the key findings of inter-rater reliability testing and recommendations on the future refinement of the Mental Health Phase of Care (MHPoC) definitions within the AMHCC. At the conclusion of the project, a decision was made in consultation with the jurisdictions to retain the current MHPoC concept.

IHPA has worked with jurisdictions and its Mental Health Working Group to finalise minor revisions to MHPoC definitions in the lead up to pricing admitted mental health care using the AMHCC.

Next steps and future work

IHPA will continue to investigate where refinements can be made for MHPoC terminology and definitions for future versions of the AMHCC.

5.7. Teaching and training

Teaching and training activities represent an important aspect of the public hospital system alongside the provision of care to patients. However, the components required for ABF are not currently available to enable these activities to be priced. As a result, teaching and training activities are block funded as part of the NEC Determination.

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

IHPA's decision

For the NEC Determination 2022–23, IHPA will continue to determine block-funding amounts for teaching, training and research activity based on advice from states and territories.

Next steps and future work

IHPA will work with jurisdictions to develop an implementation plan and timeframes for shadow pricing the ATTC, and investigate alternative models to block funding until the ATTC can be enabled.

6

Setting the national efficient price

6

Setting the national efficient price

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

6.1. National pricing model

IHPA has developed a robust pricing model that underpins the annual determination of the NEP, price weights and adjustments, based on cost and activity data from three years prior. The national pricing model is described in further detail in the [National Pricing Model Technical Specifications](#) on IHPA's website.

For the NEP Determination 2022–23 (NEP22) IHPA has deferred consideration of the proposed refinements to the national pricing model outlined in the Consultation Paper. These include adjustments to the NEP, price harmonisations and refining the private patient neutrality methodology. IHPA will review jurisdictional capacity to support these refinements for future NEP Determinations.

6.1.1. Consultative requirements for changes to the national pricing model

Under the Addendum, IHPA is required to undertake consultation with all Australian governments for proposed changes to the national funding model. These requirements are outlined below:

- Clause A42 requires IHPA to use transitional arrangements such as shadow pricing when developing new activity based funding (ABF) classification systems or costing methodologies, for two years or a period agreed with the Commonwealth and a majority of states and territories.

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

- Clause B10 specifies that IHPA will consult with the Council of Australian Governments Health Council (CHC)³ on changes that materially impact the application of the national funding model.
- Clauses B37–B40 stipulate that IHPA must seek guidance through its Jurisdictional Advisory Committee and provide a Statement of Impact outlining risks and transition arrangements to the Commonwealth, states and territories when material changes are proposed to the national funding model.

In consultation with jurisdictions, IHPA developed the [Alterations to the National Pricing Model Framework](#) (the Alterations Framework) and the [Shadow Pricing Guidelines](#) to address the Addendum requirements.

The Alterations Framework outlines the consultative mechanisms that IHPA follows when implementing changes that materially impact the application of the national funding model. The Alterations Framework provides guidelines for the Statement of Impact, which includes assessment of the proposed change against thresholds for additional CHC consultation.

The Shadow Pricing Guidelines provide guidance for the use of transitional arrangements for new or updated classification systems. This includes guiding principles for commencing shadow pricing, reporting requirements during the shadow pricing period and criteria for progression to pricing.

IHPA's decision

IHPA will use the consultation approach outlined in the Alterations Framework to consult on key pricing decisions for NEP22.

Next steps and future work

IHPA will consider further refinements to the Alterations Framework and the Shadow Pricing Guidelines as part of its annual review process.

6.2. Adjustments to the national efficient price

Clauses A46 and A47 of the Addendum require IHPA to determine adjustments to the NEP and have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:

- hospital type and size;
- hospital location, including regional and remote status; and
- patient complexity, including Indigenous status.

The Consultation Paper outlined IHPA's intention to reinvestigate the need for an adjustment for patient transport in rural areas, review the Indigenous status adjustment, review the Specified Intensive Care Unit (ICU) eligibility criteria and investigate the need for new adjustments for genetic services and socioeconomic status for NEP22.

Stakeholder feedback expressed support for the adjustments and provided evidence to support increased costs in these areas. Further detail on these submissions and IHPA's response is provided in the Consultation Report.

IHPA's decision

Due to the ongoing impact of Coronavirus Disease 2019 (COVID-19), IHPA will defer investigation of the proposed areas and adjustments for NEP22 to focus on refinements to the pricing model to account for COVID-19.

Next steps and future work

IHPA will work with jurisdictions and broader stakeholders to consider the feasibility of exploring the above areas for future determinations, pending jurisdictional capacity and capability. Specific next steps could involve undertaking costing studies to better understand the cost drivers for these areas.

6.3. Harmonising price weights across care settings

IHPA's Pricing Guidelines include 'System Design Guidelines' to inform options for the design of ABF and block-funding arrangements, including an objective for price harmonisation whereby pricing should facilitate best practice provision of appropriate site of care.

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

IHPA harmonises a number of price weights across the admitted acute and non-admitted settings so that similar services are priced consistently across settings. For NEP22, IHPA considered price harmonisation for haemodialysis and chemotherapy.

In response to the Consultation Paper, stakeholders outlined other areas where price harmonisation could be considered, including surgical procedures where no other ongoing care is required (for example, colonoscopies or nasendoscopies), same day gastroenterology patients and infusions of blood products. Further detail is provided in the Consultation Report.

Next steps and future work

IHPA will consider price harmonisation for haemodialysis and chemotherapy for the NEP Determination 2023–24 (NEP23), noting the need for further analysis on the stability of the underlying data, the suitability of these services for harmonisation and the risk of potential unintended consequences.

IHPA will also assess the stakeholder proposed harmonisations in the development of NEP23.

6.4. Unqualified newborns

In the Consultation Paper, IHPA identified that it was investigating the current funding model for unqualified newborns and assessing whether methodology changes were required.

At present, a newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is considered qualified if the infant meets at least one of the following criteria⁴:

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

If a newborn does not meet any of the above criteria the newborn patient day is considered unqualified and therefore not in-scope for cost data collections or ABF. Their costs are assigned to the mother's record and included in the delivery Diagnosis Related Group (DRG) price.

Stakeholders noted that the bundling of unqualified newborns within the maternal DRG may not adequately reflect the cost of care, and requested that IHPA review how neonatal ICU hours in a non-bundled ICU DRG are funded.

Next steps and future work

IHPA will undertake further consultation with jurisdictions and stakeholders to determine the feasibility of methodology changes for future determinations.

IHPA notes that definition changes around qualification status requires legislative changes.

6.5. Setting the national efficient price for private patients in public hospitals

The Addendum includes parameters regarding funding for private patients in public hospitals, specifically that IHPA will adjust the price for privately insured patients in public hospitals to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction, taking into account all hospital revenues.

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

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

For the NEP Determination 2021–22 (NEP21) IHPA implemented a private patient neutrality methodology whereby the private funding neutrality adjustment will be calculated as an adjustment to Commonwealth growth funding associated with services delivered to private patients in public hospitals.

IHPA's decision

IHPA's approach to private patient neutrality will remain unchanged for NEP22.

Next steps and future work

IHPA will work with jurisdictions to refine this approach for NEP23, including improving the coverage, quality and timeliness of the Hospital Casemix Protocol data set.

⁴ Newborn qualification status. Available at: <https://meteor.aihw.gov.au/content/index.phtml/itemId/327254>

6.5.1. Phasing out the private patient correction factor

The collection of private patient medical expenses has previously been problematic in the National Hospital Cost Data Collection (NHCDC). For example, some states and territories use Special Purpose Funds to collect associated revenue (for example, the MBS) and reimburse medical practitioners.

The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the NHCDC. The implementation of the Australian Hospital Patient Costing Standards Version 4.0 should have addressed the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required.

The private patient correction factor was phased out for the Northern Territory for NEP21.

Next steps and future work

IHPA will continue to work with the remaining states and territories to phase out the private patient correction factor.



7

Data collection

7

Data collection

7.1. Overview

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

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

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

IHPA continues to advocate for the routine collection of the Individual Healthcare Identifier (IHI) to provide greater transparency of the patient journey and to support implementation of alternate funding models. The importance of the IHI when implementing innovative models of care and funding approaches is outlined in Chapter 10.

7.1.1. National Benchmarking Portal

In the [Pricing Framework for Australian Public Hospital Services 2021–22](#) IHPA noted its intention to make the National Benchmarking Portal (NBP) publicly available.

IHPA has undertaken additional consultation with jurisdictions and broader stakeholders to ensure that a publicly available NBP works to enhance policy decisions and improve patient outcomes, while offering appropriate privacy protections.

Next steps and future work

IHPA will work with jurisdictions to finalise patient privacy safeguards, resolve comparability issues and develop supplementary education materials, prior to the NBP becoming publicly available in 2022.



8

Treatment of other Commonwealth programs

8

Treatment of other Commonwealth programs

8.1. Overview

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

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

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

The following Commonwealth funded pharmaceutical programs will also be removed prior to determining the underlying cost data for the NEP Determination:

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

IHPA's decision

For the NEP Determination 2022–23, IHPA does not propose any changes to the treatment of other Commonwealth programs.

9

Setting the national efficient cost

Setting the national efficient cost

9.1. Overview

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

A low volume threshold is used to determine whether a public hospital is eligible to receive block funding. All admitted hospital activity is included in assessing the hospital against the low volume threshold.

IHPA uses public hospital expenditure as reported in the National Public Hospital Establishments Database to determine the NEC for block-funded hospitals. IHPA expects that continued improvements to the data collection will lead to greater accuracy in reflecting the services and activities undertaken by block-funded hospitals.

9.2. The ‘fixed-plus-variable’ model

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

In 2019, IHPA worked with its Small Rural Hospitals Working Group to develop a ‘fixed-plus-variable’ model where the total modelled cost of each hospital is based on a fixed component as well as a variable ABF style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.

The ‘fixed-plus-variable’ model was introduced for the NEC Determination 2020–21, addressing two key objectives. It removes the potential financial disincentive when shifting services from an ABF hospital to one that is block funded. It is also more responsive to activity level changes in block-funded hospitals.

IHPA’s decision

IHPA will continue to use the ‘fixed-plus-variable’ model for the NEC Determination 2022–23 (NEC22).

9.2.1. Standalone hospitals providing specialist mental health services

Standalone hospitals providing specialist mental health services (for example, psychiatric hospitals) are treated separately from the ‘fixed-plus-variable’ cost model. At present, the efficient cost of these hospitals is determined in consultation with the relevant state or territory with reference to their total in-scope reported expenditure.

With the implementation of the Australian Mental Health Care Classification Version 1.0 for pricing admitted mental health care from 1 July 2022, admitted prices will be established for the patients treated in these standalone hospitals. The Consultation Paper sought feedback on the feasibility of transitioning block-funded standalone hospitals providing specialist mental health services to ABF.

Next steps and future work

IHPA is working with jurisdictions to facilitate the transition of block-funded standalone hospitals providing specialist mental health services to ABF.

9.3. New high cost, highly specialised therapies

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

For 2022–23, the following high cost, highly specialised therapies have been recommended for delivery in public hospitals based on advice from the Commonwealth:

- Kymriah[®] – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah[®] or Yescarta[®] – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Qarziba[®] – for the treatment of high risk neuroblastoma
- Luxturna[™] – for the treatment of inherited retinal dystrophies
- Tecartus[®] – for the treatment of relapsed or refractory mantle cell lymphoma.

IHPA's decision

The indicative block-funded expenditure for the delivery of these high cost, highly specialised therapies based on the advice of states and territories will be included in NEC22.

Next steps and future work

IHPA will continue to work with jurisdictions to review and update its [Impact of New Health Technology Framework](#) to incorporate the Addendum clauses regarding the inclusion of new high cost, highly specialised therapies recommended for delivery in Australian public hospitals.

10

Future funding models

10.1. Overview

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

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

The Addendum to the National Health Reform Agreement 2020–25 (the Addendum) provides opportunities for states and territories to trial innovative models of care and outlines the Independent Hospital Pricing Authority’s (IHPA) role in supporting these reforms.

Under the Addendum, IHPA is required to develop a methodology to support the trialling of innovative models of care and provide the Council of Australian Governments Health Council (CHC)⁵ with advice on continuing proposed trials for a further period or translation into a permanent model of care.

Specifically, the Addendum outlines that innovative models of care and funding reform may be developed and trialled at the program level (including bundled payments, capitation payments, refinements to ABF and outcomes based payments) and at the system level (including blended funding models and pooling of payment streams across programs and providers).

⁵ The Council of Australian Governments has been dissolved. The Health Ministers’ Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to CHC, including matters relating to the national bodies.

10.2. Investigation of alternate funding models

While ABF works well for funding predictable one-off episodes of care, it may not incentivise the provision of health services that are delivered across multiple care settings.

For example, a reasonably predictable care pathway may be better suited to a single payment for a bundle of care than multiple episodic payments under current ABF arrangements.

Conversely, patients with complex and chronic health conditions who are frequent users of hospital services may benefit from receiving care under a capitation model. Reducing unnecessary hospitalisations can lead to better health outcomes, improved patient experiences and reduced costs.

Bundled payments: Bundled payments are made to health providers for a clinically defined episode or bundle of related health care services. Bundled payments may be appropriate for clear, well-defined care pathways spanning multiple care settings or over longer periods (for example, stroke or hip or knee replacement).

Capitation payments: Capitation payments are made to health providers or fund holders for the care of a patient over a defined period of time, where the provider is accountable for services consumed by the patient during that period. Capitation models work well for chronic conditions where the care pathway is not well defined and may extend over many years (for example, chronic kidney disease).

Guided by review of national and international literature and advice from clinical experts, IHPA has undertaken analysis to categorise patient cohorts that may be amenable to ABF, bundling or capitation payments. This analysis shows that around 30 per cent of the patients currently funded under ABF could potentially benefit from alternate funding approaches. This is outlined in **Table 1**.

Table 1. Potential distribution of funding between ABF and alternate funding options, following analysis of 2018–19 linked data

Funding type	Patients		Acute admissions		Other events (emergency and non-admitted)		National weighted activity units (across all streams)	
	n	%	n	%	n	%	n	%
ABF	2,018,109	70.3%	3,212,972	50.4%	11,387,292	51.6%	3,992,426	51.2%
Bundling	529,008	18.4%	1,265,531	19.9%	5,788,939	26.2%	1,644,980	21.1%
Capitation	322,148	11.2%	1,894,176	29.7%	4,880,189	22.1%	2,165,866	27.8%
Total	2,869,265	100%	6,372,679	100%	22,056,420	100%	7,803,272	100%

10.3. Next steps for alternate funding models

10.3.1. Critical success factors

Reform to pricing and funding models has the potential to alter the incentives in the public hospital system away from acute admitted activity towards community-focused, value based care and a focus on outcomes. However, to achieve this there are a number of critical success factors that need to be addressed.

Clinical engagement

The design of new classification and pricing systems will require advice and support from clinical experts, particularly in identifying risk adjustment parameters and ensuring that proposed groupings for alternate funding models are clinically meaningful.

Data linkage and ICT requirements

At present, data linkage is extremely limited between primary, secondary and hospital-based care.

Therefore, the success of introducing any alternate funding model relies on utilisation of the Individual Healthcare Identifier (IHI) in all national data sets. The IHI is a unique number used to identify an individual for health care purposes and would enable a patient to be tracked across the different classification system data sets more accurately. This will allow for the pathway of care to be classified and costs attributed accordingly.

IHPA commenced work on collecting the IHI in 2019 and, pending additional consultation with jurisdictions to address any privacy or information technology concerns, expects to make significant progress on implementing the IHI into national health data sets from 1 July 2022.

Change management

Successful implementation of alternate funding models will require a significant change in paradigm across the hospital system, where the initial focus on alternate funding models for hospital services can be broadened beyond the hospital setting. IHPA will work closely with all jurisdictions to ensure that changes are well communicated and that adequate time is given for changes in service provision and data reporting requirements to occur.

Determining the fund holder

Choosing the appropriate fund holder for any proposed alternate funding model is critical in the funding model's long term success. Potential fund holders for alternate funding models could be the health service provider (for instance, individual health care providers or health service facilities), the local hospital network or the state or territory, with careful consideration required for what works best for each different alternate funding model.

The capacity and capability to take on the risk of bundled and capitation payments will be an important consideration as jurisdictions consider who is best placed to be the fund holder in any potential new models.

Evaluation

Finally, there must be formal evaluations of alternate funding models to assess measurable outcomes for patients and support continued improvements in efficiency through substitution of the most appropriate service.

Specific funding models require tailored evaluation measures. IHPA will work with jurisdictions, its advisory committees, internal and external working groups, hospital managers, clinicians, patients and broader stakeholders to develop these evaluation measures.

10.3.2. Trialling innovative models of care

As provided by the Addendum, IHPA is to facilitate exploration and trial of new and innovative approaches to public hospital funding. Clause A99 of the Addendum stipulates that states and territories can seek to trial innovative models of care, either:

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

In response to the Consultation Paper, stakeholders outlined further recommendations for the investigation of innovative funding approaches. IHPA notes the preference for states and territories to nominate their own models of care or services for consideration under the innovative funding model clauses of the Addendum, rather than specific models of care or services determined by IHPA.

Jurisdictions provided state and territory led innovative models of care and services for consideration for trialling under the Addendum clauses for 2022–23 and future determinations. These included chronic care capitation models, bundled payment cohorts, the use of telehealth in other settings such as emergency departments, specialist access programs and mental health responder programs.

Next steps and future work

IHPA is in the process of developing project parameters and business rules to facilitate piloting state and territory nominated innovative models of care and services for 2022–23, pending jurisdiction capability and capacity, to inform translation into the national pricing model.

In consultation with its advisory committees and clinical experts, IHPA will work with interested jurisdictions to develop specific definitions and classification, counting, costing and pricing rules for the nominated innovative models of care and services, along with trial parameters and evaluation methodology.

11

Pricing and funding for safety and quality

Pricing and funding for safety and quality

11.1. Overview

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

Under the Addendum, IHPA is required to advise on an option or options for a comprehensive and risk adjusted model to determine how pricing and funding could be used to improve patient outcomes across three key areas: sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions.

The Addendum also contains provisions for evaluating the above reforms and provision of advice to the Council of Australian Governments Health Council (CHC)⁶ on options for the further development of safety and quality related reforms, including examining ways for reducing avoidable and preventable hospitalisations.

11.2. Sentinel events

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

From 1 July 2017, IHPA introduced a funding approach for sentinel events whereby an episode of care with a sentinel event will be assigned a national weighted activity unit (NWAU) of zero, applicable to all hospitals, whether funded on an activity or block funded basis.

This approach is reinforced by clause A165 of the Addendum, which stipulates that any episode of care with a sentinel event will not be funded by the Commonwealth.

⁶ The Council of Australian Governments has been dissolved. The Health Ministers' Meetings, comprised of all Australian health ministers, has been established as its replacement to consider matters previously brought to CHC, including matters relating to the national bodies.

IHPA's decision

For the NEP Determination 2022–23 (NEP22), IHPA will continue to assign zero NWAU to episodes with a sentinel event using Version 2.0 of the Australian Sentinel Events List, available on the [Commission's website](#).

11.3. Hospital acquired complications

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

The HACs funding approach was introduced from 1 July 2018 and reduces funding for any episode of admitted acute care where a HAC occurs. This approach incorporates a risk adjustment model and recognises that the presence of a HAC increases the complexity and cost of an episode of care. Further information on the HACs funding approach and risk adjustment model is available within the National Pricing Model Technical Specifications on the [IHPA website](#).

The Commission is responsible for the ongoing curation of the HACs list to ensure it remains clinically relevant. The Commission published Version 3.1 of the HACs list in March 2021.

IHPA's decision

For NEP22, IHPA will use Version 3.1 of the HACs list, available on the [Commission's website](#).

11.4. Avoidable hospital readmissions

An avoidable hospital readmission occurs when a patient who has been discharged from hospital (the index admission) is admitted again within a certain time interval (the readmission), and the readmission is clinically related to the index admission and has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

The avoidable hospital readmissions funding approach was introduced from 1 July 2021 and involves the application of a risk adjusted NWAU reduction to the index episode, based on the total NWAU of the readmission episode, to apply where there is a readmission to any hospital within the same jurisdiction.

IHPA developed a discrete risk adjustment model for each readmission condition, which assigns the risk of being readmitted for each episode of care. Further information on the avoidable hospital readmissions funding approach and risk adjustment model is available within the National Pricing Model Technical Specifications on the [IHPA website](#).

IHPA's decision

For NEP22, IHPA will continue to implement the avoidable hospital readmissions funding adjustment using Version 1.0 of the avoidable hospital readmissions list, available on the [Commission's website](#).

11.4.1. Commercial readmissions software

In March 2020, IHPA engaged 3M Health Information Systems to develop a readmissions software tool for the Australian data set, based on the 3M™ Potentially Preventable Readmissions software. The software tool aims to identify whether a readmission is clinically related to a prior admission, based on the patient's diagnosis and procedures in the index admission and the reason for readmission.

This project is ongoing and IHPA will work with jurisdictions and the Commission to investigate opportunities for refinements to the avoidable hospital readmissions funding approach and the current list of readmission conditions.

11.5. Evaluation of safety and quality reforms

Clauses A172 and A174 of the Addendum stipulate that IHPA will provide advice to CHC evaluating the implemented safety and quality reforms, to support the consideration of new or additional reforms. IHPA is required to work with jurisdictions, national bodies and other related stakeholders to establish a framework to evaluate safety and quality reforms against the following principles:

- reforms are evidence based and prioritise patient outcomes
- reforms are consistent with whole-of-system efforts to deliver improved patient health outcomes
- reforms are transparent and comparable
- reforms provide budget certainty.

In response to the Consultation Paper, stakeholders provided valuable feedback to support the development of evaluation measures. In particular, jurisdictions noted that evaluation measures should be meaningful, transparent, replicable, actionable and assessable at the clinician, health service and jurisdiction levels.

Stakeholders also provided considerations for undertaking the evaluation process, noting that the evaluation process should aim to understand if the reform has been effective, if refinements are required and whether the reform has caused any unintended consequences.

Next steps and future work

IHPA will continue to work with jurisdictions, the Commission and key stakeholders to finalise the approach for the evaluation of the implemented pricing and funding approaches for sentinel events, HACs and avoidable hospital readmissions.

11.6. Avoidable and preventable hospitalisations

Reducing avoidable and preventable hospital admissions can support better health outcomes, improve patient safety and lead to greater efficiency in the health system.

Under the Addendum, IHPA, the Commission and the Administrator of the National Health Funding Pool are required to provide advice to CHC on options for developing upon the existing safety and quality related reforms, including examining ways that avoidable and preventable hospitalisations can be reduced through changes to the Addendum.

A preliminary review of national and international literature has indicated that potentially preventable hospitalisations (PPHs) could be a primary focal area for reducing avoidable and preventable hospitalisations through changes in pricing and funding.

PPHs are hospital admissions for a condition where the admission could have potentially been prevented through the provision of appropriate individualised preventative health interventions and early disease management, delivered in primary and community care settings.

The Commission's [Fourth Australian Atlas of Healthcare Variation](#) (the Fourth Atlas) identifies that in 2017–18, more than 330,000 PPHs could be attributed to five condition groups: chronic obstructive pulmonary disease, heart failure, diabetes complications, kidney infections and urinary tract infections, and cellulitis.

Reducing PPHs for these patient cohorts would support better overall health outcomes and improve public hospital efficiency. Key recommendations highlighted by the Fourth Atlas include:

- integrated models of care encompassing community care, primary care and hospital care
- supporting better access to multidisciplinary teams and improved communication between hospital and community settings
- ensure access to community continence services and education to facilitate preventative care through patient-led management.

Stakeholders welcomed a whole-of-system approach to reducing avoidable and preventable hospitalisations and provided several considerations for evaluating potential pricing and funding approaches:

- reform should be reproducible and implementable by hospitals and not overly complex
- consider factors such as socio-demographics and access to primary health care, particularly in patients with chronic and complex conditions
- provide appropriate alignment of penalties and incentives with achieving the desired outcome.

Next steps and future work

IHPA will continue to work with the jurisdictions and the national bodies to investigate options for reducing avoidable and preventable hospitalisations.

As part of this work, IHPA and the national bodies have provided joint advice to health ministers on potential options, with a view to target recurring hospitalisations arising from patients with chronic and complex health needs and to consider integration of care across activity streams and settings.



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