Australian
Private Hospitals
Association

APHA Budget Submission for Financial Year 2026-27

January 2026

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Executive Summary

Australia's private hospital sector is facing a critical period of ongoing financial and operational instability, with no end in sight. Despite delivering nearly half of all hospital admissions, private hospitals are under increasing pressure from rising costs, workforce shortages, declining profitability, and regulatory uncertainty. This submission outlines the key challenges confronting the sector and proposes a suite of targeted, practical measures to restore financial viability, support workforce development, and ensure the sector's long-term sustainability.

Key recommendations include legislating a minimum payout ratio of 90 cents in the dollar for private health insurers, investing in digital infrastructure and cybersecurity, expanding workforce training programs, and re-establishing robust data collection mechanisms. These measures are not just about healthcare; they are essential to Australia's broader economic resilience. A strong private hospital sector reduces pressure on public hospitals, supports jobs, and ensures timely access to high-quality care for all Australians.

Private hospitals perform 70% of all planned surgeries in Australia – 1.72 million a year. They provide 1.67 million medical treatments each year.[1]

While private hospital closures and service cancellations have marred recent years and plunged both private healthcare and public hospitals into crisis, the contribution of private hospitals to the health and wellbeing of Australians, and the health system as a whole, remains pivotal.

It is a credit to private hospital operators and their staff that the sector managed to care for the surgical, medical, psychiatric and rehabilitation needs of over 5.14 million admitted patients last year - up 3% on last year, despite combating an ever-deepening existential threat.

Australians reap a massive return on zero investment in private hospitals. While over 700 public hospitals are funded by taxpayers to the tune of around $400 billion over five years, private hospitals receive no funding from taxpayers.

Yet, Australia's 633 private hospitals account for 70% of all planned surgeries, 61% of acute mental health care, 81.5% of rehabilitation hospitalisations and 1.67 million medical treatments each year, including 54% of all chemotherapy.

With 12.6 million Australians (or 45% of the population) holding private hospital insurance, the sector's fundamental importance to the lives of those directly relying on it traverses all walks of life across metropolitan, suburban, peri urban, regional and rural Australia. It also indirectly positively impacts the lives of all Australians, shouldering a healthcare burden that would otherwise see the public health system collapse.

Employing 155,000 Australians; including 59,132 nurses, as well as allied health professionals; private hospitals are vital community assets and an indispensable part of Australia's health care system.

[1] Australian Institute of Health and Welfare (2025) *Admitted patient care 2023–24*

1.0 Introduction

1.1 A YEAR IN REVIEW

The 2025-26 financial year has laid bare the extent of the financial and operational stress facing Australia's private hospital sector. While there was a brief improvement in profitability in FY 2022–23, the sector has since regressed, with 21.3% of private hospitals recording losses in FY 2023–24. EBITDA margins remain well below sustainable levels, rising only slightly to 5.0%—less than half of the 11.6% peak in 2018. Operating profit margins have turned negative, falling to –0.15%, indicating that many hospitals are now operating at a loss even before accounting for interest and tax.

This financial deterioration has occurred alongside rising wage costs, increased prices for medical supplies, and limited pricing flexibility due to regulatory constraints and sub-par insurer negotiations and contracting. Meanwhile, private health insurers have continued to post record profits and exorbitant management fees, further exacerbating the imbalance within the sector.

1.2 SECTORAL CHALLENGES

The private hospital sector is grappling with a range of interconnected challenges that threaten its viability and capacity to deliver care:

- Financial Instability: declining EBITDA and negative operating profit margins signal unsustainable business models for many hospitals. Rising costs, including wages, medical supplies, and infrastructure, are not being matched by increases in insurer payments.
- Workforce Shortages: significant gaps in nursing and psychiatric workforces, particularly in rural and regional areas, are limiting service delivery. Projections indicate a shortfall of over 70,000 FTE nurses by 2035 and a persistent shortage of psychiatrists across all jurisdictions.
- Regulatory and Policy Gaps: lack of a binding Code of Conduct between private hospitals and insurers has led to inconsistent contracting practices and disputes.
- Enforcement of existing private health insurance legislation remains weak due to under-resourcing.
- Data and Transparency Deficits: the discontinuation of the Private Health Establishments Collection (PHEC) has left a gap in reliable, timely data on sector performance.
- Digital and Cybersecurity Risks: increasing digitisation has exposed hospitals to cyber threats, yet many lack the resources to implement adequate protections.
- Public-Private Competition: the expansion of private services within public hospitals is undermining the private sector's viability and distorting the competitive landscape.
- Insurance Product Phoenixing: some insurers are engaging in practices that circumvent premium controls, reducing value for consumers and undermining hospital funding. This has the effect of forcing people out of Gold cover, only to take up lesser cover with many basic procedures excluded. While this is a saving to insurers, it leaves patients with substantial out-of-pocket costs.
- Rising Energy and Infrastructure Costs: energy price volatility and ageing infrastructure are increasing operational costs, with limited capacity for reinvestment.

2.0 Context

2.1 THE FINANCIAL POSITION

Industry performance data provided by the Australian Bureau of Statistics (ABS) has shown volatility in the percentage of private hospitals that have either made a profit/broken even or made a loss between FY 2020-21 to FY 2023-24.

During Covid the percentage of private hospitals that made a loss was an eyewatering 69.8% in 2021-22, this fell to 19.2% in 2022-23 but has been on an upward trend again with 21.3% of private hospitals making a loss in 2023-24. The sector has not recovered from the impacts of Covid while the benefits ratio from private health insurers since then has failed to return to pre-Covid levels of 90% - rather they have languished at 85% or lower.

ABS data on other economic sectors shows a more consistent trend in entities making a profit/breaking even or making a loss with an average observable difference of 5-7 percent points over the three financial years.

While Earnings Before Interest, Tax, Depreciation, and Amortisation (EBITDA) has shown a modest improvement from 4.2% in 2022–23 to 5.0% in 2023–24, this slight uptick does little to offset the broader downward trend. The sector's EBITDA remains less than half of its June 2018 peak of 11.6%, underscoring a prolonged period of financial strain.

This is particularly concerning given the capital-intensive nature of the private hospital sector. Hospitals require continuous investment in infrastructure, technology, and workforce, making them high-CAPEX, asset-heavy operations. A 5% EBITDA margin is well below the threshold typically considered viable for reinvestment, debt servicing, and long-term sustainability. Industry benchmarks suggest that a minimum EBITDA of 10% is necessary for a hospital to be considered financially healthy and investable. Falling short of this benchmark by half signals a sector under pressure.

Moreover, EBITDA does not account for leasing costs, maintenance, and other fixed overheads, which are substantial in this sector. These unaccounted costs further erode profitability and cash flow, making the headline EBITDA figure an incomplete and potentially misleading indicator of financial health.

Compounding the issue, the operating profit margin, a more direct measure of profitability, has deteriorated sharply. From an already low 1.4% in 2022–23, it has now turned negative, falling to -0.15% in 2023–24. This indicates that, on average, private hospitals are operating at a loss, even before accounting for interest and tax obligations.

This negative margin reflects:

- Rising wage and staffing costs amid workforce shortages
- Increased cost of medical supplies and equipment
- Limited pricing power due to regulatory constraints and insurer negotiations

As the private hospitals sector has felt the pressures of inflation, supply shocks and other conditions, it is evident that private health insurers have continued to thrive while engaging in bad faith. A report by the Australian Competition and Consumer Commission (ACCC) for FY 2024-25 identified

complaints made against PHI providers increased by 22 percent from 2023-24, with most of the contacts being made in relation to consumer protection issues and 57% of contacts received by the ACCC concerning potential false misrepresentations or misleading conduct by private health insurers.[2] This potentially inappropriate conduct has only had the effect of undermining confidence in the Australian private healthcare sector at-large.

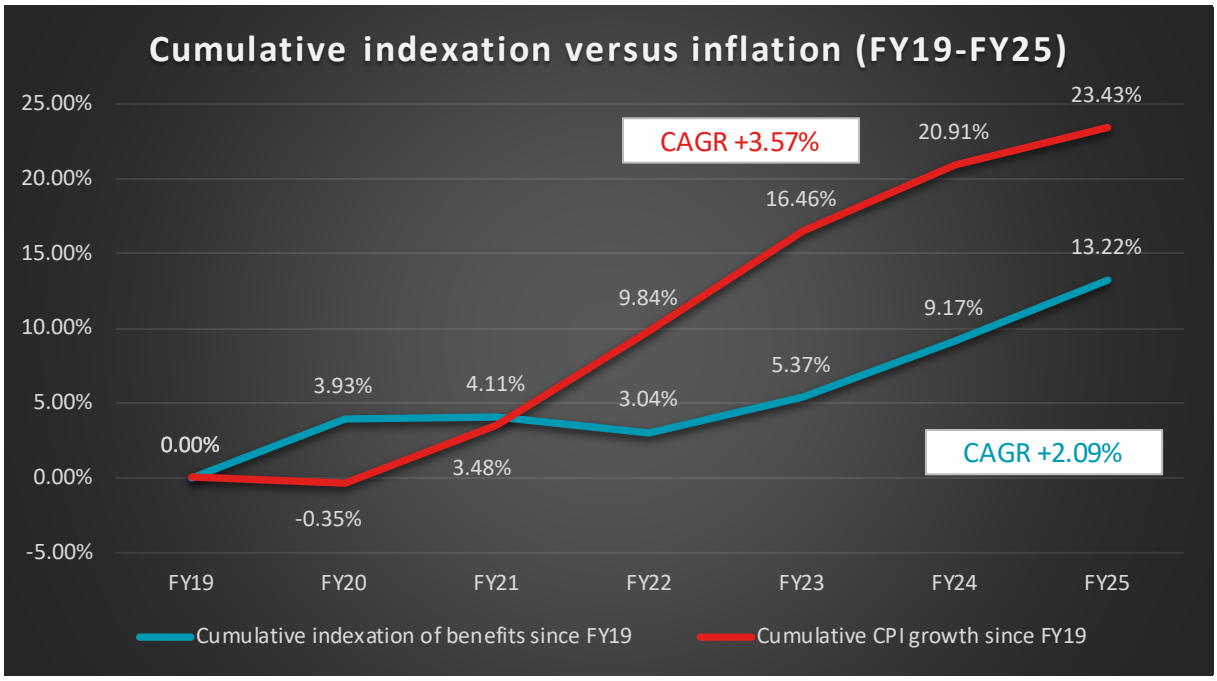

Figure 1 Data source: Consumer Price Index, Australia, ABS (2025); APRA Quarterly Private Health Insurance Statistics, APRA (2025) (CAGR: compound annual growth rate)

Cumulative Indexation versus Inflation (FY19–FY25) (Figure 1) compares two key measures over seven financial years, cumulative CPI growth and cumulative benefit indexation. It illustrates how these metrics have evolved since FY19, highlighting their respective growth trajectories and the widening gap between them.

From FY19 to FY25, cumulative CPI growth emerged as the dominant trend, rising sharply to 23.43% by FY25. This upward movement reflects sustained inflationary pressures, despite a brief dip of –0.35% in FY21, likely linked to pandemic-related economic conditions. In contrast, cumulative benefit indexation increased more moderately, reaching 13.22% over the same period. The divergence between the two measures became pronounced from FY23 onwards, with CPI recording a compound annual growth rate (CAGR) of +3.57%, compared to +2.09% for benefit indexation. This indicates that inflation has consistently outpaced benefit adjustments, creating a gap of more than ten percentage points by the end of the timeframe.

The chart underscores a critical imbalance. Benefit indexation has not kept pace with rising inflation. This trend raises concerns about affordability for consumers and financial sustainability for insurers. If CPI growth continues to outstrip benefit adjustments, policyholders may face increasing out-of-pocket costs, while insurers could encounter pressure to revise pricing strategies. Addressing this disparity will require careful policy review to ensure benefits remain aligned with economic realities and maintain equitable access to healthcare.

[2] Australian Competition and Consumer Commission, 2025, Report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance.

The average total cost weight of private hospital separations has been constant for the six financial years up to 2023-24.[3] Cost weight is a relative measure used to assess the resource intensity or complexity (costliness) of treating a particular diagnosis or medical condition compared to others within the same classification system. Essentially, it serves as a factor or multiplier applied to a group of conditions to reflect its relative costliness or resource utilisation compared to the average cost of treating all other groups of conditions. Cost weight is not a direct cost but rather a relative measure of cost intensity within the classification system.[4] The lack of benefit indexation observed is, therefore, not due to shifts towards admissions for lower priced services but failure of the market to reflect resource utilisation in the prices negotiated between insurers and hospitals.

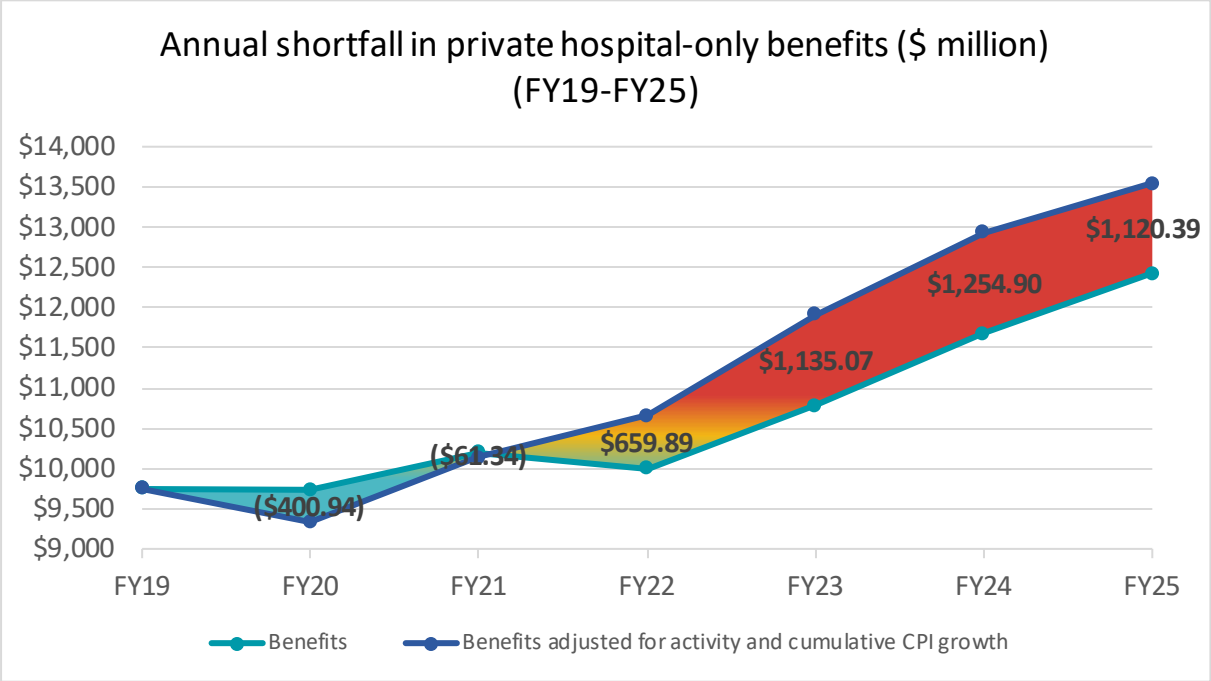

Figure 2 Data source: Consumer Price Index, Australia, ABS (2025); APRA Quarterly Private Health Insurance Statistics, APRA (2025) (Note: Hospital-only benefits exclude nursing home type patients, medical, prostheses, total chronic disease management programs, and benefits paid for general treatment.)

The annual shortfalls shown in Figure 2 indicate an unsustainable position as the commercial viability of both hospitals and insurers is undoubtedly interlinked. Private health insurance must offer economic benefit to its holders, which is derived from services provided by private hospitals. A reduction in offerings by hospitals in an attempt to continue to operate will only adversely impact the health of patients, limiting choice, access and quality, while placing more pressure on public hospitals.

2.2 PRIVATE HEALTH INSURANCE STATISTICS[5]

The 2024-25 financial year revealed a complex landscape for private health insurance in Australia, marked by growth in membership alongside persistent challenges in benefit distribution and affordability. Hospital cover participation increased from 45.2% in September 2024 to 45.4% by June 2025, adding approximately 295,000 members over the year. However, the proportion of policies

[3] Ibid.
[4] Admitted patient care 2022–23: Costs and funding, Australian Institute of Health and Welfare (2024)
[5] Australian Prudential Regulation Authority (APRA) (2025) *Quarterly private health insurance statistics*. Available at: https://www.apra.gov.au/quarterly-private-health-insurance-statistics (Accessed: 14 December 2025).

with exclusions rose to 69.5% by June 2025, reflecting a concerning trend toward reduced coverage. Health insurers paid $19.1 billion in hospital-related benefits for the year ending June 2025, a 5.9% increase year-on-year. Despite this growth, the benefits ratio paid to private hospitals remained stagnant at 84.25%, falling short of the 90% benchmark and perpetuating an average annual shortfall since 2022 of over $1 billion between the cost of care and insurer payments.

Private hospitals received an average of around $1,410 per day in health fund benefits, while day hospitals received around $870 per day, both showing annual increases. However, these payments remain insufficient to address the rising costs of care. Out-of-pocket costs for hospital episodes rose to $478 in June 2025, an 8.6% increase year-on-year, further burdening patients. This financial strain is exacerbated by the near-record profits of $2.1 billion reported by health insurers for 2024-25, alongside management expenses of $3.4 billion. These figures highlight a growing disparity between insurer profitability and the adequacy of patient coverage, raising concerns about the sustainability of the private health sector.

Private hospital activity remained robust, with 4.1 million private hospital episodes recorded for the year ending June 2025. Out of 5.1 million privately insured episodes, public hospitals accounted for 723,000 privately insured episodes, with benefits paid to public hospitals increasing to $1.27 billion for the year. Hospital-substitute treatments also grew, with 260,815 episodes recorded for the year ending June 2025, representing a 5.8% year-on-year increase. These trends in private health insurance-funded treatment in public hospitals and hospital substitutes have only compounded the impact of the entrenched shortfall in insurer payments to private hospitals.

The data also highlights the disproportionate allocation of hospital-related benefits, with 58.7% directed toward Australians aged 65 and over, despite this demographic comprising only 20.7% of insured individuals. This indicates that the majority of private health insurance holders are not deriving proportionate value for their investment in private health insurance. This imbalance underscores the need for a more equitable distribution of resources to ensure the sustainability of private hospitals and the affordability of care for all patients. The rising out-of-pocket costs and increasing exclusions in policies further emphasise the financial pressures faced by patients, who are paying more for less comprehensive coverage.

The 2024-25 statistics serve as a stark reminder of the challenges facing Australia's private health insurance sector. While membership growth is encouraging, the persistent shortfall in insurer payments to private hospitals and the rising financial burden on patients highlight the need for urgent fiscal and policy interventions to restore the sustainable operation of the sector. Addressing these disparities is essential to ensure the long-term viability of private hospitals and the equitable provision of healthcare services for the 12.6 million Australians relying on private hospital cover.

2.3 INVESTMENT TRENDS IN PRIVATE HEALTHCARE

The 2025-26 financial year has exposed the extreme financial duress that the private hospital sector is under in Australia. While the sector currently remains attractive for investment, in major part, because of the increasing technological transformation of the sector, declining profitability and workforce pressures have meant that the sector has seen an increase in facility closures and risks to attractiveness for greater investment. The ongoing sale process of Aurora Hospitals and transition of Healthscope underscored the challenges of operating private hospitals.

These trends are not new. A September 2024 article from the Australian Financial Review identified that a “surge in construction costs and collapse in profits” have caused a shift in private hospital

investors away from new health projects.[6] This followed from the release of the Federal Government's 'Private Hospital Financial Viability Health Check – Summary'.[7]

Given the sector's high capital intensity and fixed cost base, reform and targeted government support are essential to restore investor confidence. Measures such as co-investment in infrastructure, workforce development incentives, and regulatory streamlining could help stabilise margins and unlock future growth. Without intervention, the risk of deferred investment, service contraction, and consolidation will likely increase. While the sector remains fundamentally lucrative, driven by demographic trends and demand for specialised care, support and reform will be paramount.

2.4 WORKFORCE TRENDS

Workforce pressures in the sector remain significant. In 2025, the Department of Health, Disability, and Ageing undertook three workforce supply and demand studies for GPs, psychiatry[8], and nursing[9]. The studies provided projection on demand and likely gaps between the supply and demand of professionals.

2.4.1 Nursing Workforce

Nursing remains the backbone of Australia's health system, representing the largest single health profession. In 2022, there were 362,855 registered nurses employed across the country. While this figure reflects a growth of 36,573 nurses since 2017, it is not sufficient to meet the increasing healthcare demands of an ageing population and the rising incidence of chronic disease. The strain on the nursing workforce is compounded by geographic maldistribution, with regional, rural and remote communities facing persistent shortages that limit access to care and place additional pressure on metropolitan services.

National projections indicate that while both supply and demand for nurses will grow over the next decade, supply will not keep pace. By 2035, Australia is expected to face an undersupply of approximately 70,707 full-time equivalent (FTE) nurses across all sectors. Acute care alone will see a shortfall of 26,665 FTE, while the mental health sector will be short by 1,918 FTE. The total demand for nursing services is projected to rise from 334,873 FTE in 2023 to 493,282 FTE by 2035. Alarmingly, the proportion of nurses who received their initial qualification in Australia is expected to decline from 80% in 2022 to just 72% by 2035, increasing reliance on internationally trained professionals and raising questions about long-term workforce sustainability and training capacity.

These trends have serious implications for service delivery, workforce wellbeing, and patient outcomes. Without targeted strategies to boost domestic training, improve retention, and address geographic disparities, Australia risks a systemic shortfall in nursing capacity that could undermine the quality and accessibility of care nationwide.

2.4.2 Psychiatry Workforce

Mental health services are facing dire challenges. With nearly half of Australians expected to experience a mental health condition in their lifetime, and 20% experiencing mental illness in any

[6] https://www.afr.com/policy/health-and-education/investors-have-moved-away-on-private-hospitals-industry-warns-20240902-p5k75i
[7] https://www.health.gov.au/resources/publications/private-hospital-financial-viability-health-check-summary?language=en
[8] https://hwd.health.gov.au/resources/primary/psychiatry-supply-and-demand-compendium-report-june-2025.pdf
[9] https://hwd.health.gov.au/resources/primary/nursing-supply-and-demand-study-2023-2035.pdf

given year, the demand for psychiatric care is growing rapidly. The psychiatry workforce has expanded modestly, from 3,417.8 FTE psychiatrists in 2019 to 3,812.6 in 2023, representing a compound annual growth rate (CAGR) of 2.8%. However, this growth is unevenly distributed, with 85% of psychiatrists located in metropolitan areas and only 1.8% in rural and remote regions.

Australia's reliance on overseas-trained psychiatrists is increasing, particularly in underserved areas, raising concerns about long-term workforce planning and retention. The number of psychiatrists (headcount) grew from 3,701 in 2019 to 4,272 in 2023, but private sector participation is declining, with a negative CAGR of -0.3% for private FTE psychiatrists. In 2023, the FTE per 100,000 population was 17.0 in metropolitan areas, compared to just 2.2 in medium rural towns and 1.1 in small rural towns. This stark disparity reflects a deepening access gap for mental health services outside major cities.

Projections suggest that the psychiatry workforce will remain in shortage throughout the next 25 years. The baseline shortfall is estimated at 103.7 FTE in 2024, peaking at 385.4 FTE by 2033, and stabilising at around 303.2 FTE by 2048. When unmet demand is considered, the picture becomes more concerning: a 19.6% shortage in 2024 is expected to widen to 24.7% by 2033 and remain above 20% through 2048. All states and territories are projected to experience shortages, with the Northern Territory facing the most severe gap, an 83.8% shortfall in 2024.

These findings highlight the urgent need for expanded training pathways, removal of the moratorium on overseas trained psychiatrists, improved incentives for rural practice, and stronger integration between public and private sectors. Without strategic intervention, Australia will struggle to meet the growing demand for psychiatric services, particularly in regional and remote communities where access is already limited.

2.5 INTERNATIONAL PRIVATE HEALTH POLICY

The APHA Budget Submission for 2025-26 engaged with the United States' *Affordable Care Act* and its provisions on the Medical Loss Ratio (MLR), i.e., the ratio of returns on premium dollars to management costs and profit that private health insurers in the US are subject to. APHA continues to advocate for a legislated minimum return on premium dollars of at least 90 cents on the dollar towards good quality healthcare.

This budget submission considers innovations in the European Union in relation to private hospitals across a range of subjects including cybersecurity, disaster resilience, and public-private contracting.

The Union Européenne de l'Hospitalisation Privée (European Union of Private Hospitals (EUPH)) represents the interests of private hospitals in Europe and emphasises their importance to the European healthcare landscape.

Earlier this year, the EUPH called for the EU to allow private hospital sector eligibility for EU funding and public-private partnership initiatives such as EU4Health and Horizon Europe. They called on the Danish Presidency of the Council of the European Union to ensure that future preparedness frameworks establish clear, transparent mechanisms for collaboration with private healthcare providers, noting that the sector provides 42% of hospital beds in Europe.[10]

Australia stands to benefit from adopting similar approaches. Recognising private hospitals as critical infrastructure and enabling their access to Commonwealth funding for innovation, resilience, and digital transformation would strengthen the overall health system. This includes supporting cybersecurity upgrades, disaster response capabilities, and collaborative contracting models that

[10] https://www.uehp.eu/wp-content/uploads/2025/09/UEHP_PR-5.08.2025.pdf

ensure continuity of care during emergencies. By drawing on the EU's example, Australia can better position its private hospital sector to contribute to national health security and system sustainability.

Additionally, the EU has rightly recognised that digitisation has revolutionised healthcare but also given rise to risks such as cyberattacks that can lead to delays in medical procedures and disruptions. In 2023, the EU found 309 incidents affecting cybersecurity in the health sector. To address this, the EU 'is taking action to protect healthcare as critical infrastructure. A new European action plan aims to ensure that healthcare systems, institutions, and connected medical devices are resilient against cyber threats, safeguarding patient safety and trust in digital.'.[11]

The European action plan on the cybersecurity of hospitals and healthcare providers of 15 January 2025 makes several key observations:[12]

- hospitals and healthcare systems are facing mounting threats, particularly from ransomware gangs targeting them for financial gain, driven by the high value of patient data, including electronic health records
- digital tools also expand the potential targets for cybercriminals. Moreover, certain state actors do not shy away from targeting healthcare facilities. This makes the sector a potential target for cyberattacks as part of a wider hybrid campaign.
- cyberattacks not only jeopardise patient safety but also erode public trust in health infrastructure and come with significant recovery costs.
- beyond guarding against cyberattacks, a resilient and secure digital infrastructure is also essential for supporting the implementation and full deployment of the European Health Data Space
- there is no simple 'silver bullet' solution to the cybersecurity challenges in healthcare. Instead, the action plan calls for strengthened prevention, preparedness, and a more coordinated approach to solidarity while tapping into the expertise of the European cybersecurity industry.
- there is significant variability and fragmentation in the level of digitalisation and adoption of technology by healthcare providers.
- an EU Support Centre should be developed to prove clear, targeted guidance that highlights the most critical cybersecurity practices and aids healthcare providers in implementing them.
- a heavy focus on compliance should not run counter to the objective of fostering a strong cybersecurity culture. An easy-access regulatory mapping tool can help minimise the administrative burden for entities subject to multiple regulatory instruments.
- the health sector relies heavily on external contractors for cybersecurity services, highlighting the need for targeted support to strengthen defences.
    - Building on successful initiatives such as the EU Innovation Vouchers, the Member States should consider targeted measures like Cybersecurity Vouchers for micro, small, and medium-sized hospitals and healthcare providers.
    - These vouchers would provide financial assistance to put in place specific cybersecurity measures.
    - The prioritisation of the allocation of vouchers should be informed by the findings of preparedness testing and maturity assessments.
- in the education, health, and social work sectors, 66% of cybersecurity roles (EU only) are filled by employees transitioning from non-cybersecurity positions, highlighting the urgent need for reskilling and upskilling.

[11] https://commission.europa.eu/topics/digital-economy-and-society/cybersecurity-healthcare_en
[12] https://digital-strategy.ec.europa.eu/en/library/european-action-plan-cybersecurity-hospitals-and-healthcare-providers

- human error continues to be a major contributor to cybersecurity incidents in healthcare, underscoring the critical need for comprehensive staff training and cyber awareness.
- public-private cooperation and consultation with healthcare providers, other health sector entities, as well as relevant cybersecurity industry players, is essential for the successful implementation of the Action Plan.

Australia's private hospitals are increasingly being recognised as critical infrastructure in most policy circles, and as such must be supported to meet the cybersecurity mandated under law. This requires healthcare providers to implement robust protections for industrial control systems and digital health assets. For private hospitals, this means investing in secure network architecture, access controls, and threat detection systems that can withstand sophisticated attacks such as ransomware, phishing, and exploitation of public-facing applications.

Informed by lessons from the European Union's 2025 Action Plan, Australia should also prioritise standardised cybersecurity protocols, incident response readiness, and staff education across all healthcare settings. EU experience shows that human error remains a leading cause of breaches, and that smaller hospitals often lack the resources to implement best-practice security measures. Australia could adopt similar initiatives such as Cybersecurity Vouchers for small and medium-sized providers, enabling them to invest in essential protections without compromising operational budgets. Additionally, the fragmented nature of healthcare IT systems in Australia, often involving legacy infrastructure and siloed platforms, requires a coordinated national approach to interoperability and secure data exchange. By aligning cybersecurity funding with digital transformation goals, the Commonwealth can ensure that private hospitals are not only compliant but resilient, safeguarding patient safety and public trust in the health system.

3.0 Budget Measures

3.1 ARTIFICIAL INTELLIGENCE

Artificial intelligence (AI) is increasingly becoming a constant in the national economy with applications that are growing at lightspeed. There is a need to balance the uptake of AI with adequate funding and fit-for-purpose training to encourage that uptake. In private hospitals, AI offers transformative potential, from enhancing diagnostic accuracy and surgical precision to streamlining administrative workflows and improving patient outcomes. However, the uptake of AI in the private healthcare sector remains uneven, largely due to financial constraints, limited workforce readiness, and the absence of coordinated national support.

To address these barriers, the Commonwealth Government should establish a dedicated funding stream to support AI adoption and workforce training in private hospitals. This initiative would build on existing precedent. For example, in the 2024–25 Federal Budget the Government committed $39.9 million to support the safe and responsible adoption of AI across the economy, including healthcare. The 2025-26 budget, did not, however, expressly provide for funding for AI initiatives.

Extending investment in AI to the 2026-27 budget and to private hospitals would ensure that the benefits of AI are shared across the entire healthcare system. Funding should support capital investment in AI infrastructure, subsidise training programs for clinical and administrative staff, and incentivise collaborative research and development between private providers, universities, and technology firms. Training is particularly critical, as the successful integration of AI depends not only on technology availability but also on the capacity of the workforce to use it effectively and ethically.

A national funding framework would also help reduce disparities in AI adoption between public and private sectors, and between metropolitan and regional hospitals. By supporting private hospitals in this transition, the Commonwealth can foster a more equitable, innovative, and resilient healthcare system.

3.1 MANDATORY CODE OF CONDUCT

APHA has consistently advocated for the establishment of a mandatory industry code of conduct between private health insurance companies and private hospitals to guarantee transparency, accountability, and fairness in a sector that has such a consequential impact on our nation's health and well-being.

Between 1999 to 2001, the private hospital and health insurance sectors collaborated on developing a voluntary code of conduct/code of practice in an attempt to overcome the perceived unfairness in the contracting process. This was expected to lead to improved confidence and a better recognition of the mutual interests and interdependency of both stakeholders in the overall private health sector.

In or around the same time, the then-Department of Health and Aged Care, convened a round table that noted that outcomes such as hospital closures would be of concern to government where they

would deprive health fund members of ready access to appropriate care without facing unnecessary wait times and/or gap payments.[13]

The Voluntary Code of Practice for Hospital Purchaser/Provider Agreement Negotiations came into effect from 1 January 2001. At this time, 43 out of 44 registered health funds and around 160 hospitals signed onto the code.[14] The Private Health Insurance Ombudsman took carriage of disputes while the code was in effect.

However, by 2002-03 the code began to fall into disuse. It was submitted then that 'with no effective sanctions for breaches of the code it is a 'toothless tiger', mandating with punitive measures for breach is the only viable option to ensure that contract negotiations are conducted in accordance with the Code of Conduct'.[15]

In 2006-07, the Australian Competition and Consumer Commission (ACCC) noted that the code has fallen into almost complete disuse and called for its reinvigoration.[16] This was echoed, yet again in 2010-11.[17] In this period, the ACCC noted that no codes had been prescribed under the *Competition and Consumer Act 2010 (Cth)* (CCA). It is believed that the ACCC conducted a consultation during that period on a prescribed code of conduct for the private health sector.

The need for a formalised and enforceable code of conduct between private health insurers and private hospitals has only grown more urgent in the years since the original voluntary code fell into disuse. The absence of clear, binding standards has led to inconsistent contracting practices, disputes over terms, and a lack of transparency that undermines trust between stakeholders. These issues not only affect the financial sustainability of private hospitals but also have direct consequences for patient access, continuity of care, and out-of-pocket costs. Without a framework that ensures fairness and accountability, the sector risks fragmentation and inefficiencies that ultimately compromise the quality of healthcare delivery.

A prescribed code of conduct would provide a structured mechanism for resolving disputes, setting expectations for negotiation behaviour, and promoting mutual respect between insurers and providers. It would also offer government and regulators a clearer lens through which to monitor sector performance and intervene when necessary to protect public interest. Given the essential role private hospitals play in Australia's health system, particularly in relieving pressure on public hospitals and providing specialised care, a mandatory code of conduct is a vital safeguard for system stability, integrity and patient welfare. The Commonwealth should consider revisiting the ACCC's earlier consultations and work with industry stakeholders to develop a modern, enforceable code that reflects current challenges and future needs.

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[13] Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period ending 31 December 1999

[14] Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the periods 1 July 2000 to 31 December 2000 and 1 January 2001 to 30 June 2001

[15] Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 January 2002 to 30 June 2003

[16] Report to the Australian Senate on anticompetitive and other practices by health funds and providers in relation to private health insurance for the period 1 July 2005 to 30 June 2006; Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance For the period 1 July 2006 to 30 June 2007

[17] Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance For the period 1 July 2010 to 30 June 2011

3.3 COMPLIANCE AND ENFORCEMENT PRIVATE HEALTH INSURANCE LEGISLATION

The *Private Health Insurance Act 2007 (Cth)* (the Act) and associated legislation provide for discretionary, yet robust, powers to monitor and enforce compliance with the law.

Part 5-1 of the Act provides for enforcement methods available to the Commonwealth to take action against private health insurers that do not comply with the Act (in addition to those under s 84-1). The powers provided in the Act are not insignificant, but they are discretionary.

Under s 194-1, for example, the Minister may at any time and for any reason investigate a private health insurer. Other provisions allow the Minister to exercise power to compel private health insurers to produce documents or give evidence. Section 200-1 Ministerial powers to give directions further allow the Minister to force a course correction for insurers to modify their day-to-day operation, rules, or modify provisions in their constitutions. The robustness of these powers is underscored in the ability of the Minister to seek remedies in the Federal Court (s 203-1) such as compensation orders, pecuniary penalty orders, or declarations of contravention and through the ability of the Minister to revoke an insurers' entitlement to offer rebate as a premium reduction which would in effect make them uncompetitive and deter bad behaviour (s 206-1).

As illustrated above, it is not legislation that is preventing proper compliance and enforcement of private health insurance business, it is an apparent lack of government policy to this end. It is evidence that the Commonwealth Department of Health, Disability, and Ageing is under-resourced in this particular aspect of its work. There is a need for the next budget round to provide appropriations specifically to support monitoring, compliance and enforcement priorities.

We understand that it is generally government policy to take a soft approach to enforcement, not specific to the private health insurance sector but at-large. While there are circumstances that would merit this, there is a pressing need for strong and forceful action in relation to unreasonable payout ratios, deceptive conduct, contraventions of the Australian Consumer Law (the Department is recommended to collaborate with the Australian Competition and Consumer Commission (ACCC) in this regard), and other increasingly common issues.

This will restore trust and reliability in the sector, and provide patients, hospitals, government, and insurers with confidence that the sector is operating as it should, with fairness and legitimacy, and in accordance with the rule of law.

3.5 CONTRACTING BETWEEN PUBLIC-PRIVATE

The Australian Government partnership with the private health sector during the COVID-19 pandemic illustrated the advantages of collaboration and cooperation to the national health interest and private hospital viability, both of which are not mutually exclusive.

Agreements between the government and private hospitals have significant advantages in balancing the burden on public systems, allowing public patients to access world-class healthcare in private hospitals, supporting private hospital viability, and ensuring the optimum functioning of the healthcare system.

Even in the absence of public health emergencies, public patients are routinely treated in Australian private hospitals under short-term contracting arrangements. Contracting can be beneficial for public patients, allowing them to take advantage of minimal waiting times in the private hospital sector and can also assist public hospitals address unanticipated surges in demand or reduction in capacity.

Contracting in Australia has generally been *ad hoc*. Without greater certainty about the type and volume of patients to be treated and the length of contract arrangements it is unlikely that the full benefits of contracting (such as timelier access to care for public patients, and the more efficient use of resources) will be realised.

The government should consider opportunities to better ensure certainty in public-private partnerships in consultation with the sector.

There are a number of principles that should be considered when working on long-term contracting with private hospitals:

- Service agreements with the public sector must be robust, with clearly defined and mutually agreed KPIs established before commencement and reviewed regularly.
- Private hospital agreements should be tailored to their operational models, not based on public hospital frameworks that may be unsuitable.
- Payment structures must cover the full cost of service delivery—including capital, maintenance, and infrastructure—not just care components like National Weighted Activity Unit (NWAU). Short-term agreements risk long-term viability by disrupting referral patterns and relationships.
- Payments should be tied to bed capacity secured, not patient volume, to ensure predictable revenue and reduce financial exposure.
- VMO arrangements for public patients in private hospitals must be clearly defined, including payment terms and indemnity provisions.
- Financial support for wage growth (not just indexations) should be built into agreements for provision of public services.

In October 2025 the APHA and CHA called on the federal government to strengthen its hand in the current National Health Reform Agreement negotiations.

Public hospitals and state governments should no longer receive federal funding for private-in-public activity. If state-run public hospitals admit private patients, they should shoulder the gap between what Medicare and insurers pay, instead of passing it onto the taxpayer.

The last five-year agreement saw taxpayers pay some $400 billion for public hospitals and their patient loads. The next agreement should come with the caveat that public patients, especially those that cross the line for their clinical wellbeing, should immediately be transferred and treated in private hospitals. We stated at the time this should be at the States' expense.

Public hospital waiting lists are unmanageable. Yet, public hospitals across Australia are admitting massive and disproportionate numbers of private patients.

According to data from each state government, in October 2025 there were 284,987 public patients languishing on public hospital waiting lists across the country. More than 16,000 patients, that we know of, are waiting beyond the clinical threshold for the treatments they need. That means their condition deteriorates, they develop co-morbidities, and their mental health often suffers the longer they wait.

But over the last year public hospitals admitted 804,976 private patients. A decade ago, only 7% of patients treated in public hospitals were classified as private. Today, that figure has climbed to 11% nationally. The latest state-by-state numbers paint a stark reality.

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Waiting list	93,712	58,627	63,128	29,026	24,457	9,190	6,847	N/A
Waiting beyond clinical threshold	2,534	N/A	5,912	N/A	6,136	N/A	1,860	N/A
Private patients admitted in public hospitals	359,407	137,349	152,050	74,134	59,937	17,049	3,266	1,784
% of private patients	18.6%	6.6%	8.5%	10.9%	12.0%	9.9%	2.2%	1.0%

Sources: State and Territory Department of Health Statistical Dashboards on Elective Surgery

If state governments prioritised public patients, waiting lists might soon not exist and ramping could be a thing of the past as more beds are freed up from those jumping the queue.

It's no secret that state governments have come to rely on the revenue they receive from privately insured patients, but when so many public patients are pushed to the back of the queue and are waiting longer than necessary for their surgery, it becomes not only hard to justify but contributes to the health crisis.

We assert that it is not unreasonable for the Federal Government to insist that public patients no longer be second-class citizens and hold states who continue to rack up disproportionate private patient caseloads to account.

For example, by hypothecating funding for private hospitals under the NHRA to address state/territory waiting lists, the Commonwealth can have greater control over how funds are spent to align with healthcare needs.

3.5.1 Surgery Connect (SC)

In another example, the Queensland Government's Surgery Connect (SC) program exemplifies the benefits of structured public-private contracting in healthcare. In 2025, the Queensland Government committed a record $1.75 billion over four years to reduce elective surgery waiting lists by partnering with private sector providers.[18] This investment has delivered tangible outcomes, including significant reductions in planned surgery wait times, alleviation of pressure on the public hospital system, and increased admissions in private hospitals. Importantly, the program operates through direct funding from Queensland Health to private hospitals under bilateral standard-term contracts, avoiding the need for program-specific appropriations and enabling a more agile and responsive funding mechanism.

Surgery Connect demonstrates a scalable model that could be adapted nationally to address elective surgery backlogs and improve access to timely care. By leveraging the capacity and technological advantages of the private sector, a Commonwealth-led initiative based on the Surgery Connect framework could support public hospitals in managing demand more efficiently. This would not only reduce waiting times for public patients but also ensure that private hospitals remain viable and integrated into the broader health system.

[18] Surgery Connect Surge reducing surgery waitlist - Ministerial Media Statements

The economic and operational efficiencies of such a model are significant. Timely access to surgery can prevent complications, reduce emergency department presentations, and shorten hospital stays, all of which contribute to cost savings and better health outcomes. Additionally, public hospitals can focus their resources on complex and emergency cases, while routine procedures are managed through contracted private providers, optimising workforce and infrastructure utilisation.

From a patient perspective, Surgery Connect has improved outcomes and satisfaction by providing faster access to care. A national rollout could particularly benefit rural and regional populations, who often face longer wait times and limited access to specialised services. By expanding access through private hospitals, the program can help reduce health inequities and ensure more consistent care across geographic and socioeconomic boundaries.

To support a national implementation, a robust governance framework would be essential. This should include standardised contracting arrangements, integrated data systems for tracking waitlists and outcomes, and mechanisms for performance monitoring and quality assurance. Digital infrastructure would play a key role in enabling real-time visibility of capacity and demand across both public and private sectors.

Surgery Connect aligns with broader Commonwealth health priorities, including strengthening system resilience, improving equity in healthcare delivery, and fostering sustainable public-private collaboration. The program's success in Queensland provides a compelling case for national expansion, and the Commonwealth should consider working with states, territories, and the private sector to develop a coordinated, long-term strategy that builds on this proven model.

In 2025-26, the total Commonwealth contribution to state-run hospitals increased by 12 per cent to reach a record $33.9 billion. These investments were slated to help to cut waiting lists, reduce waiting times in emergency rooms, and manage ambulance ramping across our public hospitals, effectively the objectives of the Surgery Connect program.

At the very least, there is a case for the Commonwealth to partner with the States and territories, under the NHRA to fund Surgery Connect-style initiatives across the country. We anticipate that the Commonwealth would need to appropriate $4 billion dollars over 5 years to fund this program across all the states and territories.

3.5.2 Urgent Care Clinics (UCCs)

Urgent Care Clinics (UCCs) are government funded clinics- that are intended to provide urgent care services for conditions that are episodic and not immediately life threatening. Services provided by UCCs are bulk billed, meaning that patients are subject to no out-of-pocket costs.

The program was launched by the Australian Government in 2023 with the aim of alleviating pressure on hospital emergency departments (EDs), by offering short-term, episodic care for urgent but non-life-threatening conditions. Medicare UCCs are intended to be GP-led (unless specifically exempted) and are staffed and equipped to provide treatment for urgent non-life-threatening conditions, including access to diagnostic services.

In the 2025-26 budget, the Government appropriated $657.9 million over three years from 2025-26 to expand and support the Medicare Urgent Care Clinics Program. Funding intended to establish a further 50 Medicare Urgent Care Clinics across the country, with more clinics in every state and territory, as well as extending the operations of some existing clinics.

UCCs are expected to be open for extended hours, offer walk-in services without the need for appointments and provide care with no out-of-pocket costs for patients. The clinics can be co-located with existing general practices, Aboriginal Community Controlled Health Services (ACCHS) and other community health services.

Each Medicare UCC must have a local partner public hospital ED and is expected to integrate with local health services. Medicare UCCs are expected to refer patients to their usual primary care provider for follow up care and where presentations are out of scope of the Medicare UCC and can be safely and more appropriately managed by the usual primary care provider.

Private hospitals are not currently referral partners of UCCs. There is an opportunity to reduce pressure on public hospitals for acute cases that private hospitals maybe better placed to handle and offer a continuity of care.

We recommend that the Commonwealth appropriate up to $15 million for a one-year pilot program in any particular state that engages private hospitals in the UCC program.

3.6 CRITICAL INFRASTRUCTURE SECURITY AND RESILIENCE

Under the *Security of Critical Infrastructure Act 2018 (Cth)* (SOCI Act), currently only *critical hospitals* with a general intensive care unit (ICU) are considered to be healthcare and medical sector critical assets. APHA submits that this definition should be expanded to include all hospitals in Australia, beyond solely those with a general intensive care unit.

While the current legislative definition captures facilities with high-acuity capabilities, it fails to reflect the broader interdependence and systemic importance of all hospitals in maintaining national health security, continuity of care, and community resilience.

The COVID-19 pandemic and subsequent health system pressures have demonstrated that all hospitals, regardless of ICU capacity, play a vital role in surge response, continuity of elective and sub-acute care, and regional health service delivery. Many smaller or specialised hospitals, including day hospitals and sub-acute facilities, provide essential services such as cancer treatment, mental health care, rehabilitation, and elective surgery. Disruption to these services, whether through cyberattack, supply chain failure, or infrastructure compromise, can have cascading effects on the broader health system and public safety.

Moreover, the increasing digitisation of healthcare, reliance on third-party data processors, and integration of private hospitals into national health responses (e.g., during pandemics or natural disasters) underscore the need for a more inclusive and risk-based approach to defining critical infrastructure. Limiting the definition to hospitals with general ICUs overlooks the systemic vulnerabilities and operational interdependencies that exist across the entire hospital network.

Expanding the definition to include all hospitals would ensure a more comprehensive and equitable application of the SOCI Act's protective measures, including mandatory cyber incident reporting, risk management obligations, and access to government assistance in the event of a serious incident. It would also align with the Act's overarching objective to safeguard Australia's essential services from threats that could compromise national security, economic stability, and public health.

Once the legislative scope is expanded, the Commonwealth must appropriate funds to finance the upgrade of the security infrastructure for private hospitals. A conservative estimate would suggest that a minimum of $150 million over four years should be appropriated to support private hospitals in upgrading their digital and physical security infrastructure. This funding would cover:

- Cybersecurity risk assessments and compliance planning
- Upgrades to IT systems and network security
- Implementation of incident response and recovery protocols
- Staff training and awareness programs
- Integration with national threat intelligence and reporting systems

This investment would ensure that private hospitals, many of which operate with limited margins, are not disproportionately burdened by new regulatory obligations, and can meet the same security standards as their public counterparts. It would also strengthen the resilience of Australia's entire healthcare system, recognising the interdependence between public and private providers in delivering essential services.

3.6 DATA

3.6.1 The Private Health Establishments Collection (PHEC)

APHA recommends that the Commonwealth re-establish the PHEC to ensure a reliable, and consistent source of data on the viability and condition of the private hospital sector.

Previous estimates on the budgetary impact are around $3 million annually. We suggest a budgetary item that funds this data set for 3 years at a total appropriated amount of $9 million, with the option to extend funding. This will help fund resourcing with the relevant agency and support an upgrade of data collection and analysis capabilities.

The 2020-25 National Health Reform Agreement (NHRA) that was due to expire in 2025 was extended by all Australian governments by 12 months in February of that year. As the new NHRA is being negotiated, we note the following:

- The 2020-25 NHRA expressly notes the agreement of parties to it to 'develop and implement enhanced performance reporting across the whole care pathway including: Increased coverage and reporting of private hospital sector activity and performance'. This needs to be reaffirmed in the new NHRA.
- It also states that the Australian Institute of Health and Welfare (AIHW) will 'provide clear and transparent annual public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Primary Health Network'.
    - While the Australian Bureau of Statistics (ABS) has traditionally had responsibility for the PHEC (until its discontinuation post 2016-17), we believe the AIHW is better equipped to manage and publish this data set.
    - The AIHW currently collects more relevant data on hospital trends, including on admissions, specialities, funding and costs, and labour, all of which support a reinvigorated PHEC and the case for AIHW to have carriage over this data set.
- There is a clear and present need to ensure the adequate monitoring of viability and condition of the private hospital sector, as the 2024 public summary document for the Private Hospitals Health Check confirmed.
- The Commonwealth operated a suitable annual PHEC process prior to 2017-18, which provided a legitimate and reliable collection of data for the sector. The first collection conducted by ABS was in respect of 1991-92, the collection continuing successfully with a trusted and effective methodology for some 25 years.
- The absence of this collection has made it increasingly difficult to maintain stock of the challenges to the sector and costs. Existing methodologies can help reinvigorate this data collection without a time lag.

- The main outputs from the PHEC included private hospital data on structure, accreditation, facilities and specialised services, whether they were for profit or not for profit (for acute and psychiatric hospitals only), available beds, type of centre (for free-standing day hospitals only), type of activities (patients separations and the number of patient days during the year), procedures performed, morbidity data, staffing and finances.
- The methodology for the PHEC provided appropriate coverage of the sector and collected data on most, if not all, of the relevant aspects of private hospital business.
- Re-establishing the PHEC would ensure that taxpayers get value and that the sector and government have rapid access to information.

3.6.2 Australian Institute of Health and Welfare Data Reporting and Analysis

The AIHW is arguably the best one-stop-shop for reviewing trends in Australia's healthcare landscape. The agency collects, stores, analyses, and provides insights on a vast amount of data that assists governments and the private sector to take stock of improvements and shortfalls. It is, in effect, the custodian of health sector data in Australia.

Despite the large data holdings, there is a lag between when data is collected and when it is published. Admitted patient care datasets, for example, are currently only available for 2023-24, even though we are now in 2025-26. There is effectively a two (2) year delay in the publication of this data which is otherwise crucial for interested stakeholders to better understand emerging trends in admissions, service utilisation, funding (i.e. private health insurance, self-funded, Department of Veterans' Affairs etc.) and other facets of healthcare activity in Australia.

There is a need for government to tie AIHW appropriations to the timely analysis and release of data. All datasets must be published at the end of each financial year with embargoed quarterly snapshots and 'state of the sector' presentations being provided to the sector.

3.6.3 Australian Prudential Regulation Authority (APRA) Data Reporting

Like the AIHW, APRA collects and publishes a vast amount of data that is utilised by the private hospital sector to measure trends in private health insurance (PHI) business. While the summary data is helpful, it is far from a complete picture of the overall state of PHI business and activity. Different stakeholders approach the data differently, the Department of Health, Disability, and Ageing, may use a methodology for analysis that is distinct to industry bodies such as APHA or Catholic Health Australia.

A recent example is the calculation of the return ratio by the Minister for Health's office earlier in 2025. The Government has sought to include risk equalisation and state ambulance levies in this calculation of the ratio, a methodology that APHA has publicly disputed. The inclusion of these measures further distorts the true benefit ratio. Given payments to public hospitals are included in the benefits ratio, it is already an imprecise measure. More robust data analysis would help ensure consistency in the interpretation of APRA data.

Additionally, the large amount of data means that stakeholders cannot review and analyse all the data in a reasonable timeframe. Providing an end of year report with all data and trends analysed and reported on may be a cause that demands specific departmental budgetary appropriation.

3.6.4 De-fragmentation of the National Health Data Collection and Analysis Framework

Australia's national health data landscape is currently fragmented across multiple agencies and jurisdictions, resulting in inefficiencies, duplication, and significant gaps in timely, actionable insights. Key datasets are collected and managed by a range of bodies including the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS), the Australian Prudential Regulation Authority (APRA), and various state and territory health departments, each with differing methodologies, reporting timelines, and scopes.

This siloed approach undermines the ability of policymakers, providers, and researchers to form a cohesive understanding of the health system's performance, particularly in the private hospital sector.

The lack of a unified, nationally coordinated data collection and reporting framework has led to inconsistencies in how data is interpreted and used.

To address these challenges, the Commonwealth must take a leadership role in funding and coordinating a national health data reform agenda. This includes re-establishing critical datasets such as the Private Health Establishments Collection (PHEC), consolidating data governance under a central agency like the AIHW, and ensuring consistent, timely publication of key indicators. A dedicated budget allocation is essential to support the infrastructure, staffing, and technological upgrades required to modernise data systems and enable real-time analytics. By investing in a de-fragmented, integrated data framework, the Commonwealth can drive better health outcomes, enhance system accountability, and support the long-term sustainability of both public and private healthcare sectors.

3.7 DISASTER RESPONSE

Developing joint disaster response plans with private hospitals is a strategic move that not only strengthens the health system's capacity to respond to crises but also enhances economic resilience at a national level.

Private hospitals are a critical part of Australia's healthcare infrastructure, delivering nearly half of all hospital care. Yet, they are often underutilized in disaster planning and emergency response coordination. By integrating private hospitals into formal disaster response frameworks, governments can unlock additional surge capacity, diversify service delivery, and ensure continuity of care during emergencies such as pandemics, natural disasters, or mass casualty events. This reduces the burden on public hospitals and prevents system overload, which can have cascading effects on workforce productivity and economic stability.

Joint planning also enables better resource allocation, such as staffing, equipment, and logistics, across both public and private sectors. This coordination ensures that healthcare services remain operational and accessible, minimizing disruptions to the broader economy. For example, during a pandemic, maintaining elective surgeries and chronic disease management in private hospitals allows public hospitals to focus on acute care, preserving overall system functionality and reducing long-term health costs.

Moreover, disaster preparedness in the private sector supports business continuity, protects jobs, and sustains investor confidence. When private hospitals are equipped and empowered to respond to crises, they can maintain operations, safeguard their workforce, and contribute to community resilience. This stability is essential for economic recovery and growth, especially in regions where private hospitals are major employers and service providers.

Incorporating private hospitals into disaster response planning is not just a health policy, it's an economic strategy. It ensures that Australia's health system is agile, inclusive, and capable of withstanding shocks, thereby reinforcing the foundations of a resilient economy.

Appropriations for 2026-27 for the National Emergency Management Agency should include an annual amount of up to $15 million over 2 years for the agency to collaborate with private hospitals in vulnerable zones with the option to extend appropriations for an additional 4-year period for a wider roll out.

Additionally, the Commonwealth must appropriate further funds under the Disaster Ready Fund program.

The Disaster Ready Fund was established under the *Disaster Ready Fund Act 2019 (Cth),* following passage of the Emergency Response Fund Amendment (Disaster Ready Fund) Bill 2022 on 23 November 2022, to implement the Australian Government's commitment to establish a dedicated fund for disaster resilience and risk reduction. The Australian Government has committed up to $200 million per financial year for the Disaster Ready Fund over five years, from 1 July 2023 to 30 June 2028 (up to $1 billion total).

The Disaster Ready Fund is funding a diverse set of projects in partnership with Australian state, territory and local governments to deliver outcomes that support Australians to manage the physical, social and economic impacts of disasters caused by climate change and other natural hazards. It is intended to be an enduring fund, to provide all levels of government and affected stakeholders the certainty they need to plan for robust investments in resilience projects to reduce the impacts of disasters predicated by natural hazards.

The DRF's Objectives are to:

- increase the understanding of natural hazard disaster impacts, as a first step towards reducing disaster impacts in the future;
- increase the resilience, adaptive capacity and/or preparedness of governments, community service organisations and affected communities to minimise the potential impact of natural hazards and avert disasters; and
- reduce the exposure to risk, harm and/or severity of a natural hazard's impacts, including reducing the recovery burden for governments, cohorts at disproportionate disaster risk, and/or affected communities.

The DRF can provide funding for systemic risk reduction and infrastructure projects. Securing funding from the DRF can significantly enhance the viability of private hospitals in several ways. Firstly, it can provide substantial financial support for infrastructure improvements, such as upgrading facilities to withstand extreme weather events or implementing advanced emergency response systems. These enhancements not only protect the hospital's physical assets but also ensure the safety of patients and staff.

Secondly, the DRF encourages innovation in disaster preparedness, allowing hospitals to develop and implement cutting-edge solutions. This can lead to more efficient and effective emergency response strategies, reducing downtime and maintaining continuity of care during crises.

Moreover, the collaboration required during the application process fosters stronger partnerships with state and territory emergency management agencies. These relationships can enhance overall disaster response coordination and resource sharing, further bolstering national and hospital resilience.

3.8 ENERGY AFFORDABILITY AND RELIABILITY

Clean, affordable, reliable, and secure energy is at the heart of national security and economic resilience. Australia has seen a rapid increase in energy prices that have caused shocks to industry and an ageing electricity grid that raises the spectre of commercial and economic disruptions.

The energy crisis has further weakened an already struggling economy that has seen a slow post COVID-19 recovery. The economy has in effect been subject to an economic long-COVID.

Energy is a critical input to production in various sectors and an increase in energy prices strains profitability, forcing manufacturing intensive industries to scale down production and service delivery-based industries, such as healthcare to cut down offerings or cease operation all together. High energy prices also deter investment, undermining firms' productivity and competitiveness even further.

Despite a notable move towards clean energy and energy efficiency, it is unlikely that short-term gains will be sufficient to outweigh costs. A difficult investment climate for private hospitals further limits the ability of the sector to take on or absorb any additional costs.

To address the dual challenge of rising energy costs and reliability concerns, a coordinated national strategy is essential. This strategy should prioritise investment in modernising the electricity grid to improve resilience and reduce transmission losses, while also incentivising diversified energy generation, including renewables, storage solutions, and low-emission baseload options.

Government support through targeted subsidies, regulatory reform, and public-private partnerships can help stabilize energy prices and ensure consistent supply, particularly for critical sectors such as healthcare and manufacturing.

In the short term, measures such as energy price caps for essential services, demand-side management programs, and emergency support for vulnerable industries can mitigate the immediate impact of energy volatility.

Over the long term, fostering innovation in energy efficiency technologies and expanding access to clean energy infrastructure will be key to ensuring affordability and reliability. A stable and predictable energy environment will not only support economic recovery but also enhance Australia's competitiveness and national security.

3.9 INDUSTRIAL RELATIONS REFORM

Industrial relations reform and associated regulation have a direct impact on productivity, profitability, and job and commercial security. Radical changes to the IR environment in Australia pose a clear and present economic risk regardless of sector or size of enterprise. There is a need to ensure that reform is balanced and affords fairness to both employees and their employers.

The passage of the *Fair Work Legislation Amendment (Secure Jobs, Better Pay) Act 2022 (Cth)*, the *Closing Loopholes Act 2023 (Cth),* and *Closing Loopholes No. 2 Act 2024 (Cth)* are already having a considerable impact on businesses.

New rules on increasing pay for labour hire workers, multi-employer bargaining, an intractable bargaining regime, changes to the definitions of casuals and 'employee', and criminal liability for 'wage theft', are now all in effect. These changes have fundamentally altered labour relations dynamics, providing significant leverage to employees and unions, and increasing risks associated with third-party intervention by the Fair Work Commission.

Since January 2024, the number of industrial disputes backed by industrial action have generally been increasing with an increasing number of working days lost. This has put pressure on an economy still reeling from the economic and social impacts of the COVID-19 pandemic.

The private hospital sector has been subject to industrial action by the Australian Nursing and Midwifery Federation (ANMF) in the Fair Work Commission for wage increases under the Nurses Award 2020 of up to 35.8%. An increase that, if approved, would cripple Australia's national health system.

To alleviate the burden on the sector, APHA – in conjunction with Catholic Health Australia – asks that the Commonwealth provide targeted support for nurse wage increases. We ask that the Commonwealth co-fund 50% of incremental nurse wage increases ($445 million over four years) to support hospital viability, moderate premium pressures, and maintain national hospital capacity. There is precedent with the Commonwealth paying for the Aged Care nurses' Award increase in full.

Cost to Commonwealth Government over forward estimates

	2026–27	2027–28	2028–29	2029–30	Total
Funding for nurse wage increase	125	114	102	104	445
Proportion of total funding (%)	28.1	25.6	22.9	23.4	
Total cost to government ($m)	**125**	**114**	**102**	**104**	**445**

Assumptions

- Private hospital wages base ~$11.3b (2024–25); nurses are ~45–55%, implying a nursing wage base ~$5.6b.
- Nurse wage uplift 12–15% by 2027, modelled as ~13.5% compounded over four years (catch-up then ongoing EB-like increases).
- Steady-state total cost pressure of uplift (wages + super): ~$745–$940m p.a. once fully implemented.
- Commonwealth funds 50% of incremental uplift, not a permanent subsidy.
- Time-limited subsidy assumption: Support enables short-term stabilisation and efficiency gains, with services assumed to remain viable after funding ends without ongoing government support.

Implementation requirements

- Funding mechanism that is direct, defined, auditable (to avoid a patchwork of proxy subsidies).
- Clear eligibility definition of "incremental nurse wage uplift" and verification (to prevent substitution of normal wage growth into the claim).
- Time-limit and phase-down rules to prevent entrenchment as ongoing operating subsidy.

Further, proposed legislation on post-employment restraints that would render non-compete clauses in employment contracts unenforceable for employees earning below the high-income threshold threaten to cause risk to the operations of commercial entities.

3.10 NET ZERO TRANSITION

There is a need for societies to build resilience, mitigate its impacts, and seize economic opportunities. The transition to net zero is a priority for government and for our communities.[19] It also presents an opportunity for private hospitals to adapt, reduce costs, provide better care, and contribute to national emissions reductions targets.

A report published by the Department of Health, Disability, and Ageing in April 2025[20] found that the healthcare sector is currently responsible for an estimated 5.4% of Australia's total greenhouse gas emissions with hospitals accounting for 44% of these emissions. This underscores the critical role that hospitals, including private hospitals, must play in the national climate response.

A 2019 paper from the Green Building Council of Australia found that green star certified healthcare facilities showed, on average, 66% less electricity use than average Australian buildings, produce 62% fewer greenhouse gas emissions than average Australian buildings, and used 51% less potable water.[21] Since 2019, renewable energy technologies and green building practices have grown at an exponential pace.

Despite this, private hospitals face significant barriers to investing in energy efficiency upgrades, renewable energy systems, and sustainable infrastructure. Unlike public hospitals, private facilities do not have access to dedicated government funding streams for climate resilience and sustainability initiatives. This disparity limits the sector's ability to contribute to national targets and realise the long-term cost savings and health co-benefits associated with decarbonisation.

To address this, the Commonwealth should establish a dedicated Net Zero Transition Fund for Private Hospitals (NZTFPH) as an extension to the proposed $5 billion Net Zero Fund that currently seeks to support large industrial facilities to decarbonise and support the scale up of manufacturing renewable and low emissions technology.[22] This fund would support capital investment in energy-efficient infrastructure, renewable energy installations, electrification of hospital systems, and the adoption of sustainable procurement and waste management practices. Funding should also be allocated to support emissions auditing, benchmarking, and reporting to ensure transparency and accountability.

In addition, the Commonwealth should provide technical assistance and capacity-building support to help private hospitals develop and implement decarbonisation strategies. This includes access to expert advisory services, toolkits, and training programs tailored to the unique operational and regulatory environment of the private health sector.

By investing in the net zero transition of private hospitals, the Commonwealth can accelerate national emissions reductions, reduce long-term healthcare costs, and improve patient outcomes through healthier, more sustainable care environments. This investment will also ensure that private hospitals are not left behind in the national climate agenda and can continue to play a leading role in delivering high-quality, future-ready healthcare services.

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[19] https://ihub.org.au/wp-content/uploads/Report_LLHC5_Net-Zero-Energy-Emissions.pdf
[20] Estimates of Australian health system greenhouse gas emissions 2021–22
[21] https://business.nab.com.au/wp-content/uploads/2019/01/the-case-for-sustainable-healthcare.pdf
[22] https://consult.industry.gov.au/net-zero-fund

3.11 PHOENIXING

In 2024, the Office of the Commonwealth Ombudsman investigated allegations in response to a report by CHOICE Magazine that some private health insurers were engaging in practices that had the effect of circumventing the premium approval process and restricting consumer choice.[23] This conduct specifically related to insurance product phoenixing activity in relation to Gold policies.

The Ombudsman noted that even if no law had been breached, there were concerns relating to the fairness and appropriateness of such conduct for the long-term interests of consumers.

We have been strong advocates to government for the need to outlaw insurance product phoenixing by the private health insurance industry. This conduct makes health insurance unaffordable for consumers, limits patient access, and in turn also further undermines private hospital viability.

Gold products provide comprehensive cover for essential services, including maternity and mental health - both of which have been singled out as rapidly becoming unviable hospital sectors due to funding shortfalls, workforce issues, and ever-increasing costs. According to the Ombudsman's analysis, in 2023, the average premium of a new gold cover policy for a particular insurer was 21% higher than the average premium of the closed policy, in 2024, the average premium of the new policy was 14% higher. Similarly, in March 2025, a major private health fund was found to have increased the price of its Gold policy by 35% after closing its existing policy and forcing new gold members to take out extras.[24]

As these practices have clearly continued, we strongly support Federal Minister for Health Mark Butler's bid to ban this practice. APHA remains committed to working with the Minister's Office and the Commonwealth Department of Health, Disability, and Ageing to remake the legislative framework for the private health system in a manner that supports the interests of all relevant stakeholders and that places our patients at the centre of policy.

APHA is supportive of the government's efforts to outlaw insurance product phoenixing. This illustrates the success of our campaign to ensure that private hospitals are factored into the conversation that relates to their viability and that government policy is fair, reasonable, and informed. To that end, we make the following submissions:

The Public Interest Test

1.1 Section 66-10(3) of the *Private Health Insurance Act 2007* (Cth) (**PHI Act**) provides that the Minister may approve the proposed changes to premiums unless satisfied that the change 'would be contrary to the public interest'.

1.2 We understand that the government intends to amend the PHI Act to require 'insurers to apply to seek the Minister's approval of the premium for a new product against a public interest test,'[25] similar to the test in s 66-10(3) of the Act.

[23] https://www.ombudsman.gov.au/__data/assets/pdf_file/0026/314828/Public-statement-health-insurers-using-loopholes-to-increase-premiums-December-2024.pdf

[24] https://www.abc.net.au/news/2025-03-31/investigation-into-private-health-insurance-pricing-tactics/105102776

[25] Consultation Paper – Outlawing private health insurance (PHI) product phoenixing, Department of Health, Disability, and Ageing, 2025, p 1.

1.3 We note that 'public interest' is currently not defined with respect to the operation of the PHI Act[26] and risks inconsistent and unrepeatable application by the Minister (noting that s 333-1 of the PHI Act does not permit a delegation of authority for s 66-10 provisions).

1.3.1 There is a need for the government to amend legislation to provide for a clear definition of the 'public interest' to ensure accurate and appropriate interpretation and application of the law and to ensure fairness, reliability and consistency.

1.3.2 While privacy legislation also does not define 'the public interest', given that privacy is fact and context specific, it is appropriate to keep it flexible.[27] Whereas, the pursuit of public health, low cost burden on consumers and value for money, in addition to the need to ensure private hospital viability, are likely to remain constant, the PHI Act should define the 'public interest'.

1.3.3 Alternatively, we suggest that the legislation be amended to provide a non-exhaustive list of what constitutes the public interest in the context of premium settings to help provide a guide on interpreting the bounds of the test.

Discretionary Power to Approve New Policies

1.4 The proposed legislative amendments confer discretionary power on the Minister to approve new policies. We believe that this does not appropriately "outlaw" or prevent private health insurers from engaging in phoenixing.

1.5 As the public interest test is quite open-ended, it may be difficult to set guardrails and delineate the boundaries of the exercise of this power.

1.6 Insurers are likely to cite growing 'management costs' to justify the need to put in place new policies and close older ones. However, there is limited transparency around what constitutes legitimate management costs, and whether these are being used as a pretext for price increases.

1.6.1 There should be stronger requirements for insurers to justify the closure of products and the introduction of new ones, including independent scrutiny of claimed management costs and their impact on patient care.

1.7 Without strict, transparent guidelines, there is a risk that industry lobbying could influence ministerial decisions, undermining the intent to genuinely prevent phoenixing.

Interaction with the Australian Consumer Law (ACL)

1.8 The ACL under sch 2 of the *Competition and Consumer Act 2010* (Cth) provides safeguards for consumers receiving products and services, with the Act itself protecting competition in Australia.

1.9 APHA encourages the government to consider synergies between the ACL and anti-phoenixing PHI provisions and/or opportunities to leverage the provisions of the ACL within the PHI Act. We note the following provisions of the ACL that may be relevant to the current situation:

1.9.1 Part 2-1 – Misleading or deceptive conduct

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[26] https://www.health.gov.au/sites/default/files/documents/2021/12/foi-request-2712-release-documents-agendas-and-attached-documents-meetings-of-phmac-subcommittees-and-working-groups-between-september-2016-december-2018-foi-2712-issues-paper-private-health-insurance-premium-setting.pdf

[27] https://www.alrc.gov.au/publication/serious-invasions-of-privacy-in-the-digital-era-alrc-report-123/9-balancing-privacy-with-other-interests/public-interest-matters/

1.9.2 Part 3-1 – Unfair practices
1.9.3 Part 3-3 – Information standards
1.9.4 Chapter 5 – Enforcement and remedies

1.10 We suggest integrating ACL-style consumer protections directly into the PHI Act to ensure consistency and clarity in enforcement.

1.11 We further encourage collaboration between the Department of Health, Disability, and Ageing and the Australian Competition and Consumer Commission (ACCC) to monitor and enforce compliance, especially in cases where phoenixing may involve deceptive conduct.

Criminalising Phoenixing

1.12 While strengthening the approvals process for new insurance products is a positive step, it may not be sufficient to deter or eliminate phoenixing practices in private health insurance. There are several compelling reasons to consider criminalising phoenixing, rather than relying solely on administrative controls including

1.12.1 stronger deterrence and accountability
1.12.2 adequately closing loopholes and preventing evasion
1.12.3 protecting consumers
1.12.4 enabling effective monitoring and enforcement

1.13 The *Treasury Laws Amendment (Combating Illegal Phoenixing) Act 2020* (Cth) provide a precedent for imposing criminal offences and civil penalties on corporate officers and directors who engage in illegal phoenixing to evade their responsibilities.

1.13.1 The legislation effectively targets directors and officers who deliberately transfer assets from one company to another to avoid paying debts, leaving creditors and employees disadvantaged. The rationale for criminalising this conduct applies equally to phoenixing in the private health insurance sector.

1.13.1.1 Insurance phoenixing also involves deliberately avoiding regulatory scrutiny and premium controls by closing existing policies and launching near-identical ones at higher prices.

1.13.1.2 Insurance phoenixing also harms consumers (through higher premiums), private hospitals (through reduced access and funding), and the integrity of the health insurance system.

1.13.1.3 Insurance phoenixing also exploits gaps in the PHI Act to advantage one group of stakeholders over the beneficiaries.

1.14 APHA would support stronger regulatory action to ensure that insurers are unable to abrogate Parliamentary authority and intent as representatives of the people of this country.

The 2026-27 Federal Budget must provide for greater monitoring, compliance and enforcement of anti-PHI Phoenixing policy and law and for reporting on the same. Cross-agency cooperation and collaboration must be funded by staff and digital system budgetary resourcing items. We estimate the start-up cost for the above would be around $4.5 million for the first year with yearly reductions due to expected improvements in efficiency over the next 5 years.

3.12 THE PRESCRIBED LIST

The Prescribed List (PL) is a cornerstone of the legislative infrastructure supporting benefits payments to private hospitals by private health insurers[28], representing 14% of health insurance

[28] The Prescribed List is a schedule to the Private Health Insurance (Medical Devices and Human Tissue Products) Rules 2024.

expenditure[29]. The PL has recently been subject to an almost $23 million reform process (between 2021-25). While the formal process has officially come to an end, projects under the reforms, such as the removal of funding for technical support services for cardiac implantable electronic devices, are still being worked on by the Department until their natural conclusion.

Throughout the reform process, the APHA consistently raised concerns about the lack of a robust evidence base underpinning several proposed changes. These included restrictions on general use items and limitations related to gifts, benefits, and discounts. The Department, ultimately, acknowledged these concerns, concluding that such restrictions would not be appropriate. However, the broader reform agenda appeared to focus disproportionately on reducing benefits payable under the PL, without adequate consideration of the financial pressures currently threatening the viability of private hospitals.

The rising cost of medical devices, coupled with declining PL rebates, has placed private hospitals in an unsustainable position. Hospitals are increasingly forced to either reduce service offerings or absorb the cost of providing access to world-class medical devices that patients clinically need and deserve.

For example, the price of Sirtex SIR-Spheres Y-90 resin microspheres increased to $10,500 + GST per vial as of 1 October, while the PL rebate remains at $8,091—leaving hospitals to absorb over $2,400 per vial. This is particularly concerning given the product's use in palliative care, where alternatives are limited. Similarly, the Edwards Life Sciences Konect Resilia valve for cardiothoracic surgery costs $10,750 yet only attracts a rebate of $7,642.

Medical device manufacturers have indicated that while they have maintained stable pricing for years, rising freight, airline, and raw material costs have made current pricing models unsustainable. The PL, in its current form, lacks the flexibility to accommodate these market realities or to support the introduction of new, bespoke, or high-cost technologies that are essential for modern, patient-centred care.

To address these challenges, the Commonwealth should consider two key policy interventions. First, increase funding for the Medical Devices and Human Tissue Product Advisory Committee (MDHTAC) to expedite the approval of new devices and enable case-by-case determinations of appropriate benefit levels for emerging and bespoke technologies. Second, establish a dedicated PL Viability and Innovation Fund to bridge the gap between the actual cost of high-need, low-volume devices and the rebates currently available under the PL. Opportunities to expand this to high-volume, medium-cost devices should also be considered.

Additionally, the PL governance framework should be reformed to include a fast-track pathway for high-impact, low-volume devices with limited market alternatives. This would ensure timely access to critical technologies and prevent delays that compromise patient outcomes. Greater transparency in PL decision-making and structured engagement with private hospitals and clinicians are also essential to ensure that reforms are clinically informed, evidence-based, and aligned with the realities of service delivery.

Without these reforms, the PL risks becoming a barrier to innovation and equitable access, rather than a facilitator of high-quality care. The Commonwealth must act to ensure that the PL supports**,** not undermines**,** the sustainability of private hospitals and the broader healthcare system.

[29] REFORMS OF THE PRESCRIBED LIST OF MEDICAL DEVICES AND HUMAN TISSUE PRODUCTS (2021-2025) – A SUMMARY OF THE REFORM OBJECTIVES AND ACHIEVEMENTS

3.13 PUBLIC HOSPITALS ESTABLISHING PRIVATE FACILITIES

Maintaining a clear divide between public and private healthcare sectors is essential for preserving the integrity, efficiency, and sustainability of both systems.

Private hospitals operate under market-driven principles, investing heavily in infrastructure, technology, and specialised services to meet patient demand and deliver high-quality care. When public hospitals begin offering private services, it blurs the lines between the two sectors and introduces unfair competition.

Public institutions benefit from government funding, subsidies, and tax advantages, which private hospitals do not receive. If public hospitals use these resources to attract private patients, it distorts the competitive landscape and undermines the viability of private providers while putting pressure on taxpayer funds.

When public hospitals begin to compete for private patients, they risk diverting attention and resources away from their public mandate. This not only compromises service quality for public patients but also creates inefficiencies in budget allocation and workforce management.

In 2023-24, the number of private patient separations treated in public hospitals has increased to 804,976 from 719,695 in 2021-22, an 11.8% increase.[30] At the same time, key performance indicators such as planned surgery waiting lists continue to indicate that the public sector is failing to meet core expectations. These high private admissions in the public sector increase the demand for capital funding for public facilities while at the same time undermining the existing resources and infrastructure in the private sector.

If private hospitals are capable of meeting the demand for private healthcare, there is no justification for public hospitals to enter this space. Doing so duplicates services, wastes public resources, and erodes the value proposition of private care. Instead, governments should reinforce the separation by legislating against public hospitals establishing private wings or services.

This would ensure that public funds are used exclusively for public benefit, while private hospitals continue to innovate and invest in service excellence without facing subsidised competition. Such a policy would promote transparency, accountability, and sustainability across the healthcare system.

In December 2024, the NSW Department of Health announced that the Royal Prince Alfred (RPA) Hospital launched a private maternity wing for private patients, in addition to the public offering. The RPA's Private Maternity Services offered to waive up to $500 of the private health insurance gap payment.[31] This occurred parallel to the crisis engulfing private maternity services in private hospitals and at a time when government expressly noted that there would be no silver-bullet to bail out the private hospital sector at a time of heightened closures, falling viability, and the growing unsustainability of the sector.

The Commonwealth and the States and Territories must, under the new National Health Reform Agreement, resolve to cap the proportion of public hospital activity that can be devoted to the provision of services for private patients and prevent public sector facilities from opening private sector facilities, especially in specialties and sub-specialties where the private sector is able and willing to provide services to private patients.

[30] Admitted Patient Care, 2023-24, Costs and Funding, Table 7.5, Australian Institute of Health and Welfare.
[31] https://slhd.health.nsw.gov.au/sydneyconnect/2024-news/rpa-hospital-launches-private-maternity-wing

An increase in the use of public funds towards the provision of private services in public sector facilities would mean that these initiatives would need to be backed up by increased tax financing. In the current state of the national economy, this is not only unfeasible but threatens to impose further burdens on a population that is already struggling.

3.14 RETURN RATIO

APHA has advocated that the Commonwealth guarantee and legislate for a minimum Private Health Insurer Payout Ratio to increase private hospital funding, through the return to a payout ratio of 90 cents in each dollar of hospital policy premium revenue

In FY23 this dropped to 81 cents in the dollar and has recently steadied at 84 cents in the dollar (FY 24 and FY 25). Reverting to the pre-Covid ratio of 90 cents in the dollar (would increase benefits paid to hospitals by 5 percent, which would materially remediate private hospital viability challenges.

In the last three years (since the COVID-19 pandemic), $3.4 billion has been stripped out of the private health sector.[32] APHA and CHA have estimated that through this reform over $1.2 billion[33] per year would be injected into hospitals and health services, improving sustainability and workforce retention.

Cost to Commonwealth Government over forward estimates

	2026–27	2027–28	2028–29	2029–30	Total
Additional private health insurance policies	82,200	81,900	81,600	81,000	326,700
Rebate for additional private health insurance policies ($m)	72.1	73.6	75.1	76.4	297.2
Estimated diverted public admissions	17,612	17,548	17,484	17,356	70,000
Commonwealth saving from reduced public hospital activity ($m)	57.5	57.3	57.1	56.7	228.6
Total cost to government ($m)	**14.6**	**16.3**	**18.0**	**19.7**	**68.6**

Assumptions

- Premium effect: a 5%[34] increase in the payout ratio to result in an overall 90% payout ratio.[35]

[32] Calculated assuming a 90% payout ratio for the 2022–23, 2023–24 and 2024–25 financial years.
[33] An average from the 2022–23, 2023–24 and 2024–25 financial years.
[34] An average difference from the 2022–23, 2023–24 and 2024–25 financial years.
[35] Note this includes risk equalisation and ambulance levies, as using this methodology there was a 90% payout ratio prior to the COVID-19 pandemic. This is the methodology used by APRA and the Department of Health, Disability and Ageing. A 90% payout ratio is also supported by the Australian Medical Association.

- Insurer behaviour: insurers do not fully offset higher benefit outlays with premium increases (consistent with premium approval environment).
- Market adjustment: any stress among smaller/inefficient insurers is managed through orderly consolidation, not disorderly failure.
- Provider behaviour: hospitals do not materially raise prices in response to mandated payout ratios.

Implementation requirements

- Establish an explicit legislative instrument under the *Private Health Insurance Act* to set the minimum payout rule (rather than relying on indirect levers).
- Design transitional arrangements to protect smaller insurers (options already signalled in the policy):
    - Phasing for smaller insurers; and/or
    - Tiered thresholds by fund size.
- Expand/APRA reporting alignment (minor system updates).
- A Mandatory Code of Conduct for hospital contracting with an arbitration model and price transparency, overseen by the ACCC, is also essential in-tandem with 90% benefit payouts to ensure consistency and fair terms across the sector.
- Require insurers to report and publish a management expense ratio per employee (FTE), with APRA to use this metric for efficiency benchmarking and supervisory oversight.

This requirement would rationalise the portion of premium dollars that health insurers may spend on administration, marketing, executive bonuses and profits. Health insurers would be required to publicly report on the portion of premiums spent on health care and quality improvement and other activities. Insurers failing to meet the appropriate ratio of 90 cents must subsequently pay rebates to consumers.

This measure, along with a Mandatory Code of Conduct for contracting between private hospitals and health insurers, can resort a sustainable balance. The Code would ensure transparency, fairness and appropriate funding across the sector.

By ensuring a predictable and adequate flow of funds from private health insurers to hospitals, this measure would help stabilize operations, support workforce retention, and enable investment in critical infrastructure and services.

Economic resilience is closely tied to the reliability and capacity of healthcare systems. Private hospitals play a vital role in relieving pressure on public facilities, especially during health crises. A guaranteed payout ratio would reduce financial uncertainty, allowing hospitals to plan and operate more effectively. This, in turn, enhances the sector's ability to respond to emergencies, maintain service delivery, and support broader public health outcomes.

From a macroeconomic perspective, this policy would also improve transparency and accountability in the private health insurance market. By limiting the proportion of premium revenue that can be allocated to administration, marketing, and profit, and requiring public reporting, the measure promotes consumer trust and ensures that funds are directed toward actual healthcare delivery.

Rebates for insurers failing to meet the ratio further reinforce this accountability, protecting consumers and encouraging efficiency. Ultimately, restoring the historical payout ratio is not just a financial adjustment, it is a strategic investment in economic healthcare resilience.

It ensures that private hospitals remain viable and competitive, supports employment in the sector, and contributes to a more balanced and robust healthcare system. In doing so, it strengthens Australia's overall economic resilience by safeguarding one of its most critical service sectors.

3.15 SPECIALITY SPECIFIC MEASURES

3.15.1 Psychiatry

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, wind down 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 0.4% to 217,047 (down from 217,851 the previous year). Mental health care in Australia is under immense strain from funding and workforce availability 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 the 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.

A 2023 paper by APHA estimated that current trends could lead to a crisis with 10,000 people a year in urgent need of a private hospital psychiatric admission going untreated which could lead to the number of people dying by suicide increasing by up to 40% if they are unable to get the care they need and a subsequent increase in the number of mental health related emergency department admissions. The Black Dog Institute, for example, also found that 60% of young adults aged 18 to 24 could not even afford to get the help they needed. Two in five young Australian are now living with a mental illness.[36]

The closure of Toowong Private Hospital in Brisbane in June 2025 and the intervention of the Tasmanian Government to prevent the closure of The Hobart Clinic in October 2025, underscore 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.

Over 2025, APHA has advocated on a number of priorities and engaged with an array of aspects of psychiatric services in Australian private hospitals. This has included seeking funding for psychiatric

[36] https://www.blackdoginstitute.org.au/news/addressing-australias-mental-health-crisis-time-for-bold-reform/

hospitals (including through MBS items for telehealth), highlighting workforce shortages (including advocating for the removal of the moratorium on overseas trained psychiatrists) and ambulatory care in private psychiatric hospitals.

There continues to remain a critical need for Australian governments to put in place funding and policy levers that remediate the regulatory shortfalls in the private hospital sector. Issues such as fragmentation, workforce-related shortfalls, and funding gaps make the situation complex and as such requires innovative measures. Simply conducting reviews of the state of the sector will not provide the immediate action necessary to support Australians that need care now.

- It is not controversial that the Australian healthcare system requires complementarity between the public and private sectors for the system to function. Interaction between the two sectors needs to be facilitated through initiatives such as improved information sharing, public to private referral programs, and shared-care programs.
- The rise of US-style managed care through private health insurers attempting to provide parallel outpatient and in-patient psychiatric care threatens to further upend the balance in the system, adversely affect competition, and artificially limit choice and care for private patients.
    - The Commonwealth must, under appropriations for the Australian Competition and Consumer Commission (ACCC), monitor and enforce this anti-competitive conduct by insurers.[37]
- 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.
    - 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.
    - 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.
    - APHA recommends 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.
- APHA calls for immediate action to address the significant service gap in psychosocial supports for people who do not qualify for the National Disability Insurance Scheme (NDIS).
    - While the NDIS delivers tailored, long-term support for people with significant functional impairments, it does not cover the whole group of people with psychosocial disabilities.
    - This gap affects many Australians living with moderate to severe mental illness, many of whom rely on private hospitals for clinical care but lack access to the non-clinical supports essential for recovery and community participation.

[37] See also, *Determination Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group Authorisation number: AA1000542*, https://www.accc.gov.au/system/files/public-registers/documents/Final%20Determination%20-%2021.09.21%20-%20PR%20-%20AA1000542%20Honeysuckle%20nib.pdf?ref=0&download=y

    - Access to NDIS relies on the severity and permanency of a person's disability, whereas non-NDIS supports are currently fragmented between different levels of government, difficult to understand and access, and generally variable across different jurisdictions on matters of funding, availability, and eligibility criteria.2
    - NDIS modelling in the 2020 Mental Health Inquiry Report by the Productivity Commission has indicated that only about 10% of people with a severe mental illness would meet NDIS criteria, leaving a vast majority of people that need care, unable to access it.[38]
    - Governments must address the matter of both general and targeted support for people who require access to psychosocial supports outside the NDIS scheme, as a matter of priority and utilise private hospital expertise, experience, and service delivery to expand access to services that are appropriate.
- The Commonwealth should elaborate on, delineate, and provide funding for career and family participation in mental health and suicide prevention efforts and underline a role for private hospitals in delivering these supports.
    - Carer and family supports should be embedded in bilateral funding agreements, with measurable outcomes and reporting requirements. Private hospitals should be eligible to deliver or partner in delivering these supports.
    - Funding should also be provided to fund carer liaison roles within private hospitals, to facilitate communication, education, and involvement in care planning.
- The Commonwealth should establish funding arrangements to empower Primary Health Networks (PHNs) to better meet the mental health needs of their communities.
    - For this to be effective, PHNs must be supported to work collaboratively with private hospitals, which are key providers of mental health care across Australia.
        - PHNs should be required, as a matter of good policy, to engage private hospitals in regional planning and commissioning processes
        - PHNs should be given flexibility to commission services from private hospitals where appropriate, support innovative models, and fund services that have demonstrated positive outcomes, regardless of provider type where appropriate.

3.15.2 Maternity

Australian private hospitals play an indubitably critical role in the provision of maternity and obstetric care. In 2023-24, they provided 20% of separations for pregnancy, childbirth, and the puerperium. Despite this, the survivability of this sector is at risk. The Financial Health Check of 2024 found, and data has confirmed, that the number of childbirth separations have fallen and out-of-pocket fees for consultation with a specialist have increase to a median of $2,615 (An 8% increase between 2018-19 and 2022-23). Between the same period, in fact, 9 private hospitals had closed their maternity wards and 2 with maternity services closed completely.

At a time when birth rates are falling and fewer mothers are presenting to a hospital for childbirth, it is necessary to ensure that those that hold private health insurance are able to get value for money and utilise private hospitals without the prospect of high out of pocket fees while those without private health cover should be able to use public facilities without facing long waiting times and encumbrances. A study found that full-reproductive health cover is only included in gold insurance policies and many women that do hold private health insurance 'still choose to birth in public hospitals. This is related partly to the attractiveness of models of care offered by many public

[38] https://www.pc.gov.au/inquiries-and-research/mental-health-review/#final-report

hospitals, and also with the disincentive of out-of-pocket costs that accrue even with top-level health insurance'.[39]

APHA echoes its budget recommendation for the 2025-26 budget that the Commonwealth legislate to include benefits paid for maternity in risk-equalisation and silver products, which will improve the access to and affordability of private maternity services.

- The Commonwealth to change the risk equalisation regulations to include 60 percent of maternity benefits in the pool to improve affordability of insuring maternity outside of 'gold' policies and to establish a $100k regional anaesthetist stipend and an anaesthetist maternity management fee to address the workforce capacity and affordability challenges.
- The application of the proposed 60 percent risk equalisation model for maternity will reduce the drawing rate for 25- to 39-year-olds between 6.53 percent and 12.63 percent. This will materially improve the affordability of maternity and increase the likelihood of offering maternity cover.
- Attracting younger people into private health insurance and offering them an upgrade pathway to higher levels of cover throughout their lifetime will contribute to an increase in the entire pool of lives covered, which in turn will contribute overall drawing rate deflation and maintain affordability for older policyholders.

3.16 SUPPLY CHAIN RESILIENCE AND SECURITY

The Commonwealth's commitment of $22.9 million over five years from 2024–25 in the 2025-26 budget, to address intravenous (IV) fluid shortages was a timely and strategic investment in Australia's health system resilience. This funding would support the expansion of domestic IV fluid production capacity, the establishment of a panel of reliable suppliers, and a clinical review of IV fluid usage, each a critical component in ensuring continuity of care across hospitals and health services. The COVID-19 pandemic and subsequent global supply chain disruptions exposed Australia's vulnerability to shortages of essential medical products, including IV fluids, personal protective equipment, and pharmaceuticals. These disruptions not only strained clinical operations but also placed patient safety at risk, particularly in emergency and intensive care settings.

To build on this initial investment, the Commonwealth should consider a broader, long-term strategy to strengthen Australia's medical supply chains. This includes funding for the development of sovereign manufacturing capabilities for high-priority medical products, the creation of strategic national stockpiles, and the implementation of real-time supply chain monitoring systems. Investment in local production not only reduces reliance on international suppliers but also supports economic development and job creation in advanced manufacturing. Furthermore, coordinated procurement frameworks and public-private partnerships can enhance supply chain agility and ensure equitable access to critical supplies across all jurisdictions, including rural and remote communities.

In addition, the Commonwealth should support research and innovation in supply chain logistics, including the use of AI and predictive analytics to anticipate demand surges and manage inventory. Funding should also be directed toward workforce development in supply chain management, ensuring that Australia has the expertise needed to operate and maintain complex medical logistics networks. Strengthening medical supply chains is not merely a matter of operational efficiency, it is a national health security imperative. A resilient, responsive supply infrastructure is foundational to a

[39] https://insightplus.mja.com.au/2024/27/private-maternity-hospitals-extinct-by-the-end-of-this-decade/

high-performing health system and must be treated as a core component of Australia's health policy and investment agenda.

3.17 TECHNOLOGY

3.17.1 Telehealth

APHA is supportive of efforts to make health care more accessible for Australians across the country, including in rural, remote, or underserved communities and believes that the catalytic impact of telehealth on such efforts cannot be overstated. We also note the importance of telehealth services during natural disasters, health epidemics, and other events that disrupt how Australians work and engage with each other.

APHA has been a vocal advocate for the need for continuity of care guaranteed by appropriate and consistent funding models and non-volatile regulatory settings. We support the integration of telehealth into the broader private hospital digital framework to support interoperability and continuity of care.

APHA recommends that the Commonwealth:

Introduce Medicare Benefit Schedule (MBS) items for the strategic use of telehealth for inpatient consultations to reduce the disincentive for psychiatrists to continue to provide inpatient services due to loss of unpaid time in travel and administration. This measure would be cost-neutral because consultations provided by telehealth would offset the decline in consultations currently conducted on a face-to-face basis.

Reinstate MBS telehealth items for inpatient psychiatric consultations on a permanent basis for use in emergency circumstances to support continuity in the therapeutic relationship and respond to the impracticality of relying on locum support in emergency situations. This measure would be cost-neutral because consultations provided by telehealth would offset the decline in consultations currently conducted on a face-to-face basis.

3.17.2 Electronic Medical Records (EMRs)

The European Health Data Space Regulation (EHDS) aims to establish a common framework for the use and exchange of electronic health data across the European Union. In addition to its objectives, the EHDS establishes a harmonised legal and technical framework for electronic health record (EHR)[40] systems to foster interoperability and innovation.[41] The Regulation is expected to drive expansion in the digital health sector, lead to significant savings, and enhance healthcare delivery efficiency.

EHR systems generally contain a patient's medical history (including diagnosis and treatment), allergies, laboratory results, and other medical data that is collected across the patient care environment. In the EU, some member states have centralised the infrastructure to set up EHRs and

[40] This section will use 'EHR' and 'EMR' interchangeably .
[41] https://health.ec.europa.eu/publications/regulation-eu-2025327-european-health-data-space-and-amending-directive-201124eu-and-regulation-eu_en

offer support to public and private healthcare providers to set up 'personal electronic health data spaces'.[42]

A robust and well-integrated EMR environment is a cornerstone of modern healthcare infrastructure, offering substantial benefits to both private hospitals and the broader national health system. For private hospitals, EMRs improve clinical efficiency by enabling real-time access to comprehensive patient data, including medical history, medications, allergies, and diagnostic results. This supports safer, faster, and more informed clinical decision-making, reducing the risk of medical errors and enhancing patient outcomes. EHRs also streamline administrative processes by automating documentation, billing, and compliance tasks, allowing staff to focus more on patient care. Furthermore, access to structured data enables private hospitals to analyse service demand, monitor performance, and plan resource allocation more effectively, supporting financial sustainability and strategic growth.

At the national level, EHRs facilitate better care coordination across healthcare settings—public hospitals, private providers, general practitioners, and allied health professionals—ensuring continuity of care, especially for patients with chronic or complex conditions. They help reduce duplication of services by providing access to previous test results and treatment records, leading to cost savings and improved system efficiency. Aggregated and anonymised data from EHRs also supports public health surveillance, policy development, and health system planning.

Despite the benefits, there remain significant concerns with respect to data privacy and protection[43] and the cost of setting up infrastructure in the face of a fragmented national health system with varying health data systems across the different states and territories.

Academic studies have found that EMRs can contribute to greater cost saving and a better quality of care[44], but if the cost of implementing a system is high and there is no guarantee that a specific jurisdiction will have interoperable platforms, hospitals are well-reasoned to express scepticism as to the applicability of the model in Australia. This position becomes more reasonable when considered in light of the major viability crisis that the sector is being subject to with tighter cost controls and more measured appropriations.

The Commonwealth must engage with the States and Territories to develop a national EMR system and consult with the sector in that process to ensure that the high cost of setting up an EMR can be subsidised and that the fragmented digital infrastructure can be coordinated.

3.18 TRAINING

The 2025-26 Federal Budget provided $662.6 million over 5 years from 2024-25 of Commonwealth funds towards strengthening and supporting Australia's health workforce. This included:

- $606.3 million over four years from 2025–26 (and $226.3 million per year ongoing) to deliver more Australian doctors and nurses. This included:

[42] Regulation (EU) 2025/327 of the European Parliament and of the Council of 11 February 2025 on the European Health Data Space and amending Directive 2011/24/EU and Regulation (EU) 2024/2847 (Text with EEA relevance), reg 7; Overview of the national laws on electronic health records in the EU Member States and their interaction with the provision of cross-border eHealth services Final report and recommendations (2014).

[43] Federated electronic health records for the European Health Data Space, Raab, René et al., The Lancet Digital Health, Volume 5, Issue 11, e840 - e847.

[44] Uslu A, Stausberg J. Value of the Electronic Medical Record for Hospital Care: Update From the Literature. J Med Internet Res. 2021 Dec 23;23(12):e26323. doi: 10.2196/26323. PMID: 34941544; PMCID: PMC8738989.

    - $265.4 million over four years from 2025–26 (and $94.8 million per year ongoing) to expand general practitioner (GP) training through the Australian General Practice Training Program and the Remote Vocational Training Scheme to deliver 200 new general practitioner training places each year from 2026, increasing to 400 from 2028
    - $248.7 million over four years from 2025–26 (and $83.6 million per year ongoing) for salary incentives for junior doctors to specialise in general practice, and to provide paid parental leave and study leave for trainee GPs
    - $45.0 million over four years from 2025–26 (and $29.9 million per year ongoing) for 100 new medical Commonwealth Supported Places per year from 2026, increasing to 150 per year from 2028
    - $44.0 million over four years from 2025–26 (and $16.0 million per year ongoing) for 200 new junior doctor/internship rotations in primary care per year from 2026 increasing to 400 per year from 2028
    - $3.2 million over four years from 2025–26 (and $2.0 million per year ongoing) to uncap the number of medical Commonwealth Supported Places for First Nations students from 2026.
- $28.0 million over three years from 2025–26 to support the construction of the Nursing and Midwifery Academy in Victoria, to be operated by the Epworth Medical Foundation
- $16.5 million over five years from 2024–25 (and $4.6 million per year ongoing) for the costs associated with updates to the Modified Monash Model and Distribution Priority Area classification systems to reflect the latest Australian Bureau of Statistics Census data, and workforce data from the Department of Health and Aged Care
- $10.5 million over two years from 2025–26 to expand the Primary Care Nursing and Midwifery Scholarship Program to deliver an additional 100 graduate certificate/diploma scholarships and 100 masters scholarships per year to support nurses and midwives to undertake post graduate study
- $1.3 million over two years from 2024–25 to extend the Obstetrics and Gynaecology Education and Training Program by 12 months to provide training for a range of medical professionals who assist in the provision of maternity or maternity related services. The Government has already provided partial funding for this measure. The costs of this measure will also be partially met from within the existing resourcing of the Department of Health and Aged Care.

There is clear evidence that it is of interest to the Commonwealth to ensure a healthy and well-trained healthcare workforce in Australia. Our healthcare workers must be trained and equipped with the skills necessary to adapt to new technologies and new models of care so that patients can continue to expect a high standard of care from the health sector at large and its workers. Government must continue to fund workforce training programs and expand appropriations for those initiatives. This includes funding for the Specialist Training Program and Psychiatry Workforce Program.

3.18.1 Specialist Training Program (STP)

The STP is a Commonwealth-funded training program that seeks to extend vocational training for trainees into non-traditional facilities such as regional, rural, remote, and private hospitals. [45] It aims to increase the capacity and skills of the health workforce. The STP in its current iteration was due to

[45] https://www.health.gov.au/sites/default/files/2023-03/specialist-training-program-operational-framework_1.pdf

end in 2025, but this has been extended until the end of 2026, as the government commences work to redesign the program in line with the National Medical Workforce Strategy.

The Commonwealth provided $708.6 million to continue the program for 4 years from 2022. This was then-intended to mean 920 full-time equivalent places annually with at least 50% of training to occur in regional, rural and remote settings.[46] The STP provides funding to non-GP specialist medical colleges.

Despite performing over 70% of elective surgeries, private hospitals remain underutilised as a training setting. Training should occur at locations where work is being done and excluding private hospitals from training pathways, or disadvantaging them on the basis of cost alone, creates a cultural imbalance and risks market failure.

Training provided in a private hospital setting typically allows the emerging generation of surgeons and other practitioners to gain broader and deeper experience than they do in public hospitals. This ability to delve into the full gamut of surgical and clinical activity is highly valued by participants, provides a much-needed boost for the health care system, and produces better and more comprehensively trained people.

Private hospitals often bear a disproportionately high cost to support training, support under the STP helps narrow that cost, still leaving hospitals to absorb about 30% of the employment costs. Without adequate support, many private facilities are unable to sustain training infrastructure, which undermines the broader goals of workforce development.

There is also the matter of the need for better data to inform placements, need, and oversight. Improved visibility into site performance, trainee outcomes, and regional demand would enable more strategic allocation of training posts and ensure that funding is directed where it can have the greatest impact.

The STP is a highly valued resource for private hospitals, but also a fillip for the health workforce and the national health ecosystem. We encourage the Commonwealth to keep funding the program and engage with stakeholders to reform it to ensure that it can continue to keep delivering for Australians.

3.18.2 Psychiatry Workforce Program (PWP)

The PWP was funded under the 2021-22 budget 'to attract, upskill, distribute and retain key mental health professionals to address mental health workforce shortages and maldistribution' until 2026. It provides funding for salary contributions for new psychiatry training posts and supervisor positions, supporting the development of a rural and remote psychiatry training pathway and recruiting medical graduates.[47]

[46] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/7086-million-to-continue-specialist-medical-training-across-australia

[47] https://www.grants.gov.au/Go/Show?GoUuid=2b3b2742-9b97-444e-8753-eb59d18f04e5

In 2023, the Commonwealth provided an additional $27.5 million to extend the PWP from 2023 to 2026. [48] In 2025, PWP posts in private setting were also, subject to eligibility, eligible for funds to cover infrastructure and clinical supervision.[49]

Despite these investments, the demand for mental health services continues to outpace workforce growth, particularly in regional and remote communities. The PWP has proven to be a valuable mechanism for building early interest in psychiatry among junior doctors, offering structured exposure and mentorship in settings that traditionally struggle to attract and retain specialists.

However, to fully realise its potential, the program must be expanded. This includes increasing the number of funded posts, extending eligibility to a broader range of training environments, and ensuring that infrastructure and supervision costs are adequately covered, especially in private and rural settings.

Continued Commonwealth funding is essential not only to maintain momentum but to scale the program in line with national mental health priorities. The integration of private sector placements, supported by appropriate funding, will help diversify training experiences and build a more resilient, distributed workforce.

Moreover, expanding the program will support strategic alignment with the National Mental Health Workforce Strategy, ensuring that Australia is equipped to meet growing demand for psychiatric care across all regions.

3.19 WORKFORCE

The 2023 "Independent review of Australia's regulatory settings relating to overseas health practitioners" (Kruk Review) highlighted pertinent issues and a critical shortage of health practitioners in Australia with 44% of vacancies remaining unfilled at the time of the review.

It noted that "Shortages are particularly acute in distinct locations and care settings, and key specialties. People living in regional, rural and remote areas find it harder to access many forms of care". The Kruk review further emphasised that workforce shortages contribute to reduced access to care, increased workloads for health practitioners, overuse of higher cost services (such as locums and emergency care) and poorer patient outcomes such as increased waiting times.

As workforce challenges exist in both the public and private sectors, government should develop policies and put in place legislation to enable the rapid induction of overseas trained staff into the Australian healthcare system, provide flexibility, and develop data to identify gaps and shortfalls in the workforce.

At the outset, APHA suggests that the Commonwealth adopt the following recommendation of the Kruk Review:

- Ease the 10-year moratorium on the practice of overseas trained doctors seeking to practice in Australia, allowing them to practice in acute private hospital settings.
- Introduce or expand expedited pathways to registration for all professions in acknowledged areas of shortage. Eligibility for expedited pathways should be regularly considered and part of a rolling work program reported to health ministers. Priority professions to be collectively identified by health ministers. (Recommendation 9).

[48] https://www.health.gov.au/ministers/the-hon-emma-mcbride-mp/media/improving-access-to-psychiatry
[49] https://www.ranzcp.org/college-committees/public-partners/for-health-services-with-stp-posts/psychiatry-workforce-program-pwp

- Expand the use of workplace-based assessments where appropriate, including exploring collaborative models to support international medical graduates (IMGs) with general practice and public health services to help address recruitment, training and retention challenges in regional and rural Australia (Recommendation 16).
- Support better planning for Australia's future workforce needs, including developing national workforce strategies for maternity and allied health and finalising the nursing strategy already in development. National workforce modelling should be reviewed and updated at least every 5 years, and strategies, every 10 years (Recommendation 18).

4.0 Budget Recommendation Summary

Budget Measure	**Initiatives**	**Costs**	**Timeframe**
Artificial Intelligence	• Extending investment in AI to the 2026-27 budget and to private hospitals to support capital investment in AI infrastructure • Subsidising training programs for clinical and administrative staff • Incentivising collaborative research and development between private providers, universities, and technology firms.	Extension to and expansion of the $39.9 million 2024-25 federal budget funding	• 2026 to 2030
Code of Conduct	• Prescribing a Mandatory Code of Conduct between private hospitals and private health insurers	$15 million to develop the code of conduct over 5 years from 2026-27 to develop and enforce a Private Health Sector Code of Conduct and $10 million over 3 years to monitor private health markets until 2029[50]	• Consultation to commence by the Australian Competition and Consumer Commission by May 2026. • Code to be developed by October 2026. • Code to be implemented by February 2027.

[50] Estimates based on appropriations for codes of conduct in the 2019-20 (Dairy Code, appropriations to implement), 2020-21 (Dairy Code and inquiry into bargaining imbalances), and 2023-24 (Gas Code of Conduct, appropriations to develop and administer) Federal Budget.

Compliance and enforcement private health insurance legislation	• Appropriations to support monitoring, compliance and enforcement priorities.	$35 million over 5 years to the Department of Health, Disability, and Ageing to support compliance and enforcement priorities.[51]	• Strategy to be developed by May 2026 and implemented by July 2026.
Contracting between Public-Private	• Funding for a national roll out of a model based on Surgery Connect • Funding for a one-year pilot program in any particular state that engages private hospitals in the UCC program.	$4 billion across the States and Territories for a roll out of Surgery Connect. $15 million for a one-year pilot program for UCC-private hospital partnerships.[52]	• The Commonwealth to engage with states and territories on the feasibility of a Surgery Connect-style model and develop a draft framework by October 2026. • Stakeholder consultation on SC to occur until February 2027. • UCC pilot program to operate between March 2026 and March 2027.
Critical infrastructure security and resilience	• Expanding the definition of critical hospitals with ICUs to encompass all private hospitals as elements of the national critical infrastructure • Funding to finance the upgrade of the security infrastructure for private hospitals.	$250,000 for implementing the legislative change[53] $150 million < over 4 years from 2026 to 2030.[54]	• Funding to be provided for 2026 to 2030. • Expansion of the definition to occur post-stakeholder consultation and collaboration with the Department of Home Affairs by August 2026.

[51] Estimated from Australian Energy Regulator appropriations in the 2023-24 Federal Budget.
[52] Estimated cost of staffing, digital upgrades, and contract value.
[53] Estimated cost of resourcing, consultation, and executing a legislative amendment.
[54] Estimated cost of department resourcing, digital upgrades, infrastructure and hardware upgrades, and stakeholder awareness campaigns.

Data	• Re-establishing the PHEC to ensure a reliable, and consistent source of data on the viability and condition of the private hospital sector • Tying AIHW appropriations to the timely analysis and release of data. All datasets must be published at the end of each financial year with embargoed quarterly snapshots and 'state of the sector' presentations being provided to the sector. • Providing funding to APRA to improve data analysis and more comprehensive annual reporting on all data and trends • Funding to support the infrastructure, staffing, and technological upgrades required to modernise data systems and enable real-time analytics.	$9 million over three years to support reestablishment of the PHEC. APRA funding items to be developed in consultation with APRA.	• All data related initiatives to be put in place and funded from 2026 to 2029 with the option to extend. • No government consultation required.
Disaster response	• Developing joint disaster response plans with private hospitals • Funding for NEMA to collaborate with private hospitals in vulnerable zones • Appropriating further funds under the Disaster Ready Fund program.	$15 million over two years[55] . Continued and expanded funding under the Disaster Ready Fund.	• NEMA to collaborate with private hospitals between March 2026 and March 2027. • The DRF be funded beyond 2028 to 2033.
Energy affordability and reliability	• Putting in place a coordinated national strategy for private hospitals to prioritise investment in modernising the electricity grid to improve resilience and reduce transmission losses, while also incentivising diversified energy generation, including renewables,	Funding to be determined by final strategy	• Consultation by the Department of Climate Change, Energy, the Environment, and Water to occur between March 2026 and May 2026. • Strategy to be developed by October 2026.

[55] Estimated from $15 million appropriated in 2024 for Tasmania under the Disaster Ready Fund

	storage solutions, and low-emission baseload options. • Subsidising energy for private hospitals to minimise cost pressure • Putting in place energy price caps for essential services, demand-side management programs, and emergency support for the private hospital sector. • Fostering innovation in energy efficiency technologies and expanding access to clean energy infrastructure will be key to ensuring affordability and reliability.		• Energy subsidies and funding for energy efficient technology and infrastructure to be provided from March 2027 until March 2029 with the option to extend.
Industrial relations reform	• Ensuring a balance industrial relations architecture that affords fairness to employers and employees • Monitoring the impact of industrial relations reforms on private hospital operation and viability.	$1 million for monitoring[56] over 2 years	• The Commonwealth commence a review on the impact of industrial relations reform on private hospitals in July 2026 and publish a final report by September 2026. • Monitoring policy to be developed concurrently and put in place.
Net Zero Transition	• Establishing a Net Zero Transition Fund for Private Hospitals (NZTFPH) as an extension to the proposed $5 billion Net Zero Fund • Providing technical assistance and capacity-building support to help private hospitals develop and implement decarbonisation strategies.	Funding to be determined by the structure and framework of a NZTFPH.	• The Commonwealth commence multi-agency collaboration on the NZTFPH by June 2026. • Funding to be provided to private hospitals from November 2026 until March 2030.
Phoenixing	• Outlawing insurance product phoenixing	$4.5 million for the first year with yearly reductions due to	• The Commonwealth to develop a compliance policy on PHI phoenixing by June 2026.

[56] Estimated cost of staff and resourcing.

	• Greater monitoring, compliance and enforcement of anti-PHI Phoenixing policy and law and reporting • Funding for cross-agency cooperation and collaboration through staff and digital system resourcing.	expected improvements in efficiency over the next 5 years (2026-2031).	• The Parliament to introduce legislation by September 2026 to outlaw and criminalise insurance product phoenixing.
The Prescribed List	• Increasing funding for the Medical Devices and Human Tissue Product Advisory Committee (MDHTAC) to expedite the approval of new devices and enable case-by-case determinations of appropriate benefit levels for emerging and bespoke technologies. • Establishing a PL Viability and Innovation Fund to bridge the gap between the actual cost of high-need, low-volume devices and the rebates currently available under the PL. • Putting in place reforms to establish a fast-track pathway for high-impact, low-volume devices with limited market alternatives.	Consultation on need required with MDHTAC. Commonwealth to undertake work to develop a framework and modelling to establish the PL fund.	• These initiatives to be consulted on and put in place immediately following the budget process and remain ongoing.
Public hospitals establishing private facilities	• Capping the proportion of public hospital activity that can be devoted to the provision of services for private patients • Banning public sector facilities from opening private facilities	Budget Neutral, NHRA appropriations to cover negotiations	• The Commonwealth put in place the proposed initiatives following negotiation to include them in the new NHRA by 2027.
Return ratio	• Guaranteeing and legislating for a minimum Private Health Insurer Payout Ratio to increase private hospital funding,	$250,000 in 2026-27[57]	• The Parliament to legislate for a minimum payout ratio by July 2026.

[57] Estimated from average cost of staffing, consultation, and legislative amendment.

			• The new legislated payout ratio to come into force by September 2026.
Speciality Specific Measures	• Facilitating interaction between the public and private systems through initiatives such as improved information sharing, public to private referral programs, and shared-care programs. • Implementing a 12-month trial of a default benefit for private hospital-run multi-disciplinary mental health outreach programs (ambulatory outreach) • Addressing the significant service gap in psychosocial supports for people who do not qualify for the National Disability Insurance Scheme (NDIS). • Establishing funding arrangements to empower Primary Health Networks (PHNs) • Legislating to include benefits paid for maternity in risk-equalisation and silver products	Budget neutral with the exception of funding arrangements for PHNs and cost of putting in place new legislation. Funding arrangements to be developed in consultation with PHNs.	• All proposed initiatives to be consulted on between March 2026 and May 2026. • Implementation for maternity and psychiatry measures to commence from October 2026.
Supply chain resilience and security	• Funding the development of sovereign manufacturing capabilities for high-priority medical products • Creating strategic national stockpiles of medical products • Implementation of real-time supply chain monitoring systems. • Investing in local production of medical products	Continued and expanded $22.9 million funding from the 2025-26 budget.	• The Commonwealth to commence consultation through the Department of Industry, Science, and Resources and the Department of Health, Disability, and Ageing between March 2026 and October 2026. • Development of a national medical supply chain and security strategy

	• Coordinating procurement frameworks and public-private partnerships • Supporting research and innovation in supply chain logistics, including the use of AI and predictive analytics to anticipate demand surges and manage inventory. • Funding workforce development in supply chain management.		between November 2026 and April 2027. • Supply chain initiatives to come into force from July 2027.
Technology	• Introducing Medicare Benefit Schedule (MBS) items for the strategic use of telehealth for inpatient consultations. • Reinstating MBS telehealth items for inpatient psychiatric consultations on a permanent basis for use in emergency circumstances. • Coordinating with States and Territories to develop a national electronic medical record (EMR) system • Subsidising the high cost of setting up an EMR.	Budget neutral with only the administrative departmental cost of introducing and reinstating MBS items. EMR cost estimates to be developed by government.	• Formal consultation to occur between January to April 2026 on MBS items with any changes to come into effect by July 2026. • The Commonwealth to consult with the states and territories on including EMR development in the next NHRA in 2026. • The Commonwealth consider funding to subsidise EMR uptake in private hospitals upon the new NHRA taking effect, likely in 2027.
Training	• Continuing and expanding funding for the Specialist Training Program (STP) • Continuing and expanding funding for the Psychiatry Workforce Program (PWP)	Continued and expanded $708.6 million (due to lapse in 2026) for the STP. Continued and expanded appropriations for the PWP.	• Funding for the STP and PWP programs to be extended from 2026 to 2030. • The Department to consult with stakeholders in March 2026 on opportunities to expand funding under both programs. • Funding increases to come into force in October 2027 with yearly reviews and options to extend.

Workforce	• Easing the 10-year moratorium on the practice of overseas trained doctors • Introducing or expand expedited pathways to registration for all professions in acknowledged areas of shortage • Expanding the use of workplace-based assessments to support international medical graduates (IMGs) • Developing national workforce strategies for maternity and allied health • Finalising the nursing strategy • Reviewing national workforce modelling and strategies	Budget neutral with the exception of administrative and resourcing costs for government to change policy.	• Engagement with stakeholders to occur between March and August 2026 • Department to finalise policy and legislative changes by November 2026. • Reforms to be put in place in a staggered approach from January 2027 to March 2028
Industrial Relations	• Providing targeted support for nurse wage increases	$445 million over 4 years from 2026-27 to 2029-30 with increments of $125 million, $114 million, $102 million, $104 million respectively.	• Engagement with sector to occur between March to August 2026. • Commonwealth to finalise funding framework. • Support to commence upon completion of funding framework and agreement of all parties.

5.0 Conclusion

Australia's private hospital sector has passed the viability tipping point. The unabated and unaddressed crisis engulfing the sector over recent years has now seen the sector in large part unsustainable. Despite delivering nearly half of all hospital care, the sector is under growing financial strain, facing workforce shortages, regulatory uncertainty, and rising operational costs. These pressures are not new, but they have now reached a level that threatens the sustainability of private hospitals across the country.

This submission has laid out the key challenges and proposed practical, targeted solutions. These include restoring a fair and transparent funding framework, legislating a minimum payout ratio, supporting 50% of the looming Nurses Award increases, investing in digital infrastructure and cybersecurity, and expanding access to workforce training and development. APHA has also called for the re-establishment of robust data collection mechanisms to support better decision-making and policy design.

A strong private hospital sector reduces pressure on public hospitals, improves patient access, and supports jobs and investment. The Commonwealth has a clear opportunity in the 2026- Federal Budget to back in the sector and ensure it remains a reliable, high-performing partner in delivering quality healthcare.

The sector is not asking for handouts. We are advocating for smart, strategic investment in the national interest that will deliver long-term value for patients, providers, and the health system. APHA stands ready to work with government to make these reforms a reality and ensure that private hospitals can continue to play their essential role in Australia's healthcare future.