Australian
Private Hospitals
Association

APHA Rehabilitation

POSITION PAPER

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APHA Position

PURPOSE

The Rehabilitation Committee comprises representatives from States with private rehabilitation beds and is chaired by the Rehabilitation representative on the APHA Council. The primary role of the Committee is to promote the role played by APHA members in the provision of quality rehabilitation services, including by participation in appropriate committees and working groups, preparation of submissions to government and other advocacy material, liaison with other APHA committees, and by facilitating dialogue between the sector and government.

THE STATE OF REHABILITATION IN AUSTRALIA

There are 35 designated rehabilitation private hospitals in Australia.[1] Within the APHA membership, there are 54 hospitals providing various levels of rehabilitation services.[2] Separations for rehabilitation in Australia have generally increased from year to year with private hospitals playing a critical role in rehabilitation. In 2023-24, for example, 81.5% of all rehabilitation separations came from private hospitals, underscoring the importance of private hospitals to rehabilitation and the need for a healthy and well-resourced sector.

In recent years, private hospitals have experienced increased workforce and cost pressures that have an adverse impact on their ability to continue to invest and, in many cases, remain viable. The sector is united in that there is a need to continue to be able to remain viable to enable the ongoing operation of private rehabilitation hospitals and services so that our patients can continue to be confident that they will receive world-class care that is consistent, reliable, and appropriate.

PRIORITIES

The APHA Rehabilitation Committee engages with a wide variety of subject matters that include:

- Trends in rehabilitation across all sectors
- Review of the viability of rehabilitation in the private hospital sector
- Disruptions due to bundled payment arrangements
- The Australasian Rehabilitation Outcomes Centre (AROC) and opportunities for improvement
- Models of care, including Rehabilitation in the Home (RITH)

The four main priorities of the committee are as follows:

1. Remuneration issues and funding models
    a. Funding for private hospitals, including through private health insurance
        i. Remuneration for Rehabilitation is marginally indexed, though data using the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP)[3] demonstrates that complexity has not declined, year on year.
            - There has been a marked decline in the admission of higher-functioning patients to inpatient rehabilitation, as more cost-effective care models—such as Day Programs, Rehabilitation in

[1] Department of Health, Disability and Ageing, *List of declared hospitals*, updated on 6 July 2025
[2] Australian Private Hospitals Association as of 15 July 2025
[3] https://www.ihacpa.gov.au/resources/australian-national-subacute-and-non-acute-patient-classification-version-50

the Home (RITH), or self-funded outpatient options—are increasingly utilised. This shift has led to a concentration of patients with higher dependency needs within inpatient units, driving up operational costs, particularly in labour and clinical supplies. These increased costs are not adequately offset by current indexation of reimbursement.

ii. The then-Department of Health and Aged Care released a Private Hospital Financial Viability Health Check – Summary in November 2024 highlighting issues with private hospital viability. 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. Compound this funding crisis, banks will not lend to hospitals making margins of less than 10%.

iii. APHA has continued to advocate for critical reforms to the sector, including through an options paper provided to government, a 2025 Budget Submission, and responses to consultations on sector reform. The APHA has also written to the Australian Government calling for a Mandatory Code of Conduct, with an arbitration model, for contracting between private hospitals and private health insurers.

iv. Private Hospital Data Bureau (PHDB) data shows increasing activity in rehabilitation, with an annual growth rate of 4.5% between 2019-20 and 2023-24, indicating an upward trend in recovery of rehabilitation in private hospitals.[4] The preliminary PHDB Annual Report for 2023-24 indicates private rehabilitation separations in 2023-24 were 450,425 up from 377,077 in 2019-20.

v. APHA continually collects feedback on whether this aligns with the experience of our members and whether the data is reflective of the whole sector including small, medium, and large hospitals and hospital groups.

b. Workforce issues and pressures, including staffing shortages

i. Australian private hospitals have been under serious pressure with rising costs and increasing workforce challenges. For example, according to *Australian Industry,* published by the Australian Bureau of Statistics in May 2025, Australia's private hospitals generated $24.128 billion in 2023-24 in direct economic activity (income) - an increase of $539 million on the previous year. However, private hospitals experienced a sharp rise in expenses over 2023-24 to $24.164 billion - up $921 million on the previous year. Despite private hospitals' modest increase in income in 2023-24 (as stated above), their costs were higher - outstripping income to record a sector-wide operating loss of $34 million. Private hospitals paid $12.55 billion in labour costs for staff in 2023-24, up $675 million on the year before, while only employing an additional 3,000 people (for a total of 155,000 staff) on the previous year.[5] Their labour costs grew exponentially.

ii. The sector is facing critical workforce shortages in key professions such as occupational therapy, driven in part by the migration of clinicians to roles under the National Disability Insurance Scheme (NDIS) sector, which often

[4] https://www.health.gov.au/resources/publications/phdb-annual-report-2023-24-preliminary?language=en
[5] https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry/2023-24

offer more attractive conditions. Concurrently, rapidly rising labour costs are unsustainable and likely to force hospitals to reduce their service offerings or cease operations.

iii. There is a need to discuss opportunities to increase the available workforce, including overseas trained professionals, and better understand the overall sector's condition with respect to costs.

c. Vertical integration of health funds & restriction of offerings
    i. Private health insurers have developed or acquire their own rehabilitation offerings (e.g. in-home rehab, services), reducing the flow to our rehab hospitals.
    ii. Increasingly steer their members away from hospital-based rehab into their lower-cost vertically owned services.
    iii. Private hospitals have the clinical expertise, governance structures, and infrastructure to safely deliver Rehab in the Home services. However, current funding practices and contracting preferences create barriers that limit innovation and patient access.

2. Bundling arrangements and their impact
    a. There are ongoing concerns regarding the referral arrangements being implemented between health insurers and acute hospitals, for example the EMU model.
    b. The Association's understanding of the issue is as follows:
        i. Standalone rehabilitation hospitals rely on referrals from external acute care facilities, both public and private.
        ii. Private referral hospitals in agreements with health insurers to receive bundled payments for all the patient care including any after care are funded under one payment.
            - Many private acute facilities have entered episodic bundled payment arrangements in relation to orthopaedic procedures whereby an agreed bundled amount will be payable. The hospital covering the procedure is then responsible for certain medical requirements related to the episode of care, including the rehabilitation services.
        iii. Surgical hospitals face a structural disincentive to referring patients to external rehabilitation facilities under EMU agreements. This stems from the requirement that the referring hospital must allocate a portion of the bundled payment to the rehabilitation provider. This places an unreasonable financial burden on the referring hospital and introduces a risk of underpayment for the rehabilitation component of the care, potentially undermining the quality of patient outcomes.
        iv. Consequently, rehabilitation hospitals either fail to get referrals or get referrals for which they are paid by the referring hospital for fulfilling, at rates that may not reflect the complexity of care required. Rehabilitation hospitals/units are restricted to provide care to the length determined by the contract offered by the acute hospital, without undergoing a pre-admission assessment. When rehabilitation clinicians determine that extended rehabilitation is clinically necessary, the rehabilitation hospital must negotiate with the referring hospital for additional funding. This creates a misaligned financial burden and exposes both hospitals to significant risk as the capped or bundled payment may not cover the actual cost of delivering appropriate care. This financial burden is particularly misplaced, as insurers have ultimate responsibility to fund all the clinically required treatment of the patients they have insured.

v. Surgical facilities assume significant financial risk under EMU arrangements, as they are held accountable for all rehabilitation care—often without clear definitions or time limitations. If a patient requires rehabilitation months after surgery and is referred by any medical practitioner (not necessarily the operating surgeon), the acute facility remains financially liable for that care. This liability persists even when the facility has no involvement in, or awareness of, the rehabilitation episode. Moreover, if the health insurer has already reimbursed the rehabilitation provider, it retains the right to reclaim those funds from the surgical facility, further compounding the financial exposure and administrative burden. Although the risk to surgical facilities is highlighted here, overall, it contributes to private hospital risk.

3. Review of the Rehabilitation guidelines
    a. Criteria used for many years to define the type of service appropriately funded through hospital cover private health insurance are set out in the *Guidelines for Recognition of Private Hospital-Based Rehabilitation Services 2016* (Rehabilitation Guidelines).
    b. APHA maintains the Rehabilitation Guidelines continue to serve as a relevant and authoritative framework for defining specialist multidisciplinary rehabilitation. This includes not only traditional inpatient care but also emerging models of care such as rehabilitation in the home, telemedicine, and virtual consultations. APHA is of the view that all rehabilitation services—regardless of the delivery mode and setting—that are funded by private health insurers and delivered by private hospitals should be provided in a manner consistent with these Guidelines, ensuring clinical integrity and continuity of care across all modalities.
    c. Recognising the changing landscape of rehabilitation service delivery, there is a clear need to ensure that the Rehabilitation Guidelines remain current and fit-for-purpose. APHA is actively collaborating with member hospitals that provide rehabilitation services to review and update the Guidelines to ensure they align with emerging models of care and updated evidence-based practice principles of specialist multidisciplinary rehabilitation.
4. Promotion of the uniqueness of private rehabilitation
    a. Rehabilitation must be recognised as a fundamental pillar of patient-centred care within the Australian healthcare framework. As part of a holistic approach to recovery, rehabilitation encompasses a broad spectrum of evidence-based interventions aimed at restoring physical, cognitive, and psychological function following illness, injury, or surgery. These services are essential for improving long-term health outcomes and quality of life.
    b. Despite the well-documented benefits of rehabilitation, access to and delivery of these services remain at risk due to insufficient funding mechanisms and the ever-increasing cost of providing care. This undermines equitable health outcomes and places additional strain on acute care services. Rehabilitation programs must be adequately resourced and integrated across the continuum of care to ensure optimal recovery pathways for all patients.

A stronger policy focus on rehabilitation is urgently needed. Prioritising rehabilitation not only enhances patient outcomes but also contributes to system sustainability by addressing patient-centric needs. Acknowledging and investing in the central role of rehabilitation is, therefore, imperative for a more resilient, efficient, and inclusive Australian healthcare system.

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