



# JOINT POSITION

## Strengthening the sustainability of Australia's private hospital system

### BACKGROUND

Australia's health system is built on an integrated public-private model, in which public hospitals, private hospitals, and community-based services operate as interdependent components of a single national system. This mixed model has historically delivered broad access, high-quality care, and flexibility during periods of peak demand, while enabling governments to leverage private sector capacity to complement publicly funded services. That balance is now under significant strain.

Across both public and private sectors, hospitals are facing rising demand driven by population growth, ageing, increasing complexity of care, and the cumulative effects of deferred treatment during the COVID-19 pandemic. At the same time, workforce shortages are constraining capacity, increasing costs, and limiting hospitals' ability to respond to demand even where physical infrastructure exists.

The pressures confronting the system are not confined to one sector. Public hospitals are experiencing sustained access block, emergency department overcrowding, ambulance ramping, and growing elective surgery backlogs. Private hospitals, which provide a substantial share of elective surgery and act as critical surge capacity for the public system, are facing escalating input costs, contracting pressures, and increasing financial fragility. When capacity or viability is lost in one part of the system, the effects are immediately felt across the other.

These challenges are occurring in a policy environment where funding, regulation and accountability are fragmented across multiple portfolios and levels of government. While responsibilities are shared, policy responses are often siloed, creating misaligned incentives and leaving individual sectors to absorb pressures generated elsewhere in the system. This fragmentation makes it increasingly difficult for hospitals to plan, invest and sustain services.

The risks of inaction are significant. Without coordinated Commonwealth leadership, Australia faces declining hospital capacity, worsening access and affordability, increased pressure on the public system, and erosion of the mixed public-private model that underpins health system resilience.

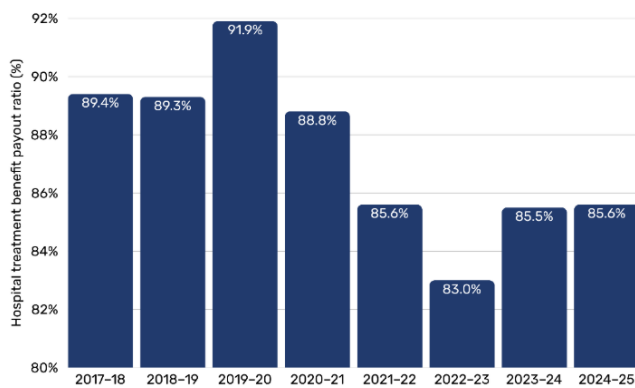
The 2026-27 Budget represents a critical opportunity to stabilise the system through targeted, time-limited interventions that recognise the interdependence of public and private care. A coordinated approach that strengthens value, supports the workforce, improves transparency, and ensures funding settings reflect real demand is essential to preserving Australia's integrated health system and ensuring patients can access timely, high-quality care regardless of where they enter the system.

In this context, Catholic Health Australia and the Australian Private Hospitals Association, together with their member hospitals, are jointly calling for coordinated system reform. In particular, they are seeking the introduction of a 90 per cent minimum benefit payout ratio for private health insurance, alongside a Mandatory Code of Conduct and targeted Commonwealth support for nurse wage increases to stabilise capacity and protect patient access across the integrated public-private system.

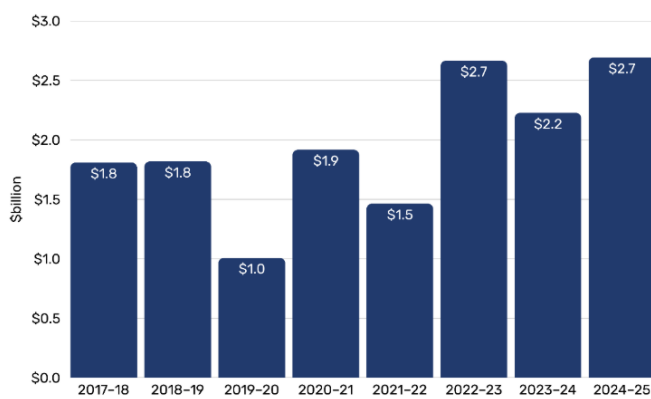
### **Legislate a 90% minimum benefit-payout ratio for private health insurance alongside a Mandatory Code of Conduct**

Australia's private health insurance sector now returns around 85 per cent of premium revenue to members, down from about 88-90 per cent before COVID-19 (Figure 1). While a fall in the payout ratio was expected during the pandemic due to reduced hospital activity, volumes have since returned to near pre-COVID levels but payout ratios have not, indicating insurers used COVID to reset pricing and lock in higher margins rather than pass the recovery back to members. At the same time, insurer management expenses (Figure 2) and profits (Figure 3) have increased, indicating that the post-COVID reduction in payouts to members has funded both higher insurer margins and higher administrative costs, rather than being returned to policyholders. In 2024-25, private health insurers reported \$2.7 billion in profits, and \$3.4 billion in management expenses. This trend has contributed to persistent pressures on hospital viability (Figure 4), reduced affordability for consumers, and diminishing public confidence in the value of private health insurance (PHI) products. In the last three years (since the COVID-19 pandemic), \$3.4 billion has been stripped out of the private health sector.<sup>1</sup>

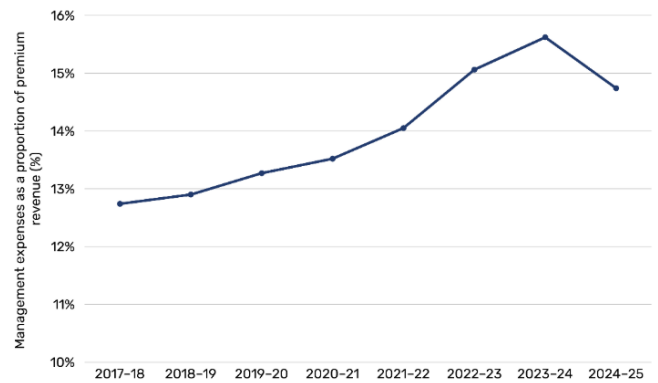
**Figure 1: Hospital treatment benefit payout ratio, 2017–18 to 2024–25<sup>2</sup>**



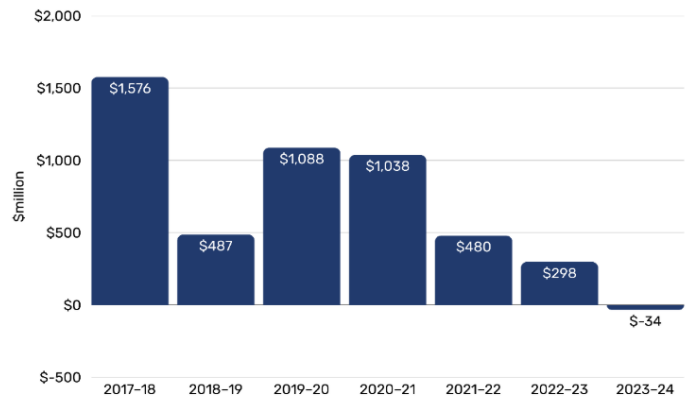
**Figure 3: Private health insurer profits before tax, 2017–18 to 2024–25<sup>4</sup>**



**Figure 2: Private health insurer management expenses as a proportion of premium revenue, 2017–18 to 2024–25<sup>3</sup>**



**Figure 4: Private hospital profits before tax, 2017–18 to 2024–25<sup>5</sup>**



Introducing a 90 per cent minimum benefit-payout ratio would inject an estimated \$1.2 billion into the hospital and health service sector,<sup>6</sup> improving system sustainability, supporting workforce retention, and strengthening the value proposition for consumers. It would also rebalance the insurer-provider relationship at a time when rising costs and contracting practices have constrained hospitals' capacity to maintain service availability. National and international experience shows that high minimum benefit expectations are both achievable and appropriate across different ownership models, with many sectors operating under regulatory settings that effectively require high payout ratios or impose strict limits on administrative and profit margins.

The reform is expected to have minimal administrative burden on government; however it is expected to increase private health insurance uptake, particularly among lower- and middle-income earners, raising Commonwealth rebate costs by around \$297 million over the forward estimates. However, improved affordability and stability in the private sector are projected to divert around 70,000 admissions from public hospitals, reducing Commonwealth hospital funding by approximately \$229 million. After accounting for these effects, the policy is estimated to have a net fiscal cost to the Commonwealth of approximately \$69 million over the forward estimates period (Table 1).

**Table 1: Cost of implementing a minimum benefit-payout ratio, 2026–27 to 2029–30**

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

To ensure that a mandated 90 per cent minimum benefit-payout ratio translates into stable funding outcomes, fair contracting behaviour, and genuine consumer value, it should be implemented in tandem with a Mandatory Code of Conduct to govern contractual relationships between private hospitals and private health insurers. The Code would prescribe minimum standards for contracting conduct, including requirements for good-faith negotiations, timely contract renewal processes, price and cost transparency, and access to an independent arbitration mechanism where negotiations fail. Oversight and enforcement would sit with the Australian Competition and Consumer Commission (ACCC), ensuring consistency across the sector and preventing the shifting of financial pressure onto providers through unilateral contract terms or delayed negotiations. An allocation of \$15 million over five years from 2026–27 would support development and enforcement of the Code, alongside \$10 million over three years to monitor private health insurance and hospital market conduct, consistent with funding provided for previous industry codes of conduct. Consultation led by the ACCC would commence by May 2026, with the Code developed by October 2026 and implemented by February 2027. This complementary reform is essential to support the minimum payout ratio by strengthening bargaining balance, improving transparency, and ensuring that increased benefit outlays are directed toward efficient, sustainable hospital care rather than dissipated through contracting inefficiencies or market power imbalances.

Mandating a 90 per cent minimum benefit-payout ratio poses capital adequacy risks for smaller insurers. Although the industry overall holds substantial capital above regulatory requirements, some smaller funds with thin buffers, higher costs, or weaker underwriting performance may face financial strain under tighter margins. This could lead to aggressive premium increases, market exits or consolidation, and reduced product offerings, particularly in regional or niche markets.

To mitigate these risks, implementation could be phased for smaller insurers or structured with tiered payout thresholds based on fund size. Evidence from other regulated markets suggests that moderate consolidation can improve efficiency and financial resilience while preserving competition. Given Australia's relatively high number of small insurers and elevated management expenses, gradual consolidation may support the sector's capacity to sustain a higher payout ratio.

Current provisions under the Private Health Insurance Act do not provide a direct mechanism to mandate a 90 per cent minimum benefit-payout ratio. While the Minister can scrutinise annual premium increases and adjust certain minimum benefit settings, these tools are indirect and not designed to enforce payout thresholds across the sector. The most durable and transparent approach would be a new or amended legislative instrument explicitly establishing a minimum payout requirement, though this would require consultation and formal amendment processes before implementation.

## **Targeted Commonwealth support for nurse wage increases**

Enterprise Agreement (EA) wage increases for nurses represent one of the most significant and immediate threats to the financial viability of Australia's private hospital sector. Public-sector wage outcomes, negotiated at the state level, typically set the effective market wage for nurses across the entire hospital system. Private hospitals are therefore compelled to match public-sector wage increases to remain competitive in attracting and retaining staff, yet they do so without access to equivalent public funding uplifts.

The private hospital sector is currently preparing for nurse wage increases in the order of 12–15 per cent by 2027, driven by state enterprise bargaining outcomes and ongoing workforce shortages. These pressures are likely to intensify following the Fair Work Commission's (FWC) current and pending wage determinations, including the nurses' work value case and aged care wage reviews.

With absent government intervention, these wage pressures risk undermining private hospital sustainability, increasing PHI premiums, and shifting demand onto already constrained public hospitals. This would weaken system-wide capacity and run counter to longstanding Commonwealth policy objectives of maintaining a strong mixed public–private hospital system.

Given these cost pressures arise largely from government-driven regulatory and industrial decisions, there is a strong policy rationale for a Commonwealth fiscal response as a one-off, time-limited intervention to support private hospitals in absorbing the initial nurse wage uplift. To mitigate these risks and preserve national hospital capacity, the Commonwealth should fund 50 per cent of the private hospital nurse wage uplift, phased over the forward estimates.

Failure to provide targeted Commonwealth support for nurse wage increases in private hospitals poses a significant risk to the stability of Australia's mixed public–private hospital system. Private hospitals must match state-set public sector wages to retain staff but, unlike public hospitals, receive no automatic funding uplift. Without intervention, some hospital, particularly smaller and regional services, may become financially unviable, insurers may face pressure to raise premiums, and service reductions or closures could shift demand onto already constrained public hospitals, increasing waiting times and system costs.

These risks arise from government-led wage decisions rather than private sector inefficiency. There is precedent for Commonwealth intervention, including statutory support measures in the 1980s and the COVID-19 Private Hospital Viability Guarantee. The most effective response would be direct Commonwealth funding of a defined share of nurse wage increases, providing certainty and transparency while avoiding complex indirect subsidies.

The proposal can be implemented within existing legislative and regulatory frameworks, without changes to industrial relations laws or private health insurance regulation. Funding could be targeted and time-limited, minimising administrative burden while preserving regulatory stability.

In 2024–25, wages and salaries in private hospitals are estimated at \$11.3 billion.<sup>7</sup> Nurses account for approximately 45–55 per cent of total wages and salaries in private hospitals,<sup>8</sup> equating to an estimated nursing wage base of approximately \$5.6 billion.<sup>9</sup>

Consistent with recent public-sector enterprise bargaining outcomes, the assumed 12–15 per cent wage uplift for nurses is not applied as a single increase, but phased over multiple years. For costing purposes, the uplift is modelled as a compounded increase of approximately 13.5 per cent over four years from 2026–27, reflecting:

- an initial catch-up to current public-sector wage settings, followed by
- smaller, ongoing annual increases consistent with established enterprise bargaining patterns.

On this basis, the total steady-state impact of a 12–15 per cent wage uplift is estimated to increase private hospital costs by approximately \$670–840 million per annum once fully implemented. Because employer superannuation contributions are calculated as a percentage of wages, wage increases also generate automatic superannuation cost growth. At the legislated Superannuation Guarantee rate of 11.5 per cent (rising to 12 per cent from 1 July 2025), the associated increase in superannuation costs is estimated at approximately \$75–100 million per annum once the wage uplift is fully implemented.

Accordingly, the total steady-state labour cost impact (wages plus superannuation) of the 12–15 per cent nurse wage uplift is estimated at approximately \$745–940 million per annum, excluding other secondary on-costs such as payroll tax, overtime and leave accruals. If fully passed through to consumers, this cost pressure would equate to an estimated 3.4–4.3 per cent increase in private health insurance premiums.<sup>10</sup>

The Commonwealth contribution is costed as 50 per cent of the incremental annual wage increase, rather than the full steady-state amount, and is phased over the forward estimates from 2026–27 (Table 2). The Commonwealth contribution is intended as a one-off, time-limited intervention to support private hospitals in absorbing the initial nurse wage uplift, rather than an ongoing subsidy of private sector wages. Under this approach, Commonwealth funding rises gradually in line with the staged implementation of enterprise agreement wage outcomes, resulting in an estimated Commonwealth cost of \$445 million over four years, with no single-year fiscal cliff.

Applying capped per-episode patient contributions to around 3.8 million same-day and 1.33 million overnight admissions annually (assuming 85% effective collection after exemptions) would generate roughly \$750 million per year, providing short-term financial stabilisation for private hospitals.

The proposed wage subsidy is designed as a temporary transition measure, not ongoing support. It would allow hospitals to absorb initial wage increases, stabilise staffing, and implement operational and pricing adjustments needed to remain viable at higher nurse wage levels. The modelling assumes the subsidy ends after the forward estimates, by which time hospitals are expected to have achieved sufficient efficiency, productivity and scale to operate sustainably without further Commonwealth assistance. The time-limited design ensures support is targeted and does not create an ongoing fiscal liability.

**Table 2:** Cost of targeted support for nurse wage increases in private hospitals, 2026–27 to 2029–30

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

<sup>1</sup> Calculated assuming a 90% payout ratio for the 2022–23, 2023–24 and 2024–25 financial years.

<sup>2</sup> Australian Prudential Regulation Authority (2018–2025). Annual private health insurance statistics. Retrieved 31/12/2025 from: <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>

<sup>3</sup> Australian Prudential Regulation Authority (2018–2025). Annual private health insurance statistics. Retrieved 31/12/2025 from: <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>

<sup>4</sup> Australian Prudential Regulation Authority (2018–2025). Annual private health insurance statistics. Retrieved 31/12/2025 from: <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>

<sup>5</sup> Australian Bureau of Statistics (2017–2025). Australian Industry, health care and social assistance private). Retrieved 31/12/2025 from: <https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry/latest-release>

<sup>6</sup> Calculated using an average of the 2022–23, 2023–24 and 2024–25 hospital treatment benefit payout ratios of approximately 85 per cent, benchmarked against a pre-COVID payout ratio of around 90 per cent, based on data from the Australian Prudential Regulation Authority (2022–2025). Annual private health insurance statistics.<sup>7</sup> Retrieved 31/12/2025 from: <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>

<sup>8</sup> Australian Bureau of Statistics (2025). Australian Industry, health care and social assistance private). Retrieved 31/12/2025 from: <https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry/latest-release>

<sup>9</sup> Based on data from CHA members.

<sup>10</sup> Calculated using Australian Bureau of Statistics Industry data and validated using data from CHA members.

<sup>11</sup> Calculated using the 2024–25 hospital treatment premiums the Australian Prudential Regulation Authority (2025). Annual private health insurance statistics. Retrieved 31/12/2025 from: <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>