

SUBMISSION

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AMA submission on the draft pricing framework for Australian private hospital services

By email: Private.Hospitals@health.gov.au

Executive summary

The Australian Medical Association (AMA) opposes the Department of Health, Disability and Ageing's proposal to introduce a private national efficient price (PNEP) as the primary mechanism for pricing private hospital services, unless it is implemented under the auspices of an appropriately constituted and funded [Private Health System Authority](#) (PHSA) with the capacity to undertake the pricing work, understand the flow-on effects, and ensure reform promotes private hospital viability, clinical independence and system sustainability.

While the consultation paper emphasises "efficiency," the AMA argues reforms must prioritise long-term financial sustainability of private hospitals, ensure value for private health insurance policyholders, and maintain timely access to high-quality care.

Key concerns include:

- **Viability risks:** A DRG-based PNEP, modeled on public hospital Activity-Based Funding (ABF), risks replicating negative outcomes seen in the public sector — such as longer waiting lists and reduced innovation.
- **Rushed implementation:** The proposed timeline is unrealistic, but without short-term solutions, there may be further private hospital closures.
- **Regulatory gaps:** Current oversight is inadequate. The AMA calls for an independent PHSA to regulate the sector and arbitrate disputes.

The AMA recommends two immediate reforms to support private hospital viability now:

1. Mandate a 90 per cent payout ratio for private health insurers to return premiums as benefits to hospitals and patients.

2. Establish the Private Health System Authority to fill regulatory gaps and oversee premium setting.

While AMA is open to limited uses of a PNEP (e.g., benchmarking contracts, calculating second-tier default benefits), we note:

- The PNEP must act as a price floor, not a ceiling.
- Prostheses and implantable devices should remain on the Prescribed List and be funded separately to protect clinical autonomy and patient safety.
- Adjustments for location, facility type, and patient complexity are essential to avoid inequities.

The AMA rejects:

- inclusion of medical costs in PNEP (to avoid undermining private practice viability)
- aggressive pricing methods (e.g., median or efficient frontier) that could destabilise hospitals
- safety and quality penalties without evidence of effectiveness.

Finally, the AMA warns the proposed reforms, combined with other concurrent changes, will impose significant resource strain on stakeholders. If government proceeds, it must fund peak bodies to participate in design and implementation.

Introduction

The AMA is deeply concerned that, as it stands, the department's private national efficient price (PNEP) proposal, as outlined in the consultation paper, appears to prioritise the issue of 'efficiency' (undefined) over the AMA's key concern: ensuring that reforms underpin the long-term financial sustainability of the private hospital sector. Any reforms must also ensure private health insurance policyholders receive better value from their coverage and can access local private hospitals in a timely manner, with confidence that they will receive the highest quality of safe and innovative patient care.

We also do not see any alternative ideas outlined that might help improve hospital viability, such as establishing a minimum payout ratio for insurers or examining the option of lifting the second-tier default benefit.

The history and consequences of activity-based funding (ABF) in public hospitals do not inspire confidence that a DRG-based PNEP will significantly improve the financial circumstances of private hospitals in Australia. As outlined in the AMA report [What happens when we fund hospitals to perform?](#), the introduction of ABF has resulted in improved efficiency, but it has also come at a cost to quality improvement and innovation, particularly with the removal of performance funding. In addition, as outlined in successive annual AMA [Public Hospital Report Cards](#), ABF has produced ever-increasing waiting lists, with performance on most measures of access, safety, and quality during 2023–24 markedly worse than five years ago across all states and territories.

The AMA must also point out that, from the perspective of doctors, the private hospital sector appears far more efficient than the public hospital sector — which relies on state and territory governments to supplement its funding when in trouble — so the impact of a PNEP may be very different from what it was when introduced in the public hospital sector.

The department states there is “momentum for reform”, whereby “providers, funders, and policymakers alike recognise the need for a more consistent, transparent and evidence-based approach to pricing”.¹ The AMA’s own conversations with these stakeholders on this issue reveal the opposite of consensus. They also highlight considerable concern among many stakeholders that the establishment of a PNEP is not the answer to current private hospital viability challenges or other private health reform dilemmas. That is particularly the case given the proposed (and seemingly rushed) timeframe for implementing a PNEP is unlikely to prevent further private hospital and private hospital service closures before 1 July 2028.

The AMA would also strongly encourage the department to undertake a full and public stakeholder consultation regarding the proposed PNEP. While we welcome the early engagement with the AMA on this proposal, we submit it would represent such a significant change to private hospital funding arrangements that it deserves to be fully scrutinised by the sector before progressing any further.

Rather than focusing on the establishment of a PNEP, the AMA strongly recommends the implementation of two key reforms for which we have been advocating for some time:

1. Regulation requiring private health funds to return an average of 90 per cent of premiums received each year in the form of benefits directly to hospitals and patients.

If there was sufficient political will to do so, this reform could be implemented relatively quickly via legislative amendments and would provide an almost immediate boost to the revenues of private hospitals currently operating at a loss.

2. The establishment of an independent, well-resourced [Private Health System Authority](#) with the power and authority to fill current regulatory gaps — not least the absence of any body able to arbitrate disputes between private health insurers, hospitals, and doctors.

Principles for a reformed system

The AMA position

The AMA does not oppose the fundamental principles, process guidelines, and system guidelines outlined in the consultation paper. Nevertheless, the AMA has several key concerns about these principles, as outlined below.

Firstly, the AMA argues that two crucially important and interrelated principles must be included as foundational elements of the reformed pricing system:

- It must protect independent clinical decision-making between doctors and patients.

- It must be designed to limit the extent and influence of vertical integration among private health insurers, which is already reducing patient choice and increasing the profits of large insurers at the expense of the rest of the private health sector.

In addition, the AMA queries the following:

- How, precisely, will the implementation of a pricing framework support “innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care”ⁱⁱ? How and when will pricing be adjusted to support innovation?
- How, precisely, will transition arrangements work to ensure “no significant shocks to the system and operators”?ⁱⁱⁱ

Above all, the AMA agrees with the department that “reformed funding arrangements will need to address the regulatory and organisational elements that will accompany the model so that it is implemented, applied and updated robustly”.^{iv}

Given the gaps in current whole-of-system oversight and regulatory arrangements that have led to the crisis of private hospital viability, the AMA strongly recommends the establishment of an independent, well-resourced [Private Health System Authority](#), as proposed by the AMA, to undertake this regulatory work, including oversight of the annual premium-setting process.

How the price could be used

Uses with direct impacts

Benchmarking the adequacy of contracts with hospitals

The department proposes that a PNEP could be used to benchmark the adequacy of contracts with hospitals.

The AMA position

The AMA would be prepared to explore a carefully calculated and regularly adjusted benchmark to assess the adequacy of private health insurer contracts with private hospitals. However, it would need to be used as a price floor rather than a ceiling. This must also be coupled with the establishment of an authority, as outlined above, to ensure a price floor does not become the default price or serve as the only indicator for setting future premium increases.

Calculation of second-tier default benefits

The department proposes that a PNEP could be used to calculate second-tier default benefits.

The AMA position

The AMA would also accept a PNEP being used to calculate second-tier default benefits, given that, as outlined in the AMA's February 2025 [submission](#) on private health reform options, existing arrangements have allowed private health insurers to game the system.

Use by other payers

The department proposes that a PNEP could be used to replace funding arrangements made with other payers to the private hospital system, such as the Department of Veterans' Affairs, and various state-and territory-based accident and workers' compensation schemes.

The AMA position

The AMA recognises that there is a wide range of other payers beyond private health insurers in the private health system, each with their own funding arrangements that introduce further complexity into the contracting arrangements private hospitals must negotiate.

The AMA is open to a PNEP being used to replace these funding arrangements but defers to the views of both private hospitals and these other payers on this potential reform.

Public patients in private hospitals

The department proposes that a PNEP could be leveraged to simplify private hospital contracting with state and territory governments for the delivery of services to public patients, given that contracting conditions and prices sought vary widely across state and territory governments.

The AMA position

The AMA is open to a PNEP being used to simplify private hospital contracting with state and territory governments, given the department has also proposed adjusting the price to reflect location, facility, and patient-related price factors.

Uses with indirect impacts

Informing premium increases

The department proposes use of a PNEP to help ensure that premium increases requested by insurers "are no higher than necessary, financially justified, and in the public interest".^v

The AMA position

The AMA supports close scrutiny of premium increase requests to ensure private health insurance customers do not pay more than they should. However, this proposal appears to be at odds with other parts of the discussion paper. If the PNEP is structured as a second-tier default benefit, it is difficult to sustain the position that the department should place significant emphasis on the PNEP as

a key factor in the premium round. This appears to be a de facto method of making the PNEP the actual price, as opposed to what is suggested elsewhere in the discussion paper.

Private health insurers must also be required to submit information on the components of their management expenses, the prices of products that have opened or closed during the premium year (or are about to be opened), actual benefits paid and premium revenue, overall insurer profits (including investment income), and out-of-pocket costs associated with various products or product tiers. Insurer forecasts of premium revenue, benefits paid, management expenses, and net margins from previous premium years should also be compared with actual results, to assess how seriously their forecasts for the current premium round should be taken.

Finally, the premium-setting system should not be required merely to ensure the fiduciary duty of private health insurers, without assessing the impact and real costs incurred across the overall system — nor should it continue to rely on the “estimated” cost of providing care private health insurers submit without input from actual cost drivers.

Risk equalisation

The department suggests a PNEP could be used to make risk equalisation fairer and more transparent because it will replace the use of “volatile, insurer-specific benefit data with a neutral reference cost”. This, they suggest, will reduce “perverse incentives” that may “overcompensate more generous insurers” and undercompensate “more efficient insurers”.^{vi}

The AMA position

The AMA is not convinced by the very brief case the department makes in the consultation paper regarding the virtues of basing risk equalisation on a PNEP (a “neutral reference cost”^{vii}) rather than on actual benefits paid, given the lack of detail provided.

The AMA is also deeply concerned by the assumptions implicit in the language used in the consultation paper with respect to the “potential distortions” of the current system. The department argues that under the current system “more generous insurers (or those with weak contracting) may be overcompensated”, while “more efficient insurers may be undercompensated”.^{viii}

In other words, the department is essentially saying that insurers which provide relatively generous benefits to the public at the premium price for private health insurance cover are inefficient, whereas those that provide less generous benefits are efficient.

This is an extraordinary, revealing, and worrying statement for the department to make, given that it knows full well, and as outlined in successive AMA Private Health Insurance Report Cards,^{ix} that many of the most profitable insurers dominating the market provide relatively low benefits for treatment to their members while spending increasing amounts on “management expenses”. That is hardly efficient, or fair to taxpayers, who subsidise the private health insurance industry to the tune of \$7 billion per year^x in the form of government private health insurance incentive rebates.

Scope of services to be funded

The department proposes the following:

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.

Here, the department is proposing that a PNEP includes pricing for hospital-in-the-home services, for which private health insurer funding is currently not widespread, and for which there are currently no default benefits available to hospitals that are unable to reach a contracting arrangement with insurers.

The department also proposes that:

2. The scope of services to be included in the reformed pricing arrangements should be determined by an independent body.

The AMA position

1. In principle, the AMA supports this position, as outlined in its October 2023 research report [Out-of-home models of care in the private health system](#) and its position statement [Principles for private health insurers to cover out-of-hospital care](#). However, full AMA support will depend on the details of this proposal.

2. The AMA supports this proposal, provided that independent body is the [Private Health System Authority](#) first proposed by the AMA in 2022.

Components of an ABF system

Classifications

The department proposes the following:

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.*

The AMA position

The AMA does not object to these proposals. However, with respect to proposal 2 (as with most of the department's proposals concerning a PNEP), the "devil is in the detail". For example, who will be involved in the review AR-DRG V11.0, and who will refer DRGs identified as requiring refinement to reflect private sector service delivery to IHACPA for priority refinement?

Clearly, to be fit for purpose, these reviews will need considerable stakeholder involvement, which, for many stakeholders, will significantly worsen the current strains on their resources. This issue is further discussed under the heading "Implementation" further below.

Activity data collection

The department proposes the following:

- 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.*

The AMA position

The AMA does not object to these proposals.

Costing

The department proposes the following:

- 1. The scope of the Private Sector NHCDC (National Hospital Cost Data Collection) 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.*

The AMA position

The AMA does not object to most of these proposals, except for the suggestion that current incentive payments provided to overnight hospitals that supply data for the NHCDC should be redirected to day hospitals. As already noted, the department is proposing a raft of major changes for the private hospital sector, in addition to the implementation of the PNEP, which will represent the largest change for private hospitals in decades and will require extensive consultation and additional work for stakeholders across the system.

Instead of redirecting existing incentive payments from overnight hospitals that participate in the NHCDC, the government should continue to fund those hospitals while providing additional incentive payments to the day hospitals it wishes to involve in the data collection process.

We also note the department's own Private Hospital Financial Health Check found that private hospitals are under significant financial strain — the main reason the Private Health CEO Forum was established, and the reason for this particular consultation. Removing the financial incentives to participate in data collection risks private hospitals opting out of the process, potentially hampering the efficacy of cost data collection.

Financial disclosure framework

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

The department now also proposes working with IHACPA to develop a quality assurance process for private sector NHCDC, using data obtained through the Financial Disclosure Framework.

The AMA position

The AMA does not object to these proposals.

Setting the Private National Efficient Price

Inclusions in the price

The department proposes the following should be included in the price:

Hospital operating costs

The department proposes including hospital operating costs — such as theatre costs, accommodation, nursing, hotel services, administrative staff, insurance, and utilities — in the PNEP, and notes that the costs of these items are currently captured in the NHCDC.

The AMA position

The AMA supports the inclusion of hospital operating costs in the price.

Prescribed List of medical devices and human tissue products ('the PL')

The department proposes including prostheses and implantable devices currently listed on the PL and funded separately by insurers at a rate determined by that PL in a PNEP for hospitals. It argues that this would likely reduce medical device costs in the private sector, shorten the time to market for new devices, and reduce the regulatory costs in administering the PL.

However, the department also notes several “potential downsides” to such a move. These include, but are not limited to, the financial risk for private hospitals when the medical device a patient requires costs significantly more than the average for the relevant DRG, and the possibility that, as a result, private hospitals may choose to limit the range of devices available to clinicians. As the department notes, private hospitals — many of which are already operating in the red — would need to invest money they do not have in developing medical device procurement strategies, either individually or collectively.

The AMA position

The AMA strongly disagrees with abolishing the PL and including the cost of prostheses and implantable medical devices in the PNEP. The AMA has previously supported the continuation of the PL on the basis that it supports clinician and patient choice, and that it should be modernised rather than having the costs of prostheses included in a bundled pricing model.

Relevant stakeholders have already participated in good faith (and at considerable expense) in a process of reviewing and modernising the PL — a process that has taken many years and brought most PL prices down to within 10 per cent of those paid by the public sector. Since 2017, PL reforms have delivered more than \$2.5 billion in savings for health insurers to pass on to consumers.^{xi} Yet, as the Minister for Health himself observed in December last year, it is clear some insurers have failed to pass on the savings they extracted from that process to their policyholders.^{xii}

The department’s proposal shifts the financial risk that profitable insurers currently carry onto private hospitals, which are already suffering a crisis of financial viability that has led to many closing or discontinuing particular services. By contrast, the number of private health insurers has changed little in recent years, and their profitability has been boosted both by investment income and the reduced proportion of premiums that many are passing on to patients in the form of treatment benefits.

More importantly, the AMA is concerned about the (highly likely) risk of private hospitals finding themselves in a financial position where they limit the range of prostheses and devices available to clinicians. We are also concerned that, if this change goes ahead, prices charged by manufacturers for medical devices with little or no competition may increase, and that if smaller hospitals are left to negotiate device prices with multiple manufacturers, the prices they are forced to pay will exceed current PL prices across the board. In these circumstances, the only way the proposal to include medical devices in a PNEP could exert downward pressure on costs would be by limiting clinician choice of medical devices.

The AMA will not brook such an outcome, and neither should the department, given that it would not only reduce the clinical autonomy of medical practitioners (which goes against the stated principles of reform) but would also pose grave risks to the safety and quality of care for individual patients whose specific clinical circumstances require the use of relatively high-cost prostheses. Furthermore, such an outcome would likely undermine the value proposition of private health insurance for its members.

Finally, the department's consultation paper argument that a PNEP is the only way to decrease the time it takes for new, innovative products to become available to clinicians working in private hospitals is unfounded. If time to market is truly an issue, the department could change this immediately by ensuring all TGA-approved products are automatically listed on the PL.

The AMA strongly recommends that the cost of prostheses and devices be excluded from a PNEP, that prostheses and devices remain on the PL, and that they continue to be separately funded by insurers at the rates determined by the PL under current requirements.

Capital

The department proposes including depreciation and the costs of capital in a PNEP but notes the challenges inherent in doing so.

The AMA position

The AMA agrees that including depreciation and the cost of capital into a PNEP will be extremely difficult and contested, particularly given the diversity of the sector and its many different capital structures. Indeed, the difference between the public and private sectors in this regard is a key reason the AMA believes that a PNEP is not appropriate for the private sector.

However, capital must be included in the PNEP and set at a level that encourages investment. Otherwise, only private health insurers or other financial institutions able to make a profit through the vertical integration of healthcare services will be willing to purchase them.

On the other hand, if priced appropriately, including capital in a PNEP may well effect a much-needed transfer from the most highly profitable for-profit private health insurers to those private hospitals that are struggling financially.

Exclusions from the price

The department proposes to exclude costs that are covered by other programs, including

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

The AMA position

The AMA supports the exclusion of items funded under these programs from the PNEP.

The AMA notes that in the first proposal for a PNEP sent to the Private Health CEO Forum, the department initially proposed developing and publishing a PNEP both inclusive and exclusive of prostheses costs and medical costs.

The AMA is pleased that this proposal is not included in this consultation paper, since the CEO Forum was established to address the financial viability of private hospitals and private health insurer funding for the hospital component of care.

The AMA will not support the development of a PNEP that includes medical costs. We believe government should not be in the business of setting the fees of private medical practitioners, and we suggest that including medical costs in a PNEP would result in many of our members reducing or ceasing their provision of services to the private hospital sector. This would only exacerbate existing private hospital workforce shortages.

The AMA also notes the following:

- A clear majority of medical practitioners charge a reasonable amount, and the AMA has supported the publication of individual medical fees on the government's Medical Costs Finder website, provided that individual insurer rebates for specific MBS items are also published there.
- The vast majority of private hospital care in Australia is provided either with no direct medical fee cost to the patient through "no gap" arrangements with private health insurers (87.1 per cent) or with a "known gap" (a set out-of-pocket cost) determined by the private health insurer (10 per cent).

Calculating the price

Level at which price should be set

The department suggests several different methods that could be used to set the level of the proposed PNEP. These include setting it at the average cost of the calculated Private National Weighted Activity Unit (PWAU), using "a more aggressive point" such as the median (below-average) cost, or adopting "a more sophisticated" method such as an efficient frontier approach.^{xiii} The latter approach places an even greater emphasis on efficiency than the below-average approach, by anchoring the price to that achieved by demonstrably high value providers.^{xiv}

However, the department proposes the PNEP should be set at the average price of the calculated PWAU,^{xv} as is done for the public hospital sector.

The AMA position

If a PNEP is implemented, it should be set at the average price of the calculated PWAU,^{xvi} as is done for the public hospital sector. The average price is the only reasonable option presented in the consultation paper, but even this may not be sufficient to ensure the viability of all private hospitals.

As the department itself notes, “margins across the sector are currently below a level required for continued investment”, and therefore, using a below-average pricing point “is unlikely to be a suitable point to set the price at this point in time”.^{xvii} In fact, using a below-average price point would simply put many private hospitals out of business, and the AMA does not agree with the department’s view that “it may be appropriate to set the price” at a below-average point “in future years”.^{xviii} Patients who pay large amounts for private health insurance should have the value proposition of that investment in their health maintained.

The AMA also opposes the use of “efficient frontier pricing”, as we question IHACPA’s capacity to determine appropriate efficient frontier prices and to understand the impacts and unintended consequences. The AMA believes that efficient frontier pricing may create significant risks to the quality of patient care, in addition to the risk noted in the consultation paper that it may create “sharper revenue shocks”^{xix} for hospitals.

Adjustment to the price

Adjustments for location, facility and patient related factors

The department proposes adjusting the raw PNEP to account for cost variations beyond the control of hospital operators, such as those caused by location, the nature of the facility, and the patient profile of the hospital. It suggests that adjustments should be evidence-based and determined through a transparent process that allows hospital operators to request consideration of different factors by the price-setting body.

The AMA position

The AMA shares this view.

Location-based adjustments to account for state and territory variations in wages, freight, and other inputs outside metropolitan areas are essential if the private hospital sector is to retain its relatively small presence outside the major cities and expand that presence to improve the value of private health insurance for current and prospective policyholders living in non-metropolitan areas.

Facility-related adjustments to accommodate differences between non-profit operators, those with charitable status (which reduces their costs through various government concessions), and for-profit operators are also essential. Equally important are adjustments to reflect differences in facility size and services, and whether the facility is a teaching or training hospital that employs junior medical staff.

The AMA also agrees with the department that not all patient-related factors (including intensive care unit usage) are well accommodated by the AR-DRG pricing system,^{xx} and that factors such as age, Indigenous status, and cultural and linguistic background may need to be adjusted for in the price.

However, the AMA is concerned about how a PNEP could be adjusted to accommodate the extra costs borne by private teaching and training hospitals, given that in the public sector these activities are not considered suitable for activity-based funding.

One unresolved question is how a PNEP might account for an “adequate” or “reasonable” margin for hospitals and hospital groups, as this will vary significantly between operators and will be nearly impossible to define. The AMA has met with IHACPA to discuss the concept of a PNEP, with IHACPA making it clear that beyond the significant complexity of calculating a PNEP, it would also require government to determine what constitutes a reasonable rate of return for a private hospital.

Adjustments for safety and quality outcomes

The department notes that a common criticism of ABF is that it focuses only on outputs rather than outcomes, and that in the public hospital sector, IHACPA and the Australian Commission on Safety and Quality in Health Care (ACSQHC) have worked together to design pricing adjustments for three types of poor safety and quality outcome:

- sentinel events (rare but serious adverse events that are entirely preventable if known safety protocols are followed)
- hospital acquired complications (HACs)
- unplanned readmissions.

The department also notes that IHACPA applies a zero-payment policy to the episode of care during which events of this kind occur.

It adds that in the private sector, some insurers include safety and quality adjustments in their contracts with hospitals to account for sentinel events, HACs, and unplanned admissions. However, there is no uniform approach across the sector, which increases the complexity hospitals face in contracting, given the range of different conditions imposed by various insurers.

The department proposes it will review:

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

The AMA position

The AMA defers to input from private hospital groups on these proposals.

However, in principle, the AMA does not support these proposals, as we have yet to see any evidence that financial penalties for sentinel events, HACs, and unplanned readmissions actually lead to sustained improvements in quality and safety over the long-term. If the department insists on any adjustments for HACs, these must be based on an acknowledgement that there is a reasonable rate of readmission for all procedures, for which no financial penalty should apply.

Implementation options

The department proposes that implementation must be staged, carefully managed, and reliant on:

- the timely availability of appropriate data
- adequate capacity and capability to develop the pricing model
- an appropriate level of consultation with, and engagement from, stakeholders across the private health sector.

The department also suggests the following phases and timeframe:

- Phase 1 — development of an indicative PNEP by 1 July 2026
- Phase 1a — data improvements to enable Phase 2 to occur concurrently with Phase 1 and conclude by 1 December 2026
- Phase 2 — determination of a comprehensive PNEP by 1 July 2027 for use in the premium round at the end of 2027
- Phase 3 — PNEP to replace default benefits from 1 July 2028

The AMA position

The AMA agrees that, should it be decided the private sector implement a PNEP, the implementation must be staged, carefully managed, and reliant on the availability of appropriate data, adequate capacity and capability to develop the pricing model, and ongoing consultation with and engagement by stakeholders across the private health sector.

However, the AMA believes the timeframe for implementation is too rushed and does not account for how radical this proposed change would be for the sector.

With respect to “adequate capacity” It remains to be seen whether the government will adequately fund both the department and IHACPA to provide them with the capacity required to develop the pricing model within the proposed timeframe. As the AMA has frequently argued, we believe a statutory and independent Private Health Systems Authority, working in collaboration with IHACPA, would be better placed to undertake this work.

Equally important is the issue of consultation with, and engagement by, stakeholders across the private health sector in relation to the development and implementation of a PNEP. The AMA is concerned about the CEO Forum effectively “signing off” on the development of a PNEP, given that to date the AMA is the only body representing doctors that has been consulted. We strongly recommend broader consultation with medical colleges and societies before — not just after — any work on the development of a PNEP commences.

It is also important to remember there are many reforms, in addition to the implementation of a PNEP, under consideration by the Private Health CEO Forum. All of these require the consideration and engagement of the same group of stakeholders, with the details of implementation to be resolved over the next year or two.

This will significantly add to the strain on resources currently experienced by many private hospital groups that are already operating “in the red”, as well as other non-profit stakeholders that cannot immediately generate additional funds to adequately support this consultation and engagement process.

If, as it appears, the department is determined to introduce this radical new approach to funding private hospitals despite the very mixed views about its utility across the sector, it should consider funding all peak non-profit organisations that need to be involved in the design and implementation process.

Other considerations

National Procedure Banding Committee

The department makes no mention of the role (if any) it envisages for the National Procedure Banding Committee (NPBC) once a PNEP based on Diagnostic Related Groups is implemented. It must clarify its intentions on this issue as soon as possible.

The NPBC is an industry committee represented by equal numbers of private hospitals and private health insurers, overseeing the management, maintenance, and update of “procedure” or “theatre” bands. Each Medicare Benefit Schedule (MBS) item is allocated to a procedure band in accordance with the Procedure Banding Methodology, using similar or like items in the first instance, or a full cost analysis if no comparable item is available. Each procedure band represents a cost range. Under private hospital contracts with payers, charges and benefits are therefore individually agreed between providers and payers for each of the 15 bands, rather than for the 5,000 or so procedures listed on the MBS.

The AMA position

Many private hospitals, especially those in the day hospital sector, are funded via this MBS-based methodology either in part or in full. These hospitals may not use, or even be familiar with, DRG classification, let alone DRG-based funding. Some smaller private health insurers similarly rely on MBS-funding through procedure banding.

Should the entire private sector move to DRG-based funding (by adopting the PNEP), the NPBC would no longer be required, and the sector might experience perverse outcomes, such as certain procedures no longer being offered in some hospitals due to the way the banding system currently operates.

Contact

president@ama.com.au

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- ⁱ Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*. sent to the AMA via email on 27 October, p.5.
- ⁱⁱ Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.8.
- ⁱⁱⁱ Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.8.
- ^{iv} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.11.
- ^v Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.11.
- ^{vi} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.11.
- ^{vii} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.11.
- ^{viii} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p.12.
- ^{ix} see, for example, [AMA private health insurance report card 2024](#); [AMA private health insurance report card 2023](#).
- ^x Australian Institute of Health and Welfare. (2025). [Health expenditure Australia 2023-24](#).
- ^{xi} Nous Group (for the Department of Health and Aged Care). [Interim evaluation #1 of the Prescribed List Reforms](#), 2 November 2024; Medical Technology Association of Australia. 'Independent report shows Medtech delivering savings, while insurers pocket profits', Media release issued 13 December 2024.
- ^{xii} <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-press-conference-9-december-2024?language=en>
- ^{xiii} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p. 23.
- ^{xiv} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p. 24.
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- ^{xvii} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p. 23.
- ^{xviii} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p. 23.
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- ^{xx} Department of Health, Ageing and Disability. (2025). *Pricing Framework for Australian Private Hospital Services: Draft for comment*, p. 26.