OPTIONS TO SUPPORT VIABILITY FOR AUSTRALIA'S PRIVATE HOSPITAL SYSTEM

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Foreword

The Australian healthcare system has long been recognised as a global leader, balancing public, and private care to deliver exceptional outcomes for patients. However, the viability of the private hospital sector, a cornerstone of this hybrid model, is under significant threat. Financial pressures, evolving care models, and rising operational costs are challenging the sustainability of private hospitals, with potential ripple effects on the public system.

This paper outlines a pathway to safeguard the future of Australia's private hospital network through three key pillars: operational efficiency, a National Public-Private Hospitals Partnership, and a renewed agreement between private health insurers and hospital operators.

The challenges are complex, but the opportunities for reform are clear. By acting decisively, we can preserve the strengths of our healthcare system and secure its future for all Australians.

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The viability of Private Hospitals in Australia is under threat which could have a significant impact on delivery of health services for patients in both the Private and Public Hospital Systems.

The Australian model has historically been a global leader, but new financial pressures and a shift in models of care are disrupting and placing Private Hospital operators under pressure.

Three key solutions to mitigate the challenge include (1) a focus on operational performance and maximising existing assets and capital, (2) establishing a new Comprehensive National Partnership Model between Public and Private providers with 4 different options being outlined and a (3) new agreement between private health insurers and private hospital operators.

Introduction:

The recent financial collapse of Healthscope, while based on unique failures, is nevertheless a forewarning of emerging challenges to the broader private hospital system. This in turn poses risks of flow on with negative impacts to the already stressed public system.[1] The private system has been a fundamental pillar of Australia's health system and has been critical in supporting Australia's public hospital system, and any significant impact on the private will therefore impair the public as well.

In order to sustain the private hospital model going forward, it is therefore time to consider the treble response of more efficient private hospital operations and asset management, a National Public Private Hospitals Partnership and a new Private Health Insurers and Private Hospitals Agreement. Without implementing such responses, the risk increases of a failure of the private hospital system, leading to significant impact on the public hospital system and ultimately bringing risks to patient care.

Australia's health system was recently ranked number one in the world for its performance during the pandemic by the Commonwealth Fund in New York. The evidence behind this was substantiated in the Lancet Journal last year, which published results from the Global Burden of Disease Study, with over 11,000 public health researchers contributing. The Lancet reported an average loss of global life expectancy from the start of 2019 to the end of 2021 as minus 1.6 years. In the United States, the loss of life expectancy was 2.0 years. In Australia, by contrast, life expectancy rose by 0.2 years during the pandemic.[2] This continues to be an astonishing national achievement.

To many people however, it may seem counterintuitive that we have the number one ranked health system in the world. Hospital waiting lists for elective surgery have grown (Queensland alone is 62,727 as of May 2025), emergency department bypasses and ambulance ramping (waiting time for ambulance patients to see a Doctor in Emergency Departments) have increased and bulk billing has fallen from 88.5 percent to 77.7 percent or by nearly 11 percent since mid-2022.[3] The system is under pressure and as highlighted by some of the most recent Federal Government announcements, there is a need to reduce the costs on Australians and pressures on the State Health Systems.

However, every health system around the world is under pressure. It just happens that the Australian hybrid model of public and private shared care has arguably but factually performed better than almost any other system. Our Australian Health system is neither like the US largely private model with its soaring peaks but significant inequality of access, nor like the UK's, NHS which is facing ongoing degradation by almost every measure, is in crisis with performance and productivity declines, ballooning costs and waiting lists, in addition to reports of workforce shortages and plummeting staff morale.

Nevertheless, the singular feature of Australia's health system which gives it a clinical operational advantage, the hybrid partnership of public and

private hospitals, is under threat and needs reform. In that context, the collapse of Healthscope is not a stand-alone event, as also seen by the closure of up to eight private maternity units including Darwin, Hobart and Cairns.[4] It is widely assumed that the purchasers paid too much for Healthscope and there may have been less than perfect management, but there are also structural changes that are occurring in terms of decreasing trends for bed nights in long stay hospitals, increased use of day and low acuity facilities due to improved clinical outcomes, and increasing cost and reimbursement pressures which are placing material burdens on private long stay hospitals in general.

The October 2024 Commonwealth Department of Health and Aged Care Private Hospital Financial Viability Health Check concluded very simply: "The private hospital sector is an important part of the Australian health system, offering patient's choice, providing the hospital sector additional capacity and a complimentary workforce for public hospitals."[5]

Indeed, the Australian Private Hospitals Association "Private Hospital Viability: Immediate Response to Crisis" paper of November 2024 warned that: "The Private Hospital sector is at a critical stage. It is experiencing threats to viability, sustainability and investment. If the trends illustrated in this paper continue, they will have a greater adverse impact on private hospitals and force the sector to write off capacity to service privately insured patients. It may become unviable for many hospitals to continue operation."[6]

This warning has sadly come to pass not only with the risk to Healthscope's operation but other closures that have occurred or are foreshadowed.

The system wide consequences of a decay or failure of significant parts of the private hospital sector in Australia were expressly addressed by the APHA paper: "Without a robust private hospital sector, the objective of sharing the public health burden across the public and private pillars of the system cannot be realised."[7] In short, there would be loss of choice, increased public and private wait times, loss of jobs, increased public sector costs and perhaps even more importantly, significant risks to quality of care and medical innovation.[8]

Fortunately, there is a pathway forward over the next five years based on three key actions. First, a focus on running a fiscally and productive core business that maximises existing investments, assets and workforce to drive returns that enable the ongoing financial base and viability of operations.

Second, a National Public and Private Hospital Partnership which could include any and all of 4 different models. In essence both systems need each other and the lessons of both the 2017 and 2021 reforms and the 2020 Covid Viability Partnership can be applied now to a long term public private hospitals partnership which will strengthen both systems.

Third, there is also the opportunity for a renewed Private Hospitals and Private Health insurance Partnership which builds on the 2017 and 2021 reforms.

The sustainable viability and success of the private hospital network is therefore everyone's business. The Commonwealth Government, States, the public and private hospitals, private health insurers and both public and private hospital patients are all invested in the success of the private hospital system.

[1]https://economictimes.indiatimes.com/news/international/new-zealand/healthscope-in-critical-condition-inside-the-collapse-of-australias-second-biggest-private-hospital-network/articleshow/121408289.cms?from=mdr

[2]The Lancet, Global age-specific mortality, life expectancy, and population estimates in 204 countries and territories and 811 subnational locations, 1950–2021, and the impact of the COVID-19 pandemic: a comprehensive demographic analysis for the Global Burden of Disease Study 2021 (Report, 11 March 2021)

[3]The Commonwealth Department of Health and Aged Care, National Accounts for Medicare Bulk Billing to 31 December 2024 (10 Feb 2024)

[4]Why HealthScope maternity closures are an 'absolute crisis' and a symptom of a bigger problem - ABC News (21 Feb 2025)

[5]The Commonwealth Department of Health and Aged Care, Private Hospital Financial Viability Health Check (October 2024)

[6]Australian Private Hospitals Association, Private Hospital Viability: Immediate Response to Crisis (Nov 2024)

[7]Australian Private Hospitals Association, Private Hospital Viability: Immediate Response to Crisis (Nov 2024)

[8]Australian Private Hospitals Association, Private Hospital Viability: Immediate Response to Crisis (Nov 2024)

Section 1: The Australian Model

In order to understand the reforms which may underpin the sustainability of the Australian Private hospital system, it is necessary to understand the role of Private Hospitals in the Australian health system and the challenges they are facing.

The Australian Private Hospital system provided 41.2 percent of all hospital admissions in 2022/23 and 70 percent of all elective surgeries.[9] As of July 2024, these procedures and admissions were carried out in 647 private hospitals, although there have been some closures and openings since. Taken together, there were over 5 million admissions and procedures in a private setting in 2021/2022.[10]

The simple summary is that with over 40 percent of all hospital admissions and 70 percent of elective surgeries, the private hospital sector is fundamental not just to the viability but also to the central running of the Australian health and hospital system. Australia has a true hybrid model relying on both the public and private hospital systems.

Underpinning the Australian private hospital system is a strong private health insurance model.

The latest Australian Prudential Regulation Authority (APRA) Quarterly data shows that after a period of decline prior to 2017, following the 2017 Commonwealth reforms, private health insurance with hospital cover rose from 45.1 percent in June 2018 to 45.3 percent at the end of the March quarter in 2025. In real terms this represents an increase of over 1.2 million covered Australians from 11.25 million to 12.48 million.[11]

General private health insurance, or extras as they are commonly known, also rose from 54.3 percent in June 2018 to 55.1 percent in March 2025. This represented an increase of over 1.6 million people covered from 13.5 million to 15.1 million.[12]

The takeaway is that contrary to some reports, private health insurance has consolidated through two rounds of reform in 2017 and 2021. Covid also arguably contributed to an increase in awareness of health and the value placed on access to health coverage.

There are however competing value propositions at work with regards to uptake of PHI.

On the one hand, the cost-of-living crisis has placed added pressure on people's ability to afford private health cover, while the comparatively high quality of our public health system has raised further questions about the value of private health for some. On the other hand, increasing public health waiting lists, the Medicare levy surcharge for higher income earners and the private health insurance rebate for lower income earners have all acted as incentives to take up private health insurance.

The net result though has been a growth in Private Health Insurance (PHI) in real terms and the addition of over 1.2 million people with hospital coverage since the 2017 reforms, which established tiered private health cover as well as adding mental health and rural coverage in return for a deal with the private hospitals and device makers.

[9]The Commonwealth Department of Health and Aged Care, Private Hospital Financial Viability Health Check (October 2024)
[10]The Commonwealth Department of Health and Aged Care, Private Hospital Financial Viability Health Check (October 2024)
[11]APRA, March Quarterly PHI Membership Coverage (29 May 2025)
[12]APRA, March Quarterly PHI Membership Coverage (29 May 2025)

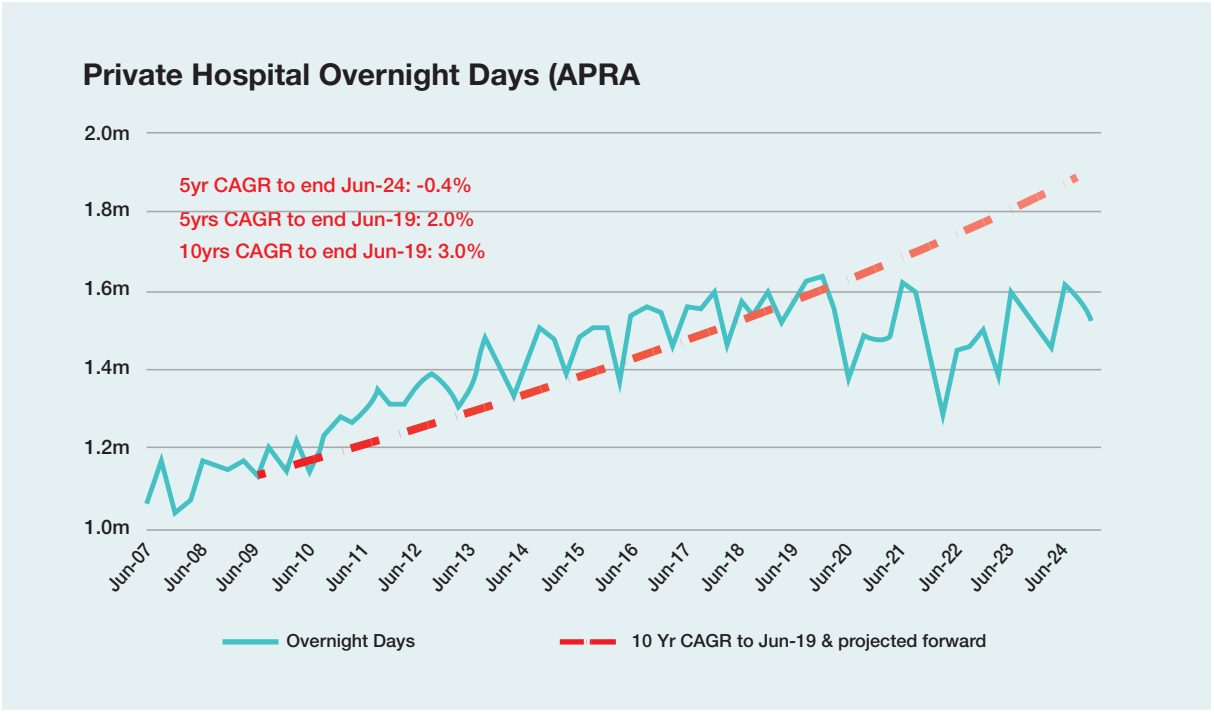
Section 2: Global and Australian Trends and Challenges

Three trends since Covid 19 have however created structural, operational and financial challenges for private hospitals.

First, there has been a shift from private overnight admissions to day procedures across much of the globe. The Commonwealth Financial Health Check found that from 2018/19 to 2022/23 private day hospital admissions had grown by a Compound Average Growth Rate (CAGR) of 2.66 percent. By contrast, overnight admissions grew by a CAGR of 0.22 percent per annum, down from 1.07% over the previous four years.[13] This represents an 80 percent drop in the growth rate of overnight procedures across the respective four-year period – a key revenue and profitability driver for Private Hospitals.

In essence, Covid crystallised and accelerated an underlying global trend: the growing preference for shorter hospital stays, driven by surgical advancements and supported by Telehealth and improved remote monitoring capabilities.

This has translated to stagnant total nights in private hospitals. More recent APRA data and analysis has shown that actual total bed nights dropped from mid-2019 to mid-2024.[14]



Australian Prudential Regulation Authority – Private Hospital Overnight Days Data (through Feb 2025)

[13]The Commonwealth Department of Health and Aged Care, Private Hospital Financial Viability Health Check (October 2024)
[14]APRA, March Quarterly PHI Membership Coverage (29 May 2025)

By June 2024, there was a negative 5-year growth rate of 0.4 percent per annum in actual bed nights in overnight private hospitals across Australia. The consequences for predominantly overnight focussed hospitals were clear, this was a structural change which will likely worsen into the future.

The second major change is the related impact of technology on the nature of both public and private care. In addition to less invasive surgical techniques requiring either shorter stays or day procedures only, Telehealth and remote monitoring are also enabling different methods of care.

Maternity recovery in hotel style accommodation is well established in Australia. Known models include partnerships between Private Hospital Operators and Hotelier groups that are subsidised for low complexity births. It is both lower cost on average than an overnight hospital stay, and in non-complex cases often preferred by patients and their families.

This Medihotel, or Low Acuity model, has been enabled by Telehealth and remote diagnostics, and has now been extended to broader patient cohorts, both around the world and particularly in South Australia and Queensland, with the support from the respective state governments. Operators such as Amplar Health and KNG Health are leading this shift and the trend toward low-cost care for otherwise non-complex but longer staying patients is likely to accelerate.[15] When it is a transfer from public hospitals, it also helps free up beds, thereby reducing public hospital waiting times.

The extension of technology into home based care has already been evident in aged care, with a fivefold increase in medical home care across Australia over the past decade. Building on this, both state governments and private hospitals are now trialing 'hospital in the home' models based on visiting nurses. Greater use of telehealth and the rapid expansion of real time monitoring devices capable of transmitting patient data directly to hospital staff are further supporting this shift. As these technologies become more widespread, 'hospital in the home' is expected to grow both globally and in Australia, fundamentally changing the model of traditional, asset-intensive hospital operations.

While the shift towards day procedures, low acuity and home care models is overwhelmingly positive, developments in patient care and health resource efficiency are also consequential in building financial challenges for individual private hospitals or providers undergoing disruption of traditional models of care.

This leads to the third major challenge, which has been an increase in costs to operate, increases in costs to sustain assets and inflation within hospital delivery. The Commonwealth Health check found an increase in private hospitals expenditure of 4.1 percent per annum from 2018/19 to 2021/22.[16] Updated data from the Australian Private Hospitals Association found that by mid 2023 there had been a five-year average growth in annual expenses of 5.3 percent.[17]

The causes of this growth in costs include growth in wages, growth in cost of materials, general inflation and in the case of Healthscope, heavy rental payments relative to both balance sheet and income.

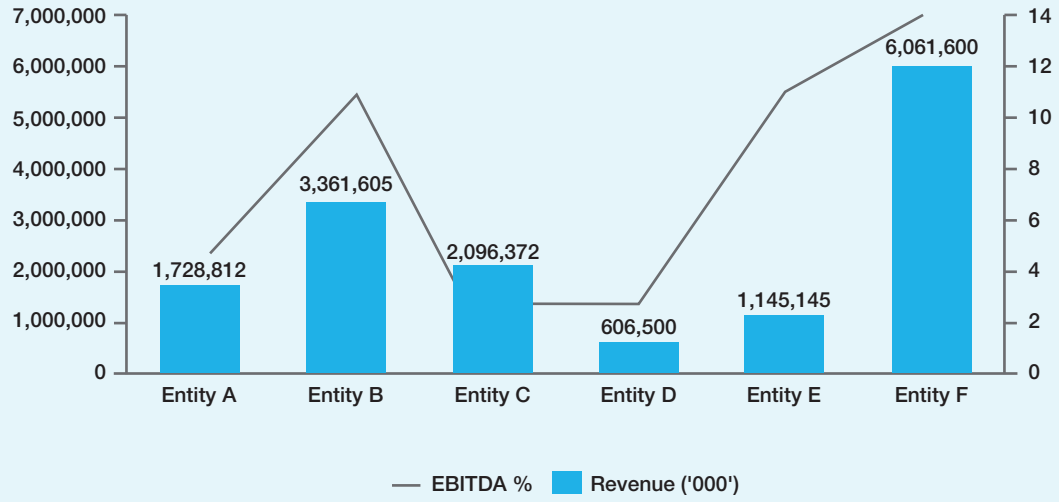
Depending on the Private Hospital operator, the major drivers of expenditure increase, have been both employee related expenses and the requirement to maintain large asset footprints. This is supported by the rise of real wages across Australia including for example the 28.4 percent increase over four years for Victorian Government nurses which in turn the Private Hospitals typically have to meet to be workforce competitive. To put this into perspective, an operator with an EBITDA of four percent would turn a significant loss if they were to match the Victorian Government increases. Additionally, the AHPA asserts that the ongoing maintenance and management of assets generally requires Hospitals to be operating at a 15 percent EBITDA return to remain financially sustainable.

The Commonwealth concluded that the net impact of these challenges was an average growth in private hospital revenue from 2018 to 2022 of 2.9 percent against an increase in costs of 4.1 percent. This in turn contributed to a decline in EBITDA from 8.7 percent to 4.4 percent across known hospitals for which data was supplied. The Commonwealth estimated a broader weighted average across the whole sector, presumably including assumptions about Ramsay Health, of an EBITDA of 7-8 percent, although no data or methods were supplied.[18] Perhaps most importantly it recognised that 33 percent of Private hospitals were already loss making on EBITDA, far from the required 15 percent of profit required to sustain assets and operations.

By contrast, the Private Hospitals Association response outlined a sector wide annual minus 13.5 percent EBITDA from 2018 to 2023 and an annual decay in operating profit before tax of 28.3 percent from $1.5 billion to $300 million.[19] These figures from the Commonwealth imply a sector under stress and the explicit statement of the APHA indicates a sector in crisis.

[15]Public hospital patients treated at Gold Coast hotels - ABC News (August 2024)
[16]The Commonwealth Department of Health and Aged Care, Private Hospital Financial Viability Health Check (October 2024)
[17]Australian Private Hospitals Association, Private Hospital Viability: Immediate Response to Crisis (Nov 2024)

FY24 Hospital Operator Analysis - Revenue and EBITDA

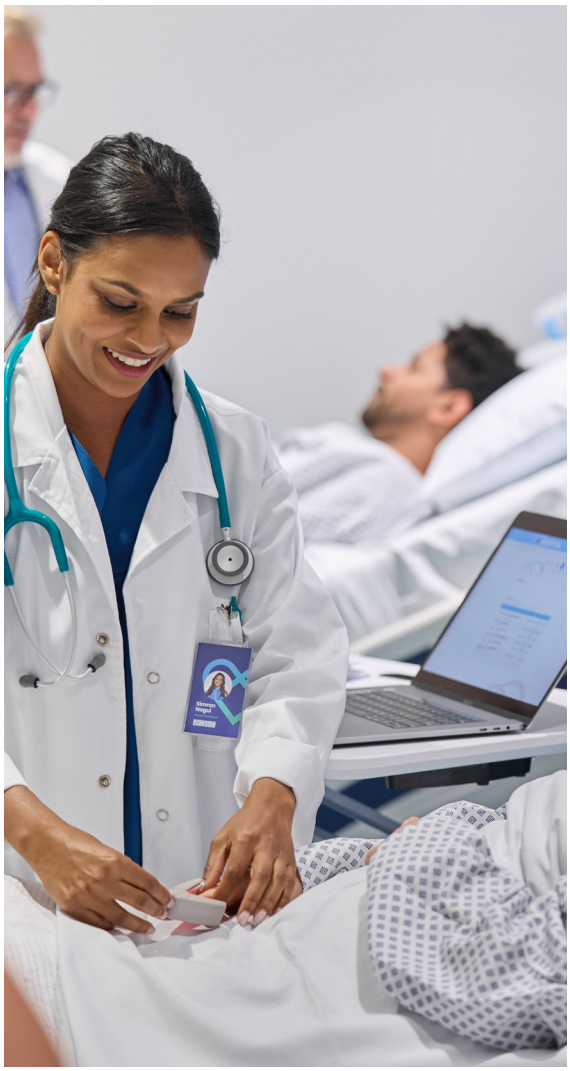


Source: Snapshot of key Hospital operator revenue and EBITDA - Australian Healthcare and Hospitals Association (ACNC)

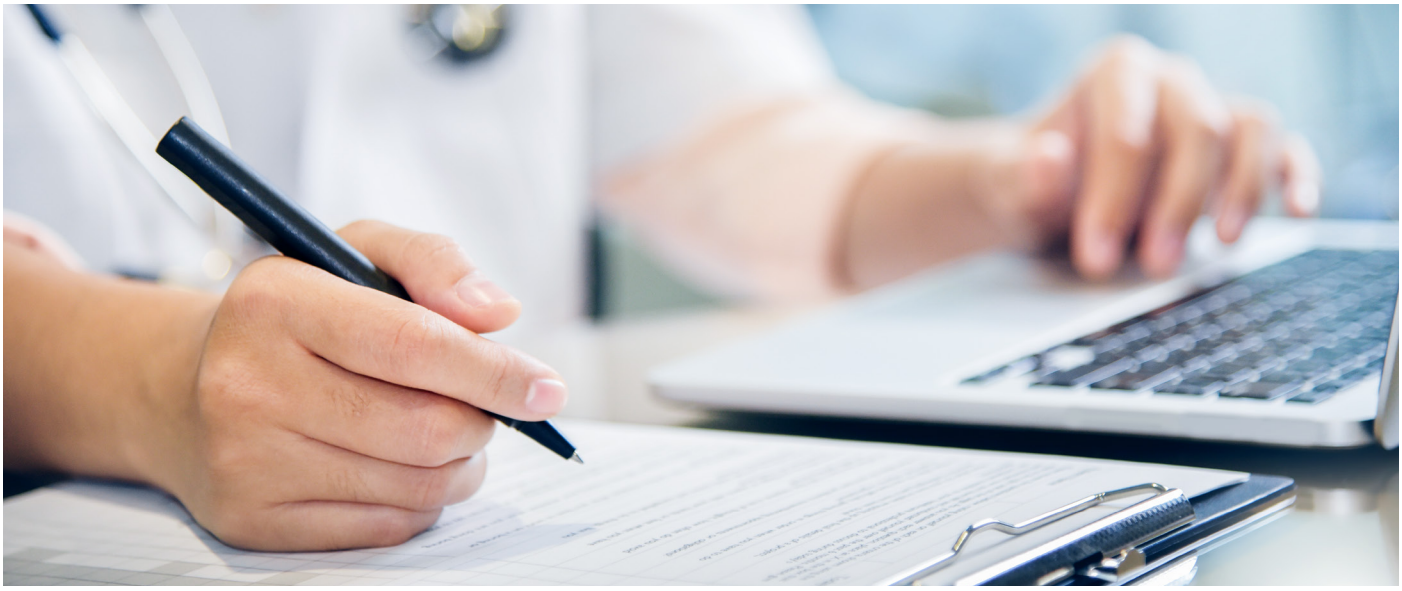
Due to these three trends, hospitals need to evolve - and will have to evolve - to become systems of care across a variety of overnight, day, low acuity and in the home settings, rather than simply being a large traditional asset intensive model of care. These changes are incumbent on the hospitals themselves and their operators, whether public or private, thereby intensifying the need for operational and fiscal discipline. They also represent a systemic challenge for Governments.

Given the impacts on revenue as well as costs and viability, there is an urgent need for Private Hospitals to focus on building financial sustainability in the short term. This is crucial while they wait for broader policy intervention that will support viability in the medium term, aiming to meet public objectives of reducing public waiting lists and emergency department congestion. The term “too big to fail” is sometimes used, but in this case, it might be said that the Australian private hospital network is “too important to fail”.

Although the Australian Hospital system isn’t in critical condition yet, intervention is required across a range of key areas. These include further enhancing operational and financial focus within the control of Private Hospital operators, building a closer and more sustainable partnership between Private Hospital operators and government and reforming key agreements that underpin the relationships between government, Health Insurers and Private Hospital operators.



[18]The Commonwealth Department of Health and Aged Care, Private Hospital Financial Viability Health Check (October 2024)
[19]Australian Private Hospitals Association, Private Hospital Viability: Immediate Response to Crisis (Nov 2024)



Section 3: Solutions

In order to address the current and future challenges facing the private hospital network and therefore the Australian health and hospital system, there are three primary actions that we would propose for consideration.

First, a refocus on operational and fiscal discipline, maximising existing investments and assets and delivering productivity.

3.1 Operational and Fiscal Discipline, Maximising Existing Investments and Assets and Delivering Productivity

From A&M's recent experiences working alongside both Public and Private Hospital operators in Australia and globally, there is a widespread need for operators to focus on sustaining financial and operational foundations in challenging conditions.

Operators across both public and private are having to refresh their modus operandi of operational and financial business performance to instil greater operational and financial discipline. Many Private Hospital Operators are exploring how to lift EBITDA in excess of 8 percent. Key topics to drive improvement include the usual methods of procurements of goods and services (clinical and non-clinical), scheduling, rostering, repairs and maintenance, cost avoidance measures and revenue capture (>15 percent YoY).

To improve business performance, operators need to take full advantage of both public investment in digital health, particularly in areas including: Artificial Intelligence and automation; telehealth; remote devices and monitoring, and greater use of patient data. These advances not only drive productivity but also support the ongoing shift in patient care, including 'care at home' and enhanced access in rural and regional locations. In its 2024 Research Paper, "Leveraging digital technology in healthcare", the Australian Productivity Commission identified significant benefits to be gained by Operators including "up to 30 percent of the tasks undertaken by the workforce could be automated using digital technology and artificial intelligence".[20] These are overwhelmingly administrative tasks, freeing up time and resources for improved patient care.

Additionally, Private Hospital operators are viewing additional infrastructure cautiously and looking to maximise existing investments. This includes the increased utilisation of facilities. Some organisations are running at lower-than-expected elective surgery capacity (many organisations have been running at 45 – 60 percent of total capacity) resulting in a material and negative impact on their financial position.

[20]Australian Government Productivity Commission, Leveraging digital technology in healthcare, Research paper (2024)

Although some Hospital Operators are reviewing their existing operations and investments which is delivering on average ~$60 million EBITDA uplift per $1 billion in revenue, there is an immediate and distinct need for governments and Private Hospital operators to explore an improved and sustained relationship – over and above the current ad hoc approach in most circumstances.

3.2 National Public Private Hospital Partnership Options

The second pillar of reform could therefore be a National Public Private Partnership with four broad options.

In 2020 the Australian Government established the Private Hospitals Viability Guarantee as the basis for a Public and Private Hospital Partnership during Covid. This served the dual purpose of retaining private capacity both during and following Covid in return for the private hospitals being available for integration into the public system to support Covid Emergency requirements as and when needed.

While the emergency conditions have passed, the integration of the system proved to be not only a vital component of Australia's response but also provided a precedent and a potential model for Public and Private partnerships going forward.

There are four potential options that could be considered to help the States meet their objectives of expanded public capacity, reduced public waiting times and the continued operation of private sector Capacity which provides 41 percent of total hospital admissions and 70 percent of elective surgery procedures.

Firstly, there is ***selected purchase of private hospital assets*** to add to public capacity.

At present most States have a long lead time and expensive capital works program to add to their existing public bed capacity. The Queensland Government has for example, a projected public hospital build program of $17.244 billion with a capital shortfall against allocated funds of $7.459 billion as found by the Sangster review.[21]

The Healthscope Administration provides States with the opportunity to carefully consider whether they should acquire individual Healthscope operations or other private assets such as Toowong Private Hospital and Wesley Hospital for integration into the public system.

From a public network capacity perspective, this approach could provide for an immediate addition of beds rather than waiting for many years, as is often the case. Notably, the cost per bed for acquiring existing facilities could range between $200,000 and $300,000 per bed (subject to the competition of assets), as compared to a new build which could cost between $6 and $6.6 million per bed.[22] In short, targeted acquisitions in strategically located areas that fit State needs can significantly accelerate public capacity, preserve essential system infrastructure and workforce, and potentially deliver beds at just 1/15th the cost of a new build, even after factoring in system integration costs.

The downside is that these are not new builds designed ground up to integrate into the State system. In some cases, capital upgrades may be required.

However, the selective purchase of private hospital assets or operations should be reviewed by each jurisdiction. In addition, there is the prospect to negotiate one-off support from the Commonwealth to help bring forward capacity at a lower cost than new builds. This could be included as part of a sign on for the next five-year National Health Reform Agreement (NHRA, which is the fundamental Federal vehicle for funding State hospitals).

Secondly, there is the prospect for ***greater use of privately provided low acuity models*** to reduce public waiting lists.

Sometimes known as Medihotels, low acuity accommodation is designed to reduce public waiting lists and costs. It does this by relocating lower needs public patients who are not yet ready to return home or into a permanent care setting - such as Disability support or aged care – into a clinically supervised hospital environment. While that can be done in an adapted Hotel, as seen for maternity, an emerging trend is to use repurposed healthcare environment such as a former aged care facility, as used for example by KNG on behalf of Queensland Health.

[21]Queensland Health, Queensland Government Capacity Expansion Program Independent Review Report (April 2025)
[22]Queensland Health, The Hospital Rescue Plan (April 2025)

The partnership model here allows States or local Health Care Systems to directly commission providers for lower acuity at a significantly less expensive cost per night than that of a Tertiary Hospital facility. In turn, this approach frees up hospital beds, helping to reduce public waiting lists.

An additional variation on this model, is that private hospital providers may choose to use lower acuity models, either within or outside of their own network, where they have low capacity or high costs. The critical component would be an agreement with private health insurers to support this model. Private health insurers would not want to pay more than they would otherwise have been paying.

As an example, it is possible to imagine a shared benefit where, if a patient were to have a low needs convalescence of five days at, say, $1500 per bed night in a private hospital, and instead they were to stay in a low acuity facility at $1000 per night, with an assumed transfer or other costs of $100 per night, then there could be a shared benefit of $200 in savings per night, or $1,000 each for the provider and insurer. It may also be possible to waive out of pockets for patients. This could place the patient in a more appropriate setting, subject to clinical governance, while saving system resources.

A third option involves ***limited contract off-take agreements*** between public and private hospitals.

A well-established example of the limited contracting model is the Queensland Surgery Connect program. As Queensland Health describes it:

"Surgery Connect is a Queensland Health initiative allowing clinically suitable public hospital patients to have surgery at a private hospital. Where possible, treatment will be offered close to home where services are available."[23]

Other States and Territories also have variations on this model as does the New Zealand Health Department.

One criticism of this model from within the private hospital sector is that it is not necessarily predictable and not necessarily phased over the cycles of demand and supply within individual hospitals or providers. It is however possible to establish a more predictable annually funded program in which there is a longer-term commitment to a defined number of procedures per year over a five-year program.

One means of supporting further limited contracting could be to include a dedicated Commonwealth sign on bonus as part of the next NHRA Agreement.

The fourth option is a ***Comprehensive National Public Private Hospitals Partnership.***

This model could involve an agreement between the Commonwealth and the States to set aside a proportion of growth funds from the new five-year NHRA due to start on July 1, 2026 for waiting list reduction in Public Hospitals through annual off-take agreements in private hospitals.

It could be an opt in model for both individual jurisdictions and individual hospital operators. Pricing could either be individually negotiated or can replicate State Hospital prices as agreed by the Independent Hospitals and Aged Care Pricing Authority (the Pricing Authority).

In order to give context, the range of value for the next five-year agreement is likely to be between $170 and $200 billion based on the starting annual benchmark for Commonwealth investment. If for example two percent of the funds were set aside for waiting list reduction, that would represent a minimum of $3.4 billion. If 40 percent - in line with the private share of hospital admissions - was reserved for public in private waiting list reduction that would represent $1.36 billion or an average of over $272 million per annum to be shared across the States and Territories on a pro rata basis for additional public in private contracting to reduce waiting lists. It may also be that the States are able to negotiate collectively or individually greater one off or ongoing allocations using this model to conduct a blitz or comprehensive waiting list program.

[23]Queensland Health, Surgery Connect (2025)

While the APHA has called for greater funding than the above, this model could nevertheless be a stable and significant contribution to both public-sector waiting list reduction and improved private hospital viability.

A Comprehensive National Public and Private Hospitals Partnership would be a foundation for long term private hospital viability without creating a bail out model and simultaneously delivering a co-benefit for public and private patients through significant waiting list reductions. In addition, such a partnership could support private hospital capacity and avoid the sovereign risk that large volumes of the current 70 percent of elective surgeries done in private hospitals, might otherwise be forced back onto the public system.

3.3 Private Health Insurer and Private Hospitals Agreement

The third and final pillar to the stabilisation of the private hospital network is a Private Health Insurers and Private Hospitals Agreement.

The central claim made by the APHA is that insurers are currently paying out 84 cents in every dollar received from patient premiums, whereas this should be 88 cents in the dollar.[24]

Insurers equally share concerns about some of the fundamental business underpinnings of private hospitals, the role of debt in causing problems and continue to seek further reductions in device prices and operational efficiencies.

Ideally, this could be resolved through a brokered agreement between peak bodies representing both sides. However, this is unlikely, primarily due to competing interests and residual ill-will that has developed over recent years, particularly post Covid. Moreover, there is a substantive concern that negotiating prices may attract legitimate scrutiny from the ACCC and should therefore be done under the auspices of a government sponsored agreement, as was the case with the 2017 Gold, Silver, Bronze and Basic Health reforms, and the 2021 Device private pricing reforms.

The most likely path to success is a Commonwealth sponsored new round of Private Health reforms, building on those introduced in 2017 and 2021. There is recent precedent not only in these two agreements but also in the current Health Technology Assessment (HTA) reforms being negotiated between the Commonwealth and the pharmaceutical sector through the agency of the peak pharmaceutical body Medicines Australia. There is also a particular incentive for the private sector in having the Commonwealth involved, with reform in return for faster assessment or other reductions in administrative costs or burden being a legitimate policy objective. Both sides have their list of requests, and the Commonwealth is uniquely placed to strike a mutually beneficial agreement or to help broker such an agreement.

There is a second and fallback option to help support agreement between both private insurers and hospitals. It may be possible to establish the Independent Hospital and Aged Care Pricing Authority as a default Pricing Authority in disputes between Insurers and private hospital providers.

The Pricing Authority is already the national body responsible for setting fair and efficient prices for public hospital services between the Commonwealth and the States. It also holds responsibility for setting prices for private aged care services. The Authority has hospital pricing capability, indeed, it is the only body which carries that capability and mandate, and it also has private pricing capability as part of its aged care mandate.

In order to undertake the dispute settlement role, the Pricing Authority would need a mandate from both the Commonwealth and the States, as well as the private hospitals and insurers on an opt in basis. In return, the Commonwealth may request that such disputes are determined on a fee for service basis, but with cost protection for small or stand-alone hospitals and the smaller not for profit insurers.

[24]Australian Private Hospitals Association, Private Hospital Viability: Immediate Response to Crisis (Nov 2024)

Conclusion

The recent Healthscope administration, while based on unique failures, is nevertheless a forewarning of emerging challenges to the broader public private hospital model which has underpinned Australia's position as the number one ranked health system in the world.

Australia has a unique health system, and in order to sustain that model going forward, we therefore need and can achieve a uniquely Australian response. This should be built on three key pillars: operational efficiency, a National Public Private Hospitals Partnership and a new Private Health Insurers and Private Hospitals Agreement.

The options proposed in this paper are only one part of the broader puzzle involved in maintaining any health system, let alone a globally top performing health system. However, they offer a pathway to help reduce significant pressures on both Government and Private hospital systems. Most importantly, the options we have outlined offer a chance to reduce waiting lists and improve outcome for patients and in turn improve their health and quality of life.

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