

AUGUST 2026

# EVIDENCE TO ACTION REIMAGINING MENTAL HEALTH CARE

New evidence on access, affordability and sustainability of Australia's mental health system



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## ABOUT THE ANALYSIS

This report draws primarily on data from the Australian Government's Hospital Casemix Protocol (HCP) and the Australian Institute of Health and Welfare (AIHW).

The analysis focuses on private health insurance (PHI)-funded inpatient mental health activity delivered in both public and private hospitals. It includes activity classified within Major Diagnostic Category (MDC) 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol and Drug Use and Dependence), using the nationally recognised Australian Refined Diagnosis Related Groups (AR-DRG) Version 10.0. Activity is measured by separations (completed admitted-patient episodes), average length of stay and bed-days.

As this approach relies on standard hospital classifications, some mental health-related activity, including some PHI-funded care, may not be captured in the analysis where mental health is not recorded as the primary reason for admission. This is estimated to represent a relatively small proportion of total activity (less than 10%).

Historical analysis covers the period FY21 to FY25. This timeframe was selected because it avoids most of the disruption associated with COVID-19 and aligns with the period following the 2019 private health insurance reforms, which introduced standardised product tiers, including Gold cover. To test whether post-pandemic recovery was influencing the results, a review of ten years of PHI-funded mental health activity was undertaken. This found that growth during FY21 to FY25 was broadly consistent with longer-term trends and was not materially inflated by COVID-19 recovery effects.

This evidence report was used to inform the Reimagining Mental Health Care Roundtable held in August 2026. Please refer to the follow up report A Shared Reform Agenda: Reimagining Mental Health Care for outcomes of the Roundtable.



# EXECUTIVE SUMMARY

Australia's mental health system is under increasing pressure, with growing consequences for patients, communities and the broader economy. More than one in five Australians aged 16 to 85 experienced a mental disorder in the previous 12 months, while almost two in five young adults aged 16 to 24 were affected. Yet access to care remains challenging, with greater than 20% of Australians delaying or foregoing mental health treatment because of cost. Constrained bed supply, workforce shortages and rising demand are further limiting timely access to care across public, private, primary and community settings, resulting in many people presenting later for treatment and with higher acuity needs.

Australia's private mental health system plays a critical role in meeting this demand. Private hospitals account for almost 30% of overnight mental health admissions and more than 90% of same-day mental health admissions, providing a significant source of capacity that helps relieve pressure on the public system.

The consequences of unmet and delayed care extend well beyond the health system. Mental ill-health and suicide are estimated to cost Australia \$200 to \$220 billion annually through increased health and social service utilisation, reduced workforce participation, absenteeism, lost productive capacity, informal care, disability and premature mortality. Improving access to effective mental health care is therefore critical not only for better patient outcomes, but also for national productivity, workforce participation and economic wellbeing.

However, Australia's private mental health system is under significant structural pressure. Rising clinical complexity and costs and mounting premium affordability pressures have increased risk exposure within Gold-tier cover, eroding participation and challenging long-term viability. If left unaddressed, these trends could exacerbate pressure on an already constrained public health system and limit choice for people with complex mental health needs.

As Australia's largest not-for-profit health insurer, HCF recognises these as whole-of-system issues and is committed to working with government and sector partners on targeted reform of system settings, product design and care models to restore value, improve support and ensure sustainability.

## ABOUT REIMAGINING MENTAL HEALTH

*Evidence to Action: Reimagining Mental Health Care* is an independent report commissioned by HCF to examine how pressures across Australia's mental health system are likely to evolve and the implications for access, affordability and sustainability.

It responds to the need for a single, integrated, robust and balanced system-level evidence base to support solutions-focused reform across the mental health system. Drawing on contemporary data and insights from HCF, national databases and the broader sector, the report examines future demand, capacity and system risk, and identifies evidence to inform collaboration and reform across government, providers, payers, consumers and the wider sector.

### The report is split into two key sections:

1. **The Challenge:** an integrated view of public and private system dynamics, identifying material system pressures and root causes.
2. **The Impact:** a forward-looking understanding of how these pressures are likely to evolve under current settings.

## KEY FINDINGS

The analysis highlights four interrelated system challenges that require coordinated reform.

### Access to private mental health care continues to narrow.

In the Australian private system, access to inpatient mental health care continues to depend on Gold-tier hospital cover, where unrestricted psychiatric benefits are included. The proportion of insured Australians holding Gold cover has fallen from approximately 40% in quarter four (Q4) 2019 to around 28% by Q4 2025, reducing the pool of people able to access comprehensive private psychiatric care. Over the same period, average premiums for the largest five funds' Gold products rose by up to 71%, placing additional pressure on upfront affordability. These dynamics have created a self-reinforcing 'Gold spiral', ultimately impacting the affordability and access of Private Health Insurance (PHI)-funded inpatient mental health care.

### Costs are rising largely because of increasing clinical complexity rather than demand volume.

Private mental health activity is concentrated in a smaller, higher-acuity cohort requiring more intensive and costly care. Between fiscal year 2020 (FY20) and FY25, total private separations fell by 4% while total benefits paid rose by 13%, driven by a significant increase in the cost of average benefits paid, particularly in overnight admissions. Amidst declining Gold memberships, this reflects an increase in benefits paid per member. In FY25, the average private health insurer benefit paid for a mental health overnight admission was \$15,541, based on Department of Health, Disability and Ageing Hospital Casemix Protocol data<sup>1</sup>. Key drivers include growing admissions for alcohol and other drug (AOD) conditions, increased complexity, especially for affective disorders, and rising workforce costs.

### **Effective system capacity remains constrained and, in some areas, fragile.**

Although workforce numbers and infrastructure have increased, gains in access have been limited. Workforce maldistribution, structural supply constraints and rising care intensity are collectively reducing throughput. Private hospitals continue to play an essential role in absorbing demand, but many providers are operating under increasing financial pressure.

### **Current funding arrangements favour acute care over earlier intervention and recovery supports.**

Despite established evidence that early intervention, step-up/step-down services and other community-based models can improve outcomes and reduce pressure on hospitals, these approaches remain difficult for PHI to fund and scale under current settings. Where government investment in this space is growing, fragmentation and restricted access to broader non-hospital care means people often access care later and at a higher level of need, increasing reliance on more intensive and costly hospital-based acute treatment.

## **LEVERS FOR REFORM**

Without reform, these dynamics will continue to compound, reducing patient choice, increasing pressure on public hospitals and making private mental health care less accessible and affordable for the Australians who rely on it.

No single intervention will address these challenges. The evidence suggests that meaningful improvement will require coordinated action across funding, product design, care delivery and workforce settings.

In preparation for the HCF Mental Health Roundtable, this report presents three complementary reform levers for consideration by governments, insurers, providers and the broader sector:

1. Shift demand through early intervention and care substitution.
2. Rebalance risk and price signals across the PHI system.
3. Expand effective supply through workforce and care model reform.

These levers are intended to inform constructive discussion across the sector about how to improve access to mental health care, support patients earlier, and ensure the long-term sustainability of both public and private mental health services.

**\$15,541<sup>1</sup>**

**The cost of an average mental health overnight admission**



<sup>1</sup> Department of Health, Disability and Ageing, Hospital Casemix Protocol data, 2024–25. Mental health admissions are defined using Major Diagnostic Categories 19 and 20. Average private health insurer benefit paid was calculated by combining hospital and fund-paid medical benefits for each diagnosis-related group. Figures may differ from published averages, which include Medicare benefits and exclude admissions without a medical component.

# THE CHALLENGE

## A SYSTEM UNDER STRAIN

Australia's mental health system is facing a structural challenge: demand is becoming more complex and costly to treat, while affordability pressures, workforce shortages and limited bed capacity are constraining access across both public and private settings. In the private system, declining participation in comprehensive cover and rising claims intensity are reducing the viability of private mental health bed capacity at the very point it is needed to relieve pressure on the public system.

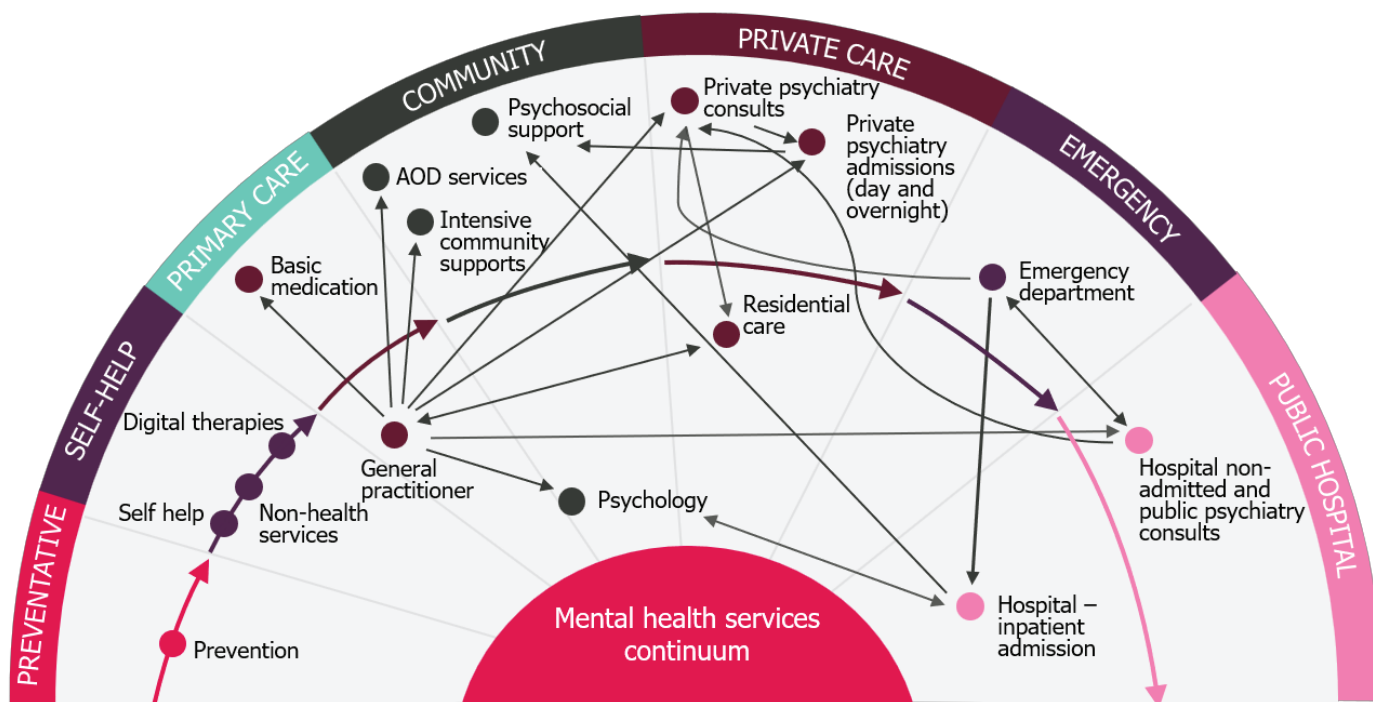
These pressures cannot be understood through a public or private lens alone. When people cannot access timely community-based or private care, they are more likely to present later, with higher acuity needs, requiring more intensive hospital-based support.<sup>2</sup> This means that a lack of early-intervention models and declining access in the private system are not only private health insurance

issues; they have direct consequences for public hospital demand, service continuity and patient choice. Without reform, these dynamics will reinforce reliance on hospital-based acute care, reduce patient choice and place further pressure on an already constrained public system.

Despite a wide range of mental health initiatives and services, and government expenditure of \$14.5 billion annually on mental health related services<sup>3</sup>, mental health care remains complex, fragmented and difficult to access. People often need to navigate disconnected public, private, primary care and community services, with access shaped by affordability, local service availability and the ability to find the right care at the right time. Figure 1 provides an overview of the complex mental health service continuum in Australia.

A recent report by the Mental Health Commission found that more than one in five Australians delayed or did not see a mental health professional because of cost, while public hospital mental health services continue to face high-acuity demand and ongoing pressure relating to access, bed availability and service continuity.<sup>4</sup> Despite sustained policy attention and investment, system outcomes remain mixed and in some areas are deteriorating.<sup>5</sup> This reflects a system that is still too reactive rather than preventative, with insufficient capacity for early intervention, care coordination and community-based support.

Figure 1. Mental health services continuum



For illustrative purposes only. Source: Nous Group

<sup>2</sup> Australian College for Emergency Medicine. Reports confirm EDs relied on to fill mental health service gaps. 31 July 2025.

<sup>3</sup> Australian Institute of Health and Welfare. Expenditure on mental health-related services. 2019-20 data. Updated 12 May 2026.

<sup>4</sup> National Mental Health Commission. National Report Card 2024. July 2025.

<sup>5</sup> Australian Government Department of Health, Disability and Ageing. What we're doing about mental health. February 2026.

## ACCESS TO PRIVATE MENTAL HEALTH SERVICES IS DECLINING

PHI plays a critical role in expanding system capacity, funding inpatient admissions and day programs, in addition to psychology and allied mental health services covered through extras cover.

In FY24, private hospitals accounted for almost 30% of overnight mental health admissions and over 90% of same-day mental health admissions, representing approximately \$710 million in total claims paid by insurers. Approximately 91% of PHI-insured activity occurred in private hospitals, with the remaining in public settings.<sup>6,7</sup>

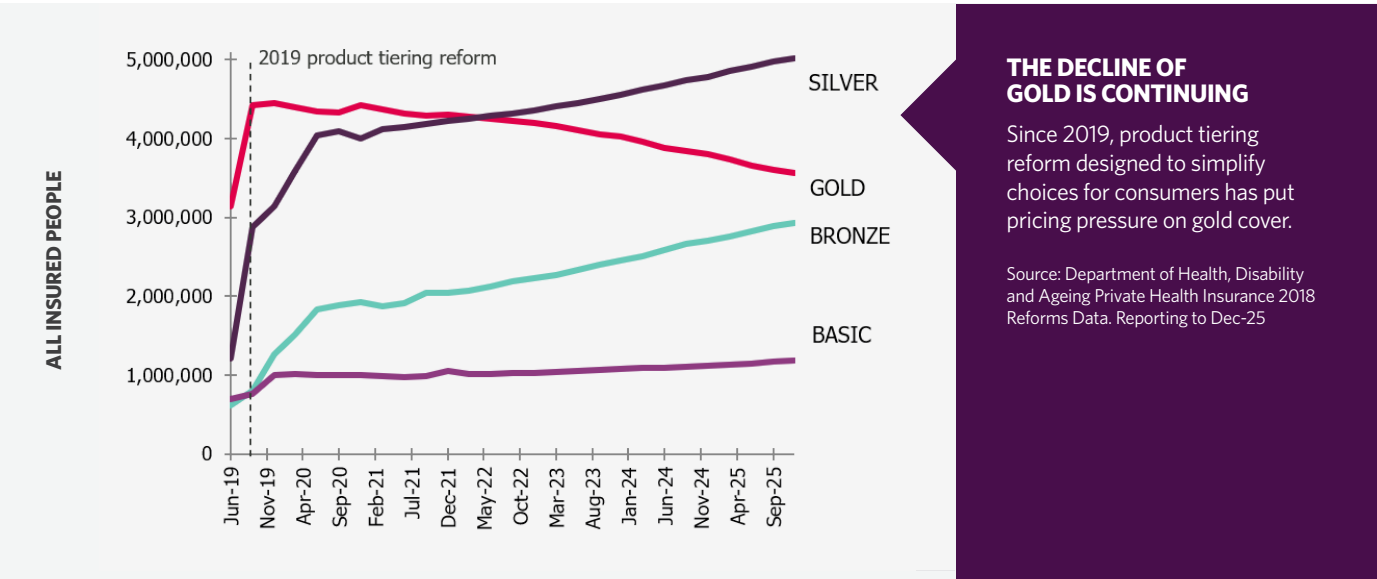
There is a vulnerability in the current model. Access to private hospital psychiatric care is closely tied to the affordability and take-up of Gold cover, where unrestricted psychiatric product benefits are included.

- Over the past five years:<sup>8</sup>
- The proportion of insured Australians holding Gold cover has fallen, from approximately 40% in Q4 2019 to approximately 28% in Q4 2025.
  - This represents a decline of approximately 885,000 insured persons in the same period.
  - Over the same period, the average premium for Gold cover increased by up to 71%.<sup>9</sup>

Figure 2 highlights the changing dynamics of insured people by hospital product tier.

Together, these trends point to a weakening access pathway: fewer Australians hold the level of cover needed to access private inpatient mental health care, while that cover is becoming less affordable.

Figure 2. Australia’s insurance policy holders by product tier



<sup>6</sup> Australian Institute of Health and Welfare. Admitted patient mental health-related care to 2023-24. Updated August 2025.

<sup>7</sup> Australian Government Department of Health, Disability and Ageing. Hospital Casemix Protocol Annual Report, 2023-24.

<sup>8</sup> Australian Prudential Regulation Authority. Quarterly private health insurance membership and benefits summary. February 2026.

<sup>9</sup> Health Services Daily. A solution to reversing the ‘Gold death spiral’. Ed Butler. 27 March 2026.

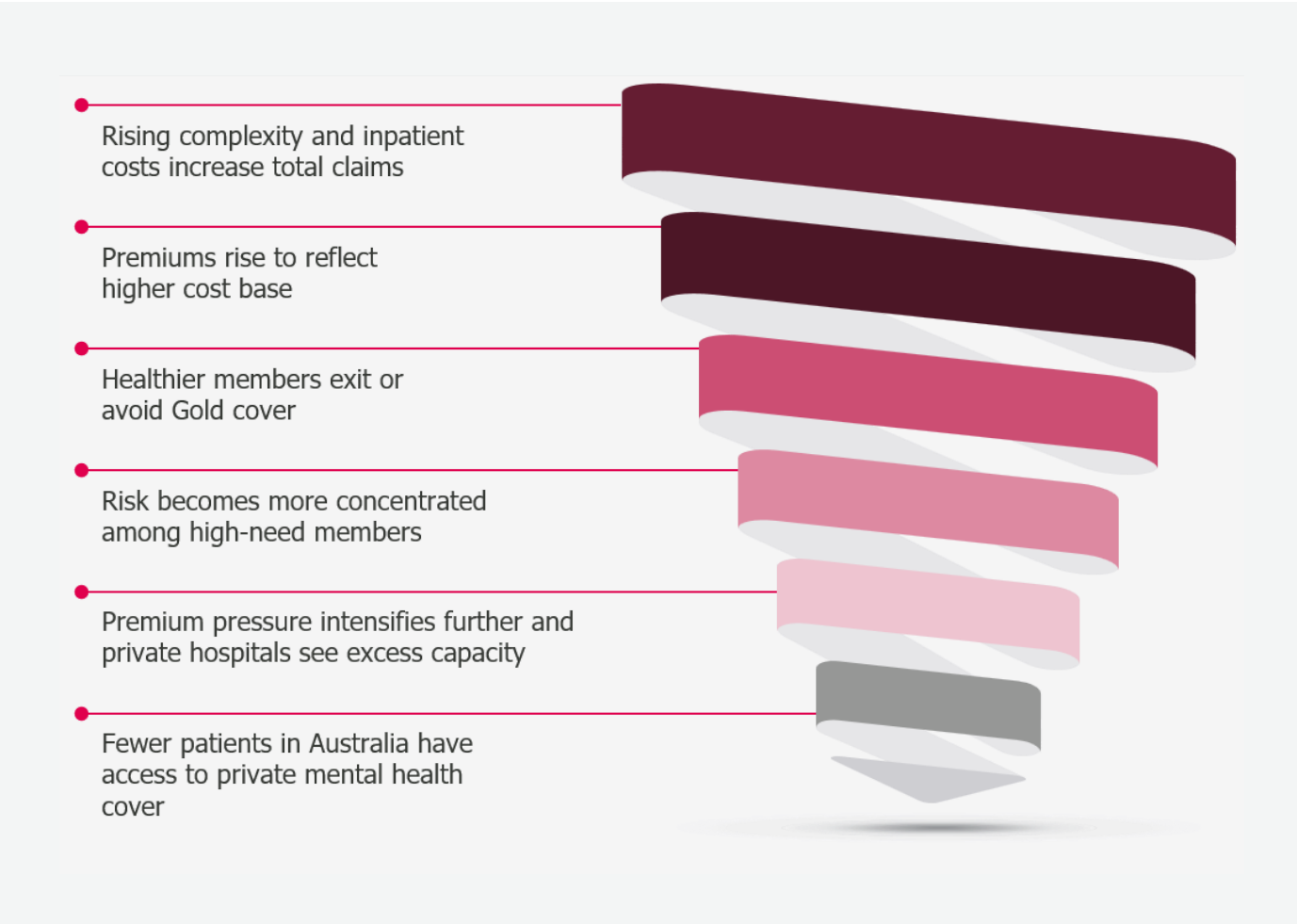
ADVERSE SELECTION AND THE ‘GOLD SPIRAL’

This decline in Gold participation reflects a structural risk problem within PHI. Because unrestricted psychiatric benefits are available only in Gold, people with known or emerging mental health needs have a strong incentive to upgrade when care is required, while lower-risk and younger members are less likely to take up or retain this level of cover.<sup>10</sup>

Over time, this creates a self-reinforcing “Gold spiral”: higher-need members concentrate within Gold, claims intensity rises, premiums increase and affordability declines, further weakening participation

among healthier members. The spiral is further compounded by use of the mental health waiting period exemption which allows members to upgrade once in a lifetime without incurring the waiting period. Analysis of market and HCF claims data suggests this effect is already material. Sector insights suggest a substantial proportion of mental health admissions occur soon after members upgrade to Gold cover, suggesting episodic selection behaviour supported by the waiting period waiver. Mental health is now one of the largest contributors to claims within Gold policies.<sup>11</sup>

Figure 3. The Gold Spiral



Note: An illustrative representation of the interaction between participation, claims concentration and premium pressure. It does not imply that each step is caused solely by the preceding factor.

<sup>10</sup> Actuaries Institute. The Psychiatric Waiver: Balancing Access and Sustainability in Gold Hospital Products. 14 December 2025.

<sup>11</sup> Australian Government Department of Health, Disability and Ageing. Private Health Insurance 2018 Reforms Data, as of December 2025.

## PRIVATE MENTAL HEALTH DEMAND IS EVOLVING

Across the Australian mental health system, hospital-based care is increasingly concentrated in working-age populations, rather than older cohorts, which are typically associated with high hospital utilisation in other clinical areas. Specialised psychiatric hospitalisations are predominantly among people aged 25 to 64, reflecting that mental health follows a younger age-cost profile than seen in areas such as orthopaedics or cardiovascular care.<sup>12</sup>

At the same time, there is a clear distinction in the roles of private and public systems. Private hospitals have expanded capacity primarily through same-day mental health admissions and increasingly treat people with affective disorders, anxiety and stress-related conditions, eating disorders, trauma-related disorders and alcohol and other drug (AOD) presentations.

Public hospitals continue to provide a substantial share of overnight care and are more likely to treat a broader and more complex diagnostic mix, including schizophrenia and other psychotic disorders, dementia-related conditions, alcohol-related disorders and severe mental illness requiring involuntary treatment.<sup>13</sup> These trends suggest the public and private systems are increasingly serving different patient cohorts rather than delivering the same care in different settings.

There are two common conditions driving an evolution in complexity, cost and admissions within private care.

For PHI-funded psychiatric activity:<sup>14</sup>



**Major affective disorders** are the single largest driver of total benefits, due to their high prevalence and recurrent nature.



**AOD** conditions are among the fastest-growing contributors to admissions and expenditure.

Together, these trends indicate that mental health demand is increasingly defined by complex, recurrent conditions affecting working-age populations, rather than episodic, low-acuity care.

## DEEP DIVE: AOD ADMISSIONS CONTRIBUTING TO SIGNIFICANT GROWTH

AOD is emerging as a material growth pressure within private mental health care. Between FY20 and FY25, AOD-related separations increased by 19% and benefits paid by 31%, while total private mental-health separations declined by 4%. This indicates that AOD is not simply moving with broader activity trends; it is becoming a larger share of a smaller, more complex private mental health casemix.

Benefits paid grew faster than separations, likely reflecting a combination of higher activity and increasing casemix or treatment intensity, rather than volume alone. In FY25, the mean benefit for major complexity alcohol separations was \$6,591, compared with \$2,773 for minor-complexity separations.<sup>15</sup>

The increase appears concentrated in alcohol-related presentations, particularly complex episodes of care. Although population-level alcohol consumption has declined or stabilised, harms remain concentrated among a smaller cohort with dependence, comorbidity and complex treatment needs. Alcohol remains Australia's leading source of AOD-related harm, accounting for 58% of AOD hospitalisations in 2023-24 and 79% among people aged 50 years and over in 2020-21. It also contributes to more ambulance attendances, hospitalisations, deaths and treatment episodes than any other drug.<sup>16</sup>

Within private care, patients admitted for AOD treatment are most commonly men aged 40-64 years. This differs from public treatment settings, where around half of treatment seekers are aged 30-49 years, suggesting differences exist between patients across settings.



**19%**  
AOD-related  
separations increased



**31%**  
Increase in AOD-related  
benefits paid



**4%**  
Total private mental-health  
separations declined



**58%**  
Of all AOD hospitalisations  
are alcohol-related 2023-24

<sup>12</sup> Australian Institute of Health and Welfare. Admitted patient mental health-related care to 2023-24. Updated August 2025.

<sup>13</sup> Ibid.

<sup>14</sup> Australian Government Department of Health, Disability and Ageing. Hospital Casemix Protocol annual report 2024-25

<sup>15</sup> Complexity (minor, moderate, major) of an admitted episode of care is defined by national classifications, based on coded clinical and demographic factors, including diagnoses, procedures, complications, comorbidities and expected resource use.

<sup>16</sup> Australian Institute of Health and Welfare. Alcohol, tobacco & other drugs in Australia. Updated 1 July 2026.

RISING COMPLEXITY AND COST IN MENTAL HEALTH CARE

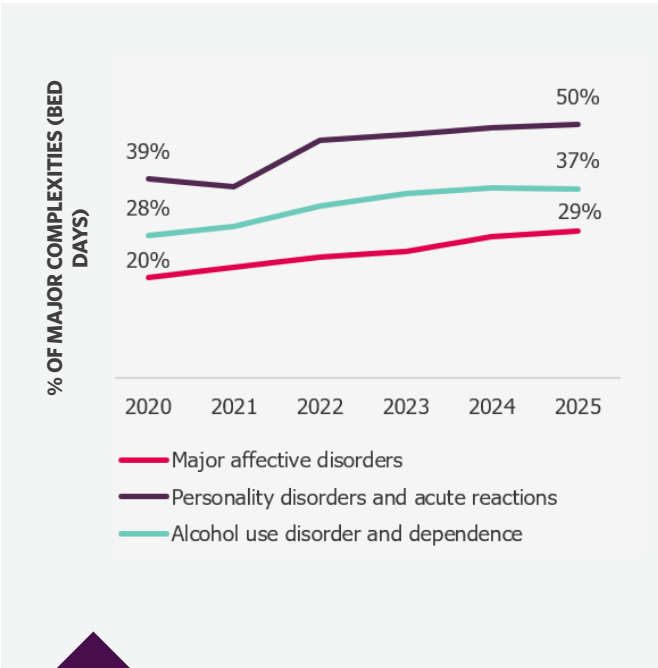
The value of total benefits paid by PHI for mental health claims is rising due to complexity and intensity, not simply volume. Between FY20 and FY25, the total number of PHI-funded mental health separations declined by 4%. In the same period, however, total benefits paid by PHIs have increased by 13%.<sup>17</sup> There is a similar trend being observed in the public system, suggesting system-wide pressures.

This divergence reflects several underlying trends:

1. Rising clinical complexity and acuity

The share of high-complexity activity has increased significantly, with more complex conditions associated with longer stays and higher per-episode costs. This is demonstrated in Figure 4. In the same period, the share of benefits paid for Major Complexity Diagnostic Related Groups (DRGs) increased from 27 to 37%. A key driver of this is average length of stay, which increased for overnight separations from 17.9 to 19.2 days between FY20 and FY25.

Figure 4. Major complexity (% of total bed days per DRG)



**THE PROPORTION OF MAJOR COMPLEXITY IS INCREASING FOR KEY DIAGNOSTIC GROUPS**

Note: Proportion relates to major versus minor complexity for each DRG and therefore these are mutually exclusive numbers.

Source: Department of Health, Disability and Ageing. Hospital Casemix Protocol annual report 2024-25.

2. Growth in high-cost conditions

The change in clinical mix towards higher-cost conditions is likely a key contributor:

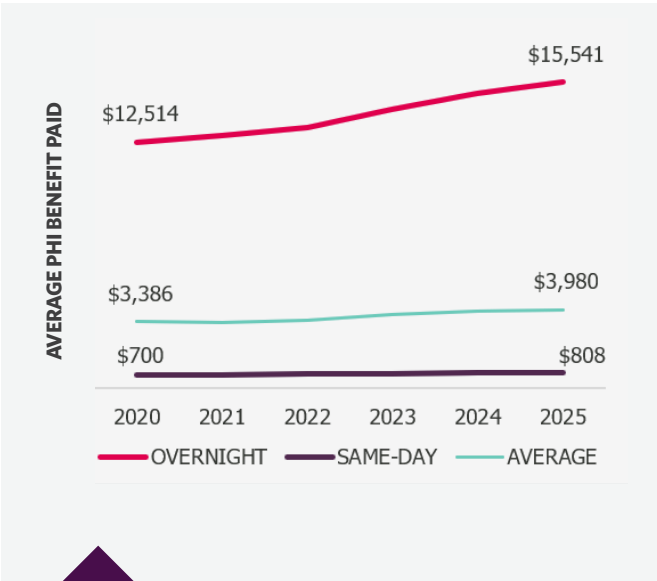
- Major affective disorders remain the largest contributor to benefits paid, but their share fell from 43% in FY20 to 38% in FY25.
- AOD conditions are growing rapidly, with an increase of 31% in benefits paid by PHI between FY20 and FY25, noting reduced activity during the COVID-19 period.
- The share of PHI benefits paid for Alcohol Use and Dependence increased from 13% in FY20 to 15% in FY25.

3. Increasing cost per separation

The private system is treating fewer patients, but at significantly higher cost per patient. Across the private system, the average benefit per mental health admission has increased by 18% in the last five years from \$3,386 in FY20 to \$3,980 in FY25 (see Figure 5), reflecting a combination of higher acuity, more intensive treatment approaches, longer stays and broader cost pressures including wage growth and inflation.

Costs can differ substantially based on the DRG. For example, the average PHI benefit paid for a major affective disorder admission (major complexity) was \$23,774 in FY25, which is comparable to major elective procedures such as knee or hip replacements (at \$24,157 and \$27,652 respectively).<sup>18</sup>

Figure 5. Mean benefit per admission



**THERE HAS BEEN AN 18% INCREASE IN AVERAGE BENEFIT PAID ACROSS ALL SEPARATIONS SINCE 2020, DRIVEN BY OVERNIGHT ADMISSIONS**

Source: Department of Health, Disability and Ageing. Hospital Casemix Protocol annual report 2024-25. Mean PHI-funded benefit shown.

<sup>17</sup> Australian Government Department of Health, Disability and Ageing. Hospital Casemix Protocol Data – up to June 2025.

<sup>18</sup> Australian Government Department of Health, Disability and Ageing. Hospital Casemix Protocol data, 2024-25. Average PHI benefit paid was calculated by combining hospital and fund-paid medical benefits for each diagnosis-related group (excl. Medicare benefits).

OVERNIGHT ADMISSIONS ARE A DOMINANT COST DRIVER

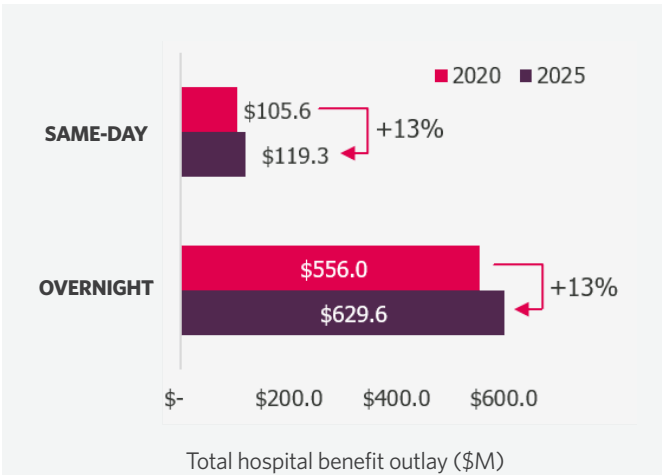
Mental ill-health can be costly because conditions may be recurrent, complex and chronic. For privately insured patients, a relatively small group of members can generate a large share of benefits paid over time because episodes recur, overnight lengths of stay are long at approximately 19 days, and care often spans many years.

Claims data highlights that overnight admissions account for less than one-third of mental health episodes yet drive approximately five times the total benefits paid of same-day episodes at \$630 million in FY25 (see Figure 6). Both have increased by 13% over the last five years, despite a relative decline in total activity across both segments.<sup>19</sup>

Across the public system, overnight care continues to play a central role in managing higher-acuity patients, particularly those who are unable to access or be effectively treated in private or community-based pathways. This reinforces the system-wide reliance on acute care for complex mental health conditions.

As a result, the overall cost challenge in mental health is driven not by total activity, but by a small proportion of high-cost, high-complexity inpatient episodes, particularly for conditions such as affective disorders and AOD.

Figure 6. Private mental health overnight vs same-day admission benefits outlay



**BENEFITS PAID BY PHI HAVE INCREASED BY 13% ACROSS BOTH SAME-DAY AND OVERNIGHT SEPARATIONS**

Source: Department of Health, Disability and Ageing. Hospital Casemix Protocol annual report 2024-25.

<sup>19</sup> Australian Government Department of Health, Disability and Ageing, Hospital Casemix Protocol data, 2024-25. Average PHI benefit paid was calculated by combining hospital and fund-paid medical benefits for each diagnosis-related group (excl. Medicare benefits).



KNOWN CONSTRAINTS IN MENTAL HEALTH SYSTEM CAPACITY

Mental health capacity is constrained by both workforce and physical infrastructure. While headline workforce numbers have grown and private hospitals continue to provide important bed capacity, effective capacity has not kept pace with rising demand, increasing acuity and the shift toward more complex, recurrent care. This means the system has limited flexibility to absorb further pressure across either public or private settings.

WORKFORCE CAPACITY IS GROWING, BUT NOT FAST ENOUGH TO MEET COMPLEXITY

The changing landscape of mental health demand sits within a broader supply-challenged environment. Capacity constraints in the total mental health system reflect not only workforce supply, but a combination of structural shortage, uneven distribution and increasing intensity of care.

While the total workforce has expanded over the past 10 years, with a 15% increase in psychiatric full-time equivalent (FTE), 20% increase in mental health nurse FTE and 28% increase in psychology FTE, this has not kept pace with rising demand.<sup>20</sup>

Key challenges include:<sup>21</sup>

- Recruitment and retention are weak across psychiatrists, mental health nurses, allied health and psychologists, with shortfalls projected to widen over the next decade.

- Geographic distribution is uneven, with regional and remote areas facing acute shortages (around 85% of psychiatrists are based in greater capital cities compared with around 70% of the Australian population).
- An ageing specialist workforce and slow training pipeline.
- Role boundaries, cross-disciplinary collaboration, and data remain inadequate to support optimal planning.

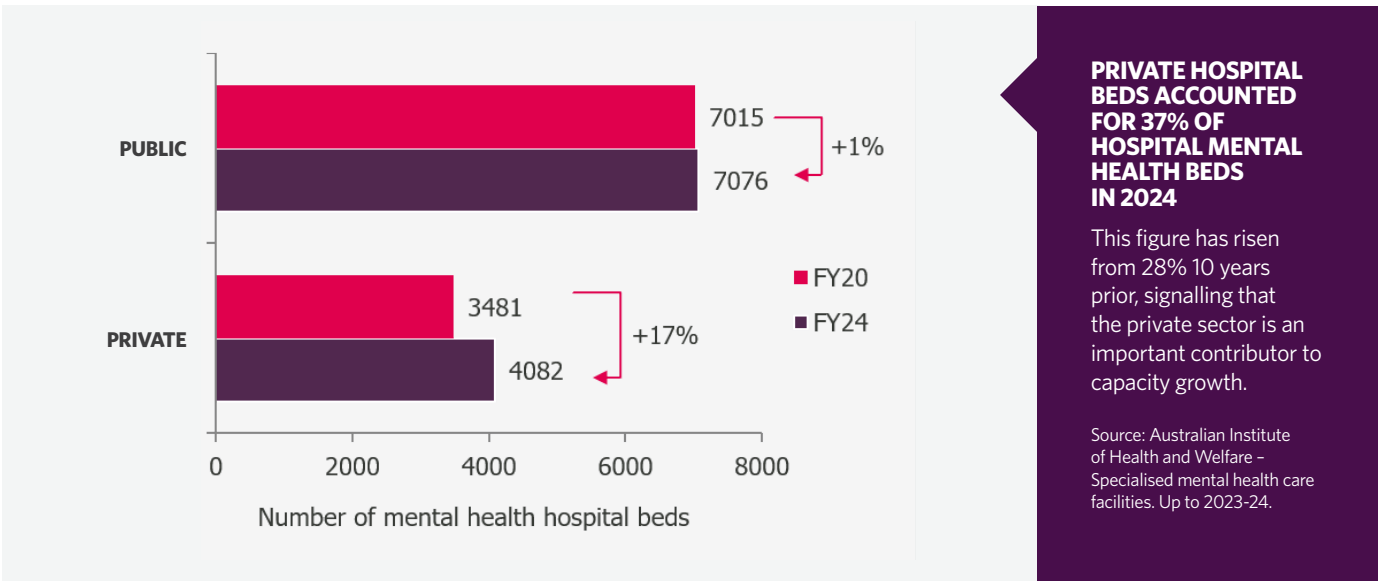
BED CAPACITY REMAINS RELIANT ON THE PRIVATE SECTOR

Physical system capacity is also constrained. Public mental health bed supply has remained relatively stable over time (see Figure 7), limiting the ability of the public system to absorb rising demand, increasing acuity and longer episodes of care.<sup>22</sup>

Historically, capacity growth has come from the private system, but this is now at risk. Recent data (since AIHW's last reporting in 2023-24) suggests the private system is still contributing to net growth in mental health beds, with seven dedicated private mental health hospital closures offset by seven new facilities that have opened.<sup>23</sup>

However, faced with growing sustainability challenges in private hospitals and stalling growth, further capital investment may be compromised. Despite this, Australia's combined psychiatric bed numbers remain below the average of OECD countries with 48.4 beds per 100,000 people versus 64 beds per 100,000 as the OECD average in 2023.<sup>24</sup>

Figure 7. Mental health hospital bed supply



<sup>20</sup> Australian Institute of Health and Welfare. Mental health workforce (to 2023-24). Updated 12 May 2026.

<sup>21</sup> Royal Australian and New Zealand College of Psychiatrists. Burnout and moral injury: Australian psychiatry at its limits. February 2024.

<sup>22</sup> Australian Medical Association. 2025 Public Hospital Report Card – Mental Health Edition. 2025.

<sup>23</sup> Private Healthcare Australia. Data shows more private mental health hospital beds are being added to the system. 15 October 2025.

<sup>24</sup> Seita A. Why psychiatric bed capacity varies widely: Strategic questions on global mental health. PLoS Med. 2025 Oct 10;22(10):e1004761. doi: 10.1371/journal.pmed.1004761. PMID: 41071837; PMCID: PMC12513577.

## SYSTEM INCENTIVES ARE MISALIGNED

The pressures described above are not the result of poor intent, but of financial and structural settings still weighted toward acute treatment rather than earlier, lower-intensity care.

This is a shared challenge across government, insurers, providers and clinicians: the system often pays most readily for the highest-cost setting, even when lower-intensity care may be clinically appropriate and more sustainable.

Australia's mental health system spans private hospitals, public hospitals, primary care and community services, but current settings do not support care to move smoothly across this continuum.



**Private hospitals** deliver same-day, lower-intensity admitted care, day programs and selected outpatient pathways.



**Public hospitals** carry much of the overnight, higher-acuity and crisis response burden, including emergency presentations, involuntary admissions and complex comorbidities.



**Community, primary care and early intervention** settings are intended to reduce escalation but remain under-funded and unevenly available.

The result is structural misalignment between where care is funded and where acuity and cost could often be managed earlier.

- PHI has limited scope to fund ambulatory care and out-of-hospital models, including crisis stabilisation, readmission avoidance and hospital equivalent day programs.
- Regulatory settings make these models difficult to establish and sustain at scale.
- Private providers remain financially dependent on inpatient activity, limiting incentives to shift care into lower-cost settings.

This leaves hospital-based treatment as both the most accessible and most incentivised pathway, while prevention, early intervention and out-of-hospital care remain structurally under-supported.

When private access tightens, community capacity is insufficient or early intervention fails, people are more likely to present later and with higher acuity. Public hospitals then absorb the overflow through emergency department pressure, longer waits, more involuntary admissions and greater reliance on overnight care.

Sustaining private mental health capacity is therefore a whole-of-system priority: it helps maintain patient choice, protect public hospital capacity and enable a more balanced model of care.



# THE IMPACT

## PROJECTING THE CONSEQUENCES OF INACTION

Understanding the current system dynamics is critical, not only in explaining present pressures, but in anticipating how these trends will evolve over time.

To assess the longer-term implications, Nous and HCF undertook detailed modelling of private inpatient mental health care over a five to 10 year horizon, integrating national datasets, HCF claims data and population projections to estimate future demand, capacity and system sustainability.

The modelling focused on private hospital demand, defined as completed inpatient separations for mental health and AOD conditions funded by PHI. Demand was modelled in two steps. First, rates of Gold-tier coverage in the Australian population were projected and multiplied by projections from the Centre for Population. Second, the rate of separations per covered person and average length of stay per separation were projected and multiplied by Gold-tier coverage projections. Across multiple models, demand was segmented by DRG, stay type, age, gender and regionality.

Supply was modelled based on the key constraints governing service delivery, particularly psychiatrist workforce capacity and effective bed availability, drawing on workforce datasets, hospital casemix data and observed length-of-stay patterns.

This approach enables a forward view of how the system may respond under current settings, and how emerging pressures may translate into gaps in access, affordability and system sustainability under different demand and policy scenarios.

The modelling highlighted several key findings and points to growing long-term challenges if current trends persist:

- Gold membership is projected to continue to decline, reducing the number of Australians able to access private mental health services.
- Care complexity across the key diagnostic groups is forecast to increase, placing further pressure on costs.

With public demand remaining high and capacity constrained, a financially sustainable private sector will play an increasingly important role in maintaining access to care.

## KEY ASSUMPTIONS USED IN FORWARD ESTIMATES



Mental health demand is defined using nationally recognised hospital categories for Mental Diseases and Disorders (MDC 19) and Alcohol and Drug Use and Dependence (MDC 20). These categories capture admissions where mental health care is the main reason a person is admitted to hospital.

As such, admissions that involve mental health but are primarily treated as medical presentations (e.g. an overdose) are not included in this analysis.



PHI-funded patients in public hospitals are assumed to remain a constant share over time.



Scenario impacts are assumed to be phased in over time, reaching full implementation by FY30.



Demand is measured as observed service utilisation (separations), with public unmet demand not modelled directly and instead sourced from the Australian Government Psychiatry Demand and Supply study.



The relationship between demand, bed capacity and psychiatric workforce requirements is assumed to remain constant over time, with 2024 activity ratios used as the baseline for future projections.

**Figure 8.** Future projections of Gold insured persons (all ages)



Note: Projections focus on the rates of Gold coverage across the population over the past five years and extend these forwards based on population projections from the Centre for Population, released January 2026.

### IF CURRENT TRENDS CONTINUE, AN ESTIMATED 1.2 MILLION PEOPLE MAY DROP GOLD COVER OVER 10 YEARS

Gold cover has continued to decline in recent years. Without intervention, this trend is expected to continue further, as shown in projected Gold cover over the next five to 10 years (see Figure 8).

There is also a risk that the decline could accelerate, with inflation expected to peak in July 2026 and the Australian Government's proposal to remove the higher private health insurance rebate for people aged over 65 from 1 April 2027 likely to increase downgrades or dropped cover. The projections are based on historical trends and do not yet account for the potential impact of these emerging policy and affordability pressures.

### THIS WILL HAVE A DAMPENING IMPACT ON PRIVATE ADMISSIONS, AMIDST INCREASING LENGTH OF STAY

Forward projections exploring private mental health separations and bed days, show that reduced PHI participation is expected to dampen private mental health admissions, but not the underlying intensity of care required, holding all things equal (see Figure 9). While fewer insured people are projected to access private inpatient mental health care, the remaining admitted cohort is estimated to become more complex, with rising bed days and average length of stay for overnight admissions estimated to increase from 19.2 days in 2025 to 22.2 days by 2036.

This is particularly evident for AOD conditions, which are already emerging as a fast-growing and high-cost driver of private mental health activity. A significant pressure point is observed in overnight care, with an estimated increase in bed days of 12%, versus an estimated decline of 22% in same-day hospitalisations.

Figure 9. Forecasted private hospital mental health admissions, average length of stay and bed days



Note: The projections focus on hospitalisations and average length of stay by diagnosis group and stay type (overnight and same-day). When multiplied together, separations and average length of stay give us an estimate of bed days. The overall bed day trend changes because the mix of diagnosis and stay types changes over time such that major complexity separations become a greater share of activity. Total bed days increase only slightly, even as hospitalisations fall, because the people who are admitted are expected to need longer stays on average.

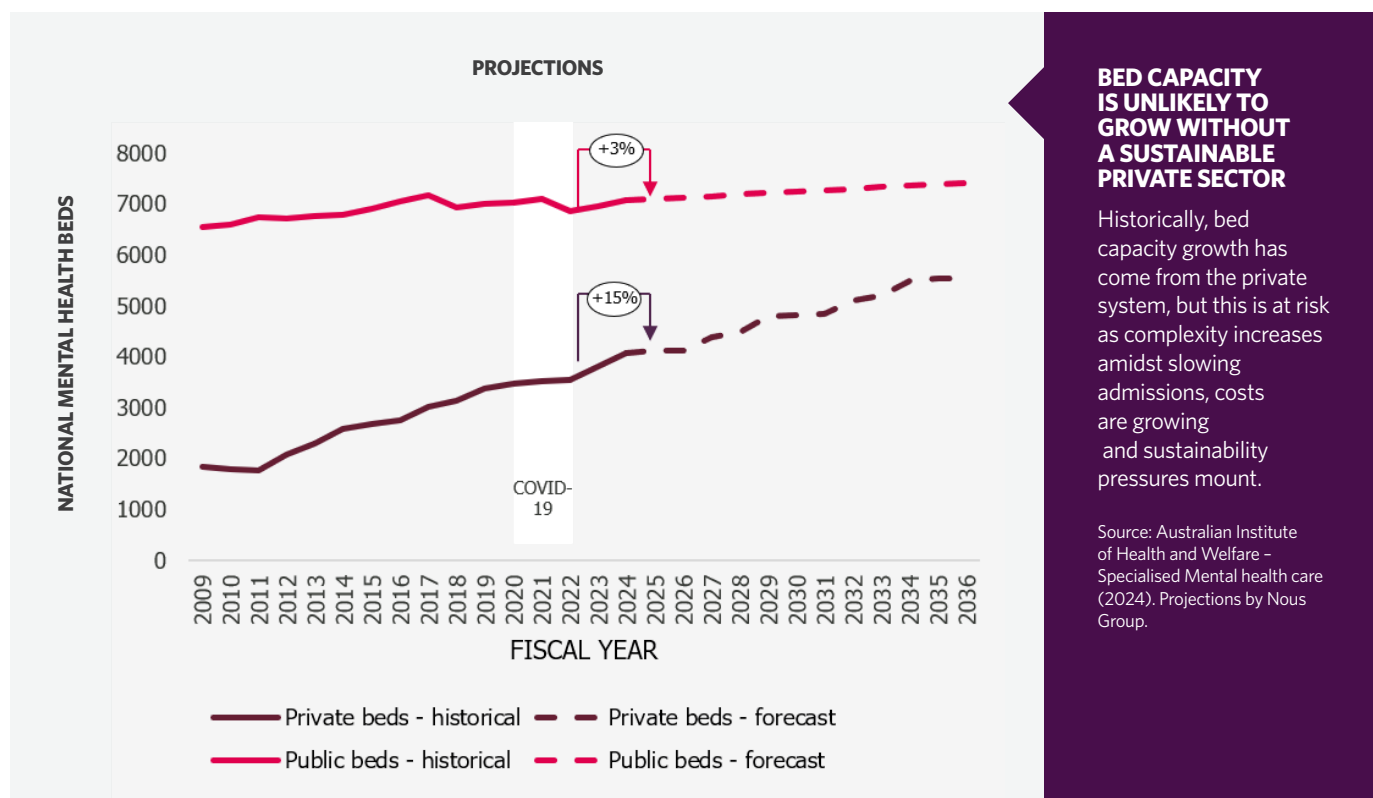
### PRIVATE BEDS ARE AN IMPORTANT CONTRIBUTOR TO MEETING LONG-TERM SYSTEM CAPACITY

Under current settings, future mental health bed capacity is likely to remain dependent on the private sector, as public bed supply has historically remained relatively stable and most growth has come from private provision. However, this is at risk as the private setting faces ongoing sustainability pressures.

Figure 10 presents a forward-looking scenario, showing what mental health bed capacity could look like if historical public and private bed trends observed to 2024 continued, and if sufficient private funding, activity and investment were available to support increased supply.

Under this scenario, growth in total bed numbers is largely supported by the private sector, while public bed supply remains relatively stable. In practice, this outcome is uncertain: reduced Gold coverage may dampen PHI-funded admissions, psychiatrist availability may constrain throughput, and existing bed numbers may not translate directly into available capacity, bed days or separations. This highlights the system’s structural reliance on private capacity, and the risk that projected growth may not materialise if financial, workforce and coverage pressures continue to intensify.

**Figure 10.** Forecasted supply of public and private mental health beds



Note: Latest AIHW bed data is available as at FY24. Therefore, forecasts do not consider private psychiatric facility closures over the past two years or the impact of slowed investment and sustainability pressures.

## UNDER CURRENT CONDITIONS, THE WORKFORCE GAP WILL CONTINUE TO WIDEN

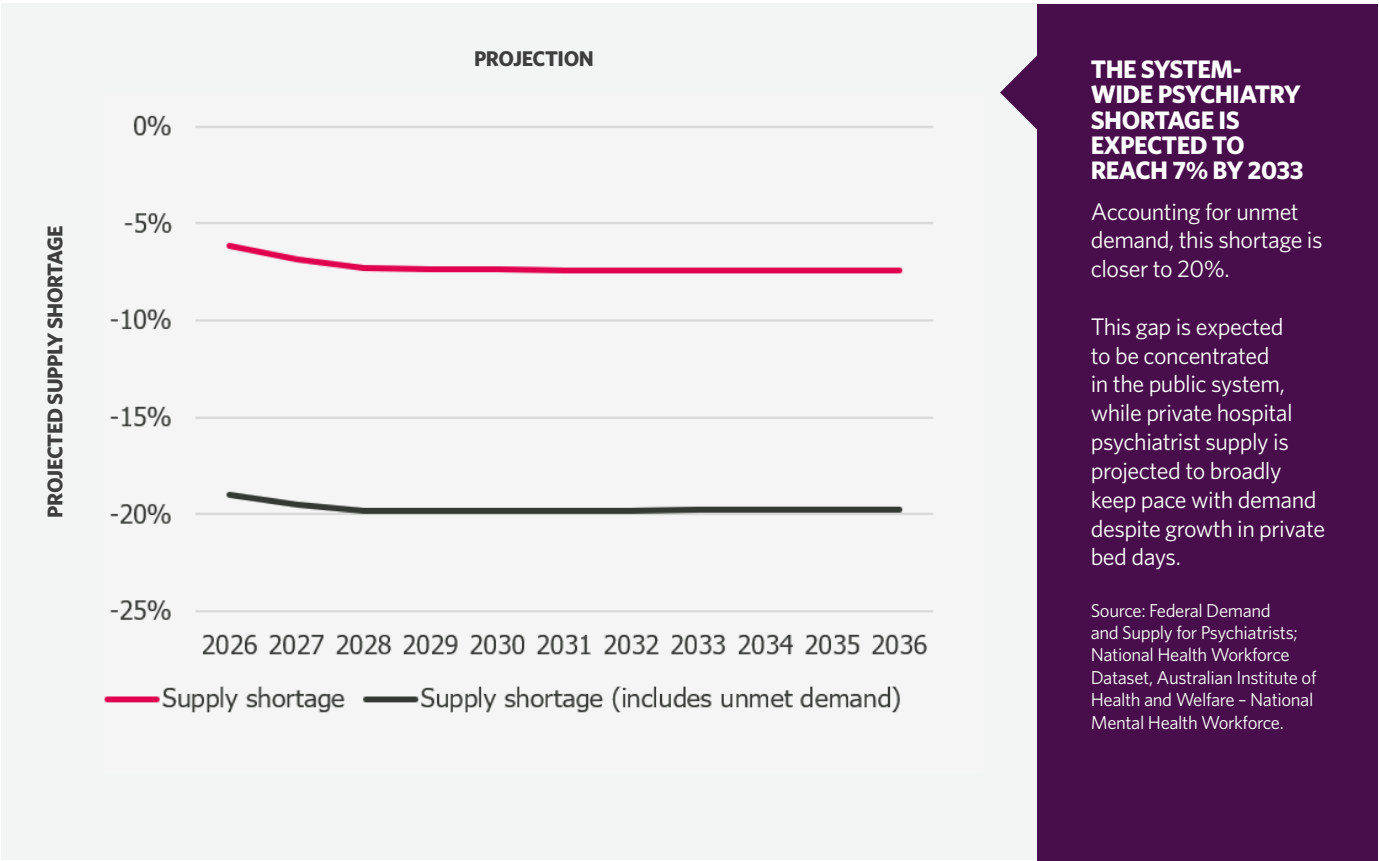
Beds are only one component of system capacity. Modelling from the Australian Government Psychiatry Supply and Demand Study indicates that the psychiatry workforce will face increasing shortages across all settings over the next decade.<sup>25</sup> As shown in Figure 11 overleaf, the projected shortfall reaches around 7% of demand by 2033 and almost 20% when unmet demand is included.

While the projected shortage is concentrated in the public system, workforce pressures are expected to constrain capacity across the broader mental health system. Burnout, an ageing workforce and long training lead times are likely to limit the pace at which psychiatrist supply can respond to growing demand.

Because available datasets do not directly identify psychiatrist FTE working in private hospitals, private-sector estimates were derived using the National Health Workforce Dataset. The analysis applies a proportional allocation based on public and private bed days and indicative staffing ratios informed by separations with and without specialised psychiatric care. Using this approach, psychiatrist FTE in private hospitals is projected to remain broadly aligned with demand, reflecting relatively modest growth in private psychiatric bed days relative to growth in the psychiatry workforce overall.

<sup>25</sup> Australian Government Department of Health, Disability and Ageing. Psychiatry Supply and Demand Study. 25 November 2025.

Figure 11. Projected sector-wide psychiatry workforce shortage for demand and unmet demand (FTE)



Note: Projections are based on the Australian Government Psychiatry Supply and Demand Study, using 2026 as the base year. The projected shortage increases through the late 2020s as workforce growth lags demand because of training lead times. Shortages stabilise from the early 2030s as new psychiatry trainees enter the workforce at a more consistent rate. Published five-year projections were interpolated to estimate annual supply and demand to 2048.

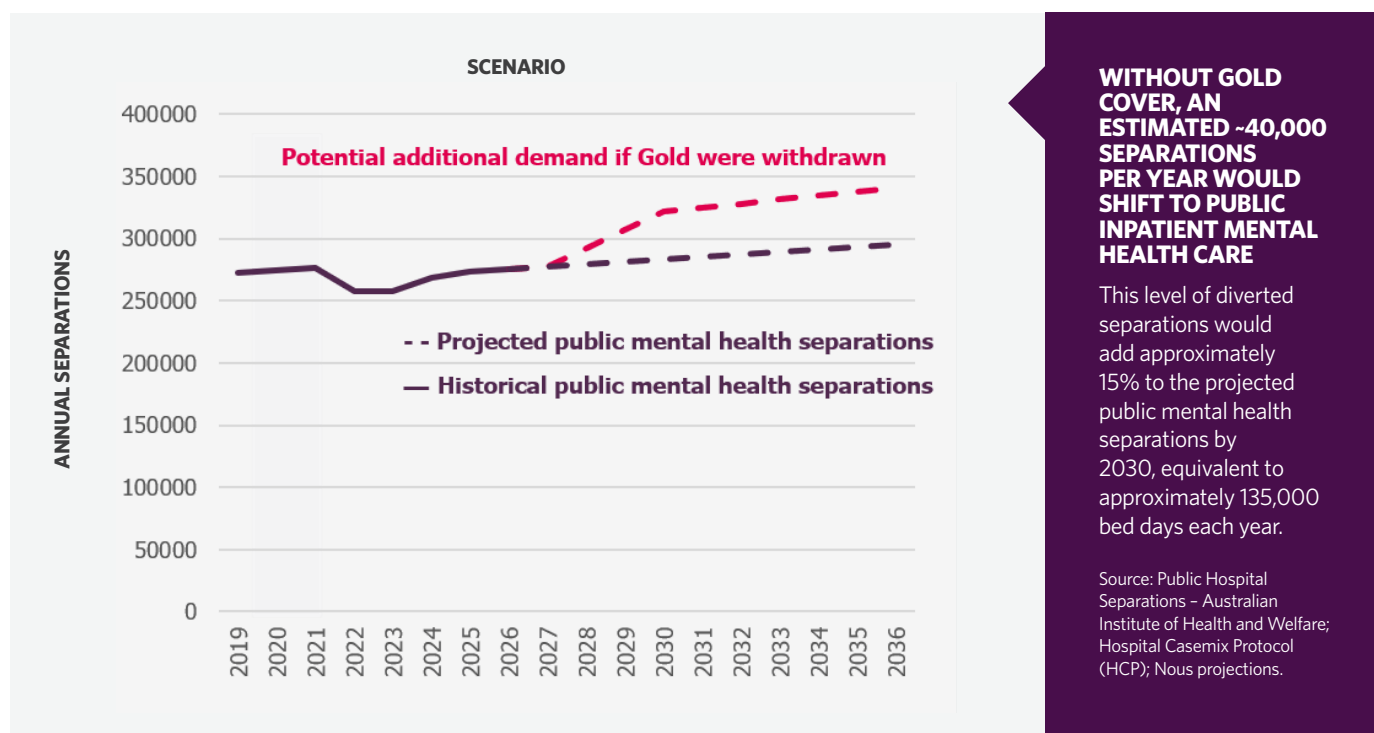
ILLUSTRATIVE MODELLING HIGHLIGHTS THE SYSTEM VALUE OF SUSTAINABLE GOLD COVER

Gold cover is an important pathway for privately insured Australians to access inpatient mental health care. As at July 2026, 13 brands did not have an open Gold product in the market. While most offered Silver Plus alternatives that retained some higher-cost services, 12 of the 13 restricted psychiatric care. In the absence of any intervention, Gold cover may continue to become a non-viable offering, and if removed, a share of patients who would otherwise be treated in private hospitals may need to rely on the public system instead. This will increase pressure on an already constrained public hospital system, making private capacity an important part of managing whole-of-system demand.

In addition, this could have significant financial consequences on Government. Figure 12 provides illustrative modelling to demonstrate the potential impact on the system if Gold cover was to be removed, resulting in an estimated 40,000 additional public mental health separations per year from 2030 onwards. A diversion of around 40,000 mental health separations to the public system could translate to at least \$385 million in net additional government expenditure per year from 2030 onwards. The level of net government expenditure considers the projected number of admissions shifting from the private to public system and the average public hospital funding required for different levels of patient complexity, offset by reductions in MBS expenditure associated with displaced private admissions.



**Figure 12.** Potential public mental health impacts of PHIs ceasing to offer Gold



Note: This scenario is for illustrative purposes only. The public sector would likely be unable to absorb this level of demand because of workforce, funding, infrastructure and other constraints. This chart shows a scenario in which Gold coverage is gradually withdrawn between 2028 and 2031 if products become non-viable to offer. Patient demand is complex and it is difficult to predict the extent to which patients will seek care elsewhere. As such, this modelling estimates demand transfer by complexity, assuming around 80% of major complexity admissions and 50% of minor-complexity or uncategorised admissions would still require hospital-based mental health care.

Additional government expenditure was estimated by applying FY25-26 National Efficient Price (NEP)<sup>26</sup> funding rates for public major-complexity, minor-complexity and uncategorised mental health admissions to projected displaced separations and deducting average MBS expenditure associated with displaced private admissions using Hospital Casemix Data.<sup>27</sup> The estimate captures the direct cost of additional public hospital admissions only, with NEP funding rates and average MBS costs held constant over the projection period. It however does not account for broader financial considerations including the impact of Medicare Levy Surcharge, PHI rebates, infrastructure and workforce expansion requirements, and broader health system impacts.

<sup>26</sup> Independent Aged Care Pricing Authority. National Efficient Price Determination 2025-26. National Efficient Price Determination 2025-26 | Resources | IHACPA

<sup>27</sup> Australian Government Department of Health, Disability and Ageing. Hospital Casemix Protocol Data – up to June 2025

# GLOSSARY

| KEY TERM                                                     | DESCRIPTION                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Admitted care or admission</b>                            | Hospital care where a person is formally admitted for treatment. This can include same-day care or an overnight stay.                                                                                                                                                                                         |
| <b>Affective disorders</b>                                   | Mental health conditions that primarily affect mood, such as depression and bipolar disorder.                                                                                                                                                                                                                 |
| <b>Alcohol and other drug (AOD) conditions</b>               | Health conditions related to alcohol or other drug use, including dependence, withdrawal or harmful use.                                                                                                                                                                                                      |
| <b>Australian Institute of Health and Welfare (AIHW)</b>     | A national agency that collects and reports data on Australia's health and welfare systems.                                                                                                                                                                                                                   |
| <b>Australian Refined Diagnosis Related Groups (AR-DRGs)</b> | A national hospital classification system that groups admitted patient episodes into categories that are clinically similar and expected to use similar hospital resources.                                                                                                                                   |
| <b>Bed days</b>                                              | A measure of hospital use. One bed day represents one patient occupying a hospital bed for one day.                                                                                                                                                                                                           |
| <b>Benefits paid</b>                                         | The amount paid by a private health insurer toward the cost of an insured member's hospital treatment and related medical services. In this report, average benefits paid are calculated by combining hospital benefits and fund-paid medical benefits for each diagnosis-related group.                      |
| <b>Casemix</b>                                               | The mix of patients treated by a hospital or service, including their conditions, complexity and expected resource needs.                                                                                                                                                                                     |
| <b>Clinical complexity</b>                                   | The level of difficulty, intensity or resource use involved in treating a patient. In AR-DRGs, complexity is assigned through national grouping rules based on coded clinical and demographic information, such as diagnoses, procedures, comorbidities, complications, length of stay and discharge details. |
| <b>Diagnostic Related Group (DRG)</b>                        | A category used to group hospital patients with similar diagnoses, treatment needs and expected resource use.                                                                                                                                                                                                 |
| <b>Full-time equivalent (FTE)</b>                            | A way of measuring workforce capacity. One FTE is equivalent to one person working full time, although it may be made up of several part-time workers.                                                                                                                                                        |
| <b>Gold cover</b>                                            | The most comprehensive private hospital insurance tier. In this report, Gold cover is important because unrestricted private hospital psychiatric benefits are generally available through Gold-tier products.                                                                                                |
| <b>Gold spiral</b>                                           | A self-reinforcing cycle where higher-need members concentrate in Gold cover, claims costs rise, premiums increase and healthier members are less likely to join or remain in Gold cover.                                                                                                                     |
| <b>Hospital Casemix Protocol (HCP)</b>                       | A national dataset used to report private hospital activity and benefits paid by private health insurers.                                                                                                                                                                                                     |
| <b>Inpatient care</b>                                        | Hospital care where a person is admitted for treatment, either for same-day care or one or more overnight stays.                                                                                                                                                                                              |
| <b>Length of stay</b>                                        | The amount of time a person spends in hospital during an admitted episode of care.                                                                                                                                                                                                                            |
| <b>Major Diagnostic Category (MDC)</b>                       | A broad grouping of hospital diagnoses within the AR-DRG system. This report focuses mainly on MDC 19, covering mental diseases and disorders, and MDC 20, covering alcohol and drug use and dependence.                                                                                                      |
| <b>Medicare Benefits Schedule (MBS)</b>                      | The list of health services subsidised by the Australian Government through Medicare.                                                                                                                                                                                                                         |

|                                               |                                                                                                                                                                                                                                                      |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Mental health waiting period exemption</b> | A once-in-a-lifetime rule that allows eligible private health insurance members to upgrade their hospital cover and access higher psychiatric benefits without serving the usual two-month waiting period.                                           |
| <b>Out-of-hospital care</b>                   | Care delivered outside a traditional hospital admission, such as community-based, home-based, digital, step-up/step-down or coordinated care models.                                                                                                 |
| <b>Private health insurance (PHI)</b>         | Insurance that helps pay for private healthcare, including private hospital treatment and some extras services depending on the policy.                                                                                                              |
| <b>Risk equalisation</b>                      | A mechanism used in private health insurance to share some claims costs across insurers, so funds with higher-cost members are partly compensated by the broader system.                                                                             |
| <b>Same-day admission</b>                     | A hospital admission where the patient is admitted and discharged on the same day.                                                                                                                                                                   |
| <b>Separation</b>                             | The end of an admitted hospital episode, usually when a patient is discharged, transferred or otherwise leaves hospital care. This report uses separations as a measure of hospital activity, and it is often used interchangeably with 'admission'. |
| <b>Step-up/step-down care</b>                 | Short-term care designed to either prevent hospital admission when a person's needs are rising, or support recovery after hospital care before returning to usual community-based supports.                                                          |
| <b>Unrestricted psychiatric benefits</b>      | Private health insurance benefits that provide full hospital cover for psychiatric services, subject to the policy settings, rather than restricted or minimum benefits only.                                                                        |

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