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Via email: [Private.Hospitals@health.gov.au](mailto:Private.Hospitals@health.gov.au)

**Catholic Health Australia Submission: Pricing Framework for Australian Private Hospital Services**

Catholic Health Australia (CHA) is pleased to provide this submission in response to the Department of Health, Disability and Ageing's consultation on the *Pricing Framework for Australian Private Hospital Services*. CHA represents Australia's largest grouping of non-government hospitals and aged care services, and our members are directly affected by the stability, transparency, and affordability of the private health system.

CHA welcomes the opportunity to engage with this important reform process. We support the objective of establishing a nationally consistent, evidence-based pricing framework for private hospital services, and we recognise the potential of a Private National Efficient Price (PNEP) to modernise contracting, improve transparency and strengthen system integrity. At the same time, our submission outlines the critical issues that must be addressed, including data and costing capability, governance arrangements, transition safeguards and the need for short-term sector stabilisation, to ensure the PNEP can be implemented safely and effectively.

We look forward to continued collaboration with the Department as this work progresses.

If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at [katharineb@cha.org.au](mailto:katharineb@cha.org.au).

Yours sincerely,



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# **Catholic Health Australia**

## **Submission: Pricing Framework for Australian Private Hospital Services**

December 2026

Catholic Health Australia

[www.cha.org.au](http://www.cha.org.au)

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

## Executive summary

Catholic Health Australia (CHA) strongly supports the Department of Health and Aged Care's (the Department's) objective to create a transparent, nationally consistent approach to pricing private hospital services through a Private National Efficient Price (PNEP). The Draft Pricing Framework for Private Hospital Services (the framework) represents an important and long-overdue step toward modernising private hospital funding, improving contracting transparency, and enhancing system-wide efficiency. However, the framework will not succeed unless it directly addresses the sector's severe and prolonged underfunding, builds a credible data and costing foundation, and introduces robust governance, transition and regulatory safeguards. The proposed timeline is highly ambitious given the number of critical elements that remain unresolved; without resolving these foundational issues first, the PNEP risks being implemented on an unstable base, undermining both its credibility and its ability to deliver meaningful reform.

CHA also stresses that several major challenges facing the private health system, including specialist out-of-pocket costs, product complexity, insurer market power, the relationship between public and private hospitals, and shortcomings in risk equalisation, sit entirely outside the pricing framework and cannot be fixed by the PNEP. These issues require parallel policy attention if meaningful sector-wide reform is to be achieved.

### The case for reform is urgent and compelling

Australia's private hospital system is experiencing structural financial distress. Over the past six years, the sector has been underfunded, while insurer profits have grown and hospital margins have collapsed. Capital investment has deteriorated, provider viability is declining, particularly for regional, stand-alone and not-for-profit hospitals, and the recent collapse of a major hospital group underscores system fragility.

Current funding arrangements are fragmented, opaque, and inefficient. Multiple payers, divergent contracting practices, inconsistent AR-DRG usage, and extensive administrative duplication prevent effective benchmarking and hinder innovation. Without a nationally consistent price that reflects the true cost of care, hospitals cannot sustainably maintain safe services, invest in workforce and infrastructure, or meet community expectations for quality and access.

### A PNEP can modernise pricing, but short-term measures are needed

A PNEP can modernise pricing, but short-term measures are needed to keep the system viable while that reform is built. The proposed PNEP is a sound, ABF-based structural reform that can bring greater transparency, consistency and accountability to private hospital pricing, support more rational contracting, and ultimately replace the current fragmented default benefit regime with a coherent national framework. However, it cannot on its own correct the sector's deep structural underfunding or avert the looming 2027 "fiscal cliff" driven by wages, inflation and escalating clinical costs, with many hospitals already managing viability on a 90-day basis.

Immediate stabilisation is therefore essential alongside development of the PNEP, including adoption of an interim inflator (which accounts for the cumulative effects of long-term underfunding, deferred capital investment, or the deteriorating asset base across the private hospital sector) to realign benefits with real cost growth, restore a more balanced distribution of margins between insurers and hospitals, and prevent further erosion of capital investment and service capacity while the more comprehensive, bundled PNEP is designed, tested and

implemented. Crucially, this interim inflator should remain in place until the mandated PNEP is fully established and operational, providing stability throughout the transition.

Following application of this interim inflator, the next priority must be correcting the underlying price baseline. CHA recommends evolving the PNEP from a purely indicative reference point to a mandated, transparent national floor price that replaces the current second-tier default benefit arrangements. This floor price should cover the full cost of service delivery and routine maintenance, with new capital funded through above-floor contracting. Over time, as capital pricing data matures, the PNEP should progress to a bundled, all-inclusive case-based payment covering both capital and operating components, with scope for hospitals and insurers to negotiate above-price payments for demonstrable quality, innovation and other value-adding components within a clearly defined envelope. This staged approach provides immediate stabilisation while laying the foundation for long-term reform, but none of these benefits will be realised unless the Department acknowledges the insufficiency of the current development timeline and the need for immediate stabilisation measures while foundational work is completed.

### **Data and costing foundations are not yet robust enough to support a credible PNEP**

The draft framework assumes that a reliable national price can be built quickly, yet the data and costing foundations required for such a model are not currently fit for purpose, making the proposed timeline highly ambitious. The private National Hospital Cost Data Collection (NHCDC) remains voluntary, incomplete and uneven in representativeness, with inconsistent participation from day hospitals, limited mental health and subacute data, and variable costing capability across providers. Significant legitimate variation in service models, technology platforms and cost structures, particularly between day hospitals, overnight hospitals, regional providers and high-acuity facilities, cannot yet be reliably captured or adjusted for. In addition, mandatory transition to a contemporary, uniform AR-DRG version is essential; without it, costing, relativities and distributional modelling will remain unreliable.

Current datasets also fail to reflect the cumulative effects of chronic underfunding, deferred maintenance, and deteriorating capital stock across the sector. Without a clear understanding of the true cost base, including capital replacement and long-term investment needs, a sophisticated pricing model built on insufficient inputs will only institutionalise scarcity and risk embedding today's artificially suppressed costs as tomorrow's benchmark. Until the system has complete, reconciled activity data, consistent application of Australian Hospital Patient Costing Standards (AHPCS) costing standards, the Independent Financial Review (IFR)-style validation, and a methodology that acknowledges capital and historical funding gaps, the PNEP cannot credibly serve as a national reference price or transition to a mandated price. Robust data foundations are essential before the model can be relied upon for regulatory or financial decisions.

### **Adjustments, boundaries, and parallel funding streams require clearer architecture**

While the framework recognises the need for adjustments to reflect unavoidable cost variation, it does not yet provide a clear architecture for how major parallel funding streams, particularly the Prescribed List (PL), training and research, will be integrated into the PNEP over time. Device costs remain one of the most significant sources of variation in the private sector, driven by legitimate differences in technology platforms, robotics systems, clinical preferences and specialist capability. Early bundling of PL items into the PNEP would risk compressing this

variation into an artificial average, undermining clinical autonomy, threatening access to advanced technologies and disproportionately disadvantaging smaller and day hospitals with limited purchasing power. The framework needs a staged, data-driven roadmap for PL integration, including safeguards for platform-dependent technologies, protections for small providers, and alignment with broader health technology assessment principles.

Similarly, the role of private hospitals in medical training and clinical research is growing, yet these activities receive no systematic funding equivalent to public-sector Teaching, Training and Research (TTR) block grants. Existing programs such as the Specialist Training Program (STP) cover only a fraction of the real costs of supervision, infrastructure, accreditation and lost productivity. Research activities, essential to innovation and high-quality care, are almost entirely unfunded in the private sector. The framework must explicitly outline how teaching, training and research will be recognised through dedicated adjustments, ensuring these critical functions are not eroded as pricing reforms mature.

Without a clear roadmap for PL bundling and formal recognition of training and research costs, the PNEP risks embedding structural gaps that undermine system capability, innovation and long-term sustainability. A coherent, staged integration plan for these elements is essential to a credible future pricing architecture.

Finally, long-term sustainability depends on a credible indexation model and a direct link between the PNEP and the annual premium round to align insurer revenue with efficient hospital costs. Without this, cost-price divergence will continue, undermining both viability and affordability.

### **Strong, independent governance is essential**

Strong, independent governance is fundamental to the success of the PNEP. While the Independent Health and Aged Care Pricing Authority (IHACPA) brings deep expertise in classification, costing standards and price development, the private system's commercial complexity, heterogeneity and multi-payer environment require a governance model that goes beyond the roles outlined in the draft framework. The Department currently acts as both policy-maker and regulator in private health, a dual role that creates inherent conflicts of interest and has historically led to weak or inconsistent enforcement, most visibly in areas like the Prescribed List. A credible national pricing system cannot depend on departmental discretion alone. CHA therefore recommends establishing an independent private health regulator with a clear statutory mandate to enforce the price, oversee data and costing compliance, monitor insurer and provider conduct, and intervene where market behaviour undermines pricing integrity or patient access. This regulator should operate alongside IHACPA's technical pricing function, supported by transparent audit processes, IFR-style assurance, and clear separation of responsibilities across data collection, price-setting, regulatory enforcement and ministerial oversight. Independent governance will be crucial to maintaining trust in the PNEP, ensuring procedural fairness, and protecting the system from distortions in a high-stakes commercial environment.

### **Transition risks and the cost of implementation and administration must be explicitly managed**

Transitioning from today's fragmented pricing environment to a nationally consistent PNEP carries substantial risks that the framework does not yet address in sufficient depth. Replacing the second-tier default benefit arrangements, relying on incomplete NHCDC coverage in early

iterations, and introducing major system changes within an ambitious timeline all create the potential for destabilising revenue shocks, particularly for smaller, regional and high-acuity hospitals already under severe financial pressure. These risks are heightened by the fact that sector readiness is highly uneven, with many providers lacking the technical, financial, and workforce capacity to absorb complex change at pace. Shadow pricing, readiness gateways and temporary stabilisation supports will be essential to prevent unintended contractions in service availability or insurer behaviour that could narrow networks or restrict patient access.

In parallel, the framework significantly underestimates the cost of implementation and ongoing administration. Establishing a functional PNEP requires major investment in data infrastructure, patient-level costing capability, coding quality, and internal analytics across every participating hospital. Larger groups may absorb this, but many stand-alone, regional and day hospitals lack the technical capacity to meet NHCDC and AHPCS requirements without dedicated support. Government will likewise require a well-resourced pricing unit, independent regulatory oversight, IFR-style assurance processes and sustained analytical capability. Without explicit recognition and funding of these costs, the PNEP risks becoming an unfunded mandate that diverts resources from patient care and exacerbates the very sustainability challenges the reform is intended to address. Clear transition supports, realistic lead times and transparent funding for implementation are therefore critical to the safe and credible rollout of the PNEP.

#### **Patient outcomes, quality and a cautious path to value-based care**

The PNEP can improve consumer experience by reducing opaque benefit variation, clarifying out-of-pocket expectations and stabilising access, but only if it accurately reflects the costs of caring for complex patients, regional communities and high-acuity services. Without well-calibrated adjustments and safeguards, it could unintentionally drive service withdrawal, consolidation or network narrowing. While linking payments to quality has long-term value, premature implementation poses risks given uneven data maturity and the limited capacity of smaller hospitals to support additional reporting. CHA therefore supports a cautious, staged approach, with early safety indicators used only in shadow pricing and subject to independent clinical review. Over time, PROMs and PREMs could support value-based care, but must be collected independently to ensure consistency and avoid disadvantaging smaller providers. Ultimately, consumer outcomes and quality improvements depend on a long-term, risk-adjusted quality architecture that is independently governed and feasible for hospitals of all sizes, and that complements the PNEP only when the system is ready.

# Submission

## Background

The Department of Health and Aged Care (the Department) has released the Draft Pricing Framework for Private Hospital Services (the framework) for public consultation. This framework represents a major policy initiative aimed at introducing greater transparency, consistency, and efficiency in the funding of private hospital services in Australia.

The introduction of a Private National Efficient Price (PNEP) is a reform that CHA has long supported. CHA has consistently advocated for a more transparent and nationally consistent approach to private hospital pricing that promotes fairness, reduces administrative duplication, and strengthens the long-term sustainability of the private hospital sector.

The proposal sets out a pathway for developing a PNEP — a benchmark price that reflects the efficient cost of delivering hospital care in the private sector. Modelled conceptually on the public hospital pricing framework administered by the Independent Health and Aged Care Pricing Authority (IHACPA), the PNEP is intended to serve as an evidence-based reference point to support more consistent and informed contracting and purchasing arrangements between private hospitals and insurers.

The draft framework proposes a phased implementation approach, beginning with foundational data development and costing work, followed by the introduction of indicative and shadow pricing, and culminating in a comprehensive PNEP. It also considers potential price adjustments to account for differences in patient complexity, location, and facility characteristics, and explores how safety and quality incentives might be incorporated into the pricing model over time.

Through this consultation process, the Department is seeking feedback from key stakeholders, including private hospitals, insurers, clinicians, and consumers, on the design, scope, and feasibility of the proposed framework. In particular, feedback is sought on the:

- proposed objectives and guiding principles
- suitability of Activity Based Funding (ABF) for private hospital services
- proposed approach to developing the PNEP and associated data requirements
- proposed implementation timelines and governance arrangements
- likely impacts, benefits, and risks of the framework.

Submissions received will inform the development of the final Pricing Framework for Private Hospital Services, expected to be released in 2026, and guide the detailed design and implementation planning that follows.

## Strategic alignment and rationale

### Purpose and objectives

CHA believes the framework's stated objectives are clear, coherent, and well-aligned with the long-term needs of the private health sector. The proposed establishment of a PNEP, grounded in Activity Based Funding (ABF) principles, represents a significant step towards improving consistency and accountability across the system. Importantly, the framework recognises the

need to maintain the distinctive features of the private system, such as patient choice, clinical independence, and innovation, while addressing inefficiencies and administrative burdens.

CHA also acknowledges that the framework aligns well with broader Commonwealth health reform agendas, including the Productivity Commission's focus on efficiency and sustainability, Medicare reforms promoting value-based care, and the Independent Health and Aged Care Pricing Authority's (IHACPA) emphasis on transparency and evidence-based pricing. The draft's design reflects these national directions while adapting them to the specific context of private health care. CHA supports this alignment, noting that it creates a coherent policy environment where both public and private funding models work towards shared goals of improving quality, affordability, and long-term sector viability.

#### **Summary**

The draft framework sets clear, well-aligned objectives. It modernises private hospital pricing through an ABF-based PNEP while preserving core features of the private system. It also aligns strongly with broader Commonwealth reforms focused on transparency, value and sustainability.

#### **Problem definition and case for change**

CHA agrees with the Department's diagnosis that the current private hospital funding system is fragmented, inefficient, and increasingly unsustainable. The existing model is characterised by multiple payers, divergent contracting methods, and inconsistent use of cost and activity classifications. Each insurer, state, or Commonwealth scheme applies its own pricing logic and incentives, resulting in significant administrative burden, opaque price variation, and barriers to innovation. The absence of a common pricing reference point prevents meaningful benchmarking and makes it difficult to assess efficiency or value across the sector.

The draft framework accurately identifies these issues and articulates a compelling rationale for reform. The current system's reliance on bespoke contracts and fee-for-service or per diem models has contributed to inconsistent incentives, poor transparency, and limited accountability. These arrangements have also hindered the ability of hospitals to plan, invest, and adapt to changing care models. Rising operating costs, constrained premium growth, and outdated policy settings have compounded these challenges, threatening the financial sustainability of providers, particularly smaller and regional hospitals. The proposed move toward a nationally consistent pricing framework, underpinned by reliable cost data and common classifications, directly responds to these pressures.

CHA also supports the framework's recognition that the current system undermines allocative and technical efficiency. Hospitals face differing reporting and billing requirements, diverting resources away from patient care, while the absence of a shared national benchmark impedes constructive insurer-provider negotiations. Introducing a PNEP would allow for a more transparent, evidence-based foundation for contracting and policy development, improving confidence in the system for all stakeholders.

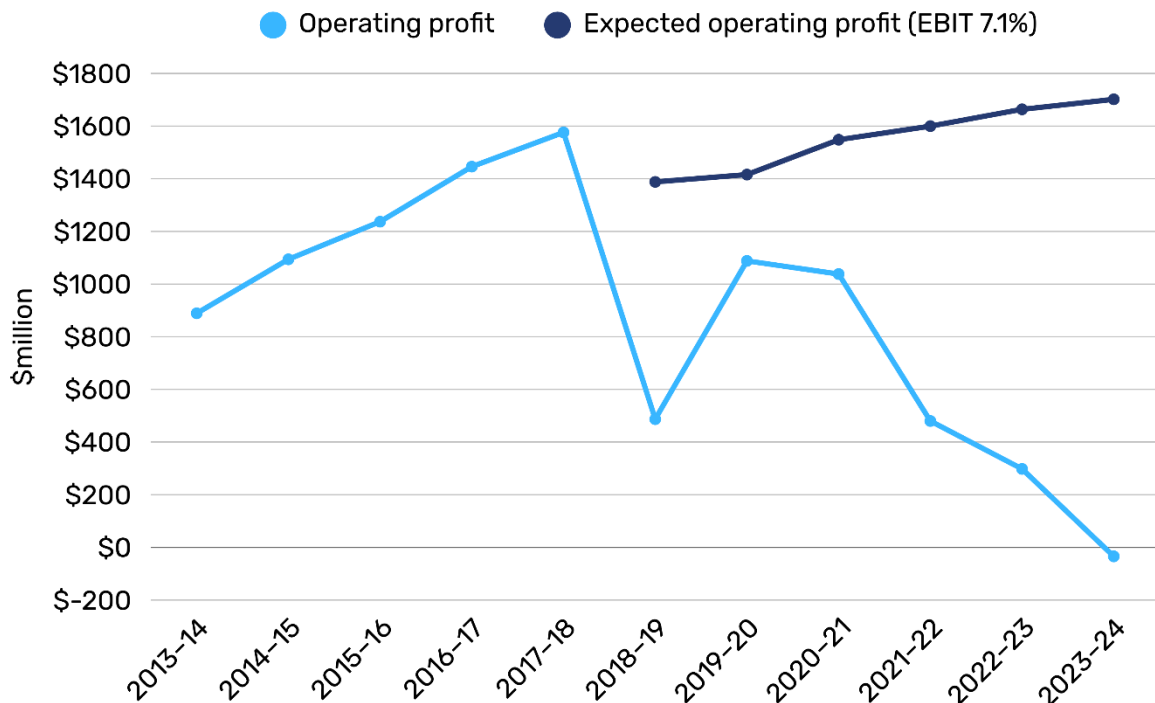
In addition to the issues identified in the draft framework, CHA notes several further challenges raised through its own consultations with CHA members. These include:

- A lack of harmonisation and consistency in Diagnosis-Related Group (DRG) classifications, leading to inefficiency and cross-subsidisation between services.

- No transparency about how individual providers perform relative to the sector, making it difficult to assess efficiency or justify investment.
- Innovation not being funded due to rigid contracting models that do not reward new or integrated models of care, such as hospital-in-the-home or community-based mental health.
- Market imbalances created by vertical integration and selective contracting by major insurers, which reduce competition and patient choice.
- Excessive administrative cost from negotiation, billing compliance, and data reporting, representing wasted system effort.
- Government policy decisions made without complete or timely information, particularly during the premium round process, leading to misaligned incentives.
- Ongoing challenges with default benefit arrangements and second-tier safety-net failures, which leave some patients and smaller hospitals exposed.
- Difficulties in demonstrating “value” or efficiency within current payment models that primarily reward activity rather than quality.

Before evaluating the technical merits of the draft PNEP framework, it is essential to clearly articulate the core structural problem facing the private health system. The risk in the current reform conversation is that significant effort is being directed toward refining the future funding model, without addressing the fundamental issue: the sector is underfunded by almost \$6 billion in the last six years, and \$1.7 billion in 2023–24 (Figure 1) and therefore cannot absorb ongoing cost inflation under current revenue settings.

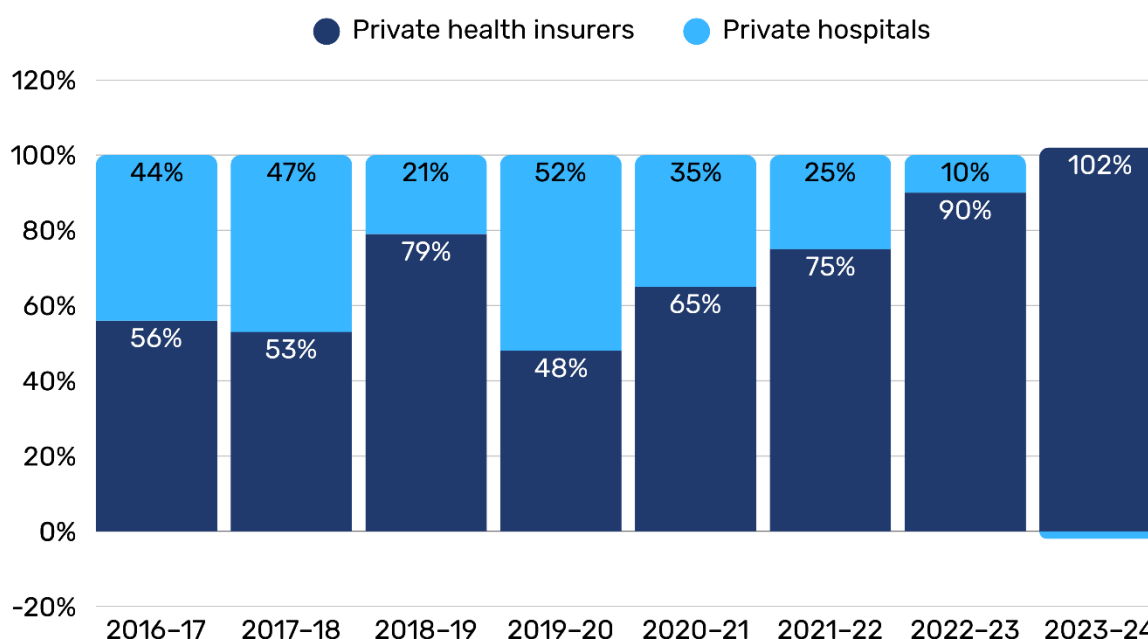
Figure 1: Private hospital operating profit versus expected operating profit, 2013–14 to 2023–24<sup>1</sup>



<sup>1</sup> To estimate the operating profit shortfall since 2018–19, the average EBIT margin was calculated between 2013–14 and 2018–19 (7.1 per cent) which was used as the benchmark for expected performance. For each subsequent year, expected operating profit was calculated by applying this 7.1 per cent margin to that year’s total income. The shortfall for each year was then derived by subtracting the actual operating profit from the expected operating profit. Data was sourced from the Australian Bureau of Statistics *Australian Industry* dataset.

In addition, the growing divergence between insurer and hospital profit shares (Figure 2) highlights an increasingly unbalanced funding environment, with insurers retaining a rising share of sector margins while hospitals face mounting financial strain. Restoring a more balanced 50/50 distribution is essential to support sector stability and ensure both sides can sustainably invest in care, noting this cannot come at the expense of adequate system funding, particularly if private health insurance revenue contracts or premium growth is constrained.

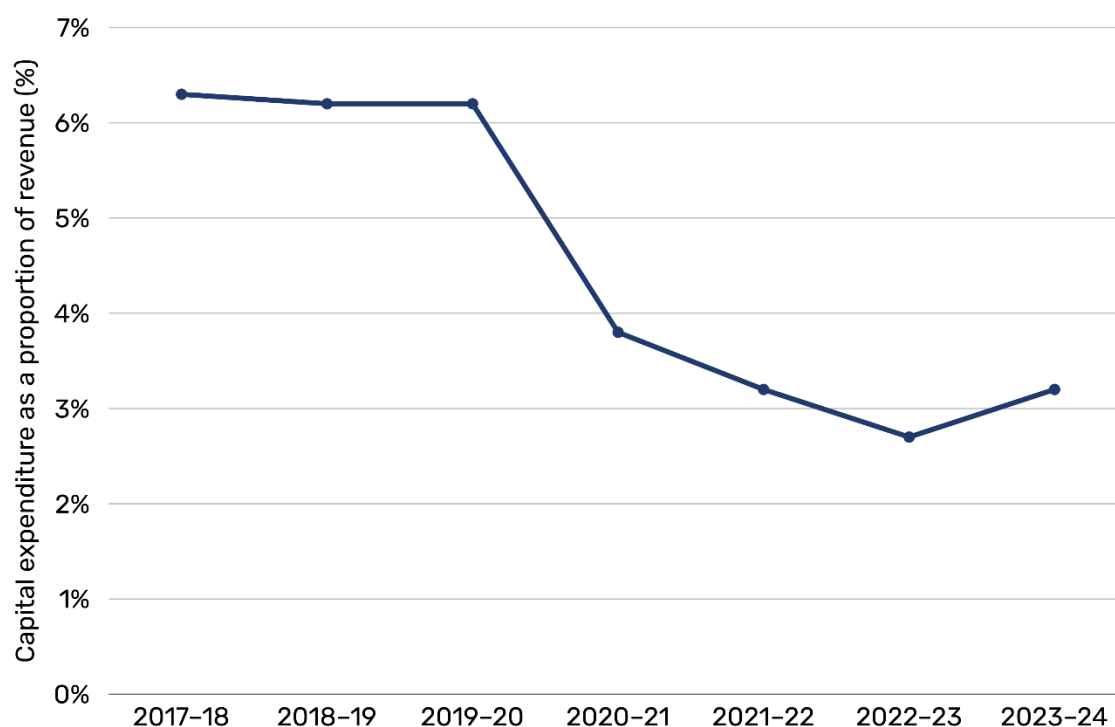
Figure 2: Operating profit of private health insurers and private hospitals before tax, 2016–17 to 2023–24<sup>2</sup>



This consistent underfunding has resulted in declining capital expenditure across the sector (Figure 3). It is therefore crucial to recognise that the current datasets do not capture the cumulative effects of long-term underfunding, deferred capital investment, or the deteriorating asset base across the private hospital sector. As a result, any baseline for a new funding model must explicitly account for these historical gaps and the capital replacement required to maintain safe, contemporary services. Establishing an accurate baseline will therefore require making reasonable assumptions about the level of underfunding, the capital needs that have accumulated over time, and the investments necessary to bring the sector back to a sustainable and functional starting point.

<sup>2</sup> This graph compares the operating profit before tax of private health insurers and private hospitals using data from the Australian Prudential Regulation Authority's *Operations of Private Health Insurers Annual Report* and the Australian Bureau of Statistics *Australian Industry* dataset. While this provides a general indication of profit differences between the two sectors, it is not a perfect measure because the data sources use different definitions, reporting methods, and coverage. Insurers and hospitals also have fundamentally different business models: insurers have lower capital expenditure needs, rely heavily on investment income, and operate in a low-margin, high-volume environment focused on risk management, while hospitals depend on revenue from delivering care, face high capital and operating costs, and manage complex, high-risk service delivery systems. These structural and financial differences—along with variations in accounting practices, reporting periods, and the inclusion of both for-profit and not-for-profit hospitals—mean the comparison should be interpreted as indicative only, offering a broad sense of relative profitability rather than a precise calculation of profit share.

Figure 3: Private hospital capital expenditure as a proportion of revenue<sup>3</sup>



#### Summary

The current private hospital funding system is fragmented, inefficient and increasingly unsustainable, with multiple payers, inconsistent pricing methods and high administrative burden undermining transparency, efficiency and innovation. CHA agrees that reform is essential, but emphasises that the core structural problem is severe and prolonged underfunding which has eroded hospital margins, widened the profit gap between insurers and providers, and driven down capital investment. A nationally consistent PNEP can improve transparency and support better contracting, but its success depends on first addressing this funding shortfall and establishing a realistic baseline that reflects the true cost of safe, modern hospital care.

## Design and technical feasibility

### Conceptual soundness

CHA considers the draft framework to be conceptually sound and grounded in well-established funding and pricing methodologies. The framework draws appropriately on the core principles of ABF used in the public hospital system — namely transparency, efficiency, and alignment of price with the cost and complexity of care — while adapting these to the distinctive characteristics of the private sector. Importantly, it does not attempt to replicate the public funding model but tailors the approach to reflect multiple private payers, contractual funding relationships, and the centrality of patient choice and clinician independence.

<sup>3</sup> This graph depicts private hospital capital expenditure as a proportion of revenue using the Australian Bureau of Statistics *Australian Industry* dataset.

However, CHA does not believe that a reference price alone goes far enough to address the underlying market failures affecting hospital sustainability, insurer behaviour and patient access. A reference price may improve transparency, but in the current contracting environment it is too passive a mechanism to correct entrenched bargaining asymmetry. Without some form of price anchoring, the framework risks replicating the status quo, leaving hospitals exposed to arbitrary insurer pricing and inconsistent policy progress.

Critically, shifting to a PNEP will not resolve the structural funding imbalance that exists today. A more sophisticated pricing model built on insufficient inputs will still yield insufficient outputs and risks institutionalising scarcity rather than fixing it. The Government must therefore make an explicit policy decision about the quantum of funding required to underpin the new model. Without a baseline correction, the PNEP, no matter how technically strong, cannot stabilise margins, meet rising workforce costs or support essential capital renewal. By 2027, the sector faces a “fiscal cliff” driven by wage pressures, inflation and escalating clinical costs, with many hospitals managing viability on a 90-day basis. No pricing model, however elegant, can substitute for adequate revenue.

More broadly, the PNEP cannot resolve the many systemic pressures that sit outside hospital pricing, including specialist out-of-pocket costs, the interaction between public and private hospitals, the growing number of private patients being treated in public hospitals in some jurisdictions (while also recognising that privately licenced public hospitals and co-located campuses operate differently and may appropriately admit private patients due to their service mix), growing product complexity following the erosion of the gold/silver/bronze/basic framework, growing administrative and data burden, and ongoing issues in risk equalisation. These factors significantly influence affordability, participation and system stability, and must be addressed in parallel if the overall reform effort is to succeed.

The framework also needs to carefully balance incentives governing *where* care is delivered. An effective PNEP should encourage care to be provided in the most clinically appropriate and cost-effective setting; however, poorly calibrated price relativities could unintentionally fuel oversaturation of the market with new day hospitals targeting profitable low-acuity high-volume activity. This would undermine the viability of overnight hospitals that must maintain 24/7 emergency, ICU and complex-care capability. The pricing architecture must therefore ensure that efficiencies in day care are supported without creating incentives for cherry-picking or structural hollowing-out of acute services.

Similarly, expecting the PNEP to mechanically drive insurers to “pass through” efficient prices does not reflect market realities. If the Department assumes insurers can increase hospital benefits without driving unsustainable premiums, this must be explicit and tested; for many funds, even modest increases risk breaching prudential limits. The PNEP also does not eliminate existing contestability problems or the administrative burden arising from fragmented contracting and insurer-driven product complexity.

In short, the PNEP is a structural reform, not a financial repair mechanism. It can modernise pricing, improve transparency and support long-term system design — but it cannot close the current funding gap, reconcile contradictory expectations around premiums versus benefits, or restore hospital viability without immediate policy action to stabilise the sector.

This context heightens concerns that the framework’s timelines underestimate the scale of work required to deliver a PNEP that is robust, credible and useable. Foundational tasks —

including data validation, costing accuracy, adjustment testing, market impact modelling and clinical governance — remain incomplete. Until these are resolved, the PNEP cannot meaningfully address current market failures or provide the stability the sector urgently needs.

For these reasons, CHA believes an immediate corrective measure is required during the transition period. The Department's slow pace in delivering structural reform, combined with insurers' reluctance to voluntarily increase payouts, has intensified financial pressure across the private hospital network. CHA therefore recommends adopting the DVA pricing model as the core interim inflator for the next premium round, supplemented where appropriate by additional mechanisms, such as insights from the IHACPA private hospital costing study or public National Hospital Cost Data Collection (NHCDC) indexation, to ensure the inflator more fully reflects real cost movements. Any interim approach must also account for the substantial funding suppressed in recent years, for example by comparing the DVA indexation with actual insurer benefit increases, and must incorporate the significant wage pressures forecast across the sector. Crucially, this interim inflator should remain in place until the mandated PNEP is fully established and operational, providing stability throughout the transition. This would deliver immediate relief to hospitals, realign benefits with true cost growth, compel insurers to increase payout ratios transparently, and bridge the system to a fully developed PNEP.

Following application of an interim inflator, the next priority should be correcting the underlying price baseline. CHA recommends evolving the PNEP from a purely indicative reference point to a mandated, transparent national floor price guaranteeing a fair minimum benefit for all hospitals and all insurers. Such a floor price would cover the full cost of service delivery and routine maintenance, with new capital funded through above-floor contracting. It would ultimately replace the existing second-tier default benefit arrangements with a more coherent, rational and transparent mechanism.

Over time, as capital pricing data matures, the PNEP should progress to a bundled, all-inclusive case-based payment covering both capital and operating components, with scope for hospitals and insurers to negotiate above-price payments for demonstrable quality, innovation and other value-adding components within a clearly defined envelope. This staged approach provides immediate stabilisation while laying the foundation for long-term reform, but none of these benefits will be realised unless the Department acknowledges the insufficiency of the current development timeline and the need for immediate stabilisation measures while foundational work is completed.

#### **Summary**

CHA supports the conceptual foundations of the PNEP but emphasises that the framework cannot succeed without first addressing the sector's underlying financial imbalance. A reference price alone will not correct entrenched market failures, resolve the significant funding gap, or stabilise hospitals facing a 2027 fiscal cliff and 90-day viability cycles. Without an explicit decision on the level of funding that must enter the system, the PNEP risks institutionalising scarcity rather than fixing it. The pricing model must also avoid creating perverse incentives that accelerate the proliferation of day hospitals targeting profitable low-acuity activity, which would undermine the viability of overnight hospitals that must maintain complex-care capability; the PNEP must balance encouraging care in cost-effective settings without enabling cherry-picking. For these reasons, CHA calls for immediate stabilisation measures alongside development of a mandated national floor price and, ultimately, a bundled case-based payment. These steps are essential to ensure the PNEP becomes a

genuine structural reform rather than a technically sophisticated model built on insufficient inputs.

### Principles and design criteria

The principles underpinning the draft framework are, in broad terms, well-aligned with established approaches to health system pricing. The emphasis on transparency, efficiency, patient-centred care, data quality, and alignment with cost and complexity mirrors the core foundations of ABF, while adapting them to a mixed-funding, multi-payer environment. In particular, the commitment to transparency through a reference price helps standardise expectations across a highly fragmented market, and the use of a structured, repeatable methodology signals an intent to bring order and predictability to a sector marked by opaque bilateral contracting. The framework's recognition of the need for robust cost data, clinical classification systems, and ongoing methodological refinement demonstrates a mature understanding of what sustainable pricing architecture requires.

There is also clear strength in the framework's acknowledgement that private hospitals operate in a fundamentally different policy and market environment to public hospitals. The principles explicitly reference patient choice, competition, and the contractual nature of private funding relationships, all of which are critical design considerations often overlooked in public-sector pricing models. The framework appropriately avoids simply transplanting the public National Efficient Price (NEP) into the private sector and instead takes the best conceptual elements (such as relativity, cost weighting, and clinical granularity) while adapting them to private-sector dynamics. This pragmatic, sector-specific approach is one of the framework's conceptual strengths.

However, while the principles are generally sound, several important gaps remain. The framework does not sufficiently address the structural distortions and market failures that undermine the functioning of the private hospital market. Principles such as "efficiency" and "transparency," while desirable, are not enough on their own to correct entrenched bargaining asymmetries where insurers hold disproportionate contracting power and can unilaterally impose prices disconnected from costs. The framework lacks a principle relating to sustainability of supply, despite the system experiencing a substantial decline in private hospital operating margins and a wave of closures and service withdrawals. Nor does it articulate a principle that addresses fair return on investment, despite capital renewal and technological modernisation being essential to clinical quality and patient safety. Equally, there is no explicit principle safeguarding equitable access, even though rising cost pressures, contracting volatility and regional service fragility are already restricting patient choice and creating emerging access inequities. These omissions limit the framework's ability to ensure that pricing reform actually supports an ongoing, viable private hospital sector.

Another missing element is the explicit integration of value-based care. While patient outcomes and experience appear implicitly within the broader objectives of the reform program, the design criteria do not yet specify how PROMs, PREMs, safety indicators, or quality improvements will be incorporated into pricing or contracting. Without these elements, the framework risks reinforcing a cost-minimisation approach rather than driving improvements in patient outcomes, appropriateness of care, and system-wide value. A modern pricing framework should set out how quality information will complement cost and activity data to guide future pricing or above-floor negotiations.

Finally, the design criteria lack a clear architectural roadmap for transitioning from the current dysfunctional default-benefit regime to a coherent national pricing system. While reference pricing is offered as an initial step, the criteria do not describe the intermediate milestones, governance mechanisms, or market safeguards necessary to evolve the reference price into a meaningful mandated price over time. This omission limits the framework's capacity to deliver predictable, staged reform and leaves too much reliance on voluntary insurer behaviour, which has historically not shifted in response to transparency alone.

#### **Summary**

The framework's principles are broadly well-aligned with ABF and appropriately tailored to the private sector, but key gaps remain. The design criteria do not yet address core market failures, including insurer bargaining power, sustainability of supply, fair capital returns, or the growing access and equity pressures emerging from contracting volatility and regional service fragility. Nor do they outline how value-based care (PROMs, PREMs, quality indicators) will ultimately integrate into pricing. The absence of a clear roadmap for transitioning from today's default-benefit regime to a mandated national price also limits the framework's ability to deliver predictable, system-wide reform.

#### **Scope and boundaries**

The proposed scope of the framework is appropriately ambitious in its intention to establish a nationally consistent approach to pricing private hospital services. Its decision to focus initially on in-scope hospital services, notably admitted care and day procedures, is sensible, reflecting both the availability of robust data and the maturity of existing classification systems such as AR-DRGs. By prioritising these areas, the framework correctly concentrates on service categories where variation is high, price opacity is entrenched, and the need for standardisation is most pressing. This phased approach also demonstrates prudent boundary-setting: starting with areas where methodological confidence is highest creates a strong foundation for later expansion.

The framework also shows strength in explicitly acknowledging that private hospitals operate in a multi-payer, contract-driven environment, which requires different boundary definitions than the public NEP. By not overreaching into clinical decisions or contracting arrangements, the framework respects the autonomy of clinicians and the commercial nature of private agreements. This avoids many pitfalls of excessive regulatory intrusion and demonstrates a balanced understanding of the respective roles of government, insurers and providers.

Despite these strengths, the scope as defined leaves several notable gaps. First, the framework does not address, or even clearly delineate, its long-term relationship with the second-tier default benefits regime, which continues to distort incentives, disadvantage certain hospitals, and fragment the pricing landscape. Without articulating how the PNEP framework will eventually replace legacy mechanisms, there is a risk of parallel, inconsistent pricing signals undermining reform. The boundaries should explicitly outline the transition pathway from the current multi-tiered, inconsistent benefit structure to a coherent national pricing architecture.

Second, the boundaries exclude key hospital functions that materially shape costs, quality and patient outcomes, most notably non-admitted care, rehabilitation, mental health, hospital-in-the-home and chronic disease management. While exclusion may be reasonable in the early stages, the framework does not yet articulate a roadmap or methodology for bringing these services into scope over time. This omission limits the framework's capacity to support

integrated models of care, multidisciplinary treatment pathways, and value-based reforms that span across care settings rather than isolating admitted care in a silo.

The framework is also limited in its treatment of capital costs and long-term investment, drawing a boundary that implicitly places capital outside the initial reference pricing model. While defensible in the short term, the framework does not set out how capital will be incorporated in future iterations, nor does it clarify the minimum data requirements or modelling approach needed to make capital a formal component of a bundled price. Without signalling future inclusion, the boundary risks reinforcing the chronic under-investment that has contributed to declining private hospital sustainability.

As outlined above, another limitation relates to the framework's handling of quality, outcome data and patient-reported measures (PROMs and PREMs). These elements are recognised as important but are placed conceptually outside the pricing boundary, with minimal explanation of how they will be integrated into negotiated arrangements. By failing to establish even a notional boundary around the long-term role of quality metrics, the framework risks embedding a cost-based structure without sufficient leverage to drive improvement in patient experience, safety or value.

Quality indicators must ultimately form part of a long-term, staged approach that shares risk fairly between hospitals and insurers, recognises the unique challenges faced by smaller and regional hospitals, and ensures that early quality signals do not inadvertently penalise providers with limited scale or case mix complexity. To achieve this, the framework will require an independent body capable of overseeing the collection, validation and risk-adjustment of PROMs, PREMs and safety indicators, ensuring that quality data is comparable, methodologically sound and able to inform pricing and above-floor negotiations in a fair and transparent way (further discussed below).

Finally, the framework does not clearly define its boundaries with respect to insurer obligations or insurer behaviour, instead taking a neutral stance that assumes transparency will, in itself, shift market conduct. Given the well-documented bargaining imbalance in the private health insurance market, this omission creates an incomplete boundary definition: the framework does not specify which behaviours fall within the reform's regulatory scope and which remain outside it. Without clearer delineation, there is a risk that insurers continue operating within unregulated spaces that perpetuate inefficiencies and undermine price reform.

#### **Summary**

The framework sets sensible initial boundaries by focusing on admitted care and day procedures, but it leaves major gaps that weaken its long-term coherence. It does not clearly articulate how the PNEP will replace second-tier default benefits, how excluded services (e.g. mental health, rehab, non-admitted care) will be brought into scope, or how capital and quality metrics will eventually be incorporated into pricing. The absence of defined boundaries around insurer behaviour also limits the framework's ability to address known market distortions. A clearer roadmap is needed to ensure the scope evolves toward a coherent, system-wide pricing architecture.

## Pricing model and costing foundations

### Adjustments and modifiers

CHA considers the framework's proposed approach to adjustments and modifiers to be conceptually sound and broadly aligned with contemporary national and international practice in activity-based funding. The recognition that a single "base price" cannot, on its own, reflect legitimate and unavoidable cost variation is critical. The framework appropriately identifies three main classes of adjustment — location-based, facility-related, and patient-related — and emphasises that any modifiers should be empirically derived and transparently determined. This is consistent with the approach already used in the public NEP, where the National Weighted Activity Unit (NWAU) is adjusted for factors such as remoteness and paediatric care to address unavoidable cost differences. Importantly, CHA notes that Diagnosis Related Groups (DRGs) should be the foundation of this model, with additional casemix adjustments applied for patients with materially higher resource needs, including age, chronic illness, disability, and socioeconomic disadvantage. A phased implementation will be essential to avoid discouraging the treatment of complex patients or shifting incentives in unintended ways as relativities recalibrate across DRGs.

CHA also welcomes the explicit intention to incorporate safety and quality adjustments, drawing on the joint work of IHACPA and the ACSQHC on sentinel events, hospital-acquired complications (HACs), and avoidable readmissions. In the public system, these mechanisms reduce funding where preventable complications occur, using a risk-adjusted model to avoid penalising hospitals that treat more complex casemix. Adapting this framework to the private sector has strong conceptual merit: it signals that poor-quality care should not be financially rewarded and provides a pathway for linking the PNEP to patient outcomes and safety measures over time. The draft framework's proposal to begin with established public-sector definitions and methods, rather than inventing bespoke private-sector metrics, is pragmatic and reduces duplication of effort.

However, the design detail and governance of these adjustments are underdeveloped. The framework correctly notes that adjustments should be evidence-based and transparently determined, but it does not set out clear criteria for when an adjustment is justified, how materiality will be assessed, or how often modifiers will be reviewed or retired. In the public system, IHACPA operates under a published policy for assessing adjustments to the NEP, including tests of materiality, avoidability, and data quality, and a formal process for proposing new or revised adjustments. An analogous policy is not yet articulated for the private sector. Without such a framework, there is a real risk of "adjustment creep" (the proliferation of small, overlapping modifiers that undermine simplicity and transparency) or, conversely, under-adjustment for unavoidable cost differences, particularly for rural and regional hospitals (MMM 3–7), small hospitals (<70 beds) with diseconomies of scale, and teaching and training hospitals that carry additional placement and supervision obligations.

There is also a tension between the stated preference that adjustments be "patient-based rather than provider-based wherever practicable" and the reality of the private hospital sector. Some important cost drivers — such as regional isolation, small scale, capital-intensive specialty services (including ICU, ED, neonatal nurseries, oncology, trauma, bariatric medicine, and mental health), emergency standby readiness, and 24/7 admission capability — are inherently facility-level phenomena. If the framework were to exclude these on purist grounds, it would systematically disadvantage hospitals that maintain essential acute infrastructure and

serve complex or vulnerable populations. CHA therefore considers that a limited number of well-governed facility-level adjustments will be necessary to preserve access and viability, and these should be tightly controlled through clear criteria, regular review, and transition arrangements.

A further adjustment challenge relates to service type and setting. A credible PNEP must differentiate pricing across inpatient, day-only, outpatient, rehabilitation, palliative care, mental health, hospital-in-the-home, and emerging virtual care models. While efficient day-only hospitals may attract increased funding under a pure DRG relativities model, the framework must also safeguard overnight hospitals, which carry higher fixed costs and maintain emergency and unplanned-admission capability. Standby cost adjustments will be required to ensure that the system continues to support hospitals that sustain critical acute-care capacity.

CHA also notes that adjustments must interact coherently with efficiency and benchmarking settings. Benchmarking against efficient providers may drive technical efficiency, but transitional arrangements will be essential so higher-cost hospitals are not destabilised. Similarly, annual price indexation must capture wage growth, energy costs, inflation, and the cost of new diagnostics and treatments to ensure pricing remains contemporary and sustainable. Workforce-intensive and high-medical-cost specialties, particularly in regional areas experiencing severe staff retention pressures, must be reflected in the modifier architecture.

Finally, the framework is largely silent on how adjustments will interact with future design choices, including the incorporation of capital, the move toward bundled pricing, or the eventual establishment of a national floor price. If capital and safety/quality elements are to be progressively integrated into the PNEP and, ultimately, into a bundled Private Weighted Activity Unit, the adjustment architecture must be designed with this end-state in mind. CHA therefore recommends that the framework articulate:

- a limited, prioritised set of initial adjustments (e.g., remoteness, ICU/complex care, and safety/quality modifiers)
- a formal adjustments policy, modelled on IHACPA's approach
- a commitment to simplification and consolidation as data quality improves and as the sector transitions toward comprehensive bundled pricing.

With these additions, the adjustments and modifiers framework would better balance fairness, simplicity, sustainability, and incentives, and would provide a more robust foundation for a credible, trusted PNEP in the private sector.

#### **Summary**

The framework's approach to adjustments is sensible and consistent with modern ABF practice, but it lacks the detailed rules and safeguards needed for credibility. While it rightly recognises the need for modifiers reflecting remoteness, complexity, and safety/quality, it does not yet specify how adjustments will be justified, governed, or reviewed. Key risks including adjustment creep, under-recognition of unavoidable facility-level costs, and misaligned incentives for day versus overnight hospitals, remain unaddressed. A clearer, formal adjustments policy and a prioritised, limited initial set of modifiers are needed to ensure fairness, protect complex and regional services, and support long-term transition to bundled, capital-inclusive pricing.

## Integration of parallel funding streams into the PNEP

### Prescribed List

From CHA's perspective, there are clear conceptual advantages to progressively bundling PL items into the PNEP over the long term. Bundling aligns with Activity Based Funding principles, supports more integrated episode pricing, and could reduce administrative burden, simplify billing workflows, and improve cashflow reliability. It may also streamline access to new technologies by allowing TGA-approved devices costed through NHCDC processes to enter funding arrangements more rapidly than under the current PL cycle.

However, the private sector's device landscape is highly heterogeneous, and this creates material risks for any bundling approach that relies on averaged DRG costs. Early analysis of HCP data shows substantial variation in device use and pricing across states, hospitals and technology platforms—often several thousand dollars within the same DRG. These variations are not inefficiencies but reflect structural differences in cath lab systems, robotics platforms, implant families, clinical training, credentialing, and embedded technology ecosystems. Compressing this variation into a single “average” price would distort clinical decision-making and undermine access to appropriate technologies.

The potential bundling of PL devices into the PNEP is therefore best understood as a long-term objective. Significant structural changes in the market would be required to enable it. Clinical practices, technology platforms and robotic systems vary substantially across hospitals, making simple average-based bundling risky. Without strong safeguards, bundling could distort device selection, discourage investment in advanced technologies, and create opportunities for insurers to inappropriately drive down prices. Robust regulation and protection of clinical independence are essential prerequisites.

A further critical concern is the structural disadvantage faced by smaller and day hospitals. Bundling would shift responsibility for device procurement onto hospitals, effectively requiring them to negotiate directly with manufacturers. Large hospital groups may have the purchasing scale to do this; smaller operators do not. This is the single most significant fear raised by day hospital operators, who could face higher device costs, weaker negotiating power and financial instability under a bundled regime. Any bundling model must explicitly protect smaller providers from being disadvantaged.

Bundling also cannot be considered in isolation from its effect on whole-of-episode resource use. Device choice affects theatre time, length of stay, complication risks and downstream care pathways. A bundling model that focuses only on device cost, without adjustments for these broader impacts, would distort both clinical and financial incentives. Any progression toward bundling must therefore be guided by a full health technology assessment (HTA) approach, not a narrow cost-averaging exercise.

Given these complexities, CHA maintains that full PL bundling into the PNEP is a long-term objective that should not proceed until the system has far more mature data, costing completeness and adjustment methodologies. Near-term bundling would be unsafe without a clear evidence base for managing variation, safeguarding clinical autonomy, supporting smaller providers, and ensuring the pricing model remains elastic enough to accommodate both high- and low-cost technologies without compromising access or innovation.

Accordingly, CHA recommends that the framework be strengthened by:

- acknowledging that device use and pricing vary legitimately across states, providers and clinical platforms, and that this variation must be protected, not compressed into an average
- committing to extensive analysis of HCP, NHCDC and clinical data to understand the full distribution of device costs before setting any bundling parameters
- avoiding prescriptive assumptions about which categories could be bundled early, given the high degree of underlying variation
- ensuring any future bundling model includes robust adjustments and safeguards for technical ecosystems, training differences and hospital capability
- explicitly addressing the purchasing and negotiating disadvantage of smaller and day hospitals
- ensuring strong, independent regulatory oversight to prevent insurers using bundling to inappropriately drive down prices or restrict device choice
- explicitly protecting clinical autonomy and patient choice as non-negotiable principles
- aligning bundling decisions with broader HTA principles that account for whole-of-episode impacts, not just device costs
- maintaining flexible funding mechanisms, including top-ups or separate benefits, for high-cost, rare-use or platform-dependent technologies until stable, reliable data supports integration.

#### **Summary**

CHA cautiously supports the long-term goal of bundling PL items into the PNEP, but the private device market is currently too varied and complex for safe or equitable integration. Device costs differ widely across hospitals, states and technology platforms, and these differences reflect legitimate clinical and technological factors, not inefficiency. Averaging these costs into a single DRG price would distort clinical decision-making, jeopardise access to advanced technologies and disproportionately disadvantage smaller and day hospitals with limited purchasing power. Bundling also affects whole-of-episode costs and therefore requires a full health technology assessment approach, strong regulatory safeguards, and protections for clinical autonomy. Given these risks, CHA considers PL bundling a long-term objective only, to proceed cautiously and only when data quality, costing maturity and adjustment methods are significantly improved.

#### **Pathology**

Pathology is a critical component of acute care, but in the private system it sits largely outside hospital funding structures, being reimbursed through the MBS and billed directly by pathology providers. This creates fragmentation in pricing and incentives and raises the question of whether pathology might, in the long term, be incorporated into a bundled PNEP price. There are conceptual advantages to bundling: it would create a more complete episode price, reduce some administrative complexity, and align pathology costs with broader clinical decision-making. However, these benefits must be balanced against significant feasibility challenges.

Pathology in private hospitals is predominantly Commonwealth-funded through the MBS; bundling would therefore require major policy changes to avoid shifting costs between Medicare, insurers and hospitals. In addition, pathology utilisation varies widely across specialties and providers, and current private-sector cost data is not sufficiently complete or granular to support reliable DRG-level pathology cost weights. Premature bundling risks underfunding high-acuity services or constraining clinically necessary diagnostic testing. We

also recognise that current pathology and imaging arrangements create substantial out-of-pocket costs for patients, as insurer contracts with national providers vary widely by fund and by state. This variation can generate patient and clinician dissatisfaction, and highlights the opportunity for improved visibility of insurer funding arrangements or even the development of an industry minimum standard for diagnostics.

For these reasons, CHA views pathology bundling as a potential long-term consideration, but not an essential or immediate requirement for the PNEP to be viable. The focus in the near term should be on strengthening pathology utilisation and cost data within the NHCDC, improving transparency of test-level variation, and assessing the broader policy implications for MBS-funded services. Better insight into these arrangements would support this work and help identify practical improvements without requiring immediate structural reform. Only once these foundations are in place, and only if Commonwealth policy settings evolve accordingly, should the desirability of bundling be reassessed. In the interim, maintaining the existing funding split remains necessary to avoid disruptive cost shifting and protect access to essential diagnostic services.

#### **Summary**

Pathology bundling may offer long-term conceptual benefits but is not essential to early PNEP implementation. Given its MBS funding structure, high utilisation variability, and limited private-sector cost data, bundling at this stage would create risks for access, equity, and funding stability. CHA recommends prioritising improved pathology data and transparency before reconsidering any future integration.

#### **Training**

CHA emphasises that private hospitals make a significant and growing contribution to Australia's specialist medical training pipeline, particularly as public-sector capacity becomes increasingly constrained. While private hospitals do receive some Commonwealth support for training through programs such as the Specialist Training Program (STP), which funds registrar salary support, supervision allowances, and limited infrastructure payments, these mechanisms cover only a portion of the true cost of delivering high-quality training in private settings. The broader organisational, supervisory and opportunity costs remain largely unfunded.

Private hospitals incur substantial indirect and direct costs when supporting training placements, including:

- consultant time for supervision and protected teaching
- reduced theatre or ward efficiency during training procedures
- administrative support for accreditation, rostering and reporting
- investment in training infrastructure, simulation, governance and safety oversight
- coordination with medical colleges and universities
- the cost of maintaining training pipelines across specialties with unpredictable casemix.

In contrast, public hospitals receive dedicated Teaching, Training and Research (TTR) block funding under the National Health Reform Agreement, recognising that these activities deliver system-wide workforce benefits. No equivalent, systematic funding stream exists in the private sector. As training demand increases, driven by rising registrar numbers, national workforce shortages, and college requirements for multi-setting experience, the absence of a structured

funding mechanism for private hospitals creates a growing sustainability risk. Without appropriate support, hospitals may be forced to limit or withdraw training placements, reducing national training capacity and contributing to workforce maldistribution.

CHA therefore considers that the PNEP must explicitly recognise teaching and training as a legitimate, unavoidable cost driver, and that private hospitals providing accredited training should be eligible for a dedicated adjustment or supplement. Importantly, this should not duplicate existing STP funding but should complement it, addressing the unfunded components such as supervision time, infrastructure overheads and lost productivity that STP does not cover.

#### **Summary**

CHA notes that private hospitals play an increasingly important role in Australia's specialist training pipeline but receive no systematic funding equivalent to the public-sector TTR block grant. Existing programs like the STP cover only a fraction of the real costs, leaving supervision time, infrastructure, administration and lost productivity largely unfunded. As training demand grows, this gap threatens the sustainability of private-sector training capacity. CHA therefore recommends that the PNEP include a dedicated teaching and training adjustment to recognise these unavoidable costs and complement, not duplicate, existing STP funding.

#### **Research**

Research activity is an essential component of high-quality hospital care, underpinning innovation, clinical advancement and the translation of new evidence into practice. Unlike public hospitals, which receive dedicated TTR block funding, private hospitals currently absorb the costs of research infrastructure, governance, ethics administration, data management and clinician time without systematic funding support. As the PNEP moves toward a more comprehensive and bundled pricing model, it should explicitly recognise research as a legitimate and unavoidable cost of delivering contemporary care. Incorporating an adjustment or supplement for accredited research-active hospitals would help ensure that private providers can continue to participate in clinical trials, support investigator-led studies, and contribute to national research capacity without compromising operational viability.

#### **Summary**

Research is a core component of modern hospital care, yet private hospitals currently bear these costs without dedicated funding support. The PNEP should incorporate an adjustment recognising research-related costs to ensure private providers can continue contributing to national clinical research and innovation.

#### **Visiting Medical Officer Fees**

VMO fees represent one of the largest parallel funding streams in the private hospital system, yet they sit almost entirely outside the PNEP and the existing contracting relationships between hospitals and insurers. Unlike public hospitals, where medical staff are salaried or sessionally contracted, private hospitals rely on VMOs, which are independent specialists who bill patients and insurers directly through the Medicare Benefits Schedule (MBS). This creates a structurally separate funding channel that interacts with, but is not integrated into, hospital pricing.

The separation of VMO fees from hospital funding creates important advantages. It preserves clinical independence, supports patient choice of specialist, and ensures that medical fee-setting is governed through established MBS arrangements rather than hospital-negotiated payments. VMOs are central to the private hospital model, providing the flexibility, responsiveness and entrepreneurial clinical leadership that underpin much of the sector's service innovation. The current system also allows doctors to retain control over their billing practices and business models, which is a valued feature of private medical practice.

However, this separation also introduces complexity and misalignment in the pricing framework. Because medical and hospital funding are determined through different mechanisms, and sometimes with conflicting incentives, there is limited capacity to create coherent, episode-level pricing signals that encourage coordinated, efficient care. For example, insurer gapcover arrangements can shape VMO billing behaviour, but have no connection to hospital efficiency or quality signals. Similarly, the MBS fee-for-service structure incentivises activity volume, while the PNEP aims to move towards bundled, case-based funding.

The divergence between MBS and hospital funding also poses administrative and financial risks for consumers. Patients may experience out-of-pocket costs driven by VMO fees even when the hospital component is fully covered, leading to inconsistent affordability and contributing to public dissatisfaction with private health insurance value. For hospitals, VMO billing practices can affect case-mix, length of stay, and theatre utilisation, yet hospitals have limited levers to influence these patterns under the current model.

For the PNEP to operate effectively, it must acknowledge that VMO fees are structurally outside the pricing system, but still exert significant influence on hospital operations, cost structures and patient experiences. While CHA does not support incorporating VMO fees into the PNEP or altering the independence of medical billing, the framework should commit to:

- monitoring interactions between MBS settings and hospital activity-based pricing, particularly where misaligned incentives could affect safety, quality or cost
- supporting transparency around total episode costs, including both hospital and medical fees, to help consumers understand their likely out-of-pocket charges
- aligning incentives where possible, such as through value-based contracting approaches that link quality outcomes to both hospital and VMO practice
- ensuring the PNEP does not create unintentional distortions in medical practice patterns, especially in procedural specialties where VMO activity directly shapes hospital workflow and resource use.

#### **Summary**

VMO fees sit entirely outside hospital pricing and are funded through the MBS, preserving clinical independence and patient choice which are key strengths of the private model. However, this separation also creates misaligned incentives, fragmented pricing signals, and contributes to patient out-of-pocket costs. While CHA does not support incorporating VMO fees into the PNEP, the framework must acknowledge their impact on hospital operations and safeguard against distortions. CHA recommends monitoring MBS–PNEP interactions, improving transparency on total episode costs, pursuing opportunities for aligned value-based incentives, and ensuring PNEP design does not inadvertently influence medical practice patterns.

## Data quality and costing methodology

CHA agrees that the success of the PNEP will stand or fall on the quality of the underlying activity and cost data, and acknowledges that the draft framework identifies many of the right building blocks. The decision to use the Private Hospital Data Bureau (PHDB) as the primary activity data source is sound: it is a legislated collection, submitted monthly by all private hospitals within six weeks of discharge, and includes ICD-10-AM, demographic, and funding information for all separations. Compared with the Admitted Patient Care NMDS, which is de-identified at facility level and subject to long lags, PHDB provides a timelier and more granular base for pricing. The use of Hospital Casemix Protocol (HCP) data as a complementary source, particularly for charge information and for day hospital cost estimation, is also appropriate, provided its limitations are clearly acknowledged.

The framework's description of costing methodology is also conceptually robust. It correctly anchors the PNEP in the NHCDC, using patient-level cost data costed under the Australian Hospital Patient Costing Standards (AHPCS), which are mandated by IHACPA for both public and private submissions. The NHCDC private sector collection is already used to generate AR-DRG cost weights for overnight private hospitals, and these weights inform some current insurer funding models. This aligns the private pricing framework with established national methodology: AHPCS v4.x sets out the rules for allocating all in-scope costs to episodes in a complete and consistent way, and is already used to support the public NEP.

At the same time, CHA is concerned that the current coverage and representativeness of the private NHCDC is not yet sufficient to support the weight that will be placed on it. The framework notes that the private NHCDC is a voluntary collection, currently covering around 65 per cent of overnight admitted episodes and only a subset of hospitals, with day hospital data collected irregularly. Recent IHACPA reports confirm that the private NHCDC is still a voluntary sample used to generate cost weights by AR-DRG, rather than a census-level dataset. The framework's proposal to mandate participation in the private NHCDC as a condition of being declared a private hospital, expand coverage to day hospitals, and tailor the data request to minimise burden is therefore essential. CHA strongly supports this direction and considers it a precondition for a credible PNEP.

In addition, as outlined above, the current datasets do not capture the cumulative effects of long-term underfunding, deferred capital investment, or the deteriorating asset base across the private hospital sector. As a result, any baseline for a new funding model must explicitly account for these historical gaps and the capital replacement required to maintain safe, contemporary services.

The framework also highlights practical data quality risks, especially in relation to day hospitals, mental health, subacute care and emerging models such as hospital-in-the-home. It acknowledges that many day hospitals outsource financial reporting and have a narrow service mix, limiting their capacity to undertake detailed patient-level costing under current NHCDC specifications. It further notes that mental health and subacute classifications and outcome measures (such as AN-SNAP and AMHCC) are not yet consistently collected in the private sector. CHA welcomes the proposed Phase 1a data improvements program, including rationalisation of activity collections, enhanced validation, expansion of NHCDC coverage, and improved mental health and subacute data, but considers the framework should go further in specifying tangible milestones, data quality thresholds and remediation pathways if those thresholds are not met.

On costing governance, the framework rightly points to the role of the Independent Financial Review (IFR) in the public system, which tests whether AHPCS has been applied consistently and whether all relevant costs and activity have been captured in NHCDC submissions. In the public sector, the IFR is commissioned annually to assure that NEP inputs are robust and fit-for-purpose. The draft framework proposes that the Department use data from the new Financial Disclosure Framework to build a similar quality-assurance process for the private NHCDC. CHA strongly supports this, but recommends that IFR-style scrutiny for the private sector be explicitly formalised: including publication of high-level findings, clear expectations around reconciliation between general ledgers and NHCDC submissions, and transparent treatment of outliers and missing data. Without this, there is a risk that systematic under-allocation or inconsistent costing practices could flow directly into the PNEP.

CHA also notes that the framework's implementation timetable relies heavily on data that does not yet exist in the required form. Phase 1 envisages an indicative PNEP for admitted acute care by July 2026, based on current overnight NHCDC data plus HCP-derived estimates for day hospitals; Phase 2 then moves to a comprehensive PNEP following data improvements. This sequencing is reasonable, but it heightens the need for a clear "fit for purpose" test before any PNEP is used for regulatory or floor-price purposes. In CHA's view, this test should include minimum participation and coverage benchmarks for the private NHCDC, demonstrated adherence to AHPCS, evidence that key cost buckets (e.g. labour, prostheses, overheads, capital) are being allocated consistently, and external validation that PHDB/HCP activity volumes reconcile to NHCDC activity at hospital level.

Finally, CHA considers that the framework does not yet fully address the link between costing methodology and future design choices, particularly capital inclusion and bundled pricing. The costing standards and NHCDC specifications will need to be adapted to support reliable capital costing (distinguishing between maintenance and growth capital) and to ensure that costs associated with new models of care, digital infrastructure and workforce reform are systematically captured rather than residual. Without deliberate design changes to AHPCS implementation in the private sector, there is a risk that PNEP will be built on a narrow view of "operating costs" that underestimates the true cost of maintaining a safe and contemporary private hospital network.

#### **Summary**

CHA supports the framework's reliance on PHDB, HCP and NHCDC data, and agrees that high-quality, patient-level costing is essential for a credible PNEP. While the conceptual approach is sound and aligned with AHPCS standards, current NHCDC coverage is incomplete and not yet robust enough to underpin national pricing. It also does not account for the cumulative effects of long-term underfunding, deferred capital investment, or the deteriorating asset base across the private hospital sector. Mandatory NHCDC participation, stronger validation, better day hospital, mental health and subacute data, and IFR-style assurance processes are therefore critical. CHA recommends clear data quality milestones, minimum coverage thresholds, and a formal "fit-for-purpose" test before the PNEP is used for regulatory or price-floor decisions. The framework must also ensure costing methods evolve to support future capital inclusion, bundled pricing and new models of care, so the PNEP reflects the true cost of delivering safe, modern private hospital services.

## Implementation, transition, and feasibility

### Phased implementation approach

CHA acknowledges that the framework sets out a deliberately staged implementation pathway: an indicative PNEP by July 2026, a comprehensive PNEP by July 2027 following data improvements, and full replacement of the default benefit regime by July 2028. This sequencing is sensible in principle. It begins with “no regrets” steps using existing private NHCDC data to derive an initial price for admitted acute activity, then strengthens the data foundations through a structured improvement program, before moving to system changes with regulatory consequences such as replacing second-tier default benefits. This mirrors the staged national rollout of activity-based funding in the public system, which matured over several years.

The framework also identifies three “non-negotiable conditions for success”: timely access to establishment-level NHCDC data; sufficient technical capability to build and maintain the pricing model; and meaningful engagement with the sector. These preconditions are appropriate. Phase 1 is positioned as a learning and testing phase, drawing on current overnight NHCDC data, HCP charges for day hospitals, early capital information from the Financial Disclosure Framework, and preliminary adjustment testing. If executed well, this should expose technical issues before any binding price settings occur.

However, CHA is concerned that the timeline is highly ambitious relative to current data quality and system readiness. The framework acknowledges that Phase 1a must rationalise multiple activity collections, expand NHCDC coverage, implement the Financial Disclosure Framework, and test safety and quality adjustments, all by December 2026. In contrast, public-sector ABF reform evolved over a much longer horizon with extensive refinement, shadow pricing and classification updates. Moving from a partial, voluntary private NHCDC to a comprehensive, capital-capable PNEP in such a compressed timeframe introduces significant execution risk.

A further readiness concern is DRG classification alignment. Private hospitals and insurers currently operate across multiple AR-DRG vintages. Without mandatory transition to a contemporary, uniform DRG version, costing, relativities, distributional modelling and pilot evaluation will be unreliable. DRG alignment should be a precondition for progression between phases.

What is missing is a set of explicit “gateways” or readiness tests. The framework describes what each phase will deliver but not the criteria that must be met before moving forward. For example, Phase 2 (comprehensive PNEP) and Phase 3 (replacement of default benefits) should clearly depend on minimum NHCDC coverage, including day hospitals, demonstrated consistency with costing standards, validated adjustments, and improved mental health and subacute data. Without these safeguards, the risk is that timelines override readiness, creating unstable prices or unintended market impacts.

CHA notes that the ambitious timeline also reinforces the need for short-term stabilisation measures, given the gap between immediate sector pressures and the time required to build a safe, credible pricing architecture. As outlined earlier, a temporary inflator, such as the DVA-based model, remains essential to maintain hospital viability during the transition. In parallel, the longer-term pathway must lead toward a fully bundled, comprehensive price that incorporates capital, devices, and quality signals once data maturity is achieved.

CHA therefore recommends the framework be strengthened by:

- Defining clear readiness criteria for moving between phases (e.g. coverage, reconciliation, quality thresholds).
- Including a formal shadow-pricing period where the PNEP is modelled alongside existing arrangements, including second-tier default benefits, before becoming a binding floor price.
- Sequencing early uses of the PNEP into low-risk, high-value applications (e.g. premium rounds, benchmarking, risk equalisation) before it becomes the legal basis for minimum benefits.
- Recognising the need for a short-term inflator to maintain stability while foundational data and governance structures mature.
- Clarifying that the long-term end-state is a comprehensive, bundled price, developed through staged integration of capital, devices, and quality signals as data quality improves.

With these enhancements, the phased implementation pathway would better balance urgency with prudence, ensuring momentum toward a modern, bundled pricing model while protecting system stability during the transition.

#### **Summary**

The staged rollout of the PNEP is sensible, but the timelines are ambitious given data gaps, inconsistent DRG use and readiness risks. CHA supports phased implementation but calls for clear readiness criteria, shadow-pricing, and early use confined to low-risk applications. Because full reform will take time, a short-term inflator is needed to stabilise hospitals now, with the long-term goal of moving to a fully bundled, comprehensive price once the system is ready.

#### **Sector readiness and capacity**

CHA agrees that the sector is conceptually ready for reform, but considers that its practical capacity to absorb and operationalise the proposed framework is highly uneven, and in some areas, fragile.

The 2024 *Private Hospital Sector Financial Viability Health Check* confirms that, while some large operators remain profitable, the sector overall has experienced declining margins over time as costs have risen faster than revenue, with heightened volatility from COVID-19, inflation and workforce pressures. Smaller, regional and stand-alone hospitals are identified as being at particular risk. The recent collapse of Healthscope into receivership, involving 37 hospitals and 19,000 staff, has further underscored the limited capacity of private providers to absorb additional financial or contractual shocks without transitional supports or clear, predictable funding rules. In this context, any implementation plan must assume a sector under strain, not a sector with spare capacity to manage complex change at pace.

On the technical and data side, capacity is similarly uneven. Large not-for-profit groups and national for-profit providers generally have established casemix, costing and analytics teams and are already familiar with AR-DRGs, PHDB, HCP and, in some cases, NHCDC participation. By contrast, many day hospitals and small stand-alone facilities outsource financial reporting, have limited in-house analytical capability and do not routinely undertake patient-level costing. The framework itself acknowledges that the current private NHCDC only covers around 65 per cent of overnight activity, that day hospital costing has been inconsistent, and that broader participation will require tailoring the data request and providing capacity-building support. Without explicit investment in data and costing capability, particularly for smaller and regional

providers, there is a real risk that the PNEP will be driven by the cost structures of the largest players, further marginalising those with the least capacity to contribute.

Readiness is stronger on the insurer side, where funds already employ actuaries and data scientists and many have developed DRG-based funding models or internal benchmarking tools. However, moving from proprietary, bilateral pricing models to a national reference price and, ultimately, a regulated floor price will require significant systems change, product redesign and board-level risk appetite decisions in the private health insurance sector. Absent a clear, co-designed roadmap and sufficient lead time, there is a risk that insurers default to conservative behaviours, for example, limiting network breadth or tightening utilisation management, that could unintentionally erode patient access even as pricing becomes more transparent.

On the government side, the Department and IHACPA bring deep experience from a decade of public-sector activity-based funding and NEP determination. However, the draft framework implicitly assumes that this expertise can be extended to the private system without substantial new resourcing or structural change. In reality, pricing private hospitals involves different data flows, different contracting behaviours, commercial sensitivities and a far more heterogeneous provider landscape than the state-owned public system. Effective implementation will require a dedicated private hospital pricing unit, stable funding for analytics and stakeholder engagement, and a formal governance structure that includes balanced representation from hospitals (including regional and day hospitals), insurers, clinicians and consumers.

Overall, CHA's assessment is that there is strong policy appetite for reform but constrained operational capacity. To make the framework feasible, the implementation plan should explicitly provide for:

- targeted capacity-building for smaller and regional hospitals (e.g. support for costing systems, training and data quality improvement);
- structured engagement mechanisms (technical working groups, joint insurer-provider forums) to support sector learning and problem-solving; and
- realistic lead times for major system changes (e.g. mandatory NHCDC participation, PL bundling, introduction of a floor price).

Without these supports, there is a material risk that the reform timetable outpaces sector readiness, leading to destabilisation of already fragile providers and undermining confidence in the PNEP before it is fully established.

#### **Summary**

The sector supports reform in principle, but its practical capacity to implement the PNEP varies widely. Many hospitals, especially smaller, regional and stand-alone facilities, are financially fragile and lack the technical capability to participate in complex costing and data requirements. Insurers are better prepared but will still face significant systems and product redesign challenges. Government agencies bring strong ABF experience but will require dedicated resourcing and governance tailored to the private sector. To avoid destabilising already strained providers, the framework must include targeted capacity-building, structured engagement, and realistic lead times for major changes.

#### **Transition and risk management**

CHA considers the transition from the current fragmented pricing environment to a nationally consistent PNEP to be one of the most complex elements of the reform, and one that requires

deliberate sequencing, strong safeguards, and clear contingency planning. While the framework sets out indicative milestones, it does not yet articulate the transition architecture necessary to protect hospitals, insurers and consumers from instability during the changeover period.

A central transition risk is the shift away from the second-tier default benefit arrangements, which have long functioned, albeit imperfectly, as a backstop for hospitals without negotiated contracts. Replacing this regime with a national floor price will fundamentally alter market dynamics. Without a carefully managed transition, there is a risk of distributional shocks, including sudden revenue reductions for particular hospital types, reduced service viability in regional areas, or unintended incentives for insurers to delay contracting in anticipation of reforms. CHA believes the framework must include a staged, monitored transition pathway that incorporates shadow pricing, stability tests, and phased implementation before any new minimum benefit becomes binding. In addition, targeted transition funding or temporary stabilisation payments will be essential to support hospitals most exposed to revenue shocks, ensuring service continuity and preventing avoidable closures while the new pricing architecture beds down.

There are also significant data and modelling risks. The early iterations of the PNEP will rely on incomplete NHCDC coverage, variable costing capability, and emerging data for mental health, subacute and day hospital services. If pricing is implemented before these foundations are sufficiently robust, errors or misestimations could flow directly into the national price, causing destabilising fluctuations. To mitigate this, CHA recommends a formal “readiness gateway” requiring demonstrable thresholds in data quality, coverage and reconciliation before the PNEP is used for regulatory or financial purposes.

Market behaviour presents a further transition risk. As the framework moves towards a national floor price, insurers may adjust their strategies, seeking to narrow networks, reduce contract variation, or shift utilisation management practices, to preserve negotiating leverage. Hospitals, particularly smaller and regional providers, may similarly face pressure to absorb costs or change service mix during the transition. Without clear guardrails, such behaviours could reduce patient access, weaken competition, or accelerate financial distress. The transition plan should therefore include mechanisms for ongoing monitoring of contracting trends, insurer conduct and hospital viability, supported by an escalation pathway where market distortions emerge.

Workforce and capital investment risks also require explicit management. A poorly sequenced transition may inadvertently deter capital upgrades, limit recruitment, or deepen pre-existing workforce shortages, particularly in regions already facing sustainability challenges. Transitional supplements, viability loadings, and temporary stabilisation payments may be necessary for certain hospital types until the PNEP stabilises and capital inclusions are fully incorporated into the pricing model.

Finally, transparent communication, engagement and dispute-resolution processes will be essential. Providers and insurers will need clarity on timelines, obligations, modelling assumptions and price-setting methodologies. Without consistent communication and a structured resolution mechanism, uncertainty may escalate into contestation, delays or loss of confidence in the reform.

#### **Summary**

Transitioning to a nationally consistent PNEP carries significant risks that require careful sequencing, strong safeguards and clear contingency planning. Key risks include replacing

second-tier default benefits, relying on incomplete data in early PNEP iterations, and potential destabilising behaviours by insurers or financially vulnerable hospitals. CHA recommends staged transition steps, such as shadow pricing and readiness gateways, to ensure data quality, modelling accuracy and market stability before any price becomes binding. Additional risks relate to capital investment, workforce pressures and regional hospital viability, all of which may require temporary supports. Clear communication, ongoing monitoring, and structured dispute-resolution processes will be essential to maintain confidence throughout the transition.

## **Governance, oversight, and accountability**

### **Institutional arrangements**

CHA considers the success of the PNEP will depend heavily on the strength, clarity and independence of its institutional arrangements. While the draft framework outlines the proposed roles of the Department and IHACPA, it does not yet articulate a governance model capable of stewarding a national pricing system in a complex, commercially sensitive, multi-payer environment. Effective institutional design must ensure technical integrity, procedural fairness, transparency, and balanced representation across a sector characterised by significant power asymmetries.

At the core of the system, IHACPA should serve as the independent technical authority responsible for classification, costing standards, data validation, and price development. IHACPA's established expertise in public hospital pricing provides a strong methodological foundation, but the private system's heterogeneity means that its remit must be adapted, supported with dedicated private-sector resources, and informed by deep private hospital and insurer engagement. The Department, in turn, should provide policy direction and regulatory design, while ensuring that price-setting processes remain insulated from short-term political or fiscal considerations.

A critical structural weakness remains unaddressed: the Department currently acts as both policy-maker and regulator in the private health sector, a dual role that has led to weak and inconsistent enforcement, particularly in relation to the PL and certifications. Failure to exercise regulatory powers has contributed to significant payment delays and disputes, allowing insurers to question or withhold payments with minimal justification. This places private hospitals at a structural disadvantage, forcing them to carry the burden of proof and absorb substantial administrative cost to contest decisions. Such asymmetry not only favours insurers but also embeds inefficiency and uncertainty in the system. Strengthened, independent regulatory oversight is essential to restore balance, support timely and fair payment practices, and underpin the credibility of a future PNEP.

For these reasons, CHA recommends the establishment of an independent private health regulatory function, rather than simply an advisory function. This regulatory function would operate at arm's length from government and market participants, with a clear statutory mandate to:

- enforce pricing and benefit requirements (including the PNEP as a national floor price)
- monitor insurer and provider behaviour for anti-competitive or distortive conduct
- oversee compliance with data, costing and classification standards

- investigate systemic issues, such as undue downward price pressure or access concerns
- provide transparent public reporting and recommendations to the Minister.

Structured advisory mechanisms, including representation from private hospitals (regional, metropolitan and day hospitals), insurers, clinicians, and consumers, should be built into the Authority’s processes. However, decision-making power must rest with an independent board with expertise in private sector operations, health economics, pricing, regulation and clinical governance. This ensures that no single actor can dominate or influence the integrity of the pricing system.

Clear separation of functions is also essential. The institutions responsible for data collection (PHDB, NHCDC), technical pricing work (IHACPA), regulatory enforcement (the independent regulator), and system oversight (the Minister and Parliament) must each have clearly delineated responsibilities. Transparent lines of accountability will protect against real or perceived conflicts of interest and maintain trust in the PNEP, particularly given the commercial stakes involved.

Finally, institutional arrangements must include strong audit and assurance functions. A private-sector equivalent of the public Independent Financial Review (IFR) will be required to validate costing methodologies, assess compliance, and ensure consistency in how hospitals and insurers report data. Without robust, independent scrutiny, inconsistencies in costing or data completeness risk undermining confidence in the PNEP and weakening its regulatory effect.

#### **Summary**

The effectiveness of the PNEP will depend on a strong, independent, and clearly defined governance model. While IHACPA provides the technical foundation for pricing, its role must be adapted for the private sector and supported by dedicated resources. CHA warns that the Department’s dual role as policy-maker and regulator creates conflicts of interest and has historically led to weak enforcement. To ensure credibility, CHA recommends establishing an independent private health regulator with statutory powers to enforce the national floor price, monitor insurer and provider conduct, oversee data and costing compliance, and report transparently to government. Clear separation of roles across data collection, pricing, regulation and ministerial oversight, supported by robust audit and assurance mechanisms, is essential to maintain trust and protect the integrity of the pricing system.

#### **Stakeholder engagement**

CHA considers meaningful, structured and continuous stakeholder engagement to be essential to the legitimacy and long-term success of the PNEP. A pricing framework that reshapes incentives, reallocates funding, and alters longstanding contracting dynamics cannot be implemented through technical work alone. It requires active collaboration with those who deliver care, those who fund it, and those who rely on it. While the draft framework acknowledges the need for engagement, it does not yet articulate the mechanisms, frequency or governance structures required to make stakeholder involvement systematic and enduring. CHA welcomes the Government’s decision to seek sector views on the framework, noting that this consultation represents an important step toward greater transparency and shared ownership of the reform. However, the current process also highlights the need for clearer, more predictable engagement structures as the work progresses.

For engagement to be effective, the governance architecture must include formal, ongoing and adequately resourced technical and advisory working groups. These should include:

- A technical working group, including hospitals, insurers, medical device manufacturers, IHACPA and methodological experts, to test models, review adjustments, and assess distributional impacts
- A clinical advisory group, ensuring pricing signals align with best practice, avoid perverse incentives, and appropriately recognise complexity, safety and quality
- A consumer and community advisory group, with a mandate to review transparency materials, patient experience impacts, value considerations and accessibility of information.

Such structures would mirror the consultative mechanisms that support the public NEP, while adapting them to the private sector's contractual and competitive environment. More structured forums would also reduce the need for ad-hoc consultations, ensuring that stakeholders can contribute earlier in the development cycle rather than responding to near-final decisions.

Stakeholder engagement must also be iterative and continuous, not episodic. As the PNEP moves through phased implementation, there must be clear opportunities for providers and insurers to review draft models, validate data, raise concerns, and propose refinements. This is particularly critical for small and regional providers whose capacity to engage is limited; dedicated support and simplified engagement pathways will be needed to ensure their needs are not overshadowed by larger, better-resourced organisations.

CHA also emphasises the importance of transparent feedback loops. Engagement must not only collect views but show how those views have influenced decisions. Regular publication of consultation summaries, modelling changes, and rationale for adjustments will build trust and reduce perceptions of opacity or bias, especially given the high commercial stakes in private health contracting. Establishing a consistent, transparent engagement cycle from the outset will ensure that consultation is not only undertaken, but demonstrably integrated into the policy and pricing design process.

#### **Summary**

Effective implementation of the PNEP will depend on structured, continuous and well-resourced stakeholder engagement. CHA stresses that pricing reform cannot be driven solely through technical modelling; it must actively involve hospitals, insurers, clinicians, consumers and industry. The current framework acknowledges engagement but lacks clear mechanisms or governance structures. CHA recommends formal technical, clinical and consumer advisory groups, mirroring public NEP processes, to test models, review impacts and ensure pricing signals support quality and transparency. Engagement must be iterative, with regular opportunities to validate data and refine design, particularly for smaller and regional hospitals with limited capacity. Transparent feedback loops that show how stakeholder input shapes decisions will be essential to building trust and supporting shared ownership of the reform.

#### **Monitoring, evaluation, and continuous improvement**

CHA considers robust monitoring, evaluation and continuous improvement mechanisms to be fundamental to the success, credibility and long-term adaptability of the PNEP. A pricing framework of this scale cannot remain static; it must evolve as data quality improves, as service

models change, and as the sector responds to new clinical, technological and financial pressures. While the draft framework acknowledges the importance of ongoing review, it does not yet articulate a comprehensive performance framework, evaluation methodology or governance structure to support systematic, evidence-based refinement.

A formal performance monitoring framework is essential. The PNEP will influence contracting behaviour, hospital viability, insurer expenditure, patient access, and quality of care. These impacts must be monitored through a structured suite of indicators covering:

- financial metrics (price relativities, cost coverage, benefit adequacy, distributional effects across hospital types)
- activity and utilisation patterns (case-mix shifts, changes in day vs overnight care, implications for regional access)
- quality and safety outcomes (HACs, readmissions, PROMs/PREMs once incorporated)
- market behaviour and competition (contracting trends, insurer conduct, impacts on smaller providers, patient choice).

Many of these indicators align with existing reporting mechanisms, but the framework must specify how they will be integrated into a cohesive evaluation dashboard, what thresholds will trigger further investigation, and which entity will be responsible for analysis and public reporting.

Evaluation must be both formative and summative. Formative evaluation should occur throughout implementation, enabling real-time adjustments to the pricing model as data coverage increases or unintended consequences emerge. Summative evaluation should assess the overall performance of the PNEP against its stated objectives at defined intervals, such as every three to five years. These evaluations should be independent, methodologically rigorous, and publicly released to ensure accountability and sector confidence.

Continuous improvement will also depend on a structured review cycle for pricing inputs, including the NHCDC, costing standards, adjustment parameters, safety/quality modifiers, and data completeness. The public hospital NEP benefits from annual refinement supported by formal consultation processes, clear policy principles and transparent methodological documentation. A similar rhythm is required for the private sector, with an annual (or biennial, in early years) price-setting cycle that incorporates structured feedback from technical working groups, providers, insurers and clinicians. This will help ensure the PNEP remains aligned with contemporary practice and does not entrench outdated cost structures or perverse incentives.

Data quality improvement must be embedded as a core component of evaluation. The PNEP's accuracy and fairness depend heavily on the representativeness and precision of private-sector costing and activity data. Monitoring should include explicit metrics on NHCDC participation rates, costing completeness, coding accuracy, timeliness and cross-dataset reconciliation. These metrics should be published and used to determine readiness for progressing to more advanced pricing stages, including capital inclusion, safety and quality adjustments, or bundled pricing. This ties the improvement agenda directly to pricing integrity and helps build trust in the evolving model.

Finally, continuous improvement requires mechanisms for issue escalation and policy refinement. The framework should establish clear pathways for stakeholders to raise concerns about anomalies, unintended impacts or methodological weaknesses, with defined timeframes for investigation and response. Similarly, governance bodies should have a mandated role in

guiding ongoing development, reviewing performance data, and recommending refinements to classifications, adjustments and minimum benefits.

#### **Summary**

CHA stresses that the PNEP must have a strong, transparent system for ongoing monitoring and refinement. Clear indicators are needed to track financial impacts, activity shifts, quality outcomes and market behaviour, with public reporting and defined triggers for action. Evaluation should be continual during implementation and periodic thereafter. A structured review cycle, similar to the public NEP, is essential to update costing standards, adjustments and data inputs as quality improves. Data completeness and accuracy must be core metrics, guiding when the system is ready for more advanced pricing elements. CHA also calls for formal mechanisms for raising issues and adjusting the model to ensure the PNEP remains accurate, fair and responsive over time.

### **Costs of implementation and ongoing administration**

CHA is concerned that the framework gives limited attention to the practical costs of implementing and administering the PNEP, both for government and for providers. International and Australian experience with ABF shows that building and maintaining a robust pricing system requires significant sustained investment in data infrastructure, costing systems, analytics capability and governance, not just at the centre but within every participating hospital. These costs are not incidental; they are structural overheads that must be recognised and funded if the model is to function as intended rather than becoming an additional burden on already stretched organisations.

For hospitals, implementation will require upgrades to patient-level costing systems, enhanced integration between clinical, billing and general ledger data, expanded coding and data quality functions, and ongoing resourcing for internal analytics, contract modelling and compliance. Larger groups may be better placed to absorb these requirements, but many smaller, regional and stand-alone facilities currently lack the in-house technical capability to meet NHDC standards without significant new investment. If these implementation and recurrent administrative costs are not explicitly recognised, either through dedicated support, transition funding, or explicit allowance in the efficient price, there is a real risk that the PNEP will disproportionately disadvantage providers with the least capacity to invest, further entrenching market concentration.

On the government side, the framework presupposes a substantial expansion of technical and regulatory work, including enhanced NHDC collection and validation, development of private-sector specific adjustments, impact modelling, distributional analysis, and ongoing monitoring and evaluation. This will require a dedicated private hospital pricing unit with stable, long-term funding, as well as resourcing for independent oversight and regulation (including IFR-style financial review, regulatory enforcement, and quality/PROMS/PREMS infrastructure). These functions cannot be delivered “within existing resources” without compromising quality, timeliness or trust in the resulting price.

CHA therefore recommends that the framework explicitly quantify, at least in broad terms, the expected implementation and ongoing administrative costs for both government and providers; outline how these will be funded (e.g. transitional grants, capacity-building programs, or explicit inclusion in the efficient price); and commit to monitoring administrative burden as part of the evaluation and continuous improvement cycle. Without a clear view of these costs and how

they will be met, there is a material risk that the PNEP becomes an unfunded mandate, diverting resources away from direct patient care and exacerbating exactly the sustainability pressures the reform is intended to address.

#### **Summary**

The framework does not adequately address the significant implementation and ongoing administrative costs associated with establishing a functioning PNEP. Hospitals, especially smaller and regional facilities, will require substantial investment in costing systems, data capability and compliance, while government will need dedicated, well-resourced pricing, regulatory and oversight functions. Without explicit recognition and funding of these costs, the PNEP risks becoming an unfunded mandate that strains provider capacity and undermines the very stability it seeks to deliver.

## **Economic and market implications**

### **Sector-wide financial impact**

CHA considers that the introduction of the PNEP has the potential to materially reshape the financial landscape of the private health system. The current environment, characterised by widening gaps between hospital costs and insurer reimbursements, growing volatility in contracting outcomes, and significant variation in benefit levels, has resulted in mounting financial stress for hospitals and rising uncertainty for insurers and consumers. A nationally consistent pricing framework can stabilise this environment, but only if its design and implementation carefully manage distributional impacts across providers, service types and geographic regions.

The immediate financial effect of the PNEP will depend heavily on how the initial reference price compares to existing contracted rates and default benefits. For some hospitals, particularly those with day-focused service profiles, strong cost-control, or existing DRG-based contracts, the PNEP may introduce relatively modest adjustments. For others, including regional hospitals, subacute and mental health services, overnight hospitals with fixed infrastructure, and facilities carrying high workforce or capital costs, the national price may initially fall below the cost of service provision. Without a transition strategy that includes temporary stabilisation measures and targeted loadings, the PNEP could inadvertently increase financial pressure on precisely those providers that sustain network diversity and regional access.

Insurer financial impacts will also be uneven. While the PNEP may constrain some of the price variation insurers currently negotiate, it will also introduce a more transparent and predictable cost base. This could strengthen insurers' ability to forecast benefit outlays and support more stable premium-setting. At the same time, if the national price is set above current contracted levels for some service types, insurers may face upward cost pressure in the short term, particularly during the transition to a regulated floor price. The financial impact on insurers will therefore be shaped by two factors: the degree of uplift embedded in the new price, and the pace at which the Department phases in minimum benefits and adjustments.

System-wide effects will also depend on how the PNEP interacts with existing cost drivers. Rising labour costs, workforce shortages, technology adoption, and increasing acuity in some patient cohorts mean that the PNEP must incorporate a credible and responsive indexation mechanism. If indexation is set too low, hospitals will continue to experience cost-price divergence, leading to further financial fragility and reduced reinvestment capacity. If set too

high without alignment to insurer revenue streams, it risks driving premium increases and eroding affordability for consumers. A balanced indexation model, combined with a robust capital component in the longer term, is therefore critical to maintaining financial stability across all actors. In this context, it is increasingly untenable for the annual premium round to remain a discretionary ministerial decision divorced from the underlying cost structures of the sector. The PNEP must directly inform the premium round through a transparent, technical process that aligns insurer revenue with efficient hospital costs. Without this linkage, the system risks politically driven premium outcomes that fail to reflect true cost movements, exacerbate affordability pressures, and undermine the integrity of the national price. Embedding the PNEP as a core input to premium-setting would depoliticise the process, strengthen predictability for insurers and hospitals, and ensure consumers benefit from a more rational and evidence-based pricing cycle.

In macroeconomic terms, the PNEP could improve national efficiency by reducing duplication, increasing transparency, and narrowing unjustified variation. However, this depends on the accuracy of the underlying data and the calibration of adjustments. Mispriced DRGs or underweighting of unavoidable cost differentials could distort service mix, alter hospital behaviour, or shift financial pressure onto particular parts of the system. This underscores the importance of a staged approach, shadow pricing, and readiness testing to mitigate large shocks.

#### **Summary**

The PNEP could stabilise private hospital pricing but will have uneven financial impacts. Some hospitals, especially regional, subacute and high-cost providers, may face pressure if the national price is below their costs, requiring transitional supports. Insurers will gain predictability but may face short-term cost increases. A credible indexation model and a formal link between the PNEP and the premium round are critical to avoid cost-price divergence. The benefits depend on accurate data and careful phasing to avoid market shocks.

#### **Incentives and behavioural effects**

The introduction of the PNEP will fundamentally reshape incentives across the private health system, influencing how hospitals configure services, how insurers contract and manage utilisation, and how clinicians engage with care pathways. A well-calibrated pricing model has the potential to promote efficiency, support quality improvement, and strengthen the alignment between cost and care complexity. An effective DRG-based price must also incentivise care to be delivered in the most clinically appropriate, least resource-intensive setting, ensuring that patients who can safely be treated in day settings are, while safeguarding the viability of overnight and complex-care services that require substantial fixed infrastructure. However, poorly designed incentives, or gaps in the adjustment architecture, could generate unintended behavioural responses that undermine access, equity and sustainability.

For hospitals, a nationally consistent price will introduce clearer signals about service mix and case complexity. Facilities with strong cost control, efficient day-surgery capability, and high-volume procedural care may benefit from greater price transparency and more predictable revenue streams. Conversely, hospitals that serve complex patients, maintain high fixed-cost infrastructure, or operate in regional areas may face pressure if adjustments do not fully account for unavoidable cost differentials. There is a risk that some providers could respond by

shifting case mix toward lower-cost, higher-margin activity, reducing availability of complex or unprofitable services, or narrowing clinical capability. Appropriate modifiers, viability supports, and safeguards for complexity are therefore essential to prevent distortion toward low-acuity care.

As outlined above, particular concern relates to day hospitals, which have fundamentally different cost structures and service models from overnight hospitals. If the PNEP inadvertently over-rewards day-only procedures relative to more complex or infrastructure-dependent services, it may create strong incentives for rapid proliferation of day hospitals, including new entrants targeting only profitable high-volume low-acuity activity. While day hospitals are an important part of the sector, uncontrolled expansion could saturate local markets, destabilise overnight hospitals that must maintain 24/7 emergency and critical-care readiness, and erode the cross-subsidisation that supports complex care. The pricing framework must therefore ensure that relativities do not over-incentivise day-only models at the expense of system-wide capability, clinical diversity and regional service security. Achieving this balance will be central to ensuring that DRG relativities drive appropriate care setting, not structural hollowing-out of acute capability.

Insurers will also face altered incentives. The PNEP may reduce their ability to leverage asymmetries in information and bargaining power, encouraging a transition toward more standardised contracting behaviours. Increased transparency may diminish the incentive for insurers to drive down benefits through opaque negotiation tactics, but it may also prompt some to tighten network management or shift towards more restrictive contracting models. Critically, there is a demonstrated risk that insurers may attempt to 'strip out' components of the DRG price by imposing parallel cost-cutting measures on devices, consumables or bundled service elements. This behaviour could undermine the integrity of the price signal and destabilise the very incentive structure the PNEP is intended to establish. There is a risk that insurers could prioritise providers with costs below the national price, potentially reducing consumer choice or weakening the viability of regional and not-for-profit hospitals. Regulatory guardrails and close monitoring of contracting patterns will be necessary to ensure insurers do not exploit the transition period to entrench competitive advantages.

Clinician incentives may also shift indirectly through their interaction with hospital and insurer policies. If the PNEP encourages an increased focus on day-surgery efficiency, clinicians may alter practice patterns in ways that favour shorter stays or procedural throughput. While this may improve technical efficiency, it could also create risks if not accompanied by robust quality and safety monitoring, including PROMs and PREMs. Over time, incorporating quality signals into negotiated payments above the national floor price could encourage clinicians and hospitals to collaborate around value, patient experience and outcomes rather than simply activity volume.

The PNEP will also influence patient incentives. A more consistent benefit structure will reduce unexpected out-of-pocket costs associated with benefit variability and poor contract visibility. Over time, improved transparency may help consumers better understand service value and differentiate between hospital offerings. However, if insurers respond by narrowing networks or increasing utilisation controls, patients may face reduced choice or increased administrative hurdles. The behavioural responses of insurers must therefore be monitored to ensure that reforms do not inadvertently undermine patient choice or access.

Ultimately, the behavioural effects of the PNEP will depend not only on the price itself but on the broader ecosystem of adjustments, governance, regulatory oversight and market conduct monitoring. Given the high commercial stakes and the risk of actors attempting to circumvent or dilute the DRG incentives, whether by shifting costs, redefining inclusions, or exerting commercial pressure on specific components such as devices, strong, independent regulatory oversight is essential. This reinforces CHA's recommendation for an independent private health regulator that can monitor price integrity, oversee benefit-setting conduct, and intervene where behaviour undermines the intent of the PNEP. When designed and managed well, the PNEP can realign incentives toward efficiency, quality and sustainability. Without these supports, however, it risks amplifying existing market distortions. Ensuring balanced incentives across all actors will therefore be critical to realising the full benefits of the reform.

#### **Summary**

The PNEP will change how hospitals, insurers and clinicians behave. It can improve efficiency and support appropriate care settings, but misaligned incentives could push hospitals toward low-acuity activity, weaken complex services, or prompt insurers to narrow networks or cost-shift. Strong safeguards, balanced adjustments and independent oversight are essential to prevent distortions and ensure the PNEP drives quality, access and sustainability.

#### **Long-term sustainability**

CHA considers the PNEP to be a critical structural reform with the potential to stabilise and strengthen the long-term sustainability of the private health system. A central determinant of long-term sustainability will be the credibility and stability of the national price itself. To support ongoing viability, the PNEP must be grounded in accurate, representative and continuously improving costing data. It must also be supported by a transparent and responsive indexation mechanism that reflects real cost pressures, particularly labour, energy, technology and workforce scarcity. If indexation lags behind cost growth, the system will eventually revert to the same structural imbalance that currently threatens sustainability. Conversely, if the price becomes unmoored from insurer revenue dynamics, premium growth may accelerate, eroding affordability and insurance participation. Maintaining equilibrium will require disciplined governance, periodic review, and careful calibration of indexation settings.

The PNEP also has long-term implications for capital investment and infrastructure renewal. Private hospitals must self-fund upgrades, expansions and new technology, unlike public hospitals, which receive government capital grants. A sustainable system therefore requires a pricing structure that incorporates capital replacement and, in time, new capital investment. By progressively moving toward a bundled, all-inclusive price that covers both operating and capital components, the PNEP can ensure providers have the financial certainty needed to reinvest in clinical capability, digital infrastructure and modern facilities. Without this, deferred investment could degrade service quality, reduce regional access, and limit the sector's capacity to meet future demand.

Sustainability also depends on diversity and resilience of hospital providers. A healthy private system requires a balance of large national groups, not-for-profit providers, faith-based and charitable organisations, day hospitals, and regional facilities. Diversity supports competition, innovation, and patient choice. The PNEP must therefore ensure that adjustments, particularly for remoteness, small scale, complex case-mix and specialty services, accurately reflect structural cost differences. Failure to do so risks accelerating consolidation, narrowing provider diversity, and reducing the system's overall resilience.

Insurer sustainability is likewise essential. The PNEP must embed cost discipline, but not in a way that triggers instability or encourages insurers to offset benefit increases through aggressive network management or product downgrading. A transparent national price can support insurer sustainability by improving predictability, reducing contracting friction, and clarifying appropriate benefit levels. However, the longer-term success of the model will require complementary reforms to risk equalisation, product regulation and industry incentives to ensure insurers remain committed to broad networks and high-value care.

Finally, long-term sustainability will increasingly depend on the system's ability to shift from volume-based to value-based care, particularly through the integration of quality measures, PROMs, PREMs, safety and outcome data. Over time, allowing hospitals and insurers to negotiate above the national floor price for demonstrated quality and patient experience will help realign incentives toward value, reduce unwarranted variation, and build a patient-centred pricing system that rewards outcomes rather than throughput.

### **Summary**

The PNEP can improve the long-term stability of the private health system, but only if the national price is accurate, well-indexed and based on strong costing data. A sustainable model must eventually include capital funding so hospitals can reinvest in infrastructure and technology. Sustainability also requires protecting provider diversity, supporting insurer viability, and ensuring adjustments reflect real cost differences. Over time, integrating quality measures such as PROMs and PREMs will help shift the system toward value-based care and reinforce long-term resilience, however this needs to form part of a long-term staged approach with appropriate controls in place.

## **Consumer and quality impacts**

Consumer and quality impacts are among the most critical dimensions of the PNEP, as they ultimately determine whether the pricing reform delivers tangible benefits for the people who rely on the private health system. While technical design features are essential, the success of the PNEP will be judged by whether it improves affordability, protects access, and strengthens patient safety and outcomes. Ensuring that these consumer-facing impacts are front and centre is therefore indispensable to the legitimacy and durability of the reform.

### **Affordability and access**

CHA considers the PNEP to have significant potential to improve affordability and access for consumers, two areas where the current private health system is under increasing strain. Today, consumers face a highly variable and often opaque benefit structure, with inconsistent reimbursements across insurers, unpredictable out-of-pocket costs, and contracting disputes that can lead to sudden loss of access or destabilisation of local services. A nationally consistent pricing framework, if well designed and properly implemented, can reduce this volatility and support more predictable, fair and transparent consumer experiences.

However, CHA also acknowledges that many of the most pressing drivers of affordability, particularly specialist fees and related out-of-pocket costs, sit outside the scope of the PNEP. These issues require targeted policy attention in their own right. While some could be better integrated or made more transparent through the broader reform process, others will need dedicated solutions beyond the PNEP to ensure consumers experience genuine, system-wide improvements in affordability.

A clear national reference price, and ultimately a regulated national floor price, will help reduce unexplained variation in benefits paid by insurers for the same service category. This should make out-of-pocket liabilities more predictable for consumers, particularly in areas of high variation such as overnight medical admissions, mental health, rehabilitation, and some surgical specialties. Over time, pricing transparency may also enable consumers to better understand the value of their insurance products, improving competition based on benefit design rather than marketing features or opaque exclusions.

However, affordability gains are not automatic. If the initial national price is set below cost in particular service categories or hospital types, it could trigger service withdrawal, reduced availability of complex care, or consolidation of hospital providers, particularly in regional areas where economies of scale are limited. Any such contraction in supply would have direct access impacts on consumers, ranging from longer wait times to increased travel, reduced local service options, or loss of continuity of care. It is therefore critical that the PNEP incorporate adequate adjustments for remoteness, small hospitals, high-acuity infrastructure, and unavoidable cost differentials to prevent regional or specialty service erosion.

On the insurer side, uplift in benefit levels will support access only if it is accompanied by regulatory oversight of insurer behaviour. Without clear protections, some insurers may seek to offset increased costs by narrowing networks, imposing more restrictive utilisation management, or shifting consumers into lower-value products. Such strategies could undermine the consumer benefits of the PNEP and risk entrenching inequities in access. Monitoring insurer contracting patterns and benefit design during the transition period will therefore be essential to safeguarding consumer choice.

The PNEP also offers an opportunity to improve equity in access, particularly for groups currently disadvantaged by the market. If adjustments properly recognise the higher cost of treating older people, individuals with multiple chronic conditions, people with disability, and socioeconomically disadvantaged populations, hospitals will be less financially penalised for caring for these groups. Better alignment between cost and benefit therefore reduces the risk that complex patients are informally discouraged or shifted to public hospitals due to low benefit adequacy in the private system.

Affordability effects will also depend on the interaction between the PNEP and premium-setting cycles. If the PNEP increases benefit outlays, insurers may pursue higher premiums. While some premium impact may be necessary to restore hospital sustainability, the Department must ensure that any increases are transparent, evidence-based and accompanied by consumer-facing communication explaining the connection between higher benefits and improved access or reduced out-of-pocket costs. Over the long term, better alignment between costs and benefits should reduce volatility in premium growth and improve insurer predictability, supporting more stable affordability for consumers.

#### **Summary**

The PNEP could improve affordability and access by replacing today's inconsistent, opaque benefit levels with a clear national price, giving consumers more predictable out-of-pocket costs and more stable access to services. However, its success depends on accurate adjustments for regional, complex-care and small-hospital costs to avoid service loss or reduced access. Insurer behaviour will need close oversight to prevent network narrowing or product downgrading that could undermine consumer choice. While the PNEP can improve transparency and benefit adequacy, major drivers of out-of-pocket costs, especially

specialist fees, sit outside its scope and will require separate reforms. Over time, better alignment between costs, benefits and premiums can support more stable affordability for consumers.

### Quality and safety indicators

CHA strongly supports the integration of quality and safety considerations into the PNEP, noting that pricing signals shape clinical behaviour, service design, and the broader culture of care within the private health system. While the draft framework recognises the importance of quality, it provides limited detail on how indicators will be selected, risk-adjusted, operationalised, or linked to pricing over time. To ensure the PNEP supports high-quality, patient-centred care, a more structured and transparent quality framework will be required.

A key strength of the proposed approach is the intention to draw initially on established national frameworks, including the Australian Commission on Safety and Quality in Health Care's HACs and avoidable readmission models. These indicators are well defined, clinically validated, and supported by existing public-sector risk-adjustment methodologies. Their inclusion creates a strong foundation for improving safety through pricing by signalling that preventable harm should not be financially rewarded. However, translating these mechanisms to the private sector presents challenges given differences in data completeness, variations in coding practices, and the complexity of tracking readmissions across multiple insurers and contracted providers.

A staged implementation is therefore critical. Early adoption of quality indicators should occur through shadow pricing, enabling testing, refinement and sector familiarisation without immediate financial consequences. This period should be supported by independent clinical review processes to verify attribution, ensure fairness, and prevent unintended disincentives, such as hospitals being discouraged from treating high-risk or complex patients. Over time, as data improves, quality adjustments can graduate from shadow form to partial and then full integration into the pricing model.

Beyond safety, CHA considers it essential that the PNEP ultimately incorporate indicators reflecting patient-centred value, including PROMs and PREMs. These metrics are increasingly used internationally and are central to value-based health care. However, to be credible, comparable and fair, PROMs and PREMs must be collected independently rather than through multiple competing channels. Patients are currently asked for feedback by insurers, individual specialists, and hospitals, creating survey fatigue and inconsistent data. CHA therefore recommends that PROMs and PREMs be collected through an independent body, ideally the proposed private health regulatory function, to ensure a single, streamlined point of collection on behalf of all system participants. Centralised collection would not only reduce burden on patients, but also ensure that results are risk-adjusted, transparent and shared equitably across hospitals and insurers, so that incentives and accountability are aligned rather than fragmented. Their inclusion, initially in voluntary or negotiated payment uplifts, and eventually as part of the broader pricing architecture, would incentivise hospitals and clinicians to focus not only on efficiency and throughput but on outcomes that matter to patients.

The PNEP's quality framework should also incorporate service-level and structural indicators, including accreditation status, compliance with safety standards, and availability of essential clinical supports such as intensive care, emergency readiness, and multidisciplinary care pathways. These characteristics materially influence patient outcomes and are especially relevant to hospitals serving complex casemix or regional populations. While not all structural

indicators should attract price adjustments, they should inform risk adjustment, performance monitoring, and public reporting.

**Summary**

CHA supports embedding quality and safety into the PNEP but argues the framework needs clearer detail on which indicators will be used, how they will be risk-adjusted, and how they will influence pricing. Early reliance on established measures such as HACs and avoidable readmissions is appropriate, but these must be introduced gradually through shadow pricing to ensure fairness and avoid penalising hospitals treating complex patients. Over time, the PNEP should also incorporate PROMs and PREMs, collected independently to ensure consistency and reduce patient burden. Structural and service-level indicators should inform monitoring and risk adjustment.