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| Policy and funding guidelines 2025–26 |
| Funding rules |
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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.

ISSN 2653-4207 (online/Word)

Available on the [Policy and Funding Guidelines webpage](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>.

# Contents

[Contents 2](#_Toc201148196)

[Overview of the Policy and funding guidelines 2025–26 5](#_Toc201148197)

[Policy guide 5](#_Toc201148198)

[Funding rules 5](#_Toc201148199)

[Terminology 6](#_Toc201148200)

[Part 1: Funding and pricing arrangements 7](#_Toc201148201)

[1 National funding and pricing of public hospitals 8](#_Toc201148202)

[1.1 National health reform agreement 8](#_Toc201148203)

[1.2 Pricing framework for Australian public hospitals 8](#_Toc201148204)

[1.3 Activity-based funding 9](#_Toc201148205)

[1.4 Block funding 9](#_Toc201148206)

[1.5 Victorian alignment with the national funding model 10](#_Toc201148207)

[2 Victorian pricing framework for activity-based funded health services 12](#_Toc201148208)

[2.1 Victorian ABF pricing framework principles 12](#_Toc201148209)

[2.2 Victorian ABF pricing framework scope 13](#_Toc201148210)

[2.3 Victorian efficient price 13](#_Toc201148211)

[2.4 Localised pricing adjustments 13](#_Toc201148212)

[2.5 Funding reforms 2025–26 17](#_Toc201148213)

[3 NHRA services funded outside the Victorian ABF pricing framework 18](#_Toc201148214)

[3.1 Community palliative care 18](#_Toc201148215)

[3.2 Palliative care consultancy services 18](#_Toc201148216)

[3.3 Complex care program (previously the Family Choice Program) 19](#_Toc201148217)

[3.4 Early parenting services 20](#_Toc201148218)

[3.5 Forensicare 20](#_Toc201148219)

[3.6 Genetic clinical activity 20](#_Toc201148220)

[3.7 High-cost, highly specialised therapies 20](#_Toc201148221)

[3.8 Lithotripsy 21](#_Toc201148222)

[3.9 Mental health and wellbeing 21](#_Toc201148223)

[3.10 Radiotherapy 22](#_Toc201148224)

[3.11 Small rural health services 24](#_Toc201148225)

[3.12 Subacute and non-acute care exceptions to national funding model 24](#_Toc201148226)

[3.13 Training and development 25](#_Toc201148227)

[3.14 Victorian Virtual Emergency Department 25](#_Toc201148228)

[4 Services funded in addition to the NHRA 26](#_Toc201148229)

[4.1 Alcohol and other drug services 26](#_Toc201148230)

[4.2 Community health pricing 26](#_Toc201148231)

[4.3 Local public health unit block-funded functions 26](#_Toc201148232)

[4.4 Mental health community support services 27](#_Toc201148233)

[4.5 Nationally funded centres 27](#_Toc201148234)

[4.6 Ageing, aged and home care 27](#_Toc201148235)

[4.7 Transition Care Program 28](#_Toc201148236)

[5 Compensable, cross-border and prisoner patients 30](#_Toc201148237)

[5.1 Compensable patients 30](#_Toc201148238)

[5.2 Cross-border patients 36](#_Toc201148239)

[5.3 Private patients in public hospitals 37](#_Toc201148240)

[5.4 Prisoners 37](#_Toc201148241)

[6 Improving health outcomes for Aboriginal and Torres Strait Islander patients 39](#_Toc201148242)

[6.1 Aboriginal cultural safety planning and reporting requirements 40](#_Toc201148243)

[6.2 Indicators and monitoring 40](#_Toc201148244)

[7 Pricing for quality 41](#_Toc201148245)

[7.1 Sentinel events 41](#_Toc201148246)

[7.2 Hospital acquired complications 42](#_Toc201148247)

[7.3 Avoidable hospital readmissions 42](#_Toc201148248)

[8 Health service requirements 45](#_Toc201148249)

[8.1 Patient costing 45](#_Toc201148250)

[8.2 Activity reporting 46](#_Toc201148251)

[9 National funding model arrangements 49](#_Toc201148252)

[9.1 National classifications 49](#_Toc201148253)

[9.2 National price weights 49](#_Toc201148254)

[9.3 National efficient price 49](#_Toc201148255)

[9.4 Adjustments to the national efficient price 50](#_Toc201148256)

[9.5 Payment flows under the national funding approach 50](#_Toc201148257)

[10 Prior-year adjustment: activity-based funding reconciliation 51](#_Toc201148258)

[10.1 Victorian funding recall policy 51](#_Toc201148259)

[10.2 Funding for throughput above target 54](#_Toc201148260)

[10.3 Recall with respect to public and private activity mix changes 55](#_Toc201148261)

[10.4 Reconciliation of National Health Reform Commonwealth contributions 55](#_Toc201148262)

[10.5 Reconciliation of pricing for safety and quality adjustments 55](#_Toc201148263)

[10.6 NWAU reports 55](#_Toc201148264)

[11 Calculating funding recall and adjustment 57](#_Toc201148265)

[11.1 Calculating NWAU funding recall 57](#_Toc201148266)

[11.2 Calculating HAC NWAU growth-funding adjustment 57](#_Toc201148267)

[11.3 Calculating AHR NWAU growth-funding adjustment 57](#_Toc201148268)

[11.4 Calculating TAC, WorkSafe or Department of Veterans’ Affairs NWAU funding recall 57](#_Toc201148269)

[12 Payments and cash flow 59](#_Toc201148270)

[12.1 Use of contracts 59](#_Toc201148271)

[12.2 Health service fees and charges 59](#_Toc201148272)

[12.3 Facility-based renal dialysis 59](#_Toc201148273)

[12.4 Private patient accommodation charges 60](#_Toc201148274)

[12.5 Doctors in training secondment arrangements 60](#_Toc201148275)

[13 Price tables 61](#_Toc201148276)

[13.1 NWAU 2025–26 61](#_Toc201148277)

[13.2 Other price-based activity 61](#_Toc201148278)

[13.3 Mental health services 62](#_Toc201148279)

[13.4 Early Parenting Centres 64](#_Toc201148280)

[13.5 Ageing, aged and home care 64](#_Toc201148281)

[13.6 Small rural health services – ageing, aged and home care 65](#_Toc201148282)

[13.7 Primary, community and dental health output group 66](#_Toc201148283)

[13.8 Training and development 67](#_Toc201148284)

[14 Price groups for NWAU purposes 68](#_Toc201148285)

[15 Output and activity tables 70](#_Toc201148286)

[Part 2: Funding and activity levels 78](#_Toc201148287)

[16 Budget tables 79](#_Toc201148288)

[16.1 Health service modelled budgets 2025–26 79](#_Toc201148289)

[16.2 Small rural health services expenditure budgets 2025–26 81](#_Toc201148290)

[16.3 Activity-based funding: health service expenditure budgets 2025–26 by service category 83](#_Toc201148291)

[16.4 Mental health expenditure budgets 2025–26 by service type 87](#_Toc201148292)

[16.5 Registered Community Health Centres Budgets 2025–26 92](#_Toc201148293)

[16.6 Local government authorities 2025–26 93](#_Toc201148294)

[16.7 Non-government providers 2025–26 95](#_Toc201148295)

[16.8 Other funded organisations 2025–26 98](#_Toc201148296)

[16.9 Health operations 2025–26 99](#_Toc201148297)

[17 Activity target tables 100](#_Toc201148298)

[17.1 Victorian activity targets (NWAU) 2025–26 100](#_Toc201148299)

[17.2 Indicative NWAU adjustments for safety and quality 102](#_Toc201148300)

[17.3 Victorian small rural health service activity targets 2025–26 105](#_Toc201148301)

[17.4 Non-admitted radiotherapy activity (WAU) targets 2025–26 106](#_Toc201148302)

[17.5 Transition Care Program targets 2025–26 107](#_Toc201148303)

[17.6 Non-admitted episode targets – community palliative care 108](#_Toc201148304)

[17.7 Nationally Funded Centres Program 2025–26 109](#_Toc201148305)

[17.8 Mental health acute, non-acute, subacute, and residential operational beds 2025–26 110](#_Toc201148306)

[17.9 Alcohol and other drugs output targets 2025–26 113](#_Toc201148307)

[17.10 Localised pricing adjustments to the Victorian ABF Pricing Framework 115](#_Toc201148308)

[List of tables 118](#_Toc201148309)

[Acronyms and abbreviations 120](#_Toc201148310)

# Overview of the Policy and funding guidelines 2025–26

The Policy and funding guidelines 2025–26(the guidelines) provide the system-wide terms and conditions for government-funded healthcare organisations (funded organisations). This includes health services and hospitals, community service organisations and other organisations, such as Ambulance Victoria.

The guidelines:

* reflect the role of the Department of Health (the department) as the system steward
* provide policy changes relating to operational and service delivery
* set out contractual, statutory and other duties and requirements
* detail the budgetary landscape, including funding and pricing arrangements, as well as funded activity and targets.

The guidelines comprise two separate but related publications:

* Policy guide
* Funding rules (this document).

## Policy guide

The Policy guide provides detailed information regarding operational and service delivery policy.

This includes:

* the conditions within which funded organisations operate
* the obligations, standards and requirements funded organisations are expected to adhere to.

### Part 1: Operational and service delivery policy

Part 1 provides health services with the policy changes for the year. Note that it is not a complete, holistic guide to operational and service delivery policy in Victoria.

### Part 2: Obligations, standards and requirements

Part 2 outlines the relevant standards and obligations to which funded organisations must adhere, ensuring the delivery of safe, high-quality services and responsible financial management.

## Funding rules

The Funding rules go over the funding parameters within which funded organisations are expected to work.

### Part 1: Funding and pricing arrangements

Part 1 details funding and pricing arrangements.

### Part 2: Funding and activity levels

Part 2 provides funding and activity tables that detail the modelled budgets, as well as targets for a range of programs across the health system.

In addition to these guidelines, funded organisations are expected to comply with all other applicable policies.

Ensure you are reading the most recent version of this document on the [Policy and funding guidelines webpage](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>, as it may be updated throughout the year.

References to particular statutes, regulations or contracts are descriptive only.

If there are inconsistencies or ambiguities between these guidelines and any legislation, regulations and contractual obligations with the State of Victoria (acting through the department or the Secretary of the department), the legislative, regulatory and contractual obligations take precedence.

Each funded organisation should refer to the relevant statute, regulation or contract to ascertain all details of its legal obligations. If any funded organisation has specific queries regarding its legal obligations, it should seek independent legal advice.

Service agreements are contractual arrangements between entities for the delivery of services in the community, funded by the department. For entities funded through a service agreement, visit the [service agreement website](https://fac.dhhs.vic.gov.au/service-agreement) <https://fac.dffh.vic.gov.au/service-agreement> for funding information and activity tables that underpin service agreements.

Those entities funded through a service agreement can search for activity descriptions by visiting the [Department of Families, Fairness and Housing and Department of Health activity search](https://providers.dffh.vic.gov.au/families-fairness-housing-health-activity-search) <https://providers.dffh.vic.gov.au/families-fairness-housing-health-activity-search>.

## Terminology

The term ‘funded organisations’ relates to all entities that receive departmental funding to deliver services, unless specified otherwise.

For the purposes of the *Policy guide*, the term ‘health services’ relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting, unless otherwise specified.

The term ‘community service organisations’ refers to registered community health centres, local government authorities and non-government organisations that are not health services.

The *Policy guide* is also relevant for Ambulance Victoria, Health Purchasing Victoria trading as HealthShare Victoria (HealthShare), the Victorian Institute of Forensic Mental Health (known as Forensicare) and the Parkville Youth Mental Health and Wellbeing Service. The Policy guide specifies where aspects are relevant for these organisations.

Where the term ‘department’ is used, it refers to the Department of Health, unless otherwise specified.

Part 11: Funding and pricing arrangements

# National funding and pricing of public hospitals

## National health reform agreement

Victoria is a signatory to the National Health Reform Agreement (NHRA). The NHRA sets out the shared intention of the Commonwealth, state and territory governments to improve health outcomes for all Australians. It aims to ensure the long-term strength of the Australian health system through sustainable funding arrangements for public hospitals.

The NHRA establishes a framework for accurately and transparently allocating funding for Australian public hospital services. Section 131(1)(f) of the *National Health Reform Act 2011* (Cth) (the NHR Act) and clauses A16–A24 of the Addendum to the National Health Reform Agreement 2020–26 set out the scope of public hospital services eligible for Commonwealth funding:

* all admitted services, including hospital-in-the-home programs and forensic mental health inpatient services
* all emergency department services provided by a recognised emergency department service
* non-admitted patient services and non-admitted mental health care services, including community and residential mental health care services, that could reasonably be considered a public hospital service in accordance with clauses A18–A24 of the Addendum.

The NHRA establishes national bodies with which Victoria works closely to deliver the goals of the NHRA. The national bodies are:

* Independent Health and Aged Care Pricing Authority (IHACPA) (formerly the Independent Hospital Pricing Authority)
* The Administrator of the National Health Funding Pool
* National Health Funding Body
* Australian Commission on Safety and Quality in Health Care
* Australian Institute of Health and Welfare.

For further information of the NHRA see the [NHRA webpage](https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra) <<https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra>>.

## Pricing framework for Australian public hospitals

The annual *Pricing framework for Australian public hospital services* (the framework) outlines the principles, scope and methodology adopted by the IHACPA to determine funding of in-scope public hospital services under the NHRA.

The framework sets out activity-based funding and block funding approaches.

The key difference between the two approaches is that the activity-based funding model calculates an efficient price per episode of care, while the block-funded model calculates an efficient cost for the hospital.

Find out more about the framework on the [IHACPA website](https://www.ihacpa.gov.au/health-care/pricing/pricing-framework-australian-public-hospital-services) <https://www.ihacpa.gov.au/health-care/pricing/pricing-framework-australian-public-hospital-services>.

## Activity-based funding

In 2025–26, under the national funding model (NFM), public health service entities that are in scope for activity-based funding, as defined by the NHRA, are funded through activity-based funding for the following services:

* all admitted services, including hospital-in-the-home programs and forensic mental health inpatient services
* all emergency department services provided by a recognised emergency department service
* non-admitted patient services and non-admitted mental health care services.

## Block funding

The national funding model recognises that activity-based funding is not always practicable. Some services need to be funded on a block-grant basis.

In 2025–26, IHACPA has determined that small rural health services and the following services in activity-based funded health services hospitals are eligible for block funding. This is because the technical requirements for applying activity-based funding cannot be satisfied for these services:

* teaching, training and research
* low volume rural/regional community mental health services in specified local hospital networks (LHNs)
* residential mental health services[[1]](#footnote-2)
* non-admitted home ventilation services (as defined by the Tier 2 non-admitted services classification version 9.1 class 10.19)
* high-cost, highly specialised therapies
* services not otherwise priced under clause A17 of the NHRA
* other public hospital programs approved by IHACPA for inclusion on the general list of in-scope public hospital services for 2025–26.

## Victorian alignment with the national funding model

Victoria started aligning with the national funding model from 1 July 2021 when it adopted the national weighted activity unit (NWAU) as the mechanism to fund public health services and entities that are in scope for activity-based funding, as defined by the NHRA.

While the majority of funding to public health services is provided under the NHRA, not all services delivered by public health services are in scope for funding under the NHRA. Furthermore, not all services that are within scope of the NHRA are funded in keeping with the national funding model.

Table 1.1 shows the treatment of the national funding model of various services, and Victoria’s treatment of these services. Note it is a general guide only.

Table .1:Victorian alignment with the national funding model

|  | In-scope to VIC ABF Framework | In-scope to VIC ABF Framework | In-scope to Vic ABF Framework | Out-of-scope to  Vic ABF Framework | Out-of-scope to  Vic ABF Framework | Out-of-scope to  Vic ABF Framework | Out-of-scope to  Vic ABF Framework | Out-of-scope to  Vic ABF Framework |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Funding mechanism | NWAU grant | Pricing adjustments to NWAU | NWAU grant | Block grant (to support activity) | Block grant | Activity funded | Bespoke funding | Block grant |
| NHRA status | In-scope of NEP | In-scope of NEP | In-scope of NEC | In-scope of NEP | In-scope of NEC | Out-of-scope | Out-of-scope | Out-of-scope |
| Summary of inclusions | All in-scope public hospital services with valid end classes as defined in sections 3 and 4 of the National Efficient Price Determination unless otherwise specified in this table. | * Commissioning * Classification and loading * Statewide service * Entity | * Rural and regional local health services delivering community mental health services, as listed in Appendix E of the National Efficient Cost determination 2025-26.[[2]](#footnote-3) | * Forensic admitted mental health * Early parenting centres * Palliative care - community and consultancy * Specified cancer supports * Planned surgery supplements * Mental health specific community (non-admitted) services See section 3.9. * System reform * Broader patient care supports * Legacy Grants (Table 2.24) | * Small rural hospital campuses, including of public health service entities that are in scope for activity-based funding * Teaching, training & research * Low-volume rural/regional community mental health * Residential mental health * Forensic community mental health * High-cost specialised therapies * Non-admitted home ventilation * NHRA Clause A17 services (e.g. family planning, AOD adult continuing care) * Victorian Respiratory Support Service * Victorian Virtual Emergency Department (in scope portion) * Families where a Parent has a Mental illness statewide program | * Ineligible patients (Medicare ineligible, or non-residents not exempt from fees) * Compensable patients (TAC, WorkSafe, DVA, Seamen, Armed Services, Common Law, Other) | * Community setting alcohol and other drug services * Community health * Nationally Funded Centres * MBS billed activity * Co-located GP services * Non-admitted radiotherapy * Public sector residential aged care services * Home and Community Care Program for Younger People * Aged care assessments * Transition Care Program | * Campuses not designated nationally as ABF or block funded hospitals * Contracted activities reported by the service provider, where payment is made to the purchasing hospital * Emergency presentation reported during admission * Telehealth services funded by other sources * Residential drug services * Home and community care * Primary health care * Specified mental health community support services |
| Summary of exclusions | * Lithotripsy not delivered by specified health services * Block funded activity * Small rural hospital campuses of public health service entities that are in scope for activity-based funding, as listed in Appendix A of the National efficient Cost Determination 2025-26 * Palliative care - community and consultancy * Compensable activity (i.e. TAC, WorkSafe, DVA) * Virtual Emergency Department services * Posthumous organ retrieval (bundled in transplant DRGs) * Nationally Funded Centres activity * Early Parenting Centre activity * Nursing home type admission * ECT at Royal Melbourne (hub & spoke model) * Unqualified newborns (bundled with mother’s care) * Family Choice * Genetics Melbourne * Non-admitted palliative care & consultancy * Transition care program * Victorian Respiratory Support Service |  |  |  | * Services funded by MBS, PBS * Nursing home type care |  |  |  |

# Victorian pricing framework for activity-based funded health services

The Victorian pricing framework for activity-based funded (ABF) health services (the Victorian ABF pricing framework) governs the annual process for setting the Victorian efficient price (VEP). This includes the parameters for pricing adjustments for activity funded on the basis of the NWAU.

The Victorian ABF pricing framework only applies to public health service entities that are in scope for activity-based funding, as defined by the NHRA. (Table 1.22: Price groups for NWAU purposes.)

The Victorian ABF pricing framework outlines the policy settings to achieve efficient and sustainable hospital care. It promotes simplicity, transparency and cost neutrality for the state wherever possible.

It also provides a strong price signal that allows health services to align their activities with the efficient cost per NWAU as standard practice. The Victorian ABF pricing framework supports the setting of achievable NWAU activity targets, as well as setting out policy expectations and norms around cost recovery for health care services.

## Victorian ABF pricing framework principles

The principles to determine the setting of the VEP are to:

* send a meaningful price signal to health services by ensuring –
  + all health services within a peer group are funded at the same price
  + all activity within a health service is funded at the same price
  + price reflects a reasonable cost for service delivery
  + price takes into account health services’ capacity to raise own-source revenue
* support activity targets that are achievable and affordable by setting –
  + activity targets that reflect an entity’s total funding, capacity to deliver and mix of service levels
  + provide health services with greater certainty around the VEP, by providing a clear process for annual change
* ensure transparency and administrative ease by making –
  + price setting transparent and easy to understand
  + price adjustments simple to understand and administer.

Localised price adjustments will complement NWAU activity-based funding where necessary.

This ensures the viability of health services’ care delivery, in line with the policies of the government and the department. In doing this, consideration will be given to the:

* criteria used to determine price adjustments, ensuring that they reflect the design of the Victorian health system
* flexibility needed to provide appropriate incentives for health services to commission new services and respond to strategic priorities
* objective of driving health services towards an efficient cost of service delivery.

## Victorian ABF pricing framework scope

The Victorian ABF pricing framework governs the following elements of the Victorian funding model for public hospital services that are in-scope for activity-based funding as defined by the NHRA:

* price setting for the VEP (the price paid per NWAU by Victoria)
* localised price adjustments to adjunct the activity-based funding model.

The following elements of the funding model are out of-scope of the Victorian ABF pricing framework:

* price weights – price weights are set annually by IHACPA based on national data
* total budget allocation – the overall budget envelope is set through the state appropriations and annual model budget and Statement of Priorities process
* block funding – services funded purely through block funding arrangements under the NHRA
* any activity that is out of scope for activity-based funding under the NHRA regardless of the funding arrangement in Victoria
* accountability and performance mechanisms
* incentive payments made to health services to change behaviours – these payments are not governed by the cost recovery principle and therefore not governed by the Victorian ABF pricing framework
* transition grants – implemented in 2024–25, taking into consideration health services’ financial and service delivery needs with respect to a health service’s entire budget and expenditure profile, that is, beyond just ABF activities and therefore not governed by the Victorian ABF pricing framework.

## Victorian efficient price

The VEP is the efficient price of providing public hospital services in Victoria.

In determining the VEP, the department will determine a cost-recovery rate that reflects:

* reasonable costs in the delivery of care
* unavoidable variation in the costs resulting from health service size, location and service mix
* accounts for the alternative sources of revenue that health services are able to generate.

Noting current significant variation in costs across health services and health service types, the department will retain peer group pricing with 2 VEPs (‘Metropolitan and Large Regional’ and ‘Subregional’).

The national funding model approach bases price weights on service delivery cost relative to the cost of an average admitted acute episode. In line with this, the Victorian ABF pricing framework uses admitted acute activity and related cost data, noting that the national model bases the price weights on service delivery cost relative to the cost of an average admitted acute episode.

In 2025–26, the department has set the VEP based on a reasonable cost-recovery rate at 85% of the average cost reported for admitted acute activity in 2023–24, indexed to 2025–26 as the most recent year of available cost data.

## Localised pricing adjustments

The national funding model (refer to section 8.3) is premised on the efficient cost of a service nationally, based on a predetermined service classification system.

There are many reasons why a health service may have costs above or below this average. However, for the most part, health services can manage this variation across their entire service mix.

Where this is not the case due to specific local circumstances, Victoria may seek to complement NWAU activity-based funding with localised price adjustments in the following categories:

* commissioning of new services
* classification and loadings
* statewide services
* entity.

Localised pricing adjustments can take the following forms:

* loadings, where a fixed dollar amount or percentage of the VEP is applied per NWAU
* fixed funding, where a dollar amount is determined regardless of the volume of activity delivered.

Pricing adjustments will be determined on a needs basis as assessed by the department.

Where appropriate, the department expects health services to align their costs with the determined efficient price.

If this is not possible, services should alternative service delivery options, in keeping with service and capability planning frameworks. Adjustments will only be made where all other viable options have been explored and tested.

### Adjustments for commissioning new services

The commissioning of new services typically involves the gradual introduction of additional capacity.

During phased opening of additional capacity, health services may be unable to generate adequate ABF activity to cover the fixed costs associated with operating the new service. They may also be unable to generate own-source revenue.

Additionally, health services may incur short-term fixed costs that the activity-based funding model is not designed to cover. This includes, for example, substantial recruitment expenses and initial procurement of start-up consumables.

The department may allocate additional funding to facilitate the commissioning of new services where the price is not sufficient to fund additional start-up costs.

#### Assessment criteria

* To be eligible, a service must have been established with new funding as a result of a decision of government. The department must also have determined that an adjustment is required.
* Adjustments will not be provided for minor expansions to existing services (such as new beds in an operational ward), nor for new services established with existing funding unless otherwise determined by the department.

### Adjustments for classification and loadings

In certain scenarios, the national price weight for a classification may not reflect the actual or efficient cost of delivering those services in Victoria. To support Victorian health services to provide equitable services, the department may allocate funds for services that would otherwise not be sustainable.

#### Assessment criteria

If, at the state level, Victoria is not able to achieve a sufficient cost-recovery threshold for a specific classification using the national price weight, the classification becomes eligible for consideration for a price adjustment.

Adjustments for classifications will be assessed based on the following criteria:

* classifications already receiving an adjustment for classification funding
* classifications where the national price weight has decreased by more than 20% between two consecutive NEP determinations
* updates to the national pricing framework impacting classification, such as changes to the classification system or value of loadings
* other classifications as determined by the department.

Pricing adjustment for classification will only be considered for classifications that have a cost recovery below 70% at the state level. At this point, it may be reasonable to assume that it cannot be managed within a health service’s overall budget based on the criteria below.

The pricing adjustment would only be paid to health services where:

* the specified grant amount would be more than $1 million
* the health service has 50 or more encounters for that end class in the most recent year.

Activity supported by a commissioning adjustment will not be eligible for a classification adjustment.

### Adjustments for statewide services

Statewide services require a highly skilled or specialised workforce. They are provided at a limited, if not single, number of sites in Victoria to:

* provide expert clinical skills and knowledge to the health sector on a large scale
* build local clinical capability through education and training to support patients to receive care in the right place, and/or
* support a sufficient volume of activity to ensure quality and safety.

The department’s purchase of statewide services on behalf of the state is informed by analysis of Victorian demand for the specified services, including consideration of future service requirements and the annual departmental budget.

#### Assessment criteria

The department will determine the list of designated statewide services. These services have some combination of the following characteristics:

* high cost and low volume
* highly specialised
* dependent on specialised equipment
* significant proportion of clients are outside of the health service’s ‘catchment’
* coordination activities not sufficiently captured in the NWAU.

For activities that are captured by NWAU, a pricing adjustment will only be considered for services that have a cost recovery below 70% at a minimum. At this point, it may be reasonable to assume that the service costs cannot be managed within a health service’s overall budget.

Pricing adjustments for coordination activities not sufficiently captured in NWAU will be treated separately.

### Adjustments for entity

In some circumstances, the entity type (as a result of size, location and service mix) is the driving factor of variance in cost profile when compared with national profiles for NWAU ABF services. In these cases, Victoria will provide additional funding to support a cost-recovery rate aligned with the agreed rate used to set the VEP.

Examples of this may include health services:

* with a complex cost structure due to location and/or services provided
* affected by an unprecedented event (for example natural disaster)
* that cannot generate own-source revenue at the same rate as other services due to factors outside the health service’s control
* other operational requirements of the health service as needed.

If a health service receives a positive pricing adjustment for entity, the department will work closely with the service to improve their financial position, reconfigure their service mix and improve performance against funding metrics.

A negative pricing adjustment for entity will apply where a health service increases their cost profile through undertaking more expensive activities, supported through high own-source revenue. This ensures that health services are not double funded for these activities.

#### Assessment criteria

The assessment criteria are:

* overall cost recovery for an entity is below 85%, and costs are deemed to be reasonable based on the characteristics of the health service and patient population, or
* the health service is restricted in its ability to generate own-source revenue, and
* these factors pose a risk to health service viability, as determined by department.

Where a health service does not meet one of the first 2 assessment criteria, but its cost-recovery rate poses a risk to the health service’s financial sustainability, the department may determine it appropriate to apply an adjustment for entity.

### Legacy grants

Some historical grants retained under the Victorian ABF pricing framework have not been recalculated for the purposes of health services’ 2025–26 budget allocations.

These grants have a preliminary classification based on adjustment types as outlined above. They are listed in Table 2.24: Victorian pricing adjustments 2025–26 – Legacy grants.

These grants will be reviewed to inform future budget allocations, including aligning their calculation to ensure equitable funding allocation.

## Funding reforms 2025–26

In 2025–26, the department aligned funding for in-scope non-admitted mental health care provided by designated mental health services with the national funding model. This activity will be funded based on the NWAU and VEP. Health services will be allocated a NWAU target consistent with their non-admitted budgets for 2024–25.

Health services must continue delivering all non-admitted mental health services delivered in previous years, regardless of funding model. Community service hour targets will be retained for the purpose of ensuring maintenance of activity delivery post transition to the national funding model.

‘Subcutaneous immunoglobulin (SCIg) infusion therapy – home delivered’ has also been aligned with the national funding model. This is funded on the basis of NWAU and VEP under the NHRA Tier 2 non-admitted services national classification system from 1 July 2025.

# NHRA services funded outside the Victorian ABF pricing framework

The following services are within scope of the NHRA and have funding arrangements that sit outside the Victorian ABF pricing framework. Some funding models align with the national approach, whereas others are unique to the Victorian setting.

## Community palliative care

Under the national funding model community palliative care services are NWAU activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA.

In Victoria, funding for community palliative care services is provided on a block-grant basis. The department proposes to review these funding arrangements to improve alignment with the NFM as appropriate.

Designated community palliative care services further the goals of *Victoria’s end-of-life and palliative care framework* (2016). Designated community palliative care services must provide care in line with the department’s conditions of funding for palliative care published on the [Palliative care webpage](https://www.health.vic.gov.au/patient-care/conditions-of-funding-for-palliative-care) <https://www.health.vic.gov.au/patient-care/conditions-of-funding-for-palliative-care>.

Each Victorian local government area has a designated community palliative care service. Each service has a prescribed catchment area. Designated services are required to provide a service to clients in residential aged care facilities and disability group homes, as these facilities are the client’s home.

All community palliative care services have access to flexible funds to care for clients at home. These funds are incorporated in each service’s non-admitted (community) palliative care funding allocation.

Reporting will be based on the Victorian Integrated Non-Admitted Health (VINAH) minimum dataset.

### Business rules

Activity delivered through the Community Palliative Care Program should be classified using the Tier 2 non-admitted services classification (Tier 2) non-admitted services classification. Refer to ‘Patient classification’ in section 8.3 for further information on the Tier 2 classification.

Designated community palliative care services have been required to report patient-level cost data to the Victorian Cost Data Collection (VCDC). The department will continue to engage with non-government providers and community health services in 2025–26 to work towards this requirement throughout the financial year.

## Palliative care consultancy services

Under the national funding model, palliative care consultancy services are NWAU activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA.

In Victoria, funding for palliative care consultancy services is provided on a block-grant basis.

The department funds palliative care consultancy services in 12 metropolitan health services and in the 5 rural regions.

Consultancy services work across all healthcare settings. They provide specialist advice and support to clinical services within hospitals and in the community, including to community palliative care services, residential facilities and general practitioners. They address complex issues that would otherwise require admission to hospital or the transfer of care under the palliative care team from other specialities. They provide education and training about palliative care to other clinicians and provide palliative care input for cancer streams and at chronic disease management meetings.

Palliative care consultancy services are required to report contacts in the Palliative Care Consultancy Program form in Agency Information Management System (AIMS) and report patient-level contacts to the VINAH minimum dataset.

### Regional palliative care consultancy

Regional consultancies provide regular primary and secondary consultation to generalist health services (including general practitioners, acute and subacute services) and community services (including aged care and disability services) on a regionwide basis. All generalist health and community services are expected to be able to care for people who are at the end of life. The consultancy teams provide specialist expertise and skill to support these services to provide good end-of-life care.

Funding for regional palliative care consultancy teams is provided as a block grant in 2025–26. In the majority of regions, this funding includes aged and disability link nurses. This funding is recurrent.

### Statewide palliative care consultancy

Funding for statewide palliative care consultancy teams is provided as a block grant in 2025–26. Statewide consultancy services include the Victorian Paediatric Palliative Care Program, Very Special Kids, Motor Neurone Disease Association (Vic.) and Grief Australia (previously The Australian Centre for Grief and Bereavement). This funding is recurrent.

### Business rules

Health services should maintain and report patient-level activity for hospital-based palliative care consultancy and statewide services. The mode of activity reporting will be different depending on whether the service reports data to the VINAH minimum dataset or the Non-Admitted Data Collection (NADC).

Health services should also maintain and include hospital-based palliative care consultancy as part of their reporting of patient-level costing data for to the VCDC.

## Complex care program (previously the Family Choice Program)

Under the national funding model, admitted and non-admitted complex care services are NWAU activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA, and non-admitted home ventilation services are block funded.

In Victoria, the complex care program formerly the Family Choice Program (FCP), is funded as a block grant provided to the Royal Children’s Hospital, as follows:

* home ventilation funding is funded as a block grant in line with the terms of the NHRA
* other program funding is provided as a legacy block grant, listed in Table 2.24: Victorian pricing adjustments 2025–26 – Legacy grants.

The department proposes to review these funding arrangements to improve alignment with the NFM as appropriate.

Activity delivered through the complex care hub related to the FCP should be classified using the Tier 2 non-admitted services classification. See section 8 for further information on costing and non-admitted activity reporting.

## Early parenting services

Under the national funding model, admitted and non-admitted components of early parenting services are NWAU activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA.

In Victoria, early parenting centres are predominantly block funded services. These services include Tweddle Child and Family Health Centre, Queen Elizabeth Centre and Mercy Health O’Connell Family Centre and newer services established through the early parenting centres expansion and upgrade program from 2023.

Health services in-scope for ABF, as defined by the NHRA, also receive activity-based funding based on unit prices for residential and day stay activities. See Table 1.17: Early Parenting Centres 2025–26 and Table 2.19: Early Parenting Centres activity table.

The department proposes to review funding arrangements for early parenting services delivered by health services in-scope for ABF, to improve alignment with the NFM as appropriate.

## Forensicare

The Victorian Institute of Forensic Mental Health, known as Forensicare, is a specialist stand-alone mental health service.

Under the national funding model for 2025–26, admitted services delivered by Forensicare are NWAU ABF and community mental health services are block funded.

In 2025–26, Victoria will fund the Forensicare’s admitted and non-admitted services on a block funding basis.

## Genetic clinical activity

Under the national funding model, genetic clinical activity services are NWAU activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA.

In Victoria, genetic clinical activity provided by the Victorian Clinical Genetic Services and metabolic medicine/disease unit at The Royal Melbourne Hospital are block funded in 2025–26.

The department proposes to review funding arrangements to improve alignment with the NFM as appropriate.

## High-cost, highly specialised therapies

Under the national funding model, high-cost, highly specialised therapies (HSTs) are block funded.

HSTs are defined by the IHACPA in the annual National Efficient Cost Determination and will continue to be funded to actual expenditure in 2025–26. HST grants are to be recognised by health services on the basis of actual costs incurred for delivering HSTs, including patient, product and program costs.

### Business rules

Aligned with requirements of the NHRA and the state’s reporting obligations to the Administrator of the National Health Funding Pool, health services delivering HSTs are required to report actual costs and patient data to the department annually. This occurs 11 weeks after the end of the financial year, via a supplied template.

The costs reported should correspond to the expenses incurred in the relevant financial year for patients treated in that year. Only costs incurred up to the end of the financial year should be included.

The National Health Funding Body will reconcile the actual number of patients treated and the associated costs, in consultation with IHACPA and States as part of the annual reconciliation process. The department will use the data for prior-year adjustment/recall estimations.

For all HSTs the ‘highly specialised therapy’ flag must be applied in the Victorian Admitted Episodes Dataset (VAED) to enable National Health Reform Agreement quarterly activity reporting and for the annual reconciliation process.

Health services are required to provide monthly and quarterly activity data and fulfill any ad hoc data requests from the department.

## Lithotripsy

Under the national funding model, lithotripsy services are NWAU activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA.

In Victoria, lithotripsy is provided by St Vincent’s Health as a statewide provider and a network of designated satellite providers. In 2025–26, lithotripsy episodes are only at:

* St Vincent’s Health
* Grampian’s Health
* Bendigo Health
* Barwon Health
* Goulburn Valley Health
* The Royal Children’s Hospital
* Mildura Base Hospital
* Western Health
* Mercy Health (Werribee campus only).

These services are funded through NWAU ABF.

A legacy block grant is also provided to St Vincent’s Hospital Melbourne as listed in Table 2.22: Victorian pricing adjustments 2025–26.

The department proposes to review these funding arrangements to improve alignment with the NFM as appropriate.

## Mental health and wellbeing

Mental health subacute and residential mental health services and out-of-scope non-admitted mental healthcare are block funded in 2025–26.

Some community (non-admitted) mental health services are block funded in Victoria even though they are NWAU ABF under the national model:

* autism coordinators
* families where a parent has a mental illness
* forensic threat assessment centre
* infant child youth group-based parenting support (0–11)
* specialist statewide services (dual disability, neuropsychiatry, spectrum).

## Radiotherapy

Under the NFM, radiotherapy services are activity-based funded when delivered by health services in scope for ABF, as defined by the NHRA. Radiotherapy services may be subject to a supplement, as outlined below.

Public radiotherapy services are provided at 12 hospitals in Victoria across metropolitan and regional campuses.

### Non-admitted radiotherapy funding model

In Victoria, radiotherapy is predominantly provided on a non-admitted basis and funded under a specific complexity-based funding model. Under this model, the various components of a course of radiotherapy are weighted and aggregated for each course of care. Remaining activity is admitted and may be eligible for NWAU.

The health services funded under the non-admitted radiotherapy funding model are:

* Alfred Health
* Austin Health
* Barwon Health
* Peter MacCallum Cancer Centre.

These 4 ‘hub’ services also receive funding for the bespoke services they operate across metropolitan Melbourne and regional Victoria. The remaining 3 public services are contracted services operated on behalf of the government by private providers.

Refer to the website to find [radiotherapy locations](https://www.health.vic.gov.au/health-strategies/radiotherapy-service-locations) <https://www.health.vic.gov.au/health-strategies/radiotherapy-service-locations>.

The new public Superficial X-Ray Therapy service commencing in 2025–26 will also be funded under this model.

In 2025–26 funding for non-admitted radiotherapy services will continue to comprise:

* a variable payment per weighted activity unit (WAU) to set targets for public, the Department of Veterans’ Affairs and private patient categories (costs for associated services are included in this payment and must be provided to all patients as required)
* a Department of Veterans’ Affairs premium (where applicable) above the variable payment
* a variable payment per WAU plus a fixed payment where it is a statewide radiotherapy service involving a specialist radiotherapy machine delivering the radiation therapy (Gamma Knife and MR-Linac).

The WAU price can be found in section 15 Price tables.

Current-year WAU targets are specified in the respective health services Statement of Priorities.

In addition to the state contribution for radiotherapy, health services will retain all third-party revenue. Changes to third-party revenue will be considered annually in determining WAU pricing.

### Radiotherapy data

The Victorian Radiotherapy Minimum Data Set is the key source of radiotherapy data for funding and service planning. Consultations, treatment and simulation are reported to the AIMS S8 form and at patient level to the VINAH minimum dataset or the NADC. In addition, it is expected that health services maintain and report radiotherapy patient-level costing data via the VCDC.

### Contracted radiotherapy services

The department funds contract arrangements with private sector radiotherapy operators to provide public radiotherapy services at South West Healthcare Warrnambool and at Albury Wodonga Health.

Under these arrangements, all patients are treated with no out-of-pocket costs. The private operators actively participate in public multidisciplinary cancer meetings and provide specialist outreach services across their regions.

The department also funds a contract arrangement between a private sector radiotherapy operator in Shepparton and Goulburn Valley Health. Under this arrangement, appropriate public patients at Goulburn Valley Health can receive radiotherapy with no out-of-pocket costs. A similar arrangement operates in Mildura so that appropriate public patients at Mildura Base Public Hospital can receive radiotherapy locally from a private sector radiotherapy operator with no out-of-pocket expenses.

### Non-admitted radiotherapy shared care

The department provides funding to eligible metropolitan public health services that have entered into shared care contracts with local private radiotherapy operators when there is no public service.

Under these arrangements, disadvantaged cancer patients with eligible concession cards can receive care as public patients. They access outpatient radiotherapy from a local private operator when that treatment facility is closer than a public provider. Shared care is coordinated by the public hospital as part of the patient's cancer care at no cost to the patient.

Health services that currently receive funding for radiotherapy shared care are:

* Northern Health (Northern Hospital)
* Peninsula Health (Frankston Hospital)
* Monash Health (Casey Hospital).

Targets for shared care (the number of patients for whom funding is provided) are set with health services prior to each financial year.

### Radiotherapy quality

#### Assessment against the national Radiation Oncology Practice Standards

Victorian public radiotherapy providers assess their services against the Radiation Oncology Practice Standards using the relevant self-audit tool. The tool is used as part of their internal quality management protocols.

The results of these assessments are integrated into the annual radiotherapy performance discussions with the department and are used to ensure Victorian public radiotherapy providers meet national standards.

## Small rural health services

Small rural health services (SRHS) are within scope of the NHRA as block-funded services. In the national funding model the cost of a small rural hospital is based on a fixed cost component and a variable component based on the level of NWAU activity above a set threshold.

For further information on the national funding model for small rural health services, refer to IHACPA’s [*NEC Determination*](https://www.ihacpa.gov.au/resources/national-efficient-cost-determination-2025-26%3e.) *2025–26* <<https://www.ihacpa.gov.au/resources/national-efficient-cost-determination-2025-26>>.

In Victoria, small rural health services are block funded in line with the flexible SRHS funding model introduced in 2003–04, rather than the national block funding model described in the National Efficient Determination.

SRHS can use funds provided through acute health and primary care outputs flexibly to deliver admitted and non-admitted services that meet the needs of their community. Under the tripartite agreement with the Australian Government Department of Health, multipurpose services are also able to flexibly use aged care funding to deliver residential and home-based aged care services.

Health services funded under the Victorian SRHS funding model are included in Table 2.2: Small rural health services expenditure budgets 2025–26 – $’000s and Table 2.13: Victorian small rural health service activity targets 2025–26.

## Subacute and non-acute care exceptions to national funding model

Under the national funding model, admitted subacute and non-acute care services are NWAU funded when delivered by public health service entities that are in scope for activity-based funding, as defined by the NHRA. Victoria funds this care consistent with the national funding model, with the following exceptions.

Community palliative care is block funded as described in section 3.1.

The national funding model classifies admitted subacute and non-acute care into 5 care types: rehabilitation care; palliative care; geriatric evaluation and management (GEM); psychogeriatric care, and non-acute care which is sometimes referred to as maintenance care. In Victoria, the psychogeriatric care type will not be used in 2025–26.

At the national level, where data required to assign an AN‑SNAP classification is not available, the episode is transferred to the admitted acute care model and priced according to their AR-DRG classification. This will not occur in Victoria in 2025–26, therefore activity is not funded where an AN-SNAP classification cannot be assigned.

The department does not reimburse hospitals for public nursing-home-type episodes. Health services are expected to manage nursing-home-type patients using other funded activity streams, such as the Transition Care Program. Arrangements for the Department of Veterans’ Affairs, compensable and private patients remain in place regarding the nursing-home-type process and funding.

## Training and development

Teaching and training is within scope of the NHRA as block-funded services.

The department funds workforce training and development in the form of grants as set out in the [Training and Development Funding Program Guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

Multiple streams of funding support the continuum of teaching and training activities.

Training and development funding rates are shown in Table 1.21: Training and development funding rates in 2025-26.

Find out more about [education and training for Victoria’s health workforce](https://www.health.vic.gov.au/health-workforce/education-and-training) <https://www.health.vic.gov.au/health-workforce/education-and-training>.

## Victorian Virtual Emergency Department

The Victorian Virtual Emergency Department (VVED) is within scope of the NHRA as a block-funded service.

In Victoria the VVED is funded as a block grant to Northern Health, and the service does not attract NWAU activity-based funding.

The VVED is a statewide program delivered by Northern Health. It allows select, non-urgent patients (adults and children) to receive virtual video assessments 24 hours a day, 7 days a week from emergency doctors and nurses.

### Business rules

The unit of count adopted for the virtual emergency department is a presentation. The VVED is required to report to the [Victorian Emergency Minimum Dataset (VEMD)](http://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) <www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>.

Northern Health is required to provide monthly and quarterly activity data and fulfil any ad hoc data requests from the department as outlined in its funding obligations and sector-facing Annual Agreement.

# Services funded in addition to the NHRA

The following services are outside the scope of the NHRA and are funded by Victoria, the Victorian and Australian Governments or other public funding sources.

## Alcohol and other drug services

Alcohol and other drugs (AOD) services are Victorian funded services.

The Victorian AOD services sector operates under a mixed-funding model that includes residential services and most adult community-based services, funded via drug treatment activity units against an agreed target. The price per activity unit is available in Table 1.16: Drug services – unit prices 2025–26, and targets are listed in Table 2.23: Alcohol and other drugs output targets 2025–26.

The Victorian Alcohol and Drug Collection is the data collection specification for all Victorian funded AOD treatment providers. (Reference any other guideline/business rule.)

Find out more about the [Department of Health’s AOD policy](https://www.health.vic.gov.au/alcohol-other-drugs) <https://www.health.vic.gov.au/alcohol-other-drugs>.

## Community health pricing

The Victorian Auditor-General’s report *Community health program* (2018) recommended developing a more sophisticated funding model to allow flexibility for services to adapt to changing community and client needs. Historically, Community Health Program funding included different unit prices for nursing and allied health activities. The Victorian Auditor-General's Office identified these different unit prices as a barrier to achieving Community Health Program objectives.

In January 2024, the department introduced a single unit price for 3 community health activities:

* community health
* small rural primary health – flexible services
* integrated chronic disease management.

Each community health service continues to receive the same total funding under a single unit price and will be able to use the funding flexibly. The single unit price raised the costed-nursing-unit price to be equivalent with the allied-health-unit price, with hours adjusted.

From 1 July 2025, the single unit price will be applied to all community health activities and service providers. Community health program funding is activity based, and the activity measure is service hours. Refer to Table 1.20: Community Health care output 2025–26.

## Local public health unit block-funded functions

Health services that are funded to operate a local public health unit (LPHUs) receive funding for public health activities under 2 lines:

* LPHU core operations (including health protection)
* health advancement.

Each of these is allocated to a cost centre in the Health Agencies Reporting Tool (HeART):

* M1549 for LPHU core operations (including health protection)
* M1546 for health advancement.

Further detail regarding LPHU operational and service delivery obligations are defined by the department in the [Policy guide](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> and outlined in funding letters.

The operation of an LPHU is tied to a specific, designated purpose.

As outlined in section 14.4, health services cannot redistribute these funds. Any unspent funding provided to lead health services for the operation of an LPHU must not be used for other purposes unless requested by an LPHU and explicitly approved by the department.

## Mental health community support services

Funding for Mental Health Community Support Services (MHCSS) activities is output based.

Statewide targets are set out in *Victorian State Budget Paper No. 3* (2025).

MHCSS activities are listed in the Funding and Service Agreement and represent the minimum deliverables expected for the funding provided.

Refer to the Policy guidefor more information.

## Nationally funded centres

Nationally funded centres (NFC) programs (admitted and non-admitted activity) are funded to actuals at the NFC-determined cost per procedure from a pool, with contributions from all states and territories according to a population-based formula.

The NFC programs and Victorian hosting agencies are:

* paediatric heart transplantation – The Royal Children’s Hospital
* paediatric liver transplantation – The Royal Children’s Hospital (supported by Austin Hospital)
* paediatric lung and heart–lung transplantation – The Alfred (supported by The Royal Children’s Hospital)
* adult pancreas transplantation – Monash Medial Centre Clayton
* adult islet cell transplantation – St Vincent’s Hospital (supported by St Vincent’s Institute).

See Table 1.9: Nationally Funded Centres Program 2025–26.

Find out more about the [NFC Program](https://www.health.vic.gov.au/patient-care/nationally-funded-centres) <https://www.health.vic.gov.au/patient-care/nationally-funded-centres>.

## Ageing, aged and home care

### Public sector residential aged care services

The department provides funding to health services, multipurpose service programs, and contracted non-government providers to deliver public sector residential aged care services (PSRACS).

PSRACS are funded to provide a specified number of available bed days and to meet set targets for bed availability. PSRACS receive various funding allocations based on bed type and staffing requirements, location and resident complexity, see Table 1.18 and Table 1.19 for further details.

Small Rural Health Services that provide PSRACS have different activity numbers and performance outputs, see Table 1.23: Small rural health services – outputs and activities 2025–26.

The Australian Government has the primary responsibility for funding and regulating residential aged care services under the *Aged Care Act 2024.*

In accordance with this legislation, all Victorian PSRACS must comply with minimum aged care quality and safety standards to maintain their registration with the Commonwealth.

The Aged Care Quality and Safety Commission undertakes monitoring, assessment and accreditation of residential aged care services against these standards.

### Home and Community Care Program for Younger People

The Home and Community Care Program for Younger People (HACC-PYP) is for people aged from birth to 65 years (and Aboriginal people from birth to 50 years) who need assistance with daily activities due to chronic illness, mental health issues, disability or other conditions.

HACC-PYP is activity-based funded on various service activity measures and prices. Refer to sections 12.5 and 12.6.

Find out more about the program in the [*HACC-PYP interim guidelines*](https://www.health.vic.gov.au/sites/default/files/2023-11/hacc-pyp-interim-guidelines.docx.docx) *<*https://www.health.vic.gov.au/sites/default/files/2023-11/hacc-pyp-interim-guidelines.docx.docx>.

## Transition Care Program

The Transition Care Program (TCP) is a national specialist aged care program jointly funded by the Commonwealth and state and territory governments through per diem contributions. The Commonwealth is implementing national aged care reforms in 2025–26.

The program is legislated by the *Aged Care Act 2024* and the Aged Care Rules made under that Act. The *Transition Care Program guidelines* *2022* govern the program. Health services receiving funding from the Commonwealth and state to provide TCP must be a registered provider of aged care services.

As a specialist aged care program, places are allocated by the Commonwealth through state and territory governments, rather than direct to individuals.

Health services must notify the department if they wish to change their TCP service model. This includes changes to the number of allocated TCP places and their operational location.

Where funding is affected by service changes, the service must seek the department’s agreement on the effective date and any associated funding adjustments.

Commonwealth subsidies are provided directly to health services by Services Australia (Medicare). These are paid on a monthly advance and acquittal basis for occupied places. Health services are required to submit a monthly claim form directly to Medicare for payment.

Commonwealth subsidies are paid for up to 12 weeks for each client, with an option for a single extension of up to 6 weeks where appropriate and with prior approval following an Aged Care Assessment Service (ACA).

Claimed subsidies cannot exceed the maximum number of approved TCP places at each health service.

A health service that supports clients beyond their maximum permitted stay on the program (that is, 18 weeks where a 6-week extension has been approved by an ACA) will not receive Commonwealth or state funding. Any potential discharge challenges should be known prior to this time to achieve a safe and timely discharge for the client.

Basic daily care fees received from TCP recipients are determined by the Commonwealth under the *Aged Care Act 2024*. Maximum care fee charges must not exceed 85% of the basic single age pension for care delivered in a bed-based setting and 17.5% of the basic single age pension for care delivered in a home-based setting.

These fees are adjusted twice yearly (March and September) in line with the consumer price index, which also affects the age pension payment.

All TCP ACA approvals will need to be received via the My Aged Care provider portal.

Program staff must ensure that clients have current approvals to avoid loss of the Commonwealth subsidy component for episodes of care.

Approvals can be verified with an ACA service or online with Medicare.

# Compensable, cross-border and prisoner patients

## Compensable patients

### Department of Veterans’ Affairs

The Commonwealth Department of Veterans’ Affairs (DVA) pays for public hospital services for entitled persons only as per the Hospital Services Arrangement between the Commonwealth of Australia, the Repatriation Commission, the Military Rehabilitation and Compensation Commission and the State of Victoria.

The current agreement is in effect from 1 July 2019 to 30 June 2026[[3]](#footnote-4) and sets out arrangements for the provision of hospital services to entitled persons.

DVA defines an entitled person as one who has elected to be treated under DVA arrangements and has been issued with a Gold Card, a White Card, an Orange Card (for pharmaceuticals only), or a written authorisation by DVA on behalf of the Military Rehabilitation and Compensation Commission.

DVA does not pay for hospital services for entitled persons through the Hospital Services Arrangement if the same service, or any part of the same service, is funded through any other DVA or Commonwealth program.

DVA payments are based on the IHACPA funding models. Wherever practicable, activity-based funding per the annual IHACPA National Efficient Price Determination is used.

If services or functions are more appropriately funded through block grants, the funding is calculated based on the annual IHACPA National Efficient Cost Determination. Where necessary, modifications are made to the funding to reflect the contribution that DVA makes separately to medical practitioners.

The scope of public hospital services funded on an activity or block payment basis that are eligible for payment by DVA are:

* all admitted patient treatment, including hospital-in-the-home programs
* all emergency treatment provided by recognised emergency departments (levels 3B–6, per the definition of emergency services for ABF purposes) and emergency services   
  (levels 1–3A, per the definition of emergency services for ABF purposes)
* all non-admitted patient occasions of services that are classified as Tier 2 clinics, noting that in relation to non-admitted specialist consultations and procedures and associated pathology and radiology services, privately referred and privately treated non-admitted entitled persons will continue to be billed separately and paid separately by DVA
* other non-admitted, mental health, subacute services and other services that are relevant to entitled persons and could reasonably be considered a public hospital service in accordance with IHACPA’s ‘General List’ of services eligible for a Commonwealth funding contribution.

Services paid to actuals on an activity basis include acute admitted services, subacute services, acute non-admitted services and emergency services.

Block funding is provided for teaching, training and research, non-admitted mental health services, other non-admitted services and emergency departments and non-admitted activity in block-funded hospitals.

#### Eligibility

Eligible veterans and war widows or widowers have access to a wide range of benefits and services through DVA. These include hospital, medical and allied health services, respite and convalescent care, rehabilitation aids and appliances, and assistance with transport and accommodation.

Organisations must ensure that patients formally elect to be treated as a veteran at each admission and that they collect and provide to the department the eligible veteran’s name, their DVA unique identifier, their date of birth and their sex. Final payment will only be authorised after the veteran’s eligibility has been confirmed by DVA.

Eligible veterans will not be covered under the DVA arrangement if they:

* do not elect to be treated as an entitled person (as a DVA patient) when receiving a public hospital service
* elect to be treated as a public patient under the National Health Reform Agreement (NHRA)
* are eligible under another category of compensable patient, such as a Transport Accident Commission (TAC) or WorkSafe Victoria
* elect to be treated as a private patient.

Health services will need to retrospectively reclassify patients as public patients if DVA eligibility criteria are not met. They will then need to resubmit the rejected records to the department. The department will not accept any risk for assumed revenue lost because DVA eligibility requirements have not been met.

Experience shows that those health services that actively develop service quality and marketing plans and employ veteran or patient liaison officers are more likely to retain DVA patients.

#### Admission requirements

Within 2 days of admission to hospital, health services should complete a DVA Hospital Admission Voucher (or form that captures equivalent information) for each admitted eligible veteran. Health services should ensure that the admission of eligible veterans is in accordance with Victoria’s admission policy and other relevant policies and procedures.

DVA’s expectation is that an entitled person’s admitted care commences only when the patient physically departs the clinical area of the emergency department for transfer to a ward (excluding short stay units) or an operating theatre or procedure room. Transfer to a ‘virtual ward’ with the emergency department does not constitute an admission.

DVA’s expectation is that an entitled person would not be eligible for admission if:

* they receive their entire care within the emergency department
* they are transferred to a short stay unit but do not meet DVA’s admission criteria
* they are only waiting for review by a speciality admitted team or an inpatient bed, diagnostic tests or results, transport home or transfer to another hospital, or equipment or medications.

Eligible veterans will continue to be provided public health services on a private patient basis, which entitles them to a minimum of:

* choice of doctor (subject to the doctor having rights of private practice)
* shared accommodation
* if medically necessary, private accommodation
* private accommodation, if available, where the patient or their private health insurer agrees to pay the difference between the shared and private accommodation.

Eligible veterans can access convalescent care or respite care in public health services following an acute or subacute stay without the need for financial authorisation from DVA.

DVA’s expectation is that when admitted for medical management, an entitled person must receive a minimum of 4 hours’ continuous active management, and that management must occur, at least in part, outside the emergency department in an inpatient area.

DVA may review short stay admissions and request additional supporting information for the treatment provided to ensure that appropriate payments are made.

Admitted patient care consists of the following categories:

* acute care
* rehabilitation care
* palliative care
* geriatric evaluation and management
* psychogeriatric care
* maintenance care
* newborn care
* other admitted patient care (this is where the clinical intent does not meet the criteria for any of the previous care types).

Care other than admitted care include: posthumous organ procurement; Hospital boarder.

If hospitalisation of an entitled person is likely to exceed a continuous period of 35 days, health services must review the patient’s status and either:

* complete an Acute Care Certificate or equivalent, certified by a medical practitioner, before the expiration of 30 days from the date of admission and retain this on the patient’s medical record for audit and/or reconciliation purposes
* reclassify the entitled person as a Maintenance patient. If an entitled person is reclassified as a ‘Maintenance – NHTP’, the health service should ensure the patient is assessed and a discharge plan is developed.

#### Pharmaceuticals

Health services should ensure medication reviews (including self-management) are completed before discharge by the clinical pharmacist or doctor for patients:

* who require administration of 4 or more different medications or more than 12 doses of medication daily
* where a change in medication has occurred during the admission
* where anticoagulant therapy has commenced during the admission.

Medication reviews should be documented on an appropriate approved form, be available to the patient and care providers on discharge and involve education as a component.

Contact the Veteran Affairs Pharmaceutical Advisory Centre on 1800 552 580.

#### Long stay

If the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days in any care type other than nursing-home-type and palliative care, the DVA requires that health services ensure the veteran’s status is reviewed and that either:

* a certificate similar to that previously required under s. 3B of the *Health Insurance Act 1973* is completed by a medical practitioner and held on the patient’s file for audit purposes, or
* reclassify the patient as either maintenance or, in the case of small rural health services, the eligible veteran is reclassified to a nursing-home-type patient and the changed status and payment adjusted accordingly. If the patient is reclassified, hospitals should use their best endeavours to ensure the patient is assessed and a discharge plan is developed.

The Acute Care Certificate or equivalent is no longer required to be sent to DVA.

#### Nursing-home-type patients

If eligible veterans are assessed as needing nursing-home-type or respite care and are at a multipurpose service (facilities that receive Commonwealth funding to operate residential care beds), then the health service must attempt to reclassify the patient from a hospital patient to a residential aged care recipient. If there are no residential aged care beds available, the patient should be reclassified as a nursing-home-type patient and DVA charged at the nursing-home-type patient rate. DVA will not pay for residential aged care under the arrangement.

Health services should collect any co-payment for nursing-home-type patients from the patient, with the exception of Victoria Cross or prisoners of war recipients. For this group, health services should make a claim directly based on prior approval to DVA for reimbursement using Medicare Benefits Schedule (MBS) item number NH05.

#### Discharge planning

Health services will use their best endeavours to demonstrate effective discharge planning for DVA patients including the regular contribution of a multidisciplinary team, supporting documentation, discharge follow-up and communication with care providers and family and carers (with permission from the patient).

The patient or carer should be given written documentation in the form of a discharge plan on the day of discharge. Use electronic discharge summaries if they are available.

DVA may request to see documentation of hospital discharge policies and procedures, as well as copies of the patient and hospital discharge plans.

If the patient is enrolled in a Coordinated Veterans’ Care program, then the local medical officer or nurse coordinator must also receive a copy of the patient discharge plan (and be involved as appropriate).

Health services should coordinate for a health professional to assess eligible veterans before discharge for community nursing, personal care, aids and appliances, home modifications or convalescent care.

Any aids, equipment or modifications will be arranged through DVA services in a timely manner and be available to the patient prior to discharge.

Public hospitals must provide a summary of discharge to the original referring doctor and local medical officer at, or within, 48 hours of discharge.

Referrals for community nursing services for DVA patients may be made to a program funded by the Victorian Government or Commonwealth Government, or to a DVA contracted provider.

To arrange home and personal care services for eligible veterans, health services must contact the National Veterans’ Home Care assessment agency (1300 550 450).

Discharge aids and equipment for veteran patients must be provided to facilitate safe discharge for a period of 30 days after discharge.

Find out more on DVA’s [Aids, appliances and home modifications webpage](https://www.dva.gov.au/health-and-wellbeing/home-and-care/rehabilitation-appliances-program-rap) <https://www.dva.gov.au/health-and-wellbeing/home-and-care/rehabilitation-appliances-program-rap> or call 1300 550 457 (metropolitan) or 1800 550 457 (rural).

#### Payments

If a claim is not accepted by DVA, either:

* the health service must transmit additional or corrected information to allow the claim to be accepted, or
* claims should be retrospectively reclassified to reflect the patient’s changed care type or preferences.

Health services must make changes before consolidating the VAED, otherwise funding will not be paid at either DVA or public rate.

The DVA agreement prohibits organisations from raising any charges directly on an eligible veteran, except where provided for under Commonwealth legislation. This prohibition does not, however, prevent organisations from charging a cost for providing personal services such as television access or telephone services at the facility.

The DVA agreement recognises that treatment for DVA patients may occasionally be subcontracted to a private hospital or facility.

Where that private hospital or facility is contracted to DVA, and claims for the service, DVA will pay the facility directly through their payment arrangements with Medicare Australia.

Under these circumstances, the public hospital cannot also claim payment separately for the treatment provided.

Subcontracting for transition care is exempt from this requirement, as public hospitals do not directly bill DVA for this service (see section 4.7).

### Transport Accident Commission patients

Activity and funding provided in respect of TAC compensable patients is uncapped and sits outside the NHRA arrangements.

The department provides health services payments for TAC patients in advance based on forecast NWAU activity.

This is cash-flowed to health services throughout the year. Funding for TAC patients is uncapped and adjusted to actual at the end of the year, based on data reconciled with the TAC.

For the department to receive payment from TAC, TAC must accept the claim and issue a claim number. The patient information reported by health services to the department must match those held by the TAC for each admitted patient separation.

If a TAC claim is later rejected, the department will automatically fund the claim using public NWAU in the prior-year adjustment process unless the health service has exceeded its NWAU target.

Health services should update their TAC patient records with TAC remittance advice. This will ensure the TAC accepts the updated records, and it will minimise delays in reconciling activity and payment for records.

The department will not make changes for denied or rejected claims after consolidation through the prior-year’s adjustment. Health services are required to make changes before consolidation, otherwise funding will not be paid at either the TAC or public rate.

Find out more about the [TAC’s policy, services and funding for providers](https://www.tac.vic.gov.au/providers) <https://www.tac.vic.gov.au/providers>.

View the department’s [Transport Accident Commission patients webpage](https://www.health.vic.gov.au/patient-fees-charges/transport-accident-commission-patients) <https://www.health.vic.gov.au/patient-fees-charges/transport-accident-commission-patients>.

### WorkSafe Victoria patients

Activity and funding provided for WorkSafe compensable patients is uncapped and sits outside the NHRA arrangements.

The department provides health services with payments in advance for WorkSafe patients based on forecast NWAU activity. This is cash-flowed to health services throughout the year. Funding for WorkSafe patients is uncapped and adjusted to actuals at the end of the year, based on data reconciled with the WorkSafe.

The department will only pay a rate applicable for all accepted WorkSafe patients matched with WorkSafe records.

The patient information reported by health services to the department must match that held by the WorkSafe for each admitted patient separation. If a WorkSafe claim is later rejected, the department will automatically fund the claim using public NWAU in the prior-year adjustment process unless the health service has exceeded its NWAU target.

Health services should keep their WorkSafe patient records updated with WorkSafe remittance advice. This will ensure WorkSafe accepts the updated records, and it will minimise delays in reconciling activity and payment for records.

Find out more about the current services and prices on the department’s [WorkSafe patients webpage](https://www.health.vic.gov.au/patient-fees-charges/worksafe-patients) <https://www.health.vic.gov.au/patient-fees-charges/worksafe-patients>.

### Direct-billing-compensable patients

For compensable patients who are directly billed, the following arrangements are in place:

* armed services – paid by the Department of Defence and billed through BUPA
* Australian seafarers – paid by private insurers as directed on the Seacare Australia insurers website
* international seafarers – paid by private health insurers that cover care for international seafarers
* common-law recoveries – paid by a third party where health costs are provided for under a common-law damages claim
* other compensable patients – paid by a third party where health costs are provided for under a public liability claim.

For these patients, health services should directly bill the relevant organisation responsible for payment.

Billing rates are determined by health services. These should be set to provide for full cost recovery.

Recommended fees are outlined in the policies on the department’s [Patient fees and charges for public health services webpage](https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services) <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>.

## Cross-border patients

The department allocates funding according to the expected activity levels. Normally, the department estimates its expected revenue for a relevant financial year (Commonwealth, state, net cross-border funding) and sets aside funding for known commitments to be incurred during the financial year.

In general, funded organisations are cash-flowed during the financial year according to their funding allocations. Funded organisations are expected to manage their resident and non-resident demand based on the funding provided.

Where required, adjustments to this funding for over- and underactivity are made in the following financial year according to the policies set out in section 9 ‘Prior-year adjustment: activity-based funding reconciliation’. The prior-year adjustment policy does not make adjustments for changes for annual variations in this cohort.

In accordance with clause A91 of the NHRA, cross-border agreements are developed between jurisdictions that experience significant cross-border flows. The department negotiates agreements with all other states and territories (jurisdictions), based on a standard agreement. These agreements form the basis of the flow of funds between Victoria and other jurisdictions for residents treated from those jurisdictions. Annual reconciliations of cross-border flows occur to determine the liability of each jurisdiction. This revenue/liability is then factored into the revenue available for redistribution as part of the modelled budget each year.

Under these agreements, all financial transactions are to be transacted by the relevant health departments and not through interagency transfers (for example, hospital to hospital or state health department to hospital).

Under the cross-border agreements, there is an exemption for high-cost procedures. A high-cost procedure is defined as a procedure that is not reasonably funded by the existing classification system and cost weights and are agreed to at a jurisdictional level prospectively on a case-by-case basis. For the avoidance of doubt, this definition excludes experimental procedures.

Admitted acute high-cost procedures (for example, those funded by NWAU) are defined by procedures that:

* are provided at limited sites nationally
* have low volume (< 200 separations nationally)
* cost significantly more (> $20,000) than the funding provided based on the relevant year’s [National Effidient Price Determination](https://www.ihacpa.gov.au/pricing/national-efficient-price-determination) <https://www.ihacpa.gov.au/pricing/national-efficient-price-determination>.

Prior to the procedure, hospitals may seek this exemption (in limited circumstances) from the department for services classified as high-cost procedures and that will be provided to patients who reside in another state or territory.

Subject to meeting the definition of a high-cost procedure and complying with the agreed criteria and process, hospitals may be paid a supplementary payment by the department through the prior-year adjustment process to meet the difference between the department’s funding allocation and the actual cost of the procedure paid by the resident’s jurisdiction.

Hospitals should advise the department in advance (wherever possible) and care to non-resident patients should not be subject to, or impacted by, financial arrangements and should be based on standard clinical protocols.

Hospitals may not seek an exemption for NFC procedures, as the funding for these procedures are already shared by jurisdictions and set annually by the Health Chief Executives Forum.

## Private patients in public hospitals

### Patients who elect to be a private patient

Under the NHRA consumers have the right to elect to be treated as either public or private patients within states’ public hospitals, regardless of their private health insurance status.

An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit.

On admission, the patient will be given the choice to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the state to pay for such services).

Under the NHRA funding models will be financially neutral with respect to all patients, regardless of whether patients elect to be private or public.

Private patient activity in public hospital do not attract public hospital funding under the NHRA.

### Medicare Benefits Schedule-billed services

MBS-billed services are outside the scope of the NHRA and do not attract NWAU funding. Activity that is MBS-billed must be reported as such to enable the department to monitor compliance with applicable legislation and to meet the department’s obligations under the NHRA.

The *MBS billing policy framework: Victorian public hospitals policy* states the mandatory requirements that apply to Victorian public hospitals billing under the MBS on behalf of health practitioners exercising a right of private practice. The *MBS billing policy in Victorian public hospitals: Interpretive guidelines for best practice* document interprets the relevant Commonwealth and Victorian policies, legislations and agreements and how they apply to the policy document mentioned above. This guidance document is to be read in conjunction with the policy document.

These documents are available on the department’s [MBS billing policy framework webpage](https://www.health.vic.gov.au/funding-performance-accountability/mbs-billing-policy-framework-victorian-public-hospitals) <https://www.health.vic.gov.au/funding-performance-accountability/mbs-billing-policy-framework-victorian-public-hospitals>.

Health services may operate parallel public NWAU-funded non-admitted clinics under the NHRA and MBS-billed clinics, but MBS-billed clinics can only be provided if the same service is provided on a public basis.

## Prisoners

Prisoners receiving admitted, emergency department and specialist clinic services in Victorian public hospitals are treated and funded as public patients.

Health services should not bill the Department of Justice and Community Services via primary care providers for these services provided to prisoners.

Health services are not permitted to raise additional fees or charges for pharmaceuticals or other items described in Section 11.2 Health service fees and charges.

# Improving health outcomes for Aboriginal and Torres Strait Islander patients

As part of the national funding model, all health services receive a pricing adjustment to support culturally safe services for Aboriginal patients.

In addition, health services with larger Aboriginal populations across their catchment receive a Commonwealth-funded [Aboriginal cultural safety fixed grant](https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and) <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and>.

This Aboriginal cultural safety funding aims to build health services’ responses to cultural safety and improve health outcomes for Aboriginal people attending Victorian public hospitals.

All health services, regardless of funding arrangements, must deliver culturally safe services.

These are set out in the Statement of Priorities and the *Aboriginal Health and Wellbeing Partnership Agreement and action plan 2023–2025* (2023).

This also reflects a Ministerial commitment made to the Yoorrook Justice Commission in 2024, which has the powers of a Royal Commission.

A priority action is to ensure all funding for prevention and early intervention programs and services related to Aboriginal health and wellbeing is first offered to Aboriginal community-controlled organisations (ACCOs) through appropriate procurement processes.

In addition to the Yoorrook Justice Commission, the State of Victoria has committed to negotiations on a Statewide Treaty and local Treaties.

Treaty is about making sure Aboriginal people have a say about matters that affect their lives and communities, including in relation to their healthcare.

These 2 commitments, and the department’s commitment to cultural safety, require health services to build stronger relationships with Aboriginal Victorians and ACCOs so that self-determined, culturally safe healthcare is delivered as a matter of course in public hospitals.

Health services receiving Aboriginal cultural safety fixed grants must provide cultural safety plans and progress reports to the department each year. The plans and progress reports outline cultural safety activity, outcomes and acquittal of the cultural safety funding.

The funding will support cultural safety across the whole health service organisation, as well as support the Improving Care for Aboriginal Patients program and the Koori Mental Health Liaison Officer programs.

There is recurrent funding from the *2021–22 State Budget* for phased recruitment of dedicated Koori Mental Health Liaison Officers in Infant, Child and Youth Area Mental and Health Services that will assist in supporting Aboriginal children, young people and families with access to culturally safe services.

While improved identification of Aboriginal people in mainstream health settings is a key priority, employing Aboriginal health staff is an important step in delivering culturally safe health services.

Aboriginal health staff includes people in both leadership and client-facing roles across the organisation.

These staff play key roles in planning and delivering improved discharge and referral pathways.

Health services are required to identify opportunities to employ Aboriginal health staff to meet patient and community demand including for out-of-hours presentations.

The role of Aboriginal staff is crucial to enhancing the cultural safety of Aboriginal patients and their families. However, every area across the health service has responsibilities in providing culturally safe services.

## Aboriginal cultural safety planning and reporting requirements

Hospitals in receipt of the Aboriginal cultural safety fixed grant must submit an annual cultural safety plan and progress report to the department.

Compliance with the planning and reporting requirements is an obligation of the funding. The [*Aboriginal cultural safety fixed grant guidelines*](https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and) <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and> set out these requirements and provide guidance for appropriate expenditure of funds towards improving Aboriginal cultural safety.

Refer to section 17.2 of the Policy guide for additional reporting requirements in relation to cultural safety action areas.

## Indicators and monitoring

Aboriginal cultural safety indicators for the acute setting include ‘leave against medical advice’[[4]](#footnote-5) (LAMA) for inpatients and ‘did not wait’ (DNW) for emergency department presentations.

From 2024–25, the target for health services for these 2 leave-event measures were adjusted to ‘no gap’ in rates between Aboriginal and non-Aboriginal patients.

This is to drive health equity and aligns with Victoria’s commitments under the National Agreement to Closing the Gap. Additional measures, including Aboriginal health workforce and outpatient data will continue to be explored as supplements to the higher-level cultural safety indicators.

# Pricing for quality

The NHRA includes reforms that seek to support governments in working together to provide high-quality services that deliver better health outcomes, improve patient safety and support greater efficiency in the health system. Victoria, as a signatory to the NHRA, is committed to deliver the quality and safety reforms.

Quality and safety are incorporated into hospital pricing and funding through 3 strategies:

* sentinel events
* hospital acquired complications (HACs)
* avoidable hospital readmissions (AHRs).

Victoria introduced a pricing mechanism for sentinel events in 2017–18, applied the national pricing and funding model for HACs from 2023–24, and implemented the pricing adjustment associated with AHRs in 2024–25.

## Sentinel events

Episodes of care with an avoidable sentinel event are not funded. ‘Category 11: All other adverse patient safety events resulting in serious harm or death’ is excluded, as this category is only used in Victoria and not subject to national pricing for quality.

Health services must report all sentinel events to the Sentinel Event Program, coordinated by Safer Care Victoria.

All sentinel events in categories 1–10 are analysed to determine avoidability.

If an event is found to be avoidable, a health service will not receive payment for the entire episode of care.

Sentinel events are:

* surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
* surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
* wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
* unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
* haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
* suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
* medication error resulting in serious harm or death
* use of physical or mechanical restraint resulting in serious harm or death
* discharge or release of an infant or child to an unauthorised person
* use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death
* all other adverse patient safety events resulting in serious harm or death (not subject to pricing for quality).

## Hospital acquired complications

The national funding model for acute admitted activity applies a risk-adjusted discount to the NWAU generated by each episode in which a HAC is present.

Section 10.2 ‘Calculating HAC NWAU growth-funding adjustment’ outlines the method to calculate the HAC NWAU growth-funding adjustment.

Section 9 ‘Prior-year adjustment: activity-based funding reconciliation’ outlines how this adjustment is applied as part of annual reconciliations.

Section 16.2 ‘Indicative NWAU adjustments for safety and quality’, Table 2.11: Indicative baseline NWAU adjustment in 2025–26 for HAC, is an indicative level of the HAC NWAU adjustment, against which a health service can monitor change.

HACs are:

* pressure injury
* falls resulting in fracture or intracranial injury
* healthcare-associated infection
* surgical complications requiring unplanned return to theatre
* unplanned intensive care unit admission
* respiratory complications
* venous thromboembolism
* renal failure
* gastrointestinal bleeding
* medication complications
* delirium
* incontinence
* endocrine complications
* cardiac complications
* third- and fourth-degree perineal laceration during delivery
* neonatal birth trauma.

Find out more about the HAC list, including diagnosis codes used to identify each HAC, on the Australian Government’s [Hospital-acquired complications webpage](https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications) <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications>.

The funding adjustment for HACs has been risk adjusted to take account of the increased predisposition of some patients to experience a HAC during their hospital stay and to provide funding signals, enabling hospitals to address systemic risks associated with care delivery.

Find out more about the risk adjustment model for HACs, including the risk factors for each HAC group, on the [National pricing model technical specifications 2025–26 – Independent Health and Aged Care Pricing Authority website](file:///C:/Users/lgru2306/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/SK0T922T/National%20pricing%20model%20technical%20specifications%202025–26%20–%20Independent%20Health%20and%20Aged%20Care%20Pricing%20Authority%20website) <https://www.ihacpa.gov.au/resources/national-pricing-model-technical-specifications-2025-26>.

## Avoidable hospital readmissions

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during, or subsequent to, their original hospital admission.

The AHR adjustment is calculated by deducting the cost of the readmission episode from the index episode, that is, their original admission. This adjustment is risk adjusted to account for the varying levels of risk factors relevant to the readmission condition. The list of AHRs and readmission intervals is provided in Table 1.2: Avoidable hospital readmissions and readmission intervals.

As with HACs, the AHR adjustment is paid based on the annual change in AHRs for a health service each year.

Section 10.3 ‘Calculating AHR NWAU growth-funding adjustment’ outlines the method to calculate the HAC NWAU growth-funding adjustment.

Section 9 ‘Prior-year adjustment: activity-based funding reconciliation’ outlines how this adjustment is applied as part of annual reconciliations.

Table .2: Avoidable hospital readmissions and readmission intervals

| Readmission condition | Readmission diagnosis | Readmission interval |
| --- | --- | --- |
| Pressure injury | Stage III ulcer | 14 days |
| Pressure injury | Stage IV ulcer | 7 days |
| Pressure injury | Unspecified decubitus and pressure area | 14 days |
| Pressure injury | Unstageable pressure injury | 14 days |
| Pressure injury | Suspected deep tissue injury, depth unknown | 14 days |
| Infections | Urinary tract infection | 7 days |
| Infections | Surgical site infection | 30 days |
| Infections | Pneumonia | 7 days |
| Infections | Blood stream infection | 2 days |
| Infections | Central line and peripheral line associated blood stream infection | 2 days |
| Infections | Multi-resistant organism | 2 days |
| Infections | Infection associated with devices, implants and grafts | 90 days |
| Infections | Infection associated with devices, implants and grafts in genital tract or urinary | 30 days |
| Infections | Infection associated with peritoneal dialysis catheter | 2 days |
| Infections | Gastrointestinal infections | 28 days |
| Infections | Other high impact infections | 2 days |
| Surgical complications | Postoperative haemorrhage/haematoma | 28 days |
| Surgical complications | Surgical wound dehiscence | 28 days |
| Surgical complications | Anastomotic leak | 28 days |
| Surgical complications | Cardiac vascular graft failure | 28 days |
| Surgical complications | Pain following surgery | 14 days |
| Surgical complications | Other surgical complications | 28 days |
| Respiratory complications | Respiratory failure including acute respiratory distress syndromes | 21 days |
| Respiratory complications | Aspiration pneumonia | 14 days |
| Respiratory complications | Pulmonary oedema | 30 days |
| Venous thromboembolism | Venous thromboembolism | 90 days |
| Renal failure | Renal failure | 21 days |
| Gastrointestinal bleeding | Gastrointestinal bleeding | 2 days |
| Medication complications | Drug related respiratory complications/depression | 2 days |
| Medication complications | Hypoglycaemia | 4 days |
| Medication complications | Movement disorders due to psychotropic medications | 14 days |
| Medication complications | Serious alteration to conscious state due to psychotropic medication | 14 days |
| Delirium | Delirium | 10 days |
| Cardiac complications | Heart failure | 30 days |
| Cardiac complications | Ventricular arrhythmias and cardiac arrest | 30 days |
| Cardiac complications | Atrial tachycardia | 14 days |
| Cardiac complications | Acute coronary syndrome including unstable angina, STEMI and NSTEMI | 30 days |
| Other | Constipation | 14 days |
| Other | Nausea and vomiting | 7 days |

More information on the adjustment model for AHRs, including the risk factors for each readmission condition, is contained in the [National pricing model technical specifications 2025–26 – Independent Health and Aged Care Pricing Authority website](https://www.ihacpa.gov.au/resources/national-pricing-model-technical-specifications-2025-26) <https://www.ihacpa.gov.au/resources/national-pricing-model-technical-specifications-2025-26>.

# Health service requirements

## Patient costing

Victorian public hospitals must report patient-level cost information, regardless of funding source, to the annual VCDC.

Health services must maintain and report costed data about the services used to deliver care across all hospital patient settings for all patients treated.

The data collection includes:

* admitted including acute, subacute (GEM), palliative care (including at phase of care), rehabilitation (including paediatric) and mental health (including at phase of care)
* non-admitted contacts including subacute and mental health
* home-based service delivery
* emergency activity including all emergency department presentations and urgent care centre activities
* mental health community activity, including subacute residential services (Prevention and Recovery Care (PARC), community care units, aged persons residential) and consultation liaison services (including at phase of care)
* radiotherapy
* community health services
* specialty programs such as the Victorian Perinatal Autopsy Service, statewide services and other diagnostic and therapeutic services and other specified programs
* any other programs or settings where patients have received treatment.

Health services’ cost method is to allocate actual expenditure (regardless of funding source) to patients’ actual interactions and events (including allocation of hospital overhead expenses), known as patient-level costing. This approach is more direct and sophisticated because it uses service volumes (for example, actual tests and minutes in theatre) and minimises assumptions. Thus, it provides for more accurate cost allocations at the individual patient level.

In Victoria, actual expenditure (direct and indirect/overhead) includes capital and depreciation costs. However, these are excluded from the total cost of patient. All allocated costs must reconcile with the general ledger and annual financial statements.

Costs are reported by service areas (cost centres as found in the standard chart of accounts) and by account types such as salary and wages (by professions), medical supplies or drugs, et cetera. For ease of analysis, these are mapped into generic resource categories, such as nursing, medical, theatre and pathology et cetera.

Health services must adhere to the specifications, business rules and costing guidance outlined in the documentation on the department’s [Victorian Cost Data Collection webpage](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc) <https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>.

The VCDC is guided by the *Australian hospital patient costing standards* (version 4.2 or the most recent version available). VCDC data is then submitted to the National Health Cost Data Collection via the IHACPA.

To ensure the integrity and assurance of quality data and as part of good hospital management practice, health services are expected to:

* maintain activity and costing systems
* review allocation methodologies
* reconcile financial and non-financial information to source systems
* identify and review fluctuations in cost results
* review the quality of data costed and submitted.

## Activity reporting

It is a condition of funding that health services collect and report activity data that spans a range of healthcare settings, in accordance with the department’s health data collection specifications. These include, but are not limited to, the VAED, the VEMD, the ESIS, the VINAH minimum dataset, AIMS and the CMI/ODS.

Specifications for these data sets are on the [Health data standards and systems webpage](https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems) <https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems>.

NWAU cannot be calculated for incomplete or uncoded records.

### Admitted episodes

There is a distinction between admitted and non-admitted patients throughout the classification, coding and funding systems. An admitted patient is a patient who undergoes a hospital’s formal admission process to receive treatment and/or care. Generally, admitted patients are treated in wards and non-admitted patients in outpatient clinics. Care provided in an emergency department is not considered part of admitted care.

The *VAED: criteria for reporting* 2025-26 document provides guidelines to enable health services to distinguish between admitted and non-admitted patient episodes for the purpose of data reporting.

To be reported to the VAED, patients must meet one of the admission criteria outlined in the document. Patients not meeting one of these criteria are non-admitted patients. No data for these encounters are to be reported to the VAED.

The criteria apply to public hospitals, and private health service establishments (private hospitals and day procedure centres) registered under the *Health Services Act 1988* (Vic). The reporting requirement for private health service establishments is set out in the *Health Services (Health Service Establishments) Regulations 2024* (Vic).

The [*VAED criteria for reporting* 2025-26](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) document can be accessed on the HDSS webpage <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>.

Admissions are formal admissions, or statistical (when the care type may change). Admission practices must ensure that an eligible person’s priority for receiving health services is not determined by:

* whether the person has health insurance
* the person’s financial status or place of residence
* whether the person intends to elect or elects to be treated as a public or private patient
* a person’s status as a Medicare-ineligible asylum seeker, refer to [Hospital access for people seeking asylum – policy](https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum) <https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum>.

As part of their admission practices, health services will:

* ensure that an eligible person, at the time of admission or as soon as practical thereafter, elects or confirms in writing whether they wish to be treated as a public or private patient and that this election process conforms to the National standards for public hospitals admitted patient election processes
* ensure that any ineligible person is appropriately identified as such in the VAED
* report admitted Medicare-ineligible asylum seekers to the VAED with the account class code MF – ineligible asylum seeker
* make every effort to verify the place of residence of interstate patients
* ensure that all patients admitted to hospital are asked whether they are of Aboriginal or Torres Strait Islander background. Identifying Indigenous status is a mandatory data item to be reported by hospitals to the VAED.

### Admitted episodes and care type

Each time a patient is admitted and discharged from hospital during the year, it is counted as an episode of care. Episodes can also be called admissions or separations. A single patient may have a number of separations during the year. Separations can also occur when admitted patients are transferred to another hospital, change the type of care required (see below) or die in hospital.

Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital.

The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Only one care type can be assigned at a time. If there is more than one focus of care, assign the care type that best describes the primary clinical purpose or treatment goal.

The National Minimum Data Set definitions for care type can be found at the [metadata online registry (METeOR)](https://meteor.aihw.gov.au) <https://meteor.aihw.gov.au>.

Care-type code references within this document related to the ‘care type’ data element specification in the VAED manual, available on the [Data Collections VAED webpage](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admittted-episodes-dataset>.

### Emergency services activity

Emergency department care is provided to patients registered for care in an emergency department in selected public hospitals. Emergency department presentation are reported to the VEMD.

Since 1 July 2024, health services, including Small Rural Health Services, that provide urgent care/unplanned emergency medical treatment are required to report presentations using the AIMS Urgent Care Centre form.

Urgent Care Centre activity which is MBS-billed must be reported as such to enable the department to monitor compliance with applicable legislation and to meet the department’s obligations under the NHRA.

### Subacute and non-acute care activity

All metropolitan, regional and subregional health services are delineated to provide rehabilitation and GEM services through the [*Planning the future of Victoria’s subacute service system: a capability and access planning framework* (2013)](file:///C:/Users/lgru2306/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/SK0T922T/Planning%20the%20future%20of%20Victoria’s%20sub-acute%20service%20system:%20a%20capability%20and%20access%20planning%20framework%20(2013)) <https://www.health.vic.gov.au/patient-care/subacute-planning-framework>.

Local health services delineated as level 2 can provide and report maintenance care.

Admitted GEM and rehabilitation provided in a person’s home must meet the same national METeOR definitions and required data elements as for admitted subacute GEM and rehabilitation hospital-based activity.

Home-based GEM and rehabilitation-type services can also be delivered through the HIP non-admitted platform, with activity reported in the VINAH minimum dataset.

Where admitted palliative care services are delivered in the patient’s home, health services must ensure that all obligations, standards and requirements for admitted palliative care contained in the Policy Guide are met.

While the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification system version 5.0 will be used for the purposes of classifying admitted subacute care in 2025–26, in Victoria the psychogeriatric AN-SNAP classes will not be used in 2025–26. Further information on AN-SNAP classification can be found on the [IHACPA subacute and non-acute care website](https://www.ihacpa.gov.au/health-care/classification/subacute-and-non-acute-care) <https://www.ihacpa.gov.au/health-care/classification/subacute-and-non-acute-care>.

### Non-admitted activity

Health services in scope for activity-based funding in the non-admitted stream are advised that from 2025–26, aggregate non-admitted data submitted via AIMS will not be used for calculating health service achievement against NWAU target. Patient-level data was required for the calculation of NWAU against target from 1 January 2025.

Health services in-scope for block funding in the non-admitted stream must report aggregate data on non-admitted activity using the AIMS S10, S11, S11A, S12 in accordance with the AIMS manual.

Activity that is MBS-billed must be reported as such to enable the department to monitor compliance with applicable legislation and to meet the department’s obligations under the NHRA.

#### Registration of clinics

All public health services in Victoria (NWAU activity-based or block funded) must register acute non-admitted clinics. Registration enables public hospitals to report non-admitted activity data via the AIMS and VINAH data collections.

Clinics are registered in the Non-Admitted Clinic Management System (NACMS) via the [HealthCollect portal](https://www.healthcollect.vic.gov.au) <https://www.healthcollect.vic.gov.au>. Find out more about registering clinics in the department’s [NACMS manual](https://www.health.vic.gov.au/publications/non-admitted-clinic-management-system-nacms-manual) <https://www.health.vic.gov.au/publications/non-admitted-clinic-management-system-nacms-manual>.

#### Service event and service event derivation rules

Under the national funding model the unit of count adopted for all non-admitted services is ‘service event’. Information on non-admitted patient service event counting rules and examples of how these apply is available in the annual [Tier 2 publication](https://www.ihacpa.gov.au/health-care/classification/non-admitted-care/tier-2-non-admitted-services-classification) <https://www.ihacpa.gov.au/health-care/classification/non-admitted-care/tier-2-non-admitted-services-classification>.

The VINAH minimum dataset collects information about services provided to non-admitted patients at the lowest level, which is a contact. For activity-based funding, multiple contacts for one patient delivered on the same day may be bundled into one service event. For further information on service event derivation rules see section 2, ‘Concepts and derived items’ in the [VINAH MDS manual](https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset>.

# National funding model arrangements

## National classifications

The national funding model uses various classification systems to express the relative cost weights in terms of NWAUs for each ‘group’ of activity-based funding services.

The 2025–26 national classification systems used to group patients for each activity-based funding service are:

* admitted acute patient services – AR-DRG version 11.0
* emergency department services – AECC version 1.1 (for recognised emergency departments at levels 3B–6) and urgency disposition groups (UDGs) version 1.3 (for recognised emergency departments at levels 1–3A)
* admitted mental health services – AMHCC version 1.1
* community mental health care consumers – AMHCC version 1.1
* non-admitted patient services – Tier 2 non-admitted services version 9.1
* admitted subacute and non-acute patient services – AN-SNAP version 5.0.

Victoria uses the national classification systems to classify reported activity.

## National price weights

Activity under the national model is measured in terms of the NWAU, which is a measure of health service activity expressed as a common unit against which a price is paid. The price weight per activity unit is calculated by the IHACPA through a staged process.

The process involves the calculation of cost-model parameters and then cost-weight values, by dividing the cost-model parameters by a reference cost. The cost-weight values, simply expressed, are the ratio of the average cost of all episodes in an AR-DRG to the average cost of all episodes across all DRGs. National price weights are derived once out-of-scope costs and activity are excluded, a reference (or average) cost is calculated, and model indexation rate is derived using the time series national hospital cost data collection. The Independent Health and Pricing Authority also determines adjustments to the NWAU.

Additional detail describing the transformation of cost parameters to price weights and adjustments can be found in the [National Efficient Price determination](https://www.ihacpa.gov.au/pricing/national-efficient-price-determination)NEP determination and technical specifications <https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination>.

## National efficient price

The IHACPA sets an annual national efficient price (NEP) which is published in the National Efficient Price Determination for public hospital services for each financial year. The NEP underpins activity-based funding to states and jurisdictions for Commonwealth funded public hospital services.

As described in section 2, in Victorian public hospital services the VEP is the price paid per NWAU by Victoria.

## Adjustments to the national efficient price

The national pricing framework articulates various adjustments to the NEP to reflect legitimate and unavoidable cost variations in the delivery of public hospital services. These adjustments are applied in Victoria.

Adjustments include the intensive care unit adjustment, which was introduced to address cost variations associated with treating patients in specified intensive care units (ICUs) compared with other admitted patients.

The framework specifies eligibility criteria for the ICU adjustment, and the IHACPA and jurisdictions work together to determine whether a hospital meets the eligibility criteria for inclusion or exclusion from the ICU adjustment.

Some health services operate an ICU not on the list of specified ICUs eligible for the ICU adjustment as per Appendix D of the [National Efficient Price Determination 2025–26](https://www.ihacpa.gov.au/resources/national-efficient-price-determination-2025-26) <https://www.ihacpa.gov.au/resources/national-efficient-price-determination-2025-26>. Health services can contact the department to review potential eligibility if they believe their ICU meets IHACPA’s eligibility criteria.

## Payment flows under the national funding approach

Commonwealth activity-based funding flows to health services through Victoria’s State Pool Account managed by the Administrator of the National Health Funding Pool. The Administrator (established as an independent statutory office holder) oversees both the Commonwealth and state and territory funding of the public hospital services within the scope of the NHRA. It publicly reports on funding provided to each health service and for which services.

As system manager, the Victorian Government instructs when payments are to be made out of the pool in accordance with the activity levels agreed between the state and each health service in their Statement of Priorities.

The Victorian Government will continue to manage National Health Reform block funding for block-funded services and hospitals, including small rural services. Block-funded payments will be paid to health services by the department through the [State Managed Fund](https://www.publichospitalfunding.gov.au/public-hospital-funding/pay) <https://www.publichospitalfunding.gov.au/public-hospital-funding/pay>.

For more information, refer to:

* [Pricing framework for Australian public hospital services](https://www.ihacpa.gov.au/health-care/pricing/pricing-framework-australian-public-hospital-services) <https://www.ihacpa.gov.au/health-care/pricing/pricing-framework-australian-public-hospital-services>
* [National Efficient Price Determination](https://www.ihacpa.gov.au/pricing/national-efficient-price-determination) NEP determination<https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination>
* [National Efficient Cost Determination](https://www.ihacpa.gov.au/health-care/pricing/national-efficient-cost-determination) <https://www.ihacpa.gov.au/health-care/pricing/national-efficient-cost-determination>
* [National pricing model technical specifications](https://www.ihacpa.gov.au/health-care/pricing/national-pricing-model-technical-specifications) <https://www.ihacpa.gov.au/health-care/pricing/national-pricing-model-technical-specifications>.

# Prior-year adjustment: activity-based funding reconciliation

The department allocates funding according to expected deliverables. In general, funded organisations are cash-flowed during the financial year according to their funding allocations. Where required, adjustments to this funding for over- and underactivity are made in the following financial year according to the policies set out in this section.

## Victorian funding recall policy

Funding recall will be triggered when activity is below target levels. Recall rates are set out in Table 1.3: Victorian funding recall rates 2025–26.

Recalling funds depends on accurate and timely data submission. Funded organisations should ensure they adhere to the data requirements specified in these guidelines. Significant over- or underactivity should be discussed with the department before the end of the year.

In 2025–26, based on the rates detailed in Table 1.3: Victorian funding recall rates 2025–26, the marginal NWAU policy aims to maintain minimal levels of funding for underactivity. This recognises fixed costs and variable demand, and it also incentivises efficient service delivery above target where this is cost-effective and up to a capped amount.

Department of Veterans’ Affairs and TAC activity will continue to be funded for actual activity that is approved by the Department of Veterans’ Affairs and the TAC respectively. Health services are expected to update the VAED for any rejected or denied episodes of care prior to reconciliation. Any denied or rejected records that are not amended will not be paid as either public or Department of Veterans’ Affairs when the 2025–26 prior-year adjustment is calculated.

Recall rates are based on a proportion of the price, rather than a specified dollar value. This enables rates to be applied consistently between services and to reflect price adjustments.

Small rural health services are exempt from the recall policy for acute, subacute, primary health and home and community care. Recall applies to Department of Veterans’ Affairs, TAC, Aged Care Assessment (Aged Care Assessment Service and Regional Assessment Service), and residential aged care services for small rural health services in the same way as other services.

A recall policy also applies to programs funded under the Ageing, Aged and Home Care Services output. This includes Home and Community Care Program for Younger People, and Aged Care and Aged Care Assessment (Aged Care Assessment Service and Regional Assessment Service), as outlined in Table 1.3: Victorian funding recall rates 2025–26.

NFCs activity will continue to be funded to actual activity. The NWAU associated with the NFCs, including procedures undertaken up to 3 months post discharge, will not be recognised as public–private NWAU for the purposes of calculated funding recall for acute admitted services.

An overview of the calculation process for recall can be found in section 10 Calculating funding recall.

Table 1.3: Victorian funding recall rates 2025–26

| Service | Funding recall policy |
| --- | --- |
| Acute admitted services (including mental health) except planned surgery activity (refer to ‘Planned surgery activity (admissions targets in Statement of Priorities (SOP) row)  Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)  Non-admitted services (includes mental health, HIP, genomics and specialist clinics)  Emergency non-admitted | Activity delivered below 99% of NWAU target is recalled at a rate of 100% of VEP.  Activity delivered between 99% and 100% of NWAU target is recalled at a rate of 50% of the VEP. |
| Planned surgery activity (admissions targets in SOP) | In-year recall may be applied to health services that are forecast to not achieve their end of financial year admissions target (as set out in the SOP, as the ‘Number of patients admitted from the planned surgery waiting list’).  The recallable amount will accord with the projected shortfall as against the outlined SOP target, with associated NWAU target and NWAU funding potentially recalled.  A decision will be made as early as possible (such as the mid-year point of the financial year).  The application of this in-year recall will consider potential financial impacts in light of the financial position of the health services.  Prior to actioning any in-year recall, the department will:   * undertake a comprehensive analysis of the health service’s performance and develop a detailed projected forecast * analyse the financial position of the health service * work with health services to implement non-financial interventions to support the achievement of the target * take a system-wide view to determine if recall is necessary to support the achievement of the statewide admissions target. |
| Department of Veterans’ Affairs   * Acute admitted services * Subacute admitted services (wrap includes GEM, rehabilitation, and palliative care) * Non-admitted (acute) services | Full recall of underactivity and rejected claims.  Activity must meet Department of Veterans’ Affairs requirements. |
| Transport Accident Commission and WorkSafe   * Acute admitted services | Full recall of underactivity and rejected claims.  Activity must meet Transport Accident Commission and WorkSafe requirements. |
| High-cost, highly specialised therapies | Funding will be reconciled to actual costs as per acquittal (process outlined in section 3.7). |
| Small rural health services | Recall applies to ACA, Department of Veterans’ Affairs, TAC and residential aged care services.  No recall applies for renal dialysis, National Bowl Cancer Screening Program, public and private acute, subacute, primary health and Home and Community Care. |
| Acquired brain injury unit | Full recall of underactivity at the full rate. |
| Mental health subacute and residential services | The department may recall funds associated with funded beds, which remain unopened or have been temporarily closed.  Recall will depend on statewide priorities and the need for funding redistribution to achieve these priorities as defined by the department. |
| Transition Care Program (bed-based and home-based wrapped) | * 0–5% below target: no recall. * > 5% below target: the department may apply recall. The amount subject to recall is that beyond the 5% underperformance. |
| Non-admitted radiotherapy | Funding will be recalled at the full rate for performance below target. |
| Integrated cancer services | The department may recall unexpended integrated cancer services funds. Recall will depend on statewide cancer reform priorities and the need for funding redistribution to achieve these priorities as defined by the department. |
| Community Health Care Program | * 0–5% below target: no recall. * > 5% below target: the department may recall at the full rate. The amount subject to recall is that beyond the 5% under-performance. |
| Home and Community Care Program for Younger People | * 0–5% below target: no recall. * > 5% below target: the department may recall at the full rate. The amount subject to recall is that beyond the 5% under-performance. |
| Community Health – Health Promotion | * 0–5% below target: no recall. * > 5% below target: the department may recall at the full rate. The amount subject to recall is that beyond the 5% under-performance. |
| Dental Health services | * 0–5% below target: no recall. * > 5% below target: the department may recall at the full rate. The amount subject to recall is that beyond the 5% under-performance. |
| BreastScreen Victoria services | Funding will be recalled at the full rate for performance below the department funded target.  Recall policy is subject to the terms and conditions of BreastScreen Victoria’s Funding and Service Agreement with the department. |
| Aged Care Assessment | While the department recognises that ACA may find it difficult to meet the exact annual targets for the number of assessments, in the case of sustained under-performance compared with annual targets of more than 5% for 2 years or longer, a funding reduction may be applied that corresponds to the level of under-performance.  ACA transitioned to the Single Assessment System in December 2024 which included updated performance measures and requirements. |
| Diabetes prevention | Program funding recalled per participant target not met or when program deliverables are not met. |
| Residential aged care | Recurrent funds may be recalled from service providers, including small rural residential aged care services where they reduce the number of operational places. As funding is calculated on the basis of operational places any reduction will result in a corresponding adjustment to funding. |
| LPHU core operations | Full recall for underspend. |
| Health advancement | Full recall for underspend. |
| Victorian Virtual Emergency Department | A recall adjustment will be applied at an agreed partial rate at the end of 2025–26 for Northern Health based on overall call volumes. |
| Gambling Harm Prevention and Response | The department may recall unspent funds due to performance issues pursuant to the Common Funding Agreement. |

### Exceptional events

There may be circumstances (including industrial action and natural disasters) beyond the reasonable control of health service management that prevent targeted throughput being met. At its discretion, and on a case-by-case basis, the department will consider submissions to adjust funding to health services, irrespective of throughput, for as long as such events continue.

Health services are expected to actively mitigate their financial exposure and throughput decline during and following such events.

The department will take into consideration the net change to health service finances and resources caused by exceptional events. However, health services will not receive additional funding for catch-up throughput, nor will health services receive funding for additional throughput in service areas not directly affected by these events. The department assesses the net impact of such events by assessing the data it collects on health service performance and other indicators.

## Funding for throughput above target

Funding for health service throughput above target will be based on a proportion of the funding rate (refer to Table 1.4: Funding for throughput above target 2025–26).

The Department of Veterans’ Affairs and the TAC will continue to be funded to actual activity and will therefore attract additional funding for throughout above target.

Significant under- or overactivity should be discussed with the department. TCP, nursing-home-type activity and non-admitted services are not included in the subacute wrap.

There is no funding for any overactivity for non-acute care (Community Health Program, Home and Community Care Program for Younger People, TCP, or nursing home activity).

Table .4: Funding for throughput above target 2025–26

|  |  |
| --- | --- |
| Service | Funding for throughout above target |
| Acute admitted services (including mental health)  Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)  Non-admitted services (includes HIP, genomics and specialist clinics)  Emergency non-admitted planned (elective) surgery base activity | Funding at 50% of the VEP for activity in excess of targets up to a cap of 101%. |
| High-cost, highly specialised therapies | Funding will be reconciled to actual costs as per acquittal (process outlined in section 3.7). |
| Acute admitted Hospital Acquired Complications | Full payment at VEP for an annual decrease in the HAC NWAU adjustment |
| Nationally funded centres | Funding will be reconciled to actual activity. |
| Transport Accident Commission  WorkSafe | Funding will be reconciled to actual activity for:   * acute admitted services * emergency department services * subacute admitted services (wrap includes GEM, rehabilitation, and palliative care) * mental health services. |
| Department of Veterans’ Affairs | Funding will be reconciled to actual activity for:   * acute admitted services * subacute admitted services (wrap includes GEM, rehabilitation, and palliative care) * non-admitted (acute) services. |
| Diabetes prevention | Contingency funding is available if the participant target is exceeded by no more than 5% and the department has been informed in advance. |
| Renal dialysis | Funding will be reconciled to actual activity for small rural health services. |
| National Bowel Cancer Screening Program | Funding will be reconciled to actual activity for small rural health services. |

## Recall with respect to public and private activity mix changes

The recall and throughput adjustment will no longer explicitly account for changed levels of private patient activity relative to public activity. There is no differentiation for public and private activity in the NWAU activity target. Therefore, a price-based funding adjustment cannot apply.

If the public to private ratio of activity changes over the course of the year, the resultant impact is to the NWAU per separation yield.

A change in yield will impact the speed at which health services achieve thresholds associated with the throughput or recall policies.

## Reconciliation of National Health Reform Commonwealth contributions

The NHRA requires a 6-month and annual reconciliation of Commonwealth contributions to activity-based funding. Monthly activity-based funding payments are based on estimated activity (that is, local hospital network activity targets), with the reconciliation process determining funding adjustments to align to actual activity delivered by each local hospital network.

The Administrator of the National Health Funding Pool calculates reconciliation adjustments and advises the Commonwealth Treasurer, who makes a final determination of Commonwealth national health reform funding entitlements. Adjustment of Commonwealth national health reform funding is spread equally across payments for a subsequent quarter.

## Reconciliation of pricing for safety and quality adjustments

A funding adjustment will be applied to each NWAU-funded health service where there is a change in the number of HACs and/or AHRs relative to the previous year, after adjusting for risk and complexity.

This adjustment will be paid or recalled at the full rate of VEP for the relevant health service for the annual change in HACs and/or AHRs. HAC and AHR adjustments while calculated individually, will be netted off each other to form one annual adjustment.

## NWAU reports

The NWAU values reported in Monitor will be used to assess a Health Service performance and any funding recall.

Other NWAU reports are provided to public health services via secure data exchange (Managed File Transfer portal). These reports provide NWAU information at aggregate level, broken down by various categories. These reports were developed to assist health services to submit accurate data to administrative datasets and are not intended to be used for NWAU funding reconciliation. The department intends to develop and release consolidated reports of NWAU across all service streams during 2025–26.

Patient-level extracts that include data items to support the reconciliation of NWAU values and adjustments are also available and distributed to health services.

Further information regarding NWAU reports are available at [National Funding Model implementation resources page](https://www.health.vic.gov.au/data-reporting/national-funding-model-implementation-resources) <https://www.health.vic.gov.au/data-reporting/national-funding-model-implementation-resources>.

# Calculating funding recall and adjustment

## Calculating NWAU funding recall

Step 1: Calculate the full-year total NWAU activity.

Step 2: Calculate full-year NWAU activity targets.

Step 3: Calculate the total performance percentage.

* Express the actual value as a percentage of the revised target value. This will show the extent to which the health service has performed above or below target.

Step 4: Calculate the adjustment.

To calculate the dollar amount of the throughput recall/payment adjustment:

* Multiply the performance percentage falling within the recall/payment threshold (in section 9.1 Victorian funding recall policy) by the target value (calculated in step 2).
* Multiply this by the VEP.
* Multiply that amount by the recall/payment percentage.

## Calculating HAC NWAU growth-funding adjustment

Step 1: For the current year, calculate the full-year total HAC NWAU adjustment.

Step 2: For the prior year, calculate the full-year HAC NWAU adjustment

Step 3: Calculate the change in the HAC NWAU adjustment as the difference between Step 1 and Step 2.

Step 4: Calculate the HAC growth-funding adjustment.

* Multiply Step 3 by VEP to derive the HAC NWAU funding adjustment.

The funding adjustment is applied as a prior-year adjustment at the same time as the throughput and recall adjustment.

## Calculating AHR NWAU growth-funding adjustment

Step 1: For the current year, calculate the full-year total AHR NWAU adjustment.

Step 2: For the prior year, calculate the full-year AHR NWAU adjustment and back cast to align NWAU between the current and prior year.

Step 3: Calculate the change in the AHR NWAU adjustment as the difference between Step 1 and Step 2.

Step 4: Calculate the AHR growth-funding adjustment.

* Multiply Step 3 by VEP to derive the AHR NWAU funding adjustment.

## Calculating TAC, WorkSafe or Department of Veterans’ Affairs NWAU funding recall

Funding adjustments are calculated as follows.

Step 1: Calculate the over- or underactivity.

* Calculate the over- or underactivity by subtracting the total full-year target from total full-year activity.
* A negative variance indicates that actual activity is less than the funded target (under-performance), and a positive variance indicated activity is greater than funded performance (overactivity).

Step 2: Calculate the amount of funding to be recalled or paid.

Calculate the amount of funding to be recalled (health service liability to department) or paid (department liability to health service) by multiplying the variance calculated in step 1 by the TAC / WorkSafe / Department of Veterans’ Affairs NWAU unit rate.

# Payments and cash flow

## Use of contracts

Sometimes when a health service has reduced capacity (for example, due to workforce shortages or capital works), it may contract with another service to undertake activity for a limited period. Contract arrangements of this type must be approved by the health service’s Performance and Commissioning Director.

Approval will only be granted where the health service can demonstrate that the capacity reduction is temporary and that the contract is an appropriate use of allocated NWAU, taking into account local demand for services.

Reporting guidelines and business rules for reporting of contracted care episodes are available in the VAED manual.

Episodes at the contracted hospital, that is the service provider hospital, are not eligible for NWAU activity-based funding.

## Health service fees and charges

Any fees and charges raised by health services must be in accordance with the department’s [*Patient fees and charges for public health services policy*](https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services) <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>.

Health services are permitted to raise fees for the following non-admitted patient services:

* dental services
* spectacles and hearing aids
* surgical supplies
* prostheses – however, the following categories of prostheses must be provided free of charge –
  + artificial limbs
  + prostheses that are surgically implanted, either permanently or temporarily, or are directly related to a clinically necessary surgical procedure
* external breast prostheses funded by the National External Breast Prostheses Reimbursement Program
* aids, appliances, and home modifications
* other services, as agreed between the Commonwealth and Victoria.

Upon an admitted patient being discharged, a health service may raise fees for:

* pharmaceuticals, at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments, for use outside the admitted patient separation.

This is set out in the business rules schedule of the NHRA.

## Facility-based renal dialysis

Health services providing satellite facility-based renal dialysis are required to pay their hubs a set rate for each L61Z dialysis separation based on expected activity levels, as follows:

* $123 to cover haemodialysis equipment and consumables (including equipment maintenance and servicing and real water testing)
* $86 to cover specialist services (including review and 24-hour on-call service including emergency, specialist renal coordination and services).

## Private patient accommodation charges

Section 72.1(2) of the Private Health Insurance Act 2007 states that an insurance policy covering hospital treatment must provide at least the ‘minimum benefit’ for that treatment.

The Commonwealth Minister for Health stipulates the minimum benefits payable by private health insurers for shared-ward accommodation in public hospitals through the private health insurance (benefit requirements) rules. The Commonwealth does not set a minimum benefit for single room accommodation.

Health services may make their own determination on accommodation fees to be charged to private patients who receive treatment at their campuses. In setting this fee, health services should consider:

* the benefit that private health insurance funds will assign to the public hospital in their health insurance products
* any co-payment a patient may be willing to pay as a private patient
* the amount of any co-payment or excess the hospital can viably forgo.

To assist health services with this decision, the department provides a guide to average costs and nominal cost recovery rates for private patient accommodation in the department’s [Fees manual](https://www.health.vic.gov.au/patient-fees-charges/private-patients) <https://www.health.vic.gov.au/patient-fees-charges/private-patients>.

At a minimum, these rates would be reasonable to apply to private patient charges.

Health services should note the Private Health Insurance (Health Insurance Business) Rules 2018 (Cth), part 3, section 8(b). This states that treatment provided to a person at an emergency department is excluded treatment for the purposes of private health insurance. Health services should ensure that private health funds are not billed for accommodation or services provided to admitted private patients at an emergency department.

## Doctors in training secondment arrangements

Many training programs for junior doctors involve a rotation to a site other than their parent hospital.

The parent hospital is responsible for managing and paying the annual leave of doctors in training while on rotation. If annual (or other) leave is planned within the rotation period, both hospitals should approve this leave.

Only the parent hospital is to pay out annual leave, as this is included in the overheads paid to the parent hospital (refer to Doctors in Training (Victorian Public Health Sector) (AMA Victoria/SMOF) (Single Interest Employers) Enterprise Agreement 2022–2026) (2022).

The parent hospital will make every endeavour to organise suitable relief when a doctor in training takes other leave (either planned or unexpected) for a period longer than one week. The parent hospital should also make every endeavour to ensure the relieving doctor has commensurate experience and skills to ensure the expected level of service in the external hospital can continue to be provided.

# Price tables

## NWAU 2025–26

Table .5: NWAU VEP 2025–26

|  |  |  |
| --- | --- | --- |
| Payment | Metropolitan and Large Regional ($) | Subregional ($) |
| VEP NWAU | 6,516 | 7,177 |

Note: NWAU VEP prices apply at the whole of health service level, not individual campuses.

Table .6: NWAU compensable price rates 2025–26

|  |  |
| --- | --- |
| Payment | All health services ($) |
| Department of Veterans’ Affairs: acute and subacute NWAU | 7,258 |
| Transport Accident Commission admitted NWAU | 6,323 |
| WorkSafe NWAU | 6,056 |

## Other price-based activity

Table .7: Transitional Care Program 2025–26

| Payment | All health services ($) |
| --- | --- |
| TCP bed places[[5]](#footnote-6) (per diem rate) | 178.15 |
| TCP home places (per diem rate) | 65.32 |

Table .8: Non-admitted radiotherapy 2025–26

| Payment | All health services ($) |
| --- | --- |
| WAU | 271.97 |
| Department of Veterans’ Affairs WAU | 336.11 |
| Shared care | 1,935.00 |

Table .9: Nationally Funded Centres Program 2025–26

| Payment | Hosting health service ($) |
| --- | --- |
| Islet cell transplantation | 239,694 |
| Paediatric heart transplantation – no ventricular assist device | 492,747 |
| Paediatric heart transplantation – with ventricular assist device | 1,142,329 |
| Paediatric liver transplantation | 402,396 |
| Paediatric lung/heart–lung transplantation | 351,332 |
| Pancreas transplantation | 221,205 |

## Mental health services

Table .10: Mental health – funded units applicable to clinical bed-based services 2025–26 – non-admitted care

| Service element | Funded unit | All health services ($) |
| --- | --- | --- |
| Community care unit | Available bed day | 453.67 |
| Adult PARC | Available bed day | 597.43 |
| Youth PARC | Available bed day | 712.67 |
| Aged persons nursing home supplement | Available bed day | 116.38 |
| Aged persons hostel supplement | Available bed day | 103.34 |

Table .11: Mental health – funded units applicable to clinical bed-based services 2025–26 – clinical community care

|  |  |  |
| --- | --- | --- |
| Service element | Funded unit | All health services ($) |
| Ambulatory | Community service hour | 491.95 |

Table .12: Mental health community support services unit prices 2025–26 – community support services

| Service element | Funded unit | All health services ($) |
| --- | --- | --- |
| Individualised client support packages | Client support unit | 125.33 |
| Youth residential rehabilitation – 24-hour | Bed day | 301.47 |
| Youth residential rehabilitation – non-24-hour | Bed day | 258.84 |
| Continuity of support | Client support unit | 125.33 |

Table .13: Mental health community support services unit prices 2025–26 – mutual support and self-help services

| Service element | Funded unit | All health services ($) |
| --- | --- | --- |
| Stand-alone (high availability) | Weighted block grant | 317,638 |
| Stand-alone (high availability) | Weighted block grant | Variable |
| Individual support referral and advocacy | Contact hour | 54.96 |
| Mutual support and self-help group support | Contact hour (group) | 145.44 |
| Group education and training | Contact hour (group) | 495.67 |
| Volunteer coordination | Hour | 63.72 |

Table .14: Mental health – funded units applicable to clinical bed-based services 2025–26 – non-admitted care

| Service element | Funded unit | All health services ($) |
| --- | --- | --- |
| In home | Client contact hour | 49.67 |
| Community | Client contact hour | 49.67 |
| Residential | Client contact hour | 49.67 |

Table .15: Mental health community support services unit prices 2025–26 – supported accommodation

| Service element | Funded unit | All health services ($) |
| --- | --- | --- |
| 24-hour on-site small facilities (0–11 beds) | Available bed day | 208.12 |
| 24-hour on-site small facilities (> 11 beds) | Available bed day | 72.84 |

Table .16: Drug services – unit prices 2025–26

| Service element | Funded unit | Metro unit price ($) | Rural unit price ($) |
| --- | --- | --- | --- |
| Drug treatment services – intake | Drug treatment activity unit | 1,021 |  |
| Drug treatment services – assessment | Drug treatment activity unit | 1,021 |  |
| Drug treatment services – care and recovery coordination | Drug treatment activity unit | 1,021 |  |
| Drug treatment services – counselling | Drug treatment activity unit | 1,021 |  |
| Drug treatment services – non-residential withdrawal | Drug treatment activity unit | 1,021 |  |
| Drug treatment services – therapeutic day rehabilitation | Drug treatment activity unit | 1,021 |  |
| Adult residential drug withdrawal | Drug treatment activity unit | 1,021 |  |
| Adult residential rehabilitation | Drug treatment activity unit | 1,021 |  |
| Youth residential drug withdrawal | Drug treatment activity unit | 1,021 |  |
| Youth residential rehabilitation | Drug treatment activity unit | 1,021 |  |
| Aboriginal residential rehabilitation | Drug treatment activity unit | 1,021 |  |
| Youth alcohol and drug supported accommodation | Episodes of care | 7,848 | 10,463 |
| Aboriginal alcohol and drug worker | Episodes of care | 2,643 |  |
| Youth outreach | Episodes of care | 2,338 |  |
| Specialist pharmacotherapy program | Episodes of care | 4,278 |  |
| Mobile overdose response | Episodes of care | 9,222 |  |
| Rural withdrawal | Episodes of care | 2,368 |  |
| Women’s alcohol and drug supported accommodation | Episodes of care | 7,848 |  |
| ACCO services – community model 1 | Episodes of care | 962.36 |  |
| ACCO services – community models 2 and 3 | Episodes of care | 2,973 |  |
| ACCO services – community alcohol and drug worker | Episodes of care | 2,643 |  |

## Early Parenting Centres

Table .17: Early Parenting Centres 2025–26

|  |  |  |
| --- | --- | --- |
| Service | Funded unit | All health services ($) |
| Day Stay | Number of children supported | 529.54 |
| Residential Stay | Number of children supported | 4,463 |

## Ageing, aged and home care

Table .18: Ageing, aged and home care 2025–26[[6]](#footnote-7)

Program area: Residential aged care[[7]](#footnote-8) – public sector residential aged care supplements

| Service | Funded unit | Estimated unit price ($) | |
| --- | --- | --- | --- |
| Rural small high-care supplement  1–10 places | Bed day | 12.24 | |
| Rural small high-care supplement  11–20 places | Bed day | 9.17 |
| Rural small high-care supplement  21–30 places | Bed day | 7.66 |
| Low-care supplement[[8]](#footnote-9) | Bed day | 7.01 |
| High-care supplement | Bed day | 75.72 |
| Public sector residential aged care supplement | Bed day | 13.98 |
| Complex care supplement | Bed day | 45.93 |

Program area: Home and Community Care Program for Younger People

| Service | Funded unit | Estimated unit price ($) |
| --- | --- | --- |
| HACC-PYP Access and Support | Hour | 80.29 |
| HACC-PYP Health Supports | Hour | 143.07 |
| HACC-PYP Assessment | Hour | 109.28 |
| HACC-PYP Delivered Meals | Meal | 3.96 |
| HACC-PYP Community Care | Hour | 71.60 |
| HACC-PYP Planned Activity Group | Per person | 18.94 |
| HACC-PYP Property Maintenance | Hour | 57.11 |
| HACC-PYP Volunteer Coordination | Hour | 46.58 |

Program area: HACC-PYP ACCO services[[9]](#footnote-10)

| Service | Funded unit | Estimated unit price ($) |
| --- | --- | --- |
| HACC-PYP Access and Support | Hour | 87.50 |
| HACC-PYP Occupational Therapy | Hour | 129.97 |
| HACC-PYP Podiatry | Hour | 129.97 |
| HACC-PYP Dietetics | Hour | 129.97 |
| HACC-PYP Speech Therapy | Hour | 129.97 |
| HACC-PYP Physiotherapy | Hour | 129.97 |
| HACC-PYP Counselling | Hour | 129.97 |
| HACC-PYP Assessment | Hour | 119.12 |
| HACC-PYP Delivered Meals | Meal | 4.31 |
| HACC-PYP Community Care | Hour | 59.89 |
| HACC-PYP Nursing | Hour | 119.12 |
| HACC-PYP Planned Activity Group | Person-hour | 20.11 |
| HACC-PYP Property Maintenance | Hour | 62.23 |
| HACC-PYP Volunteer Coordination | Hour | 50.74 |

## Small rural health services – ageing, aged and home care

Table .19: Small Rural Health Services 2025–26

Program area: Small rural health services – Home and Community Care

| Service | Funded unit | Estimated unit price ($) |
| --- | --- | --- |
| HACC-PYP Access and Support | Hour | 80.29 |
| HACC-PYP Health Supports | Hour | 143.07 |
| HACC-PYP Assessment | Hour | 109.28 |
| HACC-PYP Delivered Meals | Meal | 3.96 |
| HACC-PYP Community Care | Hour | 71.60 |
| HACC-PYP Planned Activity Group | Per person | 18.94 |
| HACC-PYP Property Maintenance | Hour | 57.11 |
| HACC-PYP Volunteer Coordination | Hour | 46.58 |

Program area: Small rural health services – Primary Health

|  |  |  |
| --- | --- | --- |
| Service | Funded unit | Estimated unit price ($) |
| Single unit price (allied health and nursing) | 1. Hour | 1. 125.16 |

Program area: Residential aged care[[10]](#footnote-11) – public sector residential aged care supplements

| Service | Funded unit | Estimated unit price ($) |
| --- | --- | --- |
| 1. Rural small high-care supplement 2. 1–10 places | 1. Bed day | 12.24 |
| 1. Rural small high-care supplement 2. 11–20 places | 1. Bed day | 9.17 |
| 1. Rural small high-care supplement 2. 21–30 places | 1. Bed day | 7.66 |
| 1. Low-care supplement[[11]](#footnote-12) | 1. Bed day | 7.01 |
| 1. High-care supplement | 1. Bed day | 75.72 |
| 1. Public sector residential aged care supplement | 1. Bed day | 13.98 |
| 1. Complex care supplement | 1. Bed day | 45.93 |

## Primary, community and dental health output group

Table .20: Community Health care output 2025–26

| Service | Service subsection | Funded unit | Estimated unit price ($) |
| --- | --- | --- | --- |
| 1. Family and Reproductive Rights Education Program | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Innovative Health Services for Homeless Youth | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Family planning | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Aboriginal services and support | 1. Case coordination | 1. Hours | 133.57 |
| 1. Integrated chronic disease management | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Refugee and asylum seeker health | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Healthy Mothers, Healthy Babies | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Community health | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. ACCO services | 1. Counselling/casework | 1. Hours | 135.77 |
| 1. MDC community health nurses | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |
| 1. Community Asthma Program | 1. Single unit price (allied health and nursing) | 1. Hours | 125.16 |

## Training and development

Table .21: Training and development funding rates in 2025-26

| Stream | Program | Rate per EFT ($) |
| --- | --- | --- |
| 1. Professional-entry student placements | 1. Medical, nursing, allied health, (including allied health assistance and health information management) | Not calculated based on an equivalent full-time (EFT) rate |
| 1. Transition to practice | 1. Allied health graduate – metro | 10,732 |
| 1. Transition to practice | 1. Allied health graduate – rural | 12,620 |
| 1. Transition to practice | 1. Pharmacy interns | 35,911 |
| 1. Transition to practice | 1. Medical graduate year 1 (PGY1) | 43,218 |
| 1. Transition to practice | 1. Medical graduate year 2 (PGY2) | 46,872 |
| 1. Transition to practice | 1. Nursing and midwifery | 21,358 |
| 1. Postgraduate – medical specialist training | 1. Victorian Medical Specialist Training Program | 80,537 |
| 1. Postgraduate – medical specialist training | 1. Victorian Paediatric Training Program | 109,299 |
| 1. Postgraduate – medical specialist training | 1. Basic physician training consortia | Not calculated based on an EFT rate |
| 1. Postgraduate – nursing and midwifery | 1. Nursing and midwifery postgraduates | 21,358 |

# Price groups for NWAU purposes

Table .22: Price groups for NWAU purposes

| Health services | Peer group |
| --- | --- |
| Albury Wodonga Health | Metropolitan and Large Regional |
| Alfred Health | Metropolitan and Large Regional |
| Austin Health | Metropolitan and Large Regional |
| Barwon Health | Metropolitan and Large Regional |
| Bendigo Health | Metropolitan and Large Regional |
| Calvary Health Care Bethlehem Ltd | Metropolitan and Large Regional |
| Eastern Health | Metropolitan and Large Regional |
| Goulburn Valley Health | Metropolitan and Large Regional |
| Grampians Health | Metropolitan and Large Regional |
| Latrobe Regional Health | Metropolitan and Large Regional |
| Melbourne Health | Metropolitan and Large Regional |
| Mercy Hospitals Victoria Ltd | Metropolitan and Large Regional |
| Monash Health | Metropolitan and Large Regional |
| Northern Health | Metropolitan and Large Regional |
| Parkville Youth Mental Health and Wellbeing Service | Metropolitan and Large Regional |
| Peninsula Health | Metropolitan and Large Regional |
| Peter MacCallum Cancer Institute | Metropolitan and Large Regional |
| Royal Children’s Hospital | Metropolitan and Large Regional |
| Royal Women’s Hospital | Metropolitan and Large Regional |
| St Vincents Health | Metropolitan and Large Regional |
| The Royal Victorian Eye & Ear Hospital | Metropolitan and Large Regional |
| Western Health | Metropolitan and Large Regional |
| Bairnsdale Regional Health Service | Subregional |
| Bass Coast Health | Subregional |
| Benalla Health | Subregional |
| Central Gippsland Health Service | Subregional |
| Colac Area Health | Subregional |
| Dhelkaya Health | Subregional |
| East Grampians Health Service | Subregional |
| Echuca Regional Health | Subregional |
| Gippsland Southern Health Service | Subregional |
| Kyabram District Health Service | Subregional |
| Maryborough District Health Service | Subregional |
| Mildura Base Public Hospital | Subregional |
| Northeast Health Wangaratta | Subregional |
| Portland District Health | Subregional |
| South West Healthcare | Subregional |
| Swan Hill District Health | Subregional |
| West Gippsland Healthcare Group | Subregional |
| Western District Health Service | Subregional |

# Output and activity tables

A range of inpatient, residential and community-based clinical services are provided to people with a mental illness and their families so that those who experience mental health problems can access timely, high-quality care and support to recover and live successfully in the community.

Table .23: Small rural health services – outputs and activities 2025–26

Output name: Acute health

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 35024 | Small rural – flexible health service delivery | Health services provided to small rural communities. |
| 35025 | Small rural – TAC – acute health | Transport Accident Commission-funded inpatient services. |
| 35026 | Small rural – DVA – acute health | Department of Veterans’ Affairs-funded inpatient services. |
| 35028 | Small rural – acute health service system development and resourcing | Provides funds for workforce, community, service development and IT projects that support SRHSs. |
| 35051 | Acute health – bush nursing hospitals | Provides funds to bush nursing hospitals to support a variety of purposes including inpatient services, 24-hour emergency stabilisation services, agency support and stabilisation grants. |
| 35052 | Small rural – specified services | Provides funding for services and projects as specified in applicable grant descriptions and conditions of funding. Includes specific-purpose activities of both a one-off and recurrent nature. |
| 35023 | Acute health – bush nursing centres | Provides funds to bush nursing centres to support clinical care, practical assistance, support, referral, and advocacy with the goal of improving quality of life, social function, and health. |

Output name: Small rural services

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 35010 | Small rural – aged support services | Health promotion and community service activities that support older Victorians and their carers in small rural communities. This includes seniors health promotion, aged carer support and respite, dementia services and aged care community grants. |
| 35052 | Small rural services home and community care | A range of services to support younger people who have difficulty with the activities of daily living and their carers to remain at home and participate in the community. |
| 35011 | Small rural – residential aged care | Care and support for people in small rural communities who are approved for care and accommodation in PSRACS. |
| 35042 | Small rural – drugs services | Delivery of health and aged care services as per an agreed service profile and business rules. |
| 35048 | Small rural – primary health | Suitably qualified people assessing and providing direct care. This includes therapeutic intervention, clinical care, practical assistance, support, referral, and advocacy with the goal of improving quality of life, social function and health.  Promoting health, independence, and wellbeing to prevent illness, injury and disease through screening, risk assessment, immunisation, social marketing of health information, community action for social and environmental change, organisational development, workforce development and resources. |

Table .24: Aged and home care – outputs and activities 2025–26

Output name: Aged Care Assessment – Aged Care Assessment

|  |  |  |
| --- | --- | --- |
| Activity no. | Activity name | Activity description |
| 13005 | Aged Care Assessment | To conduct Aged Care Needs Assessments (home support, comprehensive and hospital assessments) to assess the care needs of older people in Victoria. Assessment services are conducted to determine supports for those who wish to remain living in their home and community. This includes determining eligibility for services under the Aged Care Act, including residential aged care, residential respite care, Transition Care Program, the Commonwealth Home Support Program and Home Care Program packages. |

Output name: Residential aged care

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 13031 | Public sector residential aged care supplement | Supports PSRACS to deliver residential aged care. The department is reviewing the allocation of PSRACS funding and this may change in 2026–27. |
| 13059 | Residential aged care complex supplement | Supports additional care and services for a limited number of beds in metropolitan PSRACS for the care of people with complex conditions and specialised care needs. |
| 13107 | Rural small high-care supplement | Supports additional care and service delivery for small-sized high-care PSRACS (up to 30 places as at 30th June 2014) located in rural Victoria. There are 3 levels of supplement paid for services of various sizes:   * services with one to 10 high-care places * services with 11–20 high-care places * services with 21–30 high-care places. |
| 13211 | Aged annual provisions – minor works | This activity provides minor capital funds for funded organisations and includes vehicles, minor building modifications, repairs and furniture and equipment expenses. |
| 13301 | Aged quality improvement | To support safety through a range of activities including performance monitoring, workforce development, infection management, infrastructure development and social inclusion. |

Output name: Community health care

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 28066 | Innovative health services for homeless youth | To promote health care and improve access to ACCO Services that respond to and support the Aboriginal community. |
| 28068 | Family planning | Provision of therapeutic intervention, clinical care, practical assistance, support, referral and/or advocacy that is responsive and culturally relevant. |
| 28069 | Service system development | Funding to improve the planning, coordination and delivery of primary care services that is not specific to a direct care activity. For example, board expenses funding or non-recurrent funding for projects. |
| 28072 | Integrated chronic disease management | Provides funds to community health services for integrated chronic disease management encompassing direct care and change management. |
| 28076 | Refugee and asylum seeker health services | Responding to the poor health and complex health issues of arriving refugees in Victoria. |
| 28080 | Healthy Mothers Healthy Babies | To improve the health and wellbeing of mothers and babies and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. |
| 28081 | National Diabetes Services Scheme | To enhance the capacity of people with diabetes to understand and self-manage their condition and distribute of packs of needles and syringes. |
| 28048 | Language services | Provision of accredited interpreting and translation services by specialist agencies |
| 28086 | Community health | The program funds general counselling, allied health and nursing services. |
| 28090 | MDC – community health nurse | Community health nurses work with clients to identity and determine health and care needs and provide support to navigate and access services and programs to meet each individual’s needs. |
| 28091 | Community Asthma Program | The Community Asthma Program supports avoidable hospital admissions through the delivery of community-based services, with a focus on asthma self-management and improved cohesion of services for children and young people presenting with asthma symptoms. |
| 28092 | Infant Child and Family Health and Wellbeing Hubs – Community Health | Provision of integrated and community-based multidisciplinary health services and supports for children experiencing developmental, emotional, relational and behavioural challenges and their families. Hub services delivered in community health will include the establishment of the service and delivery of specialist medical appointments, allied health service hours, intake, care coordination and in-reach supports. |
| 28095 | Putting Families First – Community Health | To work as part of an interdisciplinary team to enhance family health, wellbeing and inclusion by improving identification of family health needs and access and engagement with relevant health services. |
| 35048 | Small rural – Primary Health | Provision of general counselling, allied health, nursing and health promotion services. Note this funding can be used flexibly to provide other service types under the small rural health services funding model. |

Output name: Home and Community Care Program for Younger People

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 13015 | HACC-PYP linkages | Individualised packages of care incorporating assessment, case management and funds to purchase services to support HACC-PYP clients. |
| 13023 | HACC-PYP Service Development Grant | One-off projects (up to 6 months’ duration) to improve quality, effectiveness, and efficiency of HACC-PYP services and service system. |
| 13024 | HACC-PYP assessment | This activity is described in the *Framework for assessment* *in the HACC program*. Living-at-home assessments for HACC-PYP clients include home-based holistic assessment of need, service-specific assessments, and warm transfer to more relevant programs. |
| 13026 | HACC-PYP community care | Personal and in-home supports to people birth to 65 years of age who have difficulty with the activities of daily living |
| 13038 | HACC-PYP service system resourcing | Resources to assist the sector to better meet the needs of younger people in the HACC-PYP target group and assist clients to gain better access to services. This also includes the Social and Community Service Award. |
| 13043 | HACC-PYP flexible service response | Funding to support innovative and/or developmental approaches to HACC-PYP and/or service delivery that cannot be funded under the unit pricing structure. |
| 13056 | HACC-PYP planned activity group (PAG) | Planned program of group activity to maintain a younger person’s capacity to perform the activities of daily living and social skills. PAG can be offered in a centre or in the community |
| 13063 | HACC-PYP volunteer coordination | Funding to coordinators to recruit, train and supervise volunteers and manage the volunteer services to HACC-PYP clients. |
| 13096 | HACC-PYP allied health | Allied health services, including clinical assessment, treatment, therapy, or professional advice to HACC-PYP clients, that may be provided in the home or at a centre. |
| 13097 | HACC-PYP delivered meals | Subsidy for meals delivered to people in the HACC-PYP target group at home and or in a local venue. |
| 13099 | HACC-PYP property maintenance | Assistance with home maintenance or modification, including maintenance and repair of the client’s home, garden, or yard to keep it in a safe and habitable condition, and home modification or minor renovations to the client’s home to help them cope with a disabling condition. |
| 13130 | HACC-PYP volunteer coordination – other | Block funding to offset costs of volunteer programs including volunteer reimbursements, police checks and some program costs. |
| 13217 | HACC-PYP minor capital | Minor capital funds to HACC-PYP funded organisations to maintain, refurbish or upgrade infrastructure to support HACC-PYP services. |
| 13223 | HACC-PYP nursing | Professional nursing care including direct clinical care, clinical assessment to HACC-PYP clients. |
| 13227 | ACCO services – HACC-PYP | Funding for HACC-PYP services provided by Aboriginal community-controlled organisations. |
| 13229 | HACC-PYP access and support | One-on-one support for eligible people aged birth to 65 years who experience barriers in accessing a wide range of services. |

Output name: Aged Care Assessment

|  |  |  |
| --- | --- | --- |
| Activity no. | Activity name | Activity description |
| 13109 | Aged Care Assessment evaluation | Audit data integrity and conformance with My Aged Care systems and processes. |

Output name: Aged support services

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 13019 | Personal Alert Victoria | Daily monitoring and duress response service for frail older people and people with a disability who have high ongoing health and support needs and mostly live alone. |
| 13053 | Victorian Eyecare Service | Provides subsidised eyecare and visual aids to people experiencing disadvantage via metropolitan, outreach and rural services. |
| 13155 | Dementia Services | Funding to Dementia Australia (Victoria) for direct client and carer support, sector education and training, consumer engagement and dementia awareness activities. |
| 13082 | Low-cost Accommodation Support | Outreach programs for older and vulnerable Victorians with unmet complex needs who are homeless or living in insecure or low-cost accommodation. Programs link clients to relevant health, community care and welfare services to improve their health, social connectedness and stabilise their tenancies. |

Table .25: Public health – outputs and activities 2025–26

Output name: Health advancement

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 16035 | Communication, information, and advice | To communicate information, via one or more media, to members of the public or other specific external people and groups. |
| 16308 | Injury prevention | To undertake the design, management and evaluation of projects aimed at fostering best practice in injury prevention program planning and delivery. |
| 16348 | Children’s obesity | To implement initiatives to increase healthy eating and physical activity among children. |
| 16349 | Obesity – community projects | To implement obesity prevention place-based initiatives in a community and develop activities to increase healthy eating and physical activity. |
| 16449 | Smoking/vaping information – advice and interventions | To provide smoking and vaping cessation advice/support, research and to educate the community and stakeholders about tobacco, e-cigarettes and smoking/vaping-related legislative requirements and to enforce the Tobacco Act 1987. |
| 16450 | Diabetes prevention | To undertake primary and secondary prevention initiatives aimed at reducing the number of people in the Victorian community developing type 2 diabetes and cardiovascular disease. |
| 16454 | Health promotion initiatives | To develop and support programs that prevent illness and promote wellbeing through using a mix of health promotion interventions and capacity-building strategies delivering place-based approaches in Victorian communities – including activity delivered through LPHU population health catchment plans |
| 16460 | Targeted recruitment for screening programs | To undertake a range of activities aimed at improving participation of under-screened and never-screened people in screening programs. |
| 16461 | ACCO services – public health | Funding for those public health services provided by Aboriginal community-controlled organisations. |
| 16508 | BBV and STI – health promotion | To provide for the delivery of blood-borne virus and sexually transmitted infection (BBV/STI) health-promotion/prevention services to the community or targeted population groups. |
| 16509 | BBV and STI – community-based care and support | To provide the delivery of community-based care and support to clients, carers, and significant others. |
| 16513 | Screening and preventive messages | To undertake a range of activities within the community aimed at enabling people to make positive decisions about their health and wellbeing. |
| 16514 | Screening service development | To undertake specific activities to improve service delivery, capacity, and program effectiveness. |
| 16515 | Education and training in screening programs | To undertake a range of education and training activities with program stakeholders to support and enhance the delivery of organised screening programs. |
| 16519 | Screening tests and assessments | To provide screening tests and assessments to the target population of an organised screening program. |

Output name: Health protection

| Activity no. | Activity name | Activity description |
| --- | --- | --- |
| 16037 | Immunisation education | To provide educational and promotional resources and programs for immunisation providers and the public. |
| 16038 | Tuberculosis screening – management | To provide services and activities related to tuberculosis management. |
| 16042 | Infectious disease investigation and response | To investigate sporadic cases or outbreaks of infectious disease and the institution of suitable control measures. |
| 16047 | Food system quality improvement | To oversee the State Safe Food System through intersectoral linkages with an aim of continuous improvement in system operation through consultation and cooperation. |
| 16049 | Cemetery sector governance | To undertake a range of projects relating to the governance of the cemetery sector. |
| 16084 | Childhood immunisation services | To provide subsidy payments to local governments for childhood immunisation (under 7 years old). |
| 16102 | Infectious disease surveillance | To collect, collate and report on data relating to notifiable infectious diseases, as required by legislation. |
| 16103 | Food safety surveillance | To provide microbiological testing and analysis of food samples and surfaces in food premises. |
| 16119 | Secondary school immunisation services | To provide subsidy payments to local governments for adolescent immunisation service delivery including the delivery of the secondary school immunisation program. |
| 16132 | Food safety research | To provide research into food risks. |
| 16163 | Food safety education | To provide education to local government, public and food businesses on food safety. |
| 16206 | Laboratory testing | To provide a range of laboratory tests for infectious diseases (including arbovirus where applicable), including reference functions, advice on microbiological issues and undertaking education and training in relation to laboratory services. |
| 16360 | Infectious disease education and advice | To provide education and awareness programs in the investigation and control of infectious diseases. |
| 16373 | BBV and STI – clinical services | To provide diagnoses and the clinical management of clients in relation to BBV/STIs and sexual health. |
| 16381 | Risk management and emergency response | To investigate, evaluate and respond to environmental health risks, emergencies, or incidents, and to perform activities that help us to better respond to emergencies. |
| 16505 | BBV and STI – training and development | To provide education and training to the BBV/STI sector, including volunteers and organisation staff, and coordination of information updates. |
| 16506 | BBV and STI – research | To support commission or undertake research projects related to BBV/STIs in Victoria. |
| 16507 | BBV and STI – laboratory services | To provide laboratory-testing services related to BBV/STIs in Victoria. |
| 16517 | Cancer and screening registers | To maintain a register (as prescribed by legislation where applicable) to record data about cancers and screening results for Victorians. |

Output name: Public health development

|  |  |  |
| --- | --- | --- |
| Activity no. | Activity name | Activity description |
| 16203 | Regulation of ART and associated legislation – this is the responsibility of Regulation, Risk, Integrity and Legal Division | To provide funding and support of legislation for assisted reproductive technology (ART). |
| 16107 | Public Health Research Capacity Building | To develop an evidence base that will assist Victorian medical practitioners to safely prescribe cannabidiol, a medicinal cannabis product, to children with severe intractable epilepsy. |

Part 2: Funding and activity levels

# Budget tables

## Health service modelled budgets 2025–26

Notes:

* Subtotals and totals may not add up due to rounding.
* When published, Statement of Priorities Part C supersede these tables.
* Excludes New South Wales contribution.

Table 2.1: Expenditure budgets 2025–26

Metropolitan and regional – $’000s

| **Health service** | **2025–26 Acute health services** | **2025–26 Ageing, aged and home care** | **2025–26 Ambulance services** | **2025–26 Drugs services** | **2025–26 Mental health** | **2025–26 Primary and dental health** | **2025–26 Public health** | **2025–26 Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Albury Wodonga Health | 409,009 | 1,084 |  | 1,078 | 66,206 | 4,888 | 2,783 | 485,048 |
| Alfred Health | 1,399,466 | 860 |  | 1,231 | 155,161 | 2,292 | 9,738 | 1,568,748 |
| Austin Health | 1,143,552 | 335 |  | 7,138 | 125,267 |  | 7,113 | 1,283,405 |
| Barwon Health | 822,184 | 11,187 |  | 4,198 | 140,259 | 6,142 | 4,835 | 988,805 |
| Bendigo Health | 472,561 | 10,337 |  | 2,617 | 105,206 | 1,283 | 6,056 | 598,058 |
| Calvary Health Care Bethlehem Limited | 30,189 |  |  |  |  |  |  | 30,189 |
| Eastern Health | 1,220,727 | 3,098 |  | 24,327 | 217,520 | 4,552 | 21 | 1,470,245 |
| Goulburn Valley Health | 322,374 | 3,093 |  | 3,477 | 53,108 | 1,908 | 3,296 | 387,255 |
| Grampians Health | 601,655 | 39,448 |  | 331 | 79,009 | 4,093 | 4,716 | 729,252 |
| Latrobe Regional Health | 317,319 | 579 |  | 167 | 87,734 |  | 5,255 | 411,054 |
| Melbourne Health | 1,168,659 | 3,193 | 1,308 | 327 | 118,621 |  | 17,418 | 1,309,526 |
| Mercy Hospitals Victoria Limited | 532,023 | 263 |  | 211 | 86,968 | 4,065 |  | 623,530 |
| Monash Health | 2,403,261 | 9,171 |  | 7,878 | 308,413 | 18,527 | 6,922 | 2,754,173 |
| Northern Health | 1,011,006 | 3,227 |  | 166 | 194,807 |  | 22 | 1,209,228 |
| Parkville Youth Mental Health and Wellbeing Service | 4,112 |  |  |  | 75,911 |  |  | 80,023 |
| Peninsula Health | 810,725 | 2,632 |  | 3,755 | 94,990 | 8,352 | 21 | 920,475 |
| Peter Maccallum Cancer Institute | 400,168 |  |  |  | 631 |  | 50 | 400,850 |
| St Vincents Hospital Melbourne Limited | 713,314 | 3,241 |  | 6,743 | 98,467 | 341 | 253 | 822,358 |
| The Royal Children’s Hospital | 709,424 |  |  | 210 | 35,230 | 984 | 318 | 746,165 |
| The Royal Victorian Eye and Ear Hospital | 140,022 |  |  |  |  |  | 23 | 140,045 |
| The Royal Women’s Hospital | 328,750 |  |  | 1,243 | 955 | 318 |  | 331,266 |
| Western Health | 1,412,365 | 2,830 |  | 20,152 | 152,530 | 4,041 | 6,955 | 1,598,873 |
| Total | 16,372,865 | 94,578 | 1,308 | 85,249 | 2,196,992 | 61,784 | 75,795 | 18,888,571 |

Subregional and local – $’000s

| **Health service** | **2025–26 Acute health services** | **2025–26 Ageing, aged and home care** | **2025–26 Ambulance services** | **2025–26 Drugs services** | **2025–26 Mental health** | **2025–26 Primary and dental health** | **2025–26 Public health** | **2025–26 Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Bairnsdale Regional Health Service | 122,213 | 1,590 |  | 658 |  | 162 |  | 124,623 |
| Bass Coast Health | 139,889 | 1,968 |  | 53 |  | 2,509 |  | 144,419 |
| Benalla Health | 27,558 | 1,345 |  |  |  | 1,306 |  | 30,209 |
| Central Gippsland Health Service | 85,699 | 3,880 |  | 652 |  | 2,065 |  | 92,295 |
| Colac Area Health | 48,408 | 2,505 |  | 10 |  | 709 |  | 51,632 |
| Dhelkaya Health | 53,741 | 4,199 |  |  |  | 988 |  | 58,928 |
| East Grampians Health Service | 44,286 | 1,952 |  |  |  | 962 |  | 47,201 |
| Echuca Regional Health | 121,072 | 2,247 |  | 258 |  | 1,094 |  | 124,670 |
| Gippsland Southern Health Service | 32,297 | 2,704 |  | 244 |  | 452 |  | 35,697 |
| Kyabram District Health Service | 22,572 | 1,591 |  |  |  | 1,293 |  | 25,456 |
| Maryborough District Health Service | 38,324 | 2,892 |  |  |  | 841 |  | 42,057 |
| Mildura Base Public Hospital | 189,019 | 34 |  | 482 | 32,626 |  | 21 | 222,183 |
| Northeast Health Wangaratta | 223,720 | 2,432 |  | 407 |  | 801 | 376 | 227,737 |
| Portland District Health | 51,248 | 1,355 |  |  |  | 2,108 |  | 54,711 |
| South West Healthcare | 211,810 | 2,253 |  | 739 | 42,220 | 2,418 | 159 | 259,600 |
| Swan Hill District Health | 72,731 | 2,461 |  |  |  | 1,728 |  | 76,920 |
| West Gippsland Healthcare Group | 147,613 | 3,149 |  |  |  | 1,103 |  | 151,864 |
| Western District Health Service | 75,697 | 4,367 |  |  | 128 | 735 |  | 80,928 |
| Total | 1,707,897 | 42,927 |  | 3,504 | 74,974 | 21,272 | 556 | 1,851,130 |

Combined total – $’000s

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **2025–26 Acute health services** | **2025–26 Ageing, aged and home care** | **2025–26 Ambulance services** | **2025–26 Drugs services** | **2025–26 Mental health** | **2025–26 Primary and dental health** | **2025–26 Public health** | **2025–26 Total** |
| Total | 18,080,762 | 137,505 | 1,308 | 88,753 | 2,271,966 | 83,056 | 76,351 | 20,739,701 |

## Small rural health services expenditure budgets 2025–26

Notes

* Subtotals and totals may not add up due to rounding.
* When published, Statement of Priorities Part C supersede these tables.

Table 2.2: Small rural health services expenditure budgets 2025–26 – $’000s

| **Health service** | **2025–26 Acute health services** | **2025–26 Ageing, aged and home care** | **2025–26 Mental health** | **2025–26 Primary and dental health** | **2025–26 Total** |
| --- | --- | --- | --- | --- | --- |
| Alexandra District Health | 10,315 | 155 |  | 517 | 10,987 |
| Alpine Health | 19,212 | 2,286 |  | 358 | 21,855 |
| Beaufort And Skipton Health Service | 7,151 | 1,144 |  | 172 | 8,468 |
| Beechworth Health Service | 6,170 | 1,306 |  | 403 | 7,878 |
| Boort District Health | 3,531 | 429 |  |  | 3,960 |
| Casterton Memorial Hospital | 5,802 | 1,139 |  | 42 | 6,983 |
| Central Highlands Rural Health | 34,736 | 2,684 |  | 1,239 | 38,659 |
| Cohuna District Hospital | 8,595 | 642 |  |  | 9,237 |
| Corryong Health | 6,987 | 943 |  | 141 | 8,070 |
| East Wimmera Health Service | 20,581 | 3,239 |  | 705 | 24,525 |
| Great Ocean Road Health | 8,990 | 1,352 |  | 225 | 10,567 |
| Heathcote Health | 5,042 | 594 |  | 146 | 5,782 |
| Hesse Rural Health Service | 2,794 | 1,421 |  | 662 | 4,876 |
| Heywood Rural Health | 5,027 | 565 |  |  | 5,592 |
| Inglewood And Districts Health Service | 4,026 | 763 |  | 621 | 5,410 |
| Kerang District Health | 8,843 | 1,255 |  |  | 10,098 |
| Kooweerup Regional Health Service | 6,732 | 1,044 |  |  | 7,776 |
| Mallee Track Health & Community Service | 6,938 | 1,895 |  |  | 8,833 |
| Mansfield District Hospital | 14,800 | 1,349 |  | 458 | 16,607 |
| Moyne Health Services | 7,050 | 1,485 |  | 9 | 8,544 |
| Ncn Health | 29,808 | 3,147 |  | 444 | 33,398 |
| Omeo District Health | 4,768 | 422 |  |  | 5,191 |
| Orbost Regional Health | 9,372 | 710 |  | 404 | 10,486 |
| Robinvale District Health Services | 9,344 | 1,071 |  | 270 | 10,685 |
| Rochester And Elmore District Health Service | 6,672 | 1,211 |  |  | 7,883 |
| Rural Northwest Health | 14,318 | 2,127 |  | 669 | 17,114 |
| Seymour Health | 18,134 | 1,449 |  | 102 | 19,686 |
| South Gippsland Hospital | 9,531 | 54 |  | 93 | 9,678 |
| Tallangatta Health Service | 7,372 | 731 |  | 261 | 8,365 |
| Terang And Mortlake Health Service | 7,010 | 754 |  | 1,406 | 9,170 |
| Timboon & District Healthcare Service | 6,253 | 395 |  | 314 | 6,962 |
| West Wimmera Health Service | 20,879 | 3,707 | 300 | 3,635 | 28,521 |
| Yarram And District Health Service | 7,362 | 888 |  | 620 | 8,870 |
| Yarrawonga Health | 15,147 | 1,552 |  | 755 | 17,454 |
| Yea And District Memorial Hospital | 4,350 | 435 |  | 426 | 5,211 |
| Total | 363,643 | 44,340 | 300 | 15,095 | 423,378 |

## Funding summary: health service expenditure budgets 2025–26 by service category

Notes:

* This table shows (state and Commonwealth) funding flowed through the National Health Funding Pool to activity funding.
* This table does not include public hospital services provided by small rural health services or non-health service organisations.
* Subtotals and totals may not add up due to rounding.

Table 2.3: Funding summary: health service expenditure budgets 2025–26 by service category

Metropolitan and regional – $’000s

| **Health service** | **2025–26**  **Consolidated ABF** | **2025-26**  **Community mental health ABF** | **2025–26**  **Highly Specialised Therapies** | **2025–26**  **Non admitted home ventilation** | **2025–26**  **Other mental health** | **2025–26**  **Other public hospitals** | **2025–26**  **Small rural hospitals** | **2025–26**  **Teaching, training and research** | **2025–26**  **Out of scope agreement** | **2025–26**  **Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Albury Wodonga Health[[12]](#footnote-13) | 258,933 | 27,363 |  |  | 7,758 |  |  | 9,252 | 181,742 | 485,048 |
| Alfred Health | 1,390,386 | 79,391 | 28,339 |  | 7,067 |  |  | 25,653 | 37,913 | 1,568,748 |
| Austin Health | 1,032,047 | 50,360 |  | 9,756 | 11,515 |  |  | 24,092 | 155,635 | 1,283,405 |
| Barwon Health | 896,537 | 64,285 |  |  | 7,683 |  |  | 21,535 | -1,233 | 988,805 |
| Bendigo Health | 534,803 | 56,396 |  |  | 10,676 |  |  | 14,663 | -18,480 | 598,058 |
| Calvary Health Care Bethlehem Limited | 29,523 |  |  |  |  |  |  | 636 | 31 | 30,189 |
| Eastern Health | 1,251,808 | 124,570 |  |  | 24,167 |  |  | 23,262 | 46,438 | 1,470,245 |
| Goulburn Valley Health[[13]](#footnote-14) | 298,677 | 31,031 |  |  | 6,261 |  |  | 17,800 | 33,486 | 387,255 |
| Grampians Health | 560,301 | 42,930 |  |  | 5,499 |  | 5,806 | 16,808 | 97,908 | 729,252 |
| Latrobe Regional Health | 342,419 | 51,664 |  |  | 5,095 |  |  | 10,141 | 1,734 | 411,054 |
| Melbourne Health | 1,063,744 | 54,925 | 625 |  | 5,664 |  |  | 28,686 | 155,881 | 1,309,526 |
| Mercy Hospitals Victoria Limited | 542,444 | 44,637 |  |  | 7,067 |  |  | 10,896 | 18,485 | 623,530 |
| Monash Health | 2,365,738 | 151,355 | 1,576 |  | 30,965 |  |  | 46,088 | 158,451 | 2,754,173 |
| Northern Health | 1,070,283 | 93,420 |  |  | 15,064 | 81,419 | 21,499 | 20,733 | -93,190 | 1,209,228 |
| Parkville Youth Mental Health and Wellbeing Service | 21,264 | 42,322 |  |  |  |  |  | 2,382 | 14,055 | 80,023 |
| Peninsula Health | 811,115 | 54,305 |  |  | 12,364 |  |  | 15,543 | 27,148 | 920,475 |
| Peter Maccallum Cancer Institute | 296,396 |  | 56,649 |  |  |  |  | 3,719 | 44,086 | 400,850 |
| St Vincents Hospital Melbourne Limited | 709,267 | 46,711 | 537 |  | 13,415 |  |  | 23,008 | 29,420 | 822,358 |
| The Royal Children’s Hospital | 696,140 | 24,017 | 5,823 | 2,657 | 1,828 |  |  | 10,564 | 5,135 | 746,165 |
| The Royal Victorian Eye and Ear Hospital | 147,209 |  | 2,143 |  |  |  |  | 2,231 | -11,538 | 140,045 |
| The Royal Women’s Hospital | 302,727 |  |  |  | 335 |  |  | 4,517 | 23,687 | 331,266 |
| Western Health | 1,369,097 | 54,223 |  |  | 24,870 |  |  | 26,491 | 124,192 | 1,598,873 |
| Total | 15,990,856 | 1,093,905 | 95,692 | 12,413 | 197,294 | 81,419 | 27,305 | 358,701 | 1,030,985 | 18,888,571 |

Subregional and local – $’000s

| **Health service** | **2025–26**  **Consolidated ABF** | **2025-26**  **Community mental health ABF** | **2025–26**  **Highly Specialised Therapies** | **2025–26**  **Non admitted home ventilation** | **2025–26**  **Other mental health** | **2025–26**  **Other public hospitals** | **2025–26**  **Small rural hospitals** | **2025–26**  **Teaching, training and research** | **2025–26**  **Out of scope agreement** | **2025–26**  **Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Bairnsdale Regional Health Service | 121,363 |  |  |  | 658 |  |  | 3,241 | -639 | 124,623 |
| Bass Coast Health | 141,033 |  |  |  |  |  |  | 2,057 | 1,329 | 144,419 |
| Benalla Health | 27,672 |  |  |  |  |  |  | 390 | 2,147 | 30,209 |
| Central Gippsland Health Service | 102,545 |  |  |  | 652 |  |  | 2,062 | -12,963 | 92,295 |
| Colac Area Health | 52,835 |  |  |  |  |  |  | 539 | -1,742 | 51,632 |
| Dhelkaya Health | 45,432 |  |  |  |  |  | 2,835 | 374 | 10,287 | 58,928 |
| East Grampians Health Service | 40,197 |  |  |  |  |  |  | 1,431 | 5,572 | 47,201 |
| Echuca Regional Health | 128,789 |  |  |  |  |  |  | 2,949 | -7,067 | 124,670 |
| Gippsland Southern Health Service | 31,541 |  |  |  | 244 |  |  | 305 | 3,608 | 35,697 |
| Kyabram District Health Service | 24,185 |  |  |  |  |  | 753 | 209 | 309 | 25,456 |
| Maryborough District Health Service | 36,576 |  |  |  |  |  |  | 367 | 5,114 | 42,057 |
| Mildura Base Public Hospital[[14]](#footnote-15) | 192,231 | 18,499 |  |  | 2,666 |  |  | 6,762 | 2,025 | 222,183 |
| Northeast Health Wangaratta | 205,609 |  |  |  | 407 |  |  | 3,605 | 18,116 | 227,737 |
| Portland District Health | 45,917 |  |  |  |  |  |  | 424 | 8,369 | 54,711 |
| South West Healthcare[[15]](#footnote-16) | 219,033 | 24,196 |  |  | 3,438 |  |  | 8,471 | 4,462 | 259,600 |
| Swan Hill District Health | 64,736 |  |  |  |  |  |  | 807 | 11,377 | 76,920 |
| West Gippsland Healthcare Group | 144,245 |  |  |  |  |  |  | 2,357 | 5,263 | 151,864 |
| Western District Health Service | 74,580 |  |  |  | 128 |  | 3,144 | 776 | 2,300 | 80,928 |
| Total | 1,698,517 | 42,695 |  |  | 8,193 |  | 6,732 | 37,126 | 57,867 | 1,851,130 |

Other

| **Health service** | **2025–26**  **Consolidated ABF** | **2025-26**  **Community mental health ABF** | **2025–26**  **Highly Specialised Therapies** | **2025–26**  **Non admitted home ventilation** | **2025–26**  **Other mental health** | **2025–26**  **Other public hospitals** | **2025–26**  **Small rural hospitals** | **2025–26**  **Teaching, training and research** | **2025–26**  **Out of scope agreement** | **2025–26**  **Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Victorian Institute of Forensic Mental Health[[16]](#footnote-17) | 4,804 |  |  |  | 80,642 |  |  | 4,582 | 41,775 | 131,803 |

Combined total – $’000s

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **2025–26**  **Consolidated ABF** | **2025-26**  **Community mental health ABF** | **2025–26**  **Highly Specialised Therapies** | **2025–26**  **Non admitted home ventilation** | **2025–26**  **Other mental health** | **2025–26**  **Other public hospitals** | **2025–26**  **Small rural hospitals** | **2025–26**  **Teaching, training and research** | **2025–26**  **Out of scope agreement** | **2025–26**  **Total** |
| Total | 17,694,177 | 1,136,599 | 95,692 | 12,413 | 286,129 | 81,419 | 34,038 | 400,409 | 1,130,627 | 20,871,504 |

## Mental health expenditure budgets 2025–26 by service type

Notes

* Acute admitted mental health funding amounts shown in Table 2.3: Funding summary: health service expenditure budgets 2025–26 by service category
* Subtotals and totals may not add up due to rounding.
* When published, Statement of Priorities Part C supersede these tables.
* Excludes New South Wales contribution.

Table 2.4: Mental health expenditure budgets 2025–26 by service type

Metropolitan and regional – $’000s

| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Albury Wodonga Health |  |  | 2,457 | 26,128 | 337 | 106 | 1,635 | 6,053 | 6,713 | 43,430 |
| Alfred Health |  |  | 5,394 | 77,448 | 1,508 | 326 |  | 6,457 | 7,017 | 98,151 |
| Austin Health | 1,433 | 2,601 | 2,748 | 49,937 | 1,147 | 202 |  | 7,087 | 11,347 | 76,502 |
| Barwon Health | 160 |  | 14,328 | 63,027 | 1,711 | 106 | 2,197 | 6,734 | 4,607 | 92,870 |
| Bendigo Health | 160 |  | 2,644 | 55,441 | 215 | 240 | 1,759 | 5,714 | 6,776 | 72,949 |
| Eastern Health | 160 |  | 10,556 | 118,582 | 215 | 202 | 2,910 | 8,900 | 12,514 | 154,039 |
| Goulburn Valley Health | 160 |  | 2,791 | 29,950 |  | 97 | 850 | 5,460 | 3,839 | 43,146 |
| Grampians Health | 160 |  | 3,062 | 41,632 | 330 | 175 | 1,126 | 6,279 | 4,062 | 56,826 |
| Latrobe Regional Health |  | 2,140 | 2,670 | 50,492 | 215 | 97 | 425 | 4,331 | 4,503 | 64,872 |
| Melbourne Health | 301 |  | 3,838 | 52,642 | 215 | 53 |  | 11,614 | 5,520 | 74,184 |
| Mercy Hospitals Victoria Limited |  |  | 2,325 | 44,133 |  | 123 |  | 5,062 | 7,017 | 58,660 |
| Monash Health | 160 |  | 12,985 | 148,596 | 634 | 183 | 4,324 | 9,993 | 23,234 | 200,109 |
| Northern Health | 452 |  | 4,418 | 92,747 |  | 106 | 2,483 | 9,151 | 12,459 | 121,818 |
| Parkville Youth Mental Health and Wellbeing Service | 1,095 |  | 3,347 | 42,143 | 3,145 |  |  | 2,931 |  | 52,660 |
| Peninsula Health | 160 |  | 3,276 | 53,901 |  | 92 | 1,458 | 5,513 | 9,622 | 74,021 |
| Peter Maccallum Cancer Institute |  |  |  |  |  |  |  | 631 |  | 631 |
| St Vincents Hospital Melbourne Limited |  |  | 4,673 | 44,475 |  | 142 | 3,083 | 8,361 | 7,017 | 67,751 |
| The Royal Children’s Hospital |  |  | 688 | 23,896 | 471 | 229 |  | 2,773 |  | 28,057 |
| The Royal Women’s Hospital |  |  | 431 |  |  |  |  | 333 |  | 764 |
| Western Health | 151 |  | 5,909 | 50,787 | 215 | 53 | 284 | 6,564 | 12,187 | 76,150 |
| Total | 4,547 | 4,741 | 88,541 | 1,065,958 | 10,358 | 2,530 | 22,534 | 119,943 | 138,436 | 1,457,590 |

Subregional and local – $’000s

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| Mildura Base Public Hospital |  |  | 2,442 | 17,792 | 215 | 97 |  | 3,919 | 2,182 | 26,647 |
| South West Healthcare |  |  | 2,278 | 23,388 |  | 106 |  | 4,469 | 3,273 | 33,515 |
| Western District Health Service |  |  |  |  |  |  | 128 |  |  | 128 |
| Total |  |  | 4,721 | 41,180 | 215 | 202 | 128 | 8,388 | 5,455 | 60,289 |

Small rural health – $’000s

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| West Wimmera Health Service |  |  |  |  |  |  | 298 |  |  | 298 |
| Total |  |  |  |  |  |  | 298 |  |  | 298 |

Community Health Centres – $’000s

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| Ballarat Community Health |  |  |  |  |  |  |  | 256 |  | 256 |
| Cohealth Limited |  |  |  |  |  |  |  | 256 |  | 256 |
| Eastern Access Community Health Inc |  |  |  |  |  |  |  | 256 |  | 256 |
| Total |  |  |  |  |  |  |  | 768 |  | 768 |

Non-government – $’000s

| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Eating Disorders Foundation of Victoria Inc |  |  |  |  |  |  |  | 256 |  | 256 |
| Ermha Limited |  |  |  |  |  |  |  | 256 |  | 256 |
| Harm Reduction Victoria Inc |  |  |  |  |  |  |  | 660 |  | 660 |
| La Trobe University |  |  | 1,550 |  |  |  |  | 680 |  | 2,230 |
| Mental Health Victoria Ltd |  |  |  |  |  |  |  | 142 |  | 142 |
| Mind Australia |  |  |  |  |  |  |  | 820 |  | 820 |
| Neami Limited |  |  |  |  |  |  |  | 612 |  | 612 |
| Self Help Addiction Resource Centre Inc |  |  |  |  |  |  |  | 2,933 |  | 2,933 |
| The University of Melbourne |  |  |  |  |  |  |  | 401 |  | 401 |
| Uniting (Victoria and Tasmania) Limited |  |  |  |  |  |  |  | 609 |  | 609 |
| Wellways Australia Limited |  |  |  |  |  |  |  | 407 |  | 407 |
| Total |  |  | 1,550 |  |  |  |  | 7,775 |  | 9,326 |

Other – $’000s

| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Orygen Limited |  |  |  |  |  |  |  | 205 | 5,202 | 5,407 |
| Respect Group Limited |  |  |  |  |  |  | 425 |  |  | 425 |
| The Queen Elizabeth Centre |  |  |  |  |  |  |  | 152 |  | 152 |
| Tweddle Child & Family Health Service |  |  |  |  |  |  |  | 156 |  | 156 |
| Victorian Council of Social Services |  |  |  |  |  |  |  | 203 |  | 203 |
| Victorian Institute of Forensic Mental Health | 61,893 | 2,933 | 36,572 |  |  |  |  | 5,543 |  | 106,940 |
| Total | 61,893 | 2,933 | 36,572 |  |  |  | 425 | 6,259 | 5,202 | 113,284 |

Combined total – $’000s

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **2025–26 Admitted inpatient services – other** | **2025–26  Non-acute** | **2025–26 Ambulatory** | **2025–26 Non admitted** | **2025–26 Out of scope agreement** | **2025–26 Psychosocial rehabilitation and support** | **2025–26  Residential** | **2025–26 Service system capacity** | **2025–26 Subacute** | **2025–26 Total** |
| Total | 66,440 | 7,674 | 131,384 | 1,107,138 | 10,573 | 2,733 | 23,384 | 143,134 | 149,094 | 1,641,554 |

## Registered Community Health Centres Budgets 2025–26

Notes

* This table shows the health funding to registered community health centres that receive > $1 million from specific health outputs.
* Subtotals and totals may not add up due to rounding.

Table 2.5: Registered community expenditure budgets 2025–26 – $’000s

| **Health service** | **2025–26 Acute health services** | **2025–26 Ageing, aged and home care** | **2025–26  Drugs services** | **2025–26  Mental health** | **2025–26  Primary and dental health** | **2025–26  Public health** | **2025–26  Total** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Access Health And Community Limited |  | 1,424 |  |  | 6,711 |  | 8,135 |
| Ballarat Community Health | 80 | 497 | 3,779 | 1,094 | 4,262 | 165 | 9,876 |
| Bellarine Community Health Ltd | 655 | 603 |  |  | 3,073 |  | 4,332 |
| Bendigo Community Health Services Limited |  | 218 | 5,618 | 155 | 7,415 | 238 | 13,645 |
| Bhn Better Health Network Ltd | 2,182 | 3,609 | 3,782 | 3,234 | 11,504 | 904 | 25,215 |
| Cohealth Limited |  | 6,492 | 20,112 | 16,434 | 14,384 | 219 | 57,641 |
| Dpv Health | 33 | 1,710 | 176 | 2 | 12,435 |  | 14,356 |
| Eastern Access Community Health Inc |  | 1,134 | 10,159 | 6,775 | 7,970 |  | 26,039 |
| Gateway Health Limited |  | 551 | 5,609 | 690 | 3,493 | 107 | 10,451 |
| Gippsland Lakes Complete Health Limited | 577 | 570 | 443 | 923 | 5,834 | 136 | 8,482 |
| Grampians Community Health |  | 590 | 407 | 102 | 1,171 |  | 2,270 |
| Ipc Health |  | 3,481 |  | 1,585 | 14,007 |  | 19,074 |
| Latrobe Community Health Service Limited | 1,304 | 3,467 | 7,049 | 2,536 | 11,939 |  | 26,295 |
| Merri Outreach Support Service Ltd |  | 2,163 |  | 2,562 | 8,281 |  | 13,006 |
| Nillumbik Community Health Service Ltd |  | 983 | 666 |  | 4,765 |  | 6,414 |
| North Richmond Community Health Limited | 1,892 | 100 | 12,944 |  | 3,667 | 436 | 19,040 |
| Primary Care Connect |  |  | 1,875 | 557 | 1,929 |  | 4,361 |
| Sunbury Community Health Centre Limited |  | 1,708 | 1,323 | 251 | 4,612 |  | 7,895 |
| Sunraysia Community Health Services Limited | 1,532 | 1,299 | 908 |  | 5,696 | 147 | 9,583 |
| Your Community Health | 627 | 1,401 | 766 |  | 6,113 |  | 8,908 |
| Total | 8,883 | 32,001 | 75,616 | 36,900 | 139,263 | 2,353 | 295,016 |

## Local government authorities 2025–26

Notes

* This table shows the health funding to local government authorities that receive > $1 million from specific health outputs.
* Subtotals and totals may not add up due to rounding.

Table 2.6: Local government authorities 2025–26 – $’000s

| **Health service** | **2025–26  Ageing, aged and home care** | **2025–26  Mental health** | **2025–26  Primary and dental health** | **2025–26  Public health** | **2025–26  Total** |
| --- | --- | --- | --- | --- | --- |
| Banyule City Council | 301 |  | 1,529 |  | 1,830 |
| Baw Baw Shire Council |  |  | 1,225 |  | 1,225 |
| Bayside City Council | 421 |  | 768 |  | 1,189 |
| Brimbank City Council |  | 344 | 3,328 |  | 3,672 |
| Cardinia Shire Council | 18 |  | 2,725 |  | 2,743 |
| Casey City Council | 51 |  | 8,519 |  | 8,570 |
| City of Ballarat |  | 344 | 2,140 |  | 2,484 |
| City of Boroondara |  |  | 1,222 |  | 1,222 |
| City of Darebin | 651 |  | 1,861 |  | 2,511 |
| City of Greater Geelong | 691 | 344 | 4,402 |  | 5,437 |
| City of Kingston | 1,627 |  | 1,715 |  | 3,342 |
| City of Manningham |  |  | 1,168 |  | 1,168 |
| City of Port Phillip |  |  | 1,060 |  | 1,060 |
| Frankston City Council | 924 | 340 | 2,233 |  | 3,497 |
| Glen Eira City Council | 462 |  | 1,497 |  | 1,959 |
| Greater Bendigo City Council |  |  | 2,183 | 1,794 | 3,977 |
| Greater Shepparton City Council |  |  | 1,632 |  | 1,632 |
| Hobsons Bay City Council | 159 |  | 1,272 |  | 1,431 |
| Hume City Council | 921 |  | 6,660 |  | 7,581 |
| Knox City Council |  |  | 1,794 |  | 1,794 |
| Latrobe City Council |  | 269 | 1,668 |  | 1,937 |
| Maribyrnong City Council | 95 |  | 1,206 |  | 1,301 |
| Maroondah City Council |  |  | 1,511 |  | 1,511 |
| Melbourne City Council |  |  | 1,029 |  | 1,029 |
| Melton City Council | 659 |  | 5,380 |  | 6,038 |
| Mildura Rural City Council |  | 273 | 1,582 |  | 1,855 |
| Mitchell Shire Council | 4 |  | 1,363 |  | 1,367 |
| Monash City Council |  |  | 1,789 |  | 1,789 |
| Moonee Valley City Council | 591 |  | 1,346 |  | 1,938 |
| Moreland City Council | 624 |  | 2,383 |  | 3,006 |
| Mornington Peninsula Shire Council |  |  | 1,973 |  | 1,973 |
| Municipal Association of Victoria |  |  | 40 | 1,793 | 1,833 |
| Rural City of Wangaratta | 202 | 237 | 575 |  | 1,013 |
| The City of Greater Dandenong | 1,346 |  | 2,878 |  | 4,224 |
| Whitehorse City Council |  |  | 1,520 |  | 1,520 |
| Whittlesea City Council | 926 | 344 | 4,697 |  | 5,967 |
| Wyndham City Council |  |  | 8,047 |  | 8,047 |
| Yarra Ranges Shire Council | 31 |  | 2,418 |  | 2,449 |
| All other organisations (<$1 m) | 769 | 474 | 18,243 |  | 19,486 |
| Grand Total | 11,471 | 2,969 | 108,581 | 3,587 | 126,609 |

## Non-government providers 2025–26

Notes

* This table shows the health funding to non-government providers that receive > $1 million from specific health outputs.
* Subtotals and totals may not add up due to rounding.

Table 2.7: Non-government providers 2025–26 – $’000s

| **Health service** | **2025–26  Acute health services** | **2025–26  Ageing, aged and home care** | **2025-23**  **Ambulance Services** | **2025–26  Drugs services** | **2025–26  Mental health** | **2025–26  Primary and dental health** | **2025–26  Public health** | **2025–26  Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Anglican Aged Care Services Group |  | 482 |  |  |  | 725 |  | 1,207 |
| Anglicare Victoria |  |  |  | 1,374 | 1,611 |  |  | 2,986 |
| Arbias Limited |  | 629 |  |  | 591 |  |  | 1,220 |
| Australian Centre for Grief and Bereavement Inc | 2,107 |  |  |  |  |  |  | 2,107 |
| Australian College of Optometry |  | 7,661 |  |  |  |  |  | 7,661 |
| Australian Community Support Organisation Inc |  |  |  | 16,942 | 4,050 |  |  | 20,992 |
| Australian Red Cross Blood Service | 15,250 |  |  |  |  |  |  | 15,250 |
| Australian Red Cross Society | 1,025 |  |  |  |  |  |  | 1,025 |
| Ballarat And District Aboriginal Co-Operative Limited |  | 65 |  | 1,923 | 1,758 | 243 |  | 3,989 |
| Ballarat Hospice Care Inc | 3,083 |  |  |  |  |  |  | 3,083 |
| Banksia Palliative Care Service Inc | 4,574 |  |  |  |  |  |  | 4,574 |
| Barwon Child, Youth & Family |  |  |  | 531 | 2,154 | 207 |  | 2,891 |
| Bendigo And District Aboriginal Co-Operative Ltd |  | 100 |  | 2,044 | 815 | 630 |  | 3,589 |
| Beyond Blue Limited |  |  |  |  | 2,311 |  |  | 2,311 |
| Breastscreen Victoria Inc. |  |  |  |  |  |  | 65,226 | 65,226 |
| Budja Budja Aboriginal Co-Operative Limited |  |  |  | 186 | 930 | 404 |  | 1,520 |
| Cancer Council Victoria | 894 |  |  |  |  |  | 9,682 | 10,575 |
| Caraniche Pty Ltd |  |  |  | 2,364 |  |  |  | 2,364 |
| Dandenong & District Aborigines Co-Operative Limited | 317 | 91 |  | 186 | 787 | 259 |  | 1,640 |
| Darlingford Upper Goulburn Nursing Home Inc |  | 1,846 |  |  |  |  |  | 1,846 |
| Dementia Australia Limited |  | 4,311 |  |  |  |  |  | 4,311 |
| Dhauwurd-Wurrung Elderly & Community Health Service Inc |  | 223 |  | 337 | 1,219 | 243 |  | 2,021 |
| Diabetes Australia - Victoria |  |  |  |  |  | 2,441 | 5,998 | 8,440 |
| Eastern Palliative Care Association Inc. | 14,007 |  |  |  |  |  |  | 14,007 |
| Eating Disorders Foundation Of Victoria Inc |  |  |  |  | 2,832 |  |  | 2,832 |
| Gegac | 250 | 203 |  | 1,278 | 1,206 | 502 |  | 3,438 |
| Goolum-Goolum Aboriginal Co-Operative Limited |  | 53 |  | 186 | 1,169 | 442 |  | 1,850 |
| Grow |  |  |  |  | 1,098 |  |  | 1,098 |
| Gunditjmara Aboriginal Co-Operative Limited | 306 | 141 |  | 510 | 1,323 | 613 |  | 2,892 |
| Harm Reduction Victoria Inc |  |  |  | 501 | 660 |  | 811 | 1,972 |
| Indigo North Health Inc |  | 1,895 |  |  |  | 636 |  | 2,531 |
| Kirrae Health Service Inc |  | 73 |  | 186 | 1,090 |  |  | 1,349 |
| La Trobe University | 2,847 | 1,528 |  | 128 | 2,605 | 855 |  | 7,964 |
| Lake Tyers Health & Children’s Services Association Inc |  | 7 |  | 186 | 665 | 171 |  | 1,030 |
| Liverwell Limited |  |  |  |  |  |  | 1,659 | 1,659 |
| Mackillop Family Services Limited |  | 544 |  |  | 1,273 |  |  | 1,818 |
| Mecwa |  | 14,643 |  |  |  |  |  | 14,643 |
| Melbourne City Mission | 7,515 | 222 |  |  |  |  |  | 7,737 |
| Mercy Palliative Care Ltd | 9,534 |  |  |  |  |  |  | 9,534 |
| Merri Outreach Support Service Inc |  | 1,677 |  |  |  |  |  | 1,677 |
| Mind Australia |  |  |  |  | 30,931 |  |  | 30,931 |
| Moira Inc. |  | 1,264 |  |  |  |  |  | 1,264 |
| Monash University | 1,105 |  | 1,615 |  |  |  | 456 | 3,176 |
| Mungabareena Aboriginal Corporation | 272 | 45 |  | 186 | 83 | 685 |  | 1,271 |
| Murray Valley Aboriginal Co-Operative Limited |  | 81 |  | 180 | 755 | 372 |  | 1,387 |
| Neami Limited |  |  |  |  | 23,205 |  |  | 23,205 |
| Njernda Aboriginal Corporation | 315 | 205 |  | 771 | 744 | 629 |  | 2,664 |
| Northern District Community Health |  | 289 |  |  |  | 1,657 |  | 1,945 |
| Nursing And Midwifery Health Program Victoria Ltd | 1,411 |  |  |  |  |  |  | 1,411 |
| Odyssey House, Victoria |  |  |  | 24,330 |  |  |  | 24,330 |
| Penington Institute |  |  |  | 1,145 |  |  |  | 1,145 |
| Peninsula Home Hospice | 5,016 |  |  |  |  |  |  | 5,016 |
| People Living With HIV/Aids Victoria Inc |  |  |  |  |  |  | 2,010 | 2,010 |
| Ramahyuck District Aboriginal Corporation | 313 | 151 |  | 781 | 929 | 410 |  | 2,584 |
| Red Cliffs and Community Aged Care Services Inc |  | 1,885 |  |  |  |  |  | 1,885 |
| Royal District Nursing Service Limited |  | 34,674 |  |  |  | 124 | 899 | 35,697 |
| Rumbalara Aboriginal Co-Operative Limited | 251 | 220 |  | 1,995 | 1,968 | 492 |  | 4,926 |
| Sacred Heart Mission Inc. |  | 609 |  |  | 1,707 |  |  | 2,316 |
| Self Help Addiction Resource Centre Inc |  |  |  | 986 | 3,117 |  |  | 4,103 |
| Sexual Health Victoria Incorporated |  |  |  |  |  | 4,083 | 988 | 5,071 |
| Tandem Inc |  |  |  |  | 10,111 |  |  | 10,111 |
| The Australian Nutrition Foundation-Victorian Division Inc. |  |  |  |  |  |  | 1,354 | 1,354 |
| The Goulburn Valley Hospice Care Service Inc | 2,022 |  |  |  |  |  |  | 2,022 |
| The Salvation Army (Victoria) Property Trust |  | 3,300 |  | 13,883 | 1,636 |  |  | 18,819 |
| The University of Melbourne | 1,121 |  |  | 646 | 2,885 | 294 | 8,107 | 13,053 |
| The Victorian Foundation for Survivors of Torture Inc |  |  |  |  | 2,105 | 2,417 |  | 4,522 |
| Thorne Harbour Health Ltd |  |  |  | 563 | 132 |  | 6,657 | 7,352 |
| Uniting (Victoria and Tasmania) Limited |  | 6,190 |  | 27,971 | 3,425 |  |  | 37,586 |
| Very Special Kids | 2,513 |  |  |  |  |  |  | 2,513 |
| Victoria Legal Aid |  |  |  |  | 15,374 |  |  | 15,374 |
| Victoria University |  |  | 5,000 |  |  |  |  | 5,000 |
| Victorian Aboriginal Community Controlled Health Organisation Inc | 2,497 | 362 |  | 183 | 2,842 | 3,321 | 2,503 | 11,708 |
| Victorian Aboriginal Health Service Co-Operative Limited | 315 | 226 |  | 3,312 | 4,495 | 1,364 | 275 | 9,987 |
| Victorian Clinical Genetics Services Limited | 5,693 |  |  |  |  |  | 10,416 | 16,109 |
| Victorian Cytology Service Limited |  |  |  |  |  |  | 5,204 | 5,204 |
| Victorian Health Promotion Foundation |  |  |  |  |  |  | 48,260 | 48,260 |
| Vincentcare Victoria |  | 1,274 |  |  |  |  |  | 1,274 |
| Wathaurong Aboriginal Co-Operative Limited | 307 | 108 |  | 1,887 | 1,839 | 360 | 44 | 4,544 |
| Wellways Australia Limited |  | 90 |  |  | 38,824 |  |  | 38,914 |
| Western Region Alcohol And Drug Centre Inc |  |  |  | 2,780 |  |  |  | 2,780 |
| Winda-Mara Aboriginal Corporation |  | 71 |  | 495 | 703 | 372 |  | 1,640 |
| Windana Drug & Alcohol Recovery Inc. |  |  |  | 22,187 |  |  |  | 22,187 |
| Wintringham |  | 1,090 |  |  |  |  |  | 1,090 |
| Women's Health Victoria Inc | 1,011 |  |  |  |  | 1,645 |  | 2,655 |
| Women's Health West Inc |  | 124 |  |  |  | 1,365 |  | 1,489 |
| Youth Projects Limited |  |  |  | 1,817 |  |  |  | 1,817 |
| Ysas Pty Ltd |  |  |  | 21,139 | 154 |  |  | 21,293 |
| All other organisations (<$1 m) | 11,313 | 22,968 |  | 3,051 | 10,407 | 10,482 | 1,895 | 60,115 |
| Grand Total | 97,185 | 111,616 | 6,615 | 159,152 | 188,516 | 38,440 | 172,442 | 773,966 |

## Other funded organisations 2025–26

Notes

* This table shows the health funding to local government authorities that receive > $1 million from specific health outputs.
* Subtotals and totals may not add up due to rounding.

Table 2.8: Other funded organisations expenditure budgets 2025–26 – $’000s

| **Health service** | **2025–26  Acute health services** | **2025–26  Ageing, aged and home care** | **2025–26  Ambulance services** | **2025–26  Drugs services** | **2025–26  Mental health** | **2025–26  Primary and dental health** | **2025–26  Public health** | **2025–26  Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Access Services for Koories Ltd. |  |  |  | 132 | 1,860 | 2,184 |  | 4,176 |
| Ambulance Victoria | 85,861 |  | 1,123,429 |  |  |  |  | **1,209,289** |
| Baobag |  |  |  |  |  | 4,594 |  | 4,594 |
| Child And Family Services Ballarat Inc |  |  |  |  | 1,298 |  |  | 1,298 |
| Children’s Health Partnership Pty Ltd | 157,319 |  |  |  |  |  |  | 157,319 |
| Oral Health Victoria | 5,827 |  |  |  |  | 184,661 | 574 | 191,061 |
| Exemplar Health Partnership | 78,621 |  |  |  |  |  |  | 78,621 |
| Healthshare Victoria | 49,976 |  |  |  |  |  |  | 49,976 |
| Karingal St Laurence Limited |  | 1,353 |  |  | 285 |  |  | 1,638 |
| Lifeline Australia |  |  |  |  | 1,143 |  |  | 1,143 |
| Mallee District Aboriginal Services Limited | 564 | 57 |  | 1,644 | 2,264 | 1,161 | 133 | 5,822 |
| National Blood Authority | 174,275 |  |  |  |  |  |  | 174,275 |
| Ngwala Willumbong Aboriginal Corporation |  | 131 |  | 11,847 | 1,447 | 106 |  | 13,531 |
| Oonah Health & Community Services Aboriginal Corporation |  |  |  | 180 | 827 | 167 |  | 1,174 |
| Orygen Limited |  |  |  |  | 12,260 |  |  | 12,260 |
| Plenary Health Casey Pty Ltd (Non-GST) | 16,239 |  |  |  |  |  |  | 16,239 |
| Plenary Health Ccc Pty Ltd | 156,617 |  |  |  |  |  |  | 156,617 |
| Plenary Health Chep Pty Ltd (Non-GST) | 10,138 |  |  |  |  |  |  | 10,138 |
| Respect Group Limited | 2,322 | 6,495 |  |  | 428 |  |  | 9,245 |
| Rw Health Partnerships Pty Ltd | 54,485 |  |  |  |  |  |  | 54,485 |
| South East Palliative Care Ltd | 6,555 |  |  |  |  |  |  | 6,555 |
| The Florey Institute of Neuroscience and Mental Health |  |  |  |  | 1,779 |  |  | 1,779 |
| The Queen Elizabeth Centre | 1,248 |  |  |  | 306 |  |  | 1,553 |
| Victorian Comprehensive Cancer Centre Ltd | 3,933 |  |  |  |  |  | 48 | 3,981 |
| Victorian Institute of Forensic Mental Health | 22,116 |  |  |  | 109,687 |  |  | 131,803 |
| All other organisations (<$1 m) | 2,333 | 889 |  | 689 | 3,240 | 3,590 | 240 | 10,982 |
| Total | 828,428 | 8,924 | 1,123,429 | 14,493 | 136,823 | 196,463 | 995 | 2,309,554 |

## Health operations 2025–26

Notes

* Subtotals and totals may not add up due to rounding.
* When published, Statement of Priorities Part C supersede these tables.

Table 2.9 Health operations expenditure budgets 2025–26 – $’000s

| **Provider type** | **2025–26  Acute health services** | **2025–26  Ageing, aged and home care** | **2025–26  Ambulance services** | **2025–26  Drugs services** | **2025–26  Mental health** | **2025–26  Primary and dental health** | **2025–26  Public health** | **2025–26  Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Health Service | 18,080,762 | 137,505 | 1,308 | 88,753 | 2,271,966 | 83,056 | 76,351 | 20,739,701 |
| Small Rural Health Service | 363,643 | 44,340 |  |  | 300 | 15,095 |  | 423,378 |
| Community Health Centres | 8,883 | 32,001 |  | 75,616 | 36,900 | 139,263 | 2,353 | 295,016 |
| Local Government |  | 11,471 |  |  | 2,969 | 108,581 | 3,587 | 126,609 |
| Non Government Providers | 97,185 | 111,616 | 6,615 | 159,152 | 188,516 | 38,440 | 172,442 | 773,966 |
| Other | 828,428 | 8,924 | 1,123,429 | 14,493 | 136,823 | 196,463 | 995 | 2,309,554 |
| Grand Total | 19,378,901 | 345,856 | 1,131,352 | 338,014 | 2,637,474 | 580,899 | 255,728 | 24,668,223 |

# Activity target tables

## Victorian activity targets (NWAU) 2025–26

Notes

* Note that acute admitted mental health NWAU has been included in the consolidated NWAU.
* Excludes New South Wales contribution.

Table 2.10: Victorian activity targets (NWAU) 2025–26

| **Health service** | **Consolidated NWAU** | **Admitted DVA NWAU** | **Admitted TAC NWAU** | **Subacute admitted DVA NWAU** | **Community Mental Health NWAU** | **Total NWAU** |
| --- | --- | --- | --- | --- | --- | --- |
| Albury Wodonga Health | 37,658 | 45 | 2 | 76 | 4,010 | 41,791 |
| Alfred Health | 203,809 | 135 | 8,241 | 129 | 11,886 | 224,200 |
| Austin Health | 151,386 | 220 | 700 | 204 | 7,664 | 160,174 |
| Bairnsdale Regional Health Service | 16,372 | 52 | 3 | 41 |  | 16,468 |
| Barwon Health | 132,287 | 144 | 429 | 84 | 9,673 | 142,616 |
| Bass Coast Health | 19,058 | 29 |  | 45 |  | 19,132 |
| Benalla Health | 3,594 | 29 |  | 14 |  | 3,637 |
| Bendigo Health | 78,578 | 141 | 297 | 155 | 8,508 | 87,679 |
| Calvary Health Care Bethlehem Limited | 3,165 |  |  |  |  | 3,165 |
| Central Gippsland Health Service | 13,688 | 34 | 1 | 12 |  | 13,734 |
| Colac Area Health | 7,107 | 1 |  |  |  | 7,109 |
| Corryong Health |  |  | 1 |  |  | 1 |
| Dhelkaya Health | 6,089 | 14 |  | 32 |  | 6,136 |
| East Grampians Health Service | 5,304 | 9 |  |  |  | 5,313 |
| Eastern Health | 186,283 | 145 | 178 | 231 | 18,199 | 205,034 |
| Echuca Regional Health | 17,411 | 24 | 1 | 20 |  | 17,457 |
| Gippsland Southern Health Service | 4,007 | 13 |  | 23 |  | 4,042 |
| Goulburn Valley Health | 43,835 | 67 | 125 | 92 | 4,596 | 48,716 |
| Grampians Health | 82,404 | 97 | 284 | 84 | 6,389 | 89,257 |
| Kyabram District Health Service | 3,236 | 6 |  |  |  | 3,242 |
| Maryborough District Health Service | 4,854 | 2 |  |  |  | 4,857 |
| Melbourne Health | 158,500 | 85 | 6,533 | 14 | 8,079 | 173,212 |
| Mercy Hospitals Victoria Limited | 80,196 | 19 |  | 56 | 6,773 | 87,044 |
| Mildura Base Public Hospital | 25,980 | 59 | 78 | 66 | 2,479 | 28,662 |
| Monash Health | 352,016 | 151 | 522 | 157 | 22,805 | 375,650 |
| Northeast Health Wangaratta | 27,621 | 91 | 121 | 56 |  | 27,889 |
| Northern Health | 160,351 | 66 | 167 | 104 | 14,234 | 174,922 |
| Peninsula Health | 121,350 | 182 | 230 | 295 | 8,272 | 130,329 |
| Peter Maccallum Cancer Institute | 43,601 | 61 |  |  |  | 43,662 |
| Portland District Health | 6,145 | 2 | 1 | 1 |  | 6,149 |
| South West Healthcare | 29,157 | 62 | 80 | 41 | 3,259 | 32,599 |
| St Vincents Hospital Melbourne Limited | 104,578 | 67 | 114 | 130 | 6,826 | 111,715 |
| Swan Hill District Health | 8,537 | 21 | 67 | 15 |  | 8,639 |
| The Royal Children’s Hospital | 95,956 |  | 622 |  | 3,667 | 100,245 |
| The Royal Victorian Eye and Ear Hospital | 22,117 | 12 | 1 |  |  | 22,130 |
| The Royal Women’s Hospital | 44,497 |  |  |  |  | 44,497 |
| West Gippsland Healthcare Group | 19,289 | 19 | 3 |  |  | 19,311 |
| Western District Health Service | 9,918 | 37 | 26 | 65 |  | 10,047 |
| Western Health | 199,148 | 81 | 239 | 125 | 7,794 | 207,387 |
| Latrobe Regional Health | 50,322 | 111 | 153 | 70 | 7,749 | 58,405 |
| Parkville Youth Mental Health and Wellbeing Service | 3,095 |  |  |  | 6,468 | 9,563 |
| Grand Total | 2,582,500 | 2,332 | 19,220 | 2,436 | 169,329 | 2,775,817 |

## Indicative NWAU adjustments for safety and quality

### Indicative HAC base NWAU adjustment 2024–25 for the purpose of calculating annual growth in 2025–26

Table 2.11: Indicative baseline NWAU adjustment in 2025–26 for HAC

| **Health service** | **HAC NWAU value using NWAU24 model and Q1–2, 2024–25 activity** | **HAC NWAU value using NWAU25 model and Q1–2, 2024–25 activity** |
| --- | --- | --- |
| Albury Wodonga Health | 44.0 | 36.5 |
| Alfred Health | 2,533.9 | 2,506.5 |
| Austin Health | 1,519.2 | 1,512.2 |
| Bairnsdale Regional Health Service | 77.2 | 79.4 |
| Barwon Health | 803.7 | 797.8 |
| Bass Coast Health | 24.3 | 25.4 |
| Benalla Health | 5.3 | 5.8 |
| Bendigo Health | 291.7 | 298.5 |
| Central Gippsland Health Service | 37.0 | 37.7 |
| Colac Area Health | 13.0 | 13.5 |
| Dhelkaya Health | 11.2 | 12.1 |
| East Grampians Health Service | 4.0 | 4.0 |
| Eastern Health | 1,095.3 | 1,115.7 |
| Echuca Regional Health | 36.1 | 39.4 |
| Gippsland Southern Health Service | 1.2 | 1.4 |
| Goulburn Valley Health | 266.9 | 216.5 |
| Grampians Health | 462.5 | 472.6 |
| Kyabram District Health Service | 2.0 | 2.2 |
| Latrobe Regional Health | 295.2 | 299.5 |
| Maryborough District Health Service | 8.2 | 8.2 |
| Melbourne Health | 1,345.0 | 1,391.6 |
| Mercy Hospitals Victoria Ltd | 361.8 | 401.9 |
| Mildura Base Public Hospital | 145.6 | 147.0 |
| Monash Health | 2,214.4 | 2,102.0 |
| Northeast Health Wangaratta | 134.7 | 91.8 |
| Northern Health | 689.3 | 675.9 |
| Peninsula Health | 749.6 | 759.7 |
| Peter MacCallum Cancer Institute | 267.9 | 223.1 |
| Portland District Health | 26.9 | 27.0 |
| Royal Children’s Hospital | 1,054.2 | 1,169.2 |
| Royal Victorian Eye and Ear Hospital | 3.8 | 3.7 |
| Royal Women’s Hospital | 109.6 | 130.3 |
| South West Healthcare | 146.1 | 147.9 |
| St Vincent’s Health | 927.7 | 927.2 |
| Swan Hill District Health | 7.7 | 9.6 |
| West Gippsland Healthcare Group | 42.8 | 41.6 |
| Western District Health Service | 13.8 | 14.5 |
| Western Health | 1,024.9 | 1,046.5 |
| Total | 16,797.6 | 16,795.4 |

### Indicative AHR base NWAU adjustment 2024–25 for the purpose of calculating annual growth in 2025–26

Table 2.12: Indicative baseline NWAU adjustment in 2025–26 for AHR

| **Health service** | **AHR NWAU value using NWAU24 model and Q1–2, 2024–25 activity** | **AHR NWAU value using NWAU25 model and Q1–2, 2024–25 activity** |
| --- | --- | --- |
| Albury Wodonga Health | 23.2 | 27.0 |
| Alfred Health | 1,048.9 | 955.7 |
| Austin Health | 799.1 | 745.5 |
| Bairnsdale Regional Health Service | 140.4 | 132.7 |
| Barwon Health | 571.4 | 536.1 |
| Bass Coast Health | 124.2 | 119.9 |
| Benalla Health | 14.7 | 19.5 |
| Bendigo Health | 326.1 | 299.2 |
| Central Gippsland Health Service | 82.1 | 75.9 |
| Colac Area Health | 56.0 | 44.4 |
| Dhelkaya Health | 26.2 | 25.2 |
| East Grampians Health Service | 18.0 | 16.2 |
| Eastern Health | 991.3 | 861.6 |
| Echuca Regional Health | 119.4 | 113.9 |
| Gippsland Southern Health Service | 16.7 | 40.5 |
| Goulburn Valley Health | 150.8 | 152.0 |
| Grampians Health | 317.3 | 293.6 |
| Kyabram District Health Service | 29.1 | 32.4 |
| Latrobe Regional Health | 330.7 | 319.7 |
| Maryborough District Health Service | 22.9 | 21.2 |
| Melbourne Health | 850.0 | 758.0 |
| Mercy Hospitals Victoria Ltd | 161.0 | 143.4 |
| Mildura Base Public Hospital | 109.1 | 106.3 |
| Monash Health | 1,633.3 | 1,485.2 |
| Northeast Health Wangaratta | 92.1 | 88.9 |
| Northern Health | 802.6 | 736.8 |
| Peninsula Health | 840.1 | 735.2 |
| Peter MacCallum Cancer Institute | 29.5 | 4.1 |
| Portland District Health | 36.8 | 30.6 |
| Royal Children’s Hospital | 346.7 | 331.5 |
| Royal Victorian Eye and Ear Hospital | 71.7 | 72.6 |
| Royal Women’s Hospital | 17.8 | 20.6 |
| South West Healthcare | 147.3 | 140.6 |
| St Vincent’s Health | 386.3 | 348.6 |
| Swan Hill District Health | 35.7 | 25.3 |
| West Gippsland Healthcare Group | 111.4 | 110.4 |
| Western District Health Service | 58.1 | 54.4 |
| Western Health | 866.1 | 954.0 |
| Total | 12,021.5 | 11,167.6 |

## Victorian small rural health service activity targets 2025–26

Notes

* Recall is not applied on notional NWAU targets for small rural health services.

Table 2.13: Victorian small rural health service activity targets 2025–26

| **Health service** | **NWAU admitted DVA** | **NWAU admitted TAC** | **NWAU Renal** | **Total** |
| --- | --- | --- | --- | --- |
| Alexandra District Health | 4 |  |  | 4 |
| Alpine Health | 1 |  | 40 | 41 |
| Beechworth Health Service | 10 |  |  | 10 |
| Casterton Memorial Hospital |  |  | 3 | 3 |
| Central Highlands Rural Health | 8 |  | 107 | 114 |
| Cohuna District Hospital | 10 |  | 25 | 35 |
| Corryong Health | 4 | 1 | 29 | 34 |
| East Wimmera Health Service |  |  | 23 | 23 |
| Great Ocean Road Health |  |  | 21 | 21 |
| Heathcote Health | 2 |  |  | 2 |
| Heywood Rural Health | 21 |  |  | 21 |
| Inglewood and Districts Health Service | 1 |  |  | 1 |
| Kerang District Health | 10 |  |  | 10 |
| Mansfield District Hospital | 9 |  | 48 | 57 |
| Moyne Health Services | 6 |  |  | 6 |
| NCN Health | 22 |  |  | 22 |
| Orbost Regional Health |  |  | 87 | 87 |
| Robinvale District Health Services |  |  | 176 | 176 |
| Rural Northwest Health | 2 |  |  | 2 |
| Seymour Health | 9 |  | 168 | 177 |
| South Gippsland Hospital | 6 |  |  | 6 |
| Terang and Mortlake Health Service | 3 |  |  | 3 |
| West Wimmera Health Service | 3 |  |  | 3 |
| Yarram and District Health Service | 4 |  | 55 | 60 |
| Yarrawonga Health | 4 |  | 133 | 138 |
| Yea and District Memorial Hospital | 1 |  |  | 1 |
| Grand Total | 142 | 1 | 915 | 1,058 |

## Non-admitted radiotherapy activity (WAU) targets 2025–26

Table 2.14: Non-admitted radiotherapy activity targets 2025–26

|  |  |
| --- | --- |
| **Health service** | **Radiotherapy base variable WAU** |
| Alfred Health | 78,193 |
| Austin Health | 87,303 |
| Barwon Health | 43,224 |
| Peter MacCallum Cancer Institute | 317,393 |
| Total | 526,114 |

Table 2.15: Shared care radiotherapy activity targets 2025–26

|  |  |
| --- | --- |
| **Health service** | **Radiotherapy non-admitted shared care** |
| Monash Health | 173 |
| Northern Health | 229 |
| Peninsula Health | 180 |
| Western Health | 17 |
| Total | 599 |

## Transition Care Program targets 2025–26

Table 2.16: Transition Care Program targets 2025–26

Metropolitan TCP Services

|  |  |  |  |
| --- | --- | --- | --- |
| **Health service** | **Transition care program bed day full occupancy**  Target equals 100% | **Transition care program home day full occupancy**  Target equals 100% | **Total full occupancy**  Target equals 100% |
| Alfred Health | 21,900 | 10,220 | 32,120 |
| Austin Health | 7,643 | 11,317 | 18,960 |
| Eastern Health | 23,749 | 10,533 | 34,281 |
| Melbourne Health | 8,373 | 14,652 | 23,026 |
| Mercy Hospitals Victoria Limited | 2,186 | 1,464 | 3,651 |
| Monash Health | 17,491 | 12,837 | 30,329 |
| Northern Health | 9,451 | 15,743 | 25,194 |
| Peninsula Health | 0 | 27,647 | 27,647 |
| St Vincents Hospital Melbourne Limited | 9,472 | 16,459 | 25,931 |
| Western Health | 10,943 | 14,255 | 25,198 |
| Total | 111,208 | 135,127 | 246,337 |

Regional TCP Health Services

|  |  |  |  |
| --- | --- | --- | --- |
| **Health service** | **Transition care program bed day full occupancy**  Target equals 90% | **Transition care program home day full occupancy**  Target equals 90% | **Total full occupancy**  Target equals 90% |
| Barwon Health | 12,398 | 7,302 | 19,700 |
| Bendigo Health | 18,220 | 12,814 | 31,034 |
| Goulburn Valley Health | 13,824 | 14,252 | 28,076 |
| Grampians Health | 13,847 | 9,153 | 23,000 |
| Latrobe Regional Health | 9,095 | 7,668 | 16,764 |
| Mildura Base Public Hospital | 2,981 | 3,570 | 6,551 |
| South West Healthcare | 3,645 | 3,663 | 7,309 |
| Western District Health Service | 1,094 | 1,468 | 2,562 |
| Total | 75,104 | 59,890 | 134,996 |

Combined total

|  |  |  |  |
| --- | --- | --- | --- |
| **Health service** | **Transition care program bed day full occupancy** | **Transition care program home day full occupancy** | **Total full occupancy** |
| Total | 186,314 | 195,018 | 381,332 |

## Non-admitted episode targets – community palliative care

Table 2.17: Community palliative care – new episodes for distinct clients 2025–26

|  |  |
| --- | --- |
| **Health service / organisation** | **Annual target** |
| Albury Wodonga Health | 222 |
| Bairnsdale Regional Health Service | 73 |
| Ballarat Hospice Care | 343 |
| Banksia Palliative Care Service | 1,050 |
| Barwon Health | 578 |
| Bass Coast Health | 115 |
| Bellarine Community Health Service | 137 |
| Benalla and District Memorial Hospital | 131 |
| Bendigo Health | 339 |
| Calvary Health Care Bethlehem | 1,250 |
| Central Gippsland Health Service | 133 |
| Colac Area Health | 77 |
| Dhelkaya Health | 55 |
| East Grampians Health Service | 109 |
| Eastern Palliative Care Association | 2,609 |
| Echuca Regional Health | 144 |
| Gippsland Lakes Community Health | 153 |
| Gippsland Southern Health Service | 85 |
| Goulburn Valley Hospice Care Service | 260 |
| Grampians Health | 185 |
| Kyneton District Health (Central Highlands) | 155 |
| Latrobe Community Health Service | 190 |
| Maryborough District Health Service | 44 |
| Melbourne City Mission | 1,625 |
| Mercy Palliative Care | 2,110 |
| North East Health Wangaratta | 211 |
| NCN Health | 116 |
| Peninsula Home Hospice | 780 |
| Portland and District Hospital | 52 |
| Seymour Health | 181 |
| Palliative Care South East | 1,125 |
| Southwest Health Care | 251 |
| Sunraysia Community Health Services | 191 |
| Swan Hill District Health | 108 |
| West Gippsland Healthcare Group | 141 |
| Western District Health Service | 72 |
| Western Health | 83 |
| Yarram and District Health Service | 17 |
| Total | 15,500 |

## Nationally Funded Centres Program 2025–26

Note:

* Targets are subject to approval by the Health Chief Executives Forum.
* Prices are subject to approval by the Health Chief Executives Forum.
* Paediatric liver transplantation – 55% for The Royal Children’s Hospital and 45% for Austin Health.
* Paediatric lung/heart-lung transplantation – 97% for Alfred Health and 3% for Royal Children’s Hospital.

Table 2.18: Nationally Funded Centres Program targets 2025–26

|  |  |  |
| --- | --- | --- |
| Price name | Health service | Annual target |
| NFC islet cell transplantation | St Vincents Hospital Melbourne Limited | 6 |
| NFC paediatric heart no VAD | The Royal Children’s Hospital | 5 |
| NFC paediatric heart VAD | The Royal Children’s Hospital | 9 |
| NFC paediatric lung transplantation | Alfred Health | 4 |
| NFC paediatric lung transplantation | The Royal Children’s Hospital | 0 |
| NFC pancreas transplants | Monash Health | 15 |
| NFC transplants paediatric liver | Austin Health | 5 |
| NFC transplants paediatric liver | Royal Children’s Hospital | 5 |
| Total |  | 49 |

### 

## Early Parenting Centres 2025–26

Table 2.19: Early Parenting Centres targets 2025–26

|  |  |  |
| --- | --- | --- |
| **Health service** | **Day Stay** | **Residential Stay** |
| The Queen Elizabeth Centre (Noble Park EPC) | 507 | 686 |
| Tweddle Child and Family Health Service (Footscray EPC) | 688 | 585 |
| Mercy Health (O’Connell Family Centre) | 400 | 400 |
| Tweddle Child and Family Health Service (Wyndham EPC) | 500 | 500 |
| Mercy Health (Woi-wurrung-yagila-wulumperi Whittlesea EPC) | 500 | 500 |
| Barwon Health (Barwon EPC) | 500 | 500 |
| Bendigo Health (Wayipunga Bendigo EPC) | 500 | 500 |
| Grampians Health (Grampians EPC) | 500 | 500 |
| Monash Health (Murrumbek Casey EPC) | 500 | 500 |

## Mental health acute, non-acute, subacute, and residential operational beds 2025–26

Table 2.20: Mental health acute operational beds 2025–26[[17]](#footnote-18)

Metropolitan and regional

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health service** | **Mental Health bed - acute specialist** | **Mental Health bed - acute adult** | **Mental Health bed - acute aged** | **Mental Health bed - acute child and adolescent** | **Mental health operational beds – acute** |
| Albury Wodonga Health |  | 15 | 5 |  | 20 |
| Alfred Health | 16 | 68 | 15 |  | 99[[18]](#footnote-19) |
| Austin Health | 52 | 19 |  | 23 | 94 |
| Barwon Health | 9 | 32 | 16 |  | 57 |
| Bendigo Health Care Group | 5 | 35 | 20 |  | 60 |
| Eastern Health | 4 | 84 | 30 | 12 | 130 |
| Goulburn Valley Health | 3 | 17 | 5 |  | 25 |
| Grampians Health | 5 | 23 | 10 |  | 38 |
| Latrobe Regional Health | 5 | 29 | 10 | 2 | 46 |
| Melbourne Health | 14 | 43 |  |  | 57 |
| Mercy Health | 10 | 50 |  |  | 60 |
| Monash Health | 10 | 105 | 40 | 23 | 178 |
| Northern Health |  | 105 | 34 |  | 139 |
| Parkville Youth Mental Health and Wellbeing Service | 10 |  |  | 22 | 32 |
| Royal Children’s Hospital |  |  |  | 16 | 16 |
| Peninsula Health | 6 | 29 | 15 |  | 50 |
| St Vincent’s Hospital | 5 | 39 | 20 |  | 64 |
| Victorian Institute of Forensic Mental Health | 54 |  |  |  | 54 |
| Western Health | 10 | 68 | 20 |  | 98[[19]](#footnote-20) |

Subregional and rural

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health service** | **Mental Health bed - acute specialist** | **Mental Health bed - acute adult** | **Mental Health bed - acute aged** | **Mental Health bed - acute child and adolescent** | **Mental health operational beds – acute** |
| Mildura Base Hospital |  | 10 | 2 |  | 12 |
| Southwest Health |  | 15 | 5 |  | 20[[20]](#footnote-21) |

Combined total

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health service | **Mental Health bed - acute specialist** | **Mental Health bed - acute adult** | **Mental Health bed - acute aged** | **Mental Health bed - acute child and adolescent** | **Mental health operational bed – acute** |
| Total | 218 | 786 | 247 | 98 | 1,349 |

Table 2.21: Mental health non-acute, subacute and residential operational beds 2025–26

Metropolitan and regional

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **Mental health funded bed – non-acute** | **Mental health funded bed – subacute CCU** | **Mental health funded bed – subacute PARC** | **Mental health funded bed – residential** | **Total: Mental health funded subacute and residential bed** | **Total: Mental health funded subacute and residential bed days** |
| Albury Wodonga Health |  | 26 | 10 | 15 | 51 | 15,834 |
| Alfred Health |  | 20 | 10 |  | 30 | 9,314 |
| Austin Health[[21]](#footnote-22) |  | 22 | 32 | 20 | 74 | 22,974 |
| Barwon Health |  | 12 | 12 | 45 | 69 | 21,422 |
| Bendigo Health Care Group |  | 12 | 20 | 30 | 62 | 19,249 |
| Eastern Health |  | 40 | 20 | 60 | 120 | 37,256 |
| Goulburn Valley Health |  | 10 | 10 | 20 | 40 | 12,419 |
| Grampians Health |  |  | 12 | 32 | 44 | 13,660 |
| Latrobe Regional Health |  | 14 | 20 | 10 | 44 | 13,660 |
| Melbourne Health |  | 20 | 10 |  | 30 | 9,314 |
| Mercy Health |  | 20 | 10 |  | 30 | 9,314 |
| Monash Health |  | 40 | 50 | 94 | 184 | 57,125 |
| Northern Health |  | 40 | 20 | 62 | 122 | 37,876 |
| Parkville Youth Mental Health and Wellbeing Services |  |  | 20 |  | 20 | 6,209 |
| Peninsula Health |  | 20 | 20 | 30 | 70 | 21,732 |
| St Vincent’s Hospital |  | 20 | 10 | 60 | 90 | 27,942 |
| Victorian Institute of Forensic Mental Health | 82 |  |  |  | 82 | 25,458 |
| Western Health |  | 20 | 22 |  | 42 | 13,039 |

Subregional and rural

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **Mental health funded bed – non-acute** | **Mental health funded bed – subacute CCU** | **Mental health funded bed – subacute PARC** | **Mental health funded bed – residential** | **Total: Mental health funded subacute and residential bed** | **Total: Mental health funded subacute and residential bed days** |
| Mildura Base Hospital |  |  | 10 |  | 10 | 3,105 |
| South West Health |  |  | 15 | 13 | 28 | 8,693 |

Combined total

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **Mental health funded bed – non-acute** | **Mental health funded bed – subacute CCU** | **Mental health funded bed – subacute PARC** | **Mental health funded bed – residential** | **Total: Mental health funded subacute and residential bed** | **Total: Mental health funded subacute and residential bed days** |
| Total | 82 | 336 | 333 | 491 | 1,242 | 385,594 |

## Alcohol and other drugs output targets 2025–26

Table 2.22: Alcohol and other drugs output targets 2025–26

Metropolitan and regional

| **Health service** | **DTAU – dual diagnosis residential rehabilitation** | **DTAU – residential drug withdrawal** | **DTAU – residential rehabilitation** | **DTAU – therapeutic day program** | **DTAU – intake and assessment** | **DTAU – care and recovery coordination** | **DTAU – counselling** | **Episode of care – mobile overdose response service** | **DTAU – non-residential withdrawal** | **DTAU – youth residential drug withdrawal** | **Episode of care – specialist pharmacotherapy** | **Episode of care – specialist pharmacotherapy service** | **Episode of care – youth AOD supported accommodation** | **Episode of care – youth AOD supported accommodation rural** | **Episode of care –youth outreach** | **Total** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Alfred Health |  |  |  |  |  |  |  |  |  |  |  | 140 |  |  |  | 140 |
| Austin Health |  |  |  |  |  |  |  |  |  |  |  | 140 |  |  |  | 140 |
| Barwon Health |  |  |  |  | 705 | 263 | 669 |  | 304 |  |  |  |  | 5 | 55 | 2,001 |
| Bendigo Health | 2,391 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2,391 |
| Eastern Health |  | 2,850 | 2,122 |  | 1,246 | 562 | 1,786 | 19 | 669 |  | 100 | 70 |  |  |  | 7,302 |
| Goulburn Valley Health |  | 933 |  | 848 | 237 | 196 | 622 |  | 226 |  |  |  |  |  |  | 3,062 |
| Monash Health |  | 3,113 |  |  |  |  |  |  |  |  |  |  | 32 |  | 28 | 3,173 |
| Peninsula Health |  |  |  |  | 516 | 140 | 562 |  | 253 |  |  |  | 8 |  | 109 | 1,588 |
| St Vincent’s Hospital Melbourne Limited |  | 2,769 |  |  |  |  |  |  |  |  |  |  |  |  |  | 2,769 |
| Western Health | 8,297 | 2,765 |  | 660 | 497 | 392 | 1,583 |  | 578 | 1,597 |  | 140 |  |  | 220 | 16,729 |

Subregional and local

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **DTAU – dual diagnosis residential rehabilitation** | **DTAU – residential drug withdrawal** | **DTAU – residential rehabilitation** | **DTAU – therapeutic day program** | **DTAU – intake and assessment** | **DTAU – care and recovery coordination** | **DTAU – counselling** | **Episode of care – mobile overdose response service** | **DTAU – non-residential withdrawal** | **DTAU – rural withdrawal** | **Episode of care – specialist pharmacotherapy** | **Episode of care – specialist pharmacotherapy service** | **Episode of care – youth AOD supported accommodation** | **Episode of care – youth AOD supported accommodation rural** | **Episode of care –youth outreach** | **Total** |
| Albury Wodonga Health |  | 238 |  |  |  |  |  |  |  |  |  |  |  |  |  | 238 |
| Bairnsdale Regional Health Service |  | 483 |  |  |  |  |  |  |  |  |  |  |  |  |  | 483 |
| Central Gippsland Health Service |  | 476 |  |  |  |  |  |  |  |  |  |  |  |  |  | 476 |
| Central Highlands Rural Health |  |  |  |  |  |  | 44 |  | 82 |  |  |  |  |  | 33 | 159 |
| Colac Area Health |  |  |  |  |  |  |  |  |  |  |  |  |  | 1 |  | 1 |
| Gippsland Southern Health Service |  | 238 |  |  |  |  |  |  |  |  |  |  |  |  |  | 238 |
| Mildura Base Public Hospital |  | 308 |  |  |  |  |  |  |  |  |  |  |  |  |  | 308 |
| Northeast Health Wangaratta |  | 238 |  |  |  |  |  |  |  |  |  |  |  |  |  | 238 |
| South West Healthcare |  |  |  |  |  |  |  |  |  | 120 |  | 12 |  |  |  | 132 |

Combined total

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health service** | **DTAU – dual diagnosis residential rehabilitation** | **DTAU – residential drug withdrawal** | **DTAU – residential rehabilitation** | **DTAU – therapeutic day program** | **DTAU – intake and assessment** | **DTAU – care and recovery coordination** | **DTAU – counselling** | **Episode of care – mobile overdose response service** | **DTAU – non-residential withdrawal** | **DTAU – youth residential drug withdrawal** | **DTAU – rural withdrawal** | **Episode of care – specialist pharmacotherapy** | **Episode of care – specialist pharmacotherapy service** | **Episode of care – youth AOD supported accommodation** | **Episode of care – youth AOD supported accommodation rural** | **Episode of care –youth outreach** | **Total** |
| Total | 10,688 | 14,411 | 2,122 | 1,508 | 3,201 | 1,553 | 5,266 | 19 | 2,112 | 1,597 | 120 | 100 | 502 | 40 | 6 | 445 | 41,568 |

## Localised pricing adjustments to the Victorian ABF Pricing Framework

Table 2.23: Victorian pricing adjustments 2025–26 – Legacy grants

| **Grant name** | **Adjustment type** | **Notes** |
| --- | --- | --- |
| 1069 – Commissioning Costs | Adjustments for commissioning of new services |  |
| 11 – Statewide Lithotripsy | Adjustments for statewide services |  |
| 122 – ICS Paediatric | Adjustments for statewide services |  |
| 132 – Transplants-Liver | Adjustments for statewide services |  |
| 147 – Family Choice Program | Adjustments for statewide services | Now known as Complex Care Program.  Activity classified using the Tier 2 non-admitted services classification, and unit of count is ‘service event’.  Non-admitted services to be reported as service events through the relevant AIMS form and report contacts through the VINAH minimum dataset. These service events do not attract NWAU.  Providers to maintain and report patient-level costing data to VCDC. |
| 162 – OnTrac Statewide Service | Adjustments for statewide services |  |
| 163 – PICS Long-Term Effects Follow-up VCAP Program | Adjustments for statewide services |  |
| 169 – Bronchiolitis RSV Strategy | Adjustments for statewide services |  |
| 171 – Chemotherapy Support | Adjustments for classification |  |
| 2048 - Home Dialysis - Stabilisation | Adjustments for classification |  |
| 282 – Admin – Medical Indemnity Insurance Premium (PAM) | Adjustments for classification |  |
| 283 – Transplant Retrieval | Adjustments for statewide services |  |
| 31 – State Neuropathology Service | Adjustments for statewide services |  |
| 32 – Statewide Toxicology Service | Adjustments for statewide services |  |
| 337 – Integrated Cancer Services | Adjustments for classification |  |
| 352 – Primary Ciliary Dyskinesia | Adjustments for statewide services |  |
| 384 – Genetic Clinical Activity | Adjustments for statewide services | Work under way to transition genetic clinical activity provided by the Victorian Clinical Genetic Services and metabolic medicine/disease unit at The Royal Melbourne Hospital to the national funding model. |
| 385 – Genetic Testing / Screening | Adjustments for statewide services |  |
| 388 – Hyperbaric Statewide Service | Adjustments for statewide services |  |
| 39 – HIV/AIDS Contract | Adjustments for statewide services |  |
| 427 – Perinatal and Intensive Paediatric Emergency Retrieval | Adjustments for statewide services |  |
| 438 – Victorian Artificial Limb Program | Adjustments for classification | Activity classified using the Tier 2 non-admitted services classification, and unit of count is ‘service event’.  Non-admitted services to reported as service events through the relevant AIMS form and report contacts through the VINAH minimum dataset. These service events do not attract NWAU.  Providers to maintain and report patient-level costing data to VCDC. |
| 46 – Interstate Paediatric Cardiac Service | Adjustments for statewide services |  |
| 632 – Interpreter Services Supplement | Adjustments for classification |  |
| 643 – Home Cancer Nursing Services | Adjustments for statewide services |  |
| 679 – Victorian Perinatal Autopsy (VPAS) | Adjustments for statewide services |  |
| 805 - Statewide Extracorporeal Membrane Oxygenation service | Adjustments for statewide services |  |

# List of tables

[Table 1.1:Victorian alignment with the national funding model 10](#_Toc207263717)

[Table 1.2: Avoidable hospital readmissions and readmission intervals 44](#_Toc207263718)

[Table 1.3: Victorian funding recall rates 2025–26 53](#_Toc207263719)

[Table 1.4: Funding for throughput above target 2025–26 55](#_Toc207263720)

[Table 1.5: NWAU VEP 2025–26 62](#_Toc207263721)

[Table 1.6: NWAU compensable price rates 2025–26 62](#_Toc207263722)

[Table 1.7: Transitional Care Program 2025–26 62](#_Toc207263723)

[Table 1.8: Non-admitted radiotherapy 2025–26 62](#_Toc207263724)

[Table 1.9: Nationally Funded Centres Program 2025–26 62](#_Toc207263725)

[Table 1.10: Mental health – funded units applicable to clinical bed-based services 2025–26 – non-admitted care 63](#_Toc207263726)

[Table 1.11: Mental health – funded units applicable to clinical bed-based services 2025–26 – clinical community care 63](#_Toc207263727)

[Table 1.12: Mental health community support services unit prices 2025–26 – community support services 63](#_Toc207263728)

[Table 1.13: Mental health community support services unit prices 2025–26 – mutual support and self-help services 63](#_Toc207263729)

[Table 1.14: Mental health – funded units applicable to clinical bed-based services 2025–26 – non-admitted care 63](#_Toc207263730)

[Table 1.15: Mental health community support services unit prices 2025–26 – supported accommodation 64](#_Toc207263731)

[Table 1.16: Drug services – unit prices 2025–26 64](#_Toc207263732)

[Table 1.17: Early Parenting Centres 2025–26 65](#_Toc207263733)

[Table 1.18: Ageing, aged and home care 2025–26 65](#_Toc207263734)

[Table 1.19: Small Rural Health Services 2025–26 66](#_Toc207263735)

[Table 1.20: Community Health care output 2025–26 67](#_Toc207263736)

[Table 1.21: Training and development funding rates in 2025-26 68](#_Toc207263737)

[Table 1.22: Price groups for NWAU purposes 69](#_Toc207263738)

[Table 1.23: Small rural health services – outputs and activities 2025–26 71](#_Toc207263739)

[Table 1.24: Aged and home care – outputs and activities 2025–26 72](#_Toc207263740)

[Table 1.25: Public health – outputs and activities 2025–26 76](#_Toc207263741)

[Table 2.1: Expenditure budgets 2025–26 80](#_Toc207263742)

[Table 2.2: Small rural health services expenditure budgets 2025–26 – $’000s 82](#_Toc207263743)

[Table 2.3: Funding summary: health service expenditure budgets 2025–26 by service category 84](#_Toc207263744)

[Table 2.4: Mental health expenditure budgets 2025–26 by service type 88](#_Toc207263745)

[Table 2.5: Registered community expenditure budgets 2025–26 – $’000s 93](#_Toc207263746)

[Table 2.6: Local government authorities 2025–26 – $’000s 94](#_Toc207263747)

[Table 2.7: Non-government providers 2025–26 – $’000s 96](#_Toc207263748)

[Table 2.8: Other funded organisations expenditure budgets 2025–26 – $’000s 99](#_Toc207263749)

[Table 2.9 Health operations expenditure budgets 2025–26 – $’000s 100](#_Toc207263750)

[Table 2.10: Victorian activity targets (NWAU) 2025–26 101](#_Toc207263751)

[Table 2.11: Indicative baseline NWAU adjustment in 2025–26 for HAC 103](#_Toc207263752)

[Table 2.12: Indicative baseline NWAU adjustment in 2025–26 for AHR 104](#_Toc207263753)

[Table 2.13: Victorian small rural health service activity targets 2025–26 106](#_Toc207263754)

[Table 2.14: Non-admitted radiotherapy activity targets 2025–26 107](#_Toc207263755)

[Table 2.15: Shared care radiotherapy activity targets 2025–26 107](#_Toc207263756)

[Table 2.16: Transition Care Program targets 2025–26 108](#_Toc207263757)

[Table 2.17: Community palliative care – new episodes for distinct clients 2025–26 109](#_Toc207263758)

[Table 2.18: Nationally Funded Centres Program targets 2025–26 110](#_Toc207263759)

[Table 2.19: Mental health acute operational beds 2025–26 111](#_Toc207263760)

[Table 2.20: Mental health non-acute, subacute and residential operational beds 2025–26 112](#_Toc207263761)

[Table 2.21: Alcohol and other drugs output targets 2025–26 114](#_Toc207263762)

[Table 2.22: Victorian pricing adjustments 2025–26 – Legacy grants 116](#_Toc207263763)

# Acronyms and abbreviations

ABF activity-based funding

ABO blood group system

ACA Aged Care Assessment

ACCO Aboriginal community-controlled organisations

ACHI Australian Classification of Health Interventions

ACS Australian Coding Standard

AECC Australian Emergency Care Classification

AHR Avoidable hospital readmissions

AIDS acquired immune deficiency syndrome

AIMS Agency Information Management System

AMHCC Australian Mental Health Care Classification

AN-SNAP Australian National Subacute and Non-Acute Patient

AOD alcohol and other drugs

AR-DRG Australian Refined Diagnosis-Related Groups

BBV blood-borne viruses

DNW did not wait

DRG diagnosis-related group

DVA Department of Veterans' Affairs

ESIS Elective Surgery Information System

FIM™ Functional Independence Measure

GEM geriatric evaluation and management

HAC hospital acquired complications

HACC Home and Community Care

HACC-PYP Home and Community Care Program Younger People

HeART Health Agencies Reporting Tool

HIP Health Independence Program

HIV human immunodeficiency virus

ICD International Classification of Diseases

IHACPA Independent Health and Aged Care Pricing Authority

LAMA Leave against medical advice

LOS length of stay

LPHU Local Public Health Unit

MAPS Modelling and Payment System

MBS Medicare Benefits Schedule

METeOR registry for Australian metadata standards

MHCSS Mental Health Community Support Services

NACMS Non-Admitted Clinic Management System

NADC Non Admitted Data Collection

NEC National Efficient Cost

NEP National Efficient Price

NFC Nationally Funded Centres

NHRA National Health Reform Agreement

NWAU national weighted activity unit

PARC Prevention and Recovery Care

PRNI Privately Referred Non-Inpatient

RUG-ADL Resource Utilisation Groups – Activities of Daily Living

STI sexually transmissible infections

TAC Transport Accident Commission

TCP Transition Care Program

Tier 2 non-admitted services classification

UCC urgent care centre

UDG Urgency Disposition Groups

VAED Victorian Admitted Episodes Dataset

VCDC Victorian Cost Data Collection

VEMD Emergency Minimum Dataset

VEP Victorian efficient price

VINAH Victorian Integrated Non-Admitted Health minimum dataset

VVED Victorian Virtual Emergency Department

WAU weighted activity unit

1. Residential mental health care services remain eligible for block funding if they meet the criteria outlined in Independent Health and Aged Care Pricing Authority’s and General List of In-Scope Public Hospital Services for 2025–26. See <https://www.ihacpa.gov.au/resources/general-list-scope-public-hospital-services-eligibility-policy>. [↑](#footnote-ref-2)
2. Victoria will fund these services on the basis of NWAU ABF along with the broader transition of community mental services from block funding to ABF in 2025-26. This exception to aligning to the national funding model is made on the basis that these services are forecast to exceed the National Funding Model for transitional block funding criteria for community mental health services in 2025-26. [↑](#footnote-ref-3)
3. Pending final sign off at the time of drafting this, both the Victorian Department of Health and the Commonwealth Department of Veterans’ Affairs have agreed in principle to roll over the 2023–25 Deed of Variation to the Hospitals Services Arrangement to be in effect from 1 July 2025 to 30 June 2026. [↑](#footnote-ref-4)
4. Continued analysis of Statement of Priorities leave event data and other supporting measures will inform approaches to enhance patient experiences and improve Aboriginal health and wellbeing. [↑](#footnote-ref-5)
5. State component only. [↑](#footnote-ref-6)
6. Where ‘HACC’ is referred to, the service relates to the Home and Community Care Program for Younger People (HACC-PYP). [↑](#footnote-ref-7)
7. Annual funding is generally calculated as follows:

   Number of operational places × 365.25 days per year × 99% occupancy factor × relevant unit price. Places that are not operational (for a time-limited period or ongoing), or used for any other purpose, will not attract state government PSRACS supplements. [↑](#footnote-ref-8)
8. This supplement was previously referred to as HSUA 1 EBA – hostel. [↑](#footnote-ref-9)
9. An approach for ACCO services unit prices is to be determined [↑](#footnote-ref-10)
10. Annual funding is generally calculated as follows:

    Number of operational places × 365.25 days per year × 99% occupancy factor × relevant unit price. Places that are not operational (for a time-limited period or ongoing), or used for any other purpose, will not attract state government PSRACS supplements. [↑](#footnote-ref-11)
11. This supplement was previously referred to as HSUA 1 EBA – hostel. [↑](#footnote-ref-12)
12. Excludes Albury NSW local hospital network funding contributions from New South Wales [↑](#footnote-ref-13)
13. Health service classified in National Efficient Cost Determination as rural or regional local hospital network delivering low volume of community mental health services. [↑](#footnote-ref-14)
14. Health service classified in National Efficient Cost Determination as a rural or regional local hospital network delivering a low volume of community mental health services. [↑](#footnote-ref-15)
15. Health service classified in National Efficient Cost Determination as a rural or regional local hospital network delivering a low volume of community mental health services. [↑](#footnote-ref-16)
16. Health service classified in National Efficient Cost Determination as a standalone hospital providing specialist mental health services (community mental health services only). [↑](#footnote-ref-17)
17. Bed numbers in Mental Health and AOD hubs and those under private contracts are not included. [↑](#footnote-ref-18)
18. Bed numbers will reduce after the completion of planned capital works in 2025–26. [↑](#footnote-ref-19)
19. 10 Hospital in the Home beds to be operational in 2025-26 [↑](#footnote-ref-20)
20. 20 beds will be available after the completion of planned capital works in 2025–26. [↑](#footnote-ref-21)
21. 20 extra YPARC beds to be made operational in 2025-26, 10 beds at Austin Health and 10 beds at Latrobe Regional Health [↑](#footnote-ref-22)