Australian
Private Hospitals
Association

APHA Psychiatry

POSITION PAPER

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APHA Position

PURPOSE

The Psychiatry Committee comprises a representative from each State and is chaired by the Psychiatry representative on the APHA Council. In addition to its advice to the APHA Board, the Committee also provides input to APHA's representatives on the Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS). The Committee has a national focus of advocacy and policy development on behalf of private mental health facilities. Committee members are drawn from hospitals with both independent and group ownership.

THE STATE OF PSYCHIATRY IN AUSTRALIA

The 2023 National Report Card published by the National Mental Health Commission (NMHC) noted that in 2020-2022, just over 1 in 5 people (21.5%) in Australia aged 16-85 years experienced a mental disorder in the previous 12 months. This represents a very significant section of the population.

Australia's private acute psychiatric hospitals provide services for patients suffering from moderate-to-severe mental health issues. They complement the public psychiatry hospital system, which treats a different caseload mix - meaning they are not interchangeable, nor do community clinics and out-patient services meet the same acute needs. When private psychiatric hospitals close, winddown services or have empty beds, a huge need in the community goes unmet.

According to the Australian Institute of Health and Welfare, over 2023-24 private acute psychiatric hospitals accounted for 61% of all acute mental health admissions - a decline of 1% to 217,047 (down from 217,851 the previous year).

Mental healthcare in Australia is under immense strain from significant underfunding and workforce shortages that are unable to keep pace with rising caseloads and an increasing complexity of cases. These challenges are crippling the national health system and the ability of the public and private sectors to continue to serve all those that need care.

The 2024 Private Hospital Financial Viability Health Check (the Health Check) undertaken by then-Department of Health and Aged Care highlighted declining mental health as a critical concern for the government and the viability of private hospitals. Despite providing 61% of all separations for mental health in 2023-24, the ever-increasing pressure has brought the sector to its breaking point.

The closure of Toowong Private Hospital in Brisbane in June 2025 underscores the issues around viability and sustainability. The Health Check confirmed chronic underfunding of private hospitals by health insurance companies. It cited that one-third of private hospitals were/are operating at losses. Of the remainder, most were breaking even and just a few who were making margins were recording 1-2% profits. An EY study for the Australian Government showed private hospitals must make a minimum 5% to be able to invest in procedures, treatments, technologies, service and staffs to maintain quality. Compounding this funding crisis, banks will not lend to hospitals making margins of less than 10%.

PRIORITIES

The APHA Psychiatry Committee considers and engages with a number of matters including:

1. Viability of, and funding for, psychiatric hospitals

a. Workforce shortages
    i. Australia's psychiatry workforce continues to face severe shortages, causing extended wait times and increased strain on professionals.
    ii. Many psychiatrists report experiencing burnout, with excessive caseloads and inadequate support systems, exacerbating access blocks and deteriorating mental health outcomes. To address these challenges, national efforts have focused on expanding training programs, recruitment initiatives, and workforce retention strategies.
    iii. Policymakers are working to improve access to psychiatric care, particularly in rural areas where shortages are most severe.
    iv. Despite these efforts, concerns remain about the uneven distribution of professionals and long-term sustainability of the mental health sector. Ongoing discussions emphasise the need for systemic reforms and increased investment to ensure adequate psychiatric care for communities across Australia.
b. Resignations of psychiatrists from the public system
    i. Some 200 individual senior NSW psychiatrists have indicated their intention to resign from the workforce.
    ii. With public hospitals overwhelmed, record waiting lists and many psychiatrists refusing to take any new patients at all, Australians are being denied the mental healthcare they urgently need due to bureaucratic red tape and ministerial intransigence.
    iii. With the NSW Government seeking to accommodate mental health needs in private psychiatric hospitals, the availability of more psychiatrists, is paramount.
    iv. The moratorium restricts overseas-trained doctors from practising in most private hospitals, limiting their activity to areas of designated workforce shortage. This definition ignores the ongoing critical need with respect to private in-patient psychiatric services that have arisen post-pandemic.
    v. With the backlog of patients needing in-hospital care exploding, the critical workforce demand for treatment of moderate-to-severe mental illness is most definitely apparent in private hospitals. The government's historical approach to moratorium setting is redundant and requires immediate correction.
    vi. APHA has repeatedly emphasised to the Australian Government the critical need to lift the 10-year moratorium on overseas trained health professionals, including psychiatrists. Lifting the moratorium will provide immediate relief, helping both public and private healthcare providers to manage patient load and reduce strain on hospital staff.

2. Admissions data and trends and the Private Psychiatric Hospital Data Reporting and Analysis Service (PPHDRAS)
    a. Private psychiatric care shows declining trends in numbers of patients in care, overnight separations, and average service days per bed, while same day separations have increased. CPI-adjusted charges have dropped, and many hospitals face closure, risking a significant loss of private psychiatric beds.
3. Telehealth services
    a. The shortage of psychiatrists available to admit patients has resulted in private psychiatric hospital beds being left empty, while people needing urgent admission have had nowhere else to go. Government have mistakenly emphasised out-patient care via community clinics as a solution. This does not meet the needs of the acute cases being untreated and finding their way into general hospital Emergency Departments only to, ultimately, be released back into the community.

b. Many unwell Australians have missed out on care they urgently needed because psychiatrists could not utilise telehealth for private hospital inpatients.
c. The 2024-25 Federal Budget introduced temporary Medicare Benefit Schedule items to allow the admission and some subsequent consultation of inpatients in private hospitals to be undertaken by psychiatrists via video.
d. A new trial to fund telehealth for psychiatric inpatient consultations should result in better access to psychiatric care for Australian patients. This has been implemented since Friday 1 November 2024 for an initial period of two years.
e. APHA had been campaigning for this change for over 12 months. The Australian Government has recognised the need to address the significant barriers to accessing care in the private psychiatric hospital sector, due to lack of an admission pathway.
f. The measure has provided MBS items for a psychiatrist to admit a patient to a private hospital as well as a subsequent video consultation each week of admission. This will enable inpatients to be admitted and better supported, while ensuring they are still seen face-to-face.
g. Though the causes of the wider crisis in mental health care are complex, this measure will have a direct impact on the ability of psychiatrists working in the private sector to provide timely access to care.

4. Ambulatory care in private psychiatric hospitals
    a. The current situation in private hospital psychiatric care has led to a crisis with in which many people in urgent need of private hospital psychiatric care going untreated. One reason for this is a shortage of psychiatrists available to admit people for inpatient care.
    b. A default benefit for ambulatory care could significantly improve patient access to acute psychiatric care at a time when the availability of psychiatrists to provide inpatient care is limited and diminishing.
    c. A default benefit for private hospital run multi-disciplinary mental health care programs could help to address this crisis by easing pressures on psychiatrists working in the private hospital sector by reducing the burden of pre- and post-discharge care.
    d. Ambulatory care would potentially reduce the risk of relapse during the post-discharge period by enabling prompt interventions, including mental health and allied health interventions in the home and, where necessary, prompt readmission to acute care. Prompt intervention would likely minimise the extent of intervention required even if readmission to acute care occurred.
    e. It would ensure continuity of care in periods of high risk and streamline transition into lower intensity community care provided by patients' GPs or other community services.
    f. PPHDRAS data shows an increasing trend in the prescription of anti-psychotic drugs as GPs, already under immense pressure, encounter more and more patients with moderate-to-several mental health conditions for which there are no available psychiatrists to refer.
    g. There is currently a pronounced gap in the availability of private hospital run multi-disciplinary mental health care outreach programs.
    h. APHA has recommended that government implement a 12-month trial of a default benefit for private hospital-run multi-disciplinary mental health outreach programs (ambulatory outreach) and that government convene an industry-wide group to monitor the trial and develop a national guideline for the ongoing funding of ambulatory outreach psychiatric care in the private hospital sector.

Committee Chair

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