

PERCEPTION and DECEPTION - A SYSTEM SET UP TO FAIL

Australia's public hospitals are under pressure – not only from rising demand, workforce shortages, and an ageing population, but also from systemic issues in Primary Care, Aged Care, and the NDIS. Yet one factor is often overlooked: a funding model that misrepresents the true cost of care.

The National Health Reform Agreement (NHRA), signed in August 2011 by the Commonwealth and all states and territories, committed to Activity Based Funding (ABF) for public hospitals wherever practicable. However, not all services fall under ABF. Many remain block funded – notably small rural hospitals, specialist and forensic mental health facilities, teaching, training and research, community mental health (prior to 2025), and public health.

Having been closely involved in the implementation of ABF across NSW Health and in national advisory processes, I believe it's time – fourteen years on – to reflect. ABF, as a concept and funding methodology, offers clear advantages, especially in transparency. Despite the issues discussed below, it delivered immediate benefits compared to previous mechanisms.

Still, I keep asking: ***Was Australia's hospital funding model flawed from the start?*** The National Efficient Price (NEP) does not reflect the true cost of hospital care. It's a pared-back figure, shaped by exclusions and rules designed to inform the Commonwealth's funding contribution. The gap between the NEP and the actual cost of treating patients is arguably central to today's financial pressures in the health system.

I acknowledge the technical depth of what follows – but the funding process is highly, and perhaps overly, complex. That complexity is part of the problem, and it's central to the assessment below.

NHRA Commonwealth Funding Contributions:

A key role of the NHRA is to provide a mechanism for funding States and Territories on the basis of activity actually carried out by each jurisdiction; i.e. Activity Based Funding (ABF) incorporating a standardised National Weighted Activity Unit (NWAU) and a single National Efficient Price (NEP). The NWAU value reflects the complexity of treatment and resource utilisation required for the treatment.

Under the NHRA, the Commonwealth will only contribute funding to a predetermined scope of activity and services provided by hospitals and health services. This is commonly referred to as "Inscope" activity. All other activity provided by hospitals and health services therefore does not attract any NHRA Commonwealth funding contribution and is commonly referred to as "out of Scope" activity.

Out of scope activity is funded almost entirely by the relevant State or Territory government and applies to both ABF and non ABF activities. For context, of the \$68.3 billion paid through the National Health Funding Pool in 2023/24 in respect of the NHRA funding, \$28.3 billion was contributed by the Commonwealth. Approximately 86% of Commonwealth NHRA funding in 2023-24 (\$24 billion) went against ABF payments with the remainder contributing to Block funded services. (National Health Funding Body – Annual Report 2023-24)

The Patient Costing Impact:

Public health systems across Australia have been costing health services for several decades with submissions to the National Hospital Cost Data Collection (NHCDC) made annually. Currently, States and Territories are undertaking costing studies for all hospital service for the 2024/25 financial year.

Since the introduction of the NHRA utilising ABF, costing appears to have shifted focus. It now primarily supports the Independent Hospital and Aged Care Pricing Authority's (IHACPA) NEP and National Efficient Cost (NEC) determinations – rather than helping hospitals manage their services.

Under NHRA requirements, costing must occur at the patient or encounter level. Costing hospital services becomes a complex annual task that must be consistent across jurisdictions for national comparisons.

In consultation with the States and Territories, IHACPA strengthened the Australian Hospital Patient Costing Standards (AHPCS) as a means of ensuring a high standard of costing and consistency in approach. These standards are currently published in 3 parts – Part 1: Standards, Part 2: Business Rules and Part 3: Costing Guidelines.

The AHPCS requires total health service expenditure to be allocated across all hospital services and activities. The result of the costing study must reconcile to the total expenditures reported in the health services audited annual accounts.

The AHPCS aligns with standard cost accounting principles. Compliance ensures that annual costing submissions from all jurisdictions are consistent and robust enough to support NEP and NEC determinations.

However, this is where the common understanding of costing concepts creates a misleading impression. While the cost of services (at patient level) prepared by jurisdictions may be a truer reflection of operations, the cost that flows through into the NEP determination process may in fact reflect a different story.

The perception myth:

Since the introduction of the NHRA and ABF - over time, a flawed perception has emerged wherein the public, media, politicians and even Health Service personnel perceive that the National Efficient Price, founded on costs submitted by the States and Territories, represents the *actual cost of providing hospital activity*.

Whether this “perception” has been deliberate or purely an unintended consequence is a matter for conjecture.

In reality, the NEP is not reflective of the true cost of patient care. It is a stripped-down cost measure, shaped by exclusions and funding rules.

It is reasonable to argue this gap between perception and reality is at the core of today’s health system financial pressures.

The NHRA and the Addendum to National Health Reform Agreement 2020-2025 (Consolidated) specifically states that the Commonwealth will contribute funding to Health Services, however:

- “Under this agreement, the States will be responsible for system management of public hospitals, including planning, funding and delivering of capital” (10.a.iv)
- “...the Commonwealth will not fund patient services through this Addendum if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program” (Schedule A: A9)

What this effectively means is that:

- no Commonwealth funding will be provided for capital (noting in particular, plant and equipment, medical equipment and machinery).

2. National Efficient Price Determination 2025–26

2.1 The national efficient price

The national efficient price (NEP) is \$7,258 per national weighted activity unit 2025–26 (NWAU(25)).

2.2 Calculation of the national efficient price

The NEP is based on the average cost of public hospital activity in the 2022–23 financial year of \$6,114 per NWAU(25), indexed at a rate of 5.6% per annum, plus an additional 0.81% to account for increases in the minimum superannuation guarantee between 2022–23 and 2025–26.

Consistent with clause A46(e) of the Addendum to the National Health Reform Agreement 2020–26, in calculating the NEP, the following Commonwealth funded programs have been removed prior to determining the underlying cost data of the 2022–23 reference cost:

- highly specialised drugs – section 100 funding (\$1,736.5 million in the 2022–23 financial year)
- pharmaceutical reform agreements – efficient funding of chemotherapy (section 100 funding) (\$719.0 million in the 2022–23 financial year)
- pharmaceutical reform agreements – Pharmaceutical Benefits Scheme Access Program (\$384.4 million in the 2022–23 financial year).

Where blood expenditure has been reported in the National Hospital Cost Data Collection by states and territories this has also been removed, as Commonwealth funding for this program is provided directly to the National Blood Authority. In 2022–23 this amounted to \$380.0 million.

Although IHACPA does identify some of the significant costs removed, it is necessary to wade through many other documents to identify other adjustments e.g. the various National Pricing Model 2025–26 For Australian public hospital services-Technical Specifications-March 2025

Diagram 1

- no Commonwealth NHRA funding will be provided for any activity receiving **any** funding from **any other source**, whether “in-scope” or not.

IHACPA sets the National Efficient Price (NEP) for hospital services based on the cost of delivering care - as amended by them - and excludes the cost of depreciation in its activity-based funding (ABF) calculations. Depreciation is considered by IHACPA to be a capital cost rather than an operating expense.

So, what does it really cost to deliver patient care?

Assuming all health services provided costing submissions strictly in accordance with AHPCS guidelines, the final “cost” determined by IHACPA for which it bases its national Weighted Activity Unit (NWAU) and National Efficient Price (NEP) (refer diagram 1) has a number of adjustments made, significant ones being:

- a) Depreciation and any leasing expense is removed
- b) Identified Blood costs are removed (other funding source)
- c) Pharmaceutical expenses equal to Commonwealth Pharmaceutical payments received are removed (other funding source)
- d) High cost drugs are removed (other funding source)
- e) Indirect costs for Teaching, Training and Research are removed (funded through Block component)
- f) Adjustment made to the cost of Private Health Fund, Motor Accident Authority, Department of Veteran Affairs, Workers Compensation and Self-funded patients primarily for costs which may have been avoided by the health service

Expenditure related to “out of scope” ABF activity and/or services and non ABF funded services is also excluded for setting the price. Data and information is also sourced from third parties and incorporated into the process. (The complexity of the NEP preparation is demonstrated in the IHACPA National Pricing Model 2025–26 – Technical Specifications – March 2025).

Many public hospitals have relationships with Universities, research organisations, Charitable Foundations and Philanthropic individuals. These relationships often provide workforce resources, equipment and financial support to hospital operations – the cost of which is “off books”. While the hospital benefits from these relationships the true cost of service provision can be somewhat understated resulting in significant problems if the source of funds is short term, one off or ceases.

Clearly, the price on which the Commonwealth bases ABF payments to States and Territories under the NHRA is not reflective of the true cost of patient care and *should not be interpreted as an indicator of hospital costs*. Equally, it should not be used in forming management decisions, other than revenue related.

Depreciation and Medical Equipment:

Acquisition and replacement of medical equipment has been a constant issue for hospitals for decades and is particularly exacerbated by the high cost of more sophisticated and advanced technologies.

States and Territories typically prioritise major capital projects – such as new hospitals, redevelopments, and expansions – which are planned years in advance and funded through separate infrastructure budgets. So, while state governments tend to focus capital funding on new infrastructure, the replacement of medical equipment is inconsistently provided for.

Sophisticated or high cost technologies like CT scanners, MRI machines, and surgical robots require regular upgrades, typically every 7–10 years. Funding for these is less predictable. Some replacement is covered through the states allocated specific equipment replacement programs. In other instances, Local Health Districts/Networks must find funds from their recurrent operating budgets or rely on donations or charitable foundations. As the number of hospitals and new builds increases, the problem of funding equipment replacement is compounded .

The consequences of under investment in equipment are real. In 2025, ten interventional radiologists resigned from Sydney’s Westmead Hospital, citing outdated angiography machines (“...both are over 15 years old. One of them has broken down”) and inadequate pay. Although they subsequently postponed the resignations, their initial action underscores the risks of underinvestment: compromised patient safety, clinician burnout, and service disruption.

(https://www.abc.net.au/news/2025-06-27/nsw-westmead-hospital-interventional-radiologists-resign/105467494?utm_campaign=abc_news_web&utm_content=link&utm_medium=content_shared&utm_source=abc_news_web)

As IHACPA’s legislative role is to set the National Efficient Price (NEP) for public hospitals, with State and Territory governments directly responsible for funding capital for public hospitals, IHACPA determines depreciation doesn’t need to be in the NEP. In other words, the NEP and the

reported cost basis underpinning it, makes no provision for equipment utilisation and subsequent equipment replacement.

Historically, equipment operating leases were utilised to alleviate the restrictions imposed by limited capital budgets. The operating lease cost was an accepted cost of patient services and included in the cost base for price weights and NEP. The 2019 introduction of AASB 16 (IFRS 16) further complicated matters by reclassifying operating leases as capital expenses—effectively removing them from the NEP cost base.

As mentioned, Australia’s ABF model excludes capital and consequently, asset replacement, preventing hospitals from using depreciation to build cash reserves. Without adequate state support, hospitals resort to extending equipment beyond a safe lifespan or delay upgrades — as demonstrated by the action taken by the Westmead Hospital Interventional Radiologists.

This hidden underinvestment in equipment, which affects patient safety, service quality, and ultimately efficiency could be avoided if the NEP included as a minimum, a component for medical equipment depreciation, reflecting the cost of medical equipment resource usage in patient treatment.

There is also a significant secondary costing, funding, equity and management impact caused by the exclusion of depreciation (or an asset utilisation charge). Inequities are created between services due to how NWAU price weights and NEP methodology are applied. Specialties such as general medicine are labour intensive with a low medical equipment requirement. Other specialties such as oncology, interventional radiology, ICU’s and operating theatres are more equipment and technology intensive.

NWAU price weights and the NEP will tend to underprice those equipment intensive services relative to their true cost structure and consequently overprice the less equipment dependant services. In turn, this will put hospitals at greater risk of not being able to manage their ABF budgets and compounding issues for larger rural hospitals.

Health services cannot continue with a funding model that pretends hospitals have adequate financial capacity to maintain medical equipment standards. Options for reform include:

- Including medical equipment depreciation in the National Efficient Price so funding reflects the true cost of care.
- Adjusting funding price weights to reflect the equipment intensity of different specialties.

Without this reform, hospitals will continue to struggle with outdated equipment and the consequential impact on clinician morale and patients will face growing risks.

The Public/Private divide:

The current pressures in the Australian health system, particularly financial, have seen growing disruption within the Private health sector with a number of operators curtailing services or leaving altogether. Of particular note is the recent position of Healthscope to enter receivership and exit from the Northern Beaches Hospital contract.

Private operators, unlike public hospitals, must generate returns on capital — including shareholder funds and borrowings — and plan for asset replenishment. Depreciation and Cost of Capital are key elements that must be factored into their pricing mechanisms. Teaching and Training, Blood and blood products, Pharmaceuticals and High Cost Drugs must also be provided for.

There is also a significant variation in the scale of activity and range of services provided by private hospitals, compared to the public sector, which will bias any “averaging” methodology such as ABF.

So, is it appropriate to relate public health system funding and performance standards to private hospitals? Given the extent of adjustments, inclusions and exclusions by IHACPA to public system costing submission data, is it also appropriate to apply NWAU cost weights to private hospital activity?

The Covid19 pandemic highlighted the need for closer integration between the public and private hospital sector to satisfy the health and health prevention needs of the population. A clearer understanding of the cost profiles and challenges between the two sectors is required if the private sector is to survive.

A system set up to fail:

The current NEP/NEC model creates a perception that hospitals are being funded appropriately and “efficiently” — but that efficiency is an illusion.

The NEP reflects a pared-back cost model shaped by funding exclusions, not actual service delivery costs and coupled with an indexation model that may not reflect everchanging patient care.

This deception — whether deliberate or an unintended consequence — underpins much of the financial stress facing health services today. It

rewards services that are labour-intensive but equipment-light, while starving those that depend on expensive, life-saving technology. It understates the “true” cost of service provision.

Basic Reform options to align hospital funding with the true cost of care

<p> Include Equipment Depreciation</p> <p>Reflect the real cost of using and replacing medical equipment in the NEP.</p>	<p> Adjust Price Weights</p> <p>Update NWAU weights to account for equipment-heavy specialties like ICU and radiology.</p>	<p> Use Actual Resource Costing</p> <p>Ensure costing reflects real-world service delivery — not just what’s eligible for Commonwealth funding.</p>
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For effective management of the public health system costing must reflect actual resource use — including depreciation of clinical equipment and “off book” support. Health services must utilise robust costing information, built on sound costing principles and *not influenced by funding considerations.*

This should include, at the very minimum, depreciation of clinical equipment (representing the resource utilisation component on top of consumables). Only when the true cost of services is known can effective management decisions be made.

The NHRA was developed at a time where there was clearer delineation between the various elements making up the Australian health system. In the current health climate, there exists a complete blurring between the lines of Primary Care, Hospital Care, Health Prevention, Aged Care and the NDIS. The fact that the Commonwealth, States and Territories could not agree a new Addendum to the NHRA in time for the expiry of the current addendum is perhaps fortuitous as it provides us with an opportunity to *reassess roles and responsibilities. This should cover both the cost and subsequent funding that sits within each.*

Until then, we will continue trying to manage a system designed to fail.

It is critical time now to reflect and learn so that the (unintended) consequences of the public hospital pricing methods are not carried through into the aged care sector (currently being priced by IHACPA) and NDIS.

Opinion Author

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Neville is currently a partner in 3C's Plus consultancy providing assistance and advice on costing and funding, specialising in Health related services.