FROM THE DESK

Message from the CEO



Stephen Hockey
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The second half of 2026 is testing healthcare boards on every front at once. In this edition, we look at six forces converging on the same underlying question — who is leading your organisation through it.

Our lead piece examines what genuine implementation of the new National Health Reform Agreement will demand of system leadership over the next five years, beyond the funding announcement itself. We then turn to workforce stability, why retention has become a board-level governance issue, and why the most acute nursing shortage right now sits in senior leadership rather than the frontline.

Elsewhere, we look at the executive talent required to lead virtual care at scale, the leadership demands created by aged care's collision with Australia's new merger law, and the trust test now facing health fund and private hospital leaders as affordability becomes the sector's sharpest consumer issue.

These aren't abstract trends to us — they're the conversations we have every day with boards, CEOs and senior executives across Australia. If any of this resonates, with your organisation or your own career, I'd welcome a confidential discussion.

Stephen Hockey
Director, Predictus Search

01 — HEALTH REFORM · LEAD ARTICLE

The fine print of a $25 billion deal: what the National Health Reform Agreement means for hospital leadership

Australia just signed its biggest hospital funding deal in a decade. The real story starts now, in how it's run.

National Cabinet's signing of the 2026–2031 National Health Reform Agreement Addendum in February was the kind of moment that generates a press release and a press conference, then quietly recedes from view while the work of actually running a health system continues underneath it. That would be a mistake here. The Addendum, which takes effect from 1 July, commits a record $219.6 billion in Commonwealth base funding to public hospitals through 2030–31, including $25 billion in new investment — roughly three times the additional funding delivered under the previous five-year agreement.

It is built around three stated objectives: better health outcomes and value for patients, stronger shared stewardship between the Commonwealth and the states, and a simpler, more equitable funding model. A new Service Model Reform Funding stream begins in 2027–28, designed to support exactly the kind of structural change the sector has spent years calling for.

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None of that money arrives self-executing. The AMA still estimates an underlying funding gap of around $9.6 billion, and there is a real critique that the deal remains weighted toward hospital activity rather than the upstream prevention work that would reduce demand on those hospitals over time. That tension between what was signed and what gets delivered is precisely where leadership becomes the deciding variable.

Implementing an agreement of this scale means negotiating genuinely shared stewardship across Commonwealth and state lines — something Australian health bureaucracies have historically found difficult even with goodwill on both sides — and translating five-year national priorities into the kind of local operational change that shows up in waiting times rather than in a communiqué.

Health services that move early to build executives — COOs, CFOs, system reform directors — who are genuinely fluent in Commonwealth–state funding architecture, not just hospital operations, will be the ones who shape how the next five years play out rather than simply administer around the edges of it.

FOR BOARDS

Intergovernmental and system-reform fluency is becoming a mainstream executive search requirement, not a public-sector specialism.

INDUSTRY INSIGHTS · 02 — RETENTION & BURNOUT

Workforce stability is now a leadership mandate, not an HR initiative

Burnout has moved from a workforce metric to a board-level risk. A recent industry survey found 55% of healthcare workers were actively looking for a new role, and 84% felt under-appreciated — against a backdrop where general workforce engagement in Australia has been flat for over a decade.

Executive recruiters report employers deliberately reweighting how they assess senior candidates: leadership style, communication and demonstrated team-stabilisation ability now sit alongside a candidate's record of operational delivery.

Research attributes roughly 70% of the variance in team engagement to the quality of direct management — meaning the calibre of leader appointed at any level cascades through retention outcomes.

Turnover at the very top makes this self-reinforcing. CFOs, COOs and Chief Nursing Officers are consistently the roles most likely to follow a departing CEO out the door, often within months, taking institutional knowledge and team trust with them.

KEY BOARD QUESTIONS

Does our succession plan get the same rigour as our financial risk register? Does every senior brief test a candidate's track record on culture and retention, not only their record of delivering change?

KEY INDUSTRY TRENDS · 03 — SENIOR NURSING LEADERSHIP

Australia's nursing shortage has two layers, and the recruitment industry has mostly fixed the wrong one

Easier visas are filling shifts. They are not filling Director of Nursing and Nurse Unit Manager roles, and that's the layer that bites first.

From March 2025, experienced nurses from a select group of countries have been able to register to work in Australia without sitting additional exams, cutting processing time by as much as a year. It is a sensible, overdue piece of policy, and it has provided real relief in aged care specifically, where more than half of residential staff are already overseas-born. For organisations managing day-to-day shift coverage, that matters. It does very little, however, for the layer of the workforce crisis that actually determines whether a service can meet its compliance obligations: senior nursing leadership.

Government workforce projections have nurse manager demand growing by roughly a quarter through 2026, reaching around 22,600 roles nationally — one of the fastest-growing and best- remunerated leadership categories anywhere in the health sector.

That growth is colliding with a specific, time-bound pressure point: the new Aged Care Act's mandatory 24/7 registered nurse requirement, in force since November 2025, has made Directors of Nursing and Nurse Unit Managers among the hardest roles in the sector to fill. The reason is structural: these positions require years of accumulated local clinical credibility plus genuine change-management capability. No visa pathway manufactures that overnight. Many senior nurses who do have it are themselves within a decade of retirement.

FOR SEARCH

Identify experienced senior nurses now and actively accelerate their path into DoN and NUM appointments — ahead of the next compliance deadline, not in response to it.



04 — VIRTUAL CARE

Hospital-in-the-home has outgrown its pilot phase, and so has the job description for leading it

Virtual care stopped being a pandemic workaround years ago. The leadership roles built for it are only now catching up.

It is worth being precise about how far hospital-in-the-home and virtual care have moved from their pandemic origins, because the leadership implications follow directly. South Australia's My Home Hospital, a public-private partnership, delivers genuinely acute care through multidisciplinary teams with round-the-clock coordination, pathology, imaging and medication delivery built into the model rather than bolted onto it. Victoria's Virtual Emergency Department, the largest of its kind in the southern hemisphere, now has $437 million committed to double its capacity and convert it from pilot to permanent infrastructure.

The Productivity Commission estimates better digital integration across the system could save more than $5 billion annually, largely through reduced duplicate testing and automated administration. None of that reads like a stopgap. It reads like core infrastructure that simply hasn't finished being recognised as such.

The leadership response is catching up, unevenly. Organisations are creating roles purpose-built for this model rather than assigning it as an add-on: a dedicated chief executive at Amplar Health Home Hospital, a national Virtual and Home Healthcare division at St Vincent's, Clinical Director appointments specifically for virtual and integrated care at health services such as Metro South.

These roles require someone who carries genuine clinical credibility while also designing remote monitoring infrastructure and governance frameworks that don't yet have a decades-old playbook.

FOR BOARDS

Treat virtual care leadership as its own category, not a subset of digital health or operations — define who leads it before the model is fully built out, not after.



05 — AGED CARE

Aged care providers are being asked to consolidate and comply at the same time

The AN-ACC price rose to $295.64 from October 2025, yet providers continue to warn the increase doesn't fully cover the actual cost of delivering care. The economic logic that follows from underfunded unit pricing is well understood: providers chase scale to make the numbers work.

At precisely that moment, Australia introduced its most significant merger law change in fifty years. Since 1 January 2026, aged care has been named explicitly, alongside private equity and digital platforms, as an ACCC focus area. Even mid-size acquisitions can now trigger formal review, with penalties up to $50 million for failing to notify.

Opal HealthCare grew from 101 to 144 care communities in two years through acquisition regardless — integrating culture, systems and care programs across each new site while absorbing exactly this regulatory complexity.

FOR SEARCH

Regulatory and integration experience belongs in the brief as a non-negotiable for any leadership appointment tied to an active growth or consolidation strategy.

06 — AFFORDABILITY

Private health's affordability problem has quietly become a leadership credibility problem

Private hospital cover premiums rose 4.41% from April 2026, the largest increase in nearly a decade, while roughly 100,000 fewer Australians hold private hospital cover than a year earlier. A proposed cut to the over-65s rebate could affect close to three million older policyholders.

The economics are arguably reasonable — medical and hospital costs grew 5% over the past financial year, ahead of the approved premium rise. The public conversation is not going as well, and that gap is becoming the real story: whether premiums map to benefits members can actually access.

Health fund CEOs face growing scrutiny to make that case publicly and credibly, while private hospital leaders are pushed to expand no-gap arrangements as a retention strategy for an increasingly price-sensitive membership base.

FOR SEARCH

The executives most valuable here can hold transparency, commercial sustainability and patient access in the same conversation — credibly, with members, regulators and boards at once.

FEATURED JOB VACANCIES

Open searches across healthcare, pathology & life sciences

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REGIONAL MANAGER – NSW BASED

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Six forces reshaping healthcare leadership — *who is leading your organisation through it?*

August Market & Leadership Outlook — How Australian healthcare organisations can navigate sustained complexity in 2026.

EDITION
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