Australian
Private Hospitals
Association

APHA budget submission 2025

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CONTENTS

Executive Summary

APHA has undertaken analysis of APRA data and compared it with historical statistics to develop an understanding of the actual nature of viability in the private hospital sector and provide an evidentiary basis for possible corrective measures.

The shortfall in revenue in acute hospital or "hospital-only" benefits[1] is calculated by applying cumulative inflation and benefit indexation since the reference to a financial quarter or year. The sector's profitability within the reference financial year (FY) is estimated to be the profitability of the *Hospitals (private)* industry subdivision in the same year.

We have listed some key trends and data below to provide a summary of our findings.

- The quarterly shortfall relative to cumulative inflation since the June 2019 quarter first exceeded $200 million in December 2022. The CPI increase in the twelve months up to 31 December 2022, 7.8 percent, was the largest annual CPI increase since June 1990.
- The quarterly shortfall, calculated using cumulative CPI growth and benefit indexation since June 2019, was $248 million for the June 2024 quarter.
- The annualised shortfall on the benefits for FY2024 was about $1.254 billion. The shortfall has been steadily increasing from $660 million in FY20 to the present.
- The number of day-only episodes has been increasing steadily by around 100,000 per year while the number of overnight episodes has seen a smaller increase of around 50,000 annually.
- The total revenue increase required per year is between one 1.0 to 1.2 billion dollars.
- APHA recognises that cumulative shortfalls over more than half a decade cannot easily be addressed in a one or two-year period. However, a $450 million uplift in revenue per year can be achieved via a $75 day-only (DO) and $200 overnight (ON) copayment per admission.
- A copayment setting of $150/$250 (DO/ON) would achieve further significant relief while containing the additional expenditure below $650 million per year over two years.

DO/ON copayment (per episode)	DO copayment (total) (n=2,905,437)	ON copayment (total) (n=1,127,256)	Private hospital sector copayment (total)
$50/$100	$145,271,850	$112,725,600	$257,997,450
$50/$150	$145,271,850	$169,088,400	$314,360,250
$75/$150	$217,907,775	$169,088,400	$386,996,175
$75/$200	$217,907,775	$225,451,200	$443,358,975
$100/$200	$290,543,700	$225,451,200	$515,994,900

[1] Acute hospital benefits exclude nursing home type patients, medical, prostheses, total chronic disease management programs, and benefits paid for general treatment.

$100/$250	$290,543,700	$281,814,000	$572,357,700
$125/$250	$363,179,625	$281,814,000	$644,993,625

Table 1 The estimated funding that would accrue at different copayment settings

- APHA analysed the financial demand of achieving between 20 and 50 percent of the required uplift. This is proposed to be achieved via a copayment on each day-only (DO) and overnight (ON) admission.
- The total annual DO and ON copayments for the whole sector are based on the numbers of DO and ON episodes that occurred in FY2024.
- The operating profit margin for the sector has fallen considerably from approximately 9.6 percent in June 2018 to a low of 1.4 percent in June 2023 (Figure 1). Data for FY 2023-2024 has not yet been released by the Australian Bureau of Statistics.
- The average wages and salaries have also risen steadily since June 2015 from $58,000 to around $68,000 in June 2022. Employment only increased by around 1,000 people between June 2022 and June 2023 but selected labour costs rose by over $400 million.

THE PROBLEM

- The data exhibits a critical shortfall of funds for private hospitals to continue to remain viable and investable. There is a need for immediate short-term government intervention to help the sector assume sustainable levels of operating profit, while working on longer-term structural reforms. APHA acknowledges that achieving a pre-COVID-19 operating profit of 9.6 percent may be difficult in the current economy with high inflation.
- The shortfall on the PHI benefits paid to private hospital operators has been steadily increasing from $660 million in 2019/20 to an annualised shortfall for 2023/24 of $1.254 billion (Figure 2) resulting in continuation of hospital and service closures.
- According to the Minister for Health's Health Check summary, about 33 percent of hospitals are loss-making on EBITDA.
- Closure of these hospitals would equate to about 1.3 million hospitalisations moving into the public system or about a 20 percent increase in current public volumes in an overburdened system, further exacerbating waiting lists and emergency department (ED) ramping.
- To restore the prior sustainability of the sector, additional revenue of at least $250 million per quarter would be required to flow into the operation of private hospitals.

THE IMMEDIATE SOLUTION

- APHA recognises that it may not be viable to cover entire annual shortfalls as they arise and herein requires interim funding to the sector of between $450 million and $650 million per annum, until such time as the government and key stakeholders have worked through longer-term structural solutions. This will provide immediate relief and address up to half of the estimated annual shortfalls.

- Given that fiscal health expenditure was $178.7 billion in 2022–23, this magnitude of relief has a relatively small impact on the federal budget, while allowing the government, private hospitals and insurers to work constructively on longer-term funding reform.[2]
- A revenue uplift of between $450 million and $650 million per year for two years would stop the cascade of loss of private hospital capacity in the form of hospital and service closures. The structure of this proposal is detailed in Table 1.
- The following paper includes a number of other immediate solutions and immediate asks such as:
    - Introducing Digital Interoperability Private Hospital Incentive to digitise paper-based records and implement interoperability across the health system.
    - Introducing Commonwealth Private Hospital Nursing Wage Subsidy that covers the difference between the PHI average weighted premium increase and, the weighted average of Private Hospital enterprise bargaining agreement (EBA) increases and any Fair Work Commission (FWC) Award increases.
    - Entering into a Private Health Insurer Payout Ratio Memorandum of Understanding to increase private hospital funding by $0.9 billion, through the return to a payout ratio of 88 cents in each dollar of hospital policy premium revenue.
    - Addressing Medicare funding disincentives to treat complex mental health inpatients, through doubling the psychiatrist inpatient consultation Medicare benefit, expand nurse practitioner's scope of practice to prescribe and be eligible for Medicare benefits for inpatient mental health consults.
    - Incentivising committed National Health Reform Agreement (NHRA) funding toward latent private capacity, by increasing the Commonwealth contribution to 60:40 when using private hospitals.
    - Including benefits paid for maternity in risk-equalisation and silver products, which would improve the access to and affordability of private maternity services.
    - Minimising earnings retained under APRA capital adequacy standards by introducing a fixed maximum ratio, with the released excess paid to hospitals.
    - Incentivising anaesthetists and surgeons to work in regional and rural private hospitals, through a Medicare Benefit Schedule regional loading.

[2] Health expenditure Australia 2022–23, AIHW (2024)

1.0 Introduction

HEALTH CHECK ISSUES

The release of the Australian Government's Private Hospital Financial Health Check raises significant issues. After two years of of extensive engagement and discussion by the private hospital sector, including the closure of 18 private hospitals and the culling of over 70 services in other hospitals, we are no nearer to a solution for the failure of private health insurers to meet the actual cost of care in facilities across the country.

Private hospitals play an increasingly pivotal role in the delivery of essential healthcare services to Australians. In 2022/23 private hospitals treated 41.2 percent of all hospitalisations, an increase from 40.3 percent in 2018/19, and deliver about 70 percent of all elective surgery. The viability and continued investment in private hospitals is crucial to the ongoing sustainability and delivery of quality healthcare services for Australians.

While the Health Check notes the bleak picture for the private hospital sector, it fails to fully appreciate the situation due to erroneous accounting that skews the true facts. The report cites that expenditure had increased by 4.1 percent, while revenue had only gone up by 2.9 percent between 2018-19 to 2021-22.

However, the report then employs a 'weighted average EBITDA margin' to estimate that the sector's margins were likely to be between 7 percent and 8 percent in 2022-23. APHA rejects this methodology and its estimate. A weighted EBITDA does not accurately reflect the overall state of the sector and instead seems to subscribe to an unreasonable, alternate narrative.

Data from the Australian Bureau of Statistics shows a fall in private hospital earnings before interest, tax, depreciation and amortisation (EBITDA) between 2020-21 and 2022-23, from $2.003 billion to $925 million. During the same period, operating profit before tax fell from $1.038 billion to $280 million. The data is clear that EBITDA and profit before tax fell dramatically between 2020-21 to 2022-23.[3]

In fact, the 2022-23 EBITDA margin is 4.21 percent - a far cry from the Health Check's estimate. And still well below the minimum 5 percent threshold that represents the required free cash to reinvest in hospital services. It is important to note that the 5 percent threshold only permits reinvestment in the status quo and does not permit any form of advancement. In a sector that carries significant debt, EBITDA margins realistically need to meet a 10 percent threshold, at least, to provide adequate cash flow for capital expenditure, debt servicing, and attracting investment.

PURPOSE

The Australian Private Hospitals Association (APHA) has identified an urgent need for an uplift of revenue to the private hospital sector, following confirmation of the sector's financial distress by the

[3] Australian Bureau of Statistics, *Australian Industry* (2022-23), ABS. < https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry/latest-release)>.

Private Hospital Sector Financial Health Check conducted by the Department of Health and Aged Care (the Department). There is a need for long-term solutions and reforms to help recovery in the sector. However, this document addresses short-term needs to ensure that the sector can continue to operate while long-term reforms are considered and developed.

The sector has been under significant financial pressure in the face of slow growth of private health insurance (PHI) benefits relative to rising costs of operation, and regulatory reforms aimed at reducing benefits paid for hospital treatment. There is an immediate need for increased funding to ensure that the sector can continue to offer the highest quality of healthcare to privately insured patients in Australia.

Government has a responsibility to ensure that their constituents can access high quality healthcare under a value-for-money value proposition. It is accordingly responsible for promoting the health of the healthcare sector, not undermining it or refusing to take remedial action where required. A failure to adequately support the sector will amount to an abrogation of responsibility. The sector understands the immense pressures on households that have arisen out of the cost-of-living crisis in Australia and as such actively advocates for solutions that are considerate of that and do not place a further burden on hard working Australians. Despite inaccurate media coverage, any increase in out-of-pocket costs for patients is a measure of last resort. It will be a lack of action by government that will force the sector to make difficult decisions.

In the period from 2018/19 to 2023/24 PHI price indexation has fallen well short of cost inflation (Figure 2; Table 2) resulting in substantially reduced operating margins and balance sheet strength across the sector.

The Australian Prudential Regulation Authority (APRA) released quarterly private health insurance statistics on 27 August 2024 for the June 2024 quarter. APHA has conducted internal analysis and evaluation of the data in the APRA report and the Australian Bureau of Statistics (ABS) reports on inflation and the performance of Australian and New Zealand Standard Industrial Classification (ANZSIC) industry subdivisions.

The data and analysis present comparative trends in growth of the Consumer Price Index (CPI) and indexation of benefits paid, demonstrating shortfalls between actual benefits paid and the benefits required to offset inflation, that is, fully indexed at the rate of CPI growth. These trends are presented in the context of the declining profitability of ANZSIC industry subdivision 84, *Hospitals (private)*.

Recognising the substantial threat to a significant proportion of the overall health system's capacity, this proposal paper attempts to bring clarity to the magnitude of uplift required and what a conservative proportion of the required uplift accrues to in annual monetary terms.

2.0 Context

1.0 THE DATA

Industry performance data provided by the Australian Bureau of Statistics (ABS) has shown a high degree of volatility in the percentage of private hospitals that have either made a profit/broken even or made a loss between FY 2020-21 to FY 2022-23. The percentage of private hospitals that have made a profit or broken even stood at 93 percent in FY 2020-21. This plummeted to 30.2 percent in FY 2021-22. While there was a rebound to 80.8 percent in FY 2022-23, the legacy of these losses, ongoing shortfalls in health fund payments and inflationary pressures have put private hospitals in a precarious position.

The percentage of private hospitals that made a loss was 7 percent in 2020-21 but soared to 69.8 percent in 2021-22 before subsiding to 19.2 percent in 2022-23. ABS data on other economic sectors shows a more consistent trend in entities making a profit/breaking even or making a loss with an average observable difference of 5-7 percent points over the three financial years. Further to this, the investment rate for private hospitals has fallen by almost 0.7 percent every year between 2020-2023.

Consistent and reliable financial performance is necessary for private hospitals. While government funded public hospitals are able to fall back on government intervention to support their financial requirements, private hospitals do not have the same safety net. A fall in revenue coupled with a highly volatile environment can depress the performance of private hospitals and their ability to offer good healthcare, access and continuity of care. The sector needs stabilisation and an injection of funds to continue to operate at pre-COVID optimal levels. While some larger groups may be able to continue operations whilst meeting costs, smaller private hospitals will have no choice but to succumb to bankruptcy or go into voluntary administration.

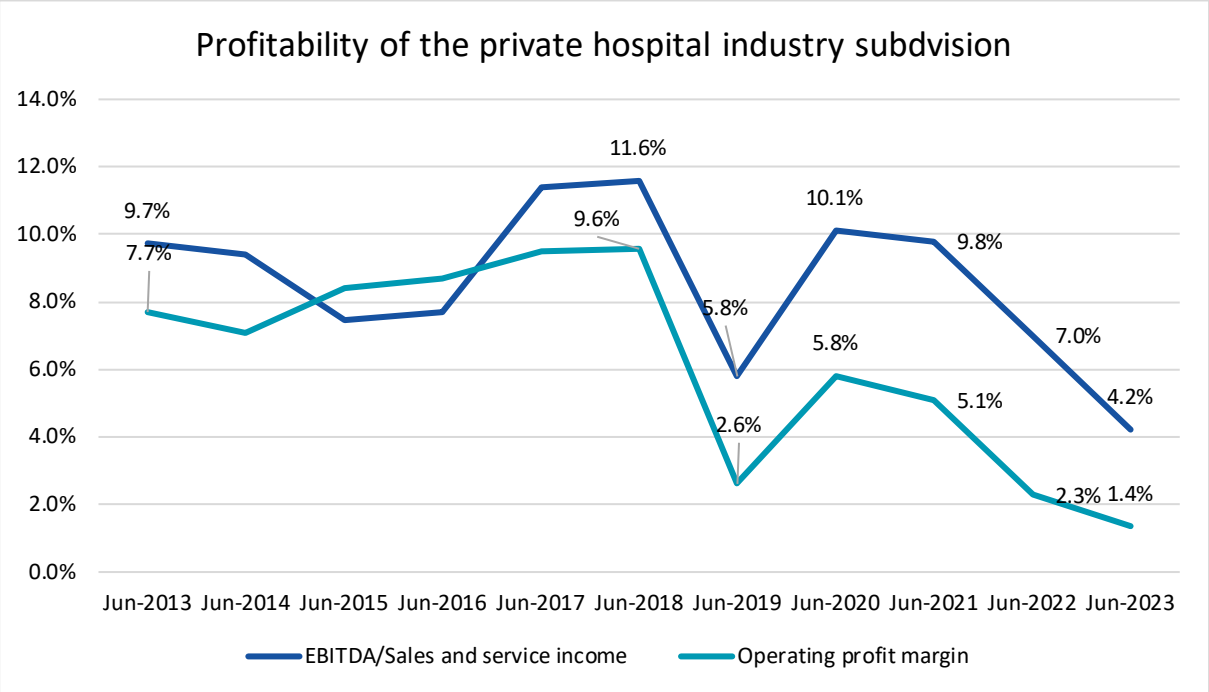

Figure 1 Data source: Health care and social assistance (private), by industry subdivision, 2022-23, ABS (2024)

As the private hospitals sector has felt the pressures of inflation, supply shocks and other conditions, it is evident that private health insurers have continued to thrive. A report by the Australian Competition and Consumer Commission (ACCC) for FY 2022-23 identified a net profit increase of 110 percent for PHI providers. At the same time, complaints made against PHI providers increased by 26.8 percent from 2021-22, with over 900 benefits-related complaints of all 3,429 complaints made, being received in 2022-23. This has only had the effect of undermining confidence in the private healthcare sector at large.

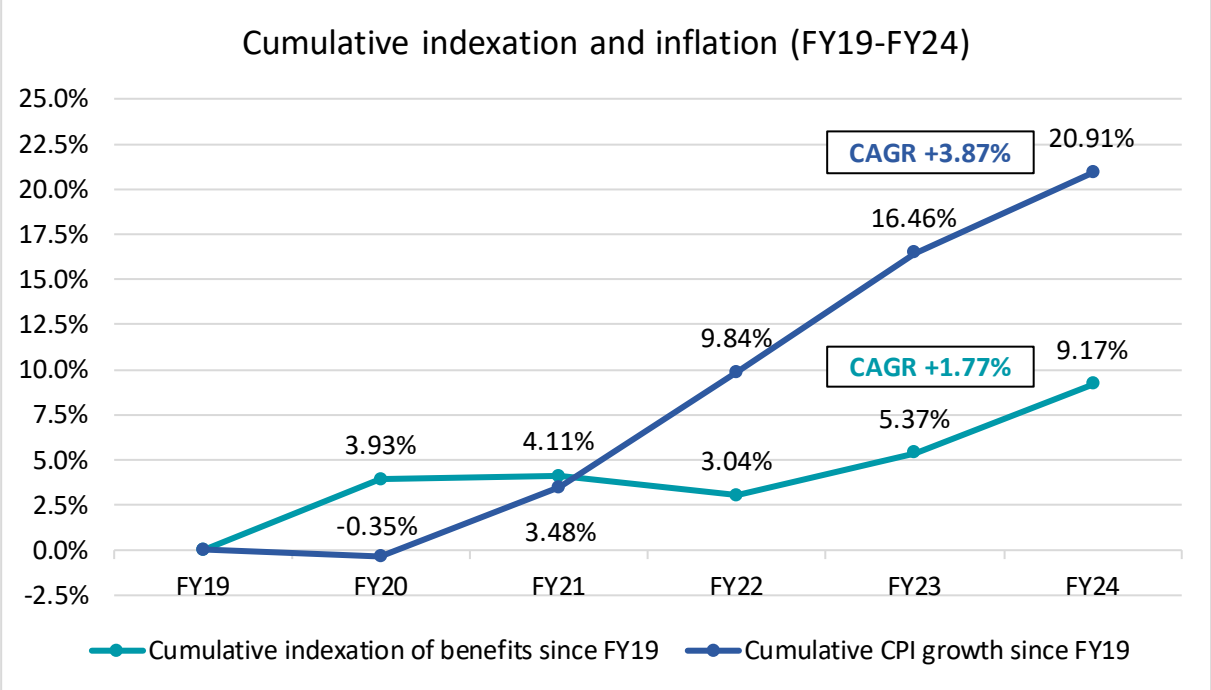

Figure 2 Data source: Consumer Price Index, Australia, ABS (2024); APRA Quarterly Private Health Insurance Statistics, APRA (2024) (CAGR: compound annual growth rate)

Note that there has been a decrease in the proportion of people covered for hospital treatment in the June quarter of 2024, compared to March 2024.[4] It would be reasonable to assume that this is both a symptom of the high cost of living and of the shortfalls in PHI coverage. The costs of private health insurance are increasing for patients. The reduced affordability of private healthcare and falls in PHI membership will result in lower growth in private hospital separations and, consequently, operating revenue.[5]

Cost weight is a relative measure used to assess the resource intensity or complexity (costliness) of treating a particular diagnosis or medical condition compared to others within the same classification system. Essentially, it serves as a factor or multiplier applied to a group of conditions to reflect its relative costliness or resource utilisation compared to the average cost of treating all other groups of

[4] Quarterly private health insurance membership and benefits summary - June 2024 | APRA
[5] wp2020n18.pdf (unimelb.edu.au)

conditions. Cost weight is not a direct cost but rather a relative measure of cost intensity within the classification system.[6]

The average total cost weight of private hospital separations has been constant for the six financial years up to 2022-23.[7] The lack of benefit indexation observed is, therefore, not due to shifts towards admissions for lower priced services but has occurred at the same mix of complexity of services.

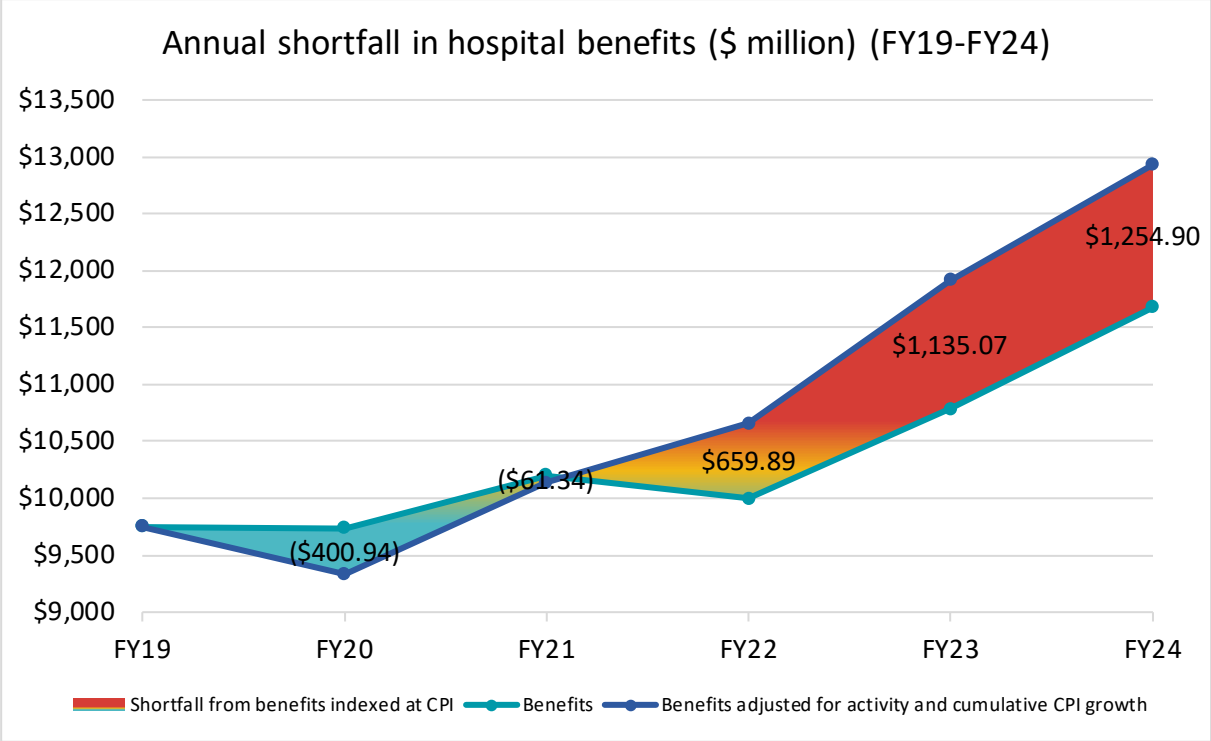

Figure 3 Data source: Consumer Price Index, Australia, ABS (2024); APRA Quarterly Private Health Insurance Statistics, APRA (2024)

The annual shortfalls shown in Figure 3 indicate an unsustainable position as the commercial viability of both hospitals and insurers is undoubtedly interlinked. Private health insurance must offer economic benefit to its holders, which is derived from services provided by private hospitals. A reduction in offerings by hospitals in an attempt to continue to operate will only adversely impact the health of our patients and the financial health of PHI providers.

The number of exclusionary policies has increased steadily from 2018 onwards, increasing the risk of patients having to pay greater out-of-pockets costs and getting less value for money, subsequently, depriving them of access to necessary healthcare. Furthermore, the proportion of in-hospital services with no gap borne by a PHI holder has reduced from 91.0 percent in 2019-20 to 88.4 percent in 2022-23. Concurrently, the average gap expense incurred has increased by 7.3 percent since 2021-22.

[6] Admitted patient care 2022–23: Costs and funding, Australian Institute of Health and Welfare (2024)
[7] Ibid.

Income, Expenditure and Key Performance Indicators of the private sector

	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	CAGR
	$m	$m	$m	$m	$m	$m	
Total income	**19,548**	**19,680**	**20,075**	**21,951**	**22,683**	**23,589**	**3.8%**
Sales and service income	16,460	18,655	18,727	20,430	21,113	21,925	5.9%
Private sector hospital-only PHI benefits	**9,428**	**9,748**	**9,734**	**10,198**	**10,000**	**10,783**	**2.7%**
DO hospital-only PHI benefits	1,988	2,057	2,000	2,200	2,219	2,452	4.3%
ON hospital-only PHI benefits	7,441	7,691	7,734	7,998	7,781	8,331	2.3%
Wages and salaries (including capitalised wages)	8,293	8,616	9,079	9,730	10,158	10,633	5.1%
Non-wages and salaries (including capitalised wages) expenses	9,691	10,624	9,934	11,157	12,066	12,610	5.4%
Total expenses	**17,984**	**19,240**	**19,013**	**20,887**	**22,224**	**23,243**	**5.3%**
EBITDA	1,907	1,081	1,894	2,003	1,480	925	-13.5%
Operating profit before tax	**1,576**	**487**	**1,088**	**1,038**	**480**	**298**	**-28.3%**
EBITDA/Sales and service income	11.6%	5.8%	10.1%	9.8%	7.0%	4.2%	-18.3%
Operating profit margin	9.6%	2.6%	5.8%	5.1%	2.3%	1.4%	-32.3%
Employment at end of June ('000)	133.8	136.7	138.9	142.8	149.5	151	2.4%
Average wages and salaries (including capitalised wages)	$61,981	$63,029	$65,364	$68,137	$67,946	$70,417	2.6%
Cost weight of wages and salaries (including capitalised wages)	46.1%	44.8%	47.8%	46.6%	45.7%	45.7%	-0.2%
Cost weight of non-wages and salaries (including capitalised wages) expenses	53.9%	55.2%	52.2%	53.4%	54.3%	54.3%	0.1%

Table 2 Data source: Health care and social assistance (private), by industry subdivision, 2022-23, ABS (2024); APRA Quarterly Private Health Insurance Statistics, APRA (2024) (CAGR: compound annual growth rate)

Income, Expenditure and Key Performance Indicators per episode[8] or separation[9]

	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	CAGR
Separations in private hospitals	**4,526,500**	**4,615,372**	**4,407,940**	**4,869,056**	**4,756,356**	**4,993,777**	**2.0%**
Private sector PHI-funded episodes	**3,651,401**	**3,675,429**	**3,531,415**	**3,693,083**	**3,659,136**	**3,858,423**	**1.1%**
DO PHI-funded episodes	2,527,933	2,551,951	2,446,339	2,597,162	2,619,169	2,779,517	1.9%
ON PHI-funded episodes	1,123,468	1,123,478	1,085,076	1,095,921	1,039,967	1,078,906	-0.8%
Total income/separation	**$4,319**	**$4,264**	**$4,554**	**$4,508**	**$4,769**	**$4,724**	**1.8%**
Sales and service income/separation	$3,636	$4,042	$4,248	$4,196	$4,439	$4,390	3.8%
Private sector hospital-only PHI benefits/episode	$2,582	$2,652	$2,757	$2,761	$2,733	$2,795	1.6%
DO hospital-only PHI benefits/episode	$786	$806	$818	$847	$847	$882	2.3%
ON hospital-only PHI benefits/episode	$6,623	$6,846	$7,128	$7,298	$7,482	$7,722	3.1%
Wages and salaries (including capitalised wages)/separation	$1,832	$1,867	$2,060	$1,998	$2,136	$2,129	3.1%
Average wages and salaries (including capitalised wages)	$61,981	$63,029	$65,364	$68,137	$67,946	$70,417	2.6%
Non-wages and salaries (including capitalised wages) expenses/separation	$2,141	$2,302	$2,254	$2,291	$2,537	$2,525	3.4%
Total expenses/separation	**$3,973**	**$4,169**	**$4,313**	**$4,290**	**$4,672**	**$4,654**	**3.2%**
EBITDA/separation	$421	$234	$430	$411	$311	$185	-15.2%
Operating profit before tax/separation	$348	$106	$247	$213	$101	$60	-29.7%

Table 3 Data source: Admitted Patient Care, AIHW (2024); Health care and social assistance (private), by industry subdivision, 2022-23, ABS (2024); APRA Quarterly Private Health Insurance Statistics, APRA (2024) (CAGR: compound annual growth rate)

[8] Episode of admitted patient care: The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. (AIHW, 2024)

[9] Separation: An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care. (AIHW, 2024)

2.0 THE ANALYSIS

If the trends illustrated continue, there will be greater adverse impact on private hospitals making it unviable to continue to operate. While total income for the sector has increased by $906 million between FY 2022 and FY 2023, selected labour costs have increased by $575 million despite a negligible increase in people employed in the sector (151,000 in 2022-23 versus 150,000 in 2021-22). Overall expenses increased by $1.019 billion between 2021-22 and 2022-23. This would leave the overall profit before tax for all private hospitals in 2022-23 at only $298 million (Table 2). Furthermore, earnings before interest tax depreciation and amortisation have fallen sharply since 2020-21 by close to $550 million each year while operating profits have almost halved. The profit margin has also been reduced from 5 percent in 2020-21 to only 1 percent in 2022-23 (see Figure 1 above).

If the divergence of indexation and inflation continues at the observed rate, the sector would need a $5 billion increase in revenue over the next three years to be able to sustain its capacity and service offering. This preservation of capacity is critical to the wellbeing of private patients in Australia and the balance between public and private health service delivery. Revenue must increase to enable private hospitals to survive, let alone invest in their people, technology, facilities, and future capability.

There is an unfounded claim propagated by some interest groups, that there are too many beds and excess capacity in the private sector. There is no evidence to support this claim, as there are no current statistics on the number of beds in the private sector. The latest statistics on private hospital beds are from 2016-17, when they constituted 36 percent of all hospital beds.[10,11] This was proportionate, as 40 percent of hospital separations occurred in private hospitals in that year. In 2022-23, 41 percent of separations were in private hospitals. APHA expects that no more than 40 percent of hospital beds today are private and that there is currently a proportionate distribution of beds across the public and private sectors.

The case for partial government support for private hospitals is grounded in Australia's unique configuration of fiscal expenditure on universal healthcare and tax incentivisation for consumers to obtain private health insurance. Without a robust private hospital sector, the objective of sharing the public health burden across the public and private pillars of the system cannot be realised. Consequently, obtaining PHI would become redundant. Furthermore, ensuring that healthcare can be provided independently is critical to secure Australia's hospital system. For instance, during the COVID-19 pandemic, countries with strong domestic healthcare systems were better able to manage and mitigate the crisis, reducing vulnerability to external disruptions and improving crisis preparedness.

Economic stability is another key factor. Private hospitals contribute significantly to the economy by creating jobs and supporting local industries. For example, the healthcare sector is one of the largest employers in Australia, and private hospitals play a crucial role in this. In 2019, health care and social assistance provided the greatest share of jobs in the Australian economy at 13 percent with 96 percent of the jobs' growth being attributed to the private sector. Additionally, by reducing the

[10] Private Hospitals, Australia, Australian Bureau of Statistics (2018)
[11] Report on Government Services, Productivity Commission (2023)

financial burden on the public system through outsourcing specialist healthcare services, private hospitals help maintain a balanced and sustainable healthcare economy.

Most importantly, a sovereign healthcare capability can lead to improvements in the quality of care. With better control over healthcare standards, training and technology, private hospitals can ensure that patients receive the highest quality of care. For instance, investments in cutting-edge medical technologies and continuous professional development for healthcare workers can result in better patient outcomes and overall healthcare improvements.

Furthermore, supporting private hospitals can foster innovation and research within the country. By investing in local medical research and development, Australia can lead in medical advancements and treatments, which not only benefit the local population but also position the country as a global leader in healthcare.

The World Economic Forum has stressed an urgent need for global healthcare investment.[12] The UN predicts that changing conditions and demographics will put immense pressure on healthcare systems.[13] Countries have a critical need for significant investment in the sector to address challenges such as healthcare crises and climate change. The Australian private hospital sector needs urgent funding to help insulate the country against shocks and to continue to play a major role in the sovereign healthcare framework.

3.0 NURSES AND PRIORITY AWARDS

The Fair Work Commission (FWC) is currently considering matters of extreme importance to our membership. The first matter is an application by the Australian Nursing and Midwifery Federation (ANMF) in which the ANMF seeks amendments be made to the *Nurses Award 2020* which would:

- increase minimum rates for Assistants in Nursing by 26.5%; and
- increase minimum rates for Registered Nurses and Enrolled Nurses (among others) by 35.8%.

The second matter is comprised of five separate Modern Award gender undervaluation reviews (Priority Awards Gender Undervaluation Reviews). Two of the Modern Awards under review are of direct relevance to the APHA's membership:

- the *Health Professionals and Support Services Award 2020*; and
- the *Pharmacy Industry Award 2020*.

As this paper demonstrates, private hospitals in Australia are already under immense financial pressure. Indeed, a significant proportion of private hospitals are currently either only breaking even or making financial losses. For these hospitals, any unexpected increases to labour costs will likely be crippling.

[12] WEF_Global_Health_and_Healthcare_Strategic_Outlook_2023.pdf
[13] World must invest in strong health systems that protect everyone — now and into the future | UN News; Why a Change in Demographics has an Impact on the Healthcare Industry - The Future of Health.care

4.0 INTERNATIONAL CONDITION

The Australian Charter of Healthcare Rights (ACHR) provides for patient rights to access, safety, respect, partnership, information, privacy, and to give feedback. APHA strongly believes in these rights as forming the bedrock of good quality, world-class healthcare that offers patients value for money and guarantees confidence in appropriate and adequate access to healthcare. It is regrettable, however, that ACHR rights do not have the force of law. Consumers of healthcare and healthcare products in Australia expect the system to be world-leading, but it is evident that we are falling behind. The Supreme Court of Canada in *Chaoulli v Quebec (AG),* for example, ruled that the Quebec Health Insurance Act and Hospital Insurance Act that prohibited private health insurance in the face of long wait times in the public health system violated the Quebec Charter of Human Rights and Freedoms. A delay in medical treatment was found to amount to a violation of the security of a person. This case substantively confirmed the right of Canadians to access private health care, a matter not currently explicit in the Australian legal context.

Another example where Australia is lagging behind the rest of the world is the legally mandated "Medical Loss Ratio (MLR)" found in the United States legislation. The Affordable Care Act 2012 (ACA) (U.S.) included a number of provisions to reform the regulation of private health insurance in the United States. One such provision was the MLR requirement which limits the portion of premium dollars that health insurers may spend on administration, marketing, and profits. Under U.S. healthcare reform, health insurers are required to publicly required to report on the portion of premiums spent on health care and quality improvement and other activities. Insurers failing to meet the MLR appropriate standard must subsequently pay rebates to consumers. Most insurance companies that cover individuals and small businesses are required, by law, to spend at least 80% of their premium income on health care claims and quality, leaving 20% for administration, marketing, and profit.

For reference, MLRs under the ACA are calculated as follows:

$$\text{ACA MLR} = \frac{\text{Health Care Claims} + \text{Quality Improvement Expenses}}{\text{Premiums} - \text{Taxes, Licensing \& Regulatory Fees}}$$

While the concept is not necessarily alien to the Australian context (noting that APRA monitors and reports on metrics similar to the MLR), it is not legally mandated. The MLR can offer significant benefits such as better ensuring that patients receive a value for money from their insurance and that premiums and associated proposals to increase premiums support better healthcare.

It would be reasonable to expect that both PHI and private hospitals share in the objectives if better health outcomes and better value for money. International best practice and legal frameworks such as the MLR can be invaluable to consider domestically as well.

The 2024 COVID-19 Response Inquiry Report recognises the vital role that private hospitals serve in preserving and protecting public health in Australia. It notes the support that the sector provided to alleviate staff shortages in the aged care sector, for example. Further, the report also underscored the need to ensure private hospital viability through the "Private Hospitals Viability Guarantee" to support the broader public health system and sector sustainability. In that spirit, it is necessary to consider short- and medium-term options to ensure private hospital viability at-large and in the identified sectors of maternity and obstetrics care, psychiatry, and rural and regional healthcare.

3.0 Sectoral Recovery Requirements: Federal Budget

1.0 THE REQUIREMENT

As noted above, the sector potentially requires $5 billion of additional revenue over 3 years to achieve parity with other economic sectors, in terms of meeting costs and remaining viable. This would amount to roughly $416 million per quarter for the next 3 years. Funding sustainability and growth in the private hospital sector will need to be gained from either private health insurers (through increased payments), government (through subsidies and grants for example), or by increased out-of-pocket costs from patients.

APHA does not consider placing the burden on patients to compensate for shortfalls in PHI funding to be a reasonable alternative in the face of a deep and protracted cost-of-living pressures. However, in the absence of adequate support, it may be necessary to do so to be able to continue to deliver world class healthcare.

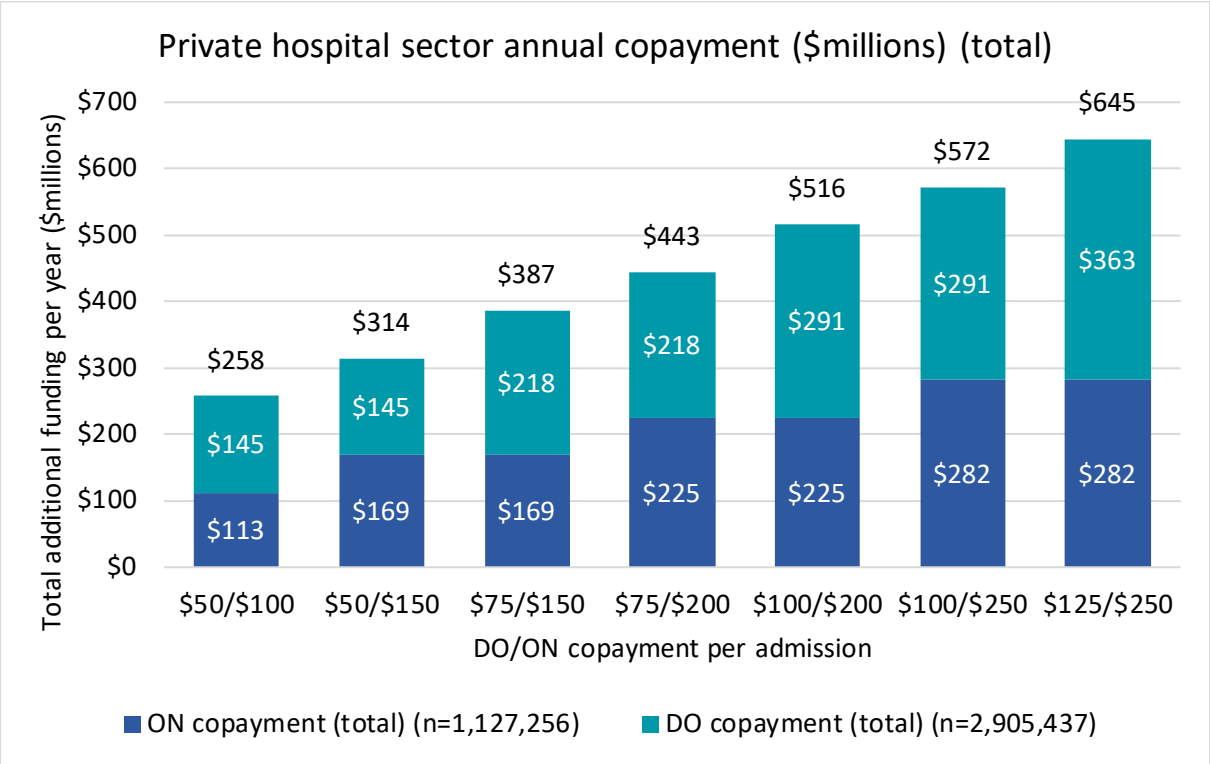

Figure 4 Copayment modelling based on numbers of day-only and overnight episodes in 2023-24 (Data source: APRA Quarterly Private Health Insurance Statistics, APRA (2024) (DO: day-only; ON: overnight)

Recognising the economic state of the country and rising inflation, a $5 billion uplift currently seems unlikely. While $5 billion over three years would enable the sector to revitalise itself and grow, a significantly smaller increase in revenue may be sufficient to stop the cascade of loss of private

hospital capacity. $3 billion flowing into the sector between FY2026 and FY2029, amounting to $250 million per quarter, would nearly eliminate the shortfalls between transacted benefits and benefits indexed at CPI without necessarily increasing hospital profitability.

2.0 THE SOURCES OF IMMEDIATE RECOVERY FUNDING

The identified shortfall in funding and subsequent threats to private hospital viability require immediate consideration of sources of finance or assistance. These include, in descending order: private health insurers, government and patients.

Private Health Insurers

Despite the competing requirements for the viability of health insurers and private hospitals, there is agreement on the need to ensure that patients have continued access to necessary care. Under the current regulatory framework, insurers pay benefits to hospitals for products and services covered by legislative instruments such as the Private Health Insurance Rules and the Prescribed List of Medical Devices and Human Tissue Products (PL). PHI is the largest direct source of funding available for private hospitals. To ensure uninterrupted provision of services, PHI must provide a consistent and reliable flow of benefits paid. This means that the PL, for instance, should not see poorly timed removals of products and elimination of benefits for essential support services.

As discussed previously, it is widely recognised that the PHI sector has sufficient financial slack to release accumulated premiums into the private hospital microeconomy. However, they have often argued that reductions in benefits are necessary for lower premiums. APHA rejects this proposition, submitting that comprehensive funding of services would increase consumers' perceived value of PHI. This would induce demand for PHI and stimulate its uptake, increasing the national pool of PHI premium funds, without needing to significantly increase premiums. Reducing benefits may lower premiums in the short-term but may compromise the quality and availability of healthcare services, ultimately slowing down the uptake of insurance coverage due to a low perception of its value.

The financial crisis confronting the private hospital sector has presented an opportunity for private health insurers to release a portion of the abnormal returns they have achieved from the time of the pandemic until now, into the care of their members in private hospitals.

Government

The Commonwealth Government does not directly fund private hospitals in Australia. However, government funding through short and long-term initiatives can be highly beneficial and be a sustainable option for private hospitals. For example, as precedent has shown, the Commonwealth has recognised the need to ensure the continuity and viability of private hospitals by providing support through daily bed payments[14], payments of hospital benefits in respect of patients in private hospitals[15] and has accordingly reserved the ability to enter into arrangements with States to these ends.[16] These support mechanisms became no longer available as the gradual development of the private health insurance framework was, at some point, deemed to eliminate the need for them.

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[14] *Health Legislation Amendment Act 1983* (Cth) s 33.

[15] *Hospital Benefits Regulations 1952* (Cth) s 20; *Hospital Benefits (Private Hospitals) Regulations 1946* (Cth) s 13.

[16] *Hospital Benefits (Private Hospitals) Regulations 1946* (Cth) s 19.

However, the current PHI framework is unable to adequately meet the needs of private hospitals to ensure viability, requiring re-consideration of past mechanisms.

Government support helps ensure more reliability and, therefore, investability in the sector. Government funding is typically aimed at long-term public health goals. This alignment allows private hospitals to plan and invest in infrastructure, technology and staff without the pressure of immediate financial returns. There are numerous programs that the government currently runs that can be leveraged or developed to support short-term viability of private hospitals (refer to 4.0). Moreover, government support can help ensure that taxpayers get a value without increases in premiums or out-of-pocket costs. These options are explored in the following section.

Patients

Private hospitals provide patients with access to new and innovative procedures and technologies, as well as the assurance that they will get the healthcare they need. Private hospitals need to have requisite structures in place to allow continued investment in good healthcare. In the absence of the required increases in revenue, from private health insurers or fiscal support, private hospitals would have to reduce their service offering or alternatively fund those offerings. The former case is not a desirable outcome as we continue to emphasise the primacy of high-quality healthcare. In the latter case, the out-of-pocket costs for patients may become necessary to simply maintain hospital operations.

At a time when families are feeling the pressures of the cost-of-living crisis, placing an increased burden on patients due to deficiencies in the private healthcare framework at-large is not desirable. In addition, this would entrench a false perception that private hospitals are profit-seeking entities that undermine the affordability of healthcare. Therefore, seeking to address the current crisis through patient out-of-pocket payments would harm patients' financial wellbeing while endangering trust in private health insurers and providers.

3.0 REQUIREMENT FROM PRIVATE HEALTH INSURANCE PROVIDERS

Quantifying The Shortfall

Private hospitals require an EBITDA of at least 15 percent to 25 percent to be investable (the difference mostly driven by taxable status of the hospital):

- 5 percent is capital costs for maintenance, replacement, upgrade and development;
- 10 percent is tax for income, payroll, mental health levy and COVID levy;
- 3 percent is debt servicing;
- 2 percent is projects and compliance costs; and
- 5 percent is retained earnings.

Current EBITDA is below 10 percent:

> "…there was a decline in the weighted average Earnings Before Interest, Tax and Depreciation (EBITDA) margins from 8.7% in 2018-19 to 4.4% in 2022-23… the department estimates that the sector's weighted average EBITDA margin is likely to have been between 7% and 8% in 2022-23."

The shortfall to be remediated (to return to FY19 investability levels) is between 10 percent and 15 percent (which equates to $1.2 billion and $1.8 billion).

Private Health Insurance Premium Impact

Private health insurers in FY24 paid 84 cents in the dollar from hospital premium revenue. If benefits returned to pre-COVID levels of 88 cents in the dollar, this would contribute a further $0.9 billion in hospital benefits. The residual $0.9 billion shortfall in funding from insurers would require a 'catch-up' premium increase of 4.1 percent. This is in addition to the normal premium increase of ≈7.4 percent needed to cover:

- underlying hospital cost inflation of between 5.25 percent and 6.15 percent; and
- utilisation running at between 1 percent and 2 percent,

totalling ≈11.5 percent premium increase for hospital policy premiums from April 2025.

This level of increase may have a material impact on CPI (given private health insurance premiums contribute to the CPI calculation).

Priority Policy Responses

To directly and efficiently address funding shortfalls and minimise the impact on CPI and household budgets, the Commonwealth could:

- Introduce Digital Interoperability Private Hospital Incentive to digitise their paper-based records and implement interoperability across the health-system, totalling $1.3 billion over 5 years (likely to deliver savings to Commonwealth and PHI, including through reduced duplication and waste across pathology and diagnostic imaging, of more than $200m annually)
    - Digitisation of private hospital clinical records and interoperability of these digital solutions are necessary for the implementation of the Commonwealth's Digital Health Blueprint and Action Plan.
    - National Digital Health Strategy seeks to improve efficiency through reduced duplication of referrals, tests and follow-up appointments, by mandating the capture of information in My Health Record.
    - Private Hospitals have insufficient margin to fund this, requiring ≈$3 billion in increased funding.
    - ≈50 percent of financial benefits realised from this digitisation of private hospitals accrues to Medicare and PHIs (through a reduction in unnecessary duplicate diagnostic tests and cheaper / safer medications).
    - The Commonwealth could provide a financial incentive to private hospitals to fund their digitisation and interoperability of clinical records. This approach is consistent with General Practice and Aged Care locally and internal case studies on healthcare digitisation; and
- Introduce Commonwealth Private Hospital Nursing Wage Subsidy that covers the difference between the PHI average weighted premium increase and, the weighted average of Private Hospital EBA increases and any FWC Award increases, totalling ≈$1.1 billion in the first year
    - Private hospitals are facing nurse salary cost increases which surpass both the indexation paid by private health insurers and the premium increases which PHIs receive.
    - Over the last five years, the published average Private Health Insurance premium increase has trailed salary cost increases (measured by Health Wage Price Index) by a cumulative 3.34 percent.
    - Forecast salary cost increases for 2025 may be 8.65 percent, whilst premium increases may be 3.15 percent. The cumulative salary inflation exceeding premium increases for 2025 is 8.84 percent. This equates to $1.1b /$7k per person. Fully funding this through PHI has a material impact on CPI and affordability.

    - The Commonwealth could subsidise private hospital salaries via a similar mechanism to the Job Keeper payment, the quantum calculated as the difference between salary inflation and PHI premium increase.
- Enter into a Private Health Insurer Payout Ratio Memorandum of Understanding to increase private hospital funding by $0.9b, through the return to a payout ratio of 88 cents in each dollar of hospital policy premium revenue, else the $0.9b increase delivered through the redistribution of the Government rebate to private hospitals (in whole or part). This option would constitute a reallocation of government spending, rather than new spending.
    - Historically, private health insurers paid hospital benefits of 88 cents from every dollar of premium revenue received for hospital policies.
    - In FY23 this dropped to 81 cents in the dollar and has recently recovered to 84 cents in the dollar.
    - Reverting to the historical ratio of 88 cents in the dollar would increase benefits paid to hospitals by 5 percent, equating to $0.9b, which would materially remediate private hospital investability challenges.
    - Separately, of the Commonwealths $6.9b private health insurance rebate $0.9b (13 percent) is not used to pay hospital benefits (8.5 percent management expenses and 4.5 percent profits).
    - The Commonwealth could enter into a Memorandum of Understanding with private health insurers whereby they agree to increase hospital benefits paid by 5 percent.
    - Alternatively, the Commonwealth could redistribute to private hospitals the rebate, in whole or part, to increase hospital revenue by $0.9b.

4.0 GOVERNMENT SHORT-TERM SOLUTIONS

APHA recognises that cumulative shortfalls over more than half a decade cannot easily be addressed in a one or two-year period. However, a $450 million uplift in revenue per year can be achieved via a $75 day-only and $200 overnight copayment per admission. Based on an average overnight admission of 5.4 days, the daily increment is less than $45 per day for overnight stays. A copayment setting of $150/$250 (DO/ON) would achieve further significant while containing the additional expenditure below $650 million per year over two years.

The previous section observes that overall costs for private hospitals increased by over $1 billion between 2021-22 and 2022-23 which is also reflective of the pre and post COVID-19 financial condition of the sector. Returning to pre-COVID-19 levels of sustainability would require an injection of $1 billion per year which is in line with the immediate, albeit ideal, requirement of $3 billion.

In the June 2024 quarter, for example, PHI paid benefits for 175,833 episodes in day hospitals and 883,618 episodes in overnight hospitals. The overall benefits paid per day amounted to an average of $861.33 and $1,366.75 for day and overnight private hospitals respectively. The average overnight episode lasted for 5.4 days in this quarter. APHA proposes that the government either subsidise or support increases in PHI benefits paid to hospitals by, at least, $250 per episode to help the sector return to necessary levels of viability and investability.

The APHA recognises that, under this option, the government will want to avoid the perverse impacts of a copayment providing an incentive for more facilities to open as a direct consequence. Therefore, we would support a moratorium for the copayment to be applied to existing licensed beds in existing facilities.

Additional Policy Response Options – Short Term

Additional initiatives include:

- Addressing Medicare funding disincentives to treat complex mental health inpatients, through doubling the psychiatrist inpatient consultation Medicare benefit and expand scope of practice to prescribe and Medicare benefits eligibility for nurse practitioner inpatient mental health consults.
    - Lifting the moratoriums on Medicare Schedule Fees (MSF) eligibility and making all suburbs designated areas of need for psychiatrists will quickly increase available workforce by hundreds of psychiatrists.
    - Improving MSF for inpatient psychiatry (including telehealth) will increase the psychiatrists' capacity to treat more patients.
    - Providing funding for transitional care for private patients (who are ineligible for Government run transitional care) will reduce clinical risks and avoid psychiatrists having no capacity to treat new patients.
- Incentivise committed NHRA funding toward latent private capacity, by increasing the Commonwealth contribution to 60:40 when using private hospitals (≈$500m of NEP activity ≈72k patients):
    - The Commonwealth to use committed expenditure from the "first year 'catch up' growth premium "to increase its contribution to 50:50 with the States where existing latent private hospital capacity is utilised, equating to ≈$500m of NEP activity (≈72k patients) and increase the PPSA to 100 percent, requiring PHI to fully fund public hospitals.
    - Assuming private hospital latent capacity is commensurate with the missing PHI activity, and the Commonwealth incentivises 3 months of contracting public patient elective surgery to private hospitals, private hospitals could deliver the equivalent of $500m of NEP activity and PHI paying commercial rates for private patients in public hospitals through a 100 percent private patient service adjustment (PPSA) which would improve public hospital revenue.
- Include benefits paid for maternity in risk-equalisation and silver products, which will improve the access to and affordability of private maternity services.
    - The Commonwealth to change the risk equalisation regulations to include 60 percent of maternity benefits in the pool to improve affordability of insuring maternity outside of 'gold' policies and to establish a $100k regional anaesthetist stipend and an anaesthetist maternity management fee to address the workforce capacity and affordability challenges.
    - The application of the proposed 60 percent risk equalisation model for maternity will reduce the drawing rate for 25- to 39-year-olds between 6.53 percent and 12.63 percent. This will materially improve the affordability of maternity and increase the likelihood of offering maternity cover.
    - Attracting younger people into private health insurance and offering them an upgrade pathway to higher levels of cover throughout their lifetime will contribute to an increase in the entire pool of lives covered, which in turn will contribute overall drawing rate deflation and maintain affordability for older policyholders.
- Expanding hospital nurse FBT Exemption eligibility to employees of for-profit hospitals will put downward pressure on nurse salary inflation (equivalent to ≈4% of salary value);
- Minimise earnings retained under APRA capital adequacy standards by introducing a fixed maximum ratio, with the released excess paid to hospitals.
- Incentivise anaesthetists and surgeons to work in regional and rural private hospitals, through a Medicare Benefit Schedule regional loading.

5.0 CURRENT LEGISLATIVE OPTIONS FOR COMMONWEALTH FUNDING

During the pandemic, private hospitals collaborated and cooperated with government to support the national COVID-19 response and made infrastructure, essential equipment, supplies, workforce and other resources available to the national health system.[17] Specifically, private hospitals supported the COVID-19 response through services including but not limited to:

- Hospital services for public patients, regardless of whether they were COVID-19 positive or negative.
- Category 1 elective surgery
- Utilisation of wards and theatres to expand ICU capacity
- Accommodation for quarantine, where necessary.

This collaboration underscores the importance of the private hospital sector to national health. Without immediate financial support, the private hospital sector faces significant risks, including more closures, further reduced services, and job losses. This would not only impact patient care but also place additional strain on the public health system. The proposed $450 to $650 million annual short-term support arrangement would stabilise the sector while long-term structural changes in revenue arrangements are negotiated and implemented. This investment will ensure that Australians continue to have access to high-quality healthcare services when they need them.

[17] Australian Government partnership with private health sector secures 30,000 hospital beds and 105,000 nurses and staff, to help fight COVID-19 pandemic | Health Portfolio Ministers | Australian Government Department of Health and Aged Care

4.0 Budget Recommendations

The APHA asserts that beyond the immediate need for funding from either health insurers or, failing that, from the Australian Government via a temporary co-payment, there are key policy levers that cost the government nothing that can make a tangible, immediate difference.

Psychiatric Hospital Viability Solutions

1.0 CAPITATION FUNDING

RECOMMENDATION

- The Commonwealth support the capitation funding model for private psychiatric facilities to support viability.

BUDGETARY IMPACT

- No immediate budgetary impact.

RATIONALE

- Under a capitation funding model providers receive a fixed payment for each patient they care for and the payment is fixed regardless of how many services are provided to the patient.
- Capitation funding models provide a strong incentive to focus on preventative care, given that this normally costs less than acute interventions and hospital admissions.
- APHA would encourage the Commonwealth to support this funding model for psychiatric care as it can ensure a stable flow of revenue for hospitals which can help hospitals manage budgets more effectively and plan for long term investments, provide a strong incentive for care efficiency, provide flexibility in service delivery to design and deliver services including innovative approaches that may not be feasible under a fee-for-service model.

2.0 REMEDY WORKFORCE ISSUES IN THE PSYCHIATRY SECTOR

RECOMMENDATION:

- Legislate to provide a mandatory minimum private health insurance benefit for private hospital provision of ambulatory care, i.e. psychiatric day programs and outreach programs. This measure would be cost neutral because the cost would be offset by savings as a result of current constraints on the provision of overnight inpatient psychiatric care.
- Introduce Medicare Benefit Schedule (MBS) items for the strategic use of telehealth for inpatient consultations to reduce the disincentive for psychiatrists to continue to provide inpatient services due to loss of unpaid time in travel and administration. This measure would be cost-neutral because consultations provided by telehealth would offset the decline in consultations currently conducted on a face-to-face basis.
- Reinstate MBS telehealth items for inpatient psychiatric consultations on a permanent basis for use in emergency circumstances to support continuity in the therapeutic relationship and respond to the impracticality of relying on locum support in emergency situations. This measure

would be cost-neutral because consultations provided by telehealth would offset the decline in consultations currently conducted on a face-to-face basis.

- Remove restrictions on overseas trained psychiatrists receiving MBS rebates for the provision of private patient in-hospital consultations. This measure would not be sufficient by itself to resolve the shortage of in-patient services, but it would assist in enabling the private hospital sector to fulfil its role as an essential part of Australia's mental health system.
- Commission an urgent review of the financial and regulatory factors which disincentivise psychiatrists providing acute in-patient care in both public and private sectors.

BUDGETARY IMPACT

- No immediate budgetary impact.

RATIONALE

- In 2019, 3,615 psychiatrists (13.7 full time equivalent (FTE) per 100,000 population), were employed in Australia. However, the ageing and feminisation of this profession has meant that although the number of psychiatrists registered with the Australian Health Professionals Registration Authority (AHPRA) has slowly increased each year, the number employed, and their full-time equivalence has not kept pace with demand.
- There has also been a noted shortage of psychiatrists admitting patients for overnight care which has reduced the number of private hospital psychiatric overnight admissions and created an additional and serious service gap in an already overstretched mental health sector.
- Without urgent action the viability of many psychiatric services provided by private hospitals will be placed in doubt as occupancy rates fall to unsustainable levels. This poses a threat not just to patients reliant on these particular services but to the mental health system as a whole. Private hospitals currently provide 45 percent of mainstream acute adult psychiatric beds.

Regulatory Solutions and Private-Public Partnerships

1.0 COLLABORATION AND COOPERATION BETWEEN PUBLIC AND PRIVATE PROCUREMENT MODELS FOR MEDICAL PRODUCTS

RECOMMENDATION

The Commonwealth consider opportunities to collaborate and cooperate with the private hospital sector to support lower costs and lower administrative burden.

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- The Commonwealth should implement a strategy to drive down the cost of medical technology and consumables for the health sector as a whole (both public and private) by:
    - establishing a national procurement scheme for medical devices and consumables.
    - aligning national procurement strategies with strategies to promote the Australian medical technology industry, ensure critical health infrastructure resilience against supply chain risks and achieve supply chain sovereignty objectives.

- leveraging partnership and cooperation between public and private sectors including through the National Medical Stockpile and government purchasing schemes.

- In Australia, private entities are not generally covered by government procurement frameworks, however, private sector entities may be permitted to benefit from government established supply arrangements.[18]

2.0 LONG-TERM CONTRACTING BETWEEN PUBLIC AND PRIVATE SYSTEMS

RECOMMENDATION

The Commonwealth consider options to encourage States to enter into long-term contracting between public and private systems.

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- The Australian Government partnership with the private health sector during the COVID-19 pandemic illustrated the advantages of collaboration and cooperation to the national health interest and private hospital viability, both of which are not mutually exclusive.
- Agreements between the government and private hospitals have significant advantages in balancing the burden on public systems, allowing public patients to access world-class healthcare in private hospitals, supporting private hospital viability, and ensuring the optimum functioning of the healthcare system.
- Even in the absence of public health emergencies, public patients are routinely treated in Australian private hospitals under short-term contracting arrangements. Contracting can be beneficial for public patients, allowing them to take advantage of lesser waiting times in the private hospital sector and can also assist public hospitals address unanticipated surges in demand or reduction in capacity.[19]
- Contracting in Australia has generally been ad hoc. Without greater certainty about the type and volume of patients to be treated and the length of contract arrangements it is unlikely that the full benefits of contracting (such as timelier access to care for public patients, and the more efficient use of resources) will be realised.[20]
- The government should consider opportunities to better ensure certainty in public-private partnerships in consultation with the sector.

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[18] Application of the Statutory Procurement Laws, Australia, Public Procurement World, Baker McKenzie Resource Hub.
[19] Public problems: Private solutions? Short-term contracting of inpatient hospital care, Deeble Institute (2014).
[20] Ibid.

3.0 AMEND THE NATIONAL HEALTH REFORM AGREEMENT (NHRA) TO EMPHASISE THE ROLE OF PRIVATE HOSPITALS AND THE NEED TO ENSURE VIABILITY

RECOMMENDATION

The Commonwealth consider options to amend the National Health Reform Agreement (NHRA) to emphasise the role of private hospitals and the need to ensure viability

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- The purpose of the NHRA is to facilitate cooperation and collaboration between the Commonwealth, States and Territories to 'improve health outcomes for all Australians and ensure the sustainability of the Australian health system'. [21]
- At present, the NHRA commits the Commonwealth to 'work collaboratively with States and national bodies to support pricing and funding reforms for public hospital services and advise on how these reforms intersect with private hospital services and primary health care services'.[22]
- There is a need to amend the NHRA to expressly state the criticality of the private hospital sector to the national health interest and accordingly provide for mechanisms to ensure sustainability and viability in the public interest.
- Under the *Federal Financial Relations Act 2009* (Cth), the Commonwealth may make payments to a state for the purpose of making a grant of financial assistance for the purpose of expenditure under the NHRA.[23] Financial assistance is payable to a State or Territory on condition that the financial assistance is spent in accordance with the NHRA.
- The Commonwealth is encouraged to engage with all stakeholders, including the private hospital sector and state and territory governments to consider options to amend the NHRA to this end and provide for adequate financial assistance mechanisms to States and Territories to help better support the sector.

4.0 ENSURE GOVERNMENT CONSULTATIONS AND PROPOSED POLICIES ARE BASED ON APPROPRIATE AND ADEQUATE DATA AND EVIDENCE TO PREVENT A BURDEN ON THE SECTOR AND REDUCE UNCERTAINTY

RECOMMENDATION

The Commonwealth ensure that government consultations and proposed policies are based on appropriate and adequate data and evidence to prevent a burden on the sector and reduce uncertainty. All proposed changes to regulation and legislation should be frozen until the

[21] NHRA, cl. 1.
[22] NHRA, A179.
[23] *Federal Financial Relations Act 2009* (Cth), Pt 3A s 15A(1).

government is able to appropriately consult with the sector on needed short, medium, and long term reforms.

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- As the recent Private Hospital Health Check and data from the ABS have demonstrated, the sector is under immense stress. There is a need to ensure that regulation is fit for purpose and does not place an additional burden on stakeholders as part of Australian government regulatory best practice.
- But there is also a need to ensure that government consultations are grounded in an appropriate evidence base. Recent consultations on general use items (GUIs), for example, have not been reflective of trends observed in publicly available data and have instead served to add an additional burden in the sector to respond and defend spurious claims.

5.0 CONTRACTING BETWEEN PUBLIC AND PRIVATE SYSTEMS TO REDUCE PUBLIC WAITING TIMES

RECOMMENDATION

The Commonwealth consider options to encourage States and Territories to enter into contracts with private hospitals for the admission of public patients in private hospitals where waiting times in the public system exceed clinically recommended times.

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- Reducing Waiting Times:
    - Current Challenge: Public hospitals often face high demand, leading to extended waiting periods for non-emergency procedures and treatments.
    - Proposed Solution: By contracting with private hospitals, the Commonwealth can alleviate pressure on public hospitals, significantly reducing waiting times for patients.
- Optimising Healthcare Resources:
    - Resource Utilisation: Private hospitals often have underutilised capacity that can be leveraged to provide care for public patients.
    - Efficiency Gains: This approach ensures that existing healthcare resources are used more efficiently, benefiting both public and private sectors.
- Improving Patient Outcomes:
    - Timely Care: Access to timely medical interventions is crucial for better health outcomes. Reducing waiting times can prevent the deterioration of patients' conditions and improve recovery rates.
    - Patient Satisfaction: Faster access to necessary treatments enhances patient satisfaction and trust in the healthcare system.
- Cost-Effectiveness:

- Economic Considerations: Contracting with private hospitals can be a cost-effective solution compared to expanding public hospital infrastructure.
- Budget Management: This strategy allows for better management of healthcare budgets by utilising existing private sector facilities.

- Adaptability and Scalability:
  - Adaptability: The proposed contracts can be tailored to specific needs and regions, providing flexibility in addressing varying levels of demand across different areas.
  - Scalable Solution: This model can be scaled up or down based on the fluctuating needs of the public healthcare system.

6.0 TYING PREMIUM INCREASES TO PAYMENTS FOR CARE IN PRIVATE HOSPITALS

RECOMMENDATION

The Commonwealth consider options to tie premium increases to payments for care in private hospitals.

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- This approach ensures a more predictable revenue stream. When premium increases are directly linked to the costs of care, hospitals can better forecast their income, which is crucial for financial planning and sustainability.
- Private hospitals often face higher operational costs compared to public hospitals. By tying premium increases to payments for care, hospitals can recover these costs more effectively, ensuring they can continue to provide high-quality services and ensure that patients get the care they need and deserve.
- With a more stable and predictable revenue, hospitals can invest in advanced medical technologies, infrastructure, and staff development. This not only improves the quality of care but also enhances sector competitiveness.

7.0 RESTORE FUNDING FOR AND RE-ESTABLISH THE PRIVATE HEALTH ESTABLISHMENTS COLLECTION (PHEC)

RECOMMENDATION

The Commonwealth re-establish and restore funding for the PHEC and ensure the adequate, reliable, and consistent monitoring of the viability and condition of the private hospital sector

BUDGETARY IMPACT

$3 million annually

RATIONALE

- The 2020-25 NHRA expressly notes the agreement of parties to it to 'develop and implement enhanced performance reporting across the whole care pathway including: Increased coverage and reporting of private hospital sector activity and performance'.[24]
- It also states that the Australian Institute of Health and Welfare (AIHW) will 'provide clear and transparent annual public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Primary Health Network'.[25]
- There is a clear and present need to ensure the adequate monitoring of viability and condition of the private hospital sector, as the recent public summary document for the Private Hospitals Health Check has confirmed.
- The Commonwealth operated a suitable PHEC process prior to 2017-18 which provided a legitimate and reliable collection of data for the sector. The absence of this has made it increasingly difficult to maintain stock of the challenges to the sector, costs, etc. Existing methodologies can help reinvigorate the PHEC without significant additional costs.

Workforce Issues: General Solutions

1.0 ADOPT THE RECOMMENDATIONS OF THE KRUK REVIEW AND SUPPORT WORKFORCE IMPROVEMENT AND ENHANCEMENT INITIATIVES AT LARGE WHICH INCLUDE TO:

- Remove the 10-year moratorium on the practice of overseas trained doctors seeking to practice in Australia.
- Introduce or expand expedited pathways to registration for all professions in acknowledged areas of shortage. Eligibility for expedited pathways should be regularly considered and part of a rolling work program reported to health ministers. Priority professions to be collectively identified by health ministers. (**Recommendation 9**).
- Expand the use of workplace-based assessments where appropriate, including exploring collaborative models to support international medical graduates (IMGs) with general practice and public health services to help address recruitment, training and retention challenges in regional and rural Australia (**Recommendation 16**).
- Support better planning for Australia's future workforce needs, including developing national workforce strategies for maternity and allied health and finalising the nursing strategy already in development. National workforce modelling should be reviewed and updated at least every 5 years, and strategies, every 10 years (**Recommendation 18).**

RECOMMENDATION

The Commonwealth adopt the recommendations of the Kruk Review and support workforce improvement and enhancement initiatives at large.

BUDGETARY IMPACT

[24] NHRA, D10(b)(v).
[25] NHRA, B58(a).

No immediate budgetary impact.

RATIONALE

- The 2023 "Independent review of Australia's regulatory settings relating to overseas health practitioners" (Kruk Review) highlighted pertinent issues and a critical shortage of health practitioners in Australia with 44% of vacancies remaining unfilled at the time of the review.
- It noted that "Shortages are particularly acute in distinct locations and care settings, and key specialties. People living in regional, rural and remote areas find it harder to access many forms of care".
- The Kruk review further emphasised that workforce shortages contribute to reduced access to care, increased workloads for health practitioners, overuse of higher cost services (such as locums and emergency care) and poorer patient outcomes such as increased waiting times.
- As workforce challenges exist in both the public and private sectors, government should develop policies and put in place legislation to enable the rapid induction of overseas trained staff into the Australian healthcare system, provide flexibility, and develop data to identify gaps and shortfalls in the workforce.

2.0 PUT IN PLACE A NURSE WAGE SUBSIDY

RECOMMENDATION

The Commonwealth develop and provide a nurse wage subsidy to the sector to prevent a further degradation of viability that is expected to arise out of the nurses award case currently being considered by the Fair Work Commission.

BUDGETARY IMPACT

$1.5 billion

RATIONALE

- The ongoing nurses awards case before the Fair Work Commission is expected to result in a significant increase in workforce costs for the private hospital sector.
- This will further undermine sector health and viability and may cause the further closure of facilities which will inevitably lead to a loss of hospital capacity.
- Workforce Australia already provides a wage subsidy ranging up to $10,000 which can apply to nurses provided that they meet the eligibility criteria, specifically for new ongoing employment positions.
- The National Wage Subsidy Pool further provides for 'a programme of wage subsidies and other incentives to employers who employ unemployed persons'.[26]
- Previously, the Commonwealth has also provided a Home Nursing Subsidy to organisations which provided a non-profit home nursing service.[27]

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[26] *Financial Framework (Supplementary Powers) Regulations 1997* (Cth) Pt 4 s125.
[27] *Home Nursing Subsidy Act 1956* (Cth) s 5 (No longer in force).

- Recognising that the nurses award case will impact existing members of the workforce, there is a need for the Commonwealth to provide a nurse wage subsidy to help cover the gap. Private hospitals simply do not have the resources to be able to sustain themselves and their staff in the current circumstances.

Other Solutions

1.0 INCREASE FUNDING AND INCENTIVES FOR PREVENTATIVE HEALTHCARE

RECOMMENDATION

The Commonwealth consider options to increase funding and incentives for preventative healthcare.

BUDGETARY IMPACT

No immediate budgetary impact.

RATIONALE

- The National Preventive Health Strategy 2021-2030 emphasises the importance of preventative health action and a whole-of-system approach to achieve this.
- The 2024 COVID-19 Response Inquiry Report noted that state and territory restrictions on various preventive health programs, including cancer-screening programs have had adverse long-term impacts. For example, between 2020 and 2022 there were 163,595 and 158,211 fewer cancer-related diagnostic procedures, based on 2017 to 2019 trends.
- Independent modelling in the same report predicted an additional 234 cases and 1,186 deaths from colorectal cancer through to 2030 because of COVID-era disruptions to screening services. Recent screening participation was considered to be a strong indicator of future screening behaviour, meaning that those who missed screening due to the pandemic were less likely to return to it in the near future.
- Only 1.8% of health care spending in Australia is for preventive interventions. An OECD analysis found that primary health care accounted for 17% of Australian health care expenditure in 2019, including 0.2% for prevention; this is lower than the OECD mean (1.0%) and the level in other high-income countries (e.g, the United Kingdom: 2.7%).[28]
- Private hospitals play a key role in preventative health efforts such as in cancer and cardiac screening and diagnosis, treatment, and in general continuity of care.
- It is evident that preventative care is a priority for the government. To ensure that the government meets its objectives to expand preventative care programs there must be consideration of funding models for preventative health care in private hospitals.
- While some stakeholders in the private health sector may advocate for PHI-owned or PHI-operated preventative care facilities and programs, we are of the opinion that this is not a reasonable proposition. Private hospitals can both undertake advanced screening and

[28] Angeles, M.R., Crosland, P. and Hensher, M. (2023), Challenges for Medicare and universal health care in Australia since 2000. Med J Aust, 218: 322-329. https://doi.org/10.5694/mja2.51844.

recommend and provide treatment were screening results in adverse health findings. PHI-operated ventures do not have the appropriate incentives to do so and may also not have the established medical infrastructure network externalities to ensure continuity of care and positive health outcomes for patients.

5.0 Conclusion

In conclusion, the private hospital sector is at a critical stage. It is experiencing significant threats to viability, sustainability, and investability. If the trends illustrated in this pre-budget submission continue, they will have a greater adverse impact on private hospitals and force the sector to write off capacity to serve privately insured patients. It may become unviable for many hospitals to continue operating. The significance, to the healthcare system in Australia, of such loss of capacity cannot be overstated. Patient access and quality in healthcare is central to our case for increased funding and support. Indifference to crippling disparity between revenue and costs in the private health sector would only hurt the welfare of privately insured people who currently make up nearly 45 percent of the Australian population.

This proposal demonstrates ways the Australian Government can constructively intervene through the federal budget for FY 2025-26. Firstly, by making insurers meet their obligations to pay for the healthcare their members receive.

Failing that, secondly, by providing a temporary two-year co-payment to ensure hospitals remain viable while the government, private hospitals and insurers progress systemic reforms via the newly announced CEO Roundtable. In this regard, the APHA has taken great care to be reasonable and seek forward-looking bare minimum solutions that have minimal or no impact on the federal budget.

Thirdly, if the measures detailed in this document are not actioned, the sector will be forced to charge patient gap fees in the order detailed in this paper to cover the shortfall left by insurance contracts. In the situation, where the government is unable or unwilling to support the sector, the Commonwealth needs to immediately allow private hospitals to charge gap fees, a nuclear option that the sector will only consider when no other viable alternatives exist. Without this, private hospitals will be forced to terminate contracts, and default to second tier funding arrangements with health insurers, which would see the out-of-pocket fees to patients rise well beyond the gap charges detailed in this proposal.

The analysis by the Australian Private Hospitals Association highlights a critical financial shortfall in the private hospital sector, with quarterly deficits exceeding $200 million since December 2022 and nearing $250 million in June 2024. Despite a total income increase of $906 million between 2021-22 and 2022-23, rising operational costs and minimal employment growth have strained the sector. The operating profit margin has plummeted from 9.6 percent in June 2018 to just 1.4 percent in June 2023, underscoring the urgent need for government intervention.

Private hospitals play a vital role in Australia's healthcare system, contributing significantly to the economy and ensuring access to quality care. However, the current financial trajectory threatens their viability. At least $250 million per quarter would be required to eliminate the ongoing shortfalls and stabilise the sector to continue to serve the nation and invest in the future of Australia's healthcare. However, APHA recognises this is likely cost-prohibitive for government.

Instead, the APHA proposes a partial achievement of that requirement via a temporary two-year co-payment of between $450 and $650 million per year, to stem the collapse of private hospital capacity in Australia. This would allow government, private hospitals and insurers to work on longer-term structural reforms.

This immediate solution is the bare minimum and critical to safeguarding the health and welfare of Australians. Furthermore, ensuring a robust private healthcare sector is critical for Australia's overall hospital system and economic stability. Government action is necessary to address these financial challenges and support the sustainable operation of private hospitals in Australia.

Appendices

APPENDIX 1: BENEFITS AND EPISODES BY TYPE OF EPISODE AND PRIVATE HOSPITAL

Quarter	Benefits ($million)				Episodes			
	DO		ON	Private sector	DO		ON	Private sector
	Day hospitals	Overnight hospitals	Overnight hospitals		Day hospitals	Overnight hospitals	Overnight hospitals	
Mar-14	91.6	284.9	1443.2	1819.7	140,075	377,143	251,397	768,615
Jun-14	100.1	314.5	1557.9	1972.5	147,248	411,208	266,702	825,158
Sep-14	104.1	325.8	1636.6	2066.4	153,201	425,252	274,666	853,119
Dec-14	105.2	336.6	1664.0	2105.8	152,273	436,815	273,656	862,744
Mar-15	96.7	298.3	1539.6	1934.6	146,311	395,970	255,373	797,654
Jun-15	109.2	333.4	1680.4	2123.0	158,142	438,374	274,065	870,581
Sep-15	110.5	338.5	1698.4	2147.4	160,323	440,299	275,161	875,783
Dec-15	111.4	353.3	1748.2	2212.9	157,801	446,054	278,163	882,018
Mar-16	95.3	305.5	1580.8	1981.6	141,514	401,211	254,467	797,192
Jun-16	112.4	360.6	1789.1	2262.1	161,067	462,356	283,555	906,978
Sep-16	114.3	365.2	1792.0	2271.6	162,937	462,064	282,255	907,256
Dec-16	113.3	367.5	1824.4	2305.2	158,066	460,628	284,137	902,831
Mar-17	101.0	336.9	1722.3	2160.2	147,495	432,323	269,647	849,465
Jun-17	116.3	373.4	1848.1	2337.8	161,077	471,078	283,848	916,003
Sep-17	113.6	377.1	1822.0	2312.6	158,086	470,827	279,947	908,860
Dec-17	118.2	394.2	1920.9	2433.3	158,389	481,504	287,946	927,839
Mar-18	103.6	358.3	1770.1	2232.0	145,788	451,006	268,871	865,665
Jun-18	123.1	399.7	1927.5	2450.2	167,038	495,295	286,704	949,037
Sep-18	120.9	394.0	1888.3	2403.2	158,845	486,237	280,827	925,909
Dec-18	123.2	416.2	1981.0	2520.5	156,980	498,844	285,098	940,922
Mar-19	107.7	369.4	1864.7	2341.7	147,430	454,253	271,906	873,589
Jun-19	119.8	406.0	1956.8	2482.7	156,187	493,175	285,647	935,009
Sep-19	124.2	424.4	2002.8	2551.4	160,626	511,007	288,150	959,783
Dec-19	122.6	422.0	2074.4	2619.0	154,896	492,220	290,998	938,114
Mar-20	106.5	391.4	1932.0	2429.9	144,241	478,916	275,519	898,676
Jun-20	93.0	316.2	1724.9	2134.1	123,435	380,998	230,409	734,842
Sep-20	121.9	413.4	1943.0	2478.3	153,381	483,049	271,096	907,526
Dec-20	128.1	433.5	1981.8	2543.4	156,289	485,201	269,793	911,283
Mar-21	115.9	407.0	1945.6	2468.6	152,443	477,816	265,218	895,477
Jun-21	129.4	450.4	2127.4	2707.3	164,624	524,359	289,814	978,797
Sep-21	131.4	458.6	2116.3	2706.3	170,885	538,856	285,799	995,540
Dec-21	132.7	459.2	1985.1	2576.9	167,428	513,443	265,057	945,928
Mar-22	103.9	377.2	1715.5	2196.5	140,783	434,574	228,608	803,965
Jun-22	124.1	432.0	1964.5	2520.5	161,373	491,827	260,503	913,703
Sep-22	128.3	448.6	1992.0	2568.8	162,531	499,165	258,688	920,384
Dec-22	138.6	501.7	2118.8	2759.1	168,990	543,851	274,402	987,243
Mar-23	123.0	447.8	1957.2	2528.0	159,828	503,654	257,319	920,801
Jun-23	138.9	525.0	2263.3	2927.2	170,670	570,828	288,497	1,029,995
Sep-23	140.5	520.7	2199.3	2860.5	170,348	554,352	278,747	1,003,447
Dec-23	147.7	522.7	2210.4	2880.8	174,860	554,807	278,323	1,007,990
Mar-24	128.6	487.9	2166.1	2782.6	158,495	531,233	272,077	961,805
Jun-24	151.5	554.6	2446.8	3152.9	175,833	585,509	298,109	1,059,451

Table 4 Source APRA Quarterly Private Health Insurance Statistics

APPENDIX 2: ANNUAL CPI INCREASES

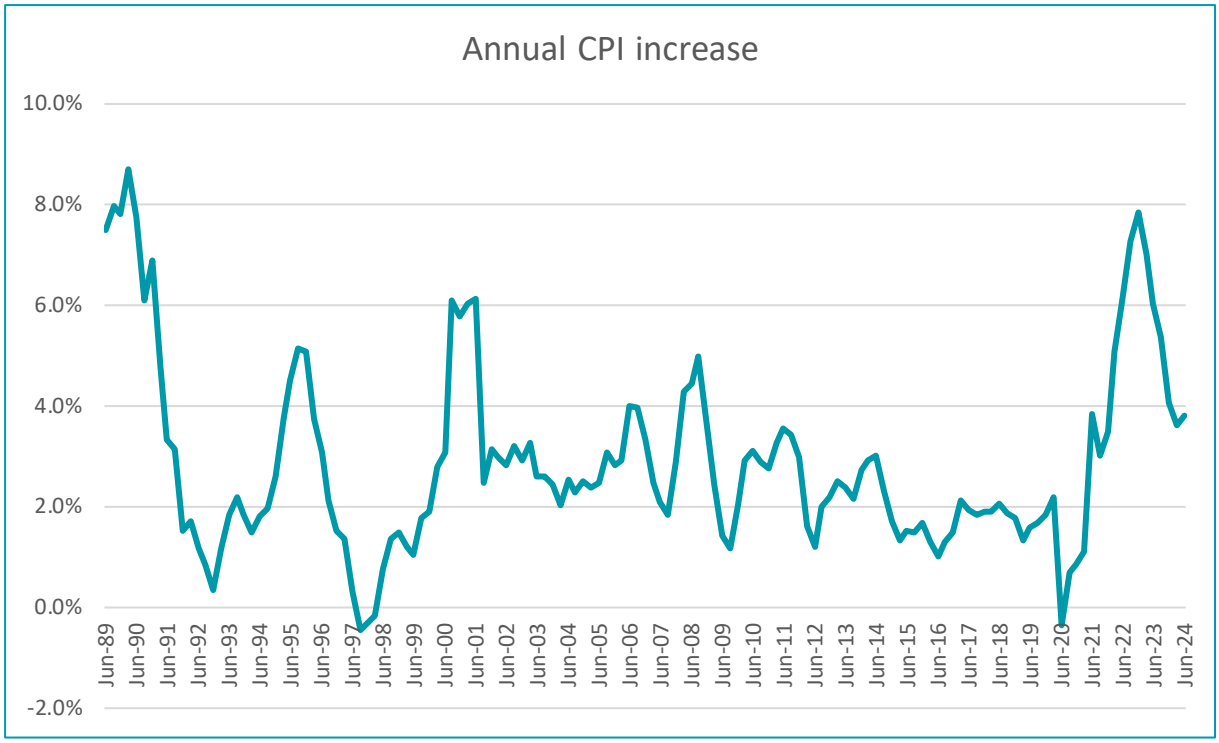

Figure 5 Annual CPI increase (Data source: ABS, Consumer Price Index)

Quarter	CPI	Annual CPI increase
Mar-14	105.4	2.9%
Jun-14	105.9	3.0%
Sep-14	106.4	2.3%
Dec-14	106.6	1.7%
Mar-15	106.8	1.3%
Jun-15	107.5	1.5%
Sep-15	108.0	1.5%
Dec-15	108.4	1.7%
Mar-16	108.2	1.3%
Jun-16	108.6	1.0%
Sep-16	109.4	1.3%
Dec-16	110.0	1.5%
Mar-17	110.5	2.1%
Jun-17	110.7	1.9%
Sep-17	111.4	1.8%
Dec-17	112.1	1.9%
Mar-18	112.6	1.9%
Jun-18	113.0	2.1%
Sep-18	113.5	1.9%
Dec-18	114.1	1.8%
Mar-19	114.1	1.3%
Jun-19	114.8	1.6%

Sep-19	115.4	1.7%
Dec-19	116.2	1.8%
Mar-20	116.6	2.2%
Jun-20	114.4	-0.3%
Sep-20	116.2	0.7%
Dec-20	117.2	0.9%
Mar-21	117.9	1.1%
Jun-21	118.8	3.8%
Sep-21	119.7	3.0%
Dec-21	121.3	3.5%
Mar-22	123.9	5.1%
Jun-22	126.1	6.1%
Sep-22	128.4	7.3%
Dec-22	130.8	7.8%
Mar-23	132.6	7.0%
Jun-23	133.7	6.0%
Sep-23	135.3	5.4%
Dec-23	136.1	4.1%
Mar-24	137.4	3.6%
Jun-24	138.8	3.8%

Table 5 Annual CPI increase (Data source: ABS, Consumer Price Index)

APPENDIX 3: CUMULATIVE BENEFIT INDEXATION AND INFLATION AT QUARTERLY INTERVALS FROM JUNE 2018

Quarter	Benefits (B)	Episodes	Non-indexed benefits adjusted for growth in number of episodes	Cumulative indexation of benefits	Cumulative CPI growth	Benefits adjusted for activity and cumulative CPI growth (B_{CPI})	Shortfall (excess) from B_{CPI}
Jun-18	$2,450,248,042.71	949,037	$2,450,248,042.71	0.00%	0.00%	$2,450,248,042.71	$0.00
Sep-18	$2,403,211,594.71	925,909	$2,390,535,579.73	0.53%	0.44%	$2,401,113,170.79	($2,098,423.92)
Dec-18	$2,520,450,621.10	940,922	$2,429,296,527.79	3.75%	0.97%	$2,452,944,547.09	($67,506,074.01)
Mar-19	$2,341,726,225.32	873,589	$2,255,454,463.19	3.83%	0.97%	$2,277,410,214.60	($64,316,010.72)
Jun-19	$2,482,710,303.73	935,009	$2,414,030,192.89	2.85%	1.59%	$2,452,483,771.18	($30,226,532.55)
Sep-19	$2,551,402,968.14	959,783	$2,477,992,340.84	2.96%	2.12%	$2,530,622,266.67	($20,780,701.47)
Dec-19	$2,619,042,030.63	938,114	$2,422,046,761.44	8.13%	2.83%	$2,490,635,696.28	($128,406,334.35)
Mar-20	$2,429,897,663.72	898,676	$2,320,224,722.57	4.73%	3.19%	$2,394,143,386.29	($35,754,277.43)
Jun-20	$2,134,102,681.26	734,842	$1,897,233,903.63	12.48%	1.24%	$1,920,739,456.42	($213,363,224.84)
Sep-20	$2,478,264,242.46	907,526	$2,343,073,879.32	5.77%	2.83%	$2,409,426,413.96	($68,837,828.50)
Dec-20	$2,543,449,425.95	911,283	$2,352,773,798.18	8.10%	3.72%	$2,440,222,027.85	($103,227,398.10)
Mar-21	$2,468,564,020.69	895,477	$2,311,965,462.40	6.77%	4.34%	$2,412,218,832.01	($56,345,188.68)
Jun-21	$2,707,266,711.21	978,797	$2,527,083,173.22	7.13%	5.13%	$2,656,791,867.06	($50,474,844.15)
Sep-21	$2,706,276,945.82	995,540	$2,570,310,679.60	5.29%	5.93%	$2,722,709,631.40	$16,432,685.58
Dec-21	$2,576,940,204.85	945,928	$2,442,221,146.85	5.52%	7.35%	$2,621,605,531.97	$44,665,327.12
Mar-22	$2,196,549,876.25	803,965	$2,075,697,436.09	5.82%	9.65%	$2,275,919,578.16	$79,369,701.91
Jun-22	$2,520,498,110.31	913,703	$2,359,021,816.19	6.85%	11.59%	$2,632,501,336.47	$112,003,226.16
Sep-22	$2,568,797,036.28	920,384	$2,376,270,993.17	8.10%	13.63%	$2,700,116,774.54	$131,319,738.26
Dec-22	$2,759,087,464.22	987,243	$2,548,889,272.42	8.25%	15.75%	$2,950,395,724.18	$191,308,259.96
Mar-23	$2,528,022,013.56	920,801	$2,377,347,614.45	6.34%	17.35%	$2,789,701,713.95	$261,679,700.39
Jun-23	$2,927,236,363.86	1,029,995	$2,659,267,481.41	10.08%	18.32%	$3,146,407,630.65	$219,171,266.79
Sep-23	$2,860,482,275.10	1,003,447	$2,590,725,174.80	10.41%	19.73%	$3,101,992,178.32	$241,509,903.22
Dec-23	$2,880,791,311.50	1,007,990	$2,602,454,408.60	10.70%	20.44%	$3,134,460,575.31	$253,669,263.81
Mar-24	$2,782,637,509.26	961,805	$2,483,212,792.25	12.06%	21.59%	$3,019,410,952.70	$236,773,443.44
Jun-24	$3,152,858,136.06	1,059,451	$2,735,317,736.92	15.26%	22.83%	$3,359,841,609.60	$206,983,473.54

Table 6 Cumulative indexation and inflation at quarterly intervals using a June 2018 reference quarter

APPENDIX 4: CUMULATIVE BENEFIT INDEXATION AND INFLATION AT QUARTERLY INTERVALS FROM JUNE 2019

Quarter	Benefits (B)	Episodes	Non-indexed benefits adjusted for growth in number of episodes	Cumulative indexation of benefits	Cumulative CPI growth	Benefits adjusted for activity and cumulative CPI growth (B_{CPI})	Shortfall (excess) from B_{CPI}
Jun-19	$2,482,710,303.73	935,009	$2,482,710,303.73	0.00%	0.00%	$2,482,710,303.73	$0.00
Sep-19	$2,551,402,968.14	959,783	$2,548,492,200.02	0.11%	0.52%	$2,561,811,845.66	$10,408,877.52
Dec-19	$2,619,042,030.63	938,114	$2,490,954,946.82	5.14%	1.22%	$2,521,332,446.17	($97,709,584.46)
Mar-20	$2,429,897,663.72	898,676	$2,386,236,030.79	1.83%	1.57%	$2,423,650,881.45	($6,246,782.27)
Jun-20	$2,134,102,681.26	734,842	$1,951,210,956.27	9.37%	-0.35%	$1,944,412,311.83	($189,690,369.43)
Sep-20	$2,478,264,242.46	907,526	$2,409,735,255.06	2.84%	1.22%	$2,439,122,270.37	($39,141,972.09)
Dec-20	$2,543,449,425.95	911,283	$2,419,711,140.44	5.11%	2.09%	$2,470,297,436.06	($73,151,989.89)
Mar-21	$2,468,564,020.69	895,477	$2,377,741,791.42	3.82%	2.70%	$2,441,949,104.60	($26,614,916.09)
Jun-21	$2,707,266,711.21	978,797	$2,598,979,685.93	4.17%	3.48%	$2,689,536,469.41	($17,730,241.80)
Sep-21	$2,706,276,945.82	995,540	$2,643,437,031.92	2.38%	4.27%	$2,756,266,661.33	$49,989,715.51
Dec-21	$2,576,940,204.85	945,928	$2,511,703,301.45	2.60%	5.66%	$2,653,916,467.47	$76,976,262.62
Mar-22	$2,196,549,876.25	803,965	$2,134,751,846.60	2.89%	7.93%	$2,303,969,980.78	$107,420,104.53
Jun-22	$2,520,498,110.31	913,703	$2,426,136,917.02	3.89%	9.84%	$2,664,946,561.29	$144,448,450.98
Sep-22	$2,568,797,036.28	920,384	$2,443,876,839.89	5.11%	11.85%	$2,733,395,350.54	$164,598,314.26
Dec-22	$2,759,087,464.22	987,243	$2,621,406,177.25	5.25%	13.94%	$2,986,758,954.57	$227,671,490.35
Mar-23	$2,528,022,013.56	920,801	$2,444,984,091.47	3.40%	15.51%	$2,824,084,412.28	$296,062,398.72
Jun-23	$2,927,236,363.86	1,029,995	$2,734,924,689.81	7.03%	16.46%	$3,185,186,681.42	$257,950,317.56
Sep-23	$2,860,482,275.10	1,003,447	$2,664,432,327.55	7.36%	17.86%	$3,140,223,814.61	$279,741,539.51
Dec-23	$2,880,791,311.50	1,007,990	$2,676,495,262.67	7.63%	18.55%	$3,173,092,380.22	$292,301,068.72
Mar-24	$2,782,637,509.26	961,805	$2,553,861,175.32	8.96%	19.69%	$3,056,624,786.49	$273,987,277.23
Jun-24	$3,152,858,136.06	1,059,451	$2,813,138,605.08	12.08%	20.91%	$3,401,251,205.44	$248,393,069.38

Table 7 Cumulative indexation and inflation at quarterly intervals using a June 2019 reference quarter

APPENDIX 5: CUMULATIVE BENEFIT INDEXATION AND INFLATION AT ANNUAL INTERVALS FROM FY2018

Financial year	Benefits (B)	Episodes	Non-indexed benefits adjusted for growth in number of episodes	Cumulative indexation of benefits	Cumulative CPI growth	Benefits adjusted for activity and cumulative CPI growth (B_{CPI})	Shortfall (excess) from B_{CPI}
FY2018	$9,428,193,776.76	3,651,401	$9,428,193,776.76	0.00%	0.00%	$9,428,193,776.76	$0.00
FY2019	$9,748,098,744.86	3,675,429	$9,490,235,891.57	2.72%	1.59%	$9,641,407,790.73	($106,690,954.13)
FY2020	$9,734,445,343.75	3,531,415	$9,118,380,842.36	6.76%	1.24%	$9,231,351,932.44	($503,093,411.31)
FY2021	$10,197,544,400.31	3,693,083	$9,535,819,855.90	6.94%	5.13%	$10,025,269,016.65	($172,275,383.66)
FY2022	$10,000,265,137.23	3,659,136	$9,448,166,132.26	5.84%	11.59%	$10,543,484,506.89	$543,219,369.66
FY2023	$10,783,142,877.92	3,858,423	$9,962,740,251.40	8.23%	18.32%	$11,787,773,200.11	$1,004,630,322.19
FY2024	$11,676,769,231.92	4,032,693	$10,412,718,582.86	12.14%	22.83%	$12,790,135,746.03	$1,113,366,514.11

Table 8 Cumulative indexation and inflation at annual intervals using a FY2018 reference financial year

APPENDIX 6: CUMULATIVE BENEFIT INDEXATION AND INFLATION AT ANNUAL INTERVALS FROM FY2019

Financial year	Benefits (B)	Episodes	Non-indexed benefits adjusted for growth in number of episodes	Cumulative indexation of benefits	Cumulative CPI growth	Benefits adjusted for activity and cumulative CPI growth (B_{CPI})	Shortfall (excess) from B_{CPI}
FY2019	$9,748,098,744.86	3,675,429	$9,748,098,744.86	0.00%	0.00%	$9,748,098,744.86	$0.00
FY2020	$9,734,445,343.75	3,531,415	$9,366,139,878.93	3.93%	-0.35%	$9,333,505,245.21	($400,940,098.54)
FY2021	$10,197,544,400.31	3,693,083	$9,794,921,288.63	4.11%	3.48%	$10,136,207,744.68	($61,336,655.63)
FY2022	$10,000,265,137.23	3,659,136	$9,704,885,891.93	3.04%	9.84%	$10,660,157,761.08	$659,892,623.85
FY2023	$10,783,142,877.92	3,858,423	$10,233,441,702.57	5.37%	16.46%	$11,918,215,641.41	$1,135,072,763.49
FY2024	$11,676,769,231.92	4,032,693	$10,695,646,568.52	9.17%	20.91%	$12,931,670,241.39	$1,254,901,009.47

Table 9 Cumulative indexation and inflation at annual intervals using a FY2018 reference financial year

END OF PRE-BUDGET SUBMISSION