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RACP submission
Pricing Framework for Australian Public Hospital Services 2027-28

June 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,300 physicians and 9,200 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Summary – RACP position

The RACP welcomes the opportunity to provide feedback on the Independent Health and Aged Care Pricing Authority's (IHACPA) proposed Pricing Framework for Australian Public Hospital Services 2027–28 (the pricing framework)

We offer the following key recommendations to guide the design and implementation of the pricing framework:

1. Refine the definition of 'value' to include patient outcomes, patient experience, quality, safety, equity, continuity of care and appropriate recognition of patient complexity alongside activity and cost in the pricing framework and all related pricing guidelines.

2. Develop national pricing approaches to recognise outcomes that reflect value, including care coordination, continuity of care, multidisciplinary management, reduced avoidable hospitalisations, and long-term patient outcomes.

3. More explicitly incorporate equity considerations into value-based pricing, recognising the additional resources that may be required to achieve equitable outcomes for Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, people with disability, those experiencing psychosocial complexity, rural and remote communities, paediatric patients and their families, and other groups facing barriers to care.

4. Refine the pricing framework and pricing guidelines to better account for disability, psychosocial complexity, discharge complexity, community reintegration needs, and other factors that increase the resources required to achieve value-based outcomes.

5. Build on the recently introduced IHACPA Data Quality Framework through the collection and integration of aggregated patient-reported outcome data (PROMs), patient-reported experience data (PREMs), and broader measures of health, function and quality of life to support meaningful assessment of value.

6. Ensure pricing arrangements appropriately reflect the work required for care coordination, discharge planning, culturally safe care, engagement with carers and families, flexible service models, virtual care models, multidisciplinary collaboration, community-based care, teaching and training, and integration between hospital and community services.

These recommendations both reinforce and build upon our prior feedback to IHACPA for previous pricing frameworks. We build the case for these recommendations in our answers below, noting we specifically address consultation questions for this round of primary interest to RACP contributing members, and aligned with the key strategic aims of the College.

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

The guideline appropriately emphasises value, outcomes and clinical innovation, building on the direction of prior pricing frameworks, and we strongly support measurement of value using a broader range of indicators than activity for fee-for-service hospital services and cost.

The RACP Model of Chronic Care Management, designed for the clinical care of complex patient groups at risk of clinical deterioration and frequent readmission to hospital, offers key insights into components that are core to a contemporary definition of value in health care; namely, measuring multidisciplinary coordination and integration, continuity of care, reduced avoidable hospitalisations and duplication of services. Value is generated through delivering the right care at the right time and in the right setting, with a focus on long-term health benefits and system sustainability.

We believe the pricing system should prioritise these measurable outcomes and that the guideline synergises with the core principles of our model. Discharge planning, care coordination, multidisciplinary case management, clinical assessment, complex clinical decision-making, non-

procedural activities and interactions between hospital, primary care and community services all require physician expertise and contribute to value as defined above and are concrete instances for reference.

The guideline could place a stronger focus on equity within how value is measured in relation to groups with relative social inequities. While equity is mentioned in the current guideline, it would benefit from further elaboration. Patients do not start from the same position, and achieving good outcomes may require additional support for people who experience significant barriers to accessing care or have more complex health needs. This includes Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, people with disability, people with psychosocial complexities, children and their families, people living in rural and remote communities, and other patient groups living with chronic disease, multimorbidity or frailty.

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 and are there other updates required to support IHACPA's consideration of value?

The revised guideline appropriately acknowledges that innovation should be assessed according to the value it delivers for patients and the health system overall, and we appreciate this acknowledgement within it as a guiding principle for individual patient level care and overall health system design.

One area for improvement would be to unpack the concept of clinical innovation further, including innovative approaches to culturally safe care and service delivery. Feedback from members of the RACP Aboriginal and Torres Strait Islander Health Committee (ATSIHC) urged IHACPA to consider the importance of recognising the contribution, interactions and activities of Aboriginal and Torres Strait Islander health workers, liaison officers and other Indigenous healthcare workers in delivering culturally safe and trauma informed support for patients and families throughout admission and discharge, communication and follow-up with community-based services. These members emphasised the importance that the guideline recognise the factors that support high quality clinical innovation, positive experiences of care for Aboriginal and Torres Strait Islander peoples, and care continuity for best outcomes. Culturally safe care requires a whole-of-hospital commitment to address barriers to accessing care and the pricing guideline should reflect this.

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

The NHRA Addendum 2026–31 defines value in a broadly suitable manner for IHACPA pricing purposes. The Addendum appropriately expands the concept of value to align with contemporary approaches to high-quality, patient-centred healthcare and provides a stronger foundation for pricing arrangements that support better health outcomes.

However, patient complexity is not explicitly recognised in the current pricing framework and is not a prominent feature of the addendum's definition of value. IHACPA should therefore continue to consider, through the operational implementation of the pricing framework, where current pricing arrangements may underestimate the resources required to achieve value for patients with the highest and most complex needs. We elaborate on this more below.

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?

While the recent introduction of frailty for AN-SNAP 5.0 is a positive step towards better recognition of some forms of patient complexity for the purpose of determining value for older priority populations, we continue to call attention to our previous recommendations for the 2025-26 pricing framework in which we urged IHACPA to additionally centre disability, psychosocial complexity, discharge complexity and community reintegration complexity in setting value thresholds.

Over and above age-related frailty, for patients living with a disability, psychosocial or other complexities, factors such as social isolation, limited family support and housing insecurity can significantly affect health outcomes, discharge planning and risk of avoidable hospital readmission. It is therefore crucial that the definition of value adopted for this and future pricing frameworks account for the additional communication supports, interdisciplinary activities, specialised equipment, engagement

with carers, care coordination and coordination with community services needed to achieve desirable outcomes.

Member feedback emphasised that for patients with a disability or psychosocial complexities, value is generated through family meetings, engagement with carers and communication across care teams, all of which often require significant clinician time and coordination but may not be adequately recognised within current funding arrangements.

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

We acknowledge IHACPA's investment in the development of a Data Quality Framework and national data set as crucial steps towards improving the consistency, completeness, usability, and reliability of hospital pricing data.

To ensure value is not measured solely by activity and cost, the further development of the recently introduced Data Quality Framework should support the broader use of aggregated patient-reported outcome measure data (PROMs), patient-reported experience measure (PREMs) data and other measures of health, function and quality of life alongside information on hospital resources and service costs.

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?

Our previous RACP submission to the Pricing Framework for Australian Public Hospital Services 2025-2026 has highlighted the need for pricing arrangements to better recognise factors that can influence access to care, resource use and health outcomes, including culturally safe care, disability-related complexity, psychosocial complexity and service delivery in rural and remote communities. While IHACPA has undertaken important work in these areas, there is further space for these factors to be appropriately reflected within national pricing arrangements.

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?

Some members raised concerns about data quality if costing data is collected from only a small subset of hospitals. Any sample of hospitals must adequately reflect the diversity of Australia's health system, including different hospital types, patient group profiles admitted, geographical areas, jurisdictions, and workforce mixes. Robust quality assurance processes are essential to ensure pricing accurately reflects the true costs of delivering care across the hospital system.

Other comments:

Indigenous adjustment

We support further refinement of Indigenous funding adjustments to better reflect the factors that affect access to care and health outcomes for Aboriginal and Torres Strait Islander peoples. These factors include remoteness and the need for outreach services, higher rates of chronic disease and disability, and the impacts of social disadvantage.

Member feedback highlighted that the Indigenous adjustment would benefit from expansion to include culturally appropriate rehabilitation-in-the-home and outreach models for Aboriginal and Torres Strait Islander people, noting gaps in availability may contribute to poorer engagement with rehabilitation and reduced continuity of care following hospitalisation.

Rural and remote access

As IHACPA is aware, delivering healthcare in rural and remote communities is associated with higher costs, workforce shortages, and services often delivered by smaller teams tasked with additional responsibilities, including care coordination, patient education and service integration, while also facing

travel demands and infrastructure constraints. Limited and unreliable digital connectivity continues to impact service delivery in rural and remote areas.

Flexible models of care, physicians working collaboratively with other health professionals, virtual care, and virtual care paired with in-person services where clinically warranted must be an ongoing funding priority to enable the additional functions performed by rural and remote hospitals and workforces to support rural patients in ways that reflect local circumstances and clinical need.

Non-admitted care

Members emphasised that activities and supports provided by hospital healthcare workers in community-based services and settings should also be recognised for their role in preventing avoidable hospital admissions, reducing emergency department presentations and supporting people to remain safely at home. The following specific scenarios were described:

- Where mental health needs frequently intersect with chronic disease, disability, substance use, homelessness and other forms of social complexity, additional resources are needed to provide safe and effective care in the community
- Where for children with complex and chronic conditions, community based care often involves ongoing activities that extend beyond the service event itself. This includes routine annual and periodic reviews required to monitor changing health needs, review of patient-generated health data, asynchronous clinical review, communication with schools and community providers, multidisciplinary case review and ongoing care coordination.

Transplantation services

It was noted that some highly specialised therapies, including organ transplantation services, may require additional cost allocations for rehabilitation support following treatment.

Teaching and supervisory activities

The RACP and contributing members consider it essential that pricing arrangements recognise the costs of research, teaching and training activities undertaken within public hospitals. These activities are critical to maintaining a sustainable specialist workforce and bolstering innovation and quality improvement.

Summary remarks

We welcome IHACPA's consideration of our recommendations and appreciate our continuing collaborative work to develop public hospital and service pricing systems that support high-quality, equitable and sustainable healthcare.

Please contact Debra Moss, Policy & Advocacy Officer for any inquiries via: policy@racp.edu.au