Australian
Private Hospitals
Association

# A Private National Efficient Price (PNEP)

**CONSULTATION SUBMISSION**

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# Contents

# 1.0 Introduction

The Australian Private Hospitals Association (APHA) has maintained an open mind on the development of a Private National Efficient Price (PNEP), especially as this has been couched as a potential solution to the viability and investability crisis impacting the sector for many years.

The draft Pricing Framework for Australian Private Hospitals Services (the Draft) raises more questions than answers. After 18 months of deliberations – including the six-month CEO Roundtable from May 2024 and the subsequent 12-month CEO Forum from December 2024 – we are concerned the Draft remains a nebulous concept and provides insufficient detail upon which to base practical assessments.

Based on this document, the Federal Department for Health, Disability and Ageing (the Department) intends to develop an indicative price by 1 July 2026. Given the scale and complexity of work still yet to be clarified and undertaken as outlined in Phase 1 of the Implementation Options, this is also a concern. The proposal seems way underdone.

In several areas the previously understood intent of a potential PNEP has changed dramatically, including shifting from an expected floor price to a yet undetermined average. It no longer comes with any mention of automatic annual indexation. Yet, it does enable health insurers to continue to negotiate contracts below any eventual indicative figure.

This unforeseen and previously unheralded development raises the question of what, if anything, a PNEP will achieve in addressing the viability and investability crisis in private hospital service delivery? In fact, it could stand to make matters worse.

Further, the Department's narrative throughout this process has been that there will be winners and losers. The Department advised that a transition period of several years would be needed, with compensation provided to losers. The Draft makes no mention of this transition or any compensation.

Key issues:

- Contrary to expectations, the Draft deals specifically with issues of cost constraint. It does not address pricing, innovation or capital expenditure factors. The APHA is concerned this could be a Trojan horse for cost-cutting at the expense of the quality and innovation in the healthcare private hospitals are renowned for and that private patients expect.

- It seeks to redistribute funds from the existing pool, not increase the size of the funding pool. Surprisingly, the Draft makes no reference to the role private health insurers need to play in meeting the rising costs of healthcare delivery.

- Alarmingly, the Draft section Direct impacts: Reference pricing for benchmarking and informing contract negotiations states:

  *"In its most basic form, a robust Private NEP would allow for improved benchmarking of costs, provide an external reference point for contract negotiations between private hospital operators and insurers and other payers"*.

The PNEP will only go as far as informing contract negotiations, and negotiations will run their course having the PNEP as a benchmark of costs that need to be covered in contracted prices. This makes the continued low balling by health insurers implicit. As such, it would fail to address the viability or investability of private hospitals.

As such, the proposed PNEP may have the perverse outcome of accelerating closures and consolidation across the sector, effectively squeezing out independent hospitals.

- The Draft makes no mention of compensation, as was raised by the Department during its briefings, leaving affected hospitals in limbo without the ability to make informed decisions.

- Erroneously, the Draft framework interchangeably uses the terms 'cost' and 'price' as though they were synonymous or functionally equivalent in commercial operations. This is evident in the section of the draft framework that discusses the level at which the price should be set, stating:

  *"Whilst the price has been broadly described as a National Efficient Price, choosing the basis for setting the price is an open question with a few options. These include simple options like setting the price at the average cost, moving to a more aggressive point like the median cost, or adopting a more sophisticated options such as setting the price on an efficient frontier approach."*

- Despite recognising the absolute need for capital expenditure and investment in quality and innovation to be vital components, nowhere in the Draft is this in any way accounted for. This must be addressed and the funding stream clearly articulated.

- Similarly, on quality and safety, the Draft deals solely with adverse incidents and seeks to penalise hospitals. However, at no point does it cite how the proposed PNEP incentivises excellence in clinical outcomes, nor the adoption of ground-breaking care, new treatments or procedures.

  There is a risk that innovative procedures would not be costed initially and would require hospitals to negotiate with health funds, separate to the PNEP, which would be counterintuitive and not serve to support greater innovation.

- The Draft fails to demonstrate how the pursuit and achievement of excellence by private hospitals is to be rewarded via, for example, higher rates from health insurers.

- The Draft, as presented, places all the burden on costs for care, investment, quality, safety and innovation on private hospitals but without a corresponding responsibility from private health insurers to acknowledge these features, let alone adequately fund them.

- Without the funding pool from insurers growing, the existing viability and investability issues remain. The Draft fails to provide for future investment which, in most cases, is unlikely to be possible. The result would be an homogenous healthcare offering that dwindles in quality over time and falls below the expectations of private patients and those paying for private health insurance.

- That the Department expects to have Phase 1 ready by 1 July 2026 is concerning, given the scant detail provided to date. That the Draft makes no call on private health insurers as the major funders of private healthcare is conspicuous and unsettling.

# 2.0 Context Setting

## 2.1 DEVELOPMENT OF THE PROPOSAL DRAFT

Before we delve into the Draft, it is important to address the lack of genuine consultation in its formulation.

### 2.1.1 CEO Forum

Despite the APHA providing advice, both in writing and verbally, on at least five occasions prior to and after the establishment of the CEO Forum, it consists of major hospital groups only.

While the bigger groups should be part of the Forum, its make-up deliberately excluded over 70% of private hospitals – notably independent hospitals and stand-alone specialty hospitals such as psychiatry and rehabilitation facilities and regional hospitals – from having any voice in the Forum's deliberations.

This flawed approach ignored the issues faced by the very hospitals at greatest risk in the ongoing viability and investability crisis.

The APHA made the point, repeatedly, that the buying power and negotiating position of a hospital group is vastly different to that of an independent hospital or day surgery.

Further, given this situation, it is inevitable that the vast majority of private hospitals will be taken by surprise by the Draft, its content and intent, despite it having far-reaching ramifications for if, and how, they continue to operate.

### 2.1.2 Consultation

Appendix A of the Draft cites the APHA as a consulted stakeholder, along with Epworth Healthcare, Sydney Adventist Hospital, Burnside Hospital and Wolper Jewish Hospital.

This is not accurate.

Since the inception of the CEO Forum the APHA was privy to three short briefings, which included an outline of expected timelines and broad subject matters discussed at the Forum. No detail was provided. There was no consultation on any substantive matter.

Further, undertakings by the Department during these briefings that such briefings would be instituted as an ongoing and more regular occurrence, never eventuated.

Similarly, the APHA member hospitals cited in the Draft – Epworth Healthcare, Sydney Adventist Hospital, Burnside Hospital and Wolper Jewish Hospital – were equally briefed in one short session, without opportunity to receive detail or provide feedback.

There is a risk the process underpinning what would be a seismic shift in private hospital operations is seen as a sector being railroaded and deliberately kept in the dark.

### 2.1.3 Time Delays

The release of the Draft was foreshadowed by the Department for circulation by August 2025. This was delayed until September 2025. But it did not eventuate until November 2025. A full three months late.

Yet, stakeholders, including the APHA, have been given just three weeks to respond to the Draft due to the desire of the Department to have feedback ready for the final CEO Forum meeting for 2025 in December.

The time constraint caused by the Department's inability to meet its own deadline is being borne by APHA, its members and others. Again, this undermines the Department's position to any claim of genuine consultation.

It is also unclear if genuine or public consultation on the PNEP is to be expected, or if a Regulatory Impact Statement or proposed legislative changes will be forthcoming from the Department beyond this Draft.

### 2.1.4 APHA Members

Given the refusal of the Department at any stage over the CEO Forum's life thus far, to genuinely engage with the vast majority of private hospitals affected by the implementation of any PNEP, the APHA is undertaking detailed briefings will all sections of its membership to garner their views, concerns and feedback on the Draft.

As by far the largest representative body for private hospitals in Australia, the APHA's membership encompassing for-profit and not-for-profit small, medium and large hospital groups; small, medium and large independent hospitals; specialist psychiatric hospitals, rehabilitation hospitals and day surgeries.

Beyond the timeframe of this Draft consultation, the APHA's position will be informed by feedback from all corners of the membership.

### 2.1.5 Medical Devices

Despite the Draft including specific reference to the Prescribe List of Medical Devices and the Department's assertion that this is an "inefficiency" to be subjected to the PNEP, it is the APHA's understanding that not a single medical device entity – Australian or otherwise – was ever contacted in the development of these proposed changes.

Such a process is highly irregular.

## 2.2 STATE OF THE SECTOR

The statement in the Draft that: *"The financial viability of the entire sector is critical. Hospital operators and funders in the private hospital sector must be financially viable"*, seemingly ignores that the funders have enjoyed record after-tax profits of over $7.2 billion in recent years.

Since 2022 private health insurance companies in Australia have recorded unprecedented profits, a remarkable feat given annual premium increases have been historically low (3% or less each year).

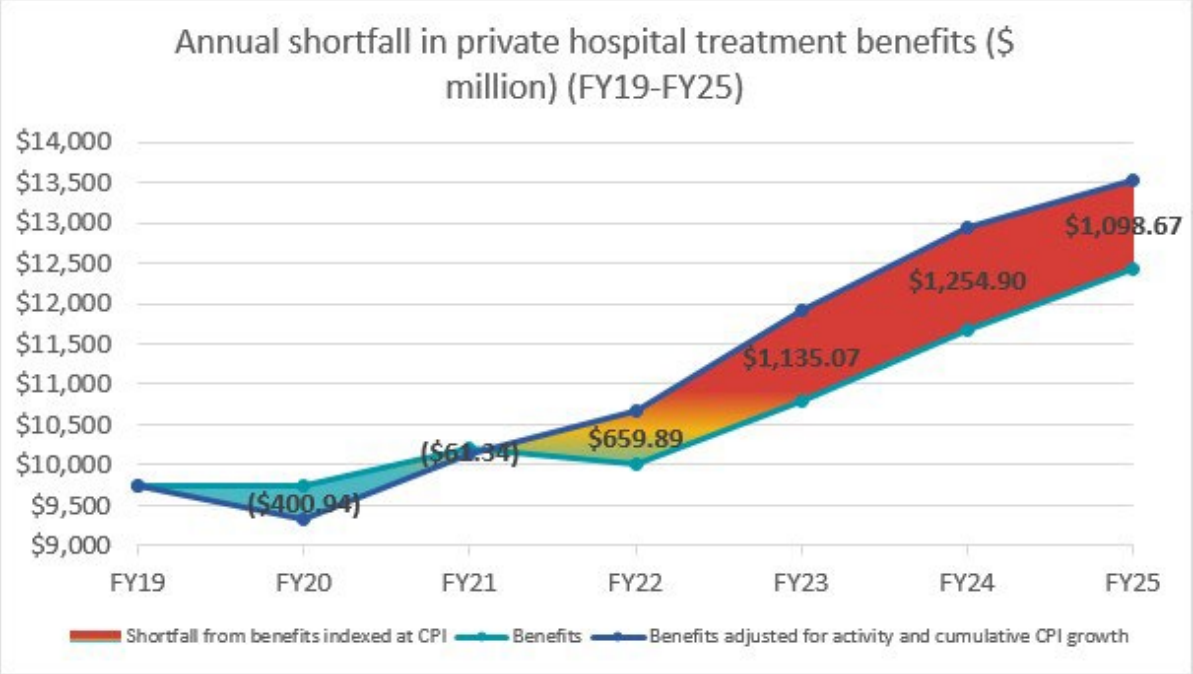
**The after-tax profits of health insurance companies in Australia for the 12 months ending June 30 each year**

- 2021-22 - $1.051 billion[1]
- 2022-23 - $2.187 billion[2]
- 2023-24 - $1.84 billion[3]
- 2024-25 - $2.132 billion[4]

On top of the record profits over recent years, the private health insurance industry increased its 'management fees' charged to customers in 2023-24 by a massive 18% - reaping another $3.4 billion a year from premiums.[5]

Over the same four-year period, analysis of annual Consumer Price Index and Australian Prudential Regulation Authority (APRA) data shows, private hospitals have been short-changed by $4 billion.

As the table below shows, the underpayment to private hospitals has grown and now consistently sits at over $1 billion a year – with a shortfall of $659.89 million (2022), $1.135 billion (2023), $1.254 billion (2024) and $1.098 billion in 2025.




*Sources: Consumer Price Index, Australia, Australian Bureau of Statistics (2025); Quarterly Private Health Insurance Statistics, Australian Prudential Regulation Authority, (released August 2025).*

[1] *Quarterly private health insurance statistics June 2022 (released 24 August 2022) page 10*

[2] *Quarterly private health insurance statistics June 2023 (released 23 August 2022) page 10*

[3] *Quarterly private health insurance performance statistics, Key metrics, September 2023 to June 2024 quarters (released 28 February 2025), Australian Prudential Regulation Authority*

[4] *Quarterly private health insurance performance statistics, Key metrics, June 2024 to June 2025 quarters (released 29 August 2025), Australian Prudential Regulation Authority.*

[5] *Quarterly private health insurance performance statistics, Key metrics, September 2023 to June 2024, Australian Prudential Regulation Authority, August 2024.*

Efficiency and productivity is a two-way street.

For example, Medibank Private, Australia's biggest health insurer with 4.2 million members, recorded a $741.5 million profit last year, up a massive 7.1% on the previous year. It's management fees reaped another $654.9 million, an increase of $40 million in just one year.

HCF, the biggest 'not-for-profit' insurer with 2 million members, reported an adjusted insurance service profit of $28.3 million in its last annual result. According to APRA, HCF's management expenses and claims handling topped $485 million.

Despite HCF having less than half of Medibank's customers, it recorded 74% of Medibank's management expenses.

These record profits and dubious expenses indicate that the private health insurance industry has more than enough fat built into its operations to rectify the funding shortfall to private hospitals without any need to increase premiums.

Traditionally, private hospitals would receive in the order of 88-90% of the premiums health insurers collect each year. This funding ratio was the norm. However, over recent years the insurance companies have been keeping more for themselves while failing to meet the rising costs of healthcare delivery in hospitals.

**Pass through of Patient Premiums to Patient Services**

| Financial Year | Revenue from Hospital Premiums ($'000) | Hospital Insurer Claims Incurred ($'000) | % Paid Towards Care |
|---|---|---|---|
| 2019–20 | 18,052,118 | 16,342,583 | 90.5% |
| 2020–21 | 18,675,551 | 16,343,663 | 87.5% |
| 2021–22 | 19,434,612 | 16,379,358 | 84.3% |
| 2022–23 | 20,092,741 | 16,400,869 | 81.6% |
| 2023–24 | 21,724,043 | 18,259,479 | 84.1% |
| 2024–25 | 23,013,181 | 19,388,545 | 84.2% |

*Sources: Australian Prudential Regulation Authority, Operations of Private Health Insurers Annual Report (FY20-25), Quarterly private health insurance performance statistics.*

That the Draft makes no mention of this established reality and puts all of the burden on the hospitals as suppliers and no responsibility on insurers as funders, does not fill the providers of quality healthcare with confidence in the PNEP.

# 3.0 Scope of the Proposal

The proposed framework should be focused on its original intent, establishing a price floor for the purposes of ensuring fair contracting with private health insurers, including automatic annual indexation. In its current form, the Draft attempts to change the private health payment framework all together, potentially exceeding the Department's mandate and authority to do so.

We note a risk that some of the proposed 'reforms' may be contrary to existing legislation and, as such, may not be legislatively or legally feasible. The proposed framework attempts to alter the operation of the following.

## 3.1 DEPARTMENT OF VETERANS' AFFAIRS (DVA) CONTRACTING WITH PRIVATE HOSPITALS

Private hospitals, through their contracts with the DVA, provide veterans with greater access to care and give back to our service members that have selflessly served our country and the national interest.

Contracts between private hospitals and the DVA provide private hospitals with additional support whilst expanding the services available to eligible patients.

These contracts, as such, lie outside the ambit of the Department of Health's authority.

The draft pricing framework specifically calls out the lack of transparency around DVA-private hospital contracts. This can be construed as departmental overreach. The DVA, as the principal agency, has and should continue to have complete oversight.

All contracts under this comply with Commonwealth procurement frameworks and DVA priorities. Any suggestion that this may not be the case, should be made with caution and only by the DVA, which has direct knowledge of any contracting arrangements.

Attempting to exercise oversight over DVA-private hospital contracts interferes with the long-held and protected sanctity of contractual relations.

## 3.2 THE PRESCRIBED LIST FOR MEDICAL DEVICES (PL)

APHA is concerned that the Department is attempting to circumvent due process and remove the PL.

The PL is a cornerstone of reimbursement for private hospitals in Australia that has just come out of a lengthy reform process. To first complete a reform process that has required the use of significant taxpayer-funded resources and comprehensive consultation with stakeholders that are directly affected by the reforms and the operation of the PL and then propose to replace it, would be a disservice to patients and hospitals.

PL should remain independent from considerations related to the PNEP. The bundling of prostheses must not occur.

APHA has raised issues with the falling and typically insufficient benefits under the PL throughout the government's reform process. Further undermining the PL would cause more harm than good to the

viability of private hospitals. If this is part of the model, then small providers are at risk of not being viable due to the inability to negotiate the same prices as larger operators.

Doctor choice based on patient need is the primary driver for prostheses selection, any attempt to bundle the PL with the PNEP threatens to interfere with cornerstone of healthcare and arbitrarily exert influence over patient/doctor choice.

We note that the PL is covered by legislation, any attempt to remove it must be tested in the Parliament.

## 3.3 SECOND-TIER DEFAULT BENEFITS (STDB)

The STDB scheme serves as a valuable safety net for patients and private hospitals. It sets the level of benefits payable to a default benefit-eligible hospital that does not have in place a contract with a particular health insurer at 85% of the average benefits paid by that insurer for the episode of care in a contracted facility.

Making the STDB more transparent would to be a far more positive, efficient and less costly way of ensuring this safety net is workable, rather than the impost of the proposed PNEP.

The private health insurance sector has previously noted that: *"2nd tier default benefits play an important role in the contractual environment between health insurers and service providers by guaranteeing a minimum payment to accredited private hospitals"*.[6]

Second-tier benefits help ensure that patients continue to have choice by being able to choose their service providers and without being subject to large out-of-pocket costs and support private hospitals in being able to serve their communities.

The importance of the STDB is underscored by its enabling of access to care to patients in a difficult contracting environment between private health insurers and private hospitals. It is inappropriate for a PNEP to replace STDBs because the two mechanisms serve fundamentally different purposes and address different needs in the private health system.

The STDP is a safety net that ensures patients still receive access to private hospitals without contracts with particular insurers. It is effectively an extra-contractual arrangement. The PNEP, on the other hand, is meant to inform and support contractual negotiations and funding arrangements between insurers and private hospitals. It is not meant to cover extra-contractual arrangements.

## 3.4 RISK-EQUALISATION AND PREMIUM SETTINGS

While premium settings will inevitably be informed by the application of a PNEP, there is a risk that placing complete reliance on the PNEP and excluding contract data to evaluate insurers' claims of expenditure growth, will reduce transparency, accountability, and falsifiability in the sector at large.

The proposal for the PNEP suggests that the PNEP could *"support cost containment efforts"*, in an environment where benefits for private hospitals have been falling and returns on premium dollars to consumers dwindling, the sector needs to have benefit levels that meet the need. Not a mechanism that serves to further constrain the ability of private hospitals to offer care and access to patients.

The proposal also suggests informing risk-equalisation with the new PNEP and replacing *"volatile, insurer-specific benefit data with a neutral reference cost"*. The entire concept of risk-equalisation

[6] https://www.accc.gov.au/system/files/Private%20Health%20Insurance%20Report%202007-08.pdf

requires consideration of the variation across insurers in benefits paid. This matter merits further investigation by the Department in line with legislation and the Private Health Insurance (Risk Equalisation Policy) Rules 2025 (Cth).

## 3.5 THE FINANCIAL DISCLOSURE FRAMEWORK

The Department seems to be attempting to use the opportunity for a PNEP to mandate the disclosure of confidential financial data by private hospital operators.

APHA has previously advised government that private hospitals have, indeed, provided data to government but that this data has not been utilised for the purposes for which it was provided.

There are risks that mandating data disclosures will impose further cost and regulatory burdens on a sector that is already under significant pressure. The compliance requirements on private hospitals, especially the smaller, independent operators, has not been explained in the Draft.

# 4.0 Assumptions, Concerns, Risks

## 4.1 INCORRECT ASSUMPTIONS

### 4.1.1 Price vs Cost

The concept of the PNEP, as outlined in the Draft, methodologically represents a cost rather than a price. It is to be derived from the National Hospital Cost Data Collection (NHCDC) having no regard for the earnings margins that are necessary for financial sustainability and the ability to attract investment.

Application of a pricing mechanism that is largely identical to that used for public hospital costing, where cost and price can innocuously reach parity, will not provide the appropriate return on equity or the economic value that must be captured by providers for them to continue to operate and invest under the ideals and conditions of free enterprise.

The PNEP is proposed as a benchmark for pricing private hospital services in Australia using Activity-Based Funding (ABF) principles. The process will involve cost data collection and distributing those costs to ultimately arrive at a private weighted average cost. The NHCDC currently collects patient-level cost data from private hospitals, including direct and indirect costs such as those associated with staffing, consumables, insurance and utilities. The PNEP will spread these costs across all hospital activity to estimate the average cost for a Private Weighted Activity Unit (PWAU).

Based on the above approach, the PNEP is fundamentally a cost-based variable being derived from the NHCDC that focuses only on the costs incurred by hospitals in delivering services. It does not include a margin or earnings component, which is a defining characteristic of a 'price'. A 'cost' reflects the resources required to produce a service, including labour, materials, and overheads. A 'price', on the other hand, includes the cost plus a structured margin that resources the financial sustainability and investment needs of the provider.

Erroneously, the Draft framework interchangeably uses the terms 'cost' and 'price' as though they were synonymous or functionally equivalent in commercial operations. This may expose the Department's fundamental lack of understanding on how private hospitals operate. This is evident in the section of the draft framework that discusses the level at which the price should be set, stating:

> *"Whilst the price has been broadly described as a National Efficient Price, choosing the basis for setting the price is an open question with a few options. These include simple options like setting the price at the average cost, moving to a more aggressive point like the median cost, or adopting a more sophisticated options such as setting the price on an efficient frontier approach.*" (DRAFT Pricing Framework for Private Hospital Services October 2025, pp 23)

The Independent Health and Aged Care Pricing Authority (IHACPA) gives an overview of the process of costing. This process can, objectively speaking, only result in a calculated cost, and never an indicative price at which negotiations between providers and payers would reach a mutually

satisfactory conclusion.[7] The overview makes the necessary distinction between costing and the separate endeavour of pricing, whose principles and practice vary greatly across the divide between the public and private hospital sectors. Concerning the role of costing, IHACPA says:

> *"Hospital costing focuses on the cost and mix of resources used to deliver patient care. Costing plays a vital role in activity-based funding. Costing informs the development of the classification system and provides valuable information for pricing purposes. Hospital patient costing is essential for understanding the total costs involved in treating a patient including the services or products used*."

The PNEP aims to drive efficiency by signalling market prices using an estimate of cost that bears the misnomer of 'efficient price'. This approach assumes that commercial entities can operate at zero-margin in the same way that state-run entities are able to. However, without consideration of the necessity of earnings margins in commercial operations, the PNEP would inevitably undermine the financial sustainability of both for-profit and not-for-profit private hospitals.

Unlike the public hospital system where taxpayers simply foot the bill for expansions, new equipment or more or new services, private hospitals – for-profit and not-for-profit, alike – must make a margin to facilitate these investments. This has been a core issue in the variability and investability issue that the proposed PNEP was supposed to address. That it is so fundamentally misunderstood by the Department is deeply concerning.

An independent report by Ernst and Young established that for-profit hospitals may require EBITDA[8] margins of 10% or more to ensure long-term ability to attract investment. [9] Analysis of 110 hospitals indicated a weighted average EBITDA margin of approximately 10% in FY19, despite the exclusion of large corporate organisations that would have further raised the average. This margin fell sharply to 3.1% in FY22 and further declined to 2.1% in FY23.

The study established that free cash flow from hospital earnings is required for the following categories of financial activities:

- Fulfilment of financial obligations to suppliers, employees, landlords, insurance, taxation, financiers (principal and interest), and compliance costs.
- Investment in training, learning and development, career pathways, opportunities, and digital enablement of people.
- Investment in digital system infrastructure and software.
- Investment towards the establishment and enhancement of property, plant and equipment via capital expenditure in the growth, development and replacement of fixed assets such as buildings, facilities and high-value machinery such as diagnostic imaging equipment and surgical robots.

[7] Independent Health and Aged Care Pricing Authority (IHACPA), *Costing overview*. Available at: https://www.ihacpa.gov.au/health-care/costing/costing-overview (Accessed: 16 November 2025).
[8] EBITDA, earnings before interest, tax, depreciation and amortisation
[9] Australian Private Hospitals Association (2024) *Private Hospital Financial Sustainability Study Report*. Final report prepared by Ernst & Young for APHA, 27 February 2024

The policy intent expressed in the draft framework creates tension between the arbitrary drive for lowest-cost 'efficiency' and the real-world need for the sustainability of free market hospital operations.

A governmental drive for this flawed so-called efficiency to be accomplished by signalling a weighted average activity 'cost' as a proxy for an efficient or equilibrium 'price' can be reasonably viewed as over-reach based on defective understanding and inappropriate data.

It is, moreover, unable to result in the estimation of the actual equilibrium price at which transacted prices are sustainable for both providers and payers. The estimation of an equilibrium price based on a costing process would be inappropriate, unless the cost is robustly adjusted to incorporate all the necessary earnings components that create the margin between the cost and the transactable price for a health service provided in a private hospital.

### 4.1.2 Appropriateness of adopting the average cost

Using average costs as the basis for setting a PNEP is a flawed assumption because it treats historical expenditure patterns as an accurate reflection of efficient care delivery.

Average costs simply aggregate what providers currently spend, which can be influenced by factors such as location, patient complexity, and service mix rather than true efficiency. There are also variances in tax burdens between not-for-profit and for-profit entities that further adds complexities to the equation, for instance, depending on the state, this can equate to a 3% margin.

This means the resulting price would not necessarily represent the most sustainable or clinically appropriate benchmark for the sector as a whole.

Instead of driving improvements, it risks locking in existing cost structures without considering whether they align with best practice or future system goals.

Reliance on averages ignores the diversity of private hospital operations. Hospitals vary in size, specialty focus, and regional context, all of which affect cost profiles.

A single national price based on averages cannot capture these differences and may lead to unintended consequences, such as underfunding hospitals that treat more complex cases or operate in higher-cost regions.

For a PNEP to be meaningful, it must be grounded in a transparent, evidence-based approach that reflects the real price of delivering safe, high-quality care across different contexts, not simply the arithmetic mean of current spending.

### 4.1.3 The 'efficient frontier' approach to focus on the 'best-performing providers'

The proposal suggests adopting a method for setting the PNEP that *"focuses on the best-performing providers after adjusting for case-mix"*.

This is problematic because best-performing providers often operate under unique circumstances that cannot be generalised.

They may have economies of scale, specialised service lines, or geographic advantages that allow them to achieve lower costs without compromising quality.

Smaller or regional hospitals, which face higher fixed costs and less predictable demand, cannot replicate these efficiencies. This does not mean they are inefficient.

Using these outliers as a benchmark risks setting a price that is unattainable for the majority of providers, creating financial pressure that could lead to service reductions or closures.

Additionally, focusing on best performers ignores the diversity of patient populations and operational contexts across the private sector.

Even with case-mix adjustments, factors such as workforce availability, infrastructure costs, and patient complexity vary significantly.

A price derived from the most efficient providers would not reflect the true cost of delivering safe, high-quality care across the system.

Instead of incentivising efficiency, it could penalise hospitals that serve more complex cases or operate in less favourable conditions.

This approach is not only unrealistic but could undermine access and equity in private healthcare delivery.

### 4.1.4 Better outcomes for patients in non-hospital settings

The proposal notes that there are better outcomes for patients in non-hospital settings. We reject this simplistic and uninformed assumption. The assumption that patients always achieve better outcomes in non-hospital settings is faulty because it oversimplifies the complexity of healthcare needs.

Certain conditions, particularly those requiring intensive monitoring, rapid intervention, or multi-disciplinary support, may be better managed in hospital environments. Private hospitals often provide specialised services, advanced technology, and highly-trained staff that cannot be replicated in community settings.

For patients with acute mental health crises, severe medical complications, or those requiring intensive monitoring, hospital environments offer structured care pathways and immediate access to multi-disciplinary teams, which are essential for stabilising health and preventing deterioration.

Suggesting that non-hospital settings inherently produce better outcomes disregards these advantages and risks underestimating the importance of timely, in-hospital interventions. Such an assumption puts patient wellbeing, indeed lives, at risk.

The assumption also ignores patient variability and social determinants of health, including:

- Non-hospital settings rely heavily on stable housing, family support, and access to community services and access to senior and experienced clinicians.

- Patients lacking these supports may experience fragmented care, poor adherence to treatment, and higher risk of complications.

Hospitals, despite being more resource-intensive, can offer structured environments that mitigate these risks.

While non-hospital care can be effective for selected cases, claiming it universally leads to better outcomes, disregards the nuanced interplay between clinical severity, resource availability, and patient circumstances.

Where private hospitals are able to provide out of hospital care, they cannot and should not be excluded from appropriate payment from private health insurers. As this section notes, certain conditions are better managed in hospital environments, where it may be more appropriate for care to be out of hospital, the private hospital provider should be adequately funded to provide immediate care and ensure the continuity of care.

The mantra from the Department appears geared towards driving down costs at the expense of quality, safety and patient outcomes.

APHA has consistently advocated that payment models must reflect the complexity of patient needs and incentivise providers to deliver care in the most clinically appropriate setting, whether in or out of hospital. Failure to provide appropriate funding for private hospitals delivering out of hospital care would create an uneven playing field, limiting patient access to integrated care pathways and reducing competition that drives quality improvements. Without fair funding, private hospitals may be unable to sustain these services, leading to gaps in care and poorer health outcomes for vulnerable patients.

## 4.2 CONCERNS AND RISKS

### 4.2.1 Whole of Sector Concerns

The Draft notes: *"that hospitals must manage dozens of bespoke contracts, each with its own pricing rules, data requirements, dispute processes, and clinical coverage – creating material administrative overhead and increasing the risk of errors or delays in payment"*.

This is true. However, the adoption in the Draft of average pricing that is still subject to contract negotiations, as opposed to the original intent of the PNEP of a floor price with annual indexation, does nothing to resolve these issues.

Similarly, the Draft makes the point that: *"hospitals and funders lack a shared, consistent benchmark for evaluating cost efficiency or service appropriateness"*. However, whichever average pricing regime is adopted, this average guide is unlikely to change the nature or timeframes of contract negotiations.

The Draft further asserts: "*that price signals are blurred, diminishing the ability of the system to reward safety, quality, innovation, or value, and enable continued investment in the sector"*. The APHA agrees. However, it is not made clear, at any point in the Draft, how or if any of these important considerations are to be incorporated into the PNEP.

The Draft goes on to make two further points without connecting them.

- It cites *"operating costs [for hospitals] are rising, driven by wage growth, inflation in medical supplies and technology, and increased regulatory requirements"*.

- The very next line states: *"Revenue growth has lagged, with private health insurers managing premium growth tightly and patient out-of-pocket costs becoming a growing affordability issue"*.

Both statements are true. Yet, there is no recognition in the Draft that:

1. Health insurers are recording record profits averaging almost $2 billion a year for the last four years.

2. Health insurers increased their management fees by 18% in 2023-24, to reap $3.4 billion a year from annual premiums.

3. Hospital insurance policies with exclusions, restrictions or limitations have exploded over the last five years by 30%, to a record 69.5% of people covered requiring patients to pay hefty out-of-pocket costs – sans surgeon, anesthetist or similar fees.

These issues are tangible and directly germane to the viability of private hospitals and the value of private health insurance related to out-of-pocket costs. That they fail to rate a mention in the Draft or the funding model for any PNEP, is disturbing.

It, therefore, seems a deliberate focus to place all the onus on hospitals as providers and none on health insurers as funders, of private healthcare.

### 4.2.2 Efficiency and Innovation

The statement in the Draft that *"efficiency and productivity are incentivised"*, noting that *"hospitals are encouraged to deliver care at the lowest cost possible without compromising quality and safety"* raises concerns about departmental understanding of how hospitals operate.

Hospitals do this as a matter-of-course, but must also invest in new technology, devices, equipment, and services to bring the latest and best treatments to their patients. How will the Department quantify this endeavour under the proposed PNEP? The Draft does not, in any way, address this.

Again, the fundamental misunderstanding of the sector is laid bare in the Draft comment that: *"the funding system also promotes the delivery of care in the most clinically appropriate and cost-effective setting"*. Determination of what is the most clinically appropriate setting and treatment is not a matter for hospitals to decide; it is a matter for doctors and their patients.

The PNEP is designed to drive so-called efficiency by forcing private hospitals to deliver care at the lowest cost possible. While this focus on technical efficiency is intended to reduce waste and align funding with the cost of care, it inherently prioritises cost reduction over other factors, such as innovation aimed at creating value based on consumer benefit.

This approach risks disincentivising investments in innovative technologies, advanced treatments, and patient-centred care models that may initially be more expensive but offer long-term benefits to patients and the healthcare system.

The drive for efficiency based on cost containment could force hospitals to focus on meeting the benchmarks set by the PNEP, which are based on average or efficient costs. This may discourage hospitals from adopting new technologies or innovative care models that do not immediately align with the PNEP.

Patients would be the losers and the value of private health insurance undermined.

For example, the inclusion of medical devices in the PNEP pricing model is intended to reduce costs and streamline processes, but it would likely lead hospitals to limit the range of devices available to

clinicians, thereby restricting patient access to cutting-edge treatments. As such, the Department's approach is likely to compromise patient outcomes.

This is particularly concerning in a sector that prides itself on innovation and patient choice.

Moreover, the focus on cost efficiency may inadvertently create a 'race to the bottom', where hospitals are forced to prioritise cost-cutting measures over investments in quality and innovation.

This could undermine the private sector's ability to differentiate itself from the public sector by offering superior patient experiences, advanced treatments and technologies, and innovative care models.

The Draft acknowledges this risk and proposes adjustments to the PNEP to account for safety and quality outcomes, such as sentinel events, hospital-acquired complications, and unplanned readmissions.

However, these adjustments must be robustly risk-adjusted and empirically derived to ensure they do not inadvertently penalise hospitals for investing in innovation.

**RECOMMENDATION:** To mitigate these risks, the PNEP must be designed to balance efficiency incentives with support for innovation and value-based care. At present, it fails to recognise this need.

This includes incorporating mechanisms to reward hospitals for adopting evidence-based technologies and care models that improve patient outcomes, even if they are initially more costly.

The document suggests that pricing should respond in a timely way to the introduction of effective new technologies and innovations, but it does not provide any specific details on how this will be achieved. Clear guidelines and processes for evaluating and incorporating innovation into the pricing model are essential to ensure that the PNEP supports, rather than stifles, the private sector's capacity for innovation.

### 4.2.3 Hospital Funding

While the Draft recognises the need for patients to be at the centre of the private hospital system, noting access and choice as primary concepts, nowhere in the paper or in the operation of a proposed PNEP is there any suggestion of how this will be funded.

Cost profiles are mentioned, however, without a much higher benefits ratio from insurers than the 84% recorded in the last two financial years of 2023-24 and 2024-25, these will suffer under a PNEP.

Further the Draft states *"innovation is critical and must be supported"*. Again, the Draft contains no detail on how this is to be supported under the PNEP. In fact, the paper seems to maintain that the existing funding profile remains the same and is simply redistributed based on average costs.

Private hospitals have long been Australia's leaders in introducing state-of-the-art procedures, Australia-first equipment and technology and revolutionary treatments and services to patients.

Yet, without the funding pool growing, the existing viability and investability issues remain, let alone provide for this investment which, in most cases, is unlikely to be possible. The result would be an homogenous healthcare offering that dwindles in quality over time and falls below the expectations of private patients and those paying for private health insurance.

### 4.2.4 Medical Devices

The suggestion to include medical devices in the PNEP pricing model is presented as a solution to reduce costs and streamline processes. However, the Draft itself highlights significant risks, such as the potential for private hospitals to limit the range of devices available to clinicians, which could compromise patient care and innovation. The inclusion of medical devices also requires private hospitals to invest in procurement strategies, which could increase their operational complexity and costs, contradicting the stated goal of reducing administrative burdens.

While the framework aims to address systemic inefficiencies and challenges in the private hospital funding system, several ideas, conclusions, suggestions, and comparisons within the document can be considered illogical or problematic when analysed critically.

While the proposed PNEP and Pricing Framework aim to address critical issues in the private hospital funding system, several aspects of the document's ideas, conclusions, and suggestions appear overly ambitious, inconsistent, or inadequately thought through. The document's language often assumes that the proposed solutions will seamlessly resolve complex challenges without fully addressing the potential risks, trade-offs, and implementation difficulties.

The proposition that the PNEP will simultaneously reduce administrative burdens, align funding with actual costs, and preserve the private sector's strengths, such as patient choice and innovation, is overly ambitious and not rooted in reality.

The draft framework acknowledges the complexity of the private hospital sector, with its diverse payer mix, clinical pathways, and contractual arrangements, yet it suggests that a single pricing model can resolve these multi-faceted issues without introducing additional government funding.

This assumption is overly simplistic and optimistic given the inherent challenges in achieving consensus among stakeholders with conflicting priorities.

### 4.2.5 Capital

The Draft mentions including capital expenditure in the PNEP, and even states *"including capital in the PNEP is critically important"*, but nowhere does it detail how.

Unlike public hospitals where the taxpayer simply foots the bill for infrastructure, resourcing, technology and the like, private hospitals must fund these themselves.

If capital costs are excluded, the price benchmark (PNEP) would only cover operating expenses (staff, consumables, utilities), ignoring the cost of maintaining and renewing assets. This creates a distorted view of the actual cost of care and could make private hospitals even less financially sustainable.

Without genuine capital consideration, private hospitals might underinvest in modern facilities or technology, reducing quality and competitiveness. It could also lead to cross-subsidisation, where hospitals rely on higher charges for other services to cover capital costs. However, the operation of a PNEP would prevent this by proposing average costs. It becomes a no-win situation for hospitals and their offerings to patients.

Public hospitals have capital funded externally, so their cost base looks lower. If private hospitals are benchmarked against that without adjustment, the comparison is inherently wrong and unfair.

Including capital ensures a level playing field when setting a national price.

An approach that considers the Weighted Average Cost of Capital and depreciation may be helpful in incorporating capital into the establishment of a more accurate PNEP.

APHA encourages the Department to conduct more substantial work and engage in comprehensive consultation with private hospitals to better conceptualise and incorporate 'capital' into the proposed framework and methodology of calculation of a PNEP.

### 4.2.6 Safety and Quality

The Draft deals solely with adverse incidents in private hospitals and seeks to penalise them. However, at no point does it cite how the proposed PNEP incentivises excellence in clinical outcomes, nor the adoption of ground-breaking care, treatments or procedures.

This section of the Draft takes a distinctly punitive approach to private hospitals but fails to demonstrate how the pursuit and achievement of excellence is to be rewarded via, for example, higher rates from health insurers.

### 4.2.7 Use of the Private Weighted Activity Unit (PWAU)

The Draft proposes the adoption of a single unit of measure, the Private Weighted Activity Unit (PWAU), for the private hospital funding model.

Despite the Draft acknowledging that the public and private weighted activity units will not be directly comparable, it nonetheless adopts an approach intended to facilitate benchmarking and comparison against the public sector.

This raises concerns about the utility of the PWAU as a benchmark, given the significant differences between the public and private hospital sectors.

### 4.2.8 Revenue Shocks and Financial Strain

The Draft also highlights the risk of revenue shocks and the need for transitional funding, which contradicts the claim that the reform can be implemented without additional government funding.

The most significant problem with implementing the Private National Efficient Price (PNEP) lies in the risk of financial instability for all private hospitals regardless of size or geographic location. The PNEP aims to establish a consistent, evidence-based benchmark for pricing private hospital services, but the transition to this new pricing model could create revenue shocks and financial strain for hospitals that currently operate with cost structures above the so-called 'efficient price'.

This is compounded by the sector's existing challenges, such as rising operating costs, workforce shortages, and the reliance on systemic cross-subsidisation to sustain low-margin services.

The draft policy proposal acknowledges that the private hospital sector is diverse, with varying business models, payer mixes, and clinical pathways.

A single pricing model, such as the PNEP, may not adequately account for these differences, potentially disadvantaging certain hospitals. For example, smaller or regional hospitals may face higher costs due to location-based factors, limited economies of scale, and workforce challenges.

If the PNEP is set at an aggressive pricing level, such as below the actual cost, it would exacerbate financial pressures and threaten the ability of these providers to remain in operation.

Economically, the absence of robust and consistent cost data across the private hospital sector is a critical gap. The current fragmented funding system lacks a shared benchmark for evaluating cost efficiency, which complicates the establishment of a reliable PNEP.

Additionally, the diversity of private hospital business models, payer mixes, and clinical pathways makes it difficult to set a single price that accurately reflects the cost of care across all providers.

The risk of revenue shocks is significant, particularly for smaller and regional hospitals that may struggle to meet the efficiency benchmarks set by the PNEP.

**RECOMMENDATION:** To mitigate these risks, the PNEP must initially be set at the floor price to meet the cost of delivering services, with adjustments for legitimate cost variations such as location-based factors, facility-related factors, case mix and patient characteristics. We further encourage the Department to consider and develop mechanisms to fund revenue shocks and financial strains that may arise as a result of the application of the PNEP.

### 4.2.9 Timeline

The phased implementation plan for the PNEP is described as *"deliberately ambitious"*, yet the document acknowledges the need for extensive data improvements, stakeholder engagement, and technical capacity building.

The timeline for implementation may be wholly unrealistic, given the challenges associated with data collection, quality assurance, and the development of a robust pricing model.

The Draft suggests:

- Phase 1 – Develop an indicative PNEP by 1 July 2026
- Phase 2 – Determination of comprehensive PNEP by 1 July 2027
- Phase 3 – PNEP replaces Default Benefits from 1 July 2028

This is insufficient time for government to adequately consult with stakeholders and incorporate feedback received into a comprehensive, reasonable, and well-informed PNEP.

That it has taken the Department 18 months, including the 12-month CEO Forum, to arrive at a point where the proposed PNEP poses more problems than solutions, demonstrates critical gaps, obvious omissions and false assumptions, yet asserts such a timeline is cause for concern.

Any implementation consideration must be underscored by best practice consultation and the development of a detailed impact assessment under the rules and requirements provided by the Office of Impact Analysis at the Department of Prime Minister and Cabinet.

Attempts to circumvent due process and fairness will only undermine the legitimacy and efficacy of the proposed changes.

### 4.2.10 Margin Repair

APHA is further concerned that in excluding or omitting any discussion on the inclusion of margins in the development of a PNEP, the Department has also not considered the matter of margin repair for the private hospital sector.

Previous sections of the Draft have provided data on the critical current viability issues being faced by private hospitals. Margins are in the negative for the overall sector, which means that margins have also been severely damaged. Consideration of a PNEP cannot solely focus on what is yet to come, it must also support the alleviation of current challenges.

The absence of a clear framework for margin repair risks perpetuating financial instability within the private hospital sector. Without targeted measures to restore profitability, hospitals may be forced to reduce services, delay capital investments, or compromise on quality of care. These outcomes would not only undermine the sustainability of private hospitals but also place additional pressure on the broader health system, which relies on private providers to complement public services.

A comprehensive PNEP must, therefore, recognise the interconnectedness of future pricing structures and current operational realities.

In addition, addressing margin repair is essential to maintaining workforce stability and patient access. Private hospitals are significant employers, with the Australian Bureau of Statistics reporting this year of 155,000 direct employees in private hospitals, and play a critical role in delivering timely care.

If financial distress continues unchecked, staff retention and recruitment will suffer, leading to longer wait times and reduced capacity for elective procedures. By incorporating strategies for margin recovery into the PNEP, the Department can help ensure that private hospitals can be viable partners in achieving national health objectives, safeguarding both patient outcomes and system resilience.

# 5.0 Additional Considerations

## 5.1 COMPETITION CONSIDERATIONS

APHA encourages the Department to collaborate with the Australian Competition and Consumer Commission (ACCC) as a PNEP will have impacts on competition in the sector. As the national regulator for competition, the ACCC's involvement in the development of an impact analysis and in a more structured framework, will be paramount.

## 5.2 WHOLE-OF-ECONOMY CONSIDERATIONS

APHA also encourages the Department to consult with the Department of Industry, Science, and Resources (DISR) on determining the PNEP because pricing in the private health sector is not purely a clinical or funding issue, it is deeply connected to broader industry dynamics.

Private hospitals operate within a competitive market that is influenced by factors such as workforce availability, supply chain costs, technology adoption, and regulatory compliance.

DISR has expertise in these areas and can provide insights into cost structures, market pressures, and investment requirements that affect the sustainability of private healthcare providers. Setting a PNEP without considering industry perspectives and whole-of-economy factors risks creating a benchmark that is disconnected from the economic realities of the sector.

For example, capital costs for advanced medical equipment, compliance with industrial regulations, and workforce training programs are significant drivers of private hospital expenses. These are not captured by clinical case-mix adjustments alone.

Collaboration ensures that the pricing model reflects both health system objectives and the operational viability of private hospitals, supporting a balanced approach that promotes efficiency without compromising quality or access.

## 5.3 UNINTENDED CONSEQUENCES CONSIDERATIONS

The implementation of the PNEP must address the risk of unintended consequences, such as gaming, inappropriate rewards, and perverse incentives. The Draft highlights the importance of transparency, evidence-based decision-making, and stakeholder engagement in the development of the pricing model.

It also emphasises the need for adjustments to account for safety and quality outcomes, such as sentinel events, hospital-acquired complications, and unplanned readmissions. These adjustments must be empirically derived and risk-adjusted to ensure fairness and equity in the pricing model. At present, the Draft fails to account for any of these factors.

# 6.0 Conclusion

## 6.1 GENERAL CONCLUSION

The Draft raises more problems than solutions to the viability and investability of private hospitals.

It reneges on the earlier promise of a floor price, with guaranteed annual indexation. We fear, based on the Draft, that it has morphed into a race to the bottom to drive down costs, with quality, safety and value as casualties. The lack of detail on costing versus pricing makes any positive assessment of the proposed PNEP impossible. The APHA would want to see detailed modelling of its application to make an informed decision.

Similarly, our members would expect such modelling to precede the introduction of such a radical plan. The Department's recognition, in briefings, that there will be winners and losers under any PNEP and that compensation would be forthcoming, is not canvased in the Draft. This needs to be addressed.

That the Department expects to have Phase 1 ready by 1 July 2026 is concerning given the scant detail provided to date. That the Draft makes no call on private health insurers as the major funders of private healthcare, is conspicuous and unsettling.

The Draft, as presented, places all of the burden on costs for care, investment, quality, safety and innovation on private hospitals but without a corresponding responsibility from private health insurers to acknowledge these features, let alone adequately fund them.

As such, we are concerned the Draft seeks to drive down costs without due regard to quality, safety, patient needs or clinical outcomes, over the high quality, innovative and patient-focused private hospital system patients expect. This is especially the case for patients with private health insurance, who rightfully expect choice, access, quality and timely treatment as cornerstones of the value proposition for their annual premiums.

## 6.2 USE OF THE PNEP

The Draft states: *"In its most basic form, a robust Private NEP would allow for improved benchmarking of costs, provide an external reference point for contract negotiations between private hospital operators and insurers and other payers"*.

This is a serious and concerning departure from what a PNEP was understood to provide and potentially presents a fatal flaw. This statement makes it clear that health insurers will still be able to impose their market dominance over hospitals to continue forcing contract rates below any so-called average.

The PNEP will only go as far as informing contract negotiations, and negotiations will run their course having the PNEP as a benchmark of costs that need to be covered in contracted prices.

This makes the continued low balling by health insurers implicit. As such, it would fail to address the viability or investability of private hospitals.

Further, stakeholders were led to believe that automatic annual indexation would be a feature of the PNEP, yet it is not mentioned in the Draft.

## 6.3 THE IDEAL SITUATION

The ideal situation for private hospitals would be one where the funding system is reformed to address the current fragmentation, inefficiencies, and lack of transparency, while preserving the sector's strengths such as patient choice, clinical independence, and innovation. This would involve the implementation of a nationally consistent, transparent, and evidence-based pricing framework, anchored by the PNEP.

Economically, this would see the establishment of a robust reference price that aligns funding with the actual cost and complexity of care. This would eliminate systemic cross-subsidisation, where hospitals rely on high-margin services to subsidise low-margin ones, and promote allocative efficiency by incentivising care delivery in the most clinically appropriate and cost-effective settings. The PNEP would also provide a shared benchmark for evaluating cost efficiency and service appropriateness, reducing adversarial contract negotiations and enabling strategic investment in the sector.

Implementation would involve the adoption of consistent classification systems across all private hospital services, such as AR-DRG for acute care, AN-SNAP for subacute and non-acute care, and AMHCC for mental health services.[10] These systems would ensure that clinical activities are grouped based on resource requirements, enabling precise cost calculations and transparent pricing. The collection of robust patient-level cost data through an expanded National Hospital Cost Data Collection (NHCDC) would further support the development of an accurate and reliable PNEP.

The ideal situation would ensure the financial sustainability of private hospitals by incorporating both operating and capital costs into the pricing model. This includes costs associated with depreciation of assets and capital investment, which are critical for funding the replacement, maintenance and expansion of infrastructure.

Logically, the ideal situation would reduce administrative burdens by replacing the current default benefit regime with the PNEP, simplifying contract negotiations and providing a legislated mechanism for non-contracted hospitals to receive payment for treating insured patients. The PNEP would also enhance transparency and accountability in the private hospital sector, providing reliable data on hospital costs to inform broader policy and regulatory settings, such as health insurance premium adjustments and risk equalisation processes.

In summary, the ideal situation for private hospitals would be one where the PNEP is implemented as a transparent, evidence-based pricing benchmark that addresses systemic inefficiencies, supports financial sustainability, and promotes equitable access to high-quality care. This would enable the private hospital sector to continue delivering innovative, patient-centred care while maintaining its long-term viability in a rapidly evolving healthcare landscape.

## 6.4 NEXT STEPS

There remains a significant amount of work that the Department needs to do before finalising, or for that matter, even putting in place a strict timeline for the development and implementation of a potential PNEP. Government, as a whole, must consider the nuances, the nuts and bolts, if you will, of a PNEP, carefully analyse its current and future impacts, and ground policy in evidentiary data.

The Commonwealth must, in the interim, legislate to put in place a return ratio on premium dollars and work to develop and implement a code of conduct for the private health sector to ensure fairness, consistency, transparency, and accountability in private health insurer conduct. APHA has

[10] We note that the shift from MBS based funding is significant especially for day surgery care, and as such requires careful consideration and implementation by government.

advocated for both these initiatives as commonsense policy that is easy and relatively quick to implement and that will have positive impacts on patients, private hospitals, and the Australian healthcare landscape.