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Department of Health and Aged Care

Information Brief

MB25-000737

Version (1)

Date sent to MO: 19/05/2025

To: Minister Butler

**Subject: INFO BRIEF | UPDATE ON PRIVATE HEALTH CEO FORUM (CEO FORUM) AND
POLICY IMPLEMENTATION**

Comments:			
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Attachments:

- A. Update on CEO Forum and policy implementation

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SHORT TERM REFORMS

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MEDIUM TERM REFORMS

Developing a Private Price for Private Hospital Services	Mixed – there is some support for further investigation of what a private price might encompass and how it could be used Support – there are both insurers and hospitals that support the use of a private price in the sector Do not support – there are both insurers and hospitals that do not support a mandated private price as it may reduce bargaining	Proceed with development of options and sector consultation Requires development of options (including options for how the price might be determined) and consideration of how these could be applied across the sector.	- Considered at a high level at the CEO Forum 13 Dec and TWG on 18 Dec 2024. - Mr James Downie has been engaged to investigate what a private price would constitute and how it could be used in the sector. The final private efficient price framework is due for completion on 30 Aug 2025. - The aim is to achieve sufficient consensus across the sector to construct an initial model in 2025.
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Minister	Minister Butler
PDR Number	MB25-000737
Subject	Info Brief Update on Private Health CEO Forum and policy implementation
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Division/Branch	Health Strategy First Nations & Sport Health Systems Strategy
Has Budget Branch been consulted if there are financial implications?	Not Applicable

Adviser/DLO comments:	Returned to Dept for: REDRAFT ☐ NFA ☐
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From: [KELLEHER, Brian](#)
To: s47E(c), s47F
Cc: s47E(c), s47F; [MCBRIDE, Paul](#); [HAWKINS, Ross](#)
Subject: RE: Private Health CEO Forum 5 September meeting pack [SEC=OFFICIAL]
Date: Tuesday, 2 September 2025 12:56:00 PM
Attachments: [CEO Forum - Slide Deck - 5 September 2025 - feedback on MO comments.pptx](#)

Thanks – minor edits and comments attached

From: s47F
Sent: Tuesday, 2 September 2025 10:49 AM
To: KELLEHER, Brian
Cc: DE TOCA, Lucas ; s47F s47E(c), s47F ; HAWKINS, Ross ; s47E(c), s47F ; STREET, Celia ; s47E(c), s47F ; MCBRIDE, Paul
Subject: RE: Private Health CEO Forum 5 September meeting pack [SEC=OFFICIAL]

Thanks Brian,

Some minor comments to consider/address but otherwise comfortable.

Cheers

s47F

From: KELLEHER, Brian <Brian.Kelleher@health.gov.au>
Sent: Monday, 1 September 2025 5:43 PM
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Subject: Private Health CEO Forum 5 September meeting pack [SEC=OFFICIAL]

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Hi s47F

As discussed attached is the Sec approved slide deck we intend to release tomorrow to the members of the Private Health CEO Forum tomorrow, to support the discussion scheduled for the morning of 5 September and meet the commitment the Sec has provided this group of providing papers approx. a week in advance of meetings.

We will also attach the current draft of the pricing framework document that I have previously discussed with you, noting it is a working draft.

Appreciate any feedback.

Regards

Brian

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Pricing Framework for Australian Private Hospital Services

DRAFT for Comment

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Executive Summary

Australia's private hospital sector is a cornerstone of the national health system, delivering 41% of all admitted hospital services¹ and offering patients choice, timely access, and innovative care. Yet the funding system underpinning the sector is fragmented, opaque, and increasingly unsustainable due to systemic cross-subsidisation of services. Over 30 private health insurers, multiple government payers, and various compensation schemes each apply different pricing models, creating unnecessary complexity, administrative burden, and inconsistent incentives. The Department of Health, Disability and Ageing has the responsibility for policy settings and a range of regulatory processes that influence the costs and prices of services delivered by the sector, but does not maintain a pricing model that identifies a benchmark price for these services.

Without a clear national pricing benchmark, contract negotiations are often adversarial, funders struggle to assess value, and smaller or regional hospitals face growing financial strain. Broader pressures – workforce shortages, inflation, outdated funding models, and inconsistent data collection – are compounding the challenge, threatening the sector's long-term viability.

This draft Pricing Framework proposes a nationally consistent, transparent, and evidence-based approach to funding private hospital services, anchored by a **Private National Efficient Price (PNEP)** informed by Activity Based Funding (ABF) principles. The PNEP would:

- Provide a robust reference point for pricing and benchmarking
- Reduce administrative burden by replacing the current default benefit regime
- Address systemic cross subsidisation of services by aligning funding with the actual cost and complexity of care
- Preserve the private sector's strengths – patient choice, clinical independence, and innovation

Implementation would be phased: an indicative PNEP by July 2026, a comprehensive price by July 2027 following data improvements, and full replacement of default benefits by July 2028. This approach balances ambition with stability, ensuring the sector has confidence in the PNEP and can adapt while maintaining high-quality, accessible care for Australians.

¹ [Hospitalisations and patient days - Hospitals - AIHW](#)

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Introduction

Australia's private hospitals are an essential pillar of the national health system. They deliver 41% of all admitted hospital services, provide choice and timely access for patients, and support innovation in models of care. However, the funding arrangements underpinning the sector are increasingly under strain. A growing body of evidence – including the [2024 Private Hospital Sector Health Check](#), stakeholder feedback and other data – points to significant complexity, inconsistency, lack of transparency and pressure on the long-term viability of private hospital operations.

This *Pricing Framework for Australian Private Hospital Services* (the Framework) has been developed to respond to these challenges through the implementation of a nationally consistent, transparent, and evidence-informed approach to pricing and funding for private hospitals. It aims to support a private hospital sector that is efficient, sustainable, and able to deliver high-quality care to the community, particularly as the sector transitions to more contemporary models of care – including shorter lengths of stay, increasing care in the community and the continued take-up of virtual care.

The Framework proposes:

- The adoption of consistent classifications across all private hospital services
- The collection of robust patient cost data
- The establishment of a Private National Efficient Price (PNEP) to replace the current default benefit regime
- A series of adjustments to the PNEP to account for the unavoidable costs of delivering services in different locations, and by different size and type of private hospital.

Australia has a long history of adopting Activity Based Funding (ABF), in both the public and private hospital sectors, and whilst the framework draws on the core principles of ABF, such as transparency, alignment of funding with activity and cost, and incentives for efficiency, this is not a direct transplant of the public hospital funding model into the private sector.

The operating environment, payer mix, clinical pathways, and contractual architecture in the private system are materially different from the public system. Accordingly, this framework selectively adapts what works from the public experience, while tailoring the model to meet the unique requirements of private hospitals.

Specifically, the framework:

- Preserves the essential features of the private system, including patient choice, clinical independence, and innovation.
- Seeks to reduce administrative burden and contracting friction, while introducing a consistent reference point for pricing.
- Recognises the role of multiple payers – private health insurers, state and federal governments, compensation schemes and others – each with distinct funding priorities.
- Accommodates the diversity of hospital business models and care offerings, from acute to subacute and non-acute services.

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- Is designed to support reform without requiring additional government funding, consistent with broader health financing policy.

The development of this framework has been informed by consultation with providers, funders, clinicians, and policy experts. It will be critical that close consultation and collaboration with all stakeholders continues if the proposals are adopted and implemented given many stakeholders have made operational and commercial decisions to mitigate against the consequences of the current funding arrangements or currently benefit from the inequalities these arrangements support.

The framework aligns with the government's policy objectives to ensure the sustainability of the private health system, promote transparency, support value-based care delivery and fundamentally ensure patients have access to high-quality care and obtain value for money when they choose to use the private hospital system.

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The case for change

A complex and fragmented approach to funding

Australia's private hospital sector plays a critical and growing role in delivering high-quality, accessible care to millions of Australians. Yet, the way this sector is funded has become increasingly complex, inconsistent, and poorly aligned with the evolving needs of patients, providers, and funders.

One of the primary sources of this complexity is the diversity of payers involved in funding private hospital services. These include:

- Private health insurers – of which there are currently 30 operating in the Australian market², each negotiating their own contracting and pricing arrangements with private hospitals.
- State and territory governments, who engage private hospitals to provide care to public patients under bilateral service agreements or overflow arrangements.
- Accident compensation schemes, such as workers compensation and motor accident insurers, each with their own regulatory and pricing frameworks; and
- The Department of Veterans' Affairs, which purchases services under a national fee-for-service model with limited pricing transparency.

Each of these payers applies its own logic, incentives, and constraints to the way it purchases care – resulting in a highly fragmented and administratively burdensome system. While some funders adopt Activity Based Funding (ABF)-style models that reference Diagnosis-Related Groups (DRGs) for acute inpatient services, there is significant variation in how these are designed, priced, and implemented. Other funders rely on per diem or flat-rate payments, which often taper with length of stay and bear limited relationship to the true cost or complexity of care.

The consequences of this fragmentation are multiple and compounding:

- **Hospitals must manage dozens of bespoke contracts**, each with its own pricing rules, data requirements, dispute processes, and clinical coverage – creating material administrative overhead and increasing the risk of errors or delays in payment.
- **Hospitals and funders lack a shared, consistent benchmark for evaluating cost efficiency** or service appropriateness, making pricing negotiations protracted and often adversarial.
- **Hospital managers are caught between different incentives and reporting requirements**, undermining consistency in care pathways and system-level accountability.
- **Pricing signals are blurred**, diminishing the ability of the system to reward safety, quality, innovation, or value, and enable continued investment in the sector.

² [Register of private health insurers | APRA](#)

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Another feature of the current funding arrangements is a heavy reliance on cross-subsidisation, as shown in Figure 1. This has ramifications for allocative efficiency across the system, as, for example, overnight hospitals need to keep providing less complex, higher margin services that could be provided in other settings, to subsidise lower margin services that cannot be carried out in other settings.

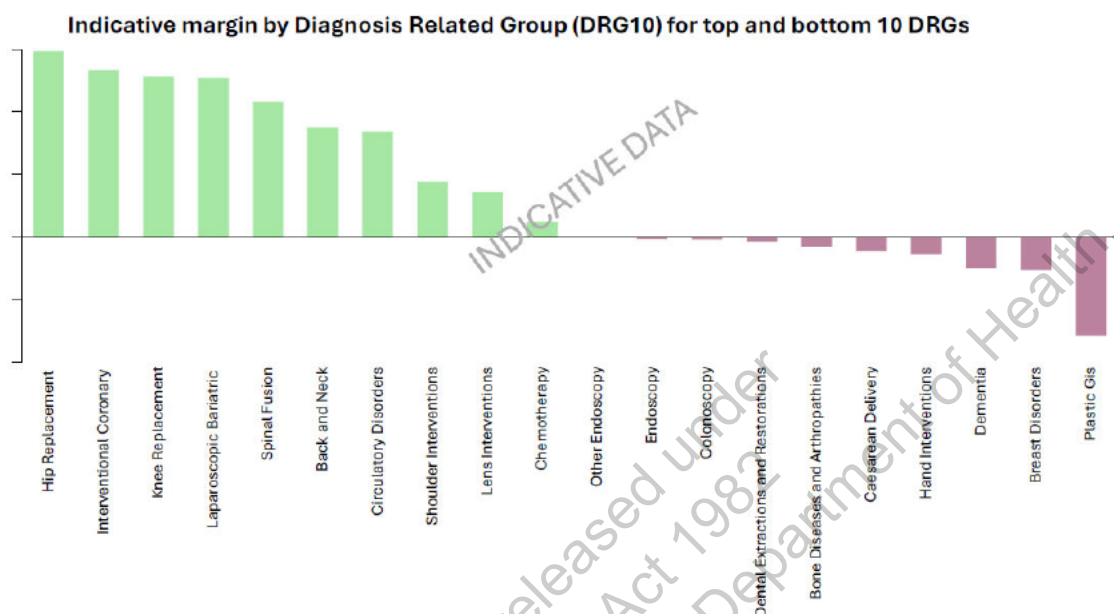


Figure 1

At the same time, broader macroeconomic and structural pressures are converging on the private hospital sector:

- **Operating costs are rising**, driven by wage growth, inflation in medical supplies and technology, and increased regulatory requirements.
- **Revenue growth has lagged**, with private health insurers managing premium growth tightly and patient out-of-pocket costs becoming a growing affordability issue.
- The sector's **financial viability is increasingly variable**, with smaller, regional and specialised providers particularly exposed to cost-revenue mismatches and workforce shortages.
- There is limited **visibility into sector-wide performance**, due to inconsistent cost data, absence of national benchmarking, and weak integration between clinical outcomes and pricing.

Recent work, including the *Private Hospital Sector Financial Health Check* led by the Department of Health and Aged Care in 2024, has confirmed that these challenges are material and system-wide, impacting not just the financial sustainability of hospital operators, but also broader patient outcomes and health system efficiency.

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Other inefficiencies

The Prescribed List of Medical Devices

The current payment arrangements for medical devices in the private sector are overly complicated and delay new products getting to market in a timely manner and ultimately limit patient choice in the private sector.

Whereas in the public sector, medical device costs are bundled into the NEP, and once a product has TGA approval, hospitals are free to use devices as is clinically appropriate, in the private sector medical device costs are unbundled, and insurers are required to pay for them only when they are included on the Prescribed List.

Maintaining the Prescribed List represents a significant administrative overhead for the Department of Health, Disability and Ageing, which is recouped, at least in part, through listing fees paid by device manufacturers.

There is also evidence that the prices paid for comparable medical devices are higher in the private sector than in the public sector, due at least in part to the Prescribed List prices setting a floor price for devices, and there have been significant reforms to the Prescribed List to address this over recent years³.

Significant reporting burden on private hospital operators

Private hospital operators are required to provide a significant amount of data to a number of different government bodies and payers. This includes reporting to:

- Hospital Casemix Protocol (HCP)
- Private Hospital Data Bureau (PHDB)
- State and territory activity data
- Cancer registry reporting

Much of this requires separate reporting for each hospital site, so a medium size operator with hospitals across 3 or 4 states and territories can be required to provide upwards of 180 – 200 data extracts in a given month.

Momentum for Reform

There is now strong momentum across the sector for change. Providers, funders, and policymakers alike recognise the **need for a more consistent, transparent, and evidence-based approach to pricing**. While all parties support flexibility and local negotiation, the absence of a **commonly accepted national pricing reference point** undermines the sector's ability to function efficiently, strategically invest, or innovate care delivery.

A national pricing framework – particularly one informed by ABF principles and tailored for the private sector – offers an opportunity to:

³ [Reforms to deliver lower prices for medical devices and lower private health insurance premiums | Health, Disability and Ageing Ministers | Australian Government Department of Health, Disability and Ageing](#)

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- **Improve consistency and transparency**, reducing the administrative burden of contracting.
- **Align funding with efficient, safe and appropriate care**, improving resource allocation and sustainability.
- **Support innovation** in clinical models, bundled care, and integrated services.
- **Inform policy and regulatory settings**, including in premium approval, product design, and safety oversight.

Importantly, this reform is not about centralising control or mandating uniformity. Rather, it is about establishing a stable, fair and flexible foundation on which diverse payer-provider relationships can evolve – guided by common principles, supported by robust data, and oriented toward better outcomes for patients and the system as a whole.

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Principles for a reformed system

Reforming a complex system will require careful and pragmatic consideration of competing priorities which necessarily require trade-offs and a clear transition pathway and timetable.

As such, it is critical that there is alignment on the fundamental principles that should be used to guide decision makers through these trade-offs as the work to design a new funding approach progresses.

The following principles have been developed through extensive consultation with providers, payers and clinical representatives. They draw, in part, on the principles established by the Independent Health and Aged Care Pricing Authority (IHACPA)⁴, but have been modified to reflect the differing context of the private system.

Fundamental Principles:

1. **Patients must be at the centre of the private hospital system**
 - a. Access: Timely access to high quality care is a critical feature of the private hospital system – this must not be disrupted by the introduction of a new approach to funding.
 - b. Choice: Patient choice underpins the private hospital sector – choice of clinician and hospital must be preserved.
2. **Innovation is critical and must be supported.** Pricing must respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes
3. **Efficiency and productivity are incentivised**, with two aspects of efficiency specifically considered:
 - a. Technical efficiency
Hospitals are encouraged to deliver care at the lowest cost possible without compromising quality or safety.
 - b. Allocative efficiency
The funding system also promotes the delivery of care in the most clinically appropriate and cost-effective setting.
4. **The financial sustainability of the entire private sector is critical.** Hospital operators and funders in the private hospital sector must be financially viable.

Process Guidelines

Process Guidelines to guide the implementation of new funding arrangements:

- **Transparency:** All steps in the determination of a Private National Efficient Price should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals, insurers or other stakeholders.
- **Stability:** The payment relativities for ABF are consistent over time.

⁴ [Pricing Framework for Australian Public Hospital Services 2025–26 | Resources | IHACPA](#)

- **Evidence-based:** Funding should be based on the best available information, that is both nationally applicable and consistently reported.

System Design Guidelines

System Design Guidelines to inform ABF design option

- **Promoting value:** Pricing supports innovative and alternative funding solutions that deliver efficient, high-quality, patient-centred care.
- **Promoting harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **Single unit of measure and price equivalence:** Pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Appropriate transition arrangements:** It is critical that there are transition arrangements in place that ensure there are no significant shocks to the system and operators and funders have time to plan for changes.
- **Patient-based:** Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.

To achieve these goals, the reformed funding arrangements will need to include the technical features of the model, but also importantly will need to address the regulatory and organisational elements that will accompany the model, so that is implemented, applied and updated robustly including with appropriate stakeholder engagement, and is based on tangible evidence.

Proposed position

That the Fundamental Principles, Process Guidelines and System Design Guidelines are adopted as the decision-making guidelines and are regularly reviewed as the development of the Private National Efficient Price progresses.

What is Activity Based Funding?

Activity Based Funding (ABF) is a method of funding healthcare services in which payments are linked to the quantity and complexity of care provided. Instead of paying providers a fixed sum or reimbursing individual line items, ABF allocates funding based on the type and volume of clinical activity delivered, such as surgeries, hospital admissions, rehabilitation episodes or outpatient consultations. Prices are adjusted to reflect the relative complexity of different types of care.

A typical ABF system includes the following components:

- **Classification:** Grouping clinical activity with similar resource requirements into categories, such as Diagnosis Related Groups (DRGs).
- **Costing:** Using structured data to calculate the cost of delivering each type of care, including direct and indirect costs.
- **Pricing:** Establishing a base price (e.g. a benchmark unit price) and applying price weights to each classification.
- **Adjustments:** Modifying prices to account for patient or service factors not captured in the classification system, such as rurality, high-dependency care, or hospital-acquired complications.

Critically, ABF systems are underpinned by a strong relationship between price and cost. This means that higher prices are paid for higher cost, more complex services, and lower prices are paid for lower cost services. This is achieved by the use of cost weights.

For example, in the public hospital system for 2024-25, DRG I03B (Spinal Fusion, Intermediate Complexity) has a price weight of 6.4321, while DRG E62C (Respiratory Infection, Minor Complexity) has a price weight of 0.5820.

These weights are then multiplied by the base price – for example, the National Efficient Price (NEP) of \$6,465 – to calculate the funding level for each service. This figure, known as the National Weighted Activity Unit (NWAU), reflects the adjusted price for the service. Using this method, DRG I03B would be assigned a price of \$41,526 ($\$6,465 \times 6.4321$), while DRG E62C would be priced at \$3,766 ($\$6,465 \times 0.5820$).

How the price could be used

There are a range of possible use cases for a Private National Efficient Price. Some represent a more significant reform to private hospital funding arrangements than others. Some will be more controversial than others. They are also not mutually exclusive. Below, the range of possible uses are discussed. They are broadly arranged into two groups:

- Use cases that directly impact payer and provider relationships
- Use cases that indirectly impact payer and provider relationships

Direct impacts

Reference pricing for benchmarking and informing contract negotiations.

There is currently no robust, whole of sector approach to benchmarking the cost of delivering services in the private hospital sector. This is a significant limitation to the private hospital sector, for a range of reasons, including:

- A lack of robust comparison of the costs of delivering hospital services in different settings and locations.
- An absence of a transparent, independently derived sector wide cost growth index that could inform contract negotiations and premium setting processes.

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

There is also an opportunity to develop a number of different benchmarks with differing use cases. For example, a benchmark price could be produced both including and excluding prostheses costs. Likewise, medical professional costs could be included or excluded, to allow for comparison of the entire cost of care across the system

Second Tier Default benefit

Default benefits are the minimum amounts that private health insurers are legally required to pay for hospital treatment when a member receives care at a non-contracted hospital, that is, a hospital with which the insurer does not have a direct agreement. These benefits are intended to ensure that members can still access treatment and receive a contribution toward their hospital costs, even in the absence of a negotiated contract.

For hospitals that are second-tier eligible (i.e. they meet minimum quality and safety standards and apply for recognition), insurers must pay 85 per cent of the average contracted benefits the insurer pays to comparable hospitals in the same state for the same service. However, there is little transparency regarding these calculations.

Replacing the second-tier default benefit regime with an independently, transparently determined Private National Efficient Price would represent a significant improvement to this

situation and provide hospital operators with confidence that prices paid for services out of contract fairly reflects the costs of providing those services.

Use by other payers

One possible use for the PNEP would be to replace the funding arrangements for other payers in the private hospital system, with a single consistent model. Currently there are a wide range of payers beyond private health insurers, including the Department of Veterans' Affairs (DVA) and the various state-based accident and workers' compensation schemes (e.g. Workcover, TAC etc).

Whilst these payments make up a relatively small amount of the total revenue in the private hospital they do introduce further complexity with additional contracting arrangements. Moving these arrangements to a single model would significantly simplify this aspect of private hospital funding.

Public patients in private hospitals

State governments engage the private sector to varying degrees to deliver services to public patients. For example, Surgery Connect is a Queensland Health initiative allowing clinically suitable public hospital patients to have surgery at a private hospital.

Private hospital operators have observed that the contractual conditions, and prices sought by state governments vary significantly. For example, in New South Wales each Local Health District is responsible for contracting and will each have different prices and payment terms.

There is an opportunity to leverage a PNEP for state government contracting, and to significantly simplify these arrangements.

Indirect impacts

Informing premium increases

The Private National Efficient Price (PNEP) could play a valuable role in informing the annual health insurance premium round process. Each year, private health insurers submit actuarially certified applications to the Department of Health, Disability and Ageing seeking approval for premium increases, which are assessed by the government to ensure they are no higher than necessary, financially justified, and in the public interest.

A transparent, nationally consistent reference price for private hospital services, grounded in a National Efficient Price, could provide a neutral benchmark to help assess whether hospital cost trends cited by insurers are reasonable. In this way, the PNEP could strengthen the integrity of premium decision-making, support cost containment efforts, and reduce reliance on opaque or idiosyncratic contract data in evaluating insurers' claims expenditure growth.

Risk equalisation

The Risk Equalisation Trust Fund (RETF) exists to share the cost of higher-risk individuals, particularly older Australians, across all private health insurers. Each fund continues to pay for its members' claims but part of the cost of high-risk patients is shared across the sector. The current equalisation process is:

- Based on actual benefits paid (not service cost or complexity)
- Subject to age and service thresholds (e.g. age-based and high-cost claims)
- Relies on rules that can lag behind changes in clinical practice or hospital pricing variation

This creates potential distortions:

- More generous insurers (or those with weak contracting) may be overcompensated
- More efficient insurers may be under compensated
- Services with the same clinical profile may attract different risk equalisation outcomes depending on contracted price and location

A Private National Efficient Price could make risk equalisation fairer, more transparent, and better aligned to clinical cost drivers. By replacing volatile, insurer-specific benefit data with a neutral reference cost, it helps reduce perverse incentives, supports efficient contracting, and builds a stronger foundation for future reform.

Informing broader policy and regulatory settings for the private Health system.

The creation of a PNEP will provide robust and reliable data on the costs of delivering different private hospital services in a range of settings and locations. This will be a rich dataset that can be used to review and improve policy and regulatory settings.

For example, a better understanding of the costs of delivering private hospital services in regional areas, may lead to evidenced based changes to private health insurance rebates or the lifetime cover rules for people in regional areas.

Additionally, having consistently classified data on the services that different patients receive and being able to associate this with private health insurance products may lead to better defined product tiers than is currently the case.

Proposed position

1. A Private National Efficient Price should be determined in a transparent and independent way on an annual basis.
2. The use case for a Private National Efficient Price will likely evolve over time. (See Implementation options)

Establishing the Scope of Services to be funded

A critical question to be addressed in the design of any activity-based funding system is the scope of services to be included in the price.

Currently in the Australian private hospital system, funding models, and hence service delivery, are focussed on traditional services that occur in a physical hospital. Whilst there are some exceptions to this, such as hospital in the home services for rehabilitation and some acute conditions, these are not widespread and are agreed between insurers and hospitals on an ad hoc basis during the contracting process. There are currently no default benefits for hospital in the home services. This fragmented approach means that hospitals are unable to scale hospital in the home services appropriately to achieve economies of scale and ensure financial viability. Enabling the delivery of care in the lowest cost, clinically appropriate setting will improve the overall efficiency of the system over time.

Furthermore, services which are delivered in non-hospital settings have been shown to provide better outcomes for patients, as well as providing lower costs for payers.

Models of care are constantly evolving, particularly in the out-of-hospital area. The current strict funding conditions in today's agreements will often be outdated by the time the contract is completed. As workforce pressures continue to grow, the pace of change required to deliver sustainable services is expected to increase.

Conversely, for public hospital services, there are a wide range of programs available to some patients who would traditionally have been admitted to a hospital bed. They can now receive treatment at home, with visits from clinicians and remote monitoring of their condition. These innovative models of care can achieve better patient outcomes, often at a lower overall cost to the system.

Proposed position

1. The scope of services eligible for private health insurance funding should more closely relate to the risk that insurers have agreed to cover for their members and be agnostic to the setting in which the service is provided.
2. The scope of services to be included in the reformed pricing arrangements should be determined by an independent body.

The components of an ABF system

Classification

Classification systems are a critical component of any Activity Based Funding (ABF) model. They consist of codes that provide a clinically meaningful way of relating the types of patients receiving care to the resources required to deliver that care.

Admitted Acute Services

Australian private hospitals have collected classification information for acute admitted patients for many years, using the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* (ICD-10-AM), *Australian Classification of Health Interventions* (ACHI) and *Australian Coding Standards* (ACS). This system includes diagnosis and procedure codes that describe the reason for admission and any procedures, such as surgery, performed during the hospital stay. All Australian hospitals are required to use the same edition of ICD-10-AM. The current edition is the Thirteenth, implemented on 1 July 2025.

These codes are grouped into categories that reflect the types and complexity of care delivered. These categories are known as Diagnosis Related Groups (DRGs). DRGs provide a standard way of relating clinical conditions to the expected resources required for treatment.

In Australia, the Australian Refined DRG (AR-DRG) system is maintained and updated by IHACPA. The system is periodically revised to reflect changes in clinical practice and care delivery. The current version is AR-DRG Version 11.0, which was released in July 2022, and IHACPA proposes that Version 12.0 be used to price admitted acute care episode from July 2026.

A key issue in the private sector is the wide variation in DRG versions used in contracting. Many payer-provider contracts are based on AR-DRG Version 6.x, which was released in 2012, while others have moved to Version 10.0. This variation limits the ability to make consistent comparisons across providers and funders.

Because all hospitals use a common ICD-10-AM/ACHI/ACS edition, regrouping acute admitted activity to a single DRG version is technically straightforward and can be implemented immediately. However, some DRGs that represent high volumes of activity in the private sector may require closer examination. Further analysis of these DRGs, following consultation, will be required.

Subacute and Non-Acute Services

Subacute and non-acute services include rehabilitation, palliative care, geriatric evaluation and management, and maintenance care. The cost of providing these services is not as closely related to a patient's diagnosis as it is in acute care. For this reason, DRGs are not well-suited for classifying these services.

The Australian National Subacute and Non-Acute Patient classification (AN-SNAP) has been developed to more accurately reflect the care needs and resource use of these patients. The

classification was first developed by the University of Wollongong in 1997 and is now maintained by IHACPA. AN-SNAP uses a combination of care type, functional assessment tools, and dependency measures to group patients. It incorporates tools such as the Functional Independence Measure (FIM) and the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL).

AN-SNAP has been used for funding in the public hospital system since 2013. It has also been adopted by some private health insurers, particularly for rehabilitation and palliative care. The AN-SNAP classification, and its underlying clinical measures are well understood and accepted by most clinicians. As such, expanding its use more broadly across the private sector would support improved pricing transparency and consistency for subacute and non-acute care.

Mental health services

Mental health services have traditionally been classified using DRGs. Like subacute care, the linkage between diagnosis and resource use is not as strong for mental health services as it is for other acute medical services. Despite this, a modified DRG approach to funding was used in the public sector for a number of years while a new classification was developed.

IHACPA has developed the Australian Mental Health Care Classification (AMHCC). This system has been specifically designed for specialist mental health services, including both admitted and community-based episodes. It incorporates a range of data inputs, such as diagnosis, legal status, service setting, and clinician-rated outcome measures.

A central component of the AMHCC is the Mental Health Phase of Care, which describes the primary focus of treatment at any given time. Phases may include acute symptom reduction, functional recovery, or relapse prevention. The classification also uses standardised outcome tools, such as the Health of the Nation Outcome Scales (HoNOS) to inform group assignment.

The Phase of Care is not currently collected widely in the private hospital sector.

Proposed position

1. Admitted acute services should be classified using Australian Refined Diagnosis Related Groups (AR-DRG). The private sector should align with the same version of AR-DRGs being used by IHACPA for public hospital funding (currently AR-DRG V11.0, noting the proposed adoption of V12.0 from July 2026).
2. AR-DRG V11.0 should be reviewed to identify any DRGs that may need further refinement to reflect private sector service delivery, including C16Z (Lens Procedures) as a priority, with any identified DRGs referred to IHACPA for priority refinement.
3. Subacute and non-acute care should be classified using AN-SNAP and align with the same version being used by IHACPA for public hospital funding (currently AN-SNAP V5.0).
4. Mental health services should be classified using a modified DRG approach initially.
5. An urgent assessment of the suitability of the Australian Mental Health Care Classification (AMHCC) for use in the private sector should be undertaken.

Activity data collection

The collection of robust, reliable activity data is critical to any ABF system for costing, pricing and funding purposes. Australia has a highly developed system of hospital data collection with well-defined data item definitions maintained by Australian Institute of Health and Welfare.

Activity data for private hospitals is currently collected through several avenues:

1. Admitted Patient Care National Minimum Data Set (APC NMDS)
2. Private Hospital Data Bureau (PHDB)
3. Hospital Casemix Protocol (HCP)

Admitted Patient Care National Minimum Data Set (APC NMDS)

The APC NMDS is collected by the Australian Institute of Health and Welfare (AIHW) and contains detailed administrative data for all public and private hospital admissions in Australia. Data is provided to the AIHW by state and territory health departments.

This data includes ICD-10-AM data, as well as patient demographic information.

The data is subject to significant time lag and is unlikely to be able to be used for price setting. Further, it is not possible to identify individual private hospitals in the NMDS, which further limits its utility in this use case.

Whilst IHACPA uses the data specifications of the APC NMDS, data is collected from states and territories on an accelerated timeframe, to contend with the data lag issue present in the national collection.

Private Hospital Data Bureau

The PHDB is collected by the Department of Health, Disability and Ageing directly from private hospitals. It includes administrative data on patients funded both individually and by private health insurers.

This data includes ICD-10-AM data, as well as patient demographic information.

Data is submitted to the department every month, with a maximum lag of 6 weeks.

Hospital Casemix Protocol

The Hospital Casemix Protocol (HCP) is also collected by the Department of Health, Disability and Ageing. Data is submitted by insurers. The collection covers all patients who have had a hospital episode that included private health insurance payments, including public hospitals.

The collection includes administrative data, hospital charge data, private insurance benefit and MBS benefit payments as well as patient out of pocket charges.

This data includes ICD-10-AM data, as well as patient demographic information.

Proposed position

1. PHDB data is the appropriate activity data source to be used in determining the PNEP.
2. Consideration should be given to streamlining the HCP and PHDB collections, noting that this would require amendments to the coverage of each collection.
3. The Department of Health, Disability and Ageing should work with states and territories and the Australian Institute of Health and Welfare to streamline the collection of activity data with a view to reduce duplication where possible.

Costing

The availability of robust, patient level cost data from a representative sample of hospitals will be critical to the success of implementing ABF in the private hospital sector. The cost data will be used to calculate the payment relativities (cost weights) for each DRG, and to calculate the PNEP.

The National Hospital Cost Data Collection (NHCDC) was established in the early 1990s to support the development of the Australian DRG system. It is now undertaken by IHACPA. It consists of two distinct collections – one covering the public hospital system, and a second collection covering the private hospital system. They are both collected under a common set of costing standards, the Australian Hospital Patient Costing Standards (AHPCS) which are mandated by IHACPA.

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The public sector NHCDC⁵ is collected on an annual basis and covers around 95 per cent of admitted activity, with coverage for other settings of care increasing as the national ABF system for public hospitals matures. The public sector NHCDC forms the basis for the determination of the NEP by IHACPA.

The private sector NHCDC⁶ is collected by IHACPA every year from a selection of overnight private hospitals and covers around 65 per cent of overnight hospital admitted patient episodes. Participation is voluntary, however, to encourage participation, IHACPA provides funding to private hospital to contribute to the costs of software and staff to undertake the collection.

In 2014 analysis⁷ was undertaken to determine the minimum sample size required to ensure the data in the private sector NHCDC was representative of the broader overnight hospital population. The analysis concluded that:

- approximately 60 per cent of all separations would be required to achieve a robust sample.
- the collection should include at least 90 hospitals and 10 hospitals 'groups' (of 2 or more hospitals) to be representative.

The data collected is used for benchmarking within the sector and the publication of a report of cost weights. The cost weights are used by some insurers in their funding models.

Day hospital cost data has been collected in some years but has not been a regular and consistent occurrence. There are specific challenges in costing activity in day hospitals, including the fact that many day hospitals have a limited range of activity, which limits the utility of patient costed data. Most day surgeries out-source their financial reporting, meaning that for many, undertaking patient costing themselves is not possible. As such, it maybe that the level of detail currently collected in the NHCDC is not appropriate for the day hospital sector.

In the public sector, the Independent Financial Review⁸ is undertaken on an annual basis. The objective of the IFR is to assess the accuracy and completeness of hospital financial reconciliations and to determine the consistency in the application of the AHPCS. Through the IFR process IHACPA can assess if appropriate in-scope costs and patient activity have been included in NHCDC submissions.

⁵ [National Hospital Cost Data Collection Public Sector | IHACPA](#)

⁶ [National Hospital Cost Data Collection Private Sector | IHACPA](#)

⁷ [National Hospital Cost Data Collection, Overnight Private Hospitals Cost Report, Round 17 \(Financial year 2012–13\).pdf](#)

⁸ [Independent Financial Review | IHACPA](#)

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Proposed position

1. The scope of the Private Sector NHCDC should be widened to include day hospitals. Consideration should be given to redirecting current incentive payments from overnight hospitals to day hospitals to support capacity building in the day hospital sector.
2. Consideration should be given to the level of detail required from Day Hospitals, and the NHCDC data request amended appropriately, to minimise the burden on smaller facilities.
3. The Minister for Health and Ageing mandate participation in the Private Sector NHCDC as a condition of being declared a Private Hospital under the Private Health Insurance Act 2007.
4. IHACPA determine a minimum participation rate for day hospitals to ensure that the Private NHCDC is representative of the entire sector.

Financial Disclosure Framework

The government has also signalled its intention to mandate the confidential disclosure of financial data by all private hospital operators to the department on a regular basis.

This data will be critical to building confidence in the Private Sector NHCDC and will allow for the comparison of the total expenditure reported by private hospitals through the Disclosure framework with the total costs reported through the NHCDC.

Proposed position

1. The Department of Health, Disability and Ageing work with IHACPA to develop a quality assurance process for private sector NHCDC, utilising data obtained from the Financial Disclosure Framework.

Setting the Private National Efficient Price

Setting the Private National Efficient Price (PNEP) will be one of the most significant design decisions within the private hospital pricing framework. The PNEP serves multiple roles. It sends a system-wide efficiency signal, offers a consistent pricing reference point for payers and providers, and may influence funding and regulatory decisions beyond the immediate hospital sector.

To serve these functions effectively, the PNEP must be built on a clear and transparent foundation. This includes defining what is in and out of scope, determining which costs are recoverable, and applying a robust, evidence-based method to calculate the price.

What is in the price

It is critically important that the scope of inclusions and exclusions from the PNEP is clearly stated. Whilst some inclusions in the price will be obvious and non-controversial, some other cost items will be open to debate.

Operating costs

The price needs to, at a minimum include the operating costs of hospitals, such as:

- Staffing (nursing, hotel services, administrative staff)
- Consumables
- Insurance
- Utilities

These costs are currently captured in the NHCDC (for overnight hospitals).

The Prescribed List of Medical Devices and Human Tissue Products

One of the most complex issues in private hospital pricing is the treatment of **prostheses and implantable devices**. Under current arrangements, the law requires private health insurers to pay a benefit for a medical device or human tissue product if:

- a Medicare benefit is payable for a service associated with the use of the device or product
- the device or product is on the Prescribed List (PL)
- the device or product has been used for or implanted into a patient as part of hospital treatment or hospital substitute treatment
- the patient has appropriate health insurance to cover for the treatment.

The effect of this is that medical devices are excluded from current funding models used by insurers to pay hospitals – they are funded separately at the rate determined by the PL.

One option is to include the cost of medical devices in the PNEP. This is attractive for several reasons:

- Likely to put downwards pressure on medical device costs for private hospitals

- Reduced time to market for new medical devices, by removing the PL approval process
- Reduction in regulatory costs in administering the PL
- More closely aligns with arrangements in the public hospital system

There are some potential downsides to the inclusion of medical devices

- Bundled support services are currently included in the PL device price (such as cardiac telemetry)
- Risk for private hospitals for when medical device costs are much higher than the average for a given DRG
- Private hospitals would need to invest in medical device procurement strategies, either individually or collectively.
- Some private hospitals may choose to limit the range of devices available to clinicians.

Proposed position

Medical devices should be included in the PNEP, with further analysis of the potential risks and mitigations of this to be undertaken.

Capital

One of the most significant differences between the public and private hospital systems is the issue of capital.

In the public hospital system, capital is excluded from the NEP. It is instead funded by state and territory governments as the owners of public hospitals.

In the private system, where hospital operators have invested capital, capital costs are necessarily funded through payments from payers. As such, including capital in the PNEP is critically important. The issue of capital is important for both for-profit and not-for-profit operators. Not-for-profit operators still need to make sufficient surpluses to ensure that they can reinvest in new capital, as demand increases and new technology becomes available.

There are several components of capital that need to be considered:

1. **Return of capital – Depreciation.** This refers to the recovery of the original investment in an asset over its useful life. Depreciation allocates the cost of the asset gradually over time, representing the wear and tear, obsolescence, or consumption of infrastructure. It ensures that funds are available to eventually replace the asset. In this context, depreciation is the return of capital, repaying the principal over time.
2. **Return on capital – Cost of Capital.** This reflects the opportunity cost of the funds invested in the asset, whether those funds came from debt, equity, or a mix of both. It compensates investors or lenders for the use of their capital, based on a required rate

of return (e.g. Weighted Average Cost of Capital (WACC)). This is the return on capital, the ongoing financing cost or expected investment yield.

Capital is priced in many regulated markets, both in Australia and internationally. Capital Asset Pricing Models (CAPM) are widely used by regulators in Australia including the Australian Energy Regulator and state-based regulators such as the Independent Pricing and Regulatory Tribunal in NSW and the Queensland Competition Authority.

There are challenges in including capital in the PNEP. For example, determining an allowable rate of return will require careful consideration and likely be contested. Data on depreciation, capital investment and costs of capital would also be required to be provided by hospital operators. Determining the Weighted Average Cost of Capital for a diverse sector, with many different capital structures will also be challenging.

Pricing capital will also introduce a new dimension to the concept of an “efficient price”.

Exclusions from the price

The PNEP will need to exclude costs that are covered through other programs. These include items such as:

- Pharmaceutical Benefits Scheme (PBS) and Highly Specialised Drugs
- Medicare Benefits Schedule (MBS) payments to doctors and diagnostic providers

Calculating the price

Defining a unit of activity

Defining the unit of activity to be priced is essential to the price setting process.

A well-defined unit of activity broadens the utility of an ABF system and should allow for benchmarking of services across traditional service and classification settings – for example to allow for the comparison of the same service delivered in a home care setting and an acute inpatient ward.

In the public hospital sector, a single unit of activity has been adopted – the National Weighted Activity Unit (NWAU). This activity unit spans the different care settings (e.g. emergency care, subacute care). Similarly, in the aged care sector a National Weighted Activity Unit (NWAU) is also employed in the residential aged care funding model.

Given the benefits of a single unit of measure, without any significant shortcomings, it is proposed a single measure of weighted activity unit is adopted.

Consideration should be given to the name of the unit of activity. Whilst referring to a National Weighted Activity Unit is attractive given it is used widely in other ABF systems

nationally; it is important to understand that the public and private weighted activity units will not be directly comparable. Given this, it is proposed that a Private Weighted Activity Unit (PWAU) is adopted as a working title.

Proposed position

1. A single unit of measure is adopted for the private hospital funding model, with the working title Private Weighted Activity Unit (PWAU)

What level should the price be set at?

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

Average Pricing

The simplest (and most commonly adopted) pricing level is to adopt the average cost. This is the approach taken to determining the National Efficient Price (NEP) for the public sector, where the NEP is the average cost of one National Weighted Activity Unit.

The rationale for adopting this in the public sector was, initially, because the range of costs across the public sector was so high when the NEP was first introduced in 2012. At that point in time some states were operating well below the national average (Victoria was 20 per cent less than the NEP), whilst other states and territories were well above the national average (The Canberra Hospital was almost 30 per cent higher than the NEP)⁹. In the intervening period, the range of costs in the public sector has reduced significantly, with the range now from 11 per cent below the NEP to 20 per cent over the NEP.

In the private sector, adopting the average may be appropriate. It reflects the full range of costs required currently to deliver services, and in aggregate reflects the prices currently paid by funders. Furthermore, the average has the benefit for being easy to explain and is widely understood as a concept.

It could be argued that an average price is not “efficient” enough and does not provide enough incentive to drive technical efficiency improvements in the sector. Additionally, the

⁹ [National Health Performance Authority Hospital Performance: Costs of acute admitted patients in public hospitals in 2011–12](#)

average can be subject to volatility if there is significant movement in high- and low-cost outliers and would need to be closely analysed each year to ensure the price remains stable.

Below average pricing

More aggressive approaches to pricing would involve setting a price below the average – such as a median, or lowest quartile.

These approaches have the benefit of providing a more stringent efficiency signal to the sector, but risks having too many operators operating below the level required to make a reasonable rate of return on capital investments to incentive continued investment in the sector.

Given the margins across the sector are currently below a level required for continued investment (as shown in the Private Hospital Sector Financial Health Check), it is unlikely to a suitable point to set the price at this point in time, but it may be appropriate to set the price here in future years.

Efficient frontier pricing

An **efficient frontier** approach to setting the Private National Efficient Price (PNEP) seeks to identify the cost and quality profile of the most efficient hospitals and use this as the benchmark for funding. Instead of averaging costs across the whole sector, the method focuses on the best-performing providers after adjusting for case mix, unavoidable cost factors, and quality standards. The core idea is to reward efficiency by anchoring the price to demonstrably high-value providers while allowing for legitimate variations in operating conditions. This approach has precedent in regulated industries such as energy, water, and airports, and has been trialled in some international health systems for targeted service lines.

The potential benefits of a frontier method are significant. It embeds **strong productivity incentives**, encouraging less efficient hospitals to reduce waste and adopt best practice. It ensures that the price reflects **achievable, not theoretical, efficiency**, since it is based on real-world performance data from providers delivering acceptable quality. Over time, this can help control system costs, improve value for money for funders, and drive greater transparency around hospital performance. By applying quality filters and robust risk adjustment, the method can also protect against a “race to the bottom” in care standards, ensuring that cost efficiency does not come at the expense of patient outcomes.

However, there are trade-offs and implementation risks. The method requires **high-quality, comparable cost and activity data** from a representative set of hospitals, something that is still developing in the private sector. If quality and risk adjustments are weak, the approach may unfairly disadvantage hospitals serving more complex or higher-cost populations. In small or specialised markets, the “efficient” price may be based on too few observations to be stable. There is also a risk of **cost gaming** or selection behaviour, where providers change coding or patient mix to appear more efficient. Finally, the approach can create sharper revenue shocks than an average-cost benchmark, which may require a phased implementation or transitional funding to maintain sector stability.

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Proposed position

The Private National Efficient Price should initially be set at the average. This should be reviewed regularly, and over time, a more aggressive pricing policy may be adopted to drive increased technical efficiency in the system.

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Adjustments to the price

In order to ensure that reformed funding model is fair and equitable, it may be necessary to adjust the PNEP to account for cost variations that are beyond the control of the hospital operator.

Types of Adjustments

There are many possible factors that may need to account for. These include:

1. Location based factors
2. Facility related factors
3. Patient related factors

Location based adjustments

The provision of health care in non-metropolitan areas is generally higher in cost than providing the same health care in metropolitan areas. Higher wages to attract and retain staff, freight costs for medical supplies and other input costs all lead to higher costs. In some cases, the inability to achieve economies of scale that can be achieved in metropolitan settings are also a factor.

Wage costs also vary by state and territory – primarily driven by differing timings in industrial bargaining cycles. It will be important that in the price setting process this is considered given that it is generally beyond the control of individual hospital operators and largely driven by local labour market conditions.

Facility related adjustments

Australia's private hospital system is diverse. It consists of for profit and not profit operators, has hospitals in major cities as well as regional centres. Some hospitals are very large and provide a wide range of complex surgeries and have large Intensive Care Units, whilst others are much smaller, providing access to same day services such as colonoscopies and lens procedures. Teaching and training are also a growing issue in the private sector – more hospitals are undertaking a training role, including through employing junior medical staff, the cost of which may also be material.

Patient related factors

Ideally the classification systems that underpin the PNEP would account for all factors that contribute to the cost of care and no patient related factors would need to be considered for further adjustments. But this not always the case. For example, some high-cost services such as ICU usage are not well explained by the DRG system. Some groups of patients are also more costly to provide services to, but these factors are not always captured in the DRG system. These factors might include age, indigenous status and patients from culturally and linguistically diverse backgrounds.

How are adjustments determined?

It is important that any adjustments are evidence based, and transparently determined, in keeping with process and system design guidelines discussed earlier. Adjustments should be empirically derived and based on data collected from private hospital operators.

Different operators will have views on what factors should be assessed for potential adjustments. It will be important to have a process in place that allows hospital operators to request the consideration of different factors by the price setting body.

Adjusting for safety and quality outcomes

One of the common criticisms of ABF is that it is concerned only with outputs, not outcomes. There has been interest in recent years in adjusting ABF payments for safety and quality outcomes. In the private sector some insurers include safety and quality adjustments in their funding arrangements with hospitals, considering issues such as sentinel events, hospital acquired complications and readmissions.

However, there is no uniform approach to this across the sector, which adds to the complexity of contracting arrangements for hospital operators, as they need to adjust to the differing conditions of each contract.

In the public hospital sector, the Australian Commission on Safety and Quality in Health Care (ACSQHC)¹⁰ and IHACPA¹¹ have worked together to design three pricing adjustments.

Sentinel Events

Sentinel events are rare but serious adverse events that result in death or severe harm to a patient and are entirely preventable if known safety protocols are followed. Examples include wrong-site surgery, retained surgical items, or maternal death from haemorrhage. In these cases, IHACPA applies a zero-payment policy for the episode of care in which the event occurred. This signals a zero-tolerance approach to the most serious breaches of clinical safety.

Hospital Acquired Complications

Hospital acquired complications (HACs) are defined as clinical complications that arise during a patient's hospital stay, which are potentially preventable with appropriate care. Examples include pressure injuries, post-operative infections, and medication-related harm. IHACPA applies a funding adjustment to episodes where a HAC is coded, reducing payment based on the severity and complexity of the complication. This encourages providers to invest in prevention and continuous safety improvement.

¹⁰ [Pricing and funding for safety and quality | Australian Commission on Safety and Quality in Health Care](#)

¹¹ [Safety and quality | IHACPA](#)

Unplanned Readmissions

An unplanned readmission to the same hospital within a clinically defined time interval, which is related to the initial admission and considered potentially preventable through improved care or discharge planning. AHRs often signal gaps in discharge planning, follow-up, or coordination of post-acute care. IHACPA applies a pricing adjustment by reducing funding for the initial admission if an avoidable readmission is identified, promoting better continuity of care and patient outcomes.

In developing these definitions and pricing adjustments, ACSQHC and IHACPA engaged a broad range of clinicians to ensure that the definitions were clinically appropriate, and that the pricing adjustments were robustly risk adjusted.

It is important that safety and quality are considered in a reformed funding approach for the private hospital sector. As such, the work by ACSQHC and IHACPA should be adopted as the starting point. To ensure the work is applicable to the private sector work should be undertaken to:

1. Review the quality and completeness of data collection for sentinel events and HACs.
2. Review the feasibility of data linkage to ensure that readmissions can be reliably measured in the private sector
3. Review the risk adjustment and pricing mechanisms to ensure that the risk adjustment method appropriately adjusts for the private hospital sector.

Implementation options

The implementation plan outlined below take a pragmatic phased approach, starting with straight forward “no regrets” options, and progress to more wholistic and complex reform steps in a staged manner. This also means that each step can be carefully evaluated prior to the next step being (or not being) taken.

The phasing of each piece of work is deliberately ambitious, but is achievable with appropriate planning, resourcing and oversight. Three non-negotiable conditions for success are:

1. **Availability of appropriate data in a timely manner:** Building a pricing model will require NHCDC episode level data, identified at an establishment level. It will be critical to gain access to the latest Private Sector NHCDC data from IHACPA as quickly as possible.
2. **Adequate capacity and capability to develop the pricing model:** The team developing the pricing model will require both skills and experience as well as capacity to be able to dedicate sufficient time to the task.
3. **An appropriate level of consultation with, and engagement from, stakeholders across the private hospital sector:** It will be important to ensure that there is adequate consultation with stakeholders across the sector, whilst also ensuring the modelling is progressed in a timely manner. It will be important that stakeholders are able, an willing, to participate in the development of the pricing model.

Phase 1 – Develop an indicative Private National Efficient Price by 1 July 2026

The output of this phase of work is an initial, indicative PNEP by 1 July 2026.

The process of establishing an initial price would allow for a better understanding of the challenges involved in the data collections that are currently available to be used and allow for detailed technical engagement with various stakeholders in the private hospital sector on a range of matters. It would also involve testing a range of different adjustments that have been proposed (for example ICU and location).

This price would be based on the private NHCDC data held by IHACPA for overnight hospitals. Estimates of the costs for day hospitals would be derived from HCP charge data. A capital pricing model would need to be designed and would rely on data from the Financial Disclosure Framework submissions.

As an initial price, it would be focussed on admitted acute activity, given the limitations in data collection for other services at this time.

This price could be used as an input, amongst other data, to inform the premium setting round at the end of 2026.

Data and Technical Foundations

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- Obtain private sector NHCDC patient-level files with establishment IDs from IHACPA.
- Secure access to HCP charge data for day hospital cost estimates.
- Collect asset value information from all hospital operators to support capital pricing.
- Establish data quality assurance protocols (coding consistency, cost allocation checks, outlier detection).

Capacity and Capability

- Build internal departmental capacity to undertake model design, cost analysis, and impact testing.
- Recruit or second technical staff with expertise in costing, economics, and actuarial modelling.
- Set up modelling infrastructure and version control processes to enable repeatable simulations.

Consultation and Engagement

- Establish Technical Working Group for pricing model design consultation.
- Form stakeholder advisory panels (insurers, private hospitals, consumer groups) for broader feedback.
- Schedule bilateral meetings with key operators to test assumptions and secure buy-in.
- Run targeted workshops on subacute, mental health, and day hospitals to flag future phases.

Model Development

- Draft position paper on inclusion of capital in the price.
- Design and prototype a capital pricing model (return of + return on capital, depreciation and maintenance options).
- Develop methodology for defining the “efficient cost” (average, frontier, hybrid approaches).
- Develop initial adjustments for ICU and location cost differentials, plus test sensitivity.
- Build and test scenarios for default benefit use and premium round linkages.

Testing and Refinement

- Produce first cut of PNEP using acute overnight data and capital model.
- Undertake distributional impact analysis across hospital types (large metro, small regional, day).
- Run sensitivity testing: different adjustment factors, capital treatments, efficiency settings.
- Share draft modelling outputs with Technical Working Group for validation and critique.

Deliverables and Communication

- Prepare technical appendix documenting data sources, assumptions, and methods.
- Develop communication pack for sector and consumer audiences explaining scope and limitations.
- Contribute input to the health insurance premium round briefing papers.

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- Publish consultation paper on next-phase expansion (subacute, mental health, non-admitted).

Phase 1a – Data improvements

Concurrently with Phase 1, a program of data improvement should be undertaken, concluding by December 2026.

- Rationalisation of activity data collections
- Improved validation and checking of activity data collections
- Collection of Mental Health data
- Confirmation of subacute data quality
- Expansion of NHCDC coverage – Day hospitals, mental health and subacute
- NHCDC Quality reviews and improvements
- Implementation of Financial Disclosure Framework
- Test treatment of safety and quality adjustments (HACs, readmissions, sentinel events).

Phase 2 – Determination of comprehensive Private National Efficient Price by 1 July 2027.

Using data from an expanded Private NHCDC, and improved data collections for mental health and subacute care, a comprehensive PNEP would be determined by 1 July 2027.

These data improvements would ensure that:

- The PNEP appropriately reflected the costs of all hospitals (overnight and day hospitals)
- Appropriate classification, costing and pricing of subacute and mental health services.
- Robust regimen of price adjustments to account for legitimate variations in input costs due to size type and location
- Implementation of a safety and quality pricing adjustment.

Releasing PNEP in July 2027 would allow it to be used in the premium round at the end of 2027, and enable insurers to price in any impact on premiums if Phase 3 were to go ahead in July 2028.

Phase 3 – Private National Efficient Price replaces Default Benefits from 1 July 2028.

From 1 July 2028, a PNEP could replace the existing default benefit regime. There are a number of questions that would need to be addressed prior to this occurring:

- At what level should default benefits be set, noting they are currently set at 85% of the average prices paid by each insurer for comparable services.
- Should the default benefit be set at a different level for different regions – for example should a higher proportion be paid for areas of identified need?

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Appendix A – Stakeholders Consulted

Private Health CEO Forum

Private hospitals

Ramsay Health Care

Healthscope

Calvary Health Care

St John of God

St Vincent's Health Australia

Healthe Care

Epworth HealthCare

Cabrini Health

Sydney Adventist Hospital

Burnside Hospital

Nexus Hospitals

Wolper Jewish Hospital

Aurora Health Care

Insurers

Medibank

BUPA

HBF

Australian Health Services Alliance

Australian Private Hospital Association

Peak bodies

Day Hospitals Australia

Catholic Health Australia

Private Health Care Australia

Medical Technology Association of Australia

Australian College of Nursing and Midwifery

Australian Medical Association

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Appendix B Data reporting duplication – example

Below is the monthly reporting schedule for a medium size hospital group operating across 4 states and territories.

Hospital Casemix Protocol (HCP)

Under the Private Health Insurance Act 2007, all hospitals must submit HCP data to health insurers for each episode of admitted hospital treatment for which health insurers have paid a benefit.

Total monthly extracts

A separate extract is required for each fund at each provider number (**15 extracts at 10 hospitals = 150 extracts per month**)

Private Hospital Data Bureau

Private hospitals submit data about each episode of admitted hospital treatment. It includes both insured and non-insured patients.

Total monthly extracts

A separate extract is required each provider number (**10 extracts per month**)

State and territory data extracts

Each state and territory requires the submission of activity data – each state and territory varies – but the extracts are based on the APC NMDS.

Total monthly extracts

A separate extract is required for each provider number (**10 extracts per month**)

Cancer Registry Extracts

Cancer Registry Extracts are also required for each hospital. There are differing reporting requirements across the different states for Cancer Registry submissions also.

Total monthly extracts

A separate extract is required for each provider number (**10 extracts per month**)

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All information in this publication is correct as at August 2025

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From: s47F
To: [KELLEHER, Brian](#)
Cc: s47E(c), s47F ; [DE TOCA, Lucas](#); s47F
Subject: RE: Private Health CEO Forum - release of the draft Private National Efficient Price framework paper [SEC=OFFICIAL]
Date: Friday, 17 October 2025 2:45:37 PM
Attachments: [image001.png](#)

Thanks Brian

From: KELLEHER, Brian
Sent: Friday, 17 October 2025 2:33 PM
To: s47F
Cc: s47E(c), s47F ; DE TOCA, Lucas ; s47F
Subject: RE: Private Health CEO Forum - release of the draft Private National Efficient Price framework paper [SEC=OFFICIAL]

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Thanks for the note s47F

We will keep you informed of our progress, including when they paper will be released.

I expect it will be Tuesday 21 October.

Regards

Brian

Brian Kelleher

Assistant Secretary

Private Hospitals Branch

Australian Government Department of Health, Disability and Ageing

M: s47E(c), s47F

Executive Assistant: s47E(c), s47F

E: s47E(c), s47F @health.gov.au

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From: s47F @Health.gov.au
Sent: Friday, 17 October 2025 1:44 PM
To: KELLEHER, Brian <Brian.Kelleher@health.gov.au>
Cc: s47E(c), s47F @Health.gov.au; DE TOCA, Lucas <Lucas.DETOCA@Health.gov.au>; s47F @Health.gov.au; s47F @Health.gov.au
Subject: RE: Private Health CEO Forum - release of the draft Private National Efficient Price framework paper [SEC=OFFICIAL]

Hi Brian

Thanks for your patience and further explanations to me offline.

Confirming the MO is comfortable for the DRAFT Pricing Framework for Australian Private Hospitals paper to be circulated to private hospitals and the following peaks:

- Private hospital peaks
- Private insurer peaks
- AMA

MTAA

Can you please retain the marker at the top of the document that this is draft and not govt policy.

In addition to your notes below and for others' benefit:

- The paper has already been shared with members of the CEO Forum (i.e. not all private hospitals and insurers)
- Wider circulation at this time won't impact the 26-27 Premium Round, negotiations of which are underway. We'll likely though reference the outcomes of the consultation and the direction the Minister wants to go in the Ministerial Statement of Expectations for the 27-28 Premium Round.
- While the dept will provide the paper directly to private hospitals (in part to help explain why IHACPA is seeking their consent to share their data with the dept), we are relying on private insurer peaks to pass it on to their members.
- Consulting on a draft pricing framework remains inline with the Government policy: Minister Butler's media release: [Working collaboratively to underpin private hospital viability | Health, Disability and Ageing Mini...](#) of 13 December 2024, the accompanying Private Health Reform Options Consultation Paper that was published in January 2025 [Consultation on Private Health Reform Options - January 2025 - Australian Government Department of ...](#) and the consultation paper on the Private Hospital Financial Data Collection Framework also published in January 2025 ([Consultation on Private Hospital Financial Data Collection Framework - Australian Government Depart...](#)).

Cheers

s47F

From: KELLEHER, Brian <Brian.Kelleher@health.gov.au>

Sent: Thursday, 16 October 2025 5:20 PM

To: s47F <s47F@Health.gov.au>

Cc: s47E(c), s47F <s47F@Health.gov.au>

Subject: Private Health CEO Forum - release of the draft Private National Efficient Price framework paper [SEC=OFFICIAL]

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Good afternoon s47F

I am following up on previous discussions with you and Ross Hawkins to obtain approval to circulate the attached draft "Pricing Framework for Australian Private Hospital Services".

The document was shared with members of the Private Health CEO Forum in September and was informed by a significant number of interviews with stakeholders across the sector (Attachment A at page 32 refers).

Release of the draft paper would:

1. help to facilitate further industry feedback as we develop this reform option and our advice to the Minister;
2. manage sector concerns that consultation on the details of this reform option

is being unfairly limited to the membership of the CEO Forum, and

3. *importantly at this time*, greatly assist the department in its request to private hospitals to consent to the release of their cost data, which is held by IHACPA, so the department can undertake modelling.

The attached email includes the draft corro from IHACPA, is now ready to be issued to private hospitals on the department's behalf. This request would be strengthened if we could also reference / attach the draft framework paper.

I would appreciate your advice / the opportunity to discuss at your earliest convenience.

Regards

Brian

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From: s47F
To: [KELLEHER, Brian](#)
Cc: [Private Hospitals](#)
Subject: RE: PNEP stakeholder engagement [SEC=OFFICIAL]
Date: Monday, 27 October 2025 7:43:17 PM

Thanks for the update Brian.

From: KELLEHER, Brian
Sent: Monday, 27 October 2025 5:33 PM
To: s47F
Cc: Private Hospitals
Subject: PNEP stakeholder engagement [SEC=OFFICIAL]

OFFICIAL

Hi s47F

Just following up on engagement with stakeholders re feedback on the private national efficient price as a potential reform option.

Late last week the IHAPA wrote to the private hospitals that contribute cost data to it, seeking their consent for IHACPA to provide the data to the department to enable us to examine the feasibility of this reform option.

Earlier today I shared the draft pricing framework with the private hospitals that had received the IHACPA letter and to the sector peaks, requesting their / their members feedback on the position statements in the paper by 24 November.

Regards

Brian

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From: s47F
To: [KELLEHER, Brian](#); [Minister Butler DLO](#)
Cc: s47E(c), s47F
Subject: RE: Summary dot points on Private Health Reform - Minister meeting with AMA [SEC=OFFICIAL]
Date: Tuesday, 11 November 2025 1:58:18 PM

Thanks Brian. This was perfect. Appreciate the quick work by the team.

Cheers

s47F

From: KELLEHER, Brian
Sent: Tuesday, 11 November 2025 10:27 AM
To: s47F Minister Butler DLO
Cc: s47E(c), s47F
Subject: RE: Summary dot points on Private Health Reform - Minister meeting with AMA [SEC=OFFICIAL]

OFFICIAL

Hi DLO

Could you please bring the email below and the attachment to the attention of s47F as her request for information was for a meeting between the Minister and the AMA this morning.

Regards

Brian

My advice below should have also noted that s47F, the AMA Vice President is a member of the Private Health CEO Forum

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From: KELLEHER, Brian
Sent: Tuesday, 11 November 2025 10:21 AM
To: s47F <s47F@Health.gov.au>
Cc: HAWKINS, Ross <Ross.Hawkins@health.gov.au>; s47E(c), s47F <[s47E\(c\), s47F@health.gov.au](mailto:s47E(c), s47F@health.gov.au)>; MCBRIDE, Paul <Paul.McBride@health.gov.au>; s47F <s47F@Health.gov.au>

Subject: Summary dot points on Private Health Reform - Minister meeting with AMA

Importance: High

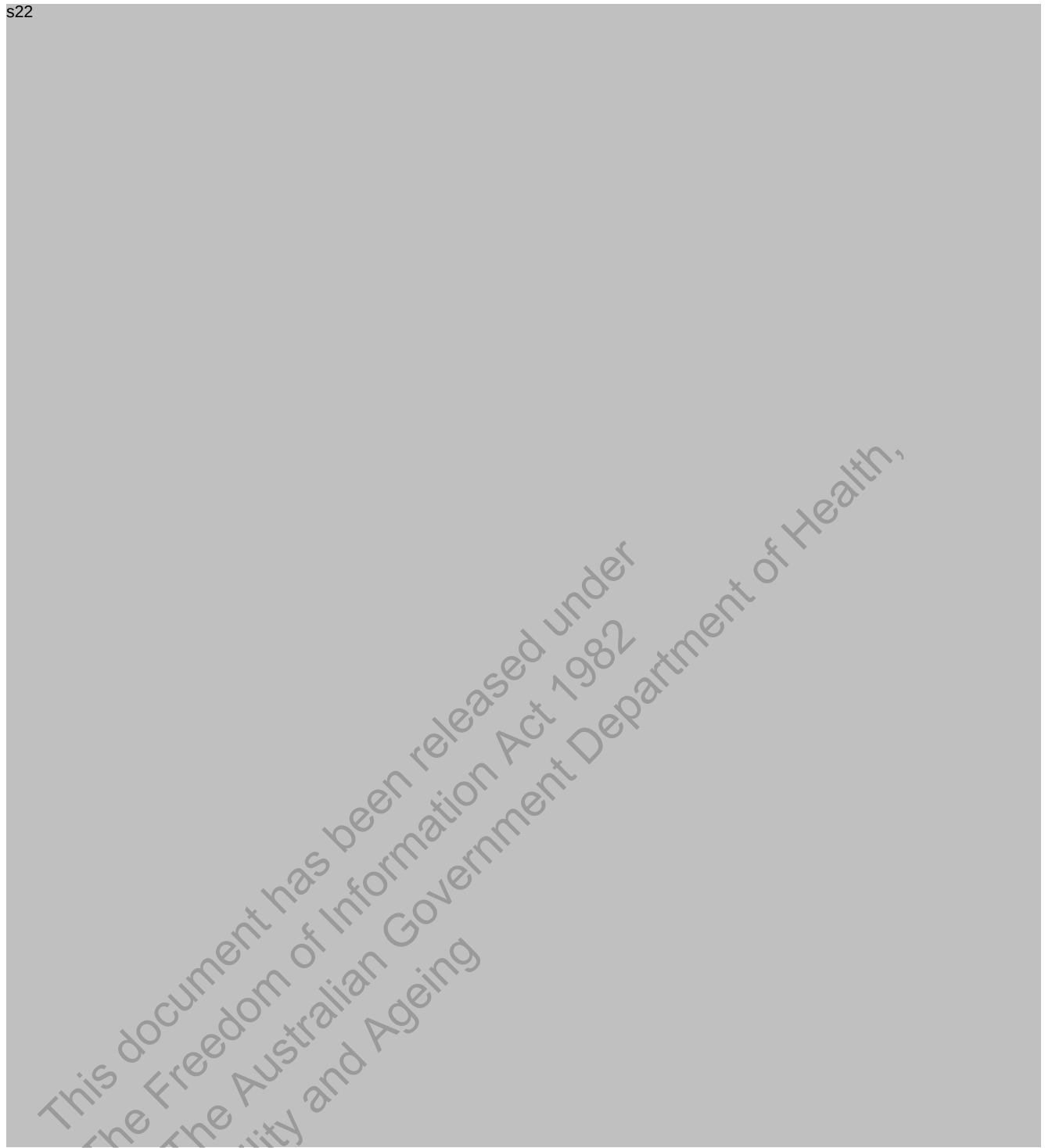
Hi s47F in response to your request earlier this morning

Please see below summary dot points on the progress of private health reforms detailed in the January 2025 paper "Private Health Reform Options – Consultation Paper" (which refers to the Minister's media release of 13 December 2024 both attached) for the Minister's meeting with the AMA this morning.

Please note below in red – a sensitivity re AMA request for increases to MBS rebates.

s22

s22



s47C



s22

Happy to discuss
Brian

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From: s47F
To: s47E(c), s47F; [HAWKINS, Ross](#)
Subject: Private hospital prices discussion paper [SEC=OFFICIAL]
Date: Wednesday, 19 November 2025 1:30:23 PM
Attachments: [image001.png](#)

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Hi s47E(c), s47F and Ross
 s47F from s47G(1)(a) just contacted me, concerned about having seen the private hospitals pricing discussion paper and alarmed the dept wasn't seeking input from consumers and clinical societies.

She said the dept's given her until Monday to provide a submission. She'll do that – it'll be a short cover letter and attach their submission from last time a DGR for cardiac services was under consideration, and it will strongly oppose the suggestion on the basis it will lead to less choice and reduce affordability for patients.

She's going to tell s47G(1)(a) to take a look and try and get something in too, s47G(1)(a)

So you think we've got a problem and need to consult wider or give them more time? I don't want to do anything overly public, but I also don't want to keep one part of the sector effectively excluded from consultation.

I would expect that any advice that eventually comes up from the dept to the Minister adequately reflects all perspectives from the sector, including consumers and clinical societies.

Cheers

s47F

Office of the Hon Mark Butler MP
 Minister for Health and Ageing
 Minister for Disability and the National Disability Insurance Scheme
 P: s47F

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From: [HAWKINS, Ross](#)
To: [DE TOCA, Lucas](#)
Subject: Re: CEO Forum - Slide Deck - 10 December 2025 - DRAFT (002).pptx [SEC=OFFICIAL]
Date: Friday, 5 December 2025 8:07:32 PM
Attachments: [image001.png](#)

Thanks LDT
 Much appreciated
 R

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From: DE TOCA, Lucas
Sent: Friday, December 5, 2025 8:34:38 AM
To: MCBRIDE, Paul ; s47E(c), s47F ; Minister Butler DLO
Cc: HAWKINS, Ross ; STREET, Celia ; s47E(c), s47F
Subject: RE: CEO Forum - Slide Deck - 10 December 2025 - DRAFT (002).pptx [SEC=OFFICIAL]

Thanks Paul and team

Appreciate the discussion and how this is a department process to gauge policy options with the sector.

The Minister remains concerned that previous CEO forum documents have given too much pre-eminence to reform options that aren't government policy (such as the PNEP) and the impact that's had in the sector.

With that in mind, and the caveats provided to the deck, and given the CEO forum next week, happy for you to proceed if you determine this a helpful next step in those considerations. Noting this isn't clearance of the proposed options.

We'll organise a catch up for the week of the 15 to discuss private health reform broadly (and how proposals fit in) ahead of Summer, noting that January will be a great time for engagement with the Minister on this.

Thank you

L

Dr Lucas de Toca PSM (*he/him*)
 Chief of Staff to the Hon Mark Butler MP,
 Minister for Health and Ageing,
 Minister for Disability and the NDIS

From: MCBRIDE, Paul
Sent: Friday, 5 December 2025 18:07
To: DE TOCA, Lucas ; s47E(c), s47F ; Minister Butler DLO
Cc: HAWKINS, Ross ; STREET, Celia ; s47E(c), s47F ; MCBRIDE, Paul ; s47E(c), s47F
Subject: CEO Forum - Slide Deck - 10 December 2025 - DRAFT (002).pptx [SEC=OFFICIAL]

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Hi Lucas s47E(c),
 s47F

After our discussion yesterday we have adjusted the slides to seek to address your concerns that the initial draft appeared to assume a level of ministerial authority that has not yet occurred.

We have also tried to make it clearer that we are seeking feedback from CEO's on issues, many of which are contentious and still need further discussion on the design elements, this is especially so for the PNEP proposal.

s22



We are very keen to hear any remaining issues or uncertainties, so feel free to call at any time, and apologies for the tight timeframes.

Cheers

Paul

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Australian Government
**Department of Health,
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Event Brief
MB25-002765
Version (1)

Date sent to MO: 17 November 2025

To: Minister Butler

**Subject: EVENT BRIEF + SPEECH - OFFICIAL OPENING OF THE FITZROY TOWER AT
 ST VINCENTS FITZROY HEALTH & INNOVATION PRECINCT**

Comments:

Contact Officer:	s47E(c), s47F	Director, Private Hospitals Branch, Health Systems Strategy Division (HSSD)	Ph: (02) 5132 s47E(c), s47F Mobile: s47E(c), s47F
Clearance Officer:	Brian Kelleher	Assistant Secretary, Private Hospitals Branch, HSSD	Ph: (02) 5132 6145 Mobile: s47E(c), s47F

Date / Time: Thursday, 20 November 2025 / 10:30 am TBC

**Meeting Type/Location: Event / Fitzroy Tower, St Vincent's Private Hospital, St Vincent's
 Fitzroy Health and Innovation Precinct**

Traditional Custodians: Wurundjeri People

Desired Outcomes:

Key Attendees/Speakers:	Title:	Organisation:	Mobile No:
s47F s47F is a member of the Private Health CEO Forum.	CEO	St Vincent's Health Australia	s47F

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C. Progress and next steps for the Private Health CEO Forum

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Attachment C**Progress and next steps for the Private Health CEO Forum**

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3. Private National Efficient Price (PNEP) for private hospital services.

- Sector feedback has supported the investigation of developing a PNEP.
- The department has developed a pricing framework for a PNEP. We are consulting with stakeholders including the AMA on this framework, and have commenced the development of a cost and price model, and to support this work has established a working group with the sector to further test the issues with implementing this reform option.
- Advice to the Minister on the PNEP will be provided in early 2026.

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Minister	Minister Butler
PDR Number	MB25-002765
Subject	**URGENT 2 day turnaround** Event Brief + Speech - official opening of the Fitzroy Tower at St Vincents Fitzroy Health & Innovation Precinct
Contact Officer	s47E(c), s47F Ph: (02) 5132 s47E(c) Mobile: s47E(c), s47F
Clearance Officer	Brian Kelleher Ph: (02) 5132 6145 Mobile: s47E(c), s47F
Division/Branch	Strategy & First Nations Health Systems Strategy
Has Budget Branch been consulted if there are financial implications?	Not Applicable
Ensuring connected products across the Portfolio	Have disability/NDIS linkages been considered and outlined as relevant? YES ☐ NO ☐ N/A ☒ Have aged care linkages been considered and outlined as relevant? YES ☒ NO ☐ N/A ☐
Adviser/DLO comments:	Returned to Dept for: REDRAFT ☐ NFA ☐

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Contracting between insurers and hospitals [Private National Efficient Price]

- Hospitals and insurers hold critical cost and performance data that is not shared transparently. This limits the ability of hospitals and insurers to negotiate on a fair and informed basis and weakens policymakers' ability to understand emerging risks, compare value or assess efficiency.
- The CEO Forum has actively examined ways to improve transparency of private hospital cost and activity data as part of the broader effort to address the sustainability challenges facing the private health sector.
- The CEO Forum has considered options such as applying more consistent contracting approaches and expanding hospital cost-data collection.
- To advance this work, the department sought feedback in October 2025 on a Draft Pricing Framework for Private Hospital Services to gauge stakeholder interest in a range of possible models.

Financial Viability of Private Hospitals
QB26-000006

- The Government has not considered adopting a Private National Efficient Price. This and other options remain under consultation, including through the Private Health CEO Forum.
- Further policy development and consultation would be required before Government could assess or quantify any potential impacts of all the various options to improve transparency and bargaining between private hospitals and insurers.

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**Financial Viability of Private Hospitals
QB26-000006**

Date last updated by Dept:	1 April 2026	Cleared by Adviser/date:	s47F 1 April 2026
Contact Officer: Assistant Secretary	Brian Kelleher	Work Phone: (02) 5132 6145	Mobile Phone: s47E(c), s47F
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