The Growth and Drivers of Australian Public Hospital Costs and Prices

Analysis and Recommendations

Supported By Special Reviewer

Dr Stephen Duckett

Commissioned by the Australian Board of Treasurers

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Acknowledgement of Country

Create Health Advisory acknowledges the Traditional Custodians of the lands across Australia. We pay our respects to Elders past, present, and emerging, and recognise their enduring connection to land, waters, and culture.

We honour the rich histories, languages, and traditions of Aboriginal and Torres Strait Islander peoples, whose stewardship of this land spans tens of thousands of years. Their wisdom and resilience continue to inspire our collective journey towards reconciliation and a more inclusive future.

In the spirit of respect and collaboration, we commit to fostering an environment where Indigenous voices are heard, valued, and central to the decisions that shape our shared future.

Executive summary

This independent report, prepared by Create Health Advisory with the support of Dr Stephen Duckett, was commissioned by state and territory Treasurers to inform future negotiations on the National Health Reform Agreement with the Commonwealth Government. It seeks to clarify the underlying drivers of recent cost growth in public hospital services and to provide a clearer evidence base to support reforms to funding arrangements, including the National Efficient Price (NEP).

More than a decade has passed since the introduction of the first Pricing Framework for Australian Public Hospital Services (the Pricing Framework). While the Pricing Framework has evolved over time, the operating environment for public hospitals has changed significantly— characterised by higher demand, more complex patient needs, rising costs, and an increasingly constrained workforce. These pressures call for a comprehensive review of the Pricing Framework and associated funding settings to ensure they remain fit for purpose.

The sharp 12.3% increase in the National Efficient Price for FY2025-26—or 5.9% growth when adjusted for backcasting—triggered considerable speculation around the drivers of the increase. However, this spike represents a structural turning point rather than a one-off anomaly. It reflects real and persistent cost growth across the system.

The Commonwealth's 6.5% cap on annual hospital funding growth is creating a growing misalignment with actual system costs, particularly as historical cost pressures flow through the National Efficient Price (NEP). The NEP for FY2025-26 reflects data from FY2022-23—a period marked by inflation, workforce shortages, and operational disruption—during which costs were already absorbed by states and territories. As these lagged pressures drive further price increases, the risk of exceeding the Commonwealths 6.5% funding cap grows, despite the expenditure being incurred years earlier. Over FY2023-24 and FY2024-25 alone, the cap is estimated to have resulted in $1.9 billion in foregone Commonwealth contributions, with further shortfalls expected as the NEP continues to rise.[1]

This report analyses the drivers of hospital cost growth, drawing on publicly available data from sources including Australian Institute of Health and Welfare (AIHW), the Productivity Commission, National Health Funding Body (NHFB) and Independent Hospital and Aged Care Pricing Authority (IHACPA). While further detailed analysis will be required, this report provides an initial synthesis of the key structural and policy factors influencing cost escalation—and considers how alternative approaches could help contain, manage or redirect growth pressures.

The analysis is intended to support state and territory Treasurers pursue a more balanced, transparent and sustainable funding partnership with the Commonwealth, while preserving the benefits of activity-based funding.

The analysis of the drivers of the growth in public hospital costs highlights four key factors which appear to be the main drivers of increases in costs:

1. The high-inflation environment in the general economy experienced following the onset of COVID-19, which has already increased non-labour costs and continues to influence labour costs;

2. The growing cohorts of stranded patients in public hospitals—who are awaiting available places in alternative accommodation or support settings (such as residential aged care facilities, supported disability accommodation, or community supports). The protracted length of stay in a hospital setting for these patients increases cost by significantly impairing the productivity of public hospitals to deliver core acute services, increases the labour intensity of their care (relative to

[1] $1.9 billion is calculated as the difference between capped and hypothetical uncapped Commonwealth contributions, accounting for price and volume changes. This information is based upon FY2023-24 actuals and preliminary FY2024-25 actuals and represents a cumulative impact.

providing appropriate care in an alternative setting), and requires health services to access costly alternative care pathways in order to maintain access for other patients;

3. National and global clinical workforce shortages across all major professional groups—which has required the use of temporary contract labour to maintain service delivery and has strengthened the bargaining power of the workforce in wage negotiations, particularly in the context of high inflation;

4. A longer-term trend of increasing complexity and frailty of the public hospital patient cohort that requires increased resource intensity to provide care.

These pressures are persistent and largely fall outside the control of states and territories.

It has been observed in the data that these pressures have driven up the cost of delivering care without a commensurate increase in activity (at least as measured in NWAUs), leading to a higher cost per NWAU. In some cases—such as with stranded patients occupying acute beds—these cost drivers also result in fewer other patients being treated, thereby reducing the potential for overall activity levels and further amplifying the cost per unit of output. As the National Efficient Price is calculated by dividing the total cost of services by total NWAU activity, rising costs coupled with constrained activity inevitably result in an increase in the NEP.

In addition, the analysis highlights that the exclusion of capital and depreciation related expenses from the Pricing Framework is placing additional strain on states and territories to maintain access, with no corresponding contribution from the Commonwealth.

Apart from general economic inflation—which is currently moderating—these primary drivers of cost are likely to persist until appropriate action is taken to address the structural and enduring issues. Resolving these drivers requires addressing capacity, pricing and funding in adjacent sectors, increasing clinical workforce supply, and strengthening non-hospital care pathways. There is a clear role for the National Health Reform Agreement and the application of modernised Pricing Frameworks – for both the hospital and aged care sectors – to ensure there are the right incentives for the health and social care system to deliver better care in the most appropriate setting. This includes supporting timely discharge, strengthening out-of-hospital care pathways, and improving system efficiency particularly as the population grows and ages.

The report also examines the impact of the significant lag in how cost pressures are reflected in the Pricing Framework, which can delay appropriate funding responses and shift a disproportionate burden onto states and territories. This lag undermines the capacity of the current funding model to respond to emerging pressures in a timely way and has direct implications for the level and distribution of Commonwealth contributions under the NHRA. Strengthening the alignment between Commonwealth funding, system priorities, and real-world cost pressures is critical to achieving a sustainable and equitable hospital funding partnership.

Recommendations

In response to the analysis of the drivers of public hospital costs and prices and to ensure the sustainability of public hospitals including maintaining access to quality care, a coordinated national reform agenda is needed across the following domains:

Improving the interface between public hospitals and other parts of the health and social care system

1. Establish a health and social care policy and funding strategy

There is considerable interplay between the different parts of the health and social care system. However, there is an absence of any coordinated policy between primary health, acute care, aged care, disability and social care. This failure of policy disproportionately impacts individuals and the public hospital system, resulting in sub optimal care being delivered at a premium cost to the system.

Recommendation 1 – It is recommended that states and territories work with the Commonwealth to establish a whole of health and social care system policy and pricing strategy that acknowledges and reinforces the existing roles and responsibilities, to direct investment into the part of the system best placed to provide the care needed.

2. Ensure national accountability for interface services and stranded patients

National agreement is needed to consistently define and report stranded patients, enabling accountability for care pathways beyond the hospital system. The Commonwealth must take greater responsibility for system interface failures—including funding and delivery of aged care, disability support, and step-down accommodation. This includes contributing capital and operational funding for transitional care capacity to relieve hospitals from the increasing burden of housing patients who no longer require acute care.

Recommendation 2 – It is recommended that:

- *a classification system for stranded patients in public hospitals is established*
- *access and pricing incentives on providers of aged, disability and step down accommodation are aligned (between the Australian National Aged Care Classification funding model and NEP) and redesigned to support patients being discharged to more appropriate care setting more quickly. This should be designed to facilitate expanded Commonwealth investment in new services and capital.*

Coordinated response to workforce shortages

3. Address workforce shortages as a structural cost driver

Clinical workforce shortages have become a structural constraint and a key driver of real cost growth. National investment is required to expand domestic training pipelines, improve retention, and reform credentialing and migration pathways. The Pricing Framework should recognise labour cost intensity in hard-to-staff or high-risk areas. Workforce planning must be coordinated nationally to limit the inflationary impacts of labour scarcity on state budgets and hospital pricing.

Recommendation 3 – It is recommended that:

- *a nationally coordinated health workforce strategy is developed that outlines the health and social care sector's workforce need and strategies to meet future needs via expansion of the domestic pipeline, training pathways, credentialling reform and migration policy to be developed jointly with the Australian Tertiary Education Commission and Jobs and Skills Australia*
- *the Public Hospital Pricing Framework incorporates measures that recognise the increased cost associated with workforce shortages via adjustments to the NEP and with reference to the lag in costing data.*

Recognise and respond to patient complexity and social disadvantage

4. Improve recognition of patient complexity and social disadvantage

Funding models must evolve to better capture increasing patient complexity, particularly in the context of an ageing population and rising multimorbidity. Enhancements to DRG complexity weightings, coding accuracy, and acuity-based funding adjustments will ensure hospitals are resourced to manage higher-need patients. The NHRA should also acknowledge the additional system costs of socioeconomic disadvantage, particularly for hospitals with growing SEIFA 1 patient cohorts.

Recommendation 4 – It is recommended that states and territories ensure patient disadvantage is appropriately recognised and captured in coding and IHACPA ensure public hospital prices and weights appropriately recognise the increasing patient complexity and social disadvantage.

Modernise the Public Hospital Pricing Framework and funding cap

5. Modernise and improve the responsiveness of the Public Hospital Pricing Framework

The current three-year lag between costs informing the price determination has resulted in a misalignment between cost, price and system pressure. This also has implications for the quantum and

timing of Commonwealth funding contributions to states and territories. The NEP should be more responsive to real-time cost shifts—similar to private sector mechanisms like the annual premium round—through shorter data lags, rolling updates, or interim adjustments. It has been 10 years since there has been any material review and change to the Pricing Framework. Improvements in how structural changes (such as workforce intensity or care model shifts) are incorporated into pricing will ensure the NEP more accurately reflects the efficient cost of service delivery.

Recommendation 5 – It is recommended that the Pricing Framework for Australian Public Hospital Services is modernised by improving the responsiveness of the NEP.

6. Reform the NHRA funding cap structure

The 6.5% Commonwealth funding cap has become disconnected from inflationary and structural cost pressures resulting in states and territories taking on more of the public hospital funding load. States and territories experiencing high levels of demand driven by population growth and ageing are further disadvantaged. Acknowledging recent developments in NHRA discussions that proposed increased funding contribution from the Commonwealth, further work on the design of the cap and the component parts is needed, including decoupling price growth from volume growth in the cap. Price increases driven by inflation, wages, and system complexity should be funded outside the cap, recognising that these are not discretionary cost decisions but systemic pressures outside state control.

Recommendation 6 – It is recommended that the funding arrangements better reflect volume growth, efficient cost growth and the implications on public hospitals of failure in other parts of the health and social care system by separately recognising price and volume growth in the determination of the funding cap.

Capital and infrastructure

7. The Commonwealth Government contribute to the cost of public hospital infrastructure

The NHRA and NEP currently exclude capital costs, despite states facing escalating infrastructure costs driven by post COVID-19 construction inflation. Commonwealth contributions should account for both operational and capital costs where those investments support national access and performance priorities, particularly for interface infrastructure like transitional care, aged care, and regional hospital redevelopment.

Recommendation 7 – It is recommended that the NHRA should incorporate the capital and operating cost of public hospital infrastructure and assets into the funding arrangements to be phased in over a 5 year period.

Diversionary care

8. Fund diversionary care and system innovation

The current public hospital funding and pricing frameworks do not incentivise or recognise the cost of avoided care. States and territories are increasingly investing in hospital avoidance models—such as co-responder models with ambulance services, alternates to primary care (e.g. Satellite Health Centres), and virtual care pathways—that may not be fully reflected in traditional admitted or ED activity measures. Future funding frameworks must be flexible enough to recognise and reward these diversionary models, ensuring that innovation in care delivery is not financially penalised.

Recommendation 8 – It is recommended that the definition of public hospital services be expanded and updated regularly to recognise diversionary and hospital avoidance services and separately fund these services outside the funding cap.

Monitoring of emerging issues

9. Continue targeted monitoring of other potential drivers

The Report considered other commonly cited cost drivers—including private-to-public substitution, shifts in primary care, and the introduction of new technologies—and found these to be relatively stable over the period of analysis. However, targeted monitoring should continue to ensure that emerging trends are

captured early, particularly where they may accelerate system cost pressures or shift volumes toward public hospitals.

Recommendation 9 – It is recommended that IHACPA establish mechanisms to monitor for material changes in the service mix and structure of public hospital services to make price adjustments.

Introduction

The National Efficient Price (NEP) is a cornerstone of the National Health Reform Agreement and underpins the Commonwealth's contribution to Activity-Based Funding (ABF) for states and territories operating public hospitals.

Each year, the Independent Health and Aged Care Pricing Authority (IHACPA) sets the NEP based on cost and activity data. The NEP provides the benchmark price per National Weighted Activity Unit (NWAU) and growth in the NEP after back-casting and determines how federal funding is distributed under the National Health Reform Agreement (NHRA) in line with service volume and complexity.

The National Weighted Activity Unit (NWAU)

The NWAU is a measure used in Australia to quantify the volume and complexity of healthcare services provided by public hospitals. Essentially, it's a way to standardise the counting and funding of various hospital activities, like emergency department visits, admissions, and outpatient appointments.

Since the NHRA's inception, the NEP has reflected a balance between cost containment and service sustainability. However, in the wake of the COVID-19 pandemic and significant macroeconomic and demographic changes, the model is under pressure. States and territories have experienced substantial increases in the cost of service delivery, driven by factors not adequately captured in previous pricing cycles.

IHACPA's December 2024 determination involved a 12.3% increase in the NEP for FY2025–26 (5.9% growth based on backcast NEP), prompting concerns regarding its magnitude and sustainability. In response, states and territories have sought an evidence-based understanding of the drivers of public hospital cost growth impacting the price.

States and territories have jointly overseen this review to identify the cost drivers and levers underpinning the NEP.

Objectives and scope

The primary objective of this review is to analyse and explain the drivers behind the increase in public hospital costs and the impact on prices. The review aims to determine whether these increases are structural, persistent, and sector wide.

This includes assessing the extent to which cost pressures arise from other parts of the health and care system, such as private health, general practice, aged care, and disability services.

Methods

This review was conducted in four key phases, each designed to build an understanding of hospital cost growth and its drivers based on available data. The approach integrated both qualitative and quantitative inputs and included engagement with all state and territory jurisdictions over a six week period.

Phase 1: Cost analysis framework and data mapping

A conceptual framework was developed to categorise cost drivers across economic, clinical, workforce, demographic, and intersectoral dimensions. Publicly available data sources were mapped, and jurisdictions provided additional datasets where available. Primary sources included IHACPA costing studies, AIHW hospital statistics, ABS inflation data, ABS workforce data, and internal jurisdictional reports.

Phase 2: Cost driver analysis data

Data was analysed according to the framework to identify patterns, causality, and the magnitude of change across drivers. The analysis included:

- Longitudinal cost comparisons (2018–2024)
- Cross-jurisdictional benchmarking
- Case study development to illustrate system pressures.

Phase 3: Jurisdictional feedback

Draft findings were shared with all states and territories for review. Jurisdictions were invited to provide commentary, case examples, and data validation. This ensured the findings reflect on-the-ground realities.

Phase 4: Synthesis and finalisation

All feedback was integrated, and a structure developed to synthesise the technical findings into a report to support action.

The growth and drivers of Australian public hospital costs

Rising costs in an inflationary environment

A foundational step in understanding the increase in public hospital costs is to assess how cost trends align with movements in the broader economy. Many of the inflationary pressures observed and experienced in the broader economy since the onset of COVID-19—including supply chain disruptions, increased demand for key inputs, and wage pressures—have flowed through to the hospital sector. While health services operate in a regulated environment with constrained pricing flexibility, they are nonetheless exposed to broader macroeconomic cost drivers, particularly in labour and non-labour inputs.

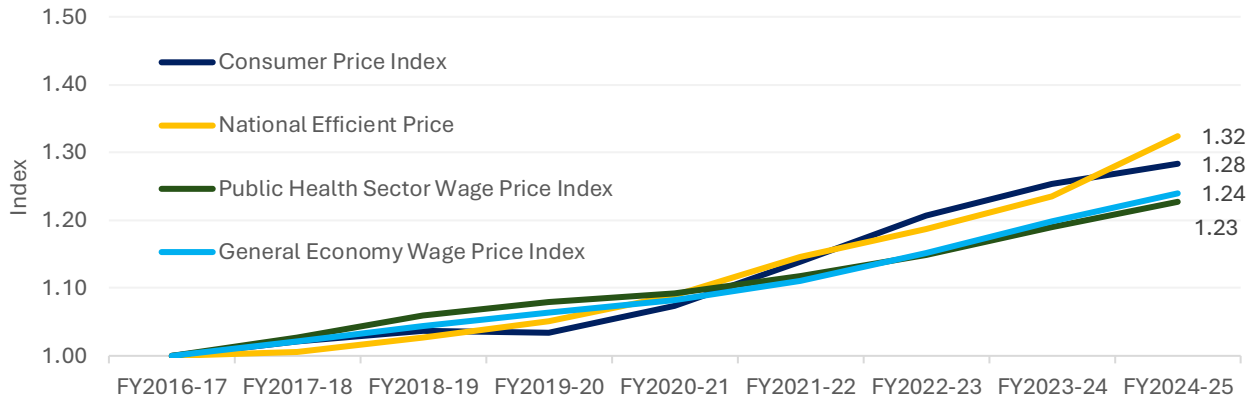
Section summary

Increases in the NEP have broadly tracked with the Consumer Price Index (CPI) until FY2024-25. Health care remains a labour-intensive industry and so future costs of public hospital care are expected to follow labour costs, which represent a looming risk of rising at a rate above inflation in the future in some jurisdictions. Left unaddressed, this will result in persistent cost pressure.

Recent data shows that the NEP — which is designed under the activity-based funding model to reflect efficient cost growth—has broadly tracked the CPI over time. **Figure 1** illustrates this alignment to FY2024-25. There is a further increase in the NEP in FY2025–26, which is attributable to a range of factors, including the increased prevalence of stranded patients, workforce pressure and increasing patient complexity which is discussed in the following sections.

Figure 1: Inflation increased significantly following the COVID-19 recovery – wage growth is catching up to this earlier phase of general cost escalation

Source: ABS: Consumer Price Index, Wage Price Indices
Source: IHACPA: National Efficient Price Determination (2015-16 to 2025-2026)
Source: RBA A Change to the Cash Rate Assumption Method for the Forecasts

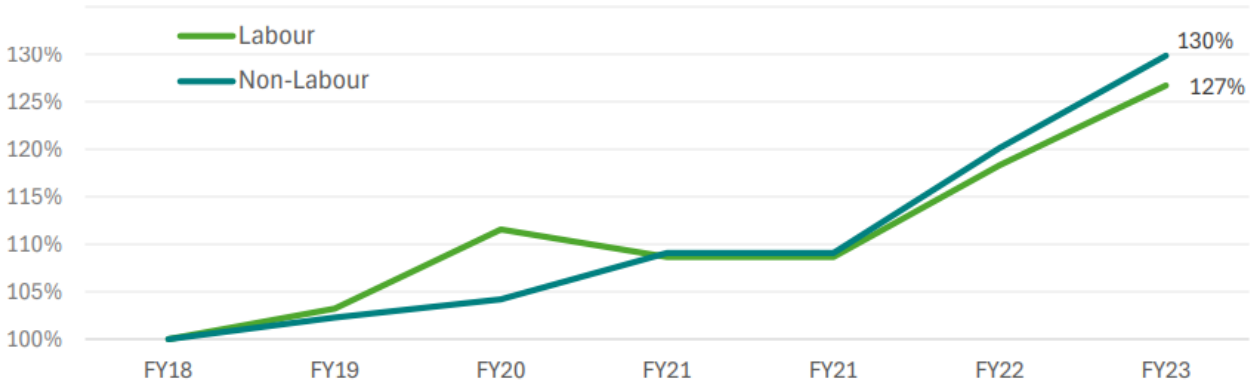


Labour costs remain the dominant expenditure for public hospitals, typically accounting for around 70% of total operational budgets.[2] These costs have increased in line with the Wage Price Index for the broader economy, and both indicators have grown at a slower cumulative rate than CPI since FY2017-18. Disaggregated analysis of acute cost per separation—a proxy for total hospital expenditure—demonstrates that labour and non-labour costs have historically grown in proportion, as shown in **Figure 2**.

[2] Based on analysis of health service financial reports.

Figure 2: Labour and non-labour costs per acute separation have largely grown in proportion since FY2017-18

Source: IHACPA: National Efficient Price Determinations 2019-20 to 2025-26



The evidence suggests that, while non-labour costs may begin to moderate in line with general CPI trends, labour costs represent a looming risk of continuing to rise at a rate above inflation in some jurisdictions. Several structural factors underpin this outlook. Firstly, the nature of hospital service delivery is shifting toward more labour-intensive models of care, driven by increasing patient complexity and persistent blockages at the interface with aged care, disability services and community supports. Secondly, ongoing clinical workforce shortages are increasing the reliance on external contract labour, driving up costs and reducing the bargaining power of Governments during wage negotiations. Finally, after years of real wage stagnation—exacerbated by CPI growth outpacing wages since the onset of the pandemic—there is growing pressure from health workers to restore purchasing power.

These cost dynamics have legitimacy not just as economic responses to post COVID-19 recovery but as structural system challenges that are likely to persist without targeted intervention. The shift in the NEP in FY2025-26, diverging from its historical alignment with CPI, reflects the lagged compounding effect of these pressures. However, due to the lag in how cost pressures are recognised in the NEP, states and territories have been required to absorb these rising costs in real time, while funding adjustments from the Commonwealth remain delayed. The impact of the lag is exacerbated as the rate of cost growth has been greater than NEP indexation for every year since FY2018-19. This misalignment has direct implications for the National Health Reform Agreement and the adequacy of Commonwealth contributions in keeping pace with real-world costs.

If left unaddressed, these trends will result in sustained real cost growth for states and territories, further stretching operational budgets and placing strain on hospital performance and access. To mitigate these impacts, policy levers must be considered that directly address workforce availability, incentivise more efficient models of care, and ensure that the Commonwealth's funding contributions—through the NEP and broader NHRA framework—are timely and reflective of genuine cost pressures. This includes reviewing how structural changes are incorporated into the NEP and exploring mechanisms to moderate real cost growth while maintaining service quality and equity of access.

Interface issues and increasing prevalence of stranded patients

A prominent and increasingly urgent challenge facing public hospitals is the growing volume of patients who remain in hospital beds despite being clinically ready for discharge. Referred to in this Report as 'stranded patients', these individuals are awaiting transfer to more appropriate settings—most often residential aged care facilities (RACFs), specialist disability accommodation, or other community-based services. This cohort has grown significantly since FY2020-21 and is now a defining feature of hospital system inefficiency, blocking access for other patients and driving up costs.

Section summary

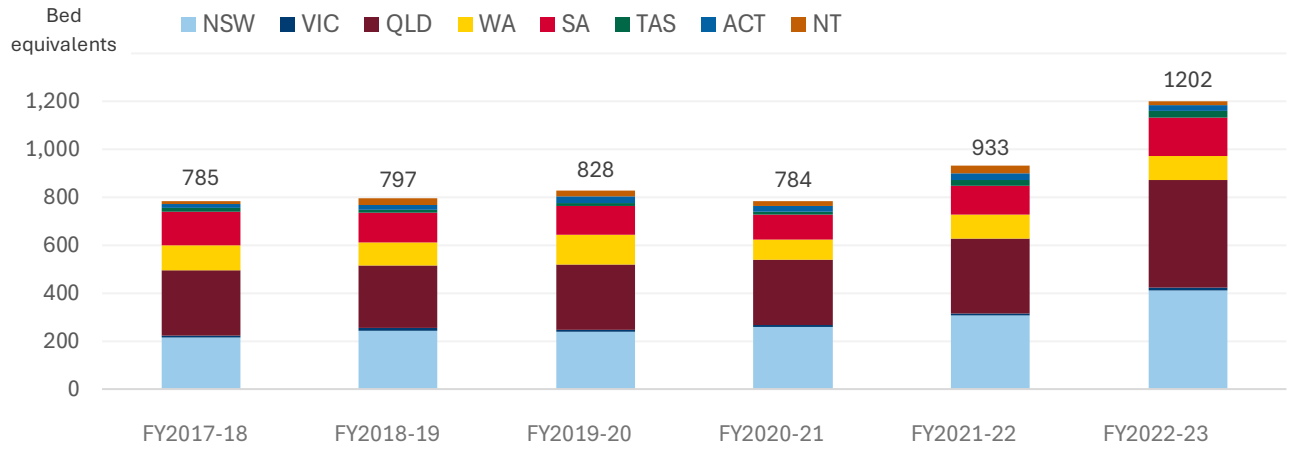
There is a growing volume of stranded patients in public hospitals. Stranded patients generate significantly lower activity (NWAU) per bed than an acute patient, while continuing to consume substantial hospital resources. This represents an opportunity cost to the public healthcare system.
This contributes to upward pressure on cost per NWAU, as fixed hospital costs are spread over a reduced number of NWAUs and public activity is increasingly contracted out to private hospitals, often at a cost higher than NEP. Over time, this leads to growth in the NEP.

Several indicators highlight the trend towards increasing volumes of stranded patients.

There has been a rapid increase in patients coded under the "maintenance care" type, a parallel increase in average lengths of stay for both acute medical and maintenance episodes, and a marked decline in aged care bed availability. Jurisdictions report that 8–10% of public hospital bed days are now occupied by patients awaiting discharge to another setting. **Figure 3** from the Productivity Commission shows a sharp rise in the number of beds occupied by long-stay patients awaiting RACF placement in all jurisdictions except Victoria, which has historically invested in a significant network of public sector aged care beds.[3] This rise in long-stay patients has occurred in a period where the number of public hospital beds per 1,000 population has fallen by 0.3% per year, ruling out a scenario where the substantial increase in long-stay patients is caused by a major increase in public hospital beds.

Figure 3: Since FY2020-21 there has been a notable increase in long stay patients awaiting RACF placement

Source: Productivity Commission – Report on Government Services (FY2017-18 – FY2022-23)

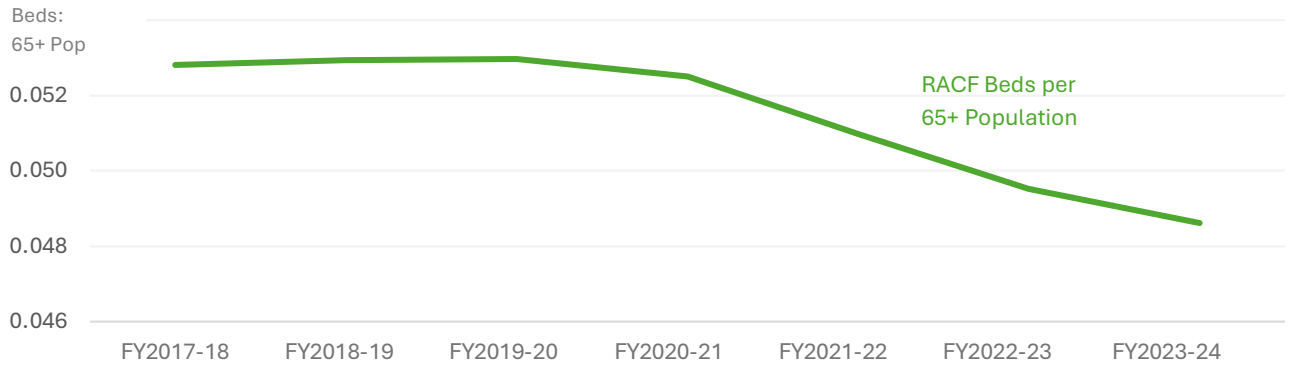


Further, **Figure 4** from the AIHW shows that at the same time stranded patients are observed to increase in public hospitals, the availability of residential aged care beds has declined for the over 65 years population.

[3] Figure 3 displays total bed equivalents based on the recorded beddays of patients awaiting RACF placement.

Figure 4: The notable increase in stranded elderly patients awaiting RACF placement from FY2021-22 onward corresponds to a decline in the volume of aged care beds relative to the 65+ Australian population

Source: Aged Care Data Tables



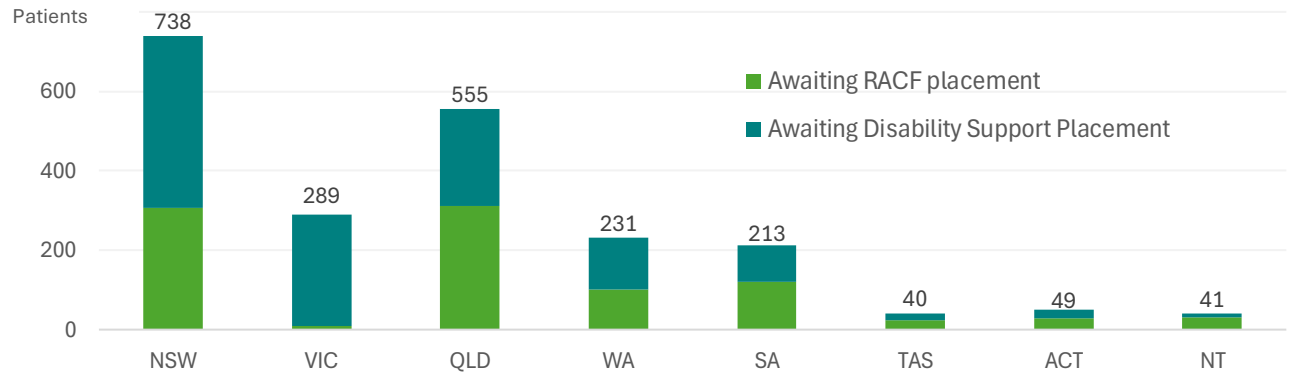
In preparation of this report, Queensland was able to provide a recent point-in-time analysis of stranded patients. This analysis showed that in February 2025:

- The volume of long stay patients has continued to grow significantly since the last publicly available data for the cohort of elderly patients awaiting RACF in FY2022-23
- In Queensland, these patient cohorts other than (i) elderly patients awaiting RACF placement and (ii) those awaiting disability placement are a significant additional group of stranded patients; comprise one third of stranded patients.
- More than half of bed days for long stay patients occurred within acute settings that is, these patients had not been reclassified as sub- or non-acute.
- Stranded patients increased by more than 40% in three years and now represent around 9% of acute bed days.

National data shows that the growth in stranded patients has driven a notable increase in Maintenance care volumes and based on input from jurisdictions, approximately half of the bed days for elderly long-stay patients awaiting aged care placement now occur within Maintenance care episodes (Figure 5).

Figure 5: Patients awaiting aged care placement are only one component of stranded patients in public hospitals – in 2022 there were a greater volume of patients awaiting discharge to disability support placement

Source: Productivity Commission – Report on Government Services (FY22); AMA 2023 'Hospital Exit Block' – with data sourced from the NDIA

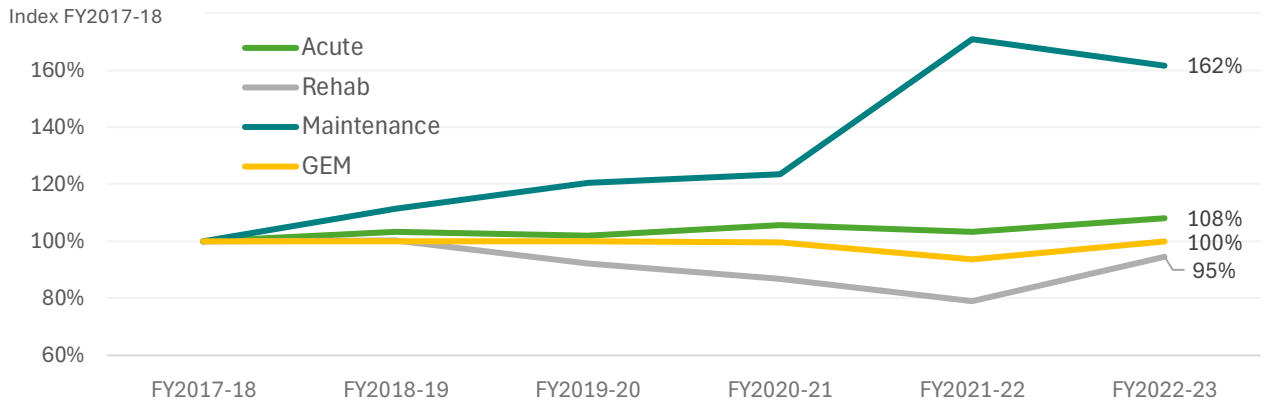


The implication of this is that measuring the impact of stranded patients on public hospitals is challenging with activity recorded across non-acute, sub-acute and acute care types.

It has been observed that the presence of stranded patients has also contributed to rising average lengths of stay in both Acute Medical Overnight and Maintenance Care episodes, as these are the primary activity streams in which such patients are typically coded. In many cases, patients remain classified—often inappropriately—as acute care pending a clear decision to reclassify, which contributes to the increase in average length of stay observed in acute care episodes (Figure 6).

Figure 6: Episode volume growth index by activity stream

Source: IHACPA: Public Sector Cost Reports FY2017-18 to FY2022-23



The growth in acute overnight medical length of stay has crowded out other acute activity – in particular (i) Acute Overnight Interventional activity – resulting in an increase in the volume of acute interventional activity delivered on a same day basis, and (ii) an increase in public activity contracted out to private hospitals in order to maintain access and performance targets. (Figure 7) (Figure 8). The increase in same day interventional activity is to some extent efficiency enhancing, but it may impact access for complex interventional patients.

Figure 7: Since FY2020-21 there has been a material increase in Acute Overnight ALOS

Source: AIHW Admitted Patient Care FY2017-18 – FY2023-24

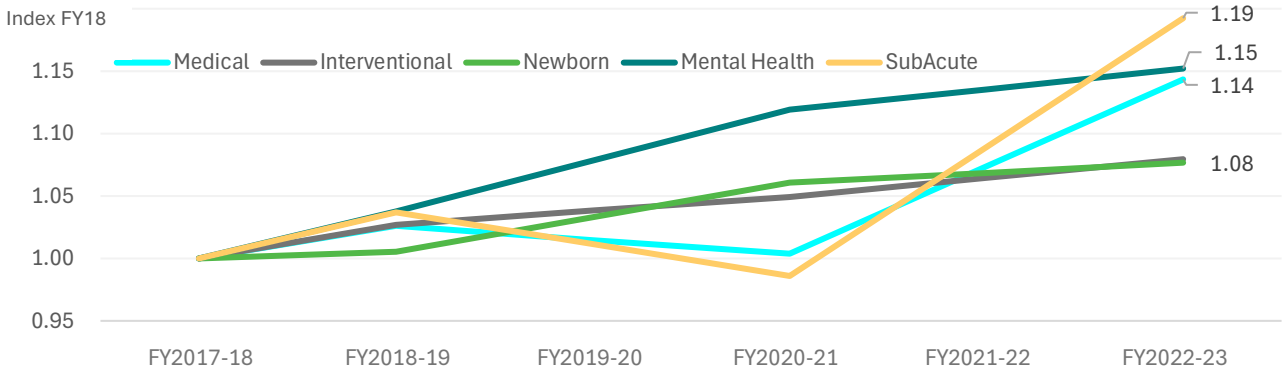
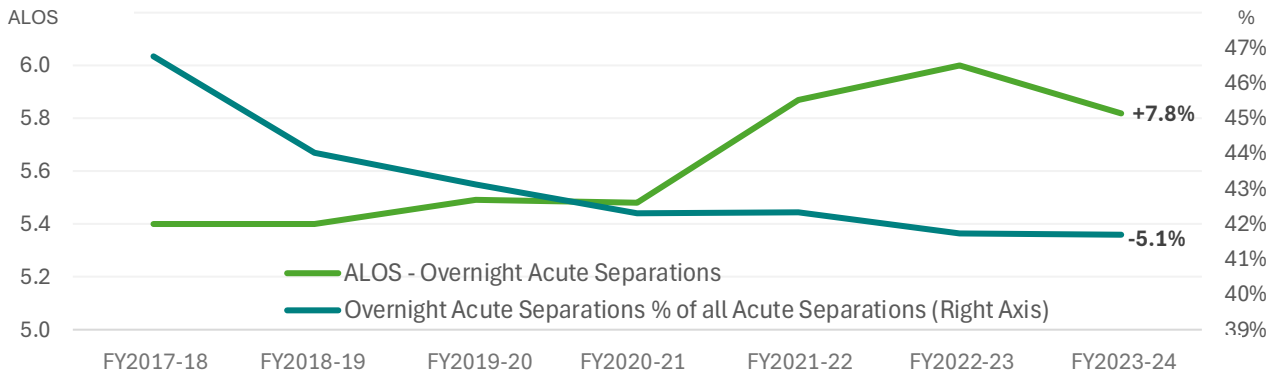


Figure 8: Admitted length of stay has grown fastest for subacute, mental health, and acute medical activity

Source: IHACPA: Public Sector Cost Reports FY2017-18 – FY2022-23



The impact of stranded patients has both direct and indirect implications for the cost of care and ultimately the price.

On a direct level, these patients generate significantly lower activity per day (NWAU) while continuing to consume substantial hospital resources. Stranded patients occupying acute beds produce only 58% to 64% of the NWAU of a typical acute bed day, while their costs are higher than if care was provided in a more appropriate setting. NHCDC Round 26 data shows that long stay and subacute patients require significantly higher labour input per NWAU, with labour accounting for approximately 72% of their cost per NWAU compared to 68% for acute admitted care. This reflects the higher labour intensity associated with caring for patients who are no longer receiving acute diagnostic or treatment services but remain in hospital for personal care, discharge planning, and ongoing support. As these patients generate fewer NWAUs per day while still requiring substantial staff time—particularly nursing and allied health—the result is a disproportionate increase in labour costs relative to activity (Figure 10). Together the higher labour inputs and lower NWAUs per day of stranded patients contributes to rising overall costs even when measured NWAU output remains flat or declines. ABF focuses on the output of hospitals, measured as NWAUs. Stranded patients represent an efficiency loss for the system with more bed days consumed with fewer patients able to be admitted and hence fewer NWAUs.

There are also significant hidden and indirect costs. Acute beds occupied by stranded patients delay elective procedures and emergency admissions, while fixed costs—such as utilities, and infrastructure—continue to accrue without commensurate output. Delays in elective surgery and emergency admissions, put further pressure on costs, with states and territories contracting more separations from private hospitals (often at a cost higher than NEP) (Figure 9).

Figure 9: An increase in stranded patients from FY21 has correlated with an increased volume of public patient activity contracted to private hospitals to maintain access and performance

Source: AIHW Admitted Patient Care FY2017-18 – FY2023-24

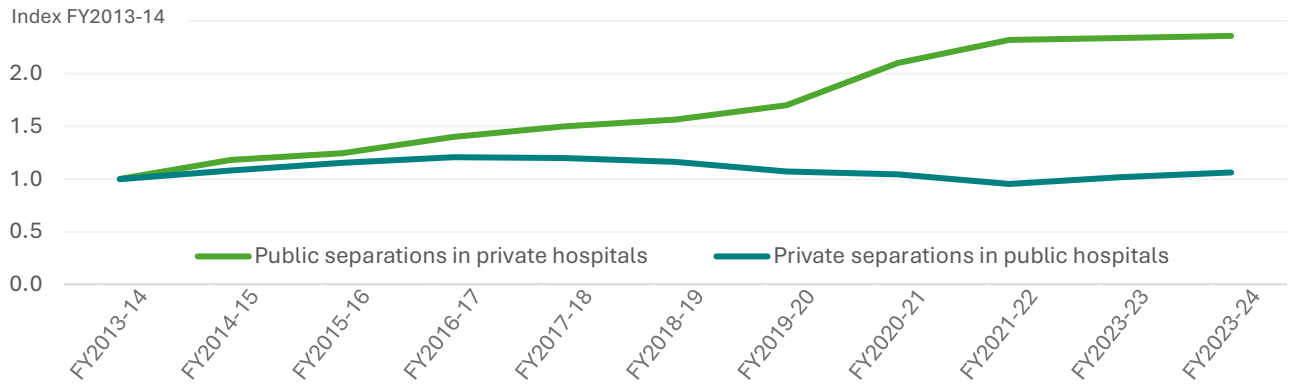


Figure 10: The increased labour intensity of activity is evident in the profile of workforce to weighted activity

Source: AIHW Admitted Patient Care FY2017-18 – FY2023-24

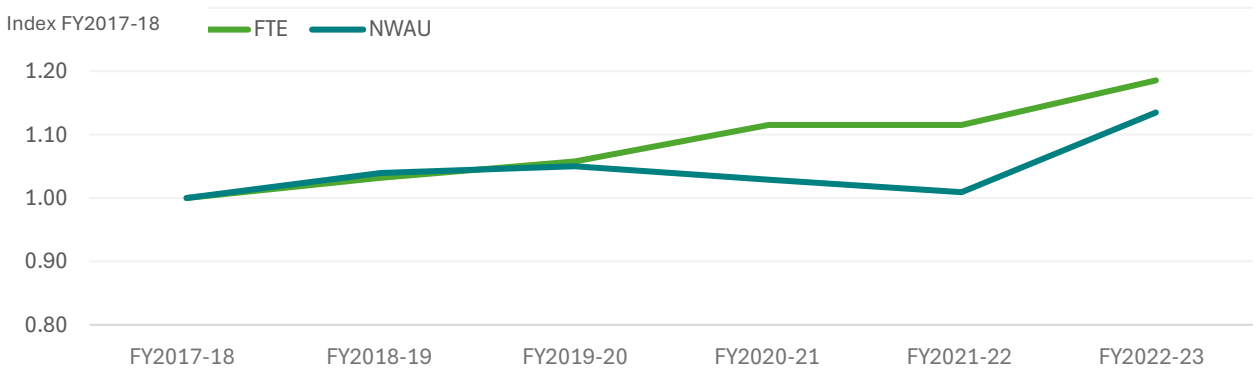
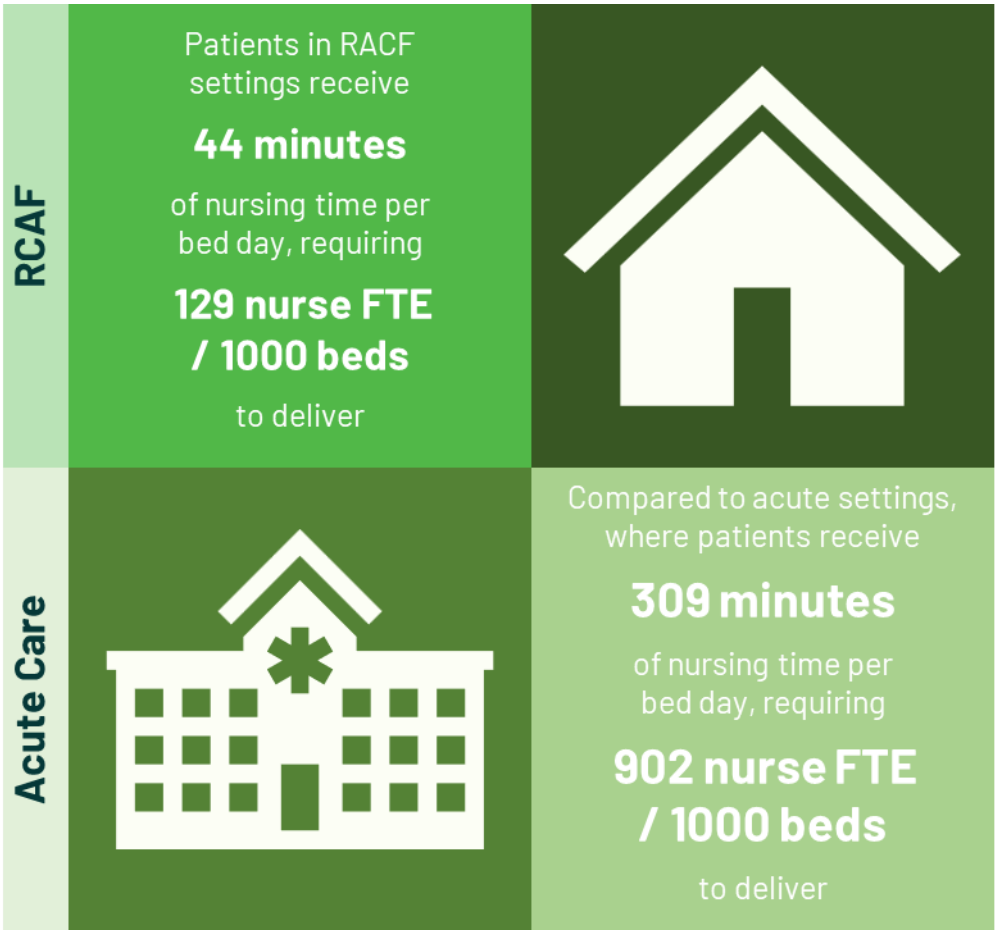


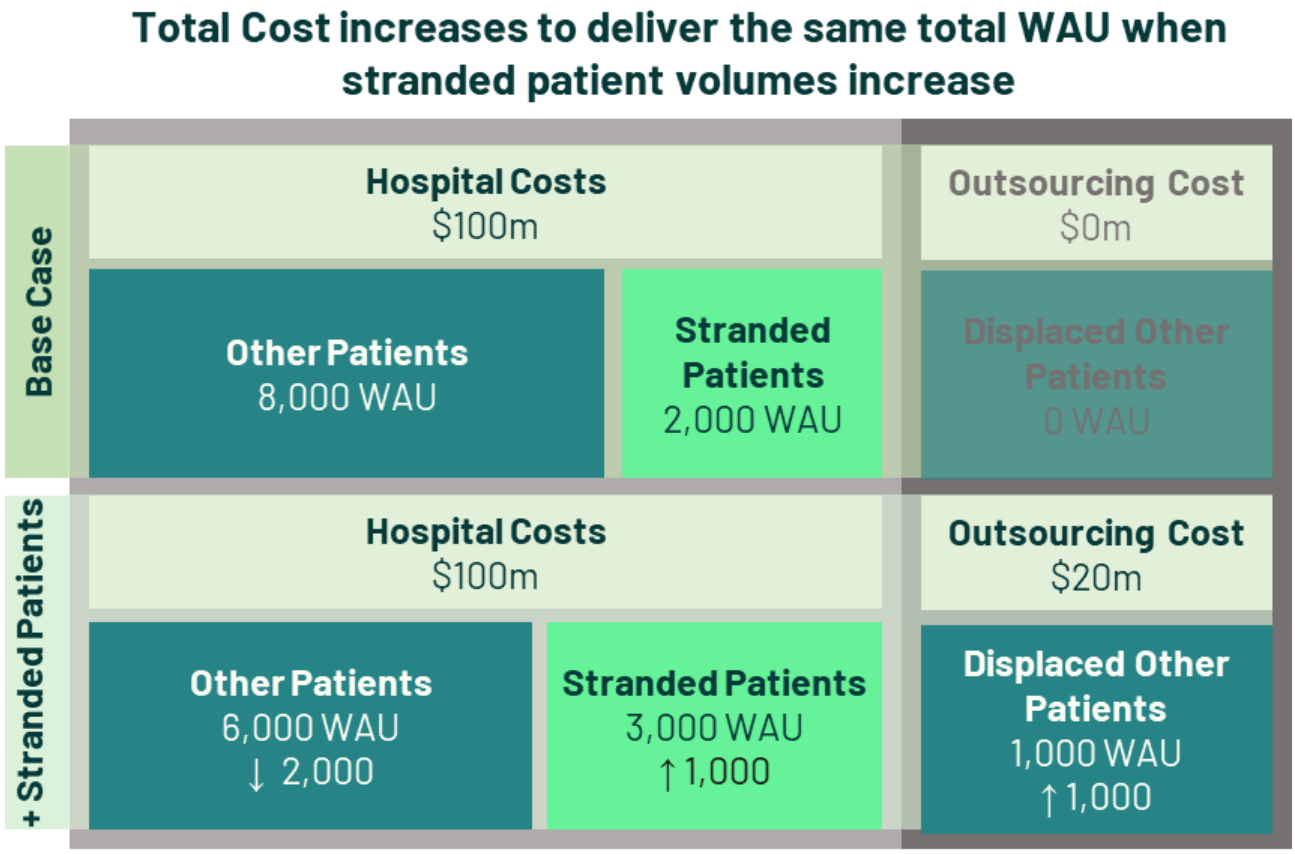
Figure 11 illustrates the impact on allocative efficiency of stranded patients. Registered nursing time required per acute bed day—approximately 308.6 minutes—is substantially higher than the 44 minutes required in RACF settings, underscoring the inefficiency of stranded patients occupying beds in acute hospitals. This equates to 902 Registered Nursing FTE per 1,000 beds p.a. in acute care vs 129 Registered Nursing FTE per 1,000 beds in RACF facilities. This also places further strain on an already overstretched workforce, compounding existing shortages and contributing to delayed productivity recovery post COVID-19.

Figure 11: Registered nurse resourcing requirements in acute versus RCAF settings



The presence of long-stay patients also contributes to upward pressure on the NEP. Figure 12 illustrates how stranded patients can occupy the same number of beds while generating lower levels of activity. This simultaneously generates a lower amount of separations and NWAU and increases cost by displacing patients that must be accommodated at additional cost in another facility. As a result, the same hospital costs (plus additional outsourcing costs) are spread over a reduced number of NWAUs which increases the average cost per NWAU. Over time, this leads to growth in the NEP.

Figure 12: Example of the impact of an increase in stranded patient volumes



Despite the visibility of this issue and emergence of this issue nationally, the policy response has been fragmented. Some states, such as Victoria, have historically invested in publicly operated residential aged care facilities to increase system capacity and improve patient flow—but this has occurred without capital funding or specific operational contributions from the Commonwealth. The absence of significant numbers of maintenance care patients in Victorian public hospitals awaiting residential care suggest that the Victorina public sector residential aged care services are accepting transfers which private services in other states do not, pointing to potential weaknesses in the incentives on private facilities.

Other states are exploring similar investments, again taking on the full financial responsibility for system blockages that originate from failures in the broader social care system. This disconnect reflects a broader misalignment in the health and aged, disability and social care interface, where public hospitals are absorbing the downstream consequences of broader system failures predominantly the responsibility of the Commonwealth.

There are several policy levers that can be considered to address this growing challenge:

1. First, national definitions and reporting of stranded patients, including the type of accommodation they are waiting for, should be standardised to enable consistent tracking and accountability. This should include the National Disability Insurance Agency (NDIA) reporting to Disability Ministers on NDIS patients in public hospitals awaiting discharge.
2. Second, the Commonwealth must take greater responsibility—through both funding and system stewardship—for ensuring timely access to aged care, disability supports, and other non-hospital services. This includes contributing to capital and operational funding for transitional or

step-down care capacity and ensuring private facilities have an incentive to take patients awaiting discharge.
    a. At present there are split responsibilities for setting incentives with respect to stranded patients and aged care, which may hinder IHACPA's ability to control and coordinate incentives in the Pricing Framework. IHACPA is responsible for setting the NEP while the Department of Health, Disability and Ageing has responsibility for the Australian National Aged Care Classification funding model.
    b. Aligning incentives in the Pricing Framework and the Australian National Aged Care Classification funding model is an area where the Commonwealth can take a coordinated approach to reducing the burden of stranded patients on public hospitals.
3. Third, adjustments to the NEP and the Pricing Framework must be more responsive to structural shifts in hospital activity profiles, ensuring that states are not financially penalised for pressures outside their control.
4. Finally, the NHRA should evolve to better reflect joint system responsibilities and provide incentives for timely discharge, more efficient use of hospital resources, and equitable arrangements across all levels of government.

Case Study: Investigating Long-Stay patients in Queensland

Queensland Health has released updated data as of February 2025, highlighting the ongoing and escalating challenge of long-stay patients and the resulting pressure on the acute hospital system. (System Policy Branch, Queensland Health, February 2025)

1. Rising Number of Stranded Patients: In 2022, the Productivity Commission reported 555 patients awaiting placement in residential aged care facilities (RACFs) or disability support services. By February 2025, this number had risen to 782 – a 40% increase over three years. This upward trend in stranded patients is expected to continue without significant intervention.
2. Growth in Long-Stay Patients and Impact on Capacity: The total number of long-stay patients has more than doubled, increasing from 512 in 2022 to 1,096 in 2025 – a 114% increase. These patients now occupy 9.3% of Queensland's available hospital beds, up from 7.9% in November 2024. This growing occupancy further restricts access to acute care and compounds hospital capacity constraints.
3. Length of Stay and Associated Costs: Older long-stay patients have a median hospital stay of 50 days, often remaining in hospital well beyond the point that they are medically ready for discharge. Younger long-stay patients are admitted for significantly longer, with an average total admission of 105 days. A substantial proportion of this time occurs after patients are clinically assessed as ready for discharge, reflecting delays in accessing appropriate post-hospital supports. Prolonged stays for medically ready patients limit hospital capacity and hinder timely admissions for others. These extended admissions contribute to reduced patient flow and operational efficiency and result in high system costs, estimated at approximately $52,000 per older long-stay patient and $218,000 per younger long-stay patient.
4. Discharge Barriers: A significant 71% of long-stay patients who are unable to be discharged face primary barriers related to access to RACF or disability support services. These include limited bed availability and delays in National Disability Insurance Scheme (NDIS) approvals and administrative processes, which prevent timely transitions out of hospital.

Case Study: Investigating Victoria's management of elderly stranded patients

Data from the Australian Medical Association shows that in 2020–21, Victoria had the lowest number of hospital patient days attributable to waiting for aged care placements compared to other jurisdictions. This performance reflects Victoria's distinctive approach, stepping into an area of Commonwealth responsibility by providing aged care services. The Victorian approach includes the availability of the Transition Care Program (TCP) and a higher proportion of publicly operated residential aged care services.

1. Transition Care Program (TCP): TCP provides a short-term care pathway that supports older people who are medically ready to leave hospital but are awaiting longer-term aged care placement. The program offers case management, medical oversight, low-intensity therapy, and personal support, typically for 4 to 6 weeks. By enabling early discharge and reducing time spent in acute care settings, TCP improves patient experience and helps alleviate hospital bed pressure. (Victoria Department of Health, Transition Care Program)

2. Public Sector Residential Aged Care Services (PSRACS): Victoria operates 171 PSRACS, making it the largest public provider of residential aged care in the country. In 2022, public beds represented approximately 9% of all residential aged care beds in Victoria—well above the 0–4% average in other jurisdictions. This higher proportion of public beds enhances placement capacity and improves access, particularly in rural areas, helping to reduce delays in discharge for older patients. (Public Sector Residential Aged Care Sector Leadership, Aged Care Pricing

Workforce shortages

A major driver of ongoing and future cost pressure in the public hospital system is the clinical workforce shortages across Australia. These shortages have been driven by a combination of changed patterns of engagement (including increased part-time working), insufficient domestic training and supply, alongside intensifying international competition for health professionals across nursing, medical, and allied health disciplines. While workforce constraints were already present in some areas prior to 2020, they became significantly more pronounced following the onset of COVID-19 and have remained elevated since.

Section summary

Workforce shortages, exacerbated by COVID-19, have resulted in wage escalation and increasing use of external contract labour to fill vacancies. This has caused significant labour cost increases.

National data shows a reported increase in workforce shortages across all major clinical streams post COVID-19, (**Figure 13**) with particular gaps in specialist areas such as psychiatry and psychology. There shortages have placed pressure on health services to maintain safe and continuous care delivery. In response services have increasingly relied on temporary and external contract labour – such as agency nurses and medical locums – to fill critical labour gaps (**Figure 14**). This response, while necessary in the short term, comes at a premium cost and undermines long-term workforce sustainability.

Figure 13: Workforce shortages have increased in all major clinical professions - with the greatest proportional increase in medical staffing, though nursing is the largest in absolute terms

Source: ABS, Job Vacancies

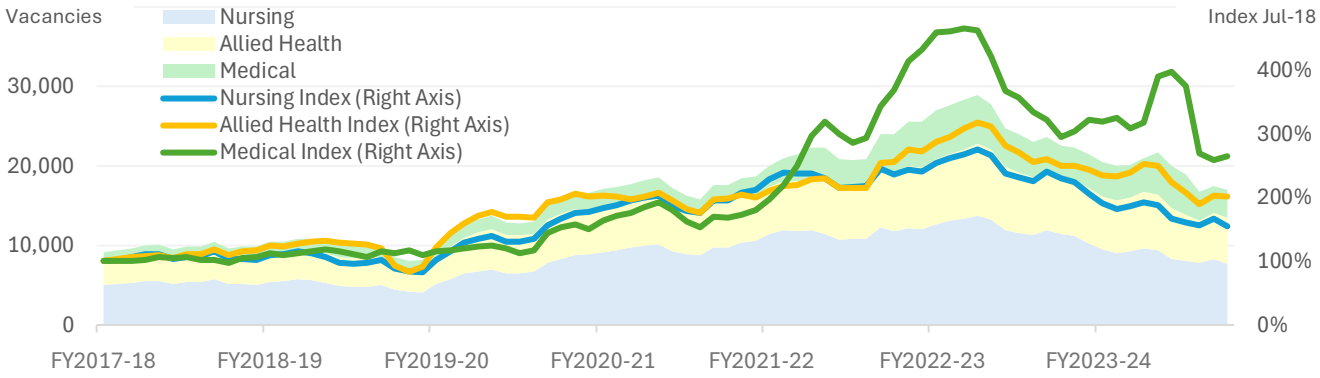
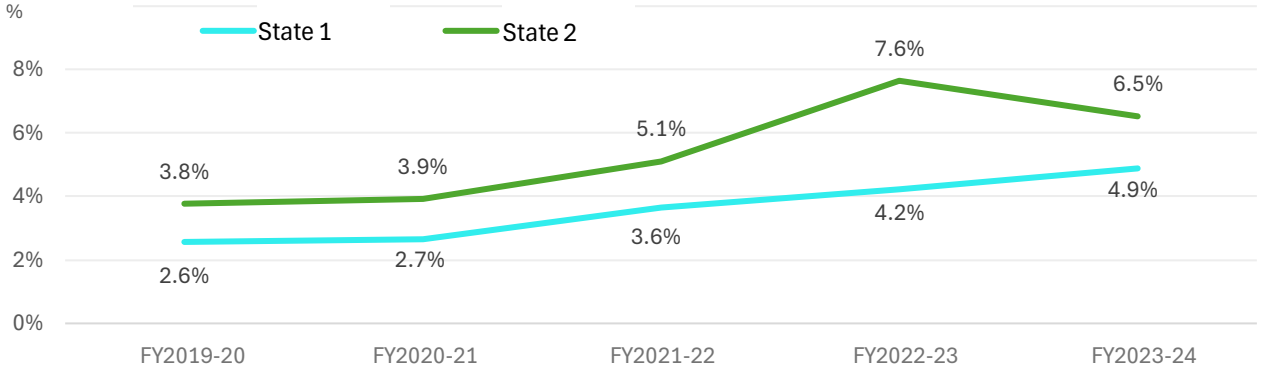


Figure 14: States and Territory health services have been required to employ a greater proportion of external labour to address workforce shortages

Source: Jurisdictional data



The legitimacy of the cost pressure is clear. Health services are operating in an environment where supply side constraints and inflationary wage expectations intersect. Following the general inflation surge post COVID-19, public sector bargaining efforts have been constrained. In the context of severe workforce shortages this significantly reduces the bargaining power of jurisdictions and contributes to above-CPI wage growth across health professions.

The ongoing impact of workforce shortages is expected to continue driving real cost growth across the system. The premium costs associated with contract labour, coupled with structural wage pressure will continue to increase operating costs—regardless of whether the overall volume of hospital activity changes. Without intervention, these pressures will compound over time, particularly in regional and remote areas where shortages are most acute and reliance on agency staffing is often the highest.

Addressing these pressures requires coordinated national action across multiple fronts. A stronger and better-funded domestic training pipeline, improved workforce retention strategies, and more flexible migration and credentialing pathways will be necessary to close the supply gap. At the same time, pricing and funding frameworks should recognise the structural nature of workforce-driven cost growth and allow for differentiated cost recognition in high-risk or hard-to-staff locations. Over the longer term, the alignment of Commonwealth and state workforce planning efforts will be essential to stabilise labour markets and contain the inflationary impacts of ongoing clinical workforce shortages.

Increased patient complexity

A further contributor to sustained real cost pressure in public hospitals is the increasing complexity of the patient population. Unlike sudden system shocks, rising patient complexity is a long-term trend that has gradually but persistently driven up the cost of care. Patients are presenting with more advanced disease, multiple comorbidities, and greater support needs, making treatment more resource-intensive over time. This trend places steady upward pressure on hospital costs and the NEP.

Section summary

Hospital patients are now older and more complex than five years ago. An increase in case mix towards elderly patients increases monitoring and labour intensity within the acute patient cohort. The impact of more complex patients is not seen in acuity weights yet due to the 3-year lag in the NEP, but effect the actual, real-time cost of service delivery for public hospitals.

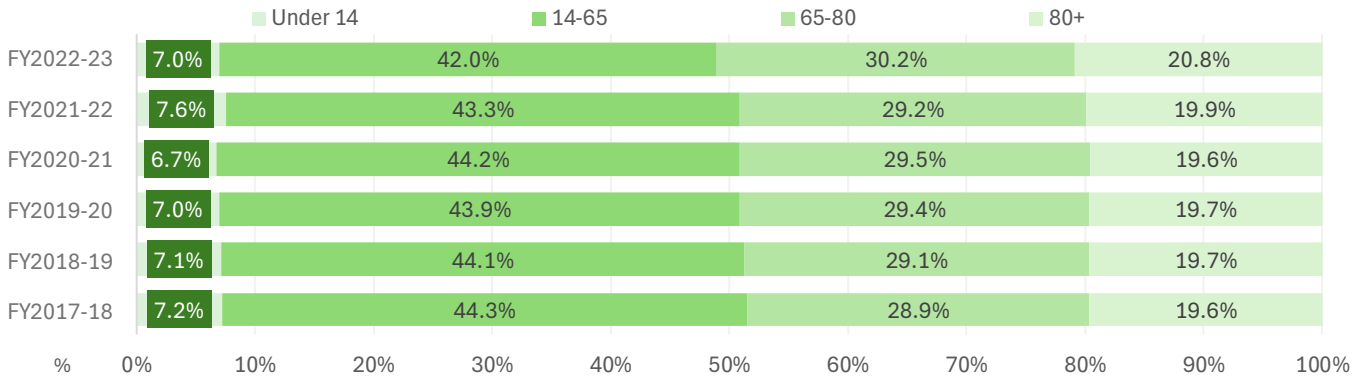
Evidence of this shift is clear across multiple indicators. The ageing of the population has been a key driver—between 1981 and 2021, the population aged 65 years and over grew at 2.2 times the rate of the population under 65.

Hospital patients are now older and more complex than five years ago. An increase in casemix towards elderly patients increases monitoring and labour intensity within the acute patient cohort.

People over 65 account for more than half of all admissions, up from 48.5% in FY2017-18. Older patients are at greater risk of needing supported care after discharge from a hospital. Delays in accessing home or residential care creates 'stranded patients' - patients who no longer need acute care but cannot be discharged (Figure 15).

Figure 15: The proportion of older patient being admitted has increased contributing to increasing complexity and stranded patients

Source: AIHW: AR-DRG Data Cubes

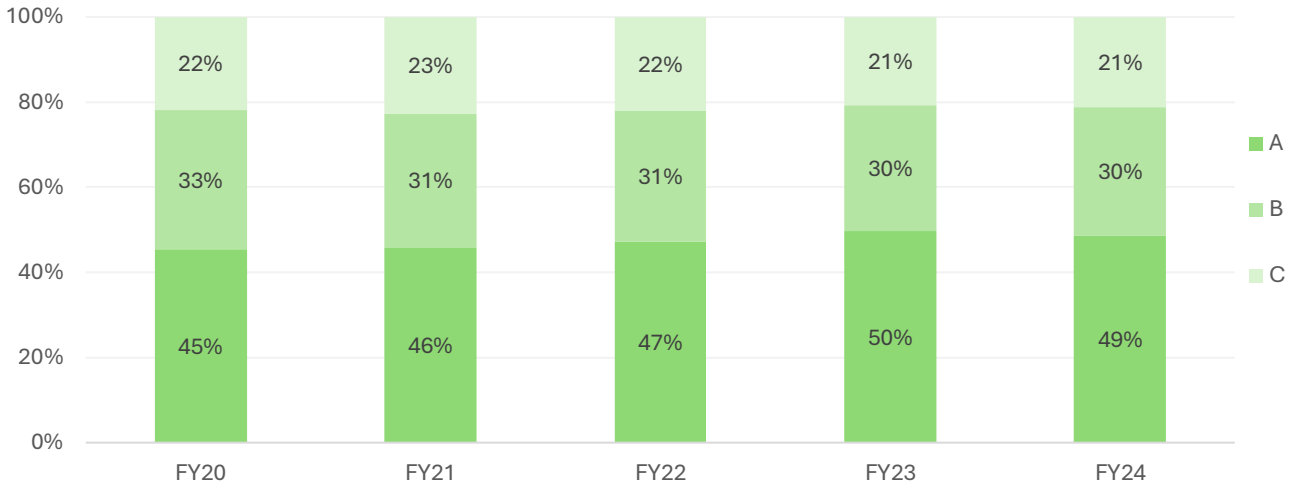


In parallel, the rising prevalence of chronic diseases such as dementia, diabetes, and cardiovascular conditions has increased the clinical complexity of admitted patients. Analysis of coded hospital activity confirms this trend, with a rising proportion of patients being assigned higher complexity weights over time (Figure 16). The DRG system provides for hierarchies of complexity levels that are formally recorded in patient data using three categories—A (major), B (intermediate), and C (minor)—though these are not always consistently captured, and some activity streams may underrepresent the true resource intensity of care. Analysis of the three-way split (A, B, C) shows an increase in beddays consumed by the most complex patients.

Figure 16: The complexity of patients (measured by beddays by assigned DRG) has contributed to increased average length of stay and resource utilisation

Source: AIHW: AR-DRG Data Cubes

**Profile only includes DRG families with A/B/C split*

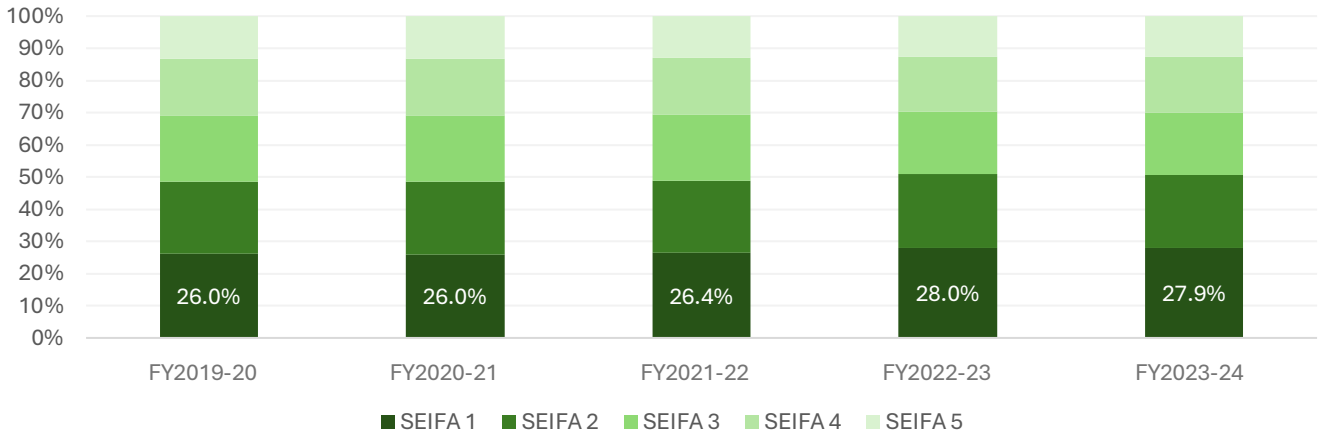


Further compounding complexity is the socioeconomic profile of hospital patients. Analysis shows that the share of acute admitted patients from the most disadvantaged SEIFA quintile (SEIFA 1) increased from 26% in FY2017–18 to 28% in FY2023–24 (Figure 17).

This growing concentration of disadvantage correlates with poorer underlying health, increased rates of multimorbidity, and greater demand for hospital and social support services—intensifying cost pressures for hospitals serving disadvantaged communities.

Figure 17: The population accessing public hospitals for care is relatively disadvantaged to the broader population – and this rate of disadvantage has steadily increased over time

** Profile only includes DRG families with A/B/C split*
Source: AIHW: AR-DRG Data Cubes



The legitimacy of complexity as a cost driver lies in its direct connection to resource use. More complex patients require more diagnostic investigation, closer monitoring, and more intensive input from clinical staff. In acute settings, this translates into longer lengths of stay, higher nursing ratios, and more frequent readmissions. Yet, the funding system does not always respond commensurately. In cases where

complexity is not fully captured in coding or is distributed across activity streams that attract lower NWAU weights, the funding return does not reflect the true cost of care. This issue is further exacerbated by the lag between changes in care models and the three-year average lag in data that informs the NEP. As complexity accelerates, the pricing framework often reflects a delayed and diluted picture of actual cost growth.

The long-term nature of this cost pressure means it is unlikely to resolve without proactive system adjustments. Without action, the burden of increasingly complex care will continue to drive real cost growth, particularly in subpopulations that require high clinical input and post-discharge support. This is not only a cost challenge but a capacity and workforce issue, as care for complex patients is typically more labour-intensive and resource-dependent than for low-acuity cases.

Policy responses must focus on improving how complexity is captured and recognised in the pricing framework; and shortening the lag between cost data and price-setting. Additionally, strategies to manage patient complexity earlier—such as investment in chronic disease management, hospital avoidance programs, and social determinants of health—can reduce the resource burden on hospitals. The alignment of funding models with the realities of an ageing, more complex population is essential to sustaining public hospital operations and ensuring funding levels accurately reflect the cost of delivering care.

Impact of the time lag for costs to inform the national efficient price and the impact on funding

There is an inherent time lag between when a patient is discharged from hospital and when their stay is coded and costed. There is then a further delay between collation and transmission of the data to IHACPA, for IHACPA to analyse the data and give notice of the new NEP. In all, this contributes to a three-year lag.

Australia's hospital pricing and funding framework—guided by the National Health Reform Agreement (NHRA)—has delivered important advances in accountability and transparency since the introduction of Activity-Based Funding (ABF). However, aspects of the current model are now under increasing pressure from the realities of a changing and inflationary healthcare environment. In particular, the combination of lagged cost data, capped funding growth, and a pricing approach that does not fully reflect real-time system pressures is contributing to growing funding challenges for states and territories.

Section summary

The NEP is developed using historical cost and activity data. This means that States and Territories must absorb cost pressure in real time, while funding relief only begins to arrive after a 3-year time lag. When the funding relief does arrive it is subject to the NHRA's 6.5% cap on Commonwealth funding increases, which creates a growing gap between actual system costs and Commonwealth contributions.

Lagged cost data and pricing impacts

IHACPA's FY2025-26 NEP determination of $7,258 represents growth of 5.9% against FY2024-25 back-cast NEP and 12.3% growth on the FY2024-25 original NEP. It is this growth that is the subject of investigation in this report. However, to understand the growth, it is important to understand the process, inputs and how the long lag in costs informing the price impacts the growth. In addition to the mechanical process of determining the price, there are implications for states and territories associated with the lag in terms of both liquidity (timing) and funding.

The National Efficient Price (NEP)

The National Efficient Price (NEP) is a benchmark price set annually by the Independent Health and Aged Care Pricing Authority (IHACPA) to determine the Commonwealth Government's funding contribution for public hospital services. It relies on admitted patient cost data to represent the average cost of an average patient episode in a public hospital, taking into account various factors like clinical and support staff salaries, accommodation, and prostheses.

The "backcast" NEP

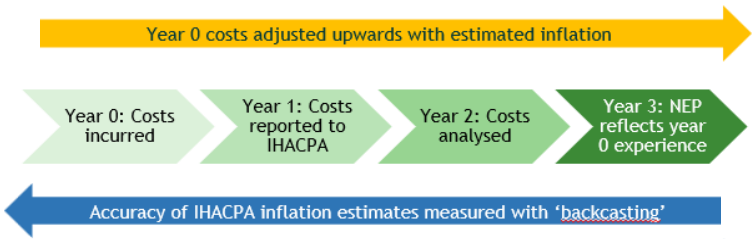
The "backcast NEP" refers to the process of recalculating the National Efficient Price (NEP) for a previous year using more up-to-date cost data and any methodological changes that have been implemented since the original NEP determination.

The process for determining the NEP is based on IHACPAs pricing framework which for the FY2025-26 NEP comprises: (Figure 18)

- FY23 costs and activity (reference year)
- Escalated for intervening years based on average growth rate for the five years prior to the Reference year
- Additional known cost movements related to the increase in the superannuation guarantee

Figure 18: There is a 3-year lag between costs informing the NEP

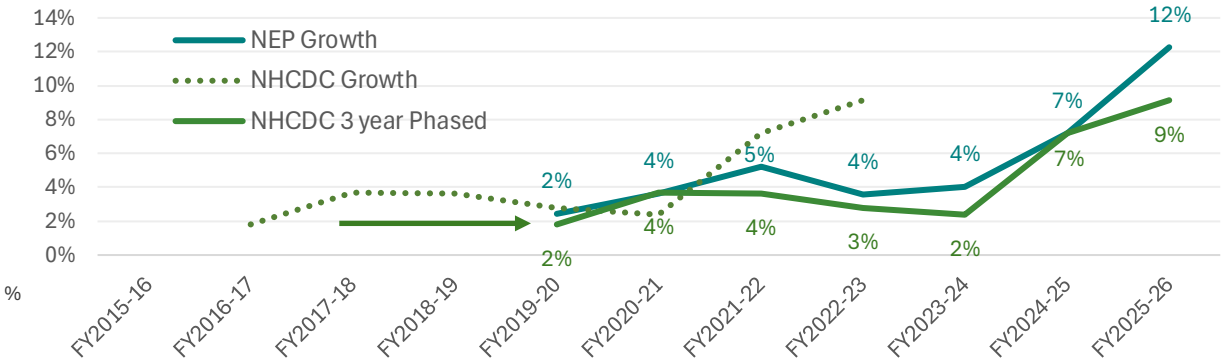
Source: Adapted from IHACPA



Fundamental to the growth in the FY2025-26 NEP is the observed change in costs in FY2022-23. This 3-year time lag in costs informing the FY2025-26 NEP means that the cost driver analysis must focus on how costs changed in the period leading up to FY2022-23 and the drivers of that change. The sharp increase in the FY2025-26 NEP is a function of the observed increase in costs in FY2022-23 – the first year 'living with COVID-19' and cost increases in prior years that had not been fully reflected in the NEP. The growth in the NEP has accelerated in the last 3 years, representing the increase in cost profile of public hospital services during and immediately following the initial COVID-19 period. (Figure 19)

Figure 19: Public Hospital costs grew sharply between FY2020-21 and FY2022-23 which are now impacting the FY2025-26 NEP

Source: IHACPA – National Efficient Price Determinations FY2019-20 – FY2025-26



The 3-year time lag to determine the NEP contrasts with the experience of private healthcare providers. The private healthcare sector sees an annual premium round occur between September and January each year, before premium changes are allowed to take effect in April. Similar to the NEP determination process, the annual premium round includes insurer submissions and a period for the Department of Health and Aged Care and the Australian Prudential Regulation Authority to assess applications. The annual premium round provides an example of a similar healthcare pricing process that can better reflect real-time system pressures.

Funding impacts of inflationary pressure and demand increases

Under the NHRA Addendum (2020–2025), annual growth in Commonwealth hospital funding is capped at 6.5%, regardless of the actual pressures experienced across the health system. In a low-inflation environment, a 6.5% cap left room for activity growth due to population growth and ageing, and technological change. However, the 6.5% cap applies even when activity levels (measured in NWAUs) rise beyond expectations, when there is price escalation in the National Efficient Price (NEP), or when hospitals face increased complexity, system strain, or delays in patient discharge.

As a result, states and territories must absorb the full cost of any growth in activity that exceeds the 6.5% threshold. There is no mechanism within the current framework to retrospectively reconcile or recover these funding shortfalls in future years. Over time, this will create a growing gap between actual system costs and Commonwealth contributions.

The challenges associated with the Commonwealth's 6.5% cap on annual hospital funding growth are becoming increasingly visible, particularly in light of recent developments in hospital pricing. The National Efficient Price (NEP) for FY2025-26 reflects cost data from three years prior, during a period of significant inflation, workforce shortages, and operational disruption. As these historical cost pressures are now being translated into the price, they are likely to drive Commonwealth funding requirements above the 6.5% cap in future years—despite these costs already having been absorbed by states and territories at the time they were incurred. Over FY2023–24 and FY2024–25 alone, the cap is estimated to have resulted in $1.9 billion in foregone Commonwealth contributions, with further shortfalls expected as the NEP continues to rise. [4]

Over the period from FY2021-22 to FY2024-25, states and territories have substantially increased their investment in health to maintain service levels in the face of rising demand and escalating input costs. Figure 3 shows the disproportionate share of Commonwealth to State funding for public hospitals.

This divergence is not solely due to the cap itself, but rather reflects the broader funding structure, including the lag between when costs are incurred and when they are reflected in the NEP. As the NEP adjusts upward to catch up with past system-wide cost growth, the risk of exceeding the 6.5% cap becomes more acute. In the absence of a mechanism to reconcile these lagged funding pressures, states are required to absorb both the historical cost growth and the immediate cost of responding to ongoing demand.

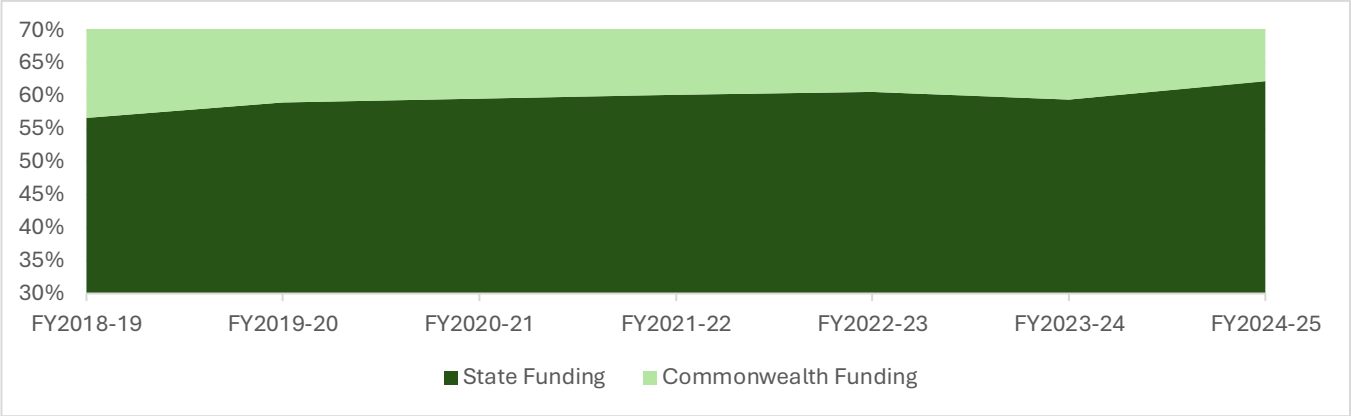
The combination of retrospective pricing and a fixed cap creates a structural misalignment between actual system costs and the Commonwealth's contribution. Without reform, this misalignment will continue to grow—limiting the responsiveness of the NHRA and shifting an increasing share of the funding burden onto the states and territories.

[4] $1.9 billion is calculated as the difference between capped and hypothetical uncapped Commonwealth contributions, accounting for price and volume changes. This information is based upon FY2023-24 actuals and preliminary FY2024-25 actuals and represents a cumulative impact.

Figure 20 shows the impact of the reducing share of overall Commonwealth hospital funding (based on total annual budgets), resulting in a cumulative fiscal impact that is not ever resolved in the current model.[5]

Figure 20: States and Territories funding has been impacted by the Commonwealth funding cap in an inflationary environment

Source: NHFB Funding Reports FY2018-19 – FY2022-23



This structural constraint continues to place significant fiscal pressure on state and territory health systems. The Commonwealth's 6.5% funding cap was introduced in a low-inflation environment (2017–18), and so there was room for reasonable activity growth within the cap. However, with inflation and the increases in costs per patient driven by stranded patients now significantly higher—particularly over the past three years—the cap has become increasingly disconnected from the real cost pressures facing hospitals and states and territories. As inflation consumes a greater share of the capped funding envelope, there is progressively less room to fund the growth in activity required to meet population need. This means states and territories are not only absorbing the full impact of inflationary pressures, but also an increasing share of total hospital funding, as the Commonwealth's contribution fails to keep pace with both rising costs and demand.

Recognising the limitations of the current funding model, the next phase of reform under the National Health Reform Agreement (NHRA) proposes to replace the existing 6.5% annual cap on Commonwealth hospital funding growth with a five-year cumulative growth cap, commencing in 2025 and running through to 2030. This shift is intended to provide a more flexible and responsive mechanism for funding hospital activity and costs over time.

In December 2023, National Cabinet endorsed an increase in the Commonwealth's contribution to public hospital funding under the NHRA. The Commonwealth committed to a 42.5% share of public hospital funding before 2030 and an increase to 45% over a maximum 10-year glide path from 1 July 2025.[6] In 2023 it was estimated that the Commonwealth would have to contribute an additional $13.2 billion to achieve the 42.5% target before 2030.

As of FY2023–24, the Commonwealth's published contribution sits at 41% and based on estimates for FY2024-25 the Commonwealth's share is anticipated to fall further, to 38%.[7] For this reason, $13.2 billion should be considered the minimum additional funding required from the Commonwealth to achieve a 42.5% share of public hospital funding before 2030. Reaching the 45% commitment over the 10-year glide path period represents a critical step toward restoring balance in shared hospital funding responsibilities and ensuring long-term system sustainability.

Importantly, the NHRA Mid-Term Review identified the need for a more fundamental structural reform. Specifically, it recommended considering decoupling the cap on volume growth from price escalation. Under this model, the Commonwealth's cap would apply only to growth in service volumes (i.e. NWAUs),

[5] Note that amounts reported in NHFB Funding Reports are based on cash movements in the National Health Funding Pool and estimated activity, which differ from the final annual determination.
[6] Meeting of National Cabinet, 6 December 2023
[7] 38% Commonwealth contribution estimate based on modelling from multiple States.

while price growth—driven by inflation, wage pressures, and other input costs—would be funded outside of the cap. This change acknowledges that price increases often reflect unavoidable system-wide pressures that should not be constrained by arbitrary funding limits and would go a long way toward correcting the current imbalance in funding contributions.

In setting the NEP, IHACPA adjusts the cost structures of the base year upwards to take account of observed economy-wide inflation and known policy changes (e.g. increases in superannuation guarantee. The more health inflation diverges from that of the broader economy, and the greater the extent of structural changes (e.g. the stranded patient issue), the more the initial estimates of price growth incorporated in the NEP are not consistent with the underlying cost growth faced by states and territories. This then leads to an increase divergence between the initially published NEP and the back-cast NEP. It places additional burden on states and territories who meet the actual costs and await the new backcast adjustments for the agreed Commonwealth funds to flow.

Costs of infrastructure and capital

Another area of growing cost pressure for states and territories is costs associated with the development and maintenance of hospital infrastructure. These costs have traditionally not been included in Commonwealth–state operating cost funding arrangements.

Section summary

Capital cost escalation – experienced when building, operating and maintaining public hospitals – is adding cost pressure to the delivery of public healthcare. Capital cost escalation is almost exclusively borne by the States and Territories, with only general maintenance costs captured in the NEP.

There are two components to costs of infrastructure and capital:

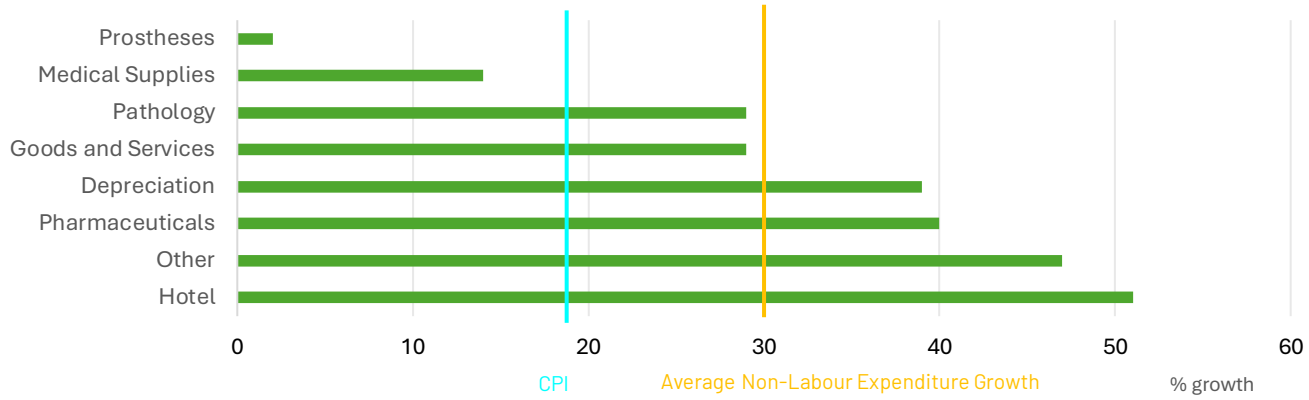
- **The capital costs associated with development of hospital infrastructure and lifecycle capital costs**, which are currently outside of the scope of the NHRA and are almost entirely borne by states and territories, in-line with this historical approach, depreciation costs are also excluded.
- **General maintenance of hospital infrastructure**, which is considered a recurrent cost and is within the scope of Activity Based Funding. The cost of infrastructure maintenance is closely tied to the cost of developing hospital infrastructure (due to common trade labour inputs and supplies).

States and territories have experienced significant escalation associated with the development and maintenance of hospital infrastructure due to economy-wide building cost escalation following the onset of COVID-19. The Case Study below provides an example of this effect, with details from recent reviews of major state hospital capital programs, outlining experiences of the impact of building cost escalation

Capital cost increases have also been reflected in recurrent costing through significantly increased depreciation—which is growing at a relatively fast rate (though note it is outside the scope of funding through the NHRA) (**Figure 21**).

Figure 21: Growth in non-labour costs per acute separation have exceeded CPI in most cost categories since FY2017-18

Source: IHACPA Public Hospital Cost Reports FY2017-18 – FY2022-23



Building cost escalation is persisting, which is expected to be a significant cost pressure currently borne only by the states and territories. There are special additional Commonwealth grants for hospital capital which may explain the anomaly of their exclusion from ordinary payment arrangements.

Case Study: Investigating capacity expansion programs

Hospital capital costs are rising due to major infrastructure programs aimed at meeting increasing capacity requirements with a growing population. While essential, these projects are largely funded by states and territories placing a growing financial burden on state and territory budgets with no ABF recognition, especially as construction and maintenance costs increase. With capital costs constantly increasing, budgets continue to blow out and could continue into the future.

1. Queensland Capacity Expansion Program (CEP) recently underwent a review. The CEP was initially announced in 2022 as a $9.785 billion program. However, with growing costs, delays and planning issues, the program is now forecast to cost the Queensland Government $16.783 billion, a 72% variance from the original planned costs. The initial budget required an increase of 70% or more to meet increased funding requirements and move to construction. The increase was driven by capital cost escalation and market constraints created by the need to deliver a significant increase in public healthcare capacity in a short period of time. The CEP is not yet complete and further budget increases may be unavoidable. (Queensland Government Capacity Expansion program independent review Report, Klok, 2025).

2. The Queensland Audit Office Review highlighted the impact of cost escalation on maintenance and repair costs. The HHS's reported a 40% increase in maintenance costs for their assets totalling $2 billion, with rising maintenance costs and deferred repairs highlighted as contributing factors.

3. A 2020 audit of the $15 billion NSW Health Infrastructure program highlighted the difficulty of delivering long-running capital programs within budget. In 2015, $2.725 billion was committed in funding health infrastructure, however, the actual budget on completion cost $279 million more. This represented a 10% variance which was largely driven by unforeseen disruption and delay and capital cost escalation (Health Capital Works Performance Audit, Audit Office, 2020).

Other factors that have been considered

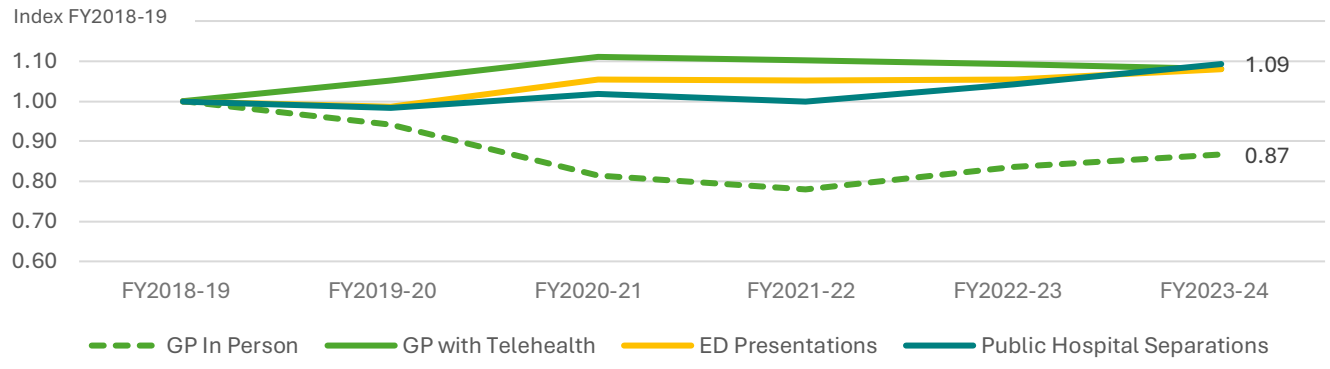
This Report considered a comprehensive range of potential drivers that could explain public hospital cost growth over the period of analysis. Assessment of the key factors that are commonly associated with public hospital cost growth was found to be:

- Private to Public Hospital Substitution: While public hospital separations have steadily increased at a faster rate than private hospital separations since FY2017-18 – it is still the case that private hospital activity volumes are growing, and the magnitude of the difference of growth rates between public and private hospitals is not significant enough to be a relevant driver of the cost dynamics observed over the period.
- Primary Care to Public Hospital Substitution: General Practice attendance volumes have seen a material shift to delivery through telehealth. When combining in-person and telehealth General Practice attendance, volumes have generally tracked in line with public hospital separation and ED attendance volumes – there is no observable clear substitution from primary care to hospital services (or vice versa). (**Figure 22**).
- Diversionary Care Models and Hospital Avoidance Pathways: It is also important to acknowledge the growing role of diversionary care models in many jurisdictions—particularly those designed to avoid unnecessary hospital or ED presentations. These may include co-responder models with ambulance services, urgent care pathways, virtual wards, or sub-acute community-based interventions. However, these activities are not consistently captured in national datasets or reporting frameworks.
- New High-Cost Treatment & Technologies: Review of the data and engagement with states & territories did not reveal any standout cost pressures due to the introduction of new technologies and treatments. The introduction of new high-cost treatments and technologies is a standard part of clinical practice and is part of the long-term trend in growth in health care costs. It is worth noting however that:
  - Not all new technologies and treatments are net cost increasing to the cost of hospital services or the health system more broadly – in fact the investment case for some treatments and technologies is predicated on net cost savings to the system over time.
  - Health services' governance and budgetary processes will typically look to limit the introduction and use of high-cost treatments and technologies except for where their net benefit can be demonstrated (though net benefits are not always financial).
  - There are existing non-ABF funding pathways (such as for PBS drugs and high-cost drugs) that provide funding for therapies that won't be included in the assessment of in-scope ABF costs.

Figure 22: Public hospital separations and ED presentations have grown largely in proportion to GP attendances – noting though that the composition of GP services has changed to now include a sizeable minority of activity delivered through telehealth modalities. An index of GP In Person attendance is included for reference, to demonstrate the material proportion of GP services now delivered through telehealth.

Source: AIHW Admitted Patient Care FY2018-19 – FY2023-24

Source: Services Australia



Conclusion

The analysis of changes in public hospital cost and activity impacting prices has highlighted a significant increase in the costs associated with operating public hospitals across Australia. Many of the identified cost escalation drivers are due to unavoidable factors, with levers outside the control of the state and territory governments. The lack of control that state and territory governments have over many elements that influence public healthcare costs has contributed to the rising NEP.

Outcome of economy-wide inflation and failures in adjacent sectors

The measured unit cost escalation that has driven recent large increases in the National Efficient Price (NEP) are an outcome of economy-wide inflation and failures in adjacent sectors – we expect this cost pressure to persist in the near term as wage outcomes catch up to recent inflation and tightness in the healthcare labour market.

Patients stranded in public hospitals

The increasing number of patients stranded in public hospitals due to unavailable aged care, disability, and appropriate community-based care has materially changed the care mix, increasing length of stay and constraining patient throughput.

The increasing number of stranded patients has also increased the labour mix.

Critical workforce shortages

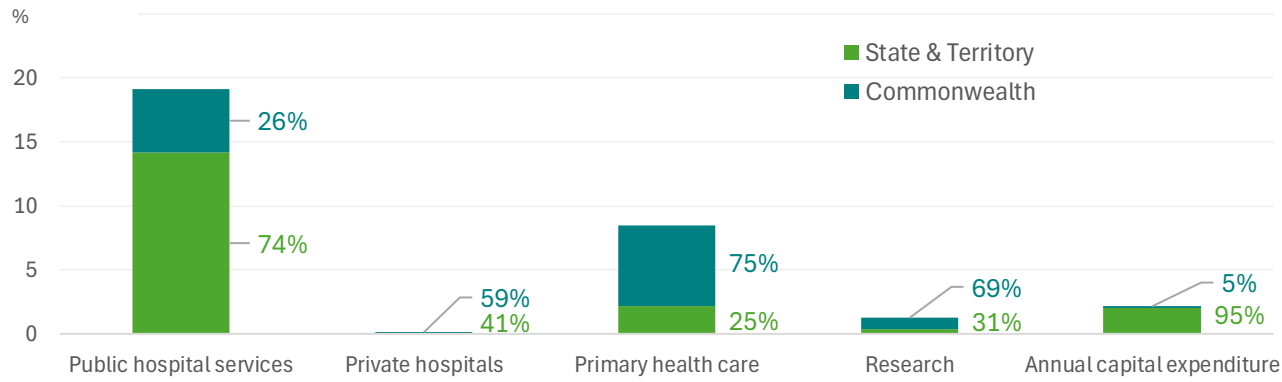
The workforce shortages following the onset of COVID-19 persist and have required the use of high-cost temporary labour to maintain patient care and impacted wage outcomes for health professional groups.

States and territories bear the majority of the volume, cost and performance risks.

Under the National Health Reform Agreement (NHRA) the states and territories bear the majority of the volume, cost and performance risks – which has seen state and territories' relative contribution to funding public hospital services continue to increase in light of the 6.5% Commonwealth funding cap. (Figure 23)

Figure 23: State and territory Governments have funded three quarters of public hospital expenditure growth since FY2017-18, most capital expenditure, and a significant portion of primary health care costs

Source: AIHW: Health Expenditure 2017-18 to 2022-23



Recommendations

In response to the analysis of the drivers of public hospital costs and prices and to ensure the sustainability of public hospitals including maintaining access to quality care, a coordinated national reform agenda is needed across the following domains:

Improving the interface between public hospitals and other parts of the health and social care system

1. Establish a health and social care policy and funding strategy

There is considerable interplay between the different parts of the health and social care system. However, there is an absence of any coordinated policy between primary health, acute care, aged care, disability and social care. This failure of policy disproportionately impacts individuals and the public hospital system, resulting in sub optimal care being delivered at a premium cost to the system.

Recommendation 1 – It is recommended that states and territories work with the Commonwealth to establish a whole of health and social care system policy and pricing strategy that acknowledges and reinforces the existing roles and responsibilities, to direct investment into the part of the system best placed to provide the care needed.

2. Ensure national accountability for interface services and stranded patients

National agreement is needed to consistently define and report stranded patients, enabling accountability for care pathways beyond the hospital system. The Commonwealth must take greater responsibility for system interface failures—including funding and delivery of aged care, disability support, and step-down accommodation. This includes contributing capital and operational funding for transitional care capacity to relieve hospitals from the increasing burden of housing patients who no longer require acute care.

Recommendation 2 – It is recommended that:

- *a classification system for stranded patients in public hospitals is established*
- *access and pricing incentives on providers of aged, disability and step down accommodation are aligned (between the Australian National Aged Care Classification funding model and NEP) and redesigned to support patients being discharged to more appropriate care setting more quickly. This should be designed to facilitate expanded Commonwealth investment in new services and capital.*

Coordinated response to workforce shortages

3. Address workforce shortages as a structural cost driver

Clinical workforce shortages have become a structural constraint and a key driver of real cost growth. National investment is required to expand domestic training pipelines, improve retention, and reform credentialing and migration pathways. The Pricing Framework should recognise labour cost intensity in hard-to-staff or high-risk areas. Workforce planning must be coordinated nationally to limit the inflationary impacts of labour scarcity on state budgets and hospital pricing.

Recommendation 3 – It is recommended that:

- *a nationally coordinated health workforce strategy is developed that outlines the health and social care sector's workforce need and strategies to meet future needs via expansion of the domestic pipeline, training pathways, credentialling reform and migration policy to be developed jointly with the Australian Tertiary Education Commission and the Jobs and Skills Australia*
- *the Public Hospital Pricing Framework incorporates measures that recognise the increased cost associated with workforce shortages via adjustments to the NEP and with reference to the lag in costing data.*

Recognise and respond to patient complexity and social disadvantage

4. Improve recognition of patient complexity and social disadvantage

Funding models must evolve to better capture increasing patient complexity, particularly in the context of an ageing population and rising multimorbidity. Enhancements to DRG complexity weightings, coding accuracy, and acuity-based funding adjustments will ensure hospitals are resourced to manage higher-need patients. The NHRA should also acknowledge the additional system costs of socioeconomic disadvantage, particularly for hospitals with growing SEIFA 1 patient cohorts.

Recommendation 4 – It is recommended that states and territories ensure patient disadvantage is appropriately recognised and captured in coding and IHACPA ensure public hospital prices and weights appropriately recognise the increasing patient complexity and social disadvantage.

Modernise the Public Hospital Pricing Framework and funding cap

5. Modernise and improve the responsiveness of the Public Hospital Pricing Framework

The current three year lag between costs informing the price determination has resulted in a misalignment between cost, price and system pressure. This also has implications for the quantum and timing of Commonwealth funding contributions to states and territories. The NEP should be more responsive to real-time cost shifts—similar to private sector mechanisms like the annual premium round—through shorter data lags, rolling updates, or interim adjustments. It has been 10 years since there has been any material review and change to the Pricing Framework. Improvements in how structural changes (such as workforce intensity or care model shifts) are incorporated into pricing will ensure the NEP more accurately reflects the efficient cost of service delivery.

Recommendation 5 – It is recommended that the Pricing Framework for Australian Public Hospital Services is modernised by improving the responsiveness of the NEP.

6. Reform the NHRA funding cap structure

The 6.5% Commonwealth funding cap has become disconnected from inflationary and structural cost pressures resulting in states and territories taking on more of the public hospital funding load. States and territories experiencing high levels of demand driven by population growth and ageing are further disadvantaged. Acknowledging recent developments in NHRA discussions that proposed increased funding contribution from the Commonwealth, further work on the design of the cap and the component parts is needed, including decoupling price growth from volume growth in the cap. Price increases driven by inflation, wages, and system complexity should be funded outside the cap, recognising that these are not discretionary cost decisions but systemic pressures outside state control.

Recommendation 6 – It is recommended that the funding arrangements better reflect volume growth, efficient cost growth and the implications on public hospitals of failure in other parts of the health and social care system by separately recognising price and volume growth in the determination of the funding cap.

Capital and infrastructure

7. The Commonwealth Government contribute to the cost of public hospital infrastructure

The NHRA and NEP currently exclude capital costs, despite states facing escalating infrastructure costs driven by post COVID-19 construction inflation. Commonwealth contributions should account for both operational and capital costs where those investments support national access and performance priorities, particularly for interface infrastructure like transitional care, aged care, and regional hospital redevelopment.

Recommendation 7 – It is recommended that the NHRA should incorporate the capital and operating cost of public hospital infrastructure and assets into the funding arrangements to be phased in over a 5 year period.

Diversionary care

8. Fund diversionary care and system innovation

The current public hospital funding and pricing frameworks do not incentivise or recognise the cost of avoided care. States and territories are increasingly investing in hospital avoidance models—such as co-

responder models with ambulance services, alternates to primary care (e.g. Satellite Health Centres), and virtual care pathways—that may not be fully reflected in traditional admitted or ED activity measures. Future funding frameworks must be flexible enough to recognise and reward these diversionary models, ensuring that innovation in care delivery is not financially penalised.

Recommendation 8 – It is recommended that the definition of public hospital services be expanded and updated regularly to recognise diversionary and hospital avoidance services and separately fund these services outside the funding cap.

Monitoring of emerging issues

9. Continue targeted monitoring of other potential drivers

The Report considered other commonly cited cost drivers—including private-to-public substitution, shifts in primary care, and the introduction of new technologies—and found these to be relatively stable over the period of analysis. However, targeted monitoring should continue to ensure that emerging trends are captured early, particularly where they may accelerate system cost pressures or shift volumes toward public hospitals.

Recommendation 9 – It is recommended that IHACPA establish mechanisms to monitor for material changes in the service mix and structure of public hospital services to make price adjustments.

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We acknowledge the policy experts across Australia who offered valuable insights through interviews, case studies, and jurisdictional feedback processes. Their firsthand experiences have grounded the analysis and ensured the relevance of findings.

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Acronyms

ABS	Australian Bureau of Statistics
ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
AECC	Australian Emergency Care Classification
AHR	Avoidable hospital readmission
AMHCC	Australian Mental Health Care Classification
ALOS	Average Length of Stay
ANAPP	Australian Non-Admitted Patient Classification Project
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
ATTC	Australian Teaching and Training Classification
CEP	Capital Expansion Program
CPI	Consumer Price Index
COVID-19	Coronavirus disease 2019
DRG	Diagnosis Related Group
eMR	Electronic medical record
HAC	Hospital acquired complication
HoNOS	Health of the Nation Outcome Scales
HHS	Hospital and Health Service
HMM	Health Ministers' Meetings
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive care unit
IHACPA	Independent Health and Aged Care Pricing Authority
LHN	Local hospital network
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NDIA	National Disability Insurance Agency
NHRA	National Health Reform Agreement
NWAU	National weighted activity unit
PBS	Pharmaceutical Benefits Scheme
The addendum	Addendum to the National Health Reform Agreement 2020–26
The commission	Australian Commission on Safety and Quality in Health Care
The mid-term review	Mid-Term Review of the NHRA Addendum 2020–2025 – Final Report
UDG	Urgency Disposition Group
WHO	World Health Organisation
WPI	Wage Price Index

Glossary

Activity Based Funding	Refers to a system for funding public hospital services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Health and Aged Care Pricing Authority.
Admitted acute care	Admitted acute care is care in which the primary treatment goal is to manage labour (obstetric), cure illness or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce severity of an illness or injury, protect against exacerbation of illness or injury which could threaten life or normal function, perform diagnostic or therapeutic procedures.
Average Length of Stay	The Average Length of Stay is calculated as the total number of patient days reported for the hospital (or group of hospitals), divided by the number of hospitalisations.
Back-casting	The process by which the effect of significant changes to the Activity Based Funding classification systems or costing methodologies are reflected in the national pricing model the year prior to implementation, for the purpose of calculating Commonwealth growth funding for each Activity Based Funding service category.
Consumer Price Index	The Consumer Price Index measures changes in the prices of goods and services that households consume. It is used to calculate inflation and the cost of living in Australia.
Direct costs	Expenses directly attributable to patient care, including medical supplies, medications, and staff time.
Independent Health and Aged Care Pricing Authority	An independent government agency that assists the Australian Government to fund hospital and aged care services more efficiently by providing evidence-based price determinations and pricing advice.
Indirect costs	Overhead expenses not directly linked to patient care, such as administrative support, facility maintenance, and utilities
National Efficient Price	An annual price set by the Independent Health and Aged Care Pricing Authority representing the average cost of providing a standardised hospital service, used to determine Commonwealth Activity Based Funding payments to states.
National Health Reform Agreement	An agreement between the Australian Government and all state and territory governments. Through this agreement, the Australian Government contributes funds to the states and territories for public hospital services. This includes services delivered through emergency departments, hospitals and community health settings.
National Hospital Cost Data Collection	The National Hospital Cost Data Collection for the public sector, collected through the states and territories, is the primary data collection used to develop the national efficient price.
National Pricing Framework	The national pricing framework is produced annually by the Independent Health and Aged Care Pricing Authority and defines the national efficient price, price weights and adjustments based on the cost and activity data from three years prior.
Non-acute care	Non-acute (or maintenance) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Patients with a care type of maintenance care often require care over an indefinite period.
Pricing Authority	The governing body of the Independent Health and Aged Care Pricing Authority established under the *National Health Reform Act 2011* (Cwlth) (the NHR Act).
Sub-acute Care	Subacute care is defined as specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction.
Wage Price Index	The Wage Price Index broadly measures changes in the wages paid by Australian businesses to employees. It is compiled and published quarterly, and individual indexes are compiled for various combinations of state/territory, sector (private/public), and industry divisions.