Private Healthcare Australia
Better Cover. Better Access. Better Care.

Draft Pricing Framework for Australian Private Hospital Services

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have more than 20 registered health funds throughout Australia as members and collectively represent more than 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for more than 15 million Australians.

Introduction

PHA welcomes the opportunity to work with government, consumers and providers to explore options for a national efficient private price. This is a welcome debate, as the current approach to hospital contracting has failed to provide best-value health care to consumers with private health insurance.

Consumers need affordable access to high-quality and high-value health care. Hospital viability depends on consumers being able to afford private health insurance – if premiums are too high, people will drop their insurance, and hospitals will have fewer patients. Thus, it is imperative any changes to hospital funding models are only made after careful examination of the effects on consumers and the premiums they pay. Any new system that increases the price of care to consumers will be self-defeating.

PHA's submission will cover the key issues that need to be addressed to transition to a potential private national efficient price, including:

- **Affordability for consumers**: The key requirement for system viability – both public and private – is that consumers can afford private health insurance. Any reforms that increase prices for consumers will not serve the system objectives. A private national efficient price should drive efficiencies.
- **Value versus cost**: Consumers need value from their health care. Most health systems are shifting focus to consumer value and health outcomes rather than provider costs as a basis for funding. A private national efficient price provides an opportunity to incentivise high value care, rather than continuing to embed low value care on a cost-plus model.
- **Transparency**: Greater transparency will lead to better decisions for providers, funders and consumers.
- **Modelling consumer impacts**: The draft paper provides options without any modelling on consumer impacts. Modelling is vital to ensure consumers, governments, payors and providers understand the full impacts of reform options.
- **Including medical devices**: The high cost of many medical devices in Australia is driving inefficiencies and costing consumers millions of dollars each week, fuelling supernormal profits for overseas medical implant and surgical supply companies. A PNEP should ensure high-value devices are easier to access for consumers, particularly where the device may decrease length of stay or otherwise improve consumer outcomes.

- **Private sector contracting improves patient outcomes:** The development of a PNEP should facilitate private sector bargaining and contracting to ensure benefits to consumers are maximised. This will include greater consistency and standardisation of some terms and conditions, allowing hospitals to be compensated for continual quality improvement through contracting.
- **Incentivising continual improvements**: A PNEP set at the existing average prices locks in old-fashioned care models and increases costs to consumers. A truly efficient PNEP will incentivise providers to look at improved models of care, better outcomes and improved value for consumers.

Hospitals must evolve to meet community expectations and modern models of care. Our health system was set up in the 1970s, when acute care in hospitals was the norm. Today, millions of Australians live with chronic conditions and require more home- and community-based services. Locking in outdated, capital-intensive hospital models that can be disempowering and inefficient is neither sustainable nor desirable.

We need to modernise health care and focus on patients in the context of their lives, rather than maintaining a provider- and facility-centred system. Ensuring the viability of every hospital is not the goal; ensuring our provider network aligns with community needs is.

A PNEP can help move our health funding system towards a more effective, efficient and higher quality system if designed with a future-focus based on modern clinical guidelines and consumer expectations. This will require significant adjustments from all stakeholders. Health funds are ready to lean into a modern fit-for-purpose system on behalf of the 15 million Australians with private health insurance.

A strong, more efficient and effective private health system will help buttress the public system, improving access to healthcare for the entire community.

Background

The most pressing issue for private health insurance consumers, as shown by several recent studies, is cost-of-living pressure – particularly the cost of premiums and out-of-pocket expenses.

These pressures have both direct and indirect impacts on private hospital viability. As household budgets tighten, more consumers are choosing health insurance policies with additional exclusions, and the proportion of members holding Gold cover has steadily declined over recent years. Out-of-pocket costs for specialist consultations are also suppressing demand: around 30% of people referred to a specialist do not attend due to cost, meaning fewer patients are being assessed for planned hospital admissions. At the same time, more private patients are receiving care in public hospitals, further reducing demand for private facilities.

Overall, private hospital occupancy is low, albeit with significant variations. There is an oversupply of private hospital beds in many parts of the country. Clinical practice has also evolved, with more procedures shifting to day surgery in line with best practice, and marginally

lower lengths of stay for inpatient procedures. However, legislated minimum benefit requirements keep lengths of stay artificially high in some areas, and Australia underutilises lower-acuity, safer facilities that are common overseas.

For many hospitals, the lack of occupancy is the critical threat to viability. Hospitals carry high fixed costs – significant infrastructure, support services, and minimum staffing levels – meaning lower activity forces each patient to bear a higher share of those fixed costs. High-fixed-cost businesses require strong throughput to remain profitable, and in extreme cases, no amount of per-patient funding can offset the financial consequences of chronically low occupancy.

Hospitals are also facing rising cost pressures, including higher wages for nurses. Healthcare has not been immune from inflation, and the costs of delivering care is now significantly higher than it was just a few years ago.

Despite these rising costs, productivity has not improved. Both public and private hospitals are treating patients at a higher cost per episode. With consumers' capacity to pay declining, improving productivity is essential to maintaining affordable care.

Workforce constraints continue to limit hospitals' ability to lift productivity. Expanding scope of practice – for example, enabling nurse practitioners to bill Medicare – offers a short-term opportunity, but most workforce reforms will take years to have an impact.

Consumer expectations have also changed. Post-COVID, consumers are more used to telehealth, community-based care, shorter lengths of stay and hospital services being provided in the home. Despite the demand for healthcare changing, hospital capacity has not adjusted.

Australia's absurdly generous reimbursement scheme for medical devices further distorts the market. Every dollar shipped overseas in supernormal profits for multinational device companies is a dollar not available for domestic health spending. Reducing the costs of medical devices to no more than New Zealand would save Australians over $300 million per annum.

Our high device prices also distort care choices. Australians are much more likely to have a knee replacement than New Zealanders, British, Canadian or European patients. The data in the draft report show procedures with high quantities of implanted devices are much more profitable for hospitals than procedures such as plastic surgery involving mainly suturing, or obstetrics.

The draft report also highlights many structural inefficiencies, including in contracting between health funds and hospitals. While there are many issues correctly identified in the paper, the draft report overstates the extent of the problems for private hospitals in negotiating contacts.

There are seven buying groups covering 29 health funds, so the suggestion health funds are each negotiating their own contracting and pricing arrangements with private hospitals is incorrect. Health funds need to manage scores of contracts with hospital groups and individual services, so reducing the administrative burden will also improve efficiencies for health funds and their members.

There are many areas where improvements can be made. The draft paper identifies several of these, and PHA has previously highlighted other areas where structural or legislative adjustments can improve productivity, effectiveness and quality of care. A PNEP has the potential to address many of the issues affecting the sector, but it is incumbent on all actors to seek continual improvement.

Response to the proposals

Fundamental Principles, Process Guidelines and System Design Guidelines

The fundamental principles in the draft report are not consistent and not agreed. We must prioritise patient access and quality care rather than the financial viability of individual private businesses.

Patients need access to good health care, but the guiding principle should be "right care, right place, right time." Health systems in Australia and internationally are seeking to reduce clinical risk to patients, keep people connected to their support networks, and deliver care in more comfortable and appropriate settings. While hospitals remain essential, many services can now be safely and effectively provided in outpatient environments or and in people's homes.

PHA agrees that patients must be at the centre of the health system. We also agree that patient choice is fundamental to the private sector. However, we disagree that this choice can only be exercised in private hospitals. A hospital-centric approach does not reflect modern clinical evidence, emerging patient preferences, or the directions being pursued in public health systems and comparable international models.

PHA also agrees that innovation must be supported, and efficiency and productivity should be incentivised.

These key points – especially that funding should support care in the most clinically appropriate and cost-effective setting – are inconsistent with the claim that the financial sustainability of the entire private sector is critical.

A viable hospital sector is essential, and services must remain affordable for consumers. However, PHA disagrees that every hospital operator and funder must be financially viable. Innovation is key to improve patient outcomes, and some private businesses will not survive the transitions required.

Further, the current policy settings – in particular default benefits - have resulted in old-fashioned care models and an oversupply of hospital beds in some geographic areas, while other areas are crying out for services. A structural adjustment is needed to ensure equitable access for all Australians. This may require more active intervention in the hospital market by state, territory and federal governments.

With the necessary changes to the fundamental principles, the Process Guidelines and System Design Guidelines are agreed.

A transparent and independent price

Transparency is critical to developing a trusted national price that is both efficient and provides value to consumers. Currently, hospital operations lack visibility, with no consistent understanding of care costs, management expenses, capital costs, or returns on investment. For example, the costs of providing services, such as call centre staff, are highlighted in private health fund statistics captured by the Australian Prudential Regulatory Authority (APRA), but private hospital groups' head office costs remain opaque.

While these cost drivers are important, it is also vital the outcomes of care are properly captured. This will require judgements on the value of care to the community.

A cost-plus model bakes in old-fashioned care, rather than driving value. Health systems around the world are working towards increasing value, with value-based care models supported by many consumer groups, health funds, the medical device and pharmaceutical industry groups, and governments worldwide.

The PNEP has the potential to not just make existing models more efficient, but to influence change in models of care to improve value. For example, high value procedures such as cataracts should be promoted by a PNEP model, while procedures that are known to promote low value care, such as spinal cord stimulators, should be discouraged. A cost-plus model as envisaged by the draft paper does not promote value and instead reinforces low-value care models in the private system.

So, in addition to properly capturing cost indices, the PNEP should also look to capture measures of value to develop a transparent, independent price. Failing to do so will result in a PNEP simply reinforcing low value care. We need to embrace the changes with a PNEP to drive higher quality, higher value care.

The scope of services eligible

PHA is disappointed the private sector has not embraced home- and community-based care to the same extent as the public system, let alone comparable countries. While health funds can accept some of the responsibility, the hospital-based model is underpinned by Australian Government regulations that include a very generous floor price for hospital services. PHA has previously recommended removing this floor price to promote innovation. Simply replacing the existing second tier default benefits regime with a PNEP based on existing practice will not do enough to promote out of hospital care.

A true efficient price can drive innovation and better care. To do this, the PNEP must be set at the actual efficient price. For example, the PNEP for services that have an out of hospital care component, should be set at that lower out of hospital care price, rather than the average. An average price just locks in the existing care pathways. The price should be based on the most efficient model.

Any proposal for a PNEP should actively encourage newer models of care with better clinical outcomes and lower burden for patients, such as those with fewer invasive procedures. For example, our system should encourage conservative management of knee pain including weight reduction and exercise options rather than incentivising knee replacements as a first-line solution. There is an historic opportunity to recentre our health system based on value to the consumer, rather than cost to the provider. It would be disappointing if this opportunity was squandered.

Classification systems for a Private National Efficient Price

PHA supports the proposed classification systems as the base costings for a PNEP and recommends quality and value adjustments be included. However, newer AR_DRG versions can occasionally have bugs, which can distort the price. For example, health fund consumers were required to pay tens of millions of dollars in additional payments to hospitals when IHACPA included a DRG for any person who had ever had COVID. This made no difference to care, yet increased costs. IHACPA subsequently revised the DRG to remove the anomaly.

PHA supports the proposal that AR-DRG V11.0 should be reviewed to identify any DRGs that may need further refinement to reflect private sector service delivery. This should be a transparent process.

The more important task is to determine the value of an intervention, not just its cost. The medical literature clearly identifies high-value interventions that are not widely available due to underfunding. There is also clear evidence in Australia of interventions that are over-used, predominantly associated with high-cost medical devices (in countries that do not reward devices so generously, doctors make different decisions). Maintaining high prices for high cost and low value procedures harms allocative efficiency and means resources cannot be shifted to higher-value interventions or to underserviced populations.

Data requirements

Data on private hospital costs are currently poor and non-transparent. Some hospitals many not even know their own internal costs, so improved data collection cannot rely solely on existing records to help determine a PNEP. Yet such data is vital for properly implementing a PNEP. If the private hospital sector, or parts of it, are unable or unwilling to provide accurate data, they should not be eligible for legislated benefits from health funds.

PHA supports work to streamline data collection between agencies, with a view to consolidating data and reducing compliance costs rather than reducing the quality of the data collected. However, the larger challenge is to collect data from all hospital providers that can inform the cost base of the most common medical procedures.

A partial data collection is not acceptable – every hospital must report. The Department's Private Hospital Viability Check was severely compromised with an unrepresentative sample of hospitals reporting data. This cannot be allowed to occur with the data to inform a PNEP. All

health funds are required to provide data, so it is not unreasonable for all hospitals to have to provide data. This should be the bare minimum requirement for any legislated funding model (including hypothecated government funding through the Private Health Insurance Rebate).

While the technical difficulties in collecting data from all hospitals should not be underestimated, it is both possible and worthwhile to ensure data collections are complete to inform a PNEP.

However, as previously noted, cost-based approaches are insufficient. A PNEP must include measures of value to ensure consumers receive high-value care. An agnostic, cost-based approach will not promote high-value care or efficiency. Nor will it ensure the right care is delivered at the right time in the right place.

The PNEP should also look at comparative data from the public sector and other jurisdictions to see what is possible in terms of efficiency. For example, most states and territories are able to provide more extensive hospital in the home services; these should be used to set the efficient price, rather than solely relying on data from the private hospital sector where lengths of stay are longer for many procedures.

PHA supports the proposals that the scope of the Private Sector National Hospital Cost Data Collection (NHCDC) should be widened to include day hospitals. Consideration should be given to redirecting current incentive payments for providing these data from overnight hospitals to day hospitals to support capacity building in the day hospital sector.

As hospitals are afforded legislative privileges for minimum pricing through legislation, PHA supports the proposal that the Minister for Health and Ageing mandate participation in the Private Sector NHCDC as a condition of being declared a Private Hospital under the *Private Health Insurance Act 2007*.

PHA does not support legislative privileges for a minimum benefit being afforded to hospitals that choose not to participate in data collection, so the proposal IHACPA determines a minimum participation rate for day hospitals to ensure the Private NHCDC is representative of the entire sector becomes irrelevant.

Quality of care measures

The draft paper seems to assume the quality of care provided by private hospitals is uniform. While PHA notes most care in the private sector is very high quality, it is not uniform. The quality measures identified in the paper are split between two sections, which are consolidated here.

In addition to the minimum frameworks currently existing in the private hospital sector, contracting with health funds has been important to improve the quality of care from a patient and consumer perspective.

The existing frameworks include some crude measurements, such as hospital acquired infections, readmission rates and sentinel events, in addition to an accreditation system. These are necessary, but insufficient to drive sustained quality improvement.

Some other measures that private hospitals and health funds can employ in contracting include promoting clinical excellence and protecting consumers from financial exploitation.

There are a range of modern clinical standards that should become more prevalent in the private system. Some of the improvements in clinical and workplace standards that should be encouraged through contracting (or as a requirement for default benefits) include:

Clinical independence

All hospital contracts should declare that clinical independence will not be compromised for commercial reasons. Clinical guidelines will be adhered to, unless the treating medical practitioner determines it is reasonable and necessary to do otherwise and is prepared to document this.

Using MyHealth Record

All private hospitals should ensure any procedures or care provided on behalf of the hospital are summarised in a patients' MyHealth Record. This includes ensuring the details of any medical devices implanted in a patient at a hospital's premises is detailed in MyHealth Record, including the Unique Device Identifier (UDI).

Providing discharge summaries to general practitioners

All private hospitals should ensure both hospital and medical discharge summaries, including procedures undertaken, are provided to a patient's general practice within a reasonable timeframe to ensure continuity of care post-discharge.

PHA notes the hospital does not hold contracted doctors' medical records so cannot send a medical discharge summary. However, PHA recommends that hospitals require their contracted medical practitioners send discharge summaries as a condition of credentialling.

Promoting gender balance and diversity in contracted medical staff

Consumer access to health care is compromised by a lack of gender balance and cultural diversity for doctors. Hospitals should be required to have plans to improve their capacity to provide services to all parts of the community.

PHA acknowledges hospitals are not responsible for the actions of medical colleges and others that have resulted in a lack of gender balance and cultural diversity. However, PHA recommends that hospitals have plans in place regardless, to assist their communities to access care from a range of practitioners wherever possible.

Occupational health and safety

Hospitals should have strong procedures to ensure the health, safety and welfare of patients and staff, including independent medical consultants, trainees and other staff.

Supporting clinical registries

Clinical quality registries promote better health care. Hospitals should require their medical consultants to contribute to registry data as a condition of contract.

Sustainability – reducing impact on environment

Hospitals should have policies and procedures in place to reduce negative impacts on the environment from emissions and waste. Every instance of low value care has not only an impact on cost to the consumer but also has a substantial, negative impact on the environment.

Patient reported measures

Over time, it is likely that experience and outcome measures such as PREMs (Patient-Reported Experience Measures) and PROMs (Patient-Reported Outcome Measures) will be required under contracts with health funds. A consistent and standardised application of experience and outcome measures will enable contracting discussions to transition faster to being patient focussed.

Develop and maintain industry standards

In previous years, hospitals and health funds worked together with clinical advisers on industry standards that helped promote mutual understanding. Examples include rehabilitation and mental health. Published guidelines enabled standard and referenced contractual clauses and mutual understanding. These processes fell into disuse for a range of reasons but could be reconsidered with departmental oversight and processes to manage competition issues.

Financial protections

Hospitals are private businesses that provide services to patients as well as to individual contractors, such as surgeons, anaesthetists and physicians. As hospitals credential medical practitioners and other non-employed staff (such as medical device sales representatives), hospitals should be encouraged to ensure all their operations, and those conducted on their premises, are transparent.

Ensuring accuracy in billing and record-keeping

There should be a strong focus on accurate billing. Funds want to have confidence they are paying the right amount. Hospitals and funds should be working to ensure the right bill is provided quickly and paid promptly.

However, funds report significant difficulties with some providers. For example, there are hospitals who bill codes in the interests of getting the claim processed quickly and then resubmit later with adjustments. This requires rework with funds.

There are significant error rates from some providers, and difficulties recovering monies. There are providers who are known to withhold records or make it challenging to get access to records to substantiate billing practices. This can lead to lengthy payment delays, or if paid and reviewed after the fact, significant time lag in recoveries.

If there are standard terms for payment, they must work both ways.

Where necessary, audit processes should be rigorously applied. Data requested for audit purposes should be provided within standardised timeframes.

Any proposals to have a 'statute of limitations' on audit are not acceptable; it would potentially allow fraud to go unpunished. Health funds will not condone fraud. If illegal or inappropriate

activity is discovered, funds must be able to recover members' funds regardless of when the activity occurred.

Financial transparency

A comprehensive profit and loss statement should be published that includes all sources of revenue (such as rebates from medical device companies), along with the full range of operating expenses (including CEO salaries and senior executive salaries above a certain threshold).

Standard declarations of interests available to patients

Standard forms of wording should be available to patients for declarations of interests, such as doctors having a financial interest in the hospital, rebates for the use of medical devices, and a disclosure regime for any benefits provided to the hospital or its medical specialists by suppliers.

Hospitals should also identify any non-hospital personnel allowed in the operating theatre (for example, medical device company staff) and seek express permission from the patient if they are to be present during surgical procedures.

Reducing out of pocket costs

Public information on out-of-pocket costs at a hospital level should be available to consumers, as this would provide incentives for hospitals to influence medical out of pocket costs for patients. This will assist both the consumer, and the hospital, as out of pocket costs are harming access to care and thus the volume of procedures performed in private hospitals.

Improved informed financial consent

Hospital contracts should require consultants who work in their premises to meet minimum Informed Financial Consent (IFC) standards. Anaesthetists and surgical assistants should be specifically targeted, to ensure a comprehensive quote is provided to patients well in advance of any planned surgery.

Further, hospitals should require medical consultants who work on their premises to maintain integrity in billing. This should include a declaration that doctors will not "shadow bill" or participate in any kind of split-billing or side-billing for services where Medicare benefits are payable. They should also have to declare all costs to the funding bodies (Medicare, health funds, DVA, Workcover, TAC) in line with the funders' rules, and all invoices raised must reflect the cost of the services provided.

Single billing

Hospitals that promote single billing from clinicians (will need to be defined) should be rewarded as this is a clear consumer benefit. Consumers want and deserve clear and precise information about the costs of their health care.

Over time, single billing should become a requirement.

Health funds and hospitals must be permitted to work together to improve quality measures, including those highlighted above. Some of these require cultural change, and many require significant investments by hospitals which need to be supported by health funds and their members who pay premiums.

To help incentivise quality improvement through contracting, PHA recommends in addition to minimum standards, the PNEP includes capacity for contracting based on quality measures, with a plus or minus 5% adjustment tied to a list of quality measures, including those listed above, and others nominated by hospitals.

Medical devices

PHA supports the proposal in the draft paper that medical devices are included in the PNEP. It is essential medical devices are included in a PNEP, and PHA will not support a model which does not include devices.

The Prescribed List (PL) requires health funds to pay many multiples of the international market price for many devices. The list is unwieldy, is difficult to administer, and is rife with errors, inconsistencies and abuses. The distorted market for medical devices drives hidden payments, a lack of transparency and conflicts of interest. At the same time, devices which can help patients avoid hospital or reduce the burden of treatment, can be difficult for consumers to access out of hospital (for example, loop recorders).

The PL is the most inefficient and highest cost component of the private system. Replacing it with a DRG-based national efficient price would help drive productivity. Conversely, a cost-plus approach to the PNEP could continue to incentivise the use of medical devices, including for low-value interventions.

Including devices in a PNEP is not a 'nice to have' option, or a factor to be introduced at a later date. It is an essential feature of a PNEP that must be implemented on day one or before (see Practical Next Steps section).

Where to initially set the Private National Efficient Price

PHA does not support setting a Private National Efficient Price at the current average. Setting a PNEP price at the average will create significant transition issues while providing none of the benefits to the consumer and the Australian community.

An average price will be inflationary, as every provider currently under the price will demand an uplift to the average. While the Department is yet to model this effect, initial estimates from PHA member funds suggest this effect would increase costs by $800-$1200 million with no improved value for consumers. At the middle of this range, around 560,000 people would likely drop their private health insurance, putting massive pressure on private hospital and health fund viability, while overwhelming the public health system. It is surprising the Australian Government has not already done this modelling before allowing the proposition to proceed, as it is clearly impractical.

As well as being inflationary and harmful to both the public and private system, an average price provides none of the benefits of a PNEP. The funding model is meant to promote innovation, but setting an average price will simply lock in existing, old-fashioned models of care. There is no incentive to improve care models, as hospitals will be well paid for the status quo. Setting the

PNEP at an actual efficient price will drive innovation, promoting the use of out of hospital care and technology to reduce patient burden of care while maintaining or improving quality.

PHA does not support any proposal to set the PNEP at an average price with a view to consider future changes to improve incentives for quality and efficiency. The transition costs are high in moving to a PNEP, so consumer value must be prioritised. PHA acknowledges using an actual efficient price for the PNEP will require many hospital operators to be paid above the PNEP in the short- to medium-term to allow for the necessary structural adjustments. This is preferable to setting an average price and hoping that efficiencies come later.

Adjustments to the price

PHA agrees adjustments should be empirically derived and based on data collected from private hospital operators. While this is necessary, it is not sufficient and does not include the patient and consumer perspectives. When considering adjustments to the NPEP, PHA recommends a consumer perspective be employed to ensure all adjustments meet consumer needs rather than provider preferences.

PHA supports rural loadings but notes this will disadvantage people in rural areas who support local health funds. Several funds have a majority of their customers based in rural areas, and these rural based funds will be required to pay more for care. These funds often contribute services to the rural community to make up for market failures, with funds owning and operating hospitals and health clinics. A significant rural loading could place these funds' operations in jeopardy, including additional health services in rural areas. While rural loadings for hospitals are important to ensure services are viable, the costs to the community may require some mitigation.

It is important that data which already incorporate the higher costs of providing rural services are well-understood, so the rural loading does not go on top of a price that already includes factors based on rurality.

As well as rural loadings, the PNEP should consider discounts on the PNEP for areas of oversupply. The current second-tier default benefits have contributed to oversupplies of beds in wealthy city areas; any rural loading should be accompanied by PNEP discounts where competition is plentiful.

The consumer principle for rural loadings and oversupply discounts to the PNEP is to help ensure access to care.

Differences in care costs between states and territories also needs to be considered in the context of health funds' exposures in particular jurisdictions. Many funds have a majority of their members in one jurisdiction – loadings or discounts on the PNEP by jurisdiction could have an outsized effect on funds.

The consumer principle for state and territory PNEP differences is again, ensuring access to care and reinforcing the universality principles of Medicare and community rating.

It is challenging to determine the consumer principles for facility-based adjustments based on ownership structures or hospital characteristics. PHA acknowledges the benefits of having, for example, ICU capacity, and agrees that an activity-based funding approach does not fully suit some services. Some adjustments may be needed for hospital characteristics, but these should be limited and the effects carefully modelled.

PHA does not support adjustments based on ownership structures – all hospitals should be aiming for high-quality, high-value efficient care.

Factors not considered in the draft paper

The use case for the PNEP presented in the draft paper does not consider a number of issues the sector will need to address.

The most significant omission is the consumer perspective. Consumers' capacity to pay health insurance premiums is being eroded with historic inflation, and PHA is surprised the paper does not highlight the need to keep premiums for consumers as low as possible. Any reform action that increases premiums risks being self-defeating.

The oversupply of hospital beds in some parts of Australia must also be addressed. A PNEP has the potential to be gamed, particularly in areas where there is an oversupply of beds and clinicians. There is a case for government to explicitly control the number of beds or services available in a particular location or use significant incentives to ensure private hospital services are not clustered. The existing second tier default arrangements result in clustering, with the default rate in North Sydney being higher than in Northern Tasmania or the Northern Territory. This mistake must not be repeated with a PNEP that has no controls or incentives on bed numbers.

Private sector bargaining is key to driving productivity and innovation. However, the draft paper does not consider the value of contracting for consumers. While it appears neutral on contracting, health funds have demonstrated that contracting for quality services delivers tangible consumer benefits. As knowledgeable agents for their members, health funds can reward hospitals for quality improvements – such as handwashing, contributing to clinical quality registries, and a range of other initiatives agreed between the hospital and the health fund. Health funds should be empowered to play a larger role in promoting high-quality care for their customers.

The most important aspect of contracting is ensuring patients do not receive out of pocket costs when they are hospitalised (other than the previously agreed excess). Any PNEP must require all hospitals to not charge patients out of pocket costs. In effect, it should not be possible with a PNEP for a hospital to charge patients for their services.

Contracts must also have controls for payment integrity. It is imperative that health funds protect their members with strong and effective measures to prevent fraud, waste and abuse. The paper does not address this issue, and it is important that any move to a PNEP ensures payment integrity for both the Australian Government and health funds.

The paper explicitly excludes discussions of doctors' fees and MBS payments in a PNEP. While this exclusion is likely justified, it ignores the ownership of hospitals by doctors, in particular day hospitals. Doctors with a financial interest are in effect paid twice for their services, as a medical provider and a hospital provider. While PHA does not object to doctors holding a financial interest in a hospital, there are examples of conflicts of interest that need to be addressed. For example, doctor-owned hospitals are more likely to admit patients for intravitreal eye injections, which significantly increase the costs for this simple procedure. A PNEP will exacerbate these conflicts of interests, and these issues will need to be carefully considered.

Every hospital system around the world, including the Australian public system, is seeking to reduce reliance on inpatient care and provide more care in the community. For example, every Australian state and territory is seeking to reduce hospitalisations for mental health conditions. The proposals for a PNEP make the false assumption that hospitals are the only providers who can provide out of hospital care. This is incorrect, as a number of providers are available to expand community care options. The paper highlights the advantages of out of hospital care but does not envisage non-hospital providers offering these hospital-substitute services.

The vital question of hospital avoidance programs is not considered in the paper. Consumers, patients, families, employers and the community as whole benefit from people receiving treatment outside of hospitals, which avoids the need for hospital care. The increased capacity of the community sector, self-care and technology has enabled many health systems to reduce reliance on hospital care. However, Australia's private health legislation limits funds' capacity to support hospital avoidance. This area needs to be addressed to ensure the best possible quality outcomes and productivity in healthcare.

As the industry continues to work on the case for a PNEP, other issues are likely to arise. Barriers to implementation can be addressed with good data, solid modelling and open discussion.

The importance of modelling the options

PHA is surprised the draft paper does not include comprehensive modelling of the options presented. It is clear from cursory work that an average PNEP would be highly inflationary, and thus not acceptable to the community. The proposed reforms are significant and important; they deserve to be properly modelled to inform the debate.

PHA looks forward to comprehensive, transparent modelling being made available. We would also welcome the opportunity to assist with this task.

Implementation options

Without the modelling to help understand the effects of PNEP options on the community and on premiums, it is difficult to do much more than speculate on the implementation options. While this modelling is not available, it is clear the timeframes envisaged in the draft paper are not realistic.

Further, the design of the PNEP will influence the use case – as a reference price, or a default benefits price, or some other option. As stated above, consumers cannot afford for the PNEP to be an average price.

That doesn't mean the industry should stand still. While this modelling is underway, PHA and our health funds will work with government and other stakeholders to assist with modelling, help with understanding consumer capacities to pay and care preferences, and the technical aspects of developing an infrastructure around a PNEP.

Health funds and hospitals can continue to work together on improving contracting and drive quality improvement. This needs to go well beyond standard contracting – as highlighted in the draft paper, the current approach is not working as well as it should.

PHA will also work with government to address the drivers of hospital viability, including out of pocket costs for medical specialists' services. PHA considers this an existential threat to the sector.

The following immediate steps can be taken while a PNEP is developed.

Practical next steps

PHA recommends several low risk, "no regret" steps to help prepare the market for a PNEP. In each case, consumers would benefit from these actions even if the PNEP does not proceed.

Introduce DRG funding for medical devices, starting with primary knee and hip replacements

PHA recommends that device costs for the most common diagnostic groups be incorporated into the PNEP. The PNEP process will take some time to implement, but there are several device classes that could immediately move to a DRG-based national efficient price framework from 1 July 2026, to later be incorporated into the PNEP. PHA is also recommending prices be set against international benchmarks, starting with New Zealand.

The most obvious is primary knee and hip replacements, due to consistency, quality data and volume. Currently, the PL has hundreds of components listed, yet well over 99% of knee and hip replacements are done as systems with a consistent group of items. The National Joint Replacement Registry has strong quality measures that clearly indicate the devices with the best performance.

The Stryker Triathlon cemented system rates highest for knee replacements. The knee grouping of the PL could be replaced by a single DRG payment of $4,956, the current cost of the most efficient system in the class in New Zealand.[1] (Knee revision components would remain on the PL in the short term). Primary hip replacements have similar characteristics.

[1] Cemented Femur and Tibial tray with XLPE insert and patella (SK324/SK327/SR076/SK419). The current cost on the PL for these devices is A$5958. The cost in New Zealand is NZ$5,704.72 which equates to A$4,956.17 as at 24 November 2025.

Of the top 200 DRGs by medical device spending, most have a standard variation of less than 5%, many less than 2%. These categories could quickly and easily be used to start introducing a DRG-based medical device funding system that could then slot into a comprehensive national efficient price mechanism as it is developed.

A consultation process and data analytics should drive this process, with DRGs with the lowest variation being introduced first. PHA notes some niche clinical areas with high variation and/or low procedure volume may not be suitable for a DRG-based approach for device funding in the absence of a PNEP, but the majority of the PL could be replaced by a process consistent with the PNEP.

Code of conduct for devices

Australia's use of medical devices is significantly different to other comparable jurisdictions, in part due to the very high prices enforced by Australian law. For example, the rates of knee replacements and spinal cord stimulators are well above international norms.

There is evidence of significant payments from medical device companies to hospitals and medical practitioners, including rebates, discounts, training and device representative support services. While many of these payments are appropriate, such as for training, others may distort the market.

PHA recommends the Australian Government implement a transparent code of conduct covering the entire industry, overseen by the Australian Competition and Consumer Commission (ACCC). This should be modelled on the medicines code of conduct.

Without this transparency, there is a risk that the funding provided by device companies is an undue influence on clinical behaviour and will compromise the operation of a PNEP.

Clear declarations from doctors who own hospitals or device companies

Where a treating medical practitioner – or the family member of a medical practitioner – has a financial interest in the services being provided, such as having an ownership stake in the hospital in which a procedure is performed, or owning the company supplying a medical device, they are required to declare this interest.

PHA notes some high-profile failures to properly declare interests, and notes these declarations are often inconsistent and not well understood by the patient.

PHA recommends the Australian Government work with the Australian Health Practitioner Regulation Agency (AHPRA) to develop a standard written form for doctors to provide to patients to ensure conflicts of interest are transparent and understood.

Conclusion

PHA welcomes the opportunity to work with the Australian Government and other stakeholders to develop a PNEP. Properly implemented, it can drive quality care, ensure patients are treated in the right place at the right time, and promote efficiency while reducing costs.

However, if implemented without careful modelling and planning, the PNEP poses significant risks. An incorrect day-one price could have long-term consequences, pushing hospitals out of business through payments that are either too low to sustain operations, or too high for consumers to afford.

There is no doubt that a structural readjustment in the sector is clearly needed. On behalf of the 15 million Australians with private health insurance, PHA and our member funds will work with all stakeholders to ensure this adjustment is smooth, sustainable and improves access and care for those relying on the private health system.