



Catholic Health Australia

Pre-Budget Submission 2026–27: Health
January 2026

Executive Summary

Australia's health system is facing mounting and interconnected pressures across private health insurance, private hospitals, and public hospital capacity. Rising costs, workforce shortages, constrained funding arrangements and opaque pricing mechanisms are undermining affordability, sustainability and access to care. Without targeted Commonwealth action in the 2026–27 Budget, these pressures will intensify, placing further strain on hospitals, the health workforce and patients.

Catholic Health Australia's (CHA's) Pre-Budget Submission 2026–27 outlines four priority reforms to stabilise the health system, strengthen value for consumers, and protect national hospital capacity across both public and private sectors.

Priority 1: Introduce a minimum benefit-payout ratio for private health insurance

Private health insurers currently return around 85 per cent of premiums to members, with rising management costs undermining confidence, hospital viability and value for money. In 2024–25, private health insurers reported \$2.7 billion in profits, and \$3.4 billion in management expenses. This has contributed to declining consumer confidence, pressure on hospital viability, and concerns about value for money. International experience and domestic insurance regulation demonstrate that higher minimum benefit-payout expectations are both achievable and appropriate. CHA proposes a **90 per cent minimum benefit-payout ratio** to better direct premiums to patient care, improve transparency and rebalance insurer–provider relationships, injecting around **\$1.2 billion per year** into hospitals and supporting workforce sustainability. The reform would involve minimal administrative costs and no direct Commonwealth outlays, with increased rebate payments largely offset by reduced public hospital funding, resulting in a **net Commonwealth fiscal cost of approximately \$69 million** over the forward estimates.

Priority 2: Provide targeted support for nurse wage increases in private hospitals

Enterprise Agreement wage increases for nurses, driven by public-sector bargaining and Fair Work Commission decisions, represent an immediate risk to private hospital viability. CHA estimates nurse wages in the private sector will rise by **12–15 per cent by 2027**, increasing labour costs by up to **\$940 million per year** and, without intervention, driving higher insurance premiums, reduced services and greater demand on public hospitals. CHA proposes a one-off, time-limited Commonwealth contribution of **50 per cent of the incremental wage increase**, phased over the forward estimates, at an estimated cost of **\$445 million over four years** to protect hospital viability, moderate premium pressures, and preserve national hospital capacity.

Priority 3: Establish the foundations for a Private National Efficient Price

Opaque pricing and incomplete cost data undermine efficiency and sustainability in the private hospital system. CHA proposes establishing a government-determined **Private National Efficient Price (PNEP)** to improve transparency in insurer–provider negotiations and support more disciplined funding arrangements. CHA recommends targeted Commonwealth investment to fund the **establishment phase** of the PNEP, including expanded cost collection, financial disclosure, independent assurance, and regulatory oversight. An investment of **\$16 million over four years** would build the data, pricing and governance capability needed for a credible national benchmark and enable a staged, low-risk transition to PNEP-informed pricing.

Priority 4: Address access block in public hospitals

Public hospitals are facing sustained pressure from rising demand, workforce constraints, and funding arrangements that have not kept pace with activity growth, resulting in limited access to care, elective

surgery backlogs, and worsening patient outcomes. CHA proposes a coordinated reform package to strengthen public hospital capacity by increasing Commonwealth funding through an **8 per cent NHRA growth rate** and a **50 per cent funding share**, improving hospital transitions to aged care, funding disability and home-based supports through dedicated discharge roles and transition accommodation, and clearing elective surgery backlogs by using private hospital capacity with time-limited Commonwealth funding. The package is estimated to cost **\$24.5 billion over four years**, reflecting the scale of system pressures and shared Commonwealth–state responsibility for timely access to hospital care.

Budget Priorities at a Glance

Private Health Insurance

- **Introduce a 90 per cent minimum benefit-payout ratio for private health insurance** to ensure premiums are directed primarily to patient care, improve transparency, and rebalance insurer–provider relationships. Cost: \$69 million over the forward estimates period. Reform should be introduced alongside a Mandatory Code of Conduct at the cost of \$15 million over five years for development and enforcement and \$10 million over three years for market monitoring.

Private Hospitals

- **Fund 50 per cent of the incremental nurse wage increase** as a one-off, time-limited intervention to support hospitals in absorbing the initial wage uplift, phased over the forward estimates. Cost: \$445 million over four years.
- **Fund the establishment phase of a Private National Efficient Price (PNEP)** including expanded cost collection, financial disclosure, independent assurance, and regulatory oversight. Cost: \$16 million over four years.

Public Hospital Capacity

- Deliver a coordinated package of reforms to 1) **uplift NHRA growth to 8 per cent and increase the Commonwealth share to 50 per cent**, 2) **fund dedicated discharge roles and transition accommodation**, and 3) **clear the elective surgery backlog by using private hospital capacity with time-limited Commonwealth funding**. Cost: \$24.5 billion over four years.

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 has underpinned health system resilience for decades.

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.

Policy Priorities

Priority 1: Introduce a minimum benefit-payout ratio for private health insurance

Decision sought

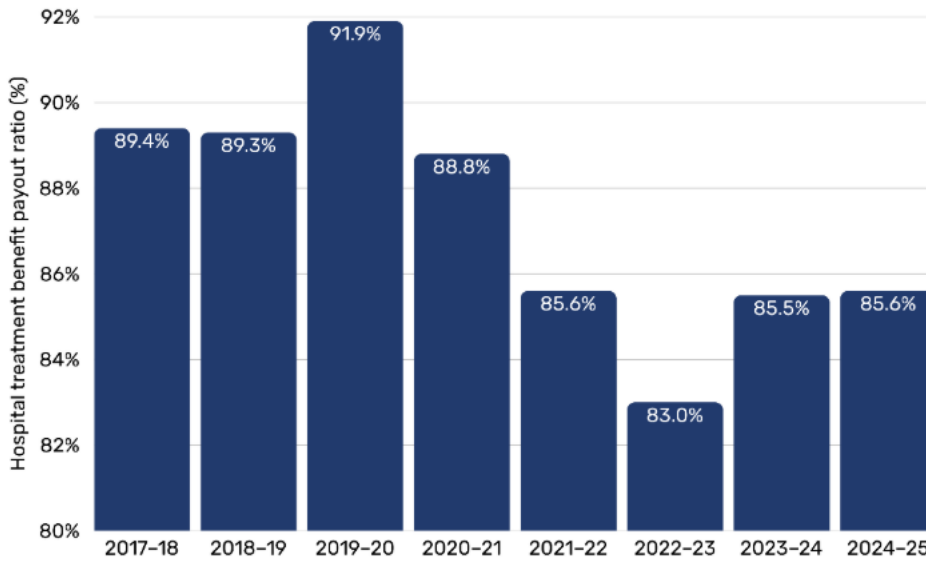
That the Commonwealth introduce a minimum benefit-payout ratio of 90 per cent for private health insurance.

Rationale

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.¹

Figure 1: Hospital treatment benefit payout ratio, 2017–18 to 2024–25²



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

² 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>

Figure 2: Private health insurer management expenses as a proportion of premium revenue, 2017–18 to 2024–25³

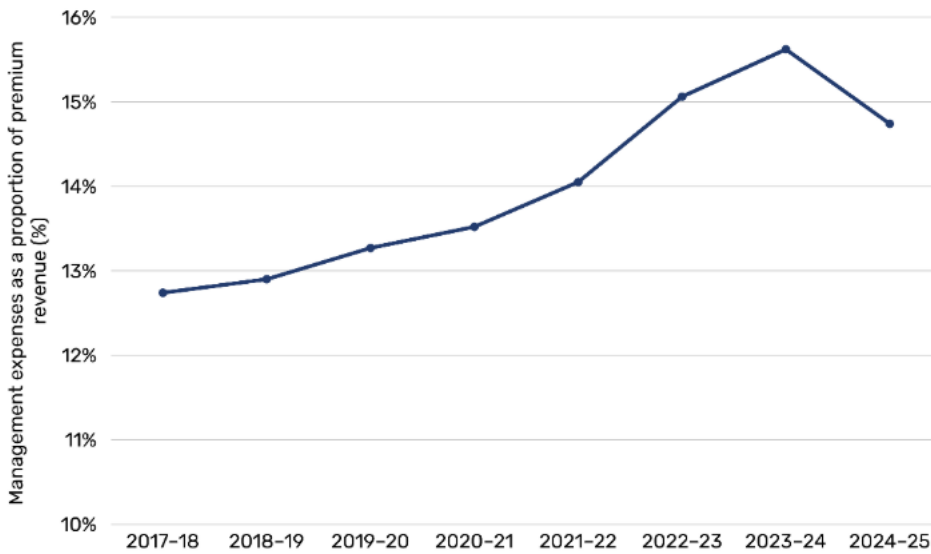
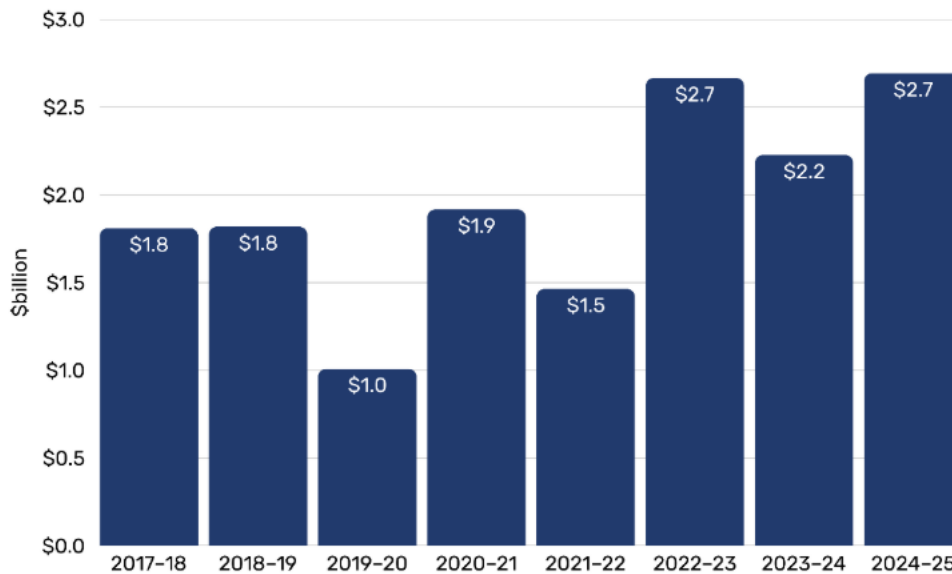


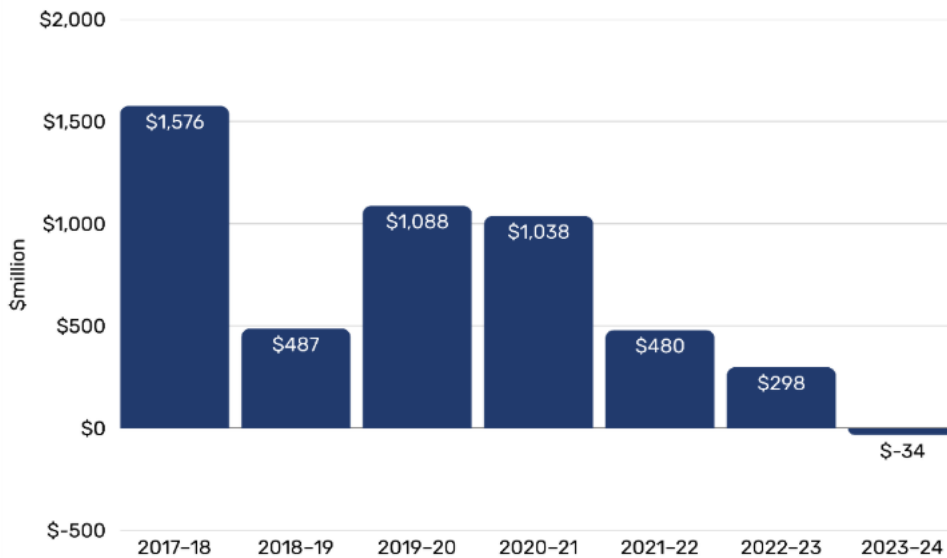
Figure 3: Private health insurer profits before tax, 2017–18 to 2024–25⁴



³ 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>

⁴ 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>

Figure 4: Private hospital profits before tax, 2017–18 to 2024–25⁵



Within Australia, several insurance sectors already operate under regulatory settings that effectively require high payout ratios or impose strict limits on administrative and profit margins. In compulsory motor accident schemes,⁶ for example, insurers’ management expenses and profit allowances are tightly capped, resulting in benefit-delivery ratios that commonly sit between 85 and 95 per cent. Similarly, the Australian Securities and Investments Commission’s (ASIC’s) product intervention powers have been used to restrict or remove low-value add-on insurance products, many of which exhibited claims ratios below 10 per cent,⁷ establishing a clear expectation that products failing to return a reasonable proportion of premiums to consumers will not be permitted to operate.

Across comparable health insurance systems internationally, minimum benefit-payout requirements are well established as a means of protecting consumers and ensuring that premium revenue is directed primarily toward frontline care. In many European health insurance systems, where insurers are primarily not-for-profit or operate under strict financial controls, payout ratios routinely exceed 90 per cent.^{8,9} In the United States, which is often viewed as a more commercialised market, federal Medical Loss Ratio rules require insurers in the individual and small-group markets to return at least 80 per cent of premiums as benefits, while insurers in the large-group market must return a minimum of 85 per cent, with rebates paid directly to consumers if these thresholds are not met.¹⁰

⁵ 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>

⁶ New South Wales Government (2022). *Cutting costs for NSW drivers*. Retrieved 31/12/2025 from: <https://www.sira.nsw.gov.au/news/media-release/cutting-costs-for-nsw-drivers>

⁷ Australian Securities and Investments Commission (2016). *ASIC puts insurers on notice to address serious failures in the sale of add-on insurance through car dealers*. Retrieved 31/12/2025 from: <https://www.asic.gov.au/about-asic/news-centre/find-a-media-release/2016-releases/16-301mr-asic-puts-insurers-on-notice-to-address-serious-failures-in-the-sale-of-add-on-insurance-through-car-dealers/#:~:text=Consumers%20obtained%20little%20financial%20benefit,for%20each%20dollar%20of%20premium>

⁸ Eurostat. (2011). *Healthcare expenditure statistics by function, provider and financing scheme*. European Commission. Retrieved 31/12/2025 from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics_by_function_provider_and_financing_scheme

⁹ BKK Bayern. (2025). *Verwaltungskosten in der GKV*. Retrieved 31/12/2025 from: <https://www.bkk-bayern.de/themen-im-fokus/verwaltungskosten-in-der-gkv/?utm>

¹⁰ Day B, Himmelstein DU, Broder M, Woolhandler S. (2015). The Affordable Care Act and medical loss ratios: No impact in first three years. *Int J Health Serv* 41(1):127-31. Doi: 10.2190/HS.45.1.i.

Together, international experience and domestic insurance regulation show that high minimum benefit expectations are both achievable and appropriate across different ownership models. Not-for-profit and for-profit insurers alike operate effectively under such frameworks overseas, and within Australia many insurance sectors already function with implicit or explicit limits on administrative costs and low-value products. In this context, where private health insurers of all types play a central role in funding hospital care, a mandated 90 per cent minimum benefit-payout ratio represents a fair and balanced standard and a logical extension of the established regulatory principles within Australia's insurance landscape. It would ensure that consumer premiums are directed primarily to care, while enabling insurers to compete on efficiency, contracting quality, and service value rather than on reducing benefit outlays.

The introduction of a Private National Efficient Price (PNEP) would further support this reform by improving transparency around the efficient cost of private hospital services, strengthening price signals in insurer-provider negotiations, and enabling clearer assessment of whether premium revenue is being directed toward care rather than administrative overhead. This policy proposal is discussed below.

Financial impact

Introducing a 90 per cent minimum benefit-payout ratio would inject an estimated **\$1.2 billion** into the hospital and health service sector,¹¹ 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.

The introduction of a minimum benefit-payout ratio would impose only modest administrative costs on government, primarily relating to policy development, consultation, legislative drafting, and minor system updates within the Australian Prudential Regulation Authority's existing reporting framework. These costs are expected to be small in scale and largely absorbed within existing departmental and regulatory resources. The reform does not require any new Commonwealth expenditure on benefits or subsidies.

There are, however, indirect fiscal impacts arising from expected changes in consumer behaviour, primarily through increased uptake of private health insurance and the resulting increase in Commonwealth outlays for the private health insurance rebate.

The main source of this indirect cost is the anticipated growth in private health insurance coverage as improved value for money – reflected in lower effective premiums associated with the higher payout ratio – encourages some individuals to take out cover. Uptake effects are estimated using published Australian assumptions for private health insurance price responsiveness,¹² rather than a proportional scaling approach. Consistent with the evidence, the behavioural response is expected to be most pronounced among individuals earning \$90,000 or less, who are not subject to the Medicare Levy Surcharge and therefore face fewer existing financial incentives to hold private health insurance.

Increased participation is also likely to generate second-round effects, as broader risk pooling and lower average premiums further enhance the attractiveness of private cover. Over time, these effects may extend to higher-income earners, including those subject to the Medicare Levy Surcharge. However, these secondary and dynamic effects are not quantified or included in the costing, meaning the estimates remain conservative.

The policy is not expected to materially increase uptake among people aged over 65 or those already subject to the Medicare Levy Surcharge, as these groups already derive relatively higher benefits from

¹¹ 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*. Retrieved 31/12/2025 from: <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>

¹² Parliamentary Budget Office (2020). *Behavioural assumptions and PBO costings*. Retrieved 31/12/2025 from: <https://www.pbo.gov.au/sites/default/files/2023-01/Behavioural%20assumptions%20and%20PBO%20costings.PDF>

private health insurance through greater utilisation or are already strongly incentivised by existing policy settings.

On this basis, the estimated fiscal impact of implementing a 90 per cent minimum benefit-payout ratio from 2026–27 is outlined in Table 1. Forward-year estimates are presented as steady-state approximations and assume a constant premium effect and broadly stable behavioural responses over time, recognising that uptake may plateau following an initial adjustment period. The costing assumes insurers do not fully offset increased benefit outlays through higher premiums, consistent with a regulated premium-approval process, and is aligned with observed demand responsiveness reported in previous policy and academic studies.

In addition to the rebate impacts, the analysis also accounts for reduced Commonwealth expenditure on public hospital services arising from diversion of activity to the private system. Improved affordability, contract stability, and service availability in the private hospital sector are expected to result in some patients (both newly insured and a subset of existing private health insurance members) electing to receive care privately in circumstances where they would otherwise have been treated as public patients. Based on published Australian evidence on private health insurance utilisation and public–private substitution behaviour,¹³ it is estimated that approximately 70,000 public hospital admissions are diverted to private care over the forward estimates, allocated across years in proportion to the additional uptake of private health insurance. The fiscal impact of this diversion is estimated to be approximately **\$508 million** over the forward estimates.¹⁴ Applying the Commonwealth’s average 45 per cent share of activity-based funding implies a corresponding reduction in Commonwealth hospital funding of approximately **\$229 million** over the forward estimates. This estimate is conservative, as it excludes potential reductions in public hospital demand arising from broader stabilisation of private hospital capacity, reduced waiting times, and behavioural switching among insured patients beyond those explicitly captured in the uptake modelling.

On this basis, after accounting for both the increased cost of the private health insurance rebate associated with higher uptake and the offsetting reduction in Commonwealth public hospital funding arising from diverted activity, the policy is estimated to have a **net Commonwealth fiscal cost of approximately \$69 million** over the forward estimates period.

¹³ This assumption draws on Australian empirical evidence showing that private health insurance primarily affects the public–private mix of hospital care through substitution rather than increased utilisation. Analyses using the Household, Income and Labour Dynamics in Australia (HILDA) Survey and administrative hospital data (including work by Eldridge and colleagues) find that individuals with private health insurance are substantially more likely to be treated as private patients and that changes in insurance coverage and affordability largely shift patients away from public hospital care rather than generating additional admissions. Australian Institute of Health and Welfare (AIHW) data further show that people with private health insurance continue to account for a material share of public hospital activity, indicating scope for behavioural switching when private hospital affordability, contracting, and service availability improve. Evidence from the COVID-19 period, when private hospital capacity was temporarily constrained and later restored, demonstrates a causal relationship between private hospital availability and public hospital demand. Taken together, this literature supports the application of a high-case assumption in which diversion reflects both new private health insurance uptake and a modest degree of behavioural switching among existing insured members, resulting in an estimated 70,000 public hospital admissions diverted to private care over the forward estimates period.

¹⁴ This estimate is derived using the National Efficient Price (NEP) expressed per National Weighted Activity Unit (NWAU), consistent with the Independent Health and Aged Care Pricing Authority’s (IHACPA) activity-based funding framework for public hospital services. The NEP for the analysis is assumed to be \$7,258 per NWAU (the 2024–25 NEP). For the purposes of this high-level estimate, an average of 1.0 NWAU per elective surgery episode is assumed. While actual NWAU values vary materially depending on procedure type, patient complexity, length of stay, and complication rates, the use of an average NWAU is considered appropriate in the absence of detailed procedure-level case-mix data and provides a reasonable estimate of the order-of-magnitude fiscal impact.

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
Total cost to government (\$m)	14.6	16.3	18.0	19.7	68.6

The expected premium and participation effects of introducing a 90 per cent minimum benefit-payout ratio are subject to several key assumptions. It is assumed that a 90 per cent payout ratio is sufficient to meet private hospital funding requirements at prevailing levels of activity, such that the reform does not generate sustained pressure for additional benefit increases that would otherwise require higher premiums to expand the overall funding pool. The costing further assumes that private health insurers, in aggregate, have sufficient capital buffers and operational flexibility to absorb higher benefit outlays primarily through reduced margins and lower management expenses rather than through premium increases, and that any financial stress among smaller or less efficient funds is managed through orderly consolidation rather than disorderly exits or material deterioration in customer service or product availability. It is also assumed that hospitals do not respond to higher mandated payout ratios by materially increasing prices, and that insurer bargaining power and existing premium-approval arrangements continue to constrain the full pass-through of increased benefit outlays into premiums. Finally, the estimates assume that consumers perceive the higher payout ratio as improved value for money, particularly among more price-sensitive groups, and that neither insurers nor providers adopt behavioural responses over the forward estimates period that materially erode the consumer value gains created by the reform.

Risks and implementation

One of the key risks associated with mandating a 90 per cent minimum benefit-payout ratio is the impact on insurers' capital adequacy, particularly for smaller funds. Aggregate industry data demonstrates private health insurers currently have a capital base of roughly \$11.86 billion versus a regulatory capital requirement of \$4.76 billion,¹⁵ suggesting that the sector as a whole has a substantial buffer and could absorb increased benefit outlays with limited risk to solvency. However, insurers with small membership bases, thinner capital buffers, higher cost structures (administration, risk equalisation imbalances, underwriting experience), or reliance on riskier revenue streams may struggle to maintain solvency

¹⁵ Australian Prudential Regulation Authority (2025). *Quarterly private health insurance performance statistics*. Retrieved 31/12/2025 from: <https://www.apra.gov.au/quarterly-private-health-insurance-performance-statistics>

under tighter margins. These funds could face capital strain, which might lead to several adverse outcomes:

- They may need to raise premiums aggressively, undermining the affordability rationale of the reform.
- Some may be forced to exit the market or consolidate with larger players.
- Others may significantly cut back on product offerings or restrict eligibility, reducing consumer choice, especially in regional or niche segments.

To reduce the risk of destabilising insurers (especially smaller ones) while still achieving the intended benefit-return reforms, several implementation design choices could be considered:

- Phased implementation for smaller insurers: Introduce the payout ratio mandate progressively over several years for smaller insurers, similar to what the Australian Prudential Regulation Authority did with the transitional arrangements for smaller insurers when they implemented the new Private Health Insurance Capital Framework in 2022. This would give smaller insurers time to restructure cost base, adjust contracting, improve operational efficiency, and rebuild reserves.
- Tiered payout ratio by fund size: Larger funds would be required to meet the 90 per cent payout ratio, while smaller funds would have a lower threshold (e.g. 85 per cent), similar to the approach in the United States.

Evidence from other regulated markets indicates that when insurer numbers are too high and dominated by very small funds, administrative costs rise and efficiency declines. Conversely, a more moderate number of well-capitalised insurers can achieve economies of scale while still preserving healthy competition. Academic literature supports this notion of “moderate concentration,” where insurers are large enough to operate efficiently but not so dominant that they can exert undue market power. With 30 private health insurers in Australia, many of them quite small, there is a reasonable argument (particularly given management expenses in 2024–25 were \$3.4 billion across all insurers, 14.7 per cent of hospital premium revenue)¹⁶ that gradual consolidation could strengthen financial resilience and improve the sector’s capacity to sustain a higher minimum benefit-payout ratio.

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.¹⁷ 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

¹⁶ 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>

¹⁷ Cost estimates are benchmarked against Commonwealth funding provided for comparable mandatory industry codes of conduct and ACCC market oversight activities, including the Dairy Code of Conduct (2019–20 and 2020–21) and the Gas Code of Conduct and gas market monitoring (2023–24). The proposed funding reflects the expected costs of consultation, code development, enforcement, dispute resolution, and ongoing market monitoring, and is proportionate to the scale and complexity of the private health insurance and hospital sectors.

efficient, sustainable hospital care rather than dissipated through contracting inefficiencies or market power imbalances.

Regulatory impact

The introduction of a minimum benefit-payout ratio would intersect with several existing regulatory levers under the *Private Health Insurance Act*, although none currently provide a direct or explicit mechanism to mandate a 90 per cent threshold. While the Minister for Health, Disability and Ageing has approval powers over annual premium increases, these powers are exercised in relation to the industry's average premium adjustment, rather than as a tool to selectively approve or deny increases for individual insurers based on their benefit-payout performance. The premium round however does enable the Minister to scrutinise industry cost structures and push for better value.

The *Private Health Insurance Act* also enables government to adjust minimum benefit settings, such as second-tier default benefits, minimum per-night payments, and complying product rules. While raising minimum per-night benefits could drive higher benefit outlays and improve payout ratios, these tools were not designed for this purpose and have limitations. In particular, second-tier benefits apply mainly when providers are out of contract, a relatively rare circumstance, and therefore cannot reliably lift overall benefit levels across the sector.

For these reasons, the most durable and transparent approach is the development of a new or amended legislative instrument under the *Private Health Insurance Act* explicitly establishing a minimum payout requirement. This would ensure national consistency, avoid reliance on indirect mechanisms, and give insurers regulatory certainty for multi-year planning and capital management. The primary challenge is timing: formal amendment processes require consultation and drafting and cannot be implemented immediately.

Priority 2: Provide targeted support for nurse wage increases in private hospitals

Decision sought

That the Commonwealth provide a one off, time-limited intervention to fund 50 per cent of the private hospital nurse wage uplift, phased over the forward estimates.

Rationale

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.

Financial impact

In 2024–25, wages and salaries in private hospitals are estimated at \$11.3 billion.¹⁸ Nurses account for approximately 45–55 per cent of total wages and salaries in private hospitals,¹⁹ equating to an estimated nursing wage base of approximately \$5.6 billion.²⁰

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.²¹ Table 2 shows the estimated annual increase in nurse wages by state and territory.

¹⁸ 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>

¹⁹ Based on data from CHA members.

²⁰ Calculated using Australian Bureau of Statistics Industry data and validated using data from CHA members.

²¹ 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>

Table 2: Estimated annual increase in nurse wages by state and territory²²

State/territory	Share of private hospital sector (%)	Estimated cost (\$m)
New South Wales	32	238–301
Victoria	26	194–244
Queensland	20	149–188
Western Australia	8	60–75
South Australia	6	45–56
Tasmania	2	15–19
Australian Capital Territory	2	15–19
Northern Territory	1	7–9
Total	—	745–940

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.

Table 3: 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	
Total cost to government (\$m)	125	114	102	104	445

Applying capped per-episode patient contributions to approximately 3.8 million same-day admissions and 1.33 million overnight admissions per year (2023–24), and assuming 85% effective collection to account for exemptions for vulnerable cohorts (e.g. chemotherapy, dialysis, Department of Veterans' Affairs-funded patients), would generate indicative gross revenue of ~\$750 million per annum, representing a material short-term stabilisation measure for private hospital finances.

²² Share of private hospital sector estimated using Australian Institute of Health and Welfare data, Australian Institute of Health and Welfare (2025). *Hospitals at a glance*. Retrieved 31/12/2025 from: <https://www.aihw.gov.au/hospitals/overview/hospitals-at-a-glance>

Importantly, the proposed wage subsidy is explicitly designed as a transition mechanism, not a permanent prop for private hospital operations. During the subsidy period, the funding allows hospitals to stabilise staffing, absorb the initial wage shock, and undertake the operational, pricing and workforce adjustments required to operate sustainably at higher nurse wage levels.

The modelling underpinning this proposal assumes that the subsidy ends at the conclusion of the forward estimates, and that by this point hospitals have embedded efficiency improvements, adjusted service mix and pricing structures, and achieved sufficient scale and productivity to remain commercially viable without ongoing Commonwealth support. In this sense, the subsidy accelerates establishment, workforce stability and quality during the transition period, rather than substituting for underlying commercial discipline.

Long-term viability of private hospitals is therefore assumed to be driven by underlying demand for services, efficient operations, appropriate workforce mix, and diversified revenue streams, not by continued reliance on government funding. The time-limited nature of the subsidy provides clarity to hospitals, insurers and government that Commonwealth support is finite, targeted, and does not create an ongoing fiscal liability.

Risks and implementation

Failure to provide targeted Commonwealth support for nurse enterprise agreement wage increases in private hospitals presents a material risk to the stability of Australia's mixed public–private hospital system. Private hospitals are price-takers in the labour market. State-negotiated public sector enterprise agreements and FWC determinations effectively set market wages for nurses across the entire hospital sector. Private hospitals must match these increases to retain staff, but unlike public hospitals, they do not receive automatic funding uplifts to absorb the additional costs.

Without Commonwealth intervention:

- Some private hospitals will become financially unviable, particularly smaller hospitals and regional services with limited capacity to absorb cost shocks.
- Some private health insurers may be unable to absorb the additional cost of nurse wage increases within existing margins, without significantly increasing premiums. The capacity to recover costs through premiums is constrained by the annual Ministerial approval process, and the increase required would directly impact affordability and risk declining participation in private health insurance.
- Where costs cannot be recovered, hospitals will be forced to reduce services, defer investment, or exit the market entirely, shifting demand onto already constrained public hospitals. This would undermine elective surgery capacity, increase waiting times, and impose additional costs on state and territory health systems.

These risks are immediate and systemic and are not the result of private sector inefficiency, but of government-led regulatory change.

The Commonwealth has traditionally been cautious about providing direct financial support to private hospitals. However, exceptional circumstances require exceptional responses, and there is strong precedent for Commonwealth intervention where private hospitals are essential to national health system capacity:

- In the 1980s, Commonwealth payments supporting private hospital costs were made under statutory schemes enacted pursuant to section 51(xxiiiA) of the Constitution to indirectly assist private hospitals in meeting rising labour costs, including nursing wages.²³

²³ Industry Commission (1997). *Private Health Insurance Report No. 57*. Australian Government Publishing Service. Retrieved 31/12/2025 from: <https://assets.pc.gov.au/2025-05/57privatehealth.pdf>

- During the COVID-19 pandemic, the Commonwealth introduced the Private Hospital Viability Guarantee, explicitly acknowledging private hospitals as critical national health infrastructure that required temporary public support to remain operational.²⁴

The most effective and administratively efficient response is for the Commonwealth to directly fund a defined proportion of nurse wage increases in private hospitals, consistent with previous approaches. This approach avoids reliance on indirect or fragmented cost-offset mechanisms – such as subsidies for utilities, capital compliance, accreditation, digital health, cybersecurity, or superannuation – which can be complex to administer and provide uncertain or uneven relief. Direct funding of wage increases delivers certainty for hospitals and insurers, improves transparency for government, and establishes a clear and direct link between policy decisions and their fiscal impact.

Regulatory impact

The proposed Commonwealth funding for nurse wage increases in private hospitals can be implemented within existing legislative, regulatory and administrative frameworks and does not require changes to primary legislation or the private health insurance regulatory regime.

Importantly, the proposal does not alter existing industrial relations arrangements, enterprise bargaining processes, or the role of the Fair Work Commission. Wage outcomes would continue to be determined through established mechanisms, with Commonwealth funding operating solely as a fiscal response to offset part of the resulting cost impact.

The proposal also does not require changes to private health insurance regulation, including premium approval processes or insurer–provider contracting arrangements. By reducing pressure on insurers to fund wage increases through higher benefits and premiums, the proposal supports the effective operation of the existing regulatory framework rather than adding complexity to it.

From an administrative perspective, the proposal can be implemented using well-established funding and reporting mechanisms, minimising compliance burden for government, hospitals and insurers. Funding can be targeted, time-limited and conditional, providing transparency and accountability while preserving regulatory stability.

Priority 3: Establish the foundations for a Private National Efficient Price

Decision sought

That the Commonwealth invest in the establishment phase of a PNEP, including funding for expanded cost collection, financial disclosure, independent assurance and regulatory oversight

Rationale

The establishment of a PNEP is a longer-term foundational reform to improve transparency, efficiency and sustainability in Australia's private hospital system. Under the proposed framework, the PNEP would be formally determined by government, providing a consistent national benchmark for private hospital pricing and a structured pathway toward more disciplined and sustainable funding arrangements over time. A government-determined PNEP would improve transparency in insurer–provider negotiations, reduce reliance on opaque bilateral pricing practices, and help moderate long-term growth in private health insurance premiums.

While initially intended to operate as a benchmark reference price, the credibility and long-term effectiveness of the PNEP depends on it being anchored in robust national data and supported by clear governance arrangements, with the capacity to inform, constrain or ultimately underpin funding

²⁴ Parliament of Australia (2020). *COVID-19: Major partnership with private hospitals*. Retrieved 31/12/2025 from: https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/FlagPost/2020/April/Agreement_with_private_hospitals

outcomes. As set out in Catholic Health Australia's submission on the Pricing Framework for Australian Private Hospital Services, the current foundations for a national price are not yet fit for purpose. The Private National Hospital Cost Data Collection (NHCDC) remains voluntary, incomplete and uneven, with inconsistent participation from day hospitals, limited coverage of mental health and subacute care, and wide variation in hospital costing capability. Without improved data capture, key differences in service models, technologies and cost structures cannot be reliably incorporated into price models. In addition, existing classification and cost datasets do not reflect the historical effects of chronic underfunding, deferred maintenance and deteriorating capital stock, limiting visibility of the true cost base required for sound price development.

Without targeted Commonwealth investment in data, costing, assurance and regulatory capability, there is a material risk that even a benchmark PNEP would lack credibility and fail to achieve its policy objectives. More importantly, such weaknesses would preclude any orderly transition to a model in which a government-determined national price plays a more substantive role in shaping private hospital funding.

To mitigate these risks, the Commonwealth should fund the initial establishment phase of the PNEP, ensuring the benchmark is robust, defensible, and scalable. This includes:

- expansion and strengthening of private hospital cost collection
- implementation of a financial disclosure framework
- independent validation and assurance processes
- a dedicated regulatory capability to oversee compliance and market conduct.

Financial impact

The primary cost driver associated with establishing the PNEP is dedicated specialist staffing, supported by modest operating expenditure for data systems, assurance, and stakeholder engagement. These costs fall across three distinct but complementary functions:

1. implementation and data capability
2. technical price calculation
3. regulatory oversight.

A dedicated PNEP implementation unit is required to undertake the foundational work necessary before a PNEP can be credibly applied. Key functions include:

- expanding national cost collection to include day hospitals and other under-represented service models
- improving data completeness, consistency and validation
- supporting hospitals to meet revised costing and disclosure requirements
- implementing a financial disclosure framework, including capital data
- undertaking modelling, testing and readiness assessments prior to use of PNEP outputs.

This function is expected to require around five full-time equivalent (FTE) staff, at a cost of around \$1.0 million per annum,²⁵ depending on the pace of implementation and the extent to which functions are delivered in-house versus externally commissioned. In addition to staffing, modest non-staff costs will be required for data systems, secure environments, external assurance and targeted sector support. These costs are estimated at \$1.0 million per annum.

In parallel, additional capacity would be required within the Independent Health and Aged Care Pricing Authority (IHACPA) to undertake the technical calculation and maintenance of the PNEP. This would

²⁵ An average cost of \$200,000 per full-time equivalent (FTE) is assumed.

build on IHACPA's existing expertise in national costing, classification systems and efficient price development in the public system, while recognising that private hospital pricing represents a new and distinct function.

This uplift would support:

- development and maintenance of PNEP methodologies
- analysis of expanded private hospital cost datasets
- iterative testing and refinement of PNEP calculations
- technical advice to government on readiness and stability of PNEP outputs.

This additional capacity is estimated to require approximately 3–4 FTE, supported by specialist analytical and modelling resources, at a cost of around \$0.5 million per annum.

A separate regulatory and oversight capability is required to support the introduction of the PNEP. This function would be distinct from both implementation and price-setting roles and would:

- oversee compliance with data and disclosure requirements
- monitor insurer and provider behaviour during the transition to PNEP-informed pricing
- manage assurance and audit processes
- intervene where conduct undermines competition, access or pricing integrity.

This capability is estimated to require approximately 5 FTE, at a cost of \$1.0 million per annum, with additional operating costs of \$0.5 per annum for legal, investigative and reporting support.

In total, the proposed establishment phase of the PNEP requires Commonwealth funding of approximately \$16 million over four years, to build the data, pricing and regulatory capability necessary to support a credible, government-determined national benchmark and enable an orderly transition to more disciplined private hospital funding arrangements (Table 3).

Table 4: Cost of establishing the foundations for a Private National Efficient Price, 2026–27 to 2029–30

	2026–27	2027–28	2028–29	2029–30	Total
PNEP implementation and data capability	2	2	2	2	8
IHACPA capacity uplift	0.5	0.5	0.5	0.5	2
PNEP regulation	1.5	1.5	1.5	1.5	6
Total cost to government (\$m)	4	4	4	4	16

Risks and implementation

Failure to adequately fund the establishment phase of the PNEP presents significant policy and system risks. Without targeted Commonwealth investment, the PNEP risks being developed and applied on the basis of incomplete, inconsistent or unrepresentative cost data, undermining confidence in the framework and limiting its practical usefulness in insurer–provider negotiations.

These risks are not theoretical. Experience from the development of public hospital pricing demonstrates that national pricing frameworks require multiple years of iterative data improvement,

validation, testing, and governance refinement before they can safely be relied upon for funding, benchmarking, or regulatory purposes. Applying the PNEP prematurely, before data maturity thresholds are met, risks embedding structural bias, disadvantaging particular service models or patient cohorts, and encouraging strategic behaviour rather than efficiency.

For these reasons, a staged and gated implementation approach is essential. Commonwealth funding should explicitly support an establishment phase in which the PNEP is developed, tested and refined, but not used in a binding or determinative way until readiness criteria are met. In practical terms, this requires Commonwealth investment to support:

- Clear readiness thresholds and phase gates, including minimum participation and representativeness benchmarks for the NHCDC, consistency in classification systems, and demonstrated stability of cost weights over time, before PNEP outputs are used for regulatory, contracting, or enforcement purposes.
- Expansion and strengthening of cost collection, particularly for day hospitals and other service models that are currently under-represented, accompanied by targeted technical support to improve costing capability and reduce compliance burden.
- Independent validation and assurance processes, analogous to IFR-style audit arrangements, to test data integrity, identify systematic bias, and provide confidence to government, insurers, and providers that PNEP outputs are robust and defensible.
- Implementation of a financial disclosure framework, including capital and asset-condition information, to ensure that efficient prices reflect sustainable service delivery rather than short-term cost suppression driven by deferred maintenance or under-investment.
- Transparent and independent governance arrangements, with clear separation between data collection, technical pricing functions, and regulatory oversight, to manage conflicts of interest, oversee transition decisions, and maintain confidence in the framework.

A staged approach also allows time to monitor and manage behavioural and market risks during transition, including potential changes to service offerings, contracting practices, or investment decisions that could adversely affect patient access or system capacity if a national price were applied too quickly or too rigidly.

Importantly, the costs associated with this implementation phase are administrative and regulatory in nature, borne by government rather than hospitals, and are modest relative to the scale of the private hospital sector and the potential system-wide consequences of a poorly implemented pricing framework.

Regulatory impact

In its initial phase, where the PNEP operates as a benchmark reference price only, no material regulatory change is required. However, implementing the PNEP as a binding funding model would require substantial regulatory reform.

The current private hospital funding framework under the *Private Health Insurance Act 2007* is built around insurer–provider contracting, supported by statutory default and second-tier default benefit arrangements, including benefit formulas linked to average charges under negotiated agreements. A binding PNEP would require amendments to primary legislation and extensive changes to subordinate Rules to establish a lawful basis for government-determined national pricing, redefine default benefit settings, and create enforceable obligations for cost collection, financial disclosure, and independent assurance.

As part of this reform, the Commonwealth would need to establish clear institutional responsibility for private hospital price determination. As outlined above, one option would be to expand the remit of the IHACPA to undertake the technical calculation and maintenance of the PNEP, drawing on its existing expertise in national costing, classification systems, and efficient price development in the public

system. This would require legislative amendments to extend IHACPA's functions beyond public hospital and aged care pricing, and to provide an explicit mandate in relation to private hospital data, methodologies, and price determinations.

Regardless of the institutional model adopted, the introduction of a binding PNEP would necessitate a dedicated regulatory and oversight function, with explicit legislative authority to:

- approve PNEP methodologies and updates
- require and enforce compliance with data submission, costing standards, and disclosure requirements
- oversee independent validation and assurance processes
- monitor insurer and provider behaviour during transition to PNEP-based funding
- intervene where conduct or implementation practices undermine pricing integrity, competition, or patient access.

Priority 4: Address access block in public hospitals

Decision sought

That the Commonwealth implement a package of reforms to address access block in public hospitals, including 1) lifting the annual growth rate applied to NHRA payments to 8 per cent and increasing the Commonwealth's share of total funding to 50 per cent, 2) funding 150 health liaison officers (HLOs) and 150 hospital discharge planners (HDPs) in addition to funding transition accommodation, and 3) clearing the elective surgery backlog by using private hospital capacity and providing targeted, time-limited funding to cover 50 per cent of the cost over two years.

Rationale

Increasing Commonwealth funding for public hospitals to meet increasing demand

Australia's public hospital system is under sustained and growing pressure, driven by population growth, ageing, increasing complexity of care, and workforce constraints. While demand for public hospital services continues to rise year on year, funding growth has not kept pace with this reality.

Under the National Health Reform Agreement (NHRA), the Commonwealth's share of public hospital funding has declined in relative terms, while states have continued to increase their contributions to ensure services remain available. States are now struggling to meet demand within existing funding arrangements, particularly as activity growth outstrips capped Commonwealth contributions. In addition, many states are placing pressure on public hospitals to deliver services below the National Efficient Price (NEP) and there is limited transparency around the extent to which hospitals are required to operate below the NEP, or how these expectations vary across jurisdictions.

Greater Commonwealth investment is therefore required, both by lifting the annual growth rate applied to NHRA payments and by increasing the Commonwealth's share of total funding. States should not be required to reduce their proportional contributions; rather, the total pool of funding must increase to reflect actual service need. States should also be required to adhere to strengthened transparency and accountability measures, including clear reporting on how funding is allocated and the NEP at which hospitals are expected to deliver services. Improved transparency will support better policy decisions, ensure funding is directed to patient care, and provide a clearer picture of system sustainability.

Improving hospital transitions into aged care, disability, and home-based supports

Exit block – the inability to discharge patients who no longer require acute hospital care due to a lack of suitable downstream supports – is a major contributor to pressure across Australia's hospital system. Patients who are clinically ready for discharge frequently remain in hospital beds because appropriate

aged care placements, disability supports, transitional accommodation, or home-based services are unavailable or delayed.

This issue reduces hospital capacity, contributes to emergency department overcrowding, increases ambulance ramping, and leads to poorer patient outcomes. Prolonged hospital stays are associated with functional decline, hospital-acquired complications, and reduced quality of life, particularly for older people and people with disability. Exit block also imposes significant costs on the health system, as acute hospital beds are among the most expensive forms of care.

Targeted discharge coordination programs have previously demonstrated success through dedicated discharge planning, early engagement with external providers, and clear accountability to improve patient flow. Examples of these programs include the New South Wales [patient flow concierge officers](#) and the [Care Finder program](#). However, a common challenge for these initiatives was a need to ensure that patients are appropriately matched with the right care settings, and not an automated referral to a specific care setting, like residential care. In addition, transition accommodation – short-term, non-acute step-down care for patients awaiting permanent supports – has been successfully used in several states to relieve pressure on hospitals. These models recognise that hospital discharge is not a single event, but a process requiring coordination across health, aged care, disability, and housing systems. Without dedicated roles and transitional capacity, hospitals are left managing problems they are not designed to solve.

Supporting public hospitals to clear the elective surgery backlog

Australia's public hospitals are facing a significant elective surgery backlog, with an estimated 290,000 patients currently waiting for procedures.²⁶ This figure is likely conservative, as it does not include patients still awaiting outpatient assessment prior to being placed on a surgical waiting list. Long waiting times result in deteriorating health, increased pain and disability, reduced workforce participation, and higher downstream health costs.

The backlog has accumulated due to a combination of factors, including pandemic-related disruptions, workforce shortages, constrained hospital capacity, and funding arrangements that limit the ability of states to rapidly scale activity. Without targeted intervention, waiting lists are likely to continue to grow, further entrenching inequities in access to care.

There is a clear opportunity to use private sector capacity to help address the backlog, complementing public hospital services rather than replacing them. Leveraging private hospitals for publicly funded procedures can increase throughput quickly, reduce waiting times, and provide patients with faster access to care. At the same time, it supports the financial viability of the private sector, which plays an important role in the broader health system and can provide surge capacity during periods of peak demand.

Targeted Commonwealth funding, delivered outside existing activity caps and on a time-limited basis, would enable jurisdictions to clear the backlog in a planned and efficient manner. This approach mirrors

²⁶ NSW: Retrieved 12/12/2025 from: <https://www.bhi.nsw.gov.au/data-portal>

ACT: Retrieved 12/12/2025 from: <https://www.canberrahealthservices.act.gov.au/about-us/Elective-Surgery-waitlist-data>

SA: Retrieved 12/12/2025 from:

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+hospital+dashboards/about+the+elective+surgery+dashboard/elective+surgery+dashboard>

WA: Retrieved 12/12/2025 from: <https://www.health.wa.gov.au/Reports-and-publications/Elective-Surgery-Wait-List-ESWL-reports/Elective-Surgery-Monthly-Report>

VIC: Retrieved 12/12/2025 from: <https://vahi.vic.gov.au/planned-surgery/patients-waiting-treatment>

NT: Retrieved 21/21/2025 from: <https://parliament.nt.gov.au/business/written-questions/wq/14th-assembly-written-questions/answers/Answer-to-Written-Question-634-Surgery-Wait-Times.pdf>

TAS: Retrieved 12/12/2025 from: <https://www.health.tas.gov.au/health-system-dashboard/monthly/surgery>

QLD: Retrieved 12/12/2025 from: <https://www.performance.health.qld.gov.au/statewide-performance/planned-care/planned-surgery-activity>

arrangements used successfully during the COVID-19 response and recognises the shared Commonwealth–state responsibility for ensuring timely access to essential surgical care.

Financial impact

Increasing Commonwealth funding for public hospitals to meet increasing demand

Lifting the annual growth rate applied to Commonwealth NHRA payments from 6.5 per cent to 8 per cent is estimated to increase Commonwealth expenditure by \$480 million in 2026–27, rising to \$2,380 million in 2029–30, with a total cost of \$5,550 million over the forward estimates period.²⁷ Lifting the Commonwealth share of NHRA payments from 45 per cent to 50 per cent, incorporating the 8 per cent annual growth, is estimated to increase Commonwealth expenditure by \$3,860 million in 2026–27, rising to \$4,860 million in 2029–30, with a total cost of \$17,390 million over the forward estimates.²⁸

Improving hospital transitions into aged care, disability, and home-based supports

Implementing 150 HLOs and 150 HDPs is estimated to cost \$124 million over the forward estimates.²⁹ Staffing numbers were indexed annually by 1.3 per cent to reflect projected growth in hospital patient days. Salaries were indexed by 1.95 per cent per annum to account for wage growth.

Transition accommodation costs were estimated using a unit-cost approach based on published state benchmarks for non-acute step-down care. A blended bed-day cost was applied, reflecting a mix of disability-specific transitional accommodation and aged-care-type step-down services. National capacity was assumed at 600 beds operating at 90 per cent occupancy. A 20 per cent uplift was applied to base operating costs to reflect program wraparound requirements, including brokerage, transport, commissioning, administration, and capability for complex needs. The cost is estimated at \$429.7 million over the forward estimates.

Supporting public hospitals to clear the elective surgery backlog

Assuming approximately 290,000 patients are currently on the elective surgery waiting list (noting this is a conservative estimate, as it excludes patients awaiting outpatient assessment prior to listing), the indicative cost to clear the backlog is estimated at \$2.1 billion.³⁰

It is proposed that the Commonwealth fund 50 per cent of the total cost over two years, equivalent to \$1.05 billion, consistent with shared Commonwealth–state responsibility for public hospital activity. This funding would be provided outside the existing cap on Commonwealth funding growth, operating in a manner analogous to the COVID-19 funding agreement, to ensure timely and targeted support to jurisdictions to address the elective surgery backlog.

²⁷ Estimated using Commonwealth NHRA payments as reported by the National Health Funding Body.

²⁸ Estimated using Commonwealth NHRA payments as reported by the National Health Funding Body.

²⁹ Base salaries were assumed to be \$115,272 per annum for HLOs and \$83,031 per annum for HDPs, reflecting current public-sector salary ranges.

³⁰ This estimate is derived using the NEP expressed per NWAU, consistent with the Independent Health and Aged Care Pricing Authority's (IHACPA) activity-based funding framework for public hospital services. The NEP for the analysis is assumed to be \$7,258 per NWAU (the 2024–25 NEP). For the purposes of this high-level estimate, an average of 1.0 NWAU per elective surgery episode is assumed. While actual NWAU values vary materially depending on procedure type, patient complexity, length of stay, and complication rates, the use of an average NWAU is considered appropriate in the absence of detailed procedure-level case-mix data and provides a reasonable estimate of the order-of-magnitude fiscal impact.

Table 5: Cost of addressing access block in public hospitals, 2026–27 to 2029–30

	2026–27	2027–28	2028–29	2029–30	Total
Lifting funding growth cap to 8%	480	1,030	1,660	2,380	5,550
Increasing NHRA share to 50%	3,860	4,170	4,500	4,860	17,390
Hospital liaison officers and hospital discharge planners	29.8	30.7	31.7	32.8	124.0
Transition accommodation	104.2	106.3	108.5	110.7	429.7
Elective surgery funding	525	525			1.01
Total cost to government (\$m)	4,999.0	5,862.0	6,300.2	7,383.5	24,543.7

Risks and implementation

Increasing Commonwealth funding for public hospitals to meet increasing demand

Failure to adjust Commonwealth public hospital funding settings in line with demand presents significant fiscal, service delivery and system sustainability risks. Without increased Commonwealth investment, states are likely to continue placing pressure on public hospitals to absorb growing activity within constrained budgets. This risks entrenching structural underfunding, undermining hospital financial viability, and exacerbating workforce pressures and service quality risks. In addition, neither governments nor the public have visibility over the extent to which hospitals are being required to operate below efficient prices, nor the implications for access, safety and sustainability.

For these reasons, increased Commonwealth funding must be accompanied by strengthened implementation and assurance arrangements. In particular, lifting the Commonwealth share and growth rate of NHRA payments should be implemented in a way that increases the total funding pool rather than displacing state effort, and that improves transparency around how funding expectations translate into hospital-level delivery requirements.

In practical terms, this requires:

- explicit maintenance-of-effort provisions to ensure states do not reduce their proportional contributions in response to higher Commonwealth funding
- mandatory, standardised reporting by states on hospital funding allocations, activity targets and the implied NEP at which services are expected to be delivered
- clearer national guidance on the appropriate use of NEP as a benchmark for hospital funding expectations, including disclosure where hospitals are funded materially below NEP
- strengthened assurance and reconciliation processes under the NHRA to support comparability, accountability, and confidence in funding arrangements.

Without these safeguards, additional Commonwealth investment risks being absorbed without resolving the underlying drivers of hospital financial stress or improving system transparency.

Improving hospital transitions into aged care, disability, and home-based supports

Failure to address exit block in a coordinated and systematic way presents ongoing risks to hospital capacity, patient outcomes, and system efficiency. Without targeted intervention, hospitals will continue to accommodate patients who no longer require acute care because appropriate downstream supports are unavailable or poorly coordinated, leading to avoidable bed occupancy, emergency department overcrowding, and ambulance ramping.

A key implementation risk is that poorly designed transition arrangements simply relocate the problem rather than resolving it. Transition accommodation, if not tightly linked to permanent aged care, disability or home-based supports, can become a holding arrangement that delays rather than facilitates discharge. Similarly, without clear authority and accountability, discharge planning roles may struggle to overcome structural barriers across systems.

Experience from previous discharge coordination initiatives demonstrates that success depends on dedicated roles, early engagement, and clear cross-system accountability. Transition models work best when they are time-limited, clinically appropriate, and embedded within a broader pathway to permanent supports.

Effective implementation therefore requires a staged and integrated approach, including:

- clearly defined eligibility and discharge readiness criteria, applied consistently across hospitals
- dedicated hospital liaison officers and discharge planners with authority to coordinate across health, aged care, disability, and housing systems
- transition accommodation designed as short-term, non-acute step-down care, with explicit pathways and timeframes for onward placement
- shared performance measures across portfolios, such as avoidable bed days and time from “ready for discharge” to discharge
- active monitoring of unintended consequences, including readmissions, prolonged transition stays, and substitution of health funding for gaps in other systems.

Without coordinated implementation and shared accountability, exit block initiatives risk delivering limited or temporary relief while underlying system pressures persist.

Supporting public hospitals to clear the elective surgery backlog

Failure to intervene decisively to address the elective surgery backlog risks entrenching long waiting times, worsening patient outcomes, and increasing downstream health costs. Without targeted support, public hospitals are unlikely to clear the backlog within existing funding, workforce, and capacity constraints, and waiting lists are likely to continue to grow.

However, there are also material risks if backlog funding is implemented without appropriate safeguards. Rapid scaling of activity, particularly through private sector capacity, could decrease the value proposition of private health insurance or result in inequitable access if lower-complexity or metropolitan patients disproportionately benefit. One-off “blitz” approaches also risk temporary improvements followed by a rebound in waiting lists if structural drivers are not addressed.

For these reasons, backlog funding should be time-limited, targeted and tightly governed. Implementation should focus on maximising additional capacity rather than reallocating existing resources, and should ensure consistency with national pricing and safety frameworks.

In practical terms, this requires:

- clear segmentation of the backlog to match patients to appropriate settings, with lower-complexity procedures delivered through private or dedicated surgical pathways and complex cases retained in public hospitals
- use of the Department of Veterans' Affairs Private Hospital and Day Procedure Centre Cost Indexation Report as the basis for costing, contracting, and performance monitoring to ensure services are delivered sustainably in private hospitals
- procurement and referral arrangements that include equity safeguards, minimum case-mix requirements, and transparent reporting
- strong clinical governance, credentialing, and quality assurance across all participating providers
- public reporting of progress against agreed waiting time and long-wait targets to maintain accountability and confidence.

Targeted Commonwealth funding, delivered outside existing activity caps and accompanied by these safeguards, provides the best opportunity to clear the backlog without creating new system risks or inequities.

Regulatory impact

Increasing Commonwealth funding for public hospitals to meet increasing demand

Lifting the annual growth rate applied to Commonwealth NHRA payments and increasing the Commonwealth share of funding would not require new primary legislation. These changes can be implemented in 2026 in the next NHRA, currently under negotiation, through renegotiation of NHRA schedules and associated intergovernmental agreements as part of the next Agreement, consistent with previous variations to funding caps and indexation arrangements.

Strengthened transparency and accountability requirements, including reporting on hospital-level funding allocations and the implied NEP at which services are expected to be delivered, can also be implemented under existing arrangements. The NHRA already contains reporting, reconciliation, and data-sharing provisions, which can be expanded through revised schedules or national reporting specifications within the next Agreement, without legislative change.

Accordingly, the regulatory impact of this measure is low. Implementation would rely on intergovernmental negotiation through the next NHRA, commencing in 2026, rather than regulatory reform, with any additional reporting obligations imposed on states through updated Agreement conditions rather than new regulatory instruments.

Improving hospital transitions into aged care, disability, and home-based supports

The proposed measures to improve hospital transitions could, in principle, be delivered through existing regulatory and program frameworks across the health, aged care, and disability systems, including through expansion of established state-based models. However, these arrangements are currently fragmented across multiple portfolios, funding streams and legislative frameworks. In practice, this siloing limits accountability, creates implementation gaps at system interfaces, and reduces the effectiveness of hospital discharge initiatives when pursued in isolation by individual jurisdictions or programs.

For this reason, the most effective and sustainable approach is to incorporate hospital transition measures into the next NHRA. Doing so would enable nationally consistent expectations; shared Commonwealth–state accountability; shared accountability between care providers across aged care, health, and disability sectors; and clearer alignment between acute hospital funding and downstream care capacity, without the need for new regulatory regimes.

Overall, regulatory impact is low. Implementation would rely on expansion and coordination of existing models and programs, with incorporation into the next NHRA providing the appropriate governance and funding framework to overcome system silos and support effective implementation from 2026.

Supporting public hospitals to clear the elective surgery backlog

The proposed approach to addressing the elective surgery backlog can be delivered within existing regulatory and funding frameworks and is best implemented through dedicated, time-limited funding incorporated into the next NHRA. The DVA Private Hospital and Day Procedure Centre Cost Indexation Report framework is already used by private hospitals and provides an appropriate mechanism for delivering care sustainably in private hospitals.

The use of private hospitals for publicly funded elective surgery is already permitted under current regulatory settings, subject to existing accreditation, credentialing and clinical governance requirements. Contracting, procurement and referral arrangements can be managed through existing state and territory mechanisms, with additional reporting and performance expectations specified as NHRA funding conditions.