12 June 2026

Via email: submissions.ihacpa@ihacpa.gov.au

Catholic Health Australia Submission: Consultation on the Pricing Framework for Australian Public Hospital Services 2027–28

Thank you for the opportunity to provide feedback on the Independent Health and Aged Care Pricing Authority's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2027–28.*

Catholic Health Australia is the nation's largest non-government provider of health, aged and community care services. Our members operate hospitals in every state and the Australian Capital Territory, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, alongside extensive community and residential aged care. As not-for-profit, mission-based providers, we have an enduring interest in a national pricing model that is efficient, equitable, clinically credible and financially sustainable.

This is the first pricing framework developed under the *Addendum to the National Health Reform Agreement 2026–31*, and CHA strongly supports its direction of better outcomes and value for patients, stronger shared stewardship, and a simpler, more equitable funding model. Our submission is offered in that constructive spirit. It focuses on getting the foundations right: embedding value carefully rather than prematurely, ensuring pricing stability mechanisms preserve rather than suppress legitimate cost growth, using the addendum's new power to project costs forward, and protecting equity for rural, remote, smaller and not-for-profit providers in any methodological change. We have also drawn particular attention to the need for pricing to support high-value, hospital-substitutive models of care such as Hospital in the Home, as well as leveraging IHACPA's unique cross-sectoral pricing mandate to address the hospital-aged care and disability interface.

We would welcome the opportunity to discuss this submission further. If you wish to discuss anything further, please contact Dr Katharine Bassett, Interim Chief Executive Officer on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia

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

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

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

Background

The Pricing Framework underpins how the Independent Health and Aged Care Pricing Authority (IHACPA) determines the national efficient price (NEP) and national efficient cost (NEC) that drive the Commonwealth's activity-based and block funding contributions to public hospitals. This year's paper is the first developed under the Addendum to the National Health Reform Agreement 2026–31, signed by all governments on 27 February 2026 and effective from 1 July 2026, which reframes national health funding around better outcomes and value for patients, stronger shared stewardship, and a simpler, more equitable funding model.

Overarching comments

This is the first pricing framework developed under the Addendum to the National Health Reform Agreement 2026–31 (the addendum), signed by all governments on 27 February 2026 and effective from 1 July 2026. The addendum reframes national health funding around three objectives: better outcomes, experiences and value for patients; stronger shared stewardship of the system; and a simpler, more equitable funding model. CHA strongly supports this direction. The proposals in this consultation, particularly the introduction of value as a pricing consideration and the renewed focus on pricing stability, are consequential, and we have framed our submission around getting the foundations right rather than moving prematurely.

Consistent with IHACPA's guidance that submissions need not address every question, we have concentrated on the matters where CHA's membership has the clearest expertise and interest. Our central messages are:

- Value should be embedded carefully, not hurriedly. The addendum's definition of value is an appropriate directional anchor, but it is broad and, on IHACPA's own assessment, not yet measurable in a nationally consistent way. For NEP27, value should continue to be expressed through existing, well-validated mechanisms such as efficiency, safety and quality, and care in the right setting, while the data and measurement infrastructure is built. Pricing must not be expected to deliver outcomes it cannot influence, nor be used to justify under-funding.
- Stability must not become suppression. CHA supports mitigating genuine statistical noise. But the boundary between 'noise' and a sustained, legitimate cost change is difficult to draw, and there is a real risk that necessary price growth, driven by documented workforce cost increases, regulatory compliance, and new models of care, is smoothed away. The criteria distinguishing the two should be transparent, rules-based and symmetric.
- Use the new power to project costs forward. The addendum permits IHACPA to consider reasonable and likely growth in cost inputs (clause A59(g)). This is the most direct remedy for the structural lag between when costs are incurred and when they are priced, and should be used to forward-index for known pressures such as the Fair Work Commission's 4.75% award increase effective 1 July 2026.
- Protect equity in any methodological change. Proposals such as sampling a subset of 'high quality' cost-data hospitals carry a selection-bias risk that would entrench metropolitan cost structures and disadvantage rural, remote, smaller and not-for-

profit-operated services. Equitable representation, including of not-for-profit providers, must be a design requirement.
- Transparency is the precondition for trust. CHA continues to advocate that the Pricing Guidelines define transparency to include the public's ability to compare how jurisdictions allocate Commonwealth funding, including the proportion spent on administration and overheads.
- Use the pricing model to see the care-economy interface. Between 8 and 10 per cent of public hospital bed days are now occupied by patients medically ready for discharge but unable to move to aged care, home care or disability supports. Funded and costed as acute care, these bed days distort the efficient price. As the pricing authority for hospitals, residential aged care and Support at Home, IHACPA is uniquely placed to make this interface visible and to support the transition and hospital-substitutive models that resolve it.

CHA makes 15 recommendations in response to IHACPA's consultation questions, set out below and developed against the relevant consultation questions. We would welcome the opportunity to work with IHACPA as this framework is finalised.

Summary of recommendations

Recommendation 1: Amend the 'Promoting value' guideline so it makes explicit that value to the patient and value to the system are complementary, that neither is subordinated to the other, and that pricing support for 'innovative and alternative funding solutions' is conditioned on demonstrable improvement in outcomes.

Recommendation 2: Endorse the revised 'Fostering clinical innovation' guideline, and strengthen the mechanism for timeliness so that pricing keeps pace with new technologies and new models of care whose costs are not yet visible in lagged cost-data collections.

Recommendation 3: Make three further updates to the Pricing Guidelines that support the consideration of value: (a) define 'Transparency' to include the public's ability to compare jurisdictional allocation of Commonwealth funding; (b) expand 'Maintaining agreed roles and responsibilities' to drive system efficiency and long-term sustainability; and (c) adopt 'equivalent care' in the 'Promoting harmonisation' guideline.

Recommendation 4: Explicitly recognise and support high-value, hospital-substitutive models of care including Hospital in the Home (HITH), virtual wards, and in-reach and out-reach services in the Pricing Guidelines and in IHACPA's costing and classification work; ensure the costing standards and the National Hospital Cost Data Collection accurately capture the distinctive cost drivers of home-based acute care so that pricing is modality-agnostic and does not disincentivise clinically appropriate care in the home; and consult providers with mature programs, including not-for-profit and private operators.

Recommendation 5: Support pricing of A16 Posthumous organ procurement in principle, and resolve the practical barriers of donor-hospital costing maturity, definition of the consented potential donor episode, cross-jurisdictional reconciliation and low-volume volatility through a shadow-pricing period and consultation with the Organ and Tissue Authority and donation and transplantation networks.

Recommendation 6: Adopt the addendum's definition of value as a directional anchor for the framework, while confirming that for NEP27 value will be reflected through existing

pricing mechanisms; pursue a phased approach that preserves the cost-based foundation of the model.

Recommendation 7: For pricing purposes specifically, complement the addendum definition with a narrower, tiered operational definition such as technical efficiency, safety and quality, and allocative efficiency now; validated outcome and experience measures as they mature, drawing on established value-based care frameworks.

Recommendation 8: Where value metrics or proxies are introduced, require that they are nationally consistent, risk-adjusted and attributable to hospital care; prioritise investment in patient-reported measures, care-continuity indicators and Individual Healthcare Identifier maturity.

Recommendation 9: In determining value for pricing, prioritise factors that are measurable, attributable, material and equity-preserving; maintain access and financial sustainability as primary considerations; and treat equity for First Nations peoples and rural and remote communities as a cross-cutting priority.

Recommendation 10: Confirm that IHACPA's explanation of unintended volatility is conceptually clear, and publish the transparent, rules-based criteria and thresholds that distinguish statistical noise from sustained cost change, so that legitimate price growth is not inadvertently suppressed.

Recommendation 11: Use the addendum's new power to project reasonable and likely growth in cost inputs (clause A59(g)) to forward-index for known and quantifiable cost pressures, including the Fair Work Commission's 4.75% award increase effective 1 July 2026, and apply any smoothing on a rules-based, symmetric and transparent basis.

Recommendation 12: Prioritise stability only where movements are demonstrably attributable to data noise, timing or completeness, are immaterial, or are one-off methodological artefacts; flow through movements that reflect sustained, structural changes in the cost of service delivery.

Recommendation 13: Before adopting any sampling of a subset of hospitals, address the selection-bias and representativeness risks, particularly against rural, remote, smaller and not-for-profit-operated services, publish transparent selection criteria, guarantee not-for-profit representation, and reconcile sampled outputs against the full National Hospital Cost Data Collection.

Recommendation 14: Explore more contemporaneous national data sources to mitigate unintended volatility, including Fair Work Commission decisions and enterprise agreements for forward indexation, ABS wage indices, Jobs and Skills Australia workforce data, care-economy interface datasets, and national data linkage, subject to clear data-quality safeguards.

Recommendation 15: Use IHACPA's unique cross-sectoral pricing mandate across public hospitals, residential aged care and Support at Home to address the hospital–aged care and disability interface: identify and separately analyse delayed-discharge and non-acute bed days so the efficient price is not distorted by care-economy interface failures; pursue data linkage across hospital, aged care and disability datasets; ensure pricing supports transition, restorative and hospital-substitutive models of care; and risk-adjust any length-of-stay, readmission or value measures so hospitals are not penalised for system gaps beyond their control.

Submission

Pricing Guidelines

CHA welcomes IHACPA's assessment that the existing Pricing Guidelines remain broadly fit for purpose and that the addendum does not displace their fundamental role of articulating pricing principles. CHA also welcomes IHACPA's judgement that the addendum's mechanisms for value-based and volatility-sensitive pricing are, at this stage, high-level and require significant cross-agency preparatory work. A measured, evidence-led approach to incorporating these concepts is the right one. Our comments below are directed at ensuring the targeted updates are well-calibrated and that the opportunity is taken to address a small number of longstanding matters.

Q1. Does the revised Pricing Guideline 'Promoting value' appropriately capture the intent of considering value to the patient and the system?

CHA supports introducing an explicit value principle and considers the proposed wording a reasonable starting point. We see two refinements that would sharpen its intent.

First, the proposed guideline groups 'patient-centred care and outcomes' with 'system-wide efficiency and quality' without acknowledging that these can be in tension. A treatment, model of care, or staffing configuration that maximises an individual patient's outcome is not always the lowest-cost option at a system level, and vice versa. The addendum is explicit that value is to be considered for patients and the system (clause A59(b)). The guideline should make clear that both dimensions are to be weighed as complementary objectives, with neither subordinated by default. This protects against the principle being read narrowly as a cost-containment device.

Second, the reference to 'innovative and alternative funding solutions' is welcome but open-ended. CHA recommends it be tied explicitly to evidence of improved outcomes or experience relative to cost, consistent with the addendum's own definition. Pricing innovation should be a means to demonstrable value, not an end in itself.

Overall, the promotion of value as a Pricing Guideline should be clearly and consistently embedded across all aspects of the pricing process. Given that the literature on pricing value-based approaches remains sparse, IHACPA is well positioned to contribute to this evidence base, and indeed has an important role to play in doing so. Genuine pricing innovation, rigorously developed and evaluated, would not only help demonstrate value in these contexts but would also strengthen the broader understanding of how value-based pricing can be operationalised, without entrenching value as merely a mechanism for cost containment.

Recommendation 1: Amend the 'Promoting value' guideline so it makes explicit that value to the patient and value to the system are complementary objectives, that neither is subordinated to the other by default, and that pricing support for innovative and alternative funding solutions is conditioned on demonstrable improvement in outcomes or experience relative to cost.

Q2. Does the revised Pricing Guideline 'Fostering clinical innovation' accurately reflect the need to consider value at a patient outcome level and for the health system overall?

CHA supports the revised guideline. The addition of language requiring innovation to 'improve outcomes and deliver value to both patients and the system' appropriately links innovation to the addendum's objective in promoting value and guards against funding novelty for its own sake.

Our caution concerns the words 'respond in a timely way'. The principal obstacle to timely pricing of innovation is structural: the national pricing model is built on lagged cost data, and genuinely new technologies and models of care such as cell and gene therapies, virtual and HITH models, and integrated multidisciplinary services typically carry high early costs and altered cost structures that are not yet visible in the costing collection. The addendum itself broadens the scope of public hospital services to include care delivered beyond the hospital door, including virtual, in-reach and out-reach models that replace or avoid admissions. The guideline's aspiration to timeliness should therefore be supported by a practical response mechanism, such as provisional or interim pricing, targeted data requests, or use of the new cost-projection power discussed at Q10, so that the principle is operable rather than aspirational.

Recommendation 2: Endorse the revised 'Fostering clinical innovation' guideline, and pair its commitment to timeliness with a concrete mechanism, such as provisional pricing, targeted data requests, or forward cost projection, so that pricing keeps pace with new technologies and new models of care whose costs are not yet captured in lagged cost-data collections.

Q3. Are there other updates required to the Pricing Guidelines to support IHACPA's consideration of value to patients and the system?

CHA considers that three further updates would strengthen the guidelines' support for value. Each reiterates a position CHA has put to IHACPA in previous submissions.

Define transparency to enable public comparison of funding allocation

The Commonwealth contributes significantly to public hospital funding under the National Health Reform Agreement, yet how those funds are translated into front-line services that are administered by states and territories is often unclear. Value at a system level cannot be evaluated without visibility of where funding is directed. CHA recommends the 'Transparency' guideline be clearly defined to include the public's ability to readily compare the performance of jurisdictions in keeping the proportion of the health budget spent on administration and overheads at reasonable levels, and to compare the funding provided to jurisdictions against the funding that reaches hospitals to provision services.

Tie government roles and responsibilities to efficiency and sustainability

CHA reiterates its proposal to expand the 'Maintaining agreed roles and responsibilities' guideline so that funding design is used not only to recognise the complementary responsibilities of each level of government, but also 'to drive required improvements in system efficiency and supporting measures to enable long-term financial sustainability of the Australian public hospital system'. This aligns directly with the addendum's second and third objectives: stronger shared stewardship and a simpler, more equitable funding model. This

would further enhance the sense of shared accountability in collectively achieving increased health care performance within the sector.

Adopt 'equivalent care' in the harmonisation guideline

CHA again recommends that the 'Promoting harmonisation' guideline refer to best-practice provision of 'equivalent care' across appropriate settings, sites and modalities, rather than 'appropriate site of care'. A modality-agnostic, outcomes-focused framing is squarely consistent with the new value principle: it aligns pricing with the value and effectiveness of care rather than the mode of its delivery, supports virtual and integrated models, and helps dismantle the barriers between care settings that fragment patient journeys.

Establishing equivalence in this way is more than a definitional refinement as it lays the conceptual foundation on which genuine value-based approaches to care can be built. By shifting the frame from where or how care is delivered to the outcomes it achieves, the guideline creates the conditions for value to be embedded meaningfully across the pricing process rather than applied superficially. Ensuring the guidelines are fit-for-purpose in giving effect to the new value principle is therefore paramount: it sets the tone for pricing innovation that genuinely supports the care economy in implementing value-based models, and, fundamentally, enables constructive discussion about what matters to the patient and how that understanding is reflected in the way care is designed and delivered.

Recommendation 3: Make three further updates to the Pricing Guidelines:

- Define 'Transparency' to include the public's ability to compare how state and territory governments allocate Commonwealth health funding, particularly the proportion spent on administration and overheads.
- Expand 'Maintaining agreed roles and responsibilities' so that funding design is used to drive system efficiency and support the long-term financial sustainability of the public hospital system.
- Revise 'Promoting harmonisation' to refer to best-practice provision of equivalent care across appropriate settings, sites and modalities.

Promoting high-value, hospital-substitutive models of care

The clearest practical test of whether the Pricing Guidelines genuinely support value and clinical innovation is how they treat hospital-substitutive models of care – including HITH, virtual wards, and in-reach and out-reach services – that deliver acute, admitted-level care in a patient's home rather than in a hospital bed. These models sit squarely within the addendum's broadening of public hospital services to encompass care delivered beyond the hospital door, including virtual, in-reach and out-reach services and other new models of care that replace or avoid hospital admissions. They are precisely the innovation the revised 'Fostering clinical innovation' and 'Promoting value' guidelines are intended to encourage, and CHA raises them here in response to Q2 and Q3.

The evidence base is mature and favourable. A meta-analysis of 61 randomised controlled trials found that HITH care, where it substitutes for in-hospital time, was associated with reduced mortality (odds ratio 0.81), reduced readmissions (odds ratio 0.75), lower costs, and higher patient and carer satisfaction; the number needed to treat at home to prevent one death was 50. On the central clinical measures, HITH reduced mortality and readmissions by

roughly one fifth. These are not marginal efficiency gains but are better outcomes at lower cost, which is the definition of value the addendum itself adopts.

This is not a theoretical model. Among CHA's members, St Vincent's has built one of the country's largest hospital-substitutive programs through St Vincent's Virtual & Home, delivering more than 180,000 in-home physical episodes and 250,000 digital episodes of care each year (the equivalent of around 200 virtual hospital beds) spanning acute care (HITH), sub-acute care (rehabilitation and palliative care at home) and virtual care. As St Vincent's has observed, continued reliance on 'bricks and mortar' bed capacity is not sustainable; substituting clinically appropriate care into the home expands capacity, meets patient preference, and relieves pressure on physical beds at a time of acute system strain.

HITH is, correctly, funded as admitted care: under the National Health Reform Agreement, HITH programs are admitted public hospital services and are priced through the Australian Refined Diagnosis Related Group classification. But pricing the same diagnosis related group identically regardless of setting carries two risks that bear directly on the value objective. First, the distinctive cost drivers of home-based acute care including clinical travel, remote-monitoring technology, virtual-ward staffing and coordination, multi-disciplinary allied health input extended-hours availability, and the standby 'readiness' cost of maintaining a virtual ward may be poorly captured by cost-allocation methods designed around ward-based delivery, leaving these models under-costed in the National Hospital Cost Data Collection. The costing standards should also allow flexibility for allied health services within a HITH episode to be delivered virtually where clinically appropriate, ensuring that costing and classification arrangements do not inadvertently assume face-to-face delivery for all disciplines.

Second, if pricing does not reflect the genuine cost of delivering care well in the home, the model can create a financial disincentive to substitute even where doing so is clinically appropriate and demonstrably higher value, which is the opposite of what the harmonisation and value principles intend. Nonetheless, the evidence on cost supports substitution. A matched costing study of 924 episodes across 31 Victorian public hospitals found that HITH delivered as a total episode substitution was 38 per cent cheaper than in-hospital care, while partial substitution was 9 per cent cheaper, after adjusting for clinical complexity. Whilst HITH is therefore expected to deliver care at lower overall cost than equivalent in-hospital episodes, this saving can only be realised sustainably if the actual cost of delivering care well in the home is accurately captured and properly priced

CHA therefore recommends that IHACPA make explicit, in both the Pricing Guidelines and its costing and classification work, that pricing should be modality-agnostic and should actively support clinically appropriate, hospital-substitutive care. This is the natural application of CHA's recommendation that 'Promoting harmonisation' refer to equivalent care across settings, sites and modalities (Recommendation 3), and it should be progressed in consultation with providers operating mature programs, including not-for-profit and private operators, whose data and operational experience are essential to costing these models accurately.

The classification and costing framework should also be condition-agnostic, supporting HITH across all clinically appropriate DRGs rather than a predetermined subset of conditions. Restricting HITH costing or pricing to particular DRGs would constrain clinical decision-making about which patients are suitable for home-based care, and would limit the ability of the pricing model to capture the full scope of HITH as the model matures and the evidence

base expands; eligibility should rest on clinical assessment and the judgement of the treating clinician, not on the classification system.

CHA also encourages IHACPA to explore the feasibility of collecting HITH-specific cost data as a distinct sub-category within the National Hospital Cost Data Collection, rather than relying on DRG-level averages that blend home-based and ward-based episodes. Costing the two modalities separately would give a clearer view of how the cost structures of home-based care differ from in-hospital delivery. This would support more accurate pricing of both, whilst also allowing for IHACPA to determine whether observed cost movements within a DRG reflect genuine changes in the cost of care or simply a shift in the proportion of episodes delivered at home.

Recommendation 4: Explicitly recognise and support high-value, hospital-substitutive models of care including HITH, virtual wards, and in-reach and out-reach services within the Pricing Guidelines and in IHACPA's costing and classification work. Ensure that the Australian Hospital Patient Costing Standards and the National Hospital Cost Data Collection accurately capture the distinctive cost drivers of home-based acute care (clinical travel, remote-monitoring technology, virtual-ward staffing and coordination, allied health input including virtual delivery, extended-hours availability, and standby capacity), so that pricing is both condition- and modality-agnostic and does not create a financial disincentive to deliver clinically appropriate care in the home; and consult providers with mature programs, including not-for-profit and private operators, when refining the classification and costing of care delivered beyond the hospital door.

Classifications used to describe and price public hospital services

Q4. What, if any, barriers are there to pricing A16 Posthumous organ procurement for NEP27?

CHA strongly supports the intent behind the new A16 Posthumous organ procurement Adjacent Diagnosis Related Group and Recommendation 2 of IHACPA's Organ and Tissue Donation and Transplantation Project. Allocating donation costs to the consented potential donor episode at the donor hospital, rather than reallocating them to transplant episodes, better reflects where costs are incurred, improves transparency, and supports the sustainability of donation activity in hospitals that are not transplant centres. Several CHA member hospitals contribute to the donation and transplantation pathway, and we want to see it well integrated and fairly funded.

CHA identifies the following matters as potential barriers to clean implementation for NEP27, each of which is resolvable:

- Donor-hospital costing maturity: Costs associated with donor management, retrieval and theatre time have historically been embedded in, or reallocated from, other episodes. Donor hospitals may not yet cost these activities discretely or consistently, which could produce unstable or unrepresentative price weights in the first cycle.
- Defining the consented potential donor episode: Clear, nationally consistent rules are needed for how the episode is identified and coded, including the treatment of cases where consent is given but donation does not ultimately proceed, and the boundary between end-of-life care and donor management.

- Cross-jurisdictional and inter-hospital flows: Donor and recipient are frequently in different local hospital networks or jurisdictions. Funding redistribution to donor hospitals through the A16 ADRG will require reconciliation arrangements that work across these boundaries.
- Low-volume volatility: Posthumous organ procurement is, by nature, low-volume and high-cost. Price weights derived from small samples are prone to the very year-on-year volatility addressed elsewhere in this consultation; multi-year data pooling will likely be required.

CHA recommends these matters be worked through with the Organ and Tissue Authority and the national donation and transplantation networks, and that A16 be shadow-priced for a period to allow costing practices to mature before any funding consequence attaches.

Recommendation 5: Support pricing of A16 Posthumous organ procurement in principle, and resolve the practical barriers including donor-hospital costing maturity, definition of the consented potential donor episode, cross-jurisdictional reconciliation, and low-volume volatility through a shadow-pricing period, multi-year data pooling, and consultation with the Organ and Tissue Authority and donation and transplantation networks.

National pricing model

Defining and measuring value

The requirement to consider value is the most significant new policy direction in this framework. CHA's mission of person-centred care, with a particular commitment to the disadvantaged makes us natural supporters of a value orientation. Precisely because we support it, we want it built on foundations that are sustainable.

Q5. To what extent is the addendum's definition of value suitable and appropriate for IHACPA to apply when considering national pricing?

The addendum defines value as 'maximising patient experience and outcomes, improving population health and high quality, evidence based clinical care, relative to the cost of delivery'. As a statement of system-wide intent this is sound and aligns with the international consensus that value is defined by the health outcomes that matter to patients relative to the cost of achieving them. CHA supports adopting it as the framework's directional anchor.

Its suitability as an operational pricing instrument for NEP27 is, however, limited, which is a limitation IHACPA itself fairly acknowledges. The definition spans patient experience, individual outcomes and population health, several elements of which cannot currently be measured in a nationally consistent way, cannot be attributed to a single hospital episode, or depend on policy levers well outside IHACPA's pricing remit. 'Improving population health', in particular, is shaped by primary care, prevention and the social determinants of health far more than by the pricing of an admitted episode. Holding hospital pricing accountable for outcomes it cannot influence would be neither fair nor effective.

CHA therefore agrees with IHACPA's judgement that, for NEP27, value should be reflected through existing, well-validated pricing mechanisms including efficiency, safety and quality adjustments, and the right-setting/harmonisation principle, while the data and measurement infrastructure to support a fuller application of value based approaches is built. Moving faster than the evidence base would risk introducing subjectivity into a model whose credibility

rests on its objectivity, and could destabilise the cost-based foundation that protects access and sustainability.

Recommendation 6: Adopt the addendum's definition of value as the framework's directional anchor, while confirming that for NEP27 value will be reflected through existing pricing mechanisms. Pursue a deliberately phased approach that preserves the cost-based foundation of the national pricing model and does not hold hospital pricing accountable for outcomes outside its influence.

Q6. Are there alternative or refined definitions of value that IHACPA should consider that are directly applicable for pricing purposes, noting current data and methodological constraints?

Rather than replacing the addendum definition, CHA recommends complementing it with a narrower operational definition for pricing that is directly measurable and attributable today, and that can expand as measurement matures. A tiered articulation would serve IHACPA well:

- **Near term – efficiency and safety value.** Technical efficiency (the efficient cost of a safe, high-quality output), the avoidance of preventable harm (sentinel events, hospital acquired complications, avoidable readmissions), and allocative efficiency (care delivered in the most appropriate setting). All are already embedded in the model and require no new measurement infrastructure.
- **Medium term – outcome and experience value.** Validated, risk-adjusted patient-reported outcome and experience measures, introduced condition-by-condition as nationally consistent collection becomes feasible.

This tiered approach is consistent with established value-based health care frameworks, which define value at the level of outcomes that matter to patients over a full cycle of care, and with international measurement efforts that standardise outcome sets for defined conditions.[1] For pricing, any operational definition should satisfy four tests: the measure must be nationally consistent, attributable to hospital care, material to funding, and capable of risk adjustment so that complex and disadvantaged cohorts are not penalised.

Recommendation 7: Complement the addendum definition with a narrower, tiered operational definition of value for pricing purposes such as technical efficiency, avoidance of preventable harm, and allocative efficiency in the near term; validated, risk-adjusted outcome and experience measures as they mature, drawing on established value-based care and outcome-measurement frameworks.

Q7. What metrics (or proxies) could be considered within a national pricing context to support consideration of value beyond the cost of its delivery?

CHA suggests IHACPA draw on a layered set of metrics, prioritising those that already have national definitions and progressively adding those that require investment to mature:

- Safety and quality (available now): sentinel events, hospital acquired complications and avoidable hospital readmissions, already in the model and the natural near-term

[1] International Consortium for Health Outcomes Measurement (ICHOM) standard sets; OECD Patient-Reported Indicator Surveys (PaRIS) initiative.

expression of value. Over the longer term, as these datasets and indicators mature, they could serve as outcome measures in their own right—capturing the downstream value of upstream behaviours such as improved medication adherence, and signalling avoided hospital-utilisation costs. Collectively, they would evidence the value realised by the system as models of care evolve.

- Care continuity (near term): timeliness and completeness of discharge summaries which is expressly within scope of the addendum's safety and quality review (clause D52(e)) as a proxy for integrated, value-generating care across the hospital boundary.
- Equity-sensitive outcomes (near term, with care): risk-adjusted readmission and discharge against medical advice (DAMA) rates, stratified by Indigenous status and other equity dimensions, as proxies for culturally safe and effective care, provided they are used to direct support rather than to penalise providers serving disadvantaged populations.
- Patient-reported measures (medium term): patient-reported outcome and experience measures (PROMs and PREMs), introduced as nationally consistent collection becomes feasible and aligned with the performance framework being developed under the addendum. In the long term, this may extend to the inclusion of the Australian Hospital Patient Experience Question Set (AHPEQS) as a national survey dataset.

Two enablers are essential. First, every value proxy must be risk-adjusted; unadjusted measures will systematically disadvantage tertiary, rural, remote and complex-cohort providers. Second, journey-level measurement depends on the maturity of Individual Healthcare Identifier reporting and national data linkage, which IHACPA rightly identifies as a current constraint and which should be a priority for investment, coordinated with the AIHW performance framework.

Recommendation 8: Where value metrics or proxies are introduced, build outward from measures that already have national definitions (safety and quality, care continuity), require that all proxies are risk-adjusted and attributable to hospital care, and prioritise investment in patient-reported measures, Individual Healthcare Identifier maturity and national data linkage to enable journey-level measurement over time.

Q8. Given all the factors IHACPA is required to consider when setting the NEP, alongside the addendum definition of value, are there particular factors that IHACPA should prioritise when determining value for pricing purposes?

CHA recommends IHACPA prioritise the factors that it can most credibly and fairly act upon through pricing. Four tests should govern prioritisation: a factor should be measurable in a nationally consistent way, attributable to hospital care, material to funding outcomes, and capable of being handled without eroding equity.

Applying those tests, the immediate priorities are the avoidance of preventable harm (the most actionable lever available today) and allocative efficiency, ensuring care is delivered in the most appropriate setting, which the harmonisation principle already supports. CHA cautions against prioritising elements of value that pricing cannot meaningfully influence, such as population health, which are better pursued through other policy levers.

Critically, the introduction of value must not displace the considerations that the addendum lists alongside it including reasonable access, clinical safety and quality, and the financial sustainability of the public hospital system. Value should be additive to these, not a route to under-funding. And consistent with the addendum's third objective and its Closing the Gap commitments, equity for First Nations peoples and for rural and remote communities should be treated as a cross-cutting priority that conditions every value judgement, not as a separate adjustment to be traded away.

Recommendation 9: In determining value for pricing, prioritise factors that are measurable, attributable, material and equity-preserving, principally the avoidance of preventable harm and allocative efficiency, while maintaining reasonable access and financial sustainability as primary considerations and treating equity for First Nations peoples and rural and remote communities as a cross-cutting priority.

Maintaining pricing stability and mitigating unintended volatility

CHA supports the objective of a stable, predictable national price and recognises that genuine statistical noise in a system as large and complex as Australia's public hospitals can distort year-to-year outcomes. Our submission on this chapter is animated by a single concern: that mechanisms designed to filter out noise must not, in practice, filter out the signal of real and sustained cost growth. With the move away from back-casting and a growth-based funding model toward the glide-path arrangements under the addendum, that distinction matters more than ever.

Q9. To what extent is IHACPA's definition and explanation of unintended volatility clear and appropriate?

CHA considers IHACPA's explanation conceptually clear and appropriate. The distinction between movements arising from statistical variation, data timing, data quality or completeness, and methodological discontinuities on the one hand, and genuine changes in the cost of service delivery on the other, is the right one in principle.

The difficulty is entirely in the application. The boundary between 'noise' and a 'sustained change' is a matter of judgement, and from a provider's perspective the risk is asymmetric: a legitimate, sustained increase in costs that is mistaken for noise, and therefore smoothed away, directly and durably under-funds care. The national pricing model already lags real costs because of the time between service delivery, data submission and price setting; additional smoothing applied on top of that lag could widen the gap between priced and actual costs. CHA therefore recommends IHACPA publish the criteria and, where possible, the quantitative thresholds it will use to classify a movement as unintended volatility, so the test is transparent and contestable rather than discretionary.

Recommendation 10: Confirm that IHACPA's explanation of unintended volatility is conceptually clear, and publish the transparent, rules-based criteria and quantitative thresholds that distinguish statistical noise from sustained cost change, so that legitimate price growth is not inadvertently suppressed and the classification is contestable rather than discretionary.

Q10. What other factors or mechanisms should be considered to promote pricing stability?

CHA endorses the measures IHACPA already applies (multi-year averaging, indexation over five years of data, and year-on-year stability of weights and parameters) as sensible buffers against noise. The single most valuable addition available to IHACPA is the addendum's new power to consider reasonable and likely growth in cost inputs and to project the NEP into the future (clause A59(g)).

This forward-looking capability is the natural remedy for the structural data lag. Where a cost increase is known and quantifiable, it should be indexed in prospectively rather than waiting for it to appear in cost data two or more years later. The clearest current example is workforce cost growth. The Fair Work Commission's 2025–26 decision increased modern award minimum wages by 4.75% and the National Minimum Wage by 6%, effective from the first full pay period on or after 1 July 2026, up from the 3.5% increase a year earlier. These increases flow through to superannuation, leave and payroll tax, and are highly material for a labour-intensive sector. Forward indexation for such known pressures would improve both stability and accuracy, and would reduce the temptation to treat genuine cost growth as volatility to be smoothed.

A further mechanism would be to cost HITH episodes as a distinct sub-category within the National Hospital Cost Data Collection, as discussed in Q3. As hospital-substitutive models of care grow, an increasing share of cost movement within a DRG will reflect changes in the proportion of episodes delivered at home rather than changes in the cost of delivering care itself. Costing these episodes distinctly would allow IHACPA to identify whether a price movement is driven by a change in the mix of settings or a change in underlying costs, and to treat it accordingly. More broadly, CHA recommends that any stabilisation mechanism be rules-based, published in advance, and symmetric, smoothing both increases and decreases, so that stability is a genuinely neutral tool rather than a one-directional dampener on price growth.

Recommendation 11: Use the addendum's power to project reasonable and likely growth in cost inputs (clause A59(g)) to forward-index for known and quantifiable cost pressures, including the Fair Work Commission's 4.75% award increase effective 1 July 2026, and apply any smoothing mechanism on a rules-based, symmetric and publicly transparent basis.

Q11. In stakeholders' views, under what circumstances should IHACPA prioritise stability in national pricing outcomes over full and immediate flow-through of observed cost changes?

CHA's position is that the answer turns on the source of the movement, not its size alone.

Stability should be prioritised where a movement is demonstrably attributable to data noise, timing or completeness; where it is immaterial to funding distribution; or where it is a one-off artefact of a methodological or classification change (precisely the circumstance back-casting previously addressed). Smoothing in these cases improves predictability without distorting the cost signal.

Conversely, IHACPA should flow through movements that reflect sustained, structural changes in the cost of delivering care including award and enterprise-agreement wage growth, regulatory and compliance cost increases, sustained input-price inflation, and the cost of new models of care that are becoming standard practice. Suppressing these in the name of stability would entrench under-funding and, over successive cycles, erode the very

sustainability the addendum seeks to protect. Where flow-through of a large but legitimate change would itself create disruptive volatility, the appropriate response is a transparent, time-limited transition path to the new price, not permanent suppression of the movement.

Recommendation 12: Prioritise stability only where movements are demonstrably attributable to data noise, timing or completeness, are immaterial, or are one-off methodological artefacts. Flow through movements that reflect sustained, structural cost changes, using a transparent, time-limited transition path where a large but legitimate change would otherwise create disruptive volatility.

Q12. What barriers, if any, are there to sampling a subset of hospitals with high quality cost data, as a potential option to mitigate unintended volatility?

CHA understands the appeal of sampling a subset of hospitals with high-quality cost data to obtain more contemporaneous cost signals. We urge caution, because the principal barrier is one of representativeness with direct equity consequences.

Hospitals with the most mature, highest-quality costing systems tend to be larger metropolitan and tertiary services. A sample skewed toward them risks embedding metropolitan cost structures and case-mix into national prices, systematically under-representing rural, remote, smaller and specialised providers, which are the very services for which CHA has consistently argued the current model already under-recognises legitimate, unavoidable costs. A sampling approach designed for stability could, if poorly constructed, worsen equity.

CHA identifies the following as the key barriers to be resolved before any sampling approach is adopted:

- Selection bias and representativeness, particularly the under-representation of rural, remote, smaller and specialised services, and of the structural cost drivers specific to them.
- Not-for-profit and non-government representation. CHA members operate public hospital services on a not-for-profit basis with distinct cost and governance structures; any sample must be constructed to represent them, not only state-operated facilities.
- Transparency of selection. The criteria for inclusion, and the basis for judging cost data ‘high quality’, must be published and consulted on under IHACPA’s National Pricing Model Consultation Policy.
- Reconciliation and reporting burden. Sampled outputs must be reconciled against the full National Hospital Cost Data Collection to detect divergence, and the additional reporting expectations on sampled hospitals must be proportionate.

Recommendation 13: Before adopting any sampling of a subset of hospitals, address the selection-bias and representativeness risks, particularly the under-representation of rural, remote, smaller, specialised and not-for-profit-operated services, publish transparent selection criteria, guarantee not-for-profit representation, and reconcile sampled outputs against the full National Hospital Cost Data Collection.

Q13. What more current national data sources could be explored to support efforts to mitigate unintended volatility?

To complement, rather than replace, the authoritative but lagged cost-data collection, CHA suggests IHACPA explore more contemporaneous sources, principally to inform forward indexation and to corroborate observed movements:

- Wage-setting sources for forward indexation: Fair Work Commission Annual Wage Review decisions and the enterprise-agreement landscape, which provide near-real-time, quantifiable signals of the largest single cost driver in the sector.
- Official economic indices: Australian Bureau of Statistics wage price and producer price indices, including health-relevant components, as timely corroboration of input-cost trends.
- Workforce and skills data: Jobs and Skills Australia analyses, to ground assumptions about workforce availability, reliance on agency and locum staffing, and associated cost premiums.
- Care-economy interface data: aged care, mental health and primary care datasets that illuminate the cost of system gaps absorbed by hospitals, such as extended stays and 'bed block', which distort activity and cost in ways national benchmarks do not capture.
- National data linkage: alignment of public hospital cost and funding data with other nationally collected datasets, building toward the journey-level view the addendum's performance framework anticipates.

Each of these sources is more timely but less standardised than the National Hospital Cost Data Collection. CHA recommends they be used as corroborating and forward-indexing inputs under clear data-quality safeguards, not as substitutes for the validated cost collection that anchors the model.

Recommendation 14: Explore more contemporaneous national data sources to mitigate unintended volatility, including Fair Work Commission decisions and enterprise agreements for forward indexation, ABS wage and price indices, Jobs and Skills Australia workforce data, care-economy interface datasets, and national data linkage, using them as corroborating and forward-indexing inputs under clear data-quality safeguards rather than as substitutes for the National Hospital Cost Data Collection.

Cross-cutting issue: the interface between hospitals, aged care and disability services

A growing share of public hospital activity is shaped not by acute clinical need but by what happens at the boundary between hospitals, aged care and disability services. CHA raises this as a cross-cutting matter because it bears directly on three threads in this consultation; the accuracy and stability of the cost data that underpins the NEP (Q9–Q13), the measurement of value and care continuity (Q7–Q8), and the addendum's objective of stronger system stewardship and more integrated care, and because IHACPA is uniquely placed to act on it.

Delayed discharge has become a structural feature of the system. A 2025 analysis by health economist Stephen Duckett found that between 8 and 10 per cent of all public hospital bed days are occupied by patients who are medically ready for discharge but cannot move to aged care or other settings, and concluded that these protracted stays are significantly impairing public hospital productivity. Separate analysis by FTI Consulting found that Australians aged 65 and over account for 44 per cent of hospitalisations and 52 per cent of patient days, and that patients approved for residential aged care spend on average an

additional 13 days in hospital awaiting a place, with home care package waits stretching well beyond 200 days. State health ministers have reported some 2,500 older people occupying hospital beds while awaiting aged care placement, which is the equivalent of around 21 full residential aged care homes. A comparable dynamic affects younger people with disability who remain in hospital while National Disability Insurance Scheme supports and accommodation are arranged.

This matters for national pricing in a specific way. These long-stay, ready-for-discharge bed days are funded and costed as admitted acute care and flow into the National Hospital Cost Data Collection, yet the care delivered during them is not acute. The result is a systematic distortion: the measured cost of acute episodes, and therefore the price weights and the efficient price, is inflated by days that reflect a failure at the care-economy interface rather than the efficient cost of delivering acute care. This is not statistical noise of the kind discussed at Q9; it is a sustained, structural distortion that the cost-based model will continue to absorb unless it is identified and treated explicitly. It also means hospitals serving communities with poor access to aged care, home care or disability supports carry costs that are largely outside their control.

IHACPA is unusually well placed to respond, because it is the pricing authority not only for public hospitals but also for residential aged care and the Support at Home program. That cross-sectoral mandate gives it a view across the interface that no other body holds. CHA encourages IHACPA to use it: to identify and separately analyse delayed-discharge and non-acute bed days so that the efficient price reflects efficient acute care; to align and link cost and activity data across the hospital, aged care and disability datasets, consistent with the data directions raised at Q13; and to ensure that pricing supports, rather than impedes, the transition, restorative and hospital-substitutive models – transition care, reablement, 'step-down' care and Geriatric Evaluation and Management in the home – that move people through the interface. This is squarely aligned with the addendum's integration objective and with the $1.8 billion Service Model Reform Fund established to test models that take pressure off public hospitals.

Finally, where IHACPA applies measures that touch on length of stay, avoidable readmissions or value, these should be risk-adjusted so that hospitals are not penalised for the consequences of system-interface failures they cannot control, consistent with CHA's position that the risk adjustment for avoidable hospital readmissions should account for the social determinants of health and access to community supports.

Recommendation 15: Use IHACPA's unique cross-sectoral pricing mandate, across public hospitals, residential aged care and Support at Home, to address the interface between hospitals, aged care and disability services. Specifically: identify and separately analyse delayed-discharge and non-acute ('ready-for-discharge') bed days so that the national efficient price reflects the efficient cost of acute care rather than being distorted by care-economy interface failures; pursue data linkage across hospital, aged care and disability datasets; ensure pricing supports transition, restorative and hospital-substitutive models of care, consistent with the addendum's integration objective and the Service Model Reform Fund; and ensure any length-of-stay, readmission or value measures are risk-adjusted so that hospitals are not penalised for system gaps beyond their control.