Catholic Health Australia

2025

# OUR POSITION
# Private patients in public hospitals

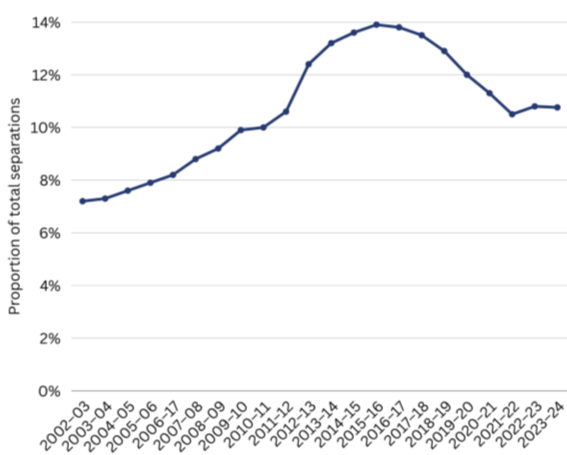
## BACKGROUND

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate over 80 hospitals in each Australian state and in the Australian Capital Territory, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, in addition to extensive community and residential aged care. CHA Members also provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 percent of home care services. This includes 350 aged care facilities and 53,000 older Australians cared for in their home.

CHA not-for-profit health, community and aged care providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care. CHA champions reforms aligned with the healing ministry of Christ and the work of Catholic congregations around the country.

The aim of our position statements is to outline CHA's policy and advocacy priorities on key issues that are essential to the mission and values of its members. A more in-depth analysis of our policy positions is available through our government submissions.

***Figure 1:*** *Public hospital separations funded by private health insurance nationally, 2002–03 to 2023–24*[1]




## POSITION

The treatment of private patients in public hospitals has become a growing and contentious feature of Australia's hospital funding landscape. Under the current National Health Reform Agreement (NHRA), patients admitted to public hospitals can elect to be treated as private, allowing the hospital to bill their private health insurer (PHI) and the Medicare Benefits Schedule (MBS) while still receiving reduced levels of public funding through Activity Based Funding (ABF).

This arrangement was originally intended to be financially neutral, ensuring that total hospital revenue was consistent regardless of a patient's funding status. However, in practice, it has created financial incentives for state and territory governments and public hospitals to encourage patients with private health insurance to use it when admitted, generating additional revenue to supplement capped Commonwealth and State funding.

Figure 1 shows the proportion of private patients in public hospitals has risen steadily over the past decade, from around 7 per cent of public hospital admissions in the early-2000s to more than 11 per cent nationally in recent years, representing hundreds of thousands of separations annually.

This trend is undermining the financial viability of the private hospital sector, as insured patients who would previously have sought care in private hospitals are instead being treated in the public system, eroding private sector activity and contributing to rising costs across health insurance products. At the same time, the expansion of private-patient activity within public hospitals places additional pressure on public hospital capacity, as beds and theatre time are consumed by patients who might otherwise have been treated in private facilities.

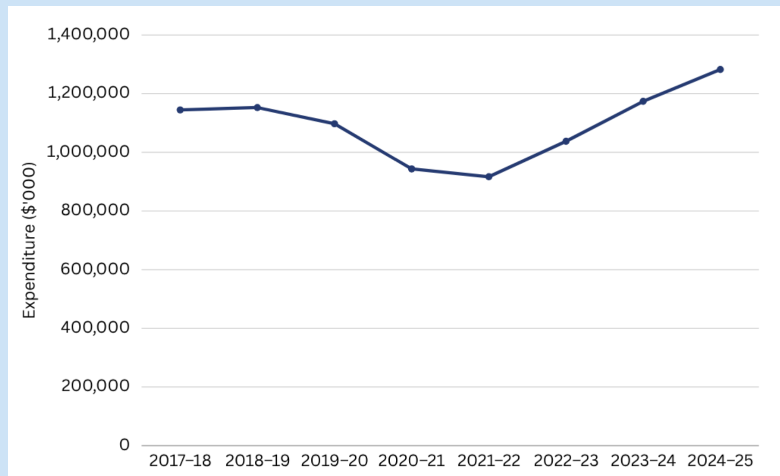
While some private-in-public activity occurs appropriately — for example, in emergency admissions or where no private capacity exists — its growing prevalence has blurred the boundaries between the public and private hospital systems. The result is a distortion of funding flows and incentives: public hospitals benefit financially in the short term from private-patient revenue, but the system as a whole faces reduced efficiency and sustainability.

## How much do private health insurers pay for private patients in public hospitals?

In Australia, PHIs are required to contribute to the cost of treating private patients in public hospitals, and they do so through a combination of statutory default benefits and negotiated agreements with state and territory governments. The default benefit, set under the *Private Health Insurance Act 2007* and the associated *Benefit Requirements Rules*, is a nationally determined minimum payment that insurers must make when one of their members is admitted as a private patient to a public hospital in the absence of any negotiated contract. It is typically a per-diem payment covering accommodation and nursing services, and ensures that states receive at least a baseline contribution from insurers for each private admission. In practice, however, most major insurers and state health departments enter into negotiated agreements that specify higher benefit rates, billing procedures, and other conditions. Medical services provided to private patients are billed separately through the MBS, and together the MBS, PHI, and any patient charges comprise the non-ABF revenue that the Independent Health and Aged Care Pricing Authority (IHACPA) assumes when discounting the NEP for private patients.

Figure 2 shows that private health insurer payments for private patients treated in public hospitals declined in 2019–20 and 2020–21, likely due to the impacts of the COVID-19 pandemic on elective surgery and hospital activity. Since then, payments have steadily increased, **reaching an estimated $1.28 billion[2] in 2024–25**, which represents around 1.2 per cent of total public hospital expenditure nationally.

***Figure 2:*** *Private health insurer payments to public hospitals for privately insured patients nationally, 2017–18 to 2024–25[3]*




## How much is spent overall on private patients in public hospitals?

In 2023–24, total expenditure on private patients treated in public hospitals is estimated to have been around $4.8 billion.[4] Of this, $1.17 billion[5] was funded by private health insurers, **with the remaining $3.6 billion coming from government sources** — primarily through the National Health Reform Agreement (NHRA) and the Medicare Benefits Schedule (MBS). In effect, this means that a substantial share of public funding is directed toward treating privately insured patients in the public system. If these patients instead received care in private hospitals, the associated $3.6 billion in government funding could be redirected to support access for public patients without private health insurance, easing pressure on public hospital capacity and waiting times.

## Why do state and territory governments and public hospitals have financial incentives to treat private patients in public hospitals?

Under the National Health Reform Agreement, public hospital services are funded jointly by the Commonwealth Government and the state and territory governments, based on the National Efficient Price (NEP) and the number of National Weighted Activity Units (NWAUs) delivered. For public patients, both levels of government contribute their agreed shares of the full NEP price for each service. When a patient elects to be private in a public hospital, however, the NEP applied to that episode is discounted to remove the cost components that are expected to be covered by other funding sources — principally the MBS and PHI benefits, and any patient out-of-pocket payments.

This adjustment is mandated under clauses A13, A43 and A44 of the NHRA Addendum, which together establish the principles of financial neutrality and payment parity. In theory, these provisions ensure that the total revenue received by a hospital for a given service is about the same whether the patient is public or private. The discounted ABF payment from the Commonwealth and state and territory governments, when added to MBS and PHI receipts, should roughly equal what would have been paid under the full NEP if the patient were treated publicly.

However, neutrality applies to total hospital revenue, not to each individual funder. When the NEP is discounted, both the Commonwealth and the state and territory governments pay their agreed proportions of that lower ABF price. The Commonwealth's reduction in ABF payments is partly offset by its separate spending through the MBS, but the state's contribution simply falls in direct proportion to the discount. Because the state has no compensating payment stream elsewhere in the system, this reduction translates into a real saving for its budget. In effect, the Commonwealth's total outlay remains roughly constant — with lower ABF spending but higher MBS payments — while the state's share declines because its funding responsibility ends with the discounted ABF amount. This practice is widely recognised and was explicitly articulated by the IHACPA in its 2017 *Private Patient Public Hospital Service Utilisation* report.[6] That review found that in most jurisdictions, public hospitals and Local Hospital Networks (LHNs) could retain private-patient revenue without a fully corresponding reduction in ABF payments, creating a "residual financial incentive" to encourage privately insured patients to elect private status. The report also noted that several state systems incorporate revenue targets for private income into hospital performance agreements.

To illustrate, suppose a public inpatient episode has a full cost of $10,000. Under the usual funding split, the Commonwealth pays 45 per cent ($4,500) and the State 55 per cent ($5,500) through the NHRA pool. If the same episode is recorded as a private patient, the NEP might be discounted by $2,000 to account for expected MBS and PHI revenue. The total hospital revenue remains about $10,000, but it is composed of $8,000 from ABF and $2,000 from MBS/PHI. The Commonwealth pays 45 per cent of $8,000 ($3,600) through ABF and roughly $2,000 via MBS, keeping its combined contribution near $5,600. The state, however, now pays 55 per cent of $8,000 ($4,400) instead of $5,500 — a saving of $1,100 on that admission. **It is estimated that state and territory governments are saving around $1 billion a year by treating private patients in public hospitals.**[7]

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The Commonwealth funding cap embedded in the NHRA further strengthens this incentive. The Commonwealth's share of hospital funding can grow by no more than 6.5 per cent per year, and all ABF payments count toward this cap. Because private-patient episodes attract discounted ABF prices, the Commonwealth's ABF spending for these cases is smaller. That means less of the capped funding pool is used, effectively allowing more hospital activity to be funded. From the states' perspective, this helps preserve headroom under the cap, allowing them to sustain or expand activity. In combination, these mechanisms deliver a twofold fiscal benefit for the states, reinforcing their financial incentive to maintain and expand private-patient activity within the public hospital system.

**Why do states and territories continue to encourage private-patient activity in public hospitals, and where did this practice originate?**

The origins of private-patient activity in public hospitals trace back to the funding reforms of the 1980s and 1990s, when the Commonwealth–state hospital funding agreements began to link Commonwealth payments to defined service outputs and capped growth rates. During that period, the Commonwealth's contributions were constrained by negotiated block grants and later by capped growth formulas, which limited the total pool of federal funding available for public hospital services. In this environment, states were explicitly encouraged to supplement public funding with "own-source" or "alternative" revenues — including revenue from private patients, workers' compensation, veterans' arrangements, and overseas visitors — as a means of maintaining hospital service levels within fixed Commonwealth budgets.

Many of the early Health Care Agreements between the Commonwealth and states contained clauses or policy language recognising that states would need to generate additional non-Commonwealth income to support their public hospitals. This was partly a reflection of fiscal realism: Commonwealth funding increases were capped, while hospital demand and input costs were rising. Private patient revenue — particularly through the MBS and PHI — was viewed as a legitimate way for states to draw in additional funding without breaching the terms of the national agreements. Hospitals were even measured and benchmarked on their ability to recover "third-party revenue," which included MBS billings and insurance reimbursements. Over time, this expectation became institutionalised within many State health systems, embedded in hospital business rules and performance targets.

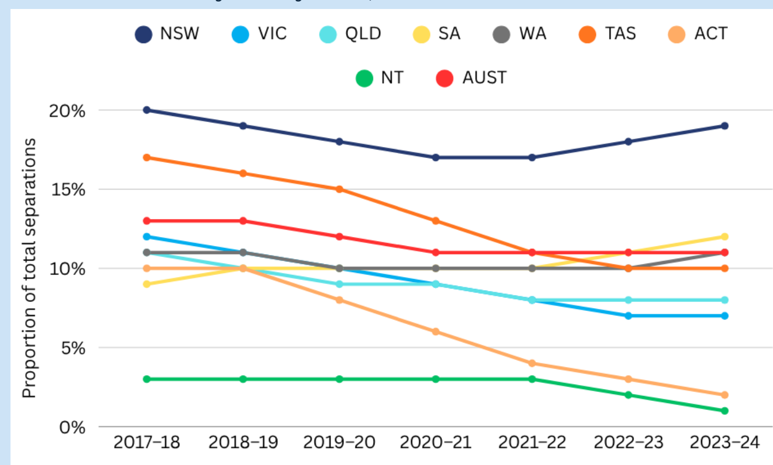
When the NHRA was introduced in 2011–12, the architecture changed but some of those historical incentives persisted in practice. While the NHRA's language stopped short of mandating that states seek such revenue, it continued to acknowledge its existence — referring to "other Commonwealth sources," "private patient charges," and "own-source income", providing it was financially neutral (as outlined previously).

There is however no formal policy directive requiring states or hospitals to actively generate private-patient revenue. In practice, the historical expectation to find "alternative revenue" has evolved into an embedded behavioural norm. States and Local Hospital Networks have maintained a focus on attracting private patients because it provides a direct fiscal benefit and because the Commonwealth pricing system recognises that such revenue exists and adjusts ABF payments accordingly.

## Which state has the highest proportion of private patients treated in public hospitals?

New South Wales (NSW) consistently records the highest proportion of private-in-public separations nationwide. Across the period 2017–18 to 2023–24, NSW's rate of private patient separations ranged between 16.7% and 19.9% of all public hospital separations, well above the national average of around 11–13%.[8] In 2023–24, NSW again topped the list, with 18.6% of public hospital separations involving private patients.[9]

***Figure 3:*** *Public hospital separations funded by private health insurance nationally and by state, 2017–18 to 2023–24*[10]




## How do public hospitals encourage patients to use their private health insurance?

Many public hospitals employ Patient Liaison Officers (PLOs) or similar roles whose purpose includes assisting patients with the financial classification process and encouraging those with PHI to elect to use it during their admission. These officers — often part of hospital finance or revenue teams — work on wards, in emergency departments, and during pre-admission to identify eligible patients, check health fund coverage, and explain the benefits and implications of private election. Their responsibilities are framed around supporting informed financial consent, but their activity also directly contributes to hospitals' and states' efforts to generate alternative revenue from private patients. Job descriptions from several state health services explicitly state that these positions are "pivotal to maximising patient fee revenue" and "encouraging private and compensable admissions," with some PLOs described as providing a roaming service across wards to engage patients soon after admission. Further details can be found in IHACPA's 2017 *Private Patient Public Hospital Service Utilisation* report.[11]

There is ongoing debate about whether private patients in public hospitals receive preferential treatment compared to public patients, and while the evidence is mixed, several studies and policy reviews suggest that disparities do occur in practice.

Further detailed in IHPA's 2017 report,[12] hospitals offer various incentives to encourage patients to use their private health insurance, including access to a private room (if available), shorter wait times for elective surgery, complimentary parking, guest meals, entertainment packages, and vouchers.

Additionally, many patients are offered no out-of-pocket costs associated with their care, as the Commonwealth Government (and therefore the taxpayer) funds the out-of-pocket costs that would normally be paid for by the patient if they were receiving care in a private hospital.

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Hospitals also employ deliberate strategies to encourage patients to use their private health insurance, including:

- providing brochures outlining the benefits of private treatment
- implementing 'nudge' tactics to increase private patient uptake
- hiring staff dedicated to persuading patients to choose private care
- collecting private health insurance details, even when patients opt for public treatment

Clinicians may also receive incentives, including the opportunity to privately practice as well as direct financial benefits.

**When is it appropriate for private patients to be treated in public hospitals?**

In some circumstances, it is reasonable and appropriate for private patients to be treated in public hospitals. For example, when a patient with private health insurance presents to a public emergency department and requires urgent admission, it is often neither practical nor clinically safe to transfer them to a private facility. Similarly, in regional or rural areas where there may be limited access to private hospitals or specialist services, treatment in a public hospital may be the only viable option. In these cases, the patient's private status does not distort access or equity — it simply reflects the reality of how emergency and geographically constrained care is delivered. However, in other situations, particularly for planned or elective procedures, the growing tendency for privately insured patients to be admitted and treated within public hospitals is less defensible. It can divert public resources toward patients who could otherwise be managed in the private system, reduce capacity for public patients, and undermine the intent of the public hospital system as a universal safety net based on clinical need rather than insurance status.

**What is the impact in public hospitals?**

The growing treatment of private patients in public hospitals has important consequences for the allocation of healthcare resources and the equity of access within the Australian health system. Public hospitals, which were designed primarily to serve patients without private health insurance, are increasingly diverting capacity, including beds, surgical theatre time, and clinical staff, toward privately insured individuals. While this generates additional revenue for hospitals and reduces pressure on state budgets, it can limit access for public patients, contributing to longer waiting times for elective procedures and inpatient admissions. In many cases, the patients receiving care as private in public hospitals could otherwise have been treated in private facilities, meaning that scarce public resources are being used to support those who already have insurance coverage. This trend undermines the foundational Medicare principle that access to care should be determined by clinical need rather than insurance status, and raises broader concerns about the sustainability and fairness of the public hospital system.

## What is the impact on private hospitals?

The increasing number of privately insured patients being treated in public hospitals is having a serious impact on the financial sustainability of private hospitals. Private facilities rely heavily on revenue from insured patients to fund operations, invest in staff, and maintain specialised services. As more insured individuals choose, or are encouraged, to receive care in public hospitals, private hospitals experience falling admissions and revenue losses, which in turn threaten their viability. This decline forces some providers to adopt cost-cutting measures, reduce service availability, or, in extreme cases, close specialised units such as maternity or rehabilitation services, particularly in regional areas where patient volumes are already limited. The weakening of the private hospital sector also undermines the broader health system: with fewer patients treated privately, more demand shifts back onto the public system, worsening waiting times and capacity pressures. In this way, the expansion of private-patient activity in public hospitals not only erodes the economic foundations of the private sector but also destabilises the intended balance between public and private care in Australia's mixed health model.

## What is the impact on private health insurance?

The increase in privately insured patients being treated in public hospitals is also having a destabilising effect on the PHI market. As more insured individuals choose to use their cover in public hospitals — often with no out-of-pocket costs and comparable access to medical specialists — many begin to question the value of maintaining private insurance. This undermines confidence in the insurance system and contributes to a gradual decline in membership, particularly among younger and healthier policyholders who are crucial to maintaining affordability. A shrinking PHI base then weakens private hospitals, as fewer insured patients seek care in their facilities, reducing revenue and investment capacity. This dynamic creates a vicious cycle, where falling participation in PHI further erodes the private hospital sector, leading to greater pressure on the public system as more patients rely on it for care. Over time, this feedback loop threatens the long-term sustainability of Australia's mixed public–private health model, where both systems are intended to operate in balance to ensure access, quality, and choice.

## What reforms could be made to discourage the use of private health insurance in public hospitals?

With the states now receiving significantly higher and more stable Commonwealth hospital funding under the NHRA, the original rationale for encouraging public hospitals to seek alternative revenue through private-patient activity no longer applies and should be retired. It is therefore recommended that the NHRA be amended to discourage the use of private health insurance within public hospitals and reinforce the principle that public hospital care should be provided on the basis of clinical need, not insurance status.

This could be achieved by introducing a 100 per cent adjustment to the Public/Private Patient Benefit Sharing mechanism, meaning that no Commonwealth ABF would be paid for these patients through the NHRA Funding Pool. Instead, all Commonwealth support would occur outside the NHRA framework via the MBS, consistent with existing Commonwealth responsibilities for private health services.

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This would simplify the hospital funding system, enhance fiscal discipline under the NHRA growth cap, and create a clearer delineation between public and private financing responsibilities. States would retain full discretion to admit and manage private patients in their public hospitals but would bear direct responsibility for any gap between hospital costs and the revenue obtained from MBS, PHI, and patient charges.

To implement this change, clause A43 in the NHRA would be redrafted to state that cost weights for private patients are to be reduced by 100 per cent for the purpose of calculating Commonwealth contributions, with all Commonwealth funding for such patients provided through non-NHRA mechanisms. Clause A44, which currently directs IHACPA to achieve payment parity, would be modified to clarify that parity testing does not apply to private patients under the 100 per cent adjustment model. Corresponding updates would be required to IHACPA's Pricing Framework and the NEP Determination, removing references to payment parity for private patients and defining a new "Private Patient Zero ABF Rule." The National Health Funding Body (NHFB) would also need to revise its business rules to exclude private-in-public activity from ABF reconciliations while continuing to monitor MBS/PBS interactions to prevent double payment.

One alternative policy approach would be to allocate any "savings" generated from treating privately insured patients in public hospitals toward bolstering access to care for regional Australians—specifically by subsidising or contracting care through private hospitals in regional areas, especially in situations where a private hospital operates as the only local provider.

The reform would also necessitate strengthened informed financial consent processes for patients, as hospitals would need to ensure that patients understand the funding and cost implications of electing private status in a public hospital. A transitional approach may be advisable — for example, phasing down the Commonwealth ABF share for private-in-public activity over several years to allow systems and revenue flows to adjust. IHACPA and NHFB could be tasked with publishing annual monitoring reports to assess the effects on hospital revenue parity, private patient volumes, and patient out-of-pocket exposure.

In addition, public health services should strengthen access and equity safeguards to ensure that private patients do not receive preferential treatment over public patients. This means upholding core access principles so that clinical urgency, rather than insurance status, determines the order and timing of care. Policies should also support the transfer of privately insured patients to private hospitals when it is clinically appropriate and in the best interests of both the patient and the efficient use of public hospital resources.

**How would removing Commonwealth ABF funding for private patients in public hospitals affect the prevalence of private-in-public activity and the financial incentives for states and hospitals?**

The proposed reform would have distinct financial and operational implications for each level of government and for hospitals. From a Commonwealth perspective, the reform would reduce NHRA outlays and slow utilisation of the funding growth cap, since private-in-public activity would no longer contribute to the ABF pool. The Commonwealth's total health expenditure would remain largely unchanged because MBS payments would continue.

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For state and territory governments, the impact of the reform would depend on how closely MBS and PHI benefits align with the cost of care. Under the current system, PHI payments are treated as supplementary revenue that offsets part of the cost of care, while the core funding is still jointly financed by the Commonwealth and the states. If the Commonwealth withdrew its ABF contribution for private-in-public activity, the PHI and MBS payments would effectively become the primary external revenue streams for those patients.

In practical terms, the states could continue to treat private patients without any formal change to legislation, but they would now be relying solely on MBS and PHI income (plus any patient charges) to fund those episodes. The existing default benefit arrangements under the Private Health Insurance Act 2007 would still apply, meaning insurers would remain legally obliged to pay the default accommodation benefit for all privately insured admissions. However, because that default rate is relatively low and does not reflect the full cost of care, the states would almost certainly seek to negotiate higher benefits directly with PHIs, either through statewide agreements or contracts at the LHN level. In other words, States would need to move from a passive position (where PHI revenue supplements Commonwealth and State funding) to an active contracting position, similar to that of private hospitals, to ensure cost recovery. Over time, this would push the relationship between states and insurers toward a more market-based footing.

As a result, hospitals would have little incentive to actively encourage patients to use their private health insurance within the public system. Over time, the number of private-in-public separations would likely fall to those cases where it is clinically necessary or unavoidable, such as emergency admissions or regions without accessible private facilities. This would restore the intended balance between the public and private sectors, ensuring that public hospital capacity is prioritised for patients who depend on it and that private insurance is used where it delivers genuine value and efficiency.

[1] Australian Institute of Health and Welfare (2003–2025). *Admitted patient care 2002–03 to 2023–24.* Retrieved 08/10/2025 from: https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

[2] Australian Prudential Regulation Authority (2025). *Quarterly private health insurance statistics September 2024 to June 2025.* Retrieved 09/10/2025 from: https://www.apra.gov.au/quarterly-private-health-insurance-statistics

[3] Australian Prudential Regulation Authority (2017–2025). *Annual private health insurance statistics 2017–18 to 2024–25.* Retrieved 09/10/2025 from: https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

[4] The total expenditure on private patients treated in public hospitals was estimated using a simplified activity-based funding approach. Data on the number of private patient separations by state and year were sourced from the Australian Institute of Health and Welfare's Admitted Patient Care, Australia reports (see reference 1), while annual NEP values were obtained from the Independent Health and Aged Care Pricing Authority's National Efficient Price Determination publications (retrieved 09/10/2025 from: https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination). The estimated expenditure for each state and year was calculated as the product of the number of private patient separations and the corresponding NEP for that financial year, divided by one million to express results in millions of dollars. This approach assumes an average of one NWAU per separation and does not apply jurisdictional loadings or private-patient pricing adjustments. The resulting figures represent indicative estimates of the cost of care, suitable for comparative and policy analysis rather than precise financial reporting.

[5] Australian Prudential Regulation Authority (2025). *Annual private health insurance statistics 2023–24.* Retrieved 09/10/2025 from: https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

[6] Independent Hospital Pricing Authority (2017). *Private patient public hospital service utilisation, final report.* Prepared by EY. Retrieved 09/10/2025 from: https://www.ihacpa.gov.au/sites/default/files/2022-02/Private%20Patient%20Public%20Hospital%20Service%20Utilisation.pdf

[7] The estimated savings to state and territory governments from private patients treated in public hospitals were derived by approximating the offsetting revenue or cost recovery associated with these patients. Savings were calculated by multiplying the estimated total expenditure on private patients — obtained using the NWAU and NEP methodology described above (reference 4) — by the proportion of treatment costs typically covered through private health insurance benefits, Medicare rebates, and patient contributions. This proportion reflects the share of total costs not borne by state funding. In the absence of jurisdiction-specific financial data, a standard coverage rate was applied across all states, representing an average reimbursement level consistent with published private patient revenue ratios in AIHW and jurisdictional health financial reports. The resulting figures provide an indicative estimate of the fiscal savings to states from private patient activity in public hospitals, acknowledging that actual savings vary according to negotiated funding arrangements, service mix, and the extent of cost recovery achieved in each jurisdiction.

[8] Australian Institute of Health and Welfare (2003–2025). *Admitted patient care 2002–03 to 2023–24.* Retrieved 08/10/2025 from: https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

[9] Australian Institute of Health and Welfare (2003–2025). *Admitted patient care 2002–03 to 2023–24.* Retrieved 08/10/2025 from: https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

[10] Australian Institute of Health and Welfare (2003–2025). *Admitted patient care 2002–03 to 2023–24.* Retrieved 08/10/2025 from: https://www.aihw.gov.au/hospitals/topics/admitted-patient-care

[11] Independent Hospital Pricing Authority (2017). *Private patient public hospital service utilisation, final report.* Prepared by EY. Retrieved 09/10/2025 from: https://www.ihacpa.gov.au/sites/default/files/2022-02/Private%20Patient%20Public%20Hospital%20Service%20Utilisation.pdf

[12] Independent Hospital Pricing Authority (2017). *Private patient public hospital service utilisation, final report.* Prepared by EY. Retrieved 09/10/2025 from: https://www.ihacpa.gov.au/sites/default/files/2022-02/Private%20Patient%20Public%20Hospital%20Service%20Utilisation.pdf