The Future of Australia's Private Hospitals: Reforms to Support Innovation in Healthcare

Final Report

Prepared by Deloitte Access Economics for Ramsay Health Care

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Disclaimer

This 'The Future of Australia's Private Hospitals: Reforms to Support Innovation in Healthcare – Final Report' (**Report**) has been prepared by Ramsay Health Care Limited ACN 001 288 768 (**Ramsay**) to facilitate discussion on the structural challenges facing the private hospital sector and proposes a suite of policy reform options that seek to address such challenges. The Report is partly in response to the Federal Health Departments proposed Private National Efficient Price (PNEP).

The Report reflects the views of Ramsay and its subsidiaries (together, the **Ramsay Group**) and has been informed by analysis conducted by Deloitte Access Economics. The reform proposals outlined in this Report are intended to strengthen private hospital viability while preserving market flexibility and appropriately balancing government and private sector objectives.

The analysis outlined in this Report has considered the views and implications of stakeholders across the system and recognises the potential for varying perspectives on some policy initiatives; however, it aims to optimise value at the system level.

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Why Australia's Private Healthcare System Needs Reform

Private hospital sustainability is core to Australia's leading public-private health system

Australia's high-performing health system relies on a structured public–private model. Around 45% of Australians hold private hospital cover, and private hospitals deliver 70% of elective surgery while also contributing $14 billion to GDP. Private hospitals relieve pressure on the public system, support patient choice and timely access, sustain regional services, enable specialist practice, and contribute to workforce development and clinical innovation.

However, the private hospital sector is under pressure:

- While Australians have kept hospital cover, downgrading has continued. Silver is now the most popular level of cover, impacting mental health and maternity services in particular
- Workforce shortages are constraining capacity in key service lines
- Labour, energy and medical supply costs are rising
- Price indexation is not keeping pace with costs; insurer payout ratios have fallen from ~88% to 84%. Payout ratios have recently improved to 86% however this is still below pre-pandemic levels.

Private Health Insurer (PHI) market concentration is increasing, with two large insurers holding approximately 50% market share and expanding into service provision. PHI sector profits have increased while private hospital sector profits have declined.

Margin compression is limiting access to capital needed to reconfigure capacity and invest in digital infrastructure to drive productivity through better connectivity across providers, government, insurers, consumers and specialists. It is also constraining investment in infrastructure modernisation and clinical innovation.

Looking ahead, there are opportunities to strengthen the system:

- Digital and AI adoption to connect healthcare services, reduce administrative burden, and deliver ~$5 billion in system-wide benefits
- Care model innovation to extend and integrate care beyond hospital settings, enabled by technology and funding reform.

Proposed suite of reforms to support health system innovation and private hospital sustainability

1. Integration and System Efficiency

1.1. Lead a Ministerial process to establish muti-year public-private collaboration and contracting.

2. Fair Bargaining

2.1. Establish mandatory code of conduct for the sector
2.2. Develop a national framework of minimum standards for contract conditions
2.3. Redesign the application of the second-tier default benefits policy
2.4. Introduce a mandated minimum hospital benefit payout ratio.

3. Transparency for Consumers

3.1. Improve affordability and predictability for consumers through a review of the design and operation of tiered products
3.2. Ensure risk equalisation settings support product affordability
3.3. Establish clear funding pathways to scale proven clinical innovations and contemporary models of care across private hospitals and PHIs
3.4. Increase transparency of specialist fees and PHI policy coverage.

4. Foster Innovation

4.1. Establish dedicated 'innovation funding' mechanisms to incentivise clinical innovation and productivity across the health system, particularly through digital transformation
4.2. Improve private hospital access to, and certainty of Research and Development (R&D) tax incentives
4.3. Modernise Medicare Benefits Schedule benefit arrangements to incentive practitioners to work at full scope of practice and to enable innovative models of care
4.4. Enable 'patient centric' health data interoperability, through sector wide adoption of modern secure digital standards including open Electronic Health Record (EHR).

5. Right Skills

5.1. Remove barriers to entry for the medical and nursing profession to increase supply
5.2. Extend existing funding and training pathways for medical specialist and nurse practitioner training
5.3. Expand specialist college rotational training pathways across public and private hospitals
5.4. Align funding for nursing salaries with public sector Enterprise Bargaining Agreement (EBA) increases and/or Fair Work Commission value case or increased rebates to consumers to support affordability during transition.

Sustained impact requires system-level value optimisation and coordinated reform. Government leadership is needed to progress a system-wide reform agenda, engage industry and clinical stakeholders, and steward the long-term sustainability of Australia's mixed public–private health system.

The Future of Australia's Private Hospitals: Reforms to Support Innovation in Healthcare

Australia's world-class health system is founded on a unique and delicate balance between public and private hospital providers. Private hospitals are integral to overall system capacity, responsiveness and performance.

The Critical Balance: Australia's Public–Private Health System

The Australian health system is designed to achieve **equitable health outcomes through timely access to safe, high-quality and affordable care** delivered within a mixed public–private model (1). Maintaining this **optimal balance is essential** to preserve access, choice and system capacity, and to avoid the pressures seen in more polarised models such as the United Kingdom or United States of America (2,3).

International benchmarking indicates that Australia performs strongly against these objectives. The Commonwealth Fund's 2024 *Mirror, Mirror* report (4) assessing ten high-income health systems including Canada, Germany, Switzerland and the United Kingdom, ranks Australia among the leading overall performers across access, care processes, administrative efficiency, equity and health outcomes. Strong performance in administrative efficiency and equity reflects the integration of universal public coverage with complementary private provision, while population health outcomes such as life expectancy amenable to healthcare remain among the strongest in the comparator group.

The private hospital sector:

Relieves pressure on the public hospital system. Private hospitals provide significant system capacity, accounting for around 40% of admissions and about 70% of planned surgery (5). By managing elective and non-urgent care, they reduce pressure on public waiting lists and enable public hospitals to focus on emergency and complex care.

Enhances patient choice and timely access. Alongside Medicare, private hospitals provide greater choice of clinician and often faster access to treatment including for many in rural and regional areas by maintaining a regional presence. This supports patient-centred care while maintaining universal access to the public system (6).

Enables medical specialists to practise. Nearly half of all medical specialists practise in the private sector, often across both public and private settings (7).This dual practice model supports medical workforce attraction, flexibility, skill development and system resilience.

Supports workforce training and development. Private hospitals contribute to workforce sustainability through training in nursing, allied health and specialist medicine, often in partnership with public hospitals, universities and colleges (8). This role is increasingly important amid workforce shortages and increasing treatment complexity.

Drives innovation in care models and technology. Private hospitals invest in new technologies, specialised equipment and care models (9). Innovations introduced in private settings often diffuse across the wider health system, reducing the need for governments to bear the full upfront investment costs.

The sector's value is reflected in the significant health, economic, and social benefits it delivers.

Private hospitals play a vital role in delivering safe, high-quality care as well as driving economic growth and reducing pressure on the public health system.

Private Hospitals: Driving Growth and Relieving Public Pressure

The private hospital sector is a major and growing contributor to Australia's economy and health system capacity. Employment has expanded from around 108,000 in 2010–11 to more than 154,000 in 2023–24 (Figure 1), reflecting sustained growth across clinical and non-clinical roles and reinforcing the sector's role as a significant national employer.

Economic contribution has also nearly doubled, increasing from $7.8 billion to $14.0 billion (0.55% of GDP) over the same period (Figure 2), highlighting the sector's role as a driver of economic activity and growth.

At the same time, private hospitals play a critical role in reducing pressure on the public system by providing additional capacity and supporting shorter wait times. Policies such as the Private Health Insurance (PHI) rebate help sustain participation in private cover, delivering clear system-wide benefits.

Each one percentage point increase in PHI coverage (around 280,000 people (4)) is associated with approximately $401 million in avoided public hospital costs, or $1,434 per insured person per year (5). This demonstrates how a strong private sector directly supports public system sustainability.

Figure 1. Growth in private hospital employment (1)(2)

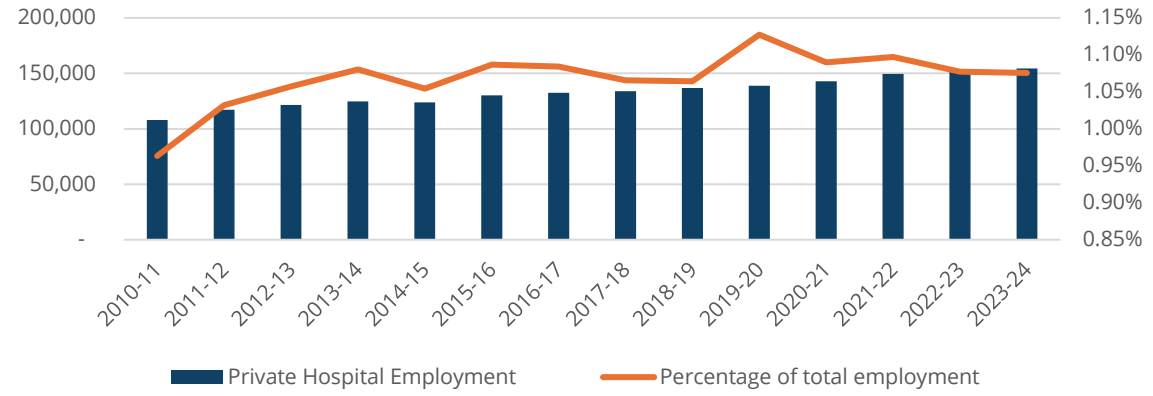
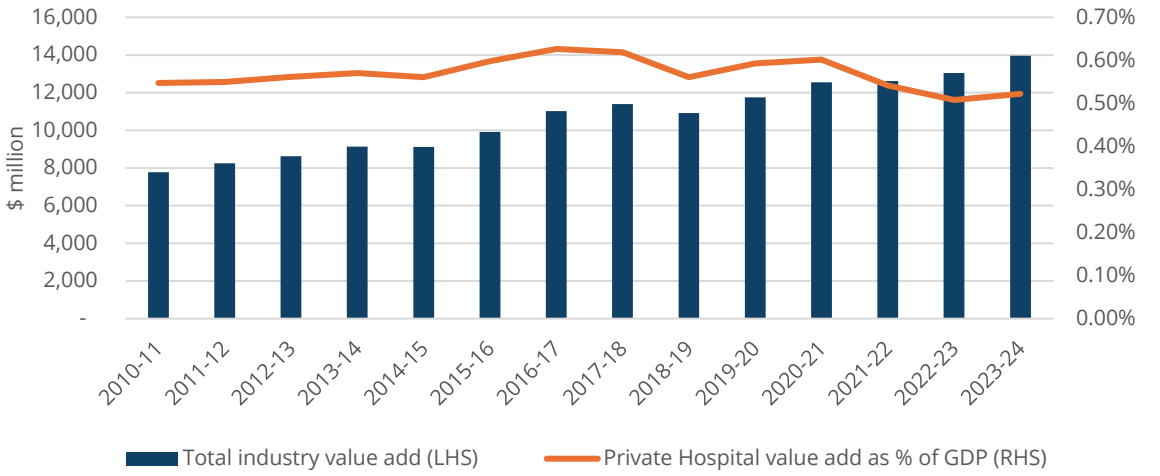


Figure 2. Private hospital value add as a % of GDP (1)(3)



*2023-24 current prices (from ABS), therefore increase in industry value add reflects nominal growth (both increase in activity and price inflation).

The private hospital sector is now facing declining total sector profit, driven by structural pressures impacting demand and financial pressures constraining access to capital.

Market Shifts and Emerging Financial Fragility

Across the sector, Earnings Before Interest, Taxes, Depreciation, and Amortisation (EBITDA) margins have declined since 2019-20, whilst total sector operating profit before tax has decreased to -$34 million in 2023-24 (refer to Figure 3). The **average sector EBITDA margin** in 2023-24 (5%) **is lower than margins required** for sector viability and investment, with an increasing number of private providers making lower returns in recent years.

The **2024 Department of Health, Disability and Ageing (DoHDA)** ***Financial Health Check*** (1) identified variability across the private hospital sector, with **differences in provider characteristics influencing profitability and the sustainability of returns**. Key trends include:

Falling EBITDA margins: Nearly all reporting hospitals saw EBITDA drop from 8.7% (2018-19) to 4.4% (2022-23), with sector-wide estimates at 7–8% in 2022-23. Margins varied significantly by hospital type.

Hospitals with negative returns: DoHDA estimates that approximately 33% of reporting private hospitals* generated negative returns in 2023-24 (Q2), increasing from ~12% of hospitals in 2017-18 (refer to Figure 4).

*Private Hospital Sample submissions to the department (provided by 243 out of 647 hospitals).

Increasing margin stress: After adjusting for activity levels and case mix, underlying cost growth rose at a compound annual rate of 4.1%, compared with revenue growth of 2.9% between 2018-19 and 2021-22.

Service and workforce strain: Workforce shortages and financial pressure have driven service closures, including over nine private hospitals closing maternity wards and two maternity services in recent years.

Figure 3. Measures of hospital profitability EBITDA and operating profit before tax and margins between 2018-19 and 2023-24 (2)

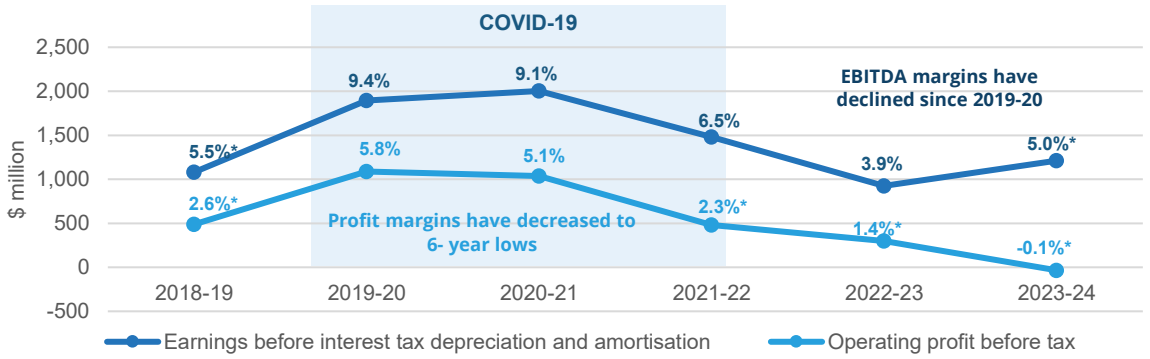
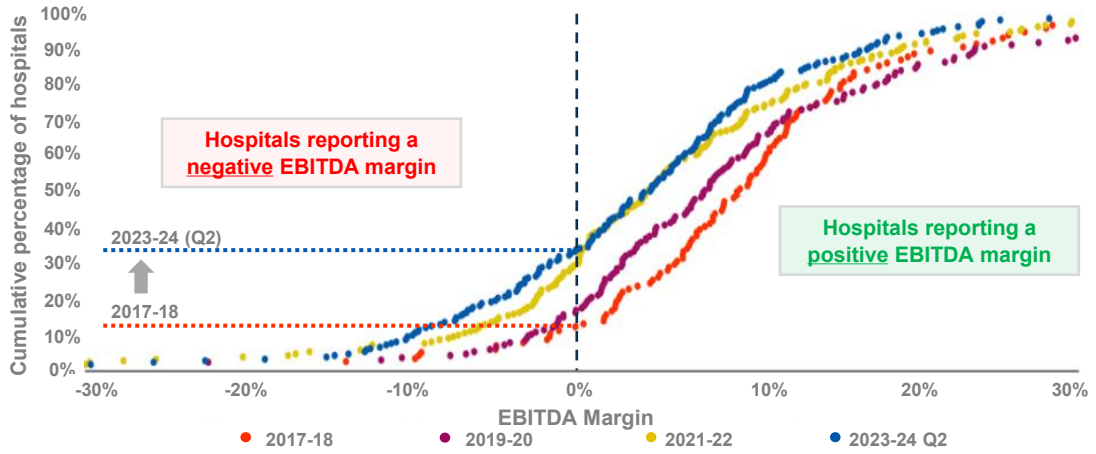


Figure 4. EBITDA margins of private hospital sample between 2017-18 and 2023-24Q2 (1)



Demand growth faces two major bottlenecks: constrained referral pathways due to reduced general practitioner attendances and initial specialist consultations, and reduced gold-tier coverage among existing members.

Slower Growth in Demand For Private Hospital Services

Demand for private hospitals has largely recovered to pre-pandemic levels, however the growth rate has decreased (refer to Figure 5), with constrained growth in referral volumes (General Practitioner (GP) attendances and specialist appointments) key driving factors.

Slower growth in GP and specialist attendance volumes has constrained referral pathways for private hospitals. Private hospital demand is influenced by the referral pathway, specifically GP attendances and specialist referral activity. GP attendances, the entry point to specialist and private hospital care, have grown by 6.1% between 2018–19 and 2024–25 (CAGR 1.0%), but this reflects a deceleration relative to pre-pandemic trends and has not kept pace with population growth. Similarly, while total specialist consultations have increased by 13% (CAGR 2.0%), growth in initial specialist attendances has declined, indicating weaker conversion from GP referrals (2).

Further demand restrictions are supported by evidence that 10-20% of people referred to a specialist in 2022-23 have delayed or cancelled appointments due to affordability concerns (3).

Concurrently, the total number of consumers with hospital insurance coverage has grown. Between September 2020 and September 2025, total hospital insurance memberships have increased by over one million members (refer to Figure 6) (4).

However, at the same time, **members are downgrading policy coverage,** shifting towards lower-tier products. The **proportion of gold tier policies has declined** from 38.7% to 28.5% between June 2020 and September 2025 (359,500 decrease in membership) (4). Key factors for policy coverage changes include affordability pressures (3), rising incidence of product phoenixing (5), rising exclusionary policies (4) and extended waiting periods (6).

Figure 5: Total private hospital separations (same day and overnight), actual and projected (1)

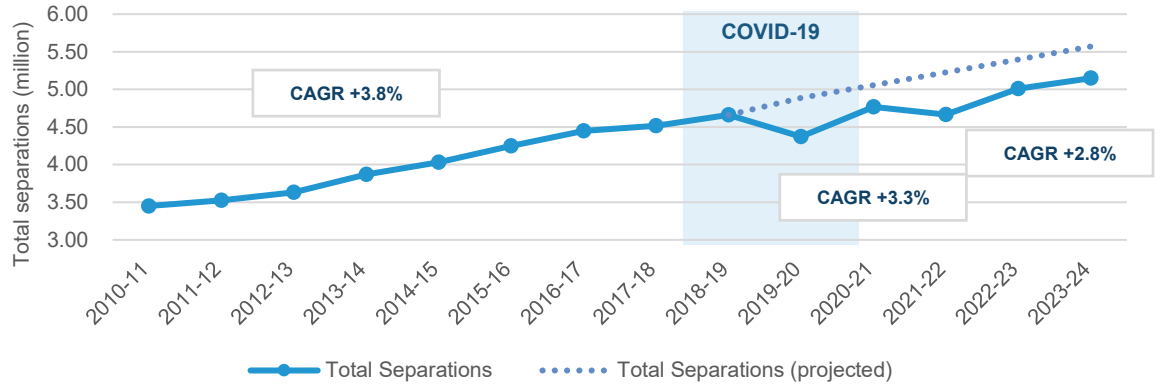
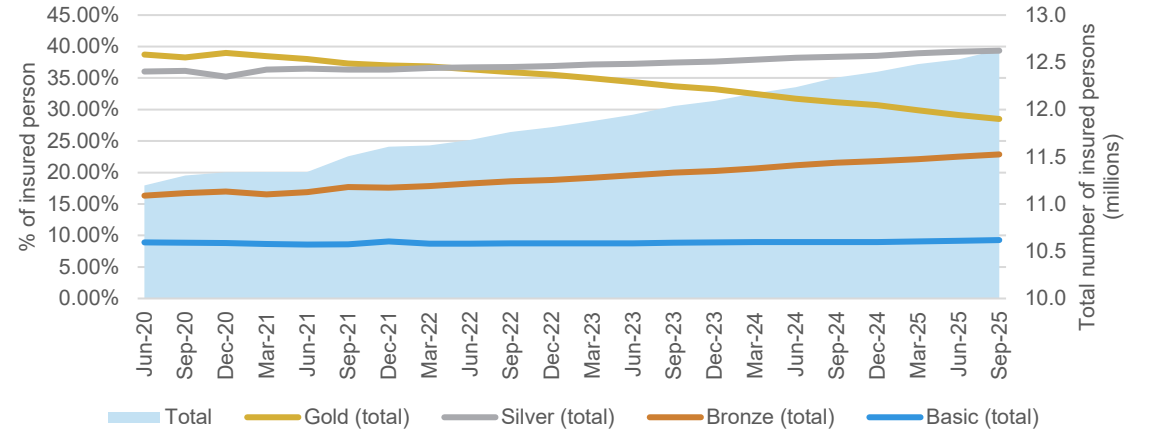


Figure 6: Total hospital policy growth and shift in policy tier coverage between June 2019 and June 2025 (4)



These pressures exist within a structurally complex and interdependent system in which funding, pricing signals and service decisions are distributed across governments, PHIs, medical specialists, consumers and private hospital providers.

Private Hospital System Stakeholders and Interdependencies

Private hospitals operate within a structurally interdependent system in which funding, regulation, clinical autonomy and consumer choice intersect. The key objective across these relationships is to sustain access to privately delivered hospital care while containing public expenditure and maintaining affordability for consumers (1). In practice, this objective is pursued through negotiated contracts, regulatory oversight and blended funding arrangements that distribute both risk and influence across stakeholders. The system does not operate through a single purchaser–provider dynamic; rather, it functions most effectively as an integrated ecosystem where coordination, and at times constructive tension between insurers, government, specialists and consumers strengthens performance and accountability (see Figure 7).

1 **Government.** As regulator, the Government (including through the Australian Prudential Regulation Authority (APRA)) administers risk equalisation and prudential standards to support community rating and insurer solvency. As demand driver, it uses the means-tested PHI rebate and related policies to support participation and affordability (2). As funder, Medicare payments to specialists and the rebate link Commonwealth expenditure to private hospital activity. These roles can create policy tension: regulatory measures to constrain premiums may limit insurer revenue and hospital payments, while efforts to reduce fiscal exposure may affect affordability and demand. Government decisions therefore influence insurer behaviour, specialist incentives, consumer choice and hospital viability.

2 **Insurers.** PHIs purchase hospital services for members at agreed cost through negotiated contracts that set episode payments, prostheses benefits and service inclusions (3). Bundled funding can promote efficiency but shifts financial risk to hospitals when costs rise faster than reimbursement (4). Market concentration amongst PHIs and bargaining power affect pricing outcomes, making hospital revenue and investment sensitive to contracting settings and premium approvals.

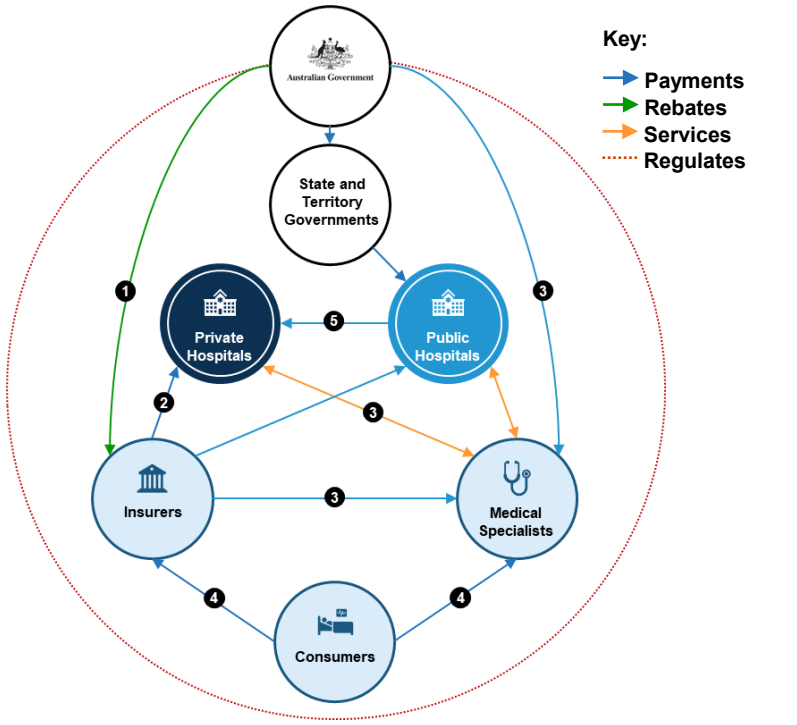
3 **Medical Specialists.** Medical specialists drive private hospital activity through referral and treatment decisions, supported by a blended remuneration model of MBS payments, insurer benefits and patient contributions known as 'out of pocket' costs (4,5). While preserving clinical independence, changes to Medicare settings, fees or affordability directly affect hospital throughput and case mix.

4 **Consumers.** Consumers fund the system through premiums and out-of-pocket payments and choose their PHI, specialist and hospital. Their behaviour shapes competition and provider networks but depends on affordability and coverage rules set by policy.

5 **Public Hospitals.** Public hospitals interact with the private sector through shared workforce, patient flows and funding pressures. Changes in private hospital affordability or capacity can shift demand to the public system, affecting waiting times and resources.

Collectively, no single actor controls demand, funding or pricing. Private hospital sector sustainability depends on the interaction of government policy, insurer purchasing, specialist decisions and consumer affordability, making the system sensitive to changes in any one component.

Figure 7. Key market relationships in the private hospital system

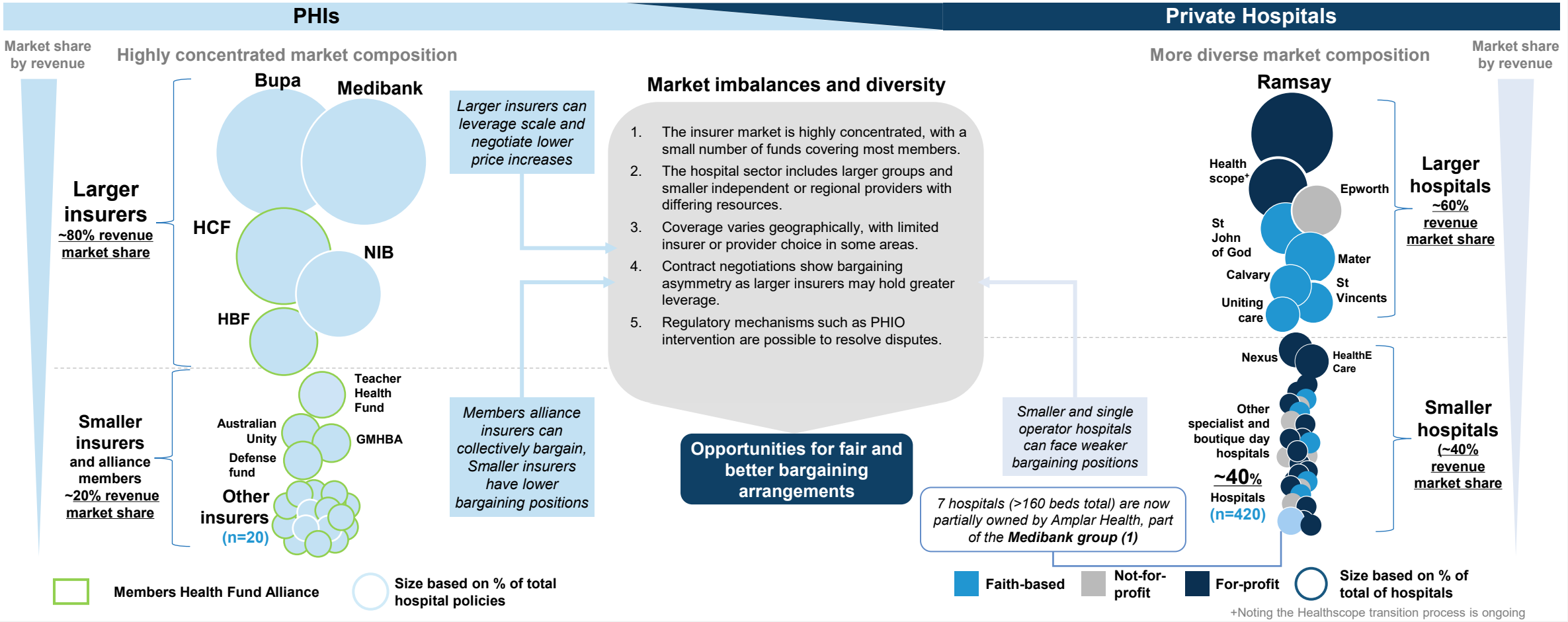


Source. Deloitte Access Economics. 2026.

Within this system, government policy, regulatory settings and private health insurance arrangements shape providers' ability to manage viability pressures. The insurer market is more concentrated which may impact negotiations, particularly with smaller hospitals.

Policy and Bargaining Dynamics Shaping the Sector

Figure 8: Schematic of market dynamics between PHIs and private hospitals (1)



Current system dynamics can result in stakeholders focus being drawn away from efforts focused on improving consumer outcomes. Providers, insurers, and administrators spend considerable time managing contractual disputes, administrative requirements, and pricing negotiations. This absorbs capacity that could otherwise be directed towards improving patient care, service quality, and system efficiency.

Current incentives and payment models mean funding flows are not reaching where they are needed to support services for insured patients, with PHI premium growth falling behind both insurer expenses and hospital cost growth.

Misaligned Incentives and Funding Flows

Since the pandemic, a growing financial imbalance has emerged between PHIs and private hospitals. The hospital benefits payout ratio represents the total amount paid to private hospital operators as a percentage of total revenue ($) collected by PHIs in hospital insurance premiums.

- These ratios have fallen from approximately 88% pre-pandemic to 84.3% in 2024-25 (see Figure 9). While the latest available data shows that hospital payout ratios have recently improved to 86%, they are yet to recover to pre-pandemic levels.
- Using 2024-25 hospital treatment premium revenue levels ($23 billion), this represents approximately $830 million annually not reaching hospitals.

Smaller and regional hospitals are likely faring worse than national averages suggest.

PHI premium revenue has grown faster than benefits paid in recent years, contributing to increased insurer profitability. Between 2020-21 and 2024–25, total premium revenue increased by an average of 4.9% annually, compared with 4.6% growth in benefits paid (refer to Figure 10).

Since 2017–18, the relative profitability of PHIs and private hospitals has diverged, with PHIs capturing an increasing share of combined system profits (refer to Figure 11).

- PHIs are generating a relatively higher share of sector profits, accounting for 65% of total profits in 2023-24, compared to 50% of total sector profits in 2017-18. Total PHI sector before tax profits for 2024-25 was recorded to be approximately $2.7 billion (1).
- Total sector PHI profit increases have been driven through hospital insurance, investment returns and expansion into new businesses.

Figure 9: Health Insurance Business (HIB) management and net margins and hospital treatment benefits payout ratios between 2016-17 to 2024-25) (1)

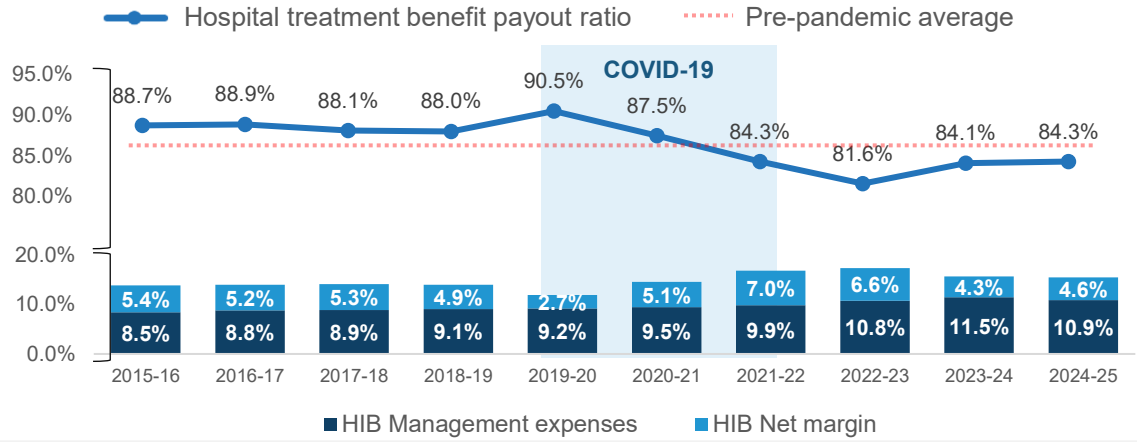


Figure 10: Indexed growth in premium revenue and insurance benefits paid since 2017-18 (1)

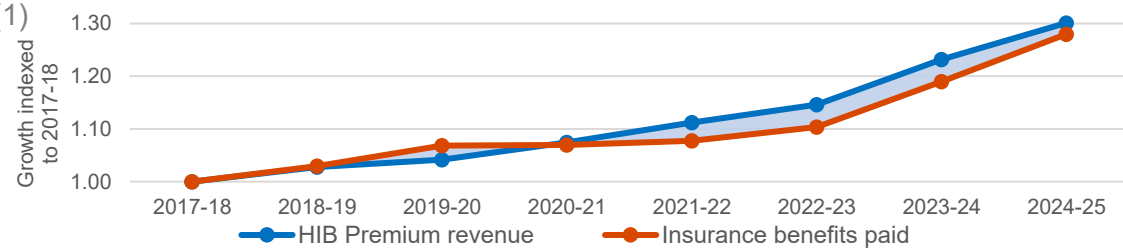
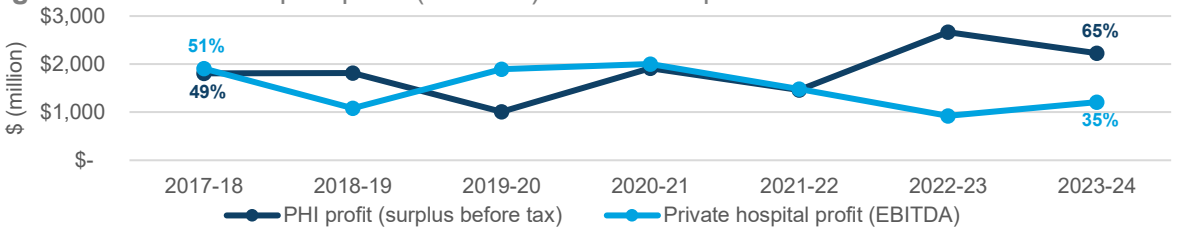


Figure 11: Private hospital profit (EBITDA) and PHI surplus before tax since 2017-18



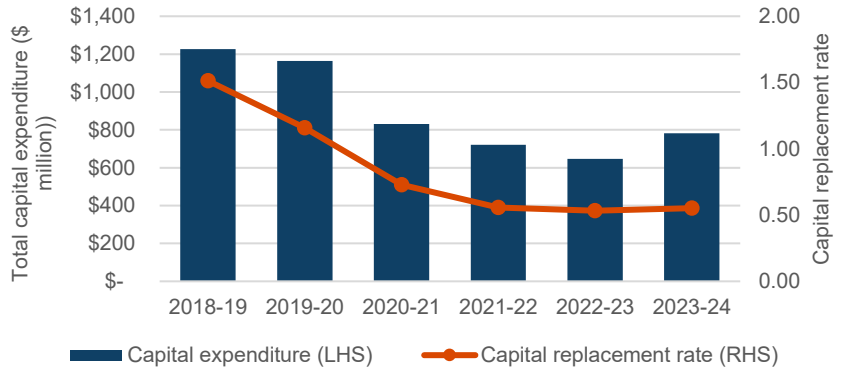
** During 2019-20, a rise in private hospital EBITDA values may be due to COVID-19 related government payments.*

In the context of structural pressures and market dynamics, it is increasingly difficult for private hospitals to access the capital required to support investment in digital technology essential to drive efficiency and productivity gains between hospital providers, government, PHIs, consumers and medical specialists.

Structural Pressure

Restricted access to affordable capital, combined with rising cost pressures, has led to a sustained decline in capital replacement rates from $1.2b to $0.8b over the same period, signaling a deterioration in the private hospital sector's ability to reinvest in critical infrastructure (refer to Figure 12). These financial constraints are reducing the sector's capacity to expand procedural services, limiting innovation, and increasing reliance on ageing facilities.

Figure 12: Total capital expenditure and capital replacement rate between 2018-19 and 2023-24 (2)



Digital Investment Gap

The Productivity Commission estimates that improved integration of digital technologies across healthcare could deliver more than $5 billion annually in efficiency gains, including reduced hospital stays and fewer duplicated tests (1).

Capital constraints are delaying or preventing investment in essential digital infrastructure needed for modern care delivery through:

- Electronic medical records
- Digitally connecting health providers, medical specialists, insurers, government and consumers
- Interoperability and data-sharing platforms
- Automation and analytics systems
- Cyber security and data governance capability
- Advanced diagnostics and digital-enabled care.

Many providers are unable to fund upgrades required to participate fully in national digital health initiatives such as My Health Record.

Australia's digital health ecosystem remains fragmented, with patient data often held across multiple disconnected systems operated by individual providers.

System Impact

Digital capability has significant productivity benefits:

- Integrated digital records reduce duplicate testing and administrative tasks
- Interoperable systems streamline referrals, discharge summaries and clinical documentation
- Automation and AI could automate up to 30% of healthcare tasks, freeing time spent on patient care.

Without adequate digital investment, specialists will continue to spend significant time on administration, information sharing across hospitals will remain limited and care will continue to be fragmented, delaying system-wide productivity gains. These limitations also reduce the sector's ability to adopt emerging models of care that rely on digitally-enabled coordination (refer to page 14).

Globally, healthcare delivery is undergoing structural transformation as care shifts beyond traditional hospital settings, while Australia's private hospital sector remains largely anchored to admitted care under current funding arrangements.

Changing Models of Care

Health care delivery is shifting away from hospital-centric models towards care delivered across community, ambulatory, virtual and home-based settings (1). Advances in digital health, data analytics and remote monitoring are enabling care to move upstream into prevention and early intervention and downstream into rehabilitation and chronic management (refer to Figure 13). Care is increasingly coordinated across a longitudinal patient journey rather than concentrated within a single hospital admission, with virtual consultations, hospital-in-the-home and day procedures reducing reliance on inpatient infrastructure.

However, much of the financing architecture for private hospitals including PHI benefit design, Medicare arrangements and contracting frameworks continues to prioritise hospital activity. As a result, the Australian private hospital sector remains positioned in the middle of the care pathway, heavily reliant on acute and non-admitted episodes with limited capacity to expand into prevention, primary care or long-term chronic disease management.

In the short term, demand for hospital-based services such as complex elective surgery, rehabilitation and mental health care is likely to grow. Over time, however, performance will increasingly depend on integration across the broader care pathway. Without broader funding mechanisms that enable participation beyond the acute episode, the sector risks becoming structurally constrained as the system's centre of gravity shifts elsewhere.

The Evolving Role of PHIs

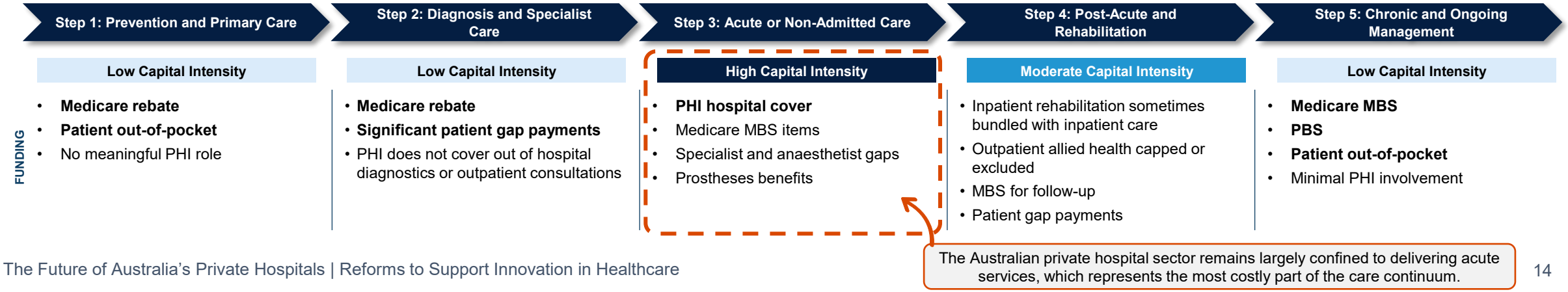
Australian PHIs are responding to these changes by extending their presence across the care continuum. To remain relevant in a more integrated system, some insurers are expanding beyond traditional hospital cover into primary, preventative and home-based services. While this reflects a strategic shift towards earlier intervention and out-of-hospital care, it has also potentially placed the insurers in competition with hospitals. For example, Medibank has developed direct healthcare provision through its investment in MyHealth (2) and Amplar Health division (3), including acquisition of the Better Medical GP network, while Bupa has built networks of medical and mental health clinics alongside dental and optical services (4). Medibank has also directly invested in private hospital services. These developments blur traditional payer–provider boundaries and reflect structural as well as technological change.

Case Study

Emerging hospital-in-the-home models illustrate both the opportunity and the challenge. For example, Ramsay Home Health Virtual Heart Failure Service uses remote monitoring technology and virtual consultations with specialist nurses to support patients with chronic heart failure at home. This technology-enabled approach delivers high-quality, lower-cost care while actively reducing hospital utilisation and preventable readmissions (5,6). The model is funded on a case-by-case basis where private health insurers agree to support participation.

The Virtual Heart Failure Service exemplifies modern care delivery models that align with core system objectives of preventing avoidable admissions and empowering consumer choice. Crucially, this service provides a highly adaptable blueprint that could be scaled and extended across a wide range of therapeutic areas.

Figure 13. Private hospitals remain anchored to admitted care



Sustainable reform of the private hospital sector requires coordinated, system-wide action. Addressing the sector's structural challenges demands a multi-faceted, practical and balanced reform approach that strengthens viability while enhancing overall system performance.

The Case for Structural Reform

Policy reform is needed to sustain the private hospital sector and its role in the broader health system. Reforms should strengthen the value of private health insurance for consumers, address unequal bargaining dynamics between hospitals and insurers, support investment in digitisation and enable private hospitals to participate in emerging models of care. Given the sector's role in elective surgery capacity, regional access and system flexibility, these reforms are essential to maintain viability and support the sector's evolution.

Principles for Policy Reform

Given the complexity of the private hospital sector, no single intervention will resolve the challenges outlined in this report. Meaningful reform will require a coordinated suite of actions implemented over time. Accordingly, the policy reforms presented on the following pages should be considered based on the following guiding principles:

- **Practical.** Reforms must be feasible to implement within current institutional, fiscal and political constraints, and broadly acceptable to key stakeholders.
- **Multifaceted.** Sector performance is shaped by highly interrelated dynamics between insurers, providers, consumers and governments; no single change alone will deliver sustained improvement.
- **Net positive.** Each reform should deliver an overall benefit for consumers, the health system and the economy, even where transition costs or trade-offs arise.
- **Balanced.** As a package, reforms should work together to manage disruption and support sector stability during implementation.
- **Productivity.** Reforms should enable increased quality of health care outcomes in Australia while improving sector efficiency and effectiveness.

Together, these principles recognise that sustainable improvement depends on a coherent set of mutually reinforcing actions designed to strengthen viability while safeguarding access, quality and overall system performance.

Policy Reform Categories

Policy reforms are grouped into five categories based on shared themes:

1. INTEGRATION AND EFFICIENCY

2. FAIR BARGAINING

3. TRANSPARENCY FOR CONSUMERS

4. FOSTER INNOVATION

5. RIGHT SKILLS

Together, these reform categories aim to strengthen private hospital viability, improve system performance, and preserve the critical public–private balance in Australia's health system.

Limitation of the Development of Policy Reforms

The reforms presented on Pages 16–22 are high-level and subject to further development. Additional detail will be required to assess full impacts and implementation complexity, and stakeholder support will depend on final design. Implementation timeframes will likewise vary based on policy specifications.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

1. INTEGRATION AND EFFICIENCY – Partnership with public hospitals to better utilise existing capacity

Policy Reform	Rationale
1.1 **Lead a Ministerial process to establish multi-year public–private system-wide agreements.** These agreements would plan service activity to focus on using excess capacity in the private system for public patients to reduce the need for Government investment in further public hospital infrastructure. Providing certainty for infrastructure investment, workforce recruitment, and operational planning. For example, this may be modelled on the National Partnership on COVID-19 Response or build from the Queensland Surgery Connect model.	Coordinate existing capacity investments across both the private and public hospital sectors to optimise the use of existing infrastructure and reduce the need for governments to fund new facilities. This should include consideration of privately insured admissions in public hospitals, noting that many privately insured patients will continue to access public hospitals regardless of insurance status, particularly for emergency and high-acuity care. Under this approach, multi-year public–private partnerships would replace short-term, variable arrangements that currently limit providers' ability to plan capacity, workforce and supply chains. Longer-term agreements would enable coordinated service planning, provide investment certainty and strengthen resilience across the mixed public–private hospital system. Leveraging private capacity will support lower wait times in the public hospital system for planned surgery, and potential exists to work together to reduce ED waiting time on co-located sites. Further opportunities exist to consider the role private hospital capacity can play in reducing bed block in public hospitals due to a lack of capacity in aged care.

2. FAIR BARGAINING – Reforming pricing and regulation to support fair bargaining

Policy Reform	Rationale
2.1 **Establish a mandatory code of conduct for the sector.**	A mandatory code of conduct would clearly define the rules governing industry participants, including private hospitals, insurers and medical specialists, and mitigate the impacts of imbalances in size, market power and resources.
2.2 Develop a **national framework of minimum standards.**	Building on Policy Reform 2.1, a national framework would reduce variation in contracting processes between private hospitals and insurers, establishing clearer and more consistent negotiation parameters.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

2. FAIR BARGAINING – Reforming pricing and regulation to support fair bargaining	
Policy Reform	**Rationale**
2.3 **Redesign the application of the second-tier default benefits policy** (currently set at 85% of each PHI's average contracted rate), for example: • Increase the fallback percentage while maintaining the current structure • Introduce an independently determined fallback reference rate where no contract exists • Apply higher rural and regional differential fallback rates to support service provision in thin markets. Pricing reform could be accompanied by: • Enhanced gap guardrails (e.g., strengthening of informed financial consent and limits on gap multiples) • Payment timeliness standards during fallback periods • Structured dispute resolution processes.	Within the current system, the second-tier default benefits policy provides a relatively low dollar value fallback payment when providers and insurers are out of contract, increasing providers' exposure to revenue loss during contracting disputes. Strengthening the fallback mechanism would reduce reliance on continuous contracting and limit the disruption associated with out-of-contract periods, while also reducing administrative burden. A higher fallback rate would moderate the ability of PHIs to exert pressure through contracting dynamics and provide greater payment reliability for providers treating privately insured patients. This is particularly important for smaller and regional private hospitals, where service viability can be more sensitive to revenue uncertainty.
2.4 Introduce a mandated **minimum hospital benefit payout ratio** from PHIs to fund the cost of care delivery provided by private hospitals without increasing premiums.	PHI hospital benefits payout ratios have declined from 88% pre-pandemic (2017–18 to 2018–19) to 84% in 2024–25, while PHI profitability has increased by 28% and private hospital profits have fallen. Introducing a mandated minimum benefits ratio has been proposed by stakeholders (e.g., APHA, AMA) as a mechanism to rebalance value distribution across the sector. Examples include Medical Loss Ratio under US *Affordable Care Act*. Such a policy would need to account for variation in individual PHI hospital payout ratios, differences in management fee structures, and APRA requirements regarding retained earnings. Alternative approaches to rebalancing value capture may focus on mechanisms that enable PHIs and private hospitals to partner on innovation in clinical models and should be considered separately.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

3. TRANSPARENCY FOR CONSUMERS – Supporting consumer needs through modernising products and payment transparency	
Policy Reform	**Rationale**
3.1 **Improve affordability and predictability for consumers through a review of the design and operation of tiered products (gold, silver, bronze, basic).** The review should aim to identify and address unintended consequences such as exclusions (e.g., obstetrics coverage restrictions), access barriers (e.g., "Plus" and "Junk" policies) and admission-time disputes. Benefits eligibility, coverage settings and minimum benefit requirements should also be considered.	Tiered products are often opaque, leaving consumers unclear about their entitlements. Reviewing their design would improve accessibility and predictability of care by aligning products with contemporary service delivery and clarifying inclusions. Reassessing legislative settings that define eligible services and restrict non-admitted models would reduce exclusions and disputes, strengthen transparency, and support affordability and system sustainability.
3.2 Ensure **risk equalisation settings support product affordability** and higher levels of cover without blunt cross-subsidisation.	The risk equalisation system is crucial to upholding the principle of community rating. Updating risk equalisation settings for services that are currently under pressure, such as obstetrics, would enable coverage to be offered at levels other than Gold (e.g., Silver), improve affordability for a larger number of consumers and support the long-term sustainability of vital services.
3.3 Establish clear **funding pathways to scale proven clinical innovations and contemporary models of care across private hospitals and PHIs**, including transitioning successful pilots into standard arrangements and extending pooled funding for chronic, complex, and community-based care to reduce admissions. For example, further application of time-limited default benefits payments for out-of-hospital services.	Establishing clear funding pathways would enable private hospitals to scale proven innovations and contemporary models of care, supporting a shift from time-limited pilots to standard funding arrangements. Insurers are also moving beyond their traditional role as purchasers of hospital services, taking a more active role in care delivery, utilisation management and population health including developing out-of-hospital models such as hospital-in-the-home to reduce costly admissions. These insurer-led services are not uniformly available to all patients, and clearer policy settings would allow private hospitals to align with and complement these initiatives. This would strengthen cross-sector coordination, accelerate uptake of lower-acuity care models and reduce avoidable admissions in a more sustainable and structured way.
3.4 Increase **transparency of specialist fees and PHI policy coverage**, to reduce uncertainty around consumer out-of-pocket expenses and insurance coverage for specific procedures and increase the likelihood of consumers utilising private hospital services (e.g., by extending the Commonwealth Medical Costs Finder).	Improved transparency of specialist fees and out-of-pocket costs may positively influence access to consultations and follow-up care, shaping referral patterns, hospital throughput and case mix. Clearer disclosure of fees and PHI coverage would reduce financial uncertainty, support informed consent and increase consumer confidence, strengthening utilisation of private hospital services.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

4. FOSTER INNOVATION – Redesigning payment mechanisms to accelerate productivity and innovation	
Policy Reform	**Rationale**
4.1 **Establish dedicated 'innovation funding' mechanisms to incentivise clinical innovation and productivity across the health system, particularly through digital transformation** (electronic medical record, interoperability, automation, data platforms, cybersecurity) and infrastructure renewal and reconfiguration. For example, this could mirror international approaches such as the US Health Information Technology for Economic and Clinical Health (HITECH) Act, which provided incentives to accelerate electronic health record adoption. A proportion of PHI payments could be specifically allocated for innovation funding. Legislative reform to the scope of services covered by PHIs could include requirement to consider payments for innovation and transformation.	Transformation initiatives will underpin productivity and future efficiency as well as long-term transformation in line with global trends in health care delivery. Digital capability and infrastructure renewal require upfront capital that many providers, particularly smaller and regional providers, cannot fund within existing operating margins. Establishing dedicated co-funded or pooled mechanisms would allow for or accelerate interoperability, data sharing and cyber resilience, enabling models of care and productivity gains that benefit the broader system. Insurance legislation and associated rules prescribe the types of services that may be covered by PHIs, including eligibility for benefits, minimum benefit requirements and exclusions for non-admitted or alternative models of care. This could be extended to require PHIs to consider innovation and transformation in hospital payments.
4.2 **Improve private hospital access to, and certainty of R&D tax incentives** for **eligible health research, clinical trials**, technology adoption, and service innovation activities, strengthening the role of private hospitals as partners in clinical innovation. Given private hospital's partnerships with specialists and significant percentage of patient care in the health system, private hospitals are well-positioned to contribute to innovation. This could include extending eligibility for R&D tax incentives beyond trial providers to hospitals that incur the costs of conducting clinical trials and providing greater clarity that innovation activities including digitally enabled care redesign, integrated care pilots and service transformation can meet the R&D threshold.	Improving private hospital access to, and certainty of, R&D tax incentives would encourage greater private hospital participation in clinical trials, technology adoption and service innovation, unlocking a sector that has often lacked the capital to engage at scale. Extending eligibility to hospitals that incur the costs of clinical trials would better recognise the role hospitals play in enabling and delivering clinical research and would enhance the sector's ability to promote world-leading innovative therapies and care models. Additionally, providing clearer eligibility and stable settings may reduce investment risk, attract research partnerships and capital, and strengthen the role of private hospitals as active contributors to Australia's highly regarded research environments. Note: The Australian Government has undertaken a *Strategic Examination of Research and Development,* with recommendations submitted in March 2026. These findings should be leveraged to ensure private hospitals are well positioned to benefit from any reforms to R&D incentives, consistent with the report's identification of health and medical research as a key national innovation pillar.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

4. FOSTER INNOVATION – Redesigning payment mechanisms to accelerate productivity and innovation	
Policy Reform	**Rationale**
4.3 **Modernise MBS benefit arrangements** and other payment mechanisms to incentivise practitioners to work to their full scope of practice and in hospital settings to deliver care in line with contemporary care models.	There are multiple opportunities to review how the MBS incentivises both medical specialists and other workforces in a private hospital setting, including targeted reforms in mental health and more broadly across other specialties. As a mental health–specific example, these include providing incentives for psychiatrists to deliver consultations in inpatient settings, with fee arrangements that better reflect the complexity of care compared to outpatient services; enabling inpatient and hospital-in-the-home telehealth consultations in private hospitals; introducing incentives for in-hospital nurse practitioners, including for therapeutic services and mental health consultations; and applying regional loadings to attract practitioners to regional hospitals.
4.4 **Enable 'patient centric' health data interoperability, through sector wide adoption of modern secure digital standards including open EHR.**	Enabling patient-centric health data interoperability across Australia's health system would address persistent fragmentation by allowing secure, real-time sharing of clinical information between providers, reducing duplication, delays, and inefficiencies. This reform would improve care quality and system sustainability while strengthening privacy, consent management, and public trust in digital health.
5. RIGHT SKILLS – Enhancing workforce access and capabilities	
5.1 **Remove barriers to entry for the medical and nursing workforce to increase supply.** For example, remove the 10-year moratorium on overseas-trained specialists (e.g., psychiatrists and other priority specialties) to expand the local Visiting Medical Officer (VMO) workforce, strengthen nursing supply in areas such as maternity and mental health, and implement reforms to enhance rural workforce access.	Workforce constraints particularly for small, regional and rural providers, and within key professions such as maternity and mental health nursing place significant limitations on service capacity, access and patient throughput. Reducing regulatory and structural barriers to workforce entry would increase supply, improve service continuity, especially in thin or high-demand markets, and support timely access to care, strengthening system sustainability. There is a specific opportunity to increase the capacity of public and private mental health inpatient services, which are currently constrained by limited psychiatrist availability for inpatient work despite significant and growing community demand.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

5. RIGHT SKILLS – Enhancing workforce access and capabilities	
Policy Reform	**Rationale**
5.2 **Extend existing funding and training pathways for specialist and Nurse Practitioner training within private hospitals** to recognise their critical service role and scope and support future supply of VMOs and advanced practice clinicians. For example, extending funding of the Private Hospital Training and Support program and the Specialist Training Program to provide flexible, role-based funding and remuneration for supervision can support trainee access and workforce supply, while expanding shared training with public hospitals particularly in specialties like orthopaedics where some procedures such as arthroplasties are predominantly delivered in the private sector. Meanwhile, offering regional placements would help to sustain continuity of care in both metropolitan and regional areas.	Private hospitals deliver a substantial share of procedural and planned care, yet training pathways remain concentrated in the public system. Expanding specialist and Nurse Practitioner training in private settings would better align workforce development with service delivery patterns, support future VMO and advanced practice supply, and strengthen capacity in high-volume specialties and regional markets.
5.3 **Expand specialist college rotational training pathways across public and private hospitals**, including regional placements, to strengthen workforce supply and distribution. This would involve establishing shared education programs, cross-sector rotations, joint supervision arrangements and infrastructure-for-workload exchanges across the public and private systems. Such models would expose trainees to high-volume private sector case mix, enable VMOs to supervise across settings, and support regional placements aligned with national workforce priorities, including underserved Aboriginal and Torres Strait Islander communities. Implementation could include additional funding for training places under the Private Hospital Training and Support program and the Specialist Training Program, as well as explicitly funded positions in the public sector to facilitate joint placements, particularly in regional or co-located hospitals.	Cross-sector rotational pathways would help to better align workforce training with service delivery patterns, support more equitable trainee distribution and strengthen regional supply. Shared education and supervision arrangements would build capacity across both sectors while improving continuity and skills transfer.

Policy reforms focus on stimulating system integration across public and private hospitals, fair bargaining, enhancing transparency of insurance products and payment mechanisms, digital and clinical innovation to drive productivity and building workforce capabilities.

5. RIGHT SKILLS – Enhancing workforce access and capabilities	
Policy Reform	**Rationale**
5.4 **Align funding for nursing salaries with public sector EBA increases** and/or Fair Work Commission value case, through a federal commitment to fund a proportion of wage growth, enabling private hospitals to remain competitive with the public system and stabilise the workforce.	Wage gaps between public and private hospitals risk workforce attrition, further reliance on agency staff, and reduced service capacity. Government support can offset public-sector wage increases to help maintain competitiveness and could stabilise nurse supply in the private hospital sector, particularly for regional and smaller providers, thereby protecting system capacity.

While all policy reforms are necessary to address the private health sector's challenges, no single measure will be sufficient on its own. Ensuring the long-term viability of the private health sector therefore depends on the development and implementation of a coordinated suite of reforms.

Prioritisation and Sequencing of Policy Reforms

The reform agenda includes 17 different policy reforms, covering a wide spectrum of areas - from integration with public hospitals and fair bargaining, to transparency, innovation, and workforce skills. The breadth of reforms reflect the complexity of the issues at hand and while every reform plays a part, no single measure can resolve the sector's structural problems alone. Without a coordinated suite of reforms, there is a significant risk that incremental or narrowly targeted interventions will fail to stabilise the sector.

Some reforms are relatively straightforward and less controversial, such as strengthening workforce pathways or improving transparency for consumers but on their own, these low-impact, low-complexity changes will not 'move the dial' on sector viability. Others, like redesigning default benefits, or mandating minimum benefit payout ratios, are more complex and likely to face resistance from certain stakeholders. However, these more complex reforms are essential for addressing the root causes of current market distortions and ensuring long-term stability.

Private health reform also creates an opportunity to reconsider how premium dollars are deployed across the system. Redirecting a greater share of funds toward system capability, such as digital infrastructure, workforce investment, or care coordination, may deliver greater long-term value than returning funds to customers through rebates when claims are lower than expected. Strategic reinvestment of premium revenue could support productivity improvements, better workforce conditions, and stronger integration across the healthcare system.

If the difficult reforms are avoided, the risk is missing the larger benefits that only systemic reform can deliver.

Coordinated Implementation Benefits

When implemented together, the reforms are designed to reinforce each other, delivering incremental and, in some cases, non-linear benefits that improve access, system stability, and sector sustainability. Specifically:

PHI and private hospital relations

Policy Reforms 2.1–2.3 would be most effective as a coordinated package, collectively strengthening the oversight and rules needed to support fair bargaining between private hospitals and PHIs. Together, they would create a coherent system of clear rules, minimum safeguards, and independent oversight, reduce negotiation asymmetry, improve transparency, and strengthen revenue stability.

Modernising PHI products

Policy Reforms 3.1 and 3.2 aim to address complementary aspects of PHI product design and would be most effective when implemented together. Product reform without risk equalisation may increase premiums or reduce insurer participation, while risk equalisation changes alone may not improve access or affordability. Coordinated implementation would align incentives, funding flows, and product structures, and support sustainable demand while maintaining insurer viability.

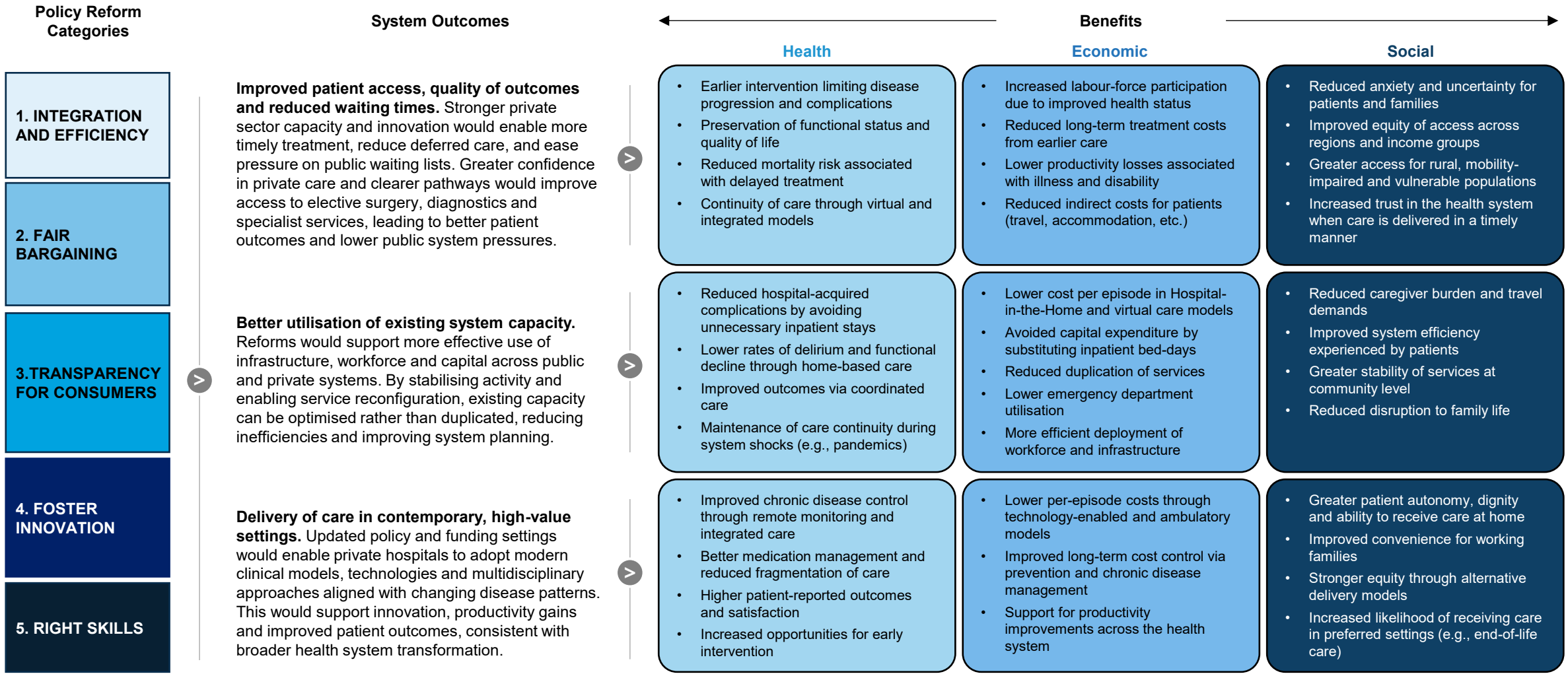
Mutually Exclusive Reforms to Increase PHI Payments to Private Hospitals

Policy Reforms 2.4 and 4.1 aim to strengthen the financial capacity of private hospitals but do so in different ways:

- *Policy Reform 2.4 — Minimum benefits payout ratio:* Aims to increase general revenue flowing to hospitals by redistributing existing premium income from insurers, providing flexible funding that providers may allocate according to operational priorities.
- *Policy Reform 4.1 — Dedicated transformation funding mechanisms:* Aims to provide targeted funding for specific purposes such as clinical innovation, digital transformation, infrastructure renewal, and productivity improvements.

Together, the five policy reform categories translate into measurable health, economic and social benefits through improved access, better use of existing system capacity and delivery of care in contemporary, high-value settings.

Benefits to the System



Achieving these outcomes will require government leadership to enable reform and build consensus across stakeholders, recognising differing perspectives while optimising value at the system level.

Government Leadership to Enable Reform

While many stakeholders recognise the need for change, collaboration across the private health sector remains a challenge. Addressing the sector's structural challenges will require more coordinated and constructive engagement between stakeholders including private hospitals and insurers, focused on outcomes that support the long-term sustainability of the system and the interests of consumers.

Government leadership is essential to engage and align stakeholders, maintain momentum, reform existing policy settings, and ensure system outcomes are achieved in the interests of consumers (refer to Figure 14).

Private Hospital Sector-led Policy Reforms

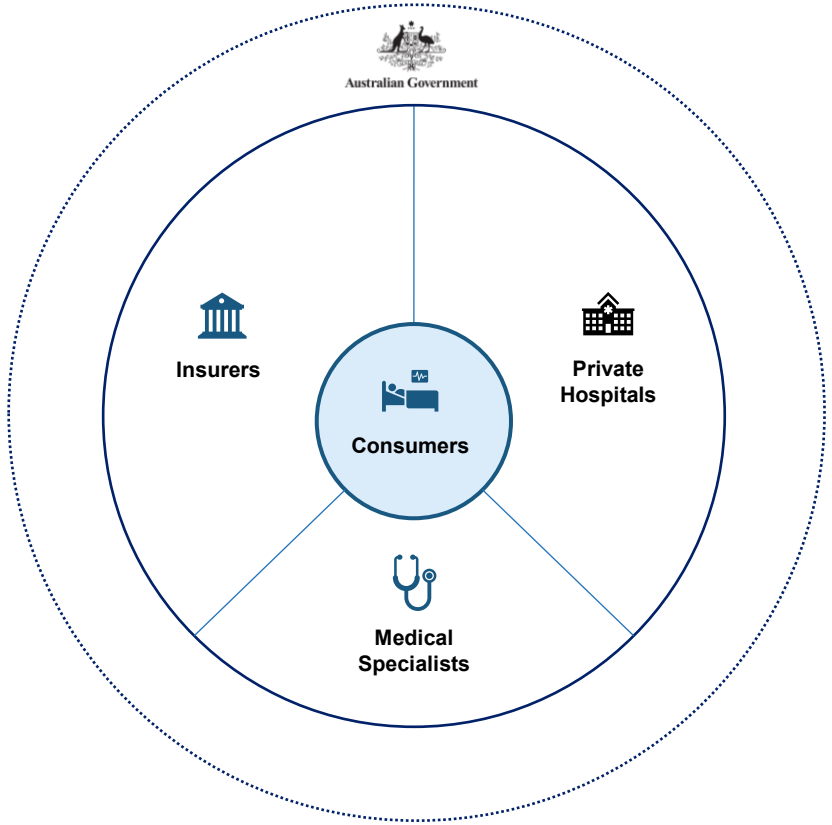
Some reforms could be progressed through greater alignment and commitment within the sector itself, particularly those aimed at improving conduct and transparency in contracting arrangements. For example, Reform 2.1 establishing a mandatory code of conduct or Reform 2.2 a national framework of minimum standards could help create clearer expectations around contracting behaviour and information sharing.

Government-led Policy Reforms

Many other reforms require government leadership because they involve legislative change, regulatory settings, or funding arrangements under public control, or because they affect stakeholders whose interests cannot be realigned without public intervention.

Sustainable improvement will therefore require a coordinated reform program supported by government leadership, structured stakeholder engagement and active system stewardship. Strengthening collaboration across the sector will be essential to maintaining the integrity, performance and consumer value of Australia's mixed public–private healthcare system.

Figure 14. System dynamics for executing policy reform



Appendix A: References

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A.1 Benefits Quantification | Page 24 (1/2)

A complete list of sources comprised of peer-reviewed literature and major national and international policy reports are shown below to support the quantifiable benefits of the private hospital system presented on Page 24.

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Sources Related to Quantification of Economic Benefits

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- New South Wales Ministry of Health. (2018–2022). *Integrated Care Strategy — Evaluation Reports.*

A.1 Benefits Quantification | Page 24 (2/2)

A complete list of sources comprised of peer-reviewed literature and major national and international policy reports are shown below to support the quantifiable benefits of the private hospital system presented on Page 24.

Sources Related to Quantification of Social Benefits

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