A review of data capture, costing and pricing for virtual care in Australian public hospitals: Insights and challenges

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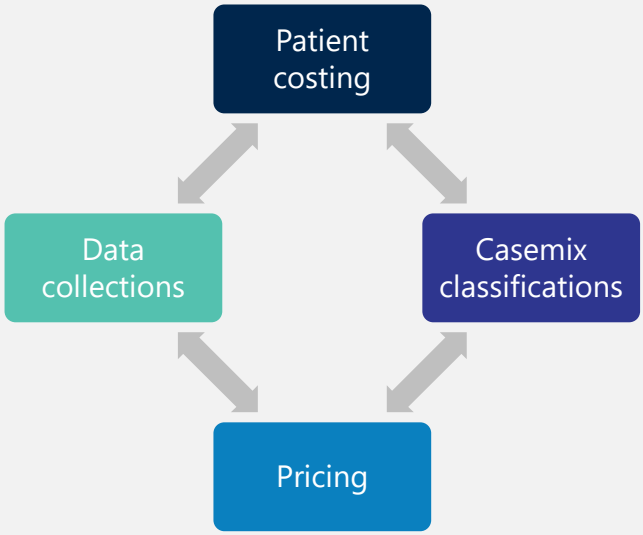
Acknowledgment

Integrating virtual care into national pricing frameworks

- IHACPA develops and refines a range of systems that enable activity based funding (ABF) for Australian public hospital services.
- Rapid expansion of virtual care delivery since the onset of the COVID-19 pandemic.
- Variation in virtual care models and data reporting.
- IHACPA commissioned a review to examine the role of virtual models of care in the health system.
- Focused on activity and cost data collections and integration into national pricing and funding.



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We undertook a national review of virtual care

The Virtual Care Project sought to:

- Identify emerging trends in the delivery of virtual care, including models of virtual care and funding mechanisms
- Understand the extent of capture of virtual care activity and costs across Australia
- Understand international trends in classifying and funding virtual care
- Identify recommendations for improved integration of virtual care into the national pricing model

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Methodology

The project was undertaken between February and June 2024, and informed by two key inputs:

Literature review and desktop scan

This included both **peer-reviewed literature** and **grey literature** covering:

- Government strategy documents and guidelines (local and international)
- Analysis of definitions and data collections to understand data capture on virtual care
- Literature on data representation, classification, costing, and funding of virtual models
- Submissions to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services (2023–24, 2024–25)*
- Materials from IHACPA and consulted stakeholders

Stakeholder consultation

Interviews, focus groups and workshops were conducted with **approximately 160 stakeholders**:

- Australian Government agencies
- Jurisdictional health departments
- Local Health Networks and health services
- Hospital and allied health representative groups
- Industry representatives
- International contacts

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Findings: Variations in virtual care models create challenges for a nationally consistent definition of virtual care

- There is a wide range of virtual care models across jurisdictions, with different modalities and interaction types used in different settings.
- Existing definitions are broad and applied inconsistently.
- Despite these variations, common models of virtual care can still be identified.
- Virtual care can be grouped into eleven models spanning public hospital service categories.

Modality	Interaction type	Service category
Telehealth	Patient–Clinician	Non-admitted
Remote patient monitoring	Clinician–Clinician	Admitted
Store and forward		Emergency

Websites and mobile applications were not included as they were not widely reported on during consultations.
Telehealth includes both videoconferencing and phone calls.

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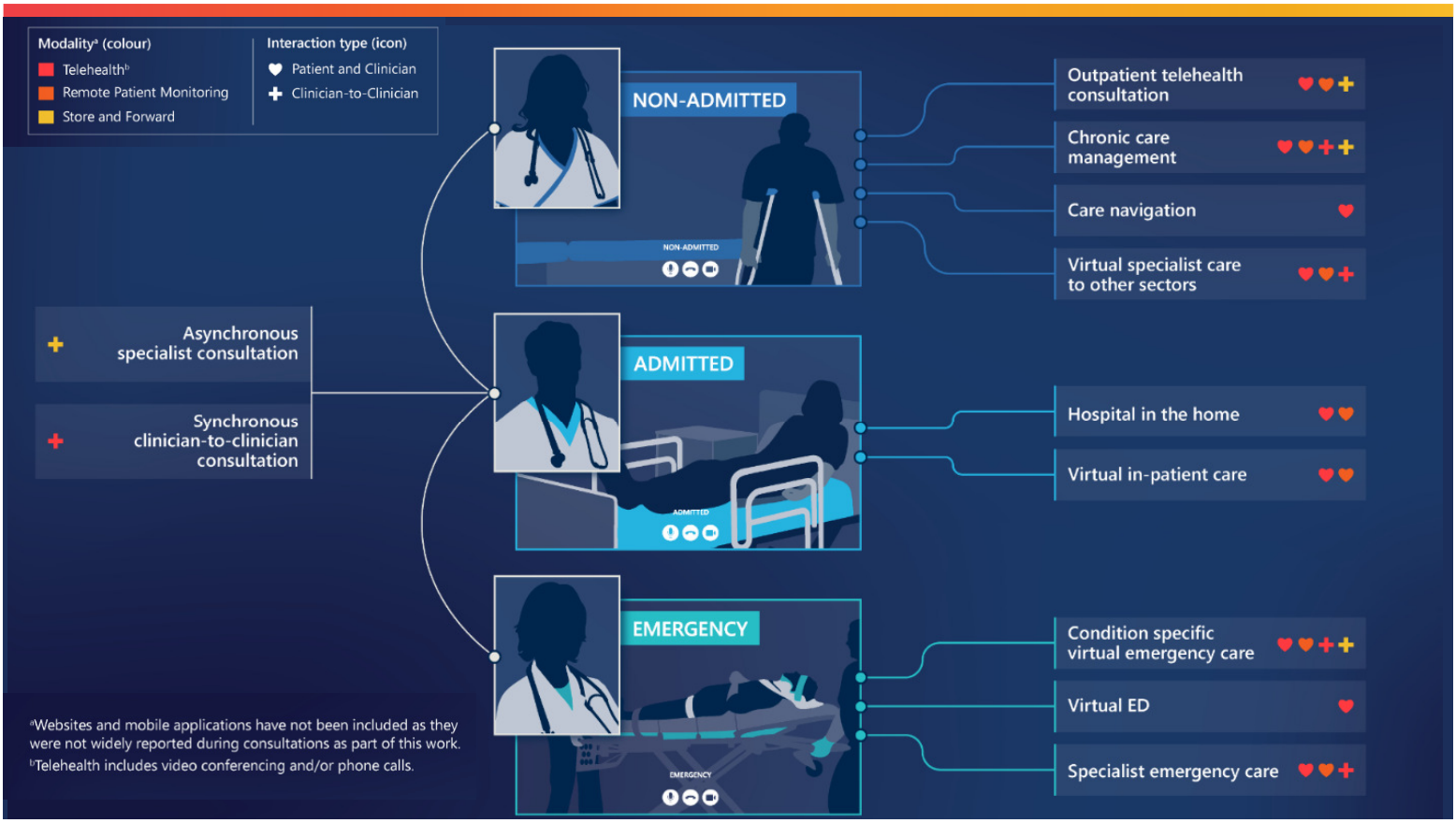

Findings: Virtual care is captured within national systems, but with gaps in visibility and attribution

PRICING/FUNDING

- Virtual care models are included in national pricing – funded through ABF or block funding.
- Under ABF, funding is tied to the patient encounter.
- Therefore, **hospitals must manage funding for external service inputs** (e.g., remote monitoring of high dependency patients, specialist stroke advice).

COSTING

- Virtual care costs are included in national costing.
- However, allocation of costs not consistently attributed to the services delivering care.
- **This masks the real cost of virtual care and makes it harder to fund, improve, and sustain innovative models**

COUNTING

- There is limited visibility of virtual care in state and national data collections.
- **This makes it difficult to observe and quantify virtual care activity, assess utilisation trends, or compare models across jurisdictions.**

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Recommendations | There are opportunities to improve the integration of virtual care into the pricing and funding for public hospital services

The project made five key recommendations relating to definition and scope, data collection, costing and pricing/funding:

1. **Developing a national definition and taxonomy of virtual care** to provide clarity on the scope and boundaries for virtual care services.
2. **Improving the visibility of virtual care in national data collections** by identifying gaps and addressing them.
3. **Improving national consistency in identifying and allocating costs of virtual care.**
4. **Consider supplementary collections** to the NHCDC to cost service innovations, including virtual care.
5. **Developing a pathway** to facilitate the transition of service innovations to ABF or alternative funding models that improve value.

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Insights for classification and funding system development

What's working:

- Australian casemix classifications have shown **flexibility**, adapting to and accommodating changes in care delivery.
- Funding models have **absorbed rapid shifts** in virtual care without intervention.
- Australian casemix classifications are designed for and used by stakeholders for **purposes beyond funding**, including safety and quality monitoring, planning and evaluation.

What still needs work:

- **Clear definitions** of virtual care for national consistency.
- **Greater visibility of virtual care in data** collection.
- **Consistent clinical costing** to reflect service innovations.
- **Policy decisions on trade-offs** of granularity in data collection, costing, classification and pricing, with their materiality and resource burden.

Definitions → Counting → Classification → Costing → Pricing

With clear definitions and counting, virtual care can flow through data collections, classifications, and patient costing, to be sustainably priced and funded within the national system

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Questions

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