Australian
Private Hospitals
Association

A Framework for Public-Private Collaboration and Cooperation

APHA FRAMEWORK PROPOSAL FOR AUSTRALIAN GOVERNMENTS

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Purpose

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This document is intended to provide a proposal for State and Territory governments to put in place a program to enhance public-private cooperation to reduce waiting lists, provide access to patients to high quality care, and support private hospital viability.

The information provided in this document must be handled in accordance with Australian Government best practice for sensitive and commercial sensitive information.

1.0 Introduction

The Australian Government's partnership with the private health sector during COVID-19 demonstrated that national health outcomes and private hospital viability are complementary, not competing, interests. That partnership offers a template, and a prompt, for more enduring structural reform.

Public patients are treated in private hospitals under short-term contracting arrangements, even outside of emergencies. These arrangements reduce wait times, ease pressure on public hospitals, and help manage unexpected surges in demand. The case for expanding and formalising such partnerships is well established. What has been lacking is a consistent, structured approach that gives both governments and private providers the certainty needed to plan, invest, and deliver.

Queensland's Surgery Connect program demonstrates what is possible. By enabling clinically suitable public patients to access surgery in private hospitals, funded directly through bilateral standard-term contracts, the program has reduced surgical wait times, relieved pressure on public hospitals, and increased private hospital activity. It is a proven, agile model with clear national potential.

This framework sets out the Australian Private Hospitals Association's (APHA) proposed non-exhaustive model for a national Surgery Connect-style program. Drawing on the Queensland experience, it identifies the design principles, funding mechanisms, and governance arrangements needed to adapt and scale the program across jurisdictions. The framework makes the case that a nationally coordinated, state-and-territory-tailored approach to public-private surgical contracting would deliver meaningful benefits: shorter wait times, stronger private hospital viability, more efficient use of health system capacity, and better outcomes for patients, particularly those in rural and regional communities where access to timely, specialised care remains most limited.

While this framework is directed at elective surgical contracting, the same collaborative principles extend naturally to sub-acute care. Private rehabilitation capacity, in stand-alone rehabilitation hospitals or hospitals offering a combination of acute and rehabilitation services, is well placed to relieve pressure on the public system and to address the problem of medically stable patients who remain in acute beds awaiting sub-acute care.

Sub-acute care nonetheless differs from elective surgery in patient complexity, length of stay, funding, and outcome measurement. Consequently, a direct replication of a surgically oriented collaborative framework would not be appropriate. APHA proposes that a dedicated sub-acute collaborative model be developed as a companion to this framework to make better use of private rehabilitation capacity, improve patient flow, and reduce pressure on acute hospitals.

2.0 Proposed Framework

2.1 PROGRAM ADMINISTRATION

A collaborative program for public-private cooperation must represent a value for money proposition for the Australian taxpayer, be fair and transparent, and be administered appropriately. This section establishes the administrative roles, responsibilities, and governance structures necessary to ensure the effective, accountable, and efficient functioning of the program at Commonwealth, state, and territory levels.

Program Administrator

Each participating Commonwealth, state, and territory health department must appoint a Program Administrator who will serve as the principal contact point for participating private hospitals and be responsible for:

- all procurement activities undertaken in connection with the program, including the execution and management of bilateral contracts with participating private hospitals;
- day-to-day program operations, including the management of referral pathways, provider registration, and contract compliance;
- conducting program reviews in accordance with the Program Review section of this framework;
- dispute management in the first instance, in accordance with the Dispute Resolution section of this framework;
- liaising with the relevant state or territory health department and the Commonwealth on funding administration and program performance; and
- any additional activities and responsibilities that the relevant jurisdiction determines are necessary from time to time to ensure the effective functioning of the program.

The Program Administrator must be a senior executive of the relevant government health agency or another suitably qualified person appointed by the relevant Minister and empowered to exercise the responsibilities set out in this section. The Program Administrator must have sufficient delegated authority to make operational decisions without requiring ministerial approval for routine program matters, in order to ensure agile and responsive program management.

Data Administrator

Each participating jurisdiction must also appoint a Data Administrator who will serve as the principal data manager for the program and be responsible for:

- collecting, analysing, publishing, and storing data related to the functioning of the program;
- ensuring that data collection and reporting processes are accurate, consistent, and sufficient to measure program outcomes and ensure transparency in program administration;
- coordinating with public hospitals and local health services to access relevant public hospital data in connection with program reviews and performance assessment;
- publishing de-identified program data in accordance with applicable privacy legislation and a data governance framework; and

- liaising with the Program Administrator on jurisdictional data matters, including the identification of data quality issues and opportunities to improve reporting processes.

The Data Administrator must be a senior executive of the relevant government health agency or another suitably qualified person appointed by the relevant Minister. The Program Administrator and Data Administrator roles may be held by the same person where the relevant jurisdiction determines this is appropriate, provided that the administrative responsibilities of each role are discharged in full.

Jurisdictional Steering Group

Each participating jurisdiction must establish a Steering Group to provide oversight and strategic guidance on program implementation within that jurisdiction. The Steering Group must be composed of:

- representatives of the relevant Commonwealth, state, or territory health department, including the Program Administrator and Data Administrator;
- representatives of participating private hospitals within the jurisdiction, nominated through a process agreed between the relevant health department and the Australian Private Hospitals Association;
- representatives of relevant clinical bodies, including surgical colleges and specialty societies, where the Steering Group determines their input is necessary to inform program design or review; and
- people with lived experience of the public hospital elective surgery system, including consumers who have been treated under the program or who have experience of public hospital waiting lists, where relevant and where suitable nominees are available.

The Steering Group must meet no less than quarterly and is responsible for:

reviewing program implementation within the jurisdiction, including performance against key performance indicators and service timeframes;

- identifying and escalating operational issues that require resolution at the program administration or ministerial level;
- providing a forum for private hospital providers to raise concerns about program design, contracting arrangements, administrative burden, or pricing without prejudice to their contractual rights;
- making recommendations to the Program Administrator on program improvements, including changes to the approved procedures list, referral processes, or reporting requirements; and
- receiving and considering reports from the Data Administrator on program data and outcomes.

Steering Group meetings must be minuted and a summary of key issues and recommendations must be provided to the relevant Minister no less than twice per year.

Ministerial Oversight

The relevant Minister retains ultimate responsibility for the program within their jurisdiction and must:

- receive and consider the annual program report and Steering Group summaries;
- approve any material changes to program design, including changes to the approved procedures list, pricing methodology, or eligibility criteria, on the recommendation of the Program Administrator and in consultation with the Steering Group; and
- table the annual program report before the relevant parliament or legislative assembly within 30 days of its completion, to ensure parliamentary accountability for the expenditure of public funds under the program.

2.2 FUNDING LOGISTICS

This section establishes the mechanisms governing the flow of funds under the program. The funding framework is designed to ensure that payments to participating private hospitals are made efficiently and transparently. A direct funding model, from the Commonwealth or state and territory health department to the participating private hospital, is a foundational design principle of this framework and must be preserved in any national implementation.

Funds must be dispersed directly from the relevant Commonwealth or state and territory health department to participating private hospital providers. Public hospitals and local health services must not be required to act as financial intermediaries in the payment of contracted private hospitals. This principle:

- ensures that private hospitals can be paid efficiently and transparently, without their revenue being contingent on the financial position or administrative capacity of individual public hospitals;
- removes the risk of payment delays arising from public hospital budget pressures, administrative backlogs, or competing funding priorities at the local health service level;
- provides greater financial certainty for participating private hospitals, supporting the workforce and infrastructure investment necessary for sustained program participation; and
- is consistent with the direct funding model that has underpinned the Surgery Connect program in Queensland and has been identified as a key contributor to that program's operational effectiveness.

Funding Flow

The flow of funds under the program must operate as follows:

- state and territory health departments must disburse funds directly to participating private hospitals upon receipt of a valid invoice submitted in accordance with the payment mechanics established under the Contracting Arrangements section of this framework;
- at no point in the funding flow must a public hospital or local health service be required to approve, authorise, or advance payment to a participating private hospital in respect of services delivered under the program.

Payment Timeframes

To support the financial viability of participating private hospitals, state and territory health departments must process and disburse payments within a reasonable timeframe and in accordance with contractual obligations.

2.3 CONTRACTING

This section establishes the contracting framework governing the relationship between the senior executive or designated program administrator, participating state and territory health departments, and private hospital providers. The framework is designed to provide sufficient certainty for long-term planning and investment, reduce the administrative burden that has characterised existing public-private contracting arrangements, and create a meaningful Commonwealth funding instrument for elective surgery that does not currently exist. Contracts must be structured to be operationally practical, financially sustainable for private hospital providers, and flexible enough to accommodate jurisdictional variation.

It is acknowledged that in practice, private hospital providers often pivot between Health Service Contracts and Surgery Connect-style contracts depending on where funding is more readily available at a given time. A well-designed national framework must accommodate this operational reality rather than seek to displace existing contracting mechanisms. Local health services must retain the ability to maintain separate contracts with private hospitals where those arrangements better serve local need, provided they are consistent with the minimum standards established by this framework.

Contract Structure

The program must operate through bilateral standard-term contracts between the relevant state or territory health department and participating private hospitals. Contracts must be offered on a medium to long-term basis, with an initial term of no less than three years, to provide private hospital providers with sufficient certainty to plan workforce, infrastructure, and service delivery. Short-term or ad hoc arrangements are to be avoided except in circumstances of demonstrated urgent need.

Nothing in this framework prevents local health services from maintaining separate contracting arrangements with private hospitals where operationally appropriate, provided those arrangements are consistent with the principles and minimum standards set out in this framework.

Pricing and Payment

Contracts must adopt a bundled case payment methodology, calculated by Diagnostic Related Group (DRG), that reflects the true cost of service delivery to private hospital providers. In developing the pricing methodology, the senior executive or designated program administrator must have regard to the following principles:

- pricing must be demonstrably competitive and must reflect fair value for the services delivered, including all associated costs borne by the provider;
- pricing must not be set unilaterally by the senior executive or designated program administrator. The recent adoption of fixed, non-negotiable pricing in the Surgery Connect tender process is identified as a significant risk to provider participation and program viability.
- any national framework must include a genuine consultation mechanism through which the private hospital sector can engage in pricing methodology determinations before they are finalised; and

- the pricing methodology must be reviewed at each contract renewal to ensure it remains reflective of current costs and efficient pricing benchmarks.

Administrative Simplification

Existing program experience has demonstrated that administrative complexity is a significant impediment to provider participation and program efficiency. Contracts under this framework must therefore:

- consolidate reporting requirements to the minimum necessary to meet program oversight and accountability obligations;
- avoid duplication of reporting across state, territory, and Commonwealth administrative systems;
- not mandate the use of any specific patient administration or referral management system that is not widely adopted across the sector or that imposes disproportionate implementation costs on providers. The experience of existing programs indicates that mandated referral management platforms can create significant administrative inefficiency and must not be replicated in a national framework without sector-wide consultation and agreement; and
- be reviewed at each contract renewal for opportunities to further reduce administrative burden without compromising program integrity.

Jurisdictional Flexibility

While this framework establishes national minimum standards for contracting, it is acknowledged that health system structures, funding arrangements, and service delivery contexts vary across jurisdictions. States and territories retain the flexibility to adapt contract terms to local circumstances, and local health services may maintain separate contracting arrangements with private hospitals where those arrangements better serve local need.

2.4 REFERRALS

To be eligible for referral under the program, patients must:

- have received a specialist outpatient consultation within the public health system confirming their clinical suitability for the proposed procedure; and
- be assessed as surgery-ready prior to entering the program. Surgery-readiness requires that all pre-operative requirements, including necessary investigations, anaesthetic assessments, and optimisation of comorbidities, have been completed before a referral is accepted by the participating hospital. This requirement is a condition precedent to referral and must be clearly reflected in contract terms to avoid providers absorbing costs associated with patients who are not clinically prepared to proceed to surgery in a timely manner.

Follow-Up Care and Post-Discharge Responsibility

Participating hospitals are responsible for all follow-up care required by the patient as a result of services delivered under the program for a period of up to 90 days post-discharge. This responsibility encompasses all clinically necessary care arising from the procedure, including further operative intervention, wound management, and specialist and allied health consultations.

The 90-day post-discharge responsibility period represents a material financial risk for providers, particularly where patients require complex or extended follow-up care. In recognition of this, contracts must:

- clearly define the scope of follow-up care obligations and the clinical circumstances that may give rise to extended or exceptional responsibility;
- provide a mechanism for providers to seek approval for reimbursement of follow-up care costs that are exceptional in nature or materially exceed what could reasonably have been anticipated at the time of referral; and
- establish a process by which providers may request approval to continue delivering follow-up care beyond 90 days, with any approved services invoiced separately in addition to the bundled case payment.
- Contracts must explicitly define what is excluded from the bundled case payment and the provider's post-discharge obligations. Consistent with the treatment of public hospital patients, items that patients take home following discharge, including discharge medications, braces, and similar consumables, are excluded from program coverage and must not be charged to patients.

2.5 PAYMENT FOR SERVICES

Payment under the program must be structured as follows:

- participating hospitals may invoice for 90% of the applicable bundled case payment upon the patient being discharged from hospital and all procedural services having been completed, subject to compliance with applicable patient record and reporting obligations;
- the remaining 10% of the bundled case payment becomes payable upon completion of all follow-up care obligations and satisfaction of discharge reporting requirements; and
- where a prosthesis is required, the cost of the prosthesis is included within the bundled case payment unless the provider demonstrates that the prosthesis cost exceeds the applicable outlier threshold for the relevant DRG, in which case a supplement payment may be approved by the relevant health department on a case-by-case basis.
- for DRGs with an identified outlier threshold, the supplement payment is the difference between that threshold and the applicable Prostheses List benefit. For DRGs without an identified outlier threshold, the supplement payment must be negotiated between the parties and must not exceed the applicable Prostheses List benefit amount.

2.6 DISPUTE RESOLUTION

This section establishes a structured, proportionate mechanism for resolving disputes arising under the program. The framework prioritises early resolution through negotiation and mediation, reserving formal escalation for matters that cannot be resolved at the operational level. The dispute resolution process is designed to preserve the integrity of the public-private partnership and minimise disruption to patient care.

Application

This section applies to disputes arising between:

- a participating private hospital and the Commonwealth, State or Territory health agency;
- a participating private hospital and a referring public hospital or health service;

This section does not apply to:

- disputes concerning individual patient care decisions, which remain subject to the clinical governance frameworks of the relevant hospital or health service; or
- matters arising under the *Privacy Act 1988* (Cth) or the Australian Privacy Principles, which must be referred to the Office of the Australian Information Commissioner (OAIC).

Notification of Dispute

A party seeking to invoke this dispute resolution process must:

- provide written notice to the other party and set out the nature of the dispute, the relevant facts, and the outcome sought; and
- make reasonable attempts to resolve the dispute informally before escalating to the formal process set out in this section.

Written notice must be provided within 30 days of the party becoming aware of the matter giving rise to the dispute. Failure to provide timely notice does not extinguish a party's right to dispute resolution but must be considered in assessing the conduct of the parties.

Stage One — Negotiation

Within 14 days of receipt of a written dispute notice, the parties must:

- nominate a senior representative with authority to negotiate and settle the dispute on behalf of their organisation; and
- meet, in person or by other agreed means, to attempt to resolve the dispute through good faith negotiation.

If the dispute is resolved at this stage, the agreed resolution must be documented in writing and signed by both parties. A program administrator or other senior executive within the relevant jurisdiction's health department must be notified of the resolution and its terms within seven days.

Stage Two — Mediation

If the dispute is not resolved within 28 days of the written notice being issued, either party may refer the matter to mediation by notifying the senior executive or responsible program administrator, in writing.

The senior executive or program administrator must, within 14 days of receiving a referral:

- appoint an independent mediator with relevant expertise in health system administration, contracting, or law; and

- convene a mediation process at a time and place agreed by the parties, or as determined by the mediator where agreement cannot be reached.

The mediator must:

- facilitate structured discussions between the parties with a view to achieving a mutually acceptable resolution;
- remain neutral and must not impose a resolution on the parties; and
- provide a written summary of the mediation outcome, including any agreed terms of resolution or, where resolution was not achieved, the matters remaining in dispute.

Stage Three — Escalation

If the dispute remains unresolved following mediation, either party may escalate the matter by written request to the relevant Commonwealth and state or territory health ministers, or their nominated delegates.

Upon receipt of an escalation request, the relevant ministers or delegates must:

- review the mediator's written summary and any submissions from the parties; and
- issue a written determination within 30 days, which must be final and binding on all parties to the dispute.

In making a determination, the ministers or delegates must have regard to:

- the purpose and objectives of the program;
- the terms of the relevant bilateral contract;
- the impact of the dispute on patient care and program continuity; and
- the conduct of the parties throughout the dispute resolution process.

Continuity of Services

For the duration of the dispute resolution process, and unless otherwise agreed in writing by the parties or directed by the Program Administrator:

(a) participating private hospitals must continue to accept and treat referred public patients in accordance with their contractual obligations; and

(b) the relevant health service/public hospital continue to process payments and administer the program without interruption.

No dispute resolution process under this section may be used as grounds to suspend or terminate services to patients currently under the care of a participating private hospital.

Confidentiality

Unless otherwise required by law or agreed by the parties, all communications, documents, and outcomes arising from the dispute resolution process must be treated as confidential and must not be disclosed to any third party without the written consent of all parties.

2.7 PROGRAM REVIEW

Regular reviews of the program are essential to assess its effectiveness, identify opportunities for improvement, and ensure the continued efficient use of public resources. The review framework is designed to draw primarily on existing public hospital and health system data.

The relevant Commonwealth, State or Territory health agency must conduct:

- an interim review of the program no later than 18 months after program commencement; and
- a comprehensive review at the conclusion of each contract term, and at intervals of no more than three years thereafter.

Reviews must be conducted using data held by, or accessible to, Commonwealth and state and territory health departments, and must not impose any additional reporting obligations on participating private hospitals beyond those specified in the Data Collection, Reporting and Management section of this framework.

Public Hospital Data Audit

Each review must include a structured audit of relevant public hospital data, which must assess:

- changes in elective surgery wait times at referring public hospitals over the review period, including movement across urgency categories;
- the volume and classification of surgical procedures referred to the program, and any corresponding reduction in public hospital surgical lists; and
- emergency department presentation rates for conditions amenable to elective surgery, as an indicator of the consequences of deferred care;

The data audit must be based on data already held within existing public hospital reporting systems, including the National Hospital Morbidity Database and the Elective Surgery Waiting Times Data Collection and be completed and reported to participating health ministers within 90 days of the end of each review period.

Review Outcomes

Following each review, the relevant Commonwealth, State or Territory health agency must prepare a Review Report in consultation with contracted private hospitals and only with the mutual agreement of the APHA that:

- assesses program performance against the key performance indicators established at program commencement;
- identifies procedural categories, geographic areas, or patient cohorts where the program has delivered the greatest benefit or where unmet need remains;
- makes recommendations regarding the continuation, expansion, modification, or cessation of any element of the program; and
- is tabled before the relevant Commonwealth and state or territory health ministers and published publicly within 30 days of completion.

Where a review identifies and recommends any change to the standard-form contract, all private hospitals, regardless of whether they are contracted or not under the relevant state or territory

program, must be consulted with for a minimum period of four (4) weeks. Following this, the relevant Australian government will produce a regulatory impact analysis (where relevant) in accordance with best practice guidance from the Commonwealth Office of Impact Analysis (OIA) as it may exist from time to time.

Any changes may only come into force 90 days after the completion of the consultation and OIA process.

Principles of Review

In conducting each review, the program reviewer must have regard to the following principles:

- reviews must be evidence-based and draw on objective, verifiable data from public health system sources;
- the administrative burden on participating private hospitals must be kept to a minimum, and private hospitals must not be required to produce data beyond that submitted in accordance with their routine reporting obligations under this framework;
- review findings must be used constructively to strengthen the program and the broader public-private partnership; and
- the review process must be transparent, with findings made publicly available in a timely manner

2.8 DATA COLLECTION

A robust strategy for the collection, analysis, reporting, and management of data is critical to adequately measure program outcomes and ensure transparency in program administration. It is also important to have such a strategy in place to allow for the identification of successes and areas for improvement over the course of the initiative.

Data Collection Requirements

Participating public hospitals must collect and record, at minimum, the following data in respect of each public patient treated under the program:

- patient demographics, including age, sex, and residential postcode;
- the nature and classification of the surgical procedure performed, recorded in accordance with the Australian Classification of Health Interventions (ACHI);
- the referring public hospital and health service and the private hospital to which the patient has been referred;
- the date of referral, date of acceptance, and date of surgery;
- pre-operative wait time, calculated from the date of listing to the date of surgery;
- length of stay and discharge destination;
- clinical outcomes, including any complications, unplanned readmissions within 28 days, and adverse events; and
- patient-reported outcome and experience measures (PROMs and PREMs), collected in accordance with a nationally consistent methodology.

The referring public hospital must, subject to the verification and approval of the discharge hospital, submit collected data to the relevant data administrator as determined by the relevant jurisdiction:

- on a quarterly basis, within 28 days of the end of each reporting quarter; and

- at the conclusion of each contract term, in the form of a final program report addressing outcomes against agreed key performance indicators.

The data administrator must consolidate and report program data to the relevant Commonwealth and state or territory health departments on a biannual basis, and must publish a de-identified annual program report made available to the public.

Data Standards and Interoperability

All data collected under the program must be recorded and transmitted in accordance with:

- the National Health Data Dictionary, as maintained by the Australian Institute of Health and Welfare (AIHW);
- applicable data security standards under the Privacy Act 1988 (Cth) and the Australian Privacy Principles; and
- any additional data standards determined by the data administrator in consultation with participating states and territories.

Where practicable, data systems used by participating public hospitals must be interoperable with existing private hospital reporting infrastructure to minimise duplication and administrative burden.

Use of Data

Data collected under this framework must be used to:

- assess program performance against key performance indicators, including reductions in surgical wait times, patient outcomes, and cost-effectiveness;
- inform ongoing program design, including the identification of procedure types, patient cohorts, or geographic areas where the program can be expanded or improved;
- support workforce and infrastructure planning across the public and private hospital sectors; and
- contribute to the national evidence base on public-private contracting in healthcare.

Data must not be used for purposes other than those specified in this framework without the informed consent of the patient or as otherwise required by law.

Governance and Oversight

An independent data governance committee, comprising representatives of the Commonwealth, participating states and territories, private hospital operators, and consumer advocates, must be established to:

- oversee compliance with data collection and reporting obligations;
- review and assess annual program reports;
- make recommendations to the data administrator on program improvements; and
- escalate material compliance failures to the relevant health minister.

Review

The data strategy must be reviewed no later than two years after program commencement, and at intervals of no more than three years thereafter, to ensure it remains fit for purpose and reflects best practice in health data governance.

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