DE-IDENTIFIED VERSION — FOR PUBLICATION

This is the de-identified version of a submission provided to APRA in two versions. Identifying details of the submitter, of the private health insurer concerned, and of third parties have been removed. The substantive policy analysis is unchanged.

Submission to APRA

Draft Prudential Standard CPS 510 Governance

Consultation closing 28 August 2026

A registered dental practitioner, Western Australia
Principal and owner of an independent dental practice
Submitted in a de-identified capacity

This submission is provided by an individual health practitioner in response to APRA's consultation on the draft Prudential Standard CPS 510 Governance. It offers the perspective of an AHPRA-registered practitioner whose profession is directly affected by the governance frameworks of APRA-regulated private health insurers, and provides a worked example of the specific governance concerns that the draft standard addresses in the vertically integrated private health insurance segment. The submission does not seek APRA enforcement action, does not seek to reopen matters closed by other regulators, does not seek to relitigate any commercial dispute, and does not ask APRA to make any determination about any institution's compliance with existing prudential standards. It is offered as policy input for APRA's consideration in finalising CPS 510 and the accompanying prudential practice guide CPG 510.

The gap, in short. The major Australian private health insurers now own and operate businesses providing the health services their own policies pay benefits for. Paragraphs 63 to 71 of the draft standard address that configuration, including at paragraph 69 the obligation to ensure that a non-regulated institution within the group conducting activities that pose a material risk to the group complies with the group's governance arrangements. Paragraph 4(d) excludes private health insurers from paragraphs 63 to 71. Section 2.6 of the consultation paper records that those provisions were not substantively examined in this review. This submission proposes a narrow remedy in Part B, which does apply to them.

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All paragraph references are to the draft Prudential Standard CPS 510 Governance (June 2026) unless otherwise indicated. References to CPS 001 are to the draft Prudential Standard CPS 001 Defined terms (June 2026).

1. About this submission

This submission is provided in response to APRA's consultation on draft Prudential Standard CPS 510 Governance released on 16 June 2026, with submissions closing on 28 August 2026.

1.1 About the submitter

I am a registered dental practitioner with thirty-six years of continuous dental registration, including registration under the National Registration and Accreditation Scheme since its commencement in Western Australia. I hold a Bachelor of Dental Science from an Australian university and I am the principal dentist and owner of an independent dental practice in Western Australia, which I have operated continuously for nearly thirty years. My practice has, until the events described in this submission, been a preferred provider under network arrangements with major Australian private health insurers, including the APRA-regulated private health insurer referred to in this submission as "the Insurer".

I mention the length of my registration because it spans the period this submission is about, and because the change in it has been marked. For most of my career the relationship between an independent practice and a private health insurer was an administrative one. Contact was occasional and claim-specific: a query about a particular item number, a request for the clinical note relating to a particular episode of treatment, resolved between the practice and the fund without difficulty. Audits occurred, but they were exceptional, individual, and directed at an identified question.

Since the major funds integrated vertically, what I have observed is different in kind rather than in degree. Auditing appears to have become systematic and programmatic rather than exceptional — conducted at a scale, and with a breadth of information demanded, that has no parallel in my earlier experience. I am not in a position to know how any particular insurer selects the practitioners it audits, and I do not assert that any entity uses automated or analytic methods. What I can say is that the scale at which audits now occur is difficult to reconcile with case-by-case human selection, and that the pattern of selection I have observed, and that colleagues in other professions have described publicly, is consistent with analytic comparison against a peer population. Section 5.9 develops the governance questions that follow if that is so.

I do not put this as a complaint about audit activity. Funds are responsible for very large sums of members' money and payment integrity is a legitimate and necessary function. My observation is narrower: two things changed at once — who owns the businesses competing with the audited practitioner, and how the auditing is done — and the governance framework surrounding both appears to have been slow to adjust. The material at Section 3.8A suggests this is not peculiar to my own experience or to dentistry. It is that gap between how much the activity has changed and how little the governance around it has, that this submission is about.

What is most striking from the practitioner's side of that relationship is how little of the governance is visible. I am not in a position to say what oversight occurs inside any regulated entity, and I do not assert that there is none. What I can report is what is available to the practitioner on the receiving end of a determination: no published standard setting out what constitutes improper billing; no identifiable person accountable for the determination; no reasons recorded at the time it is made; no appeal to anyone other than the function that made it; and no indication that the entity's Board is aware the function operates, at what scale, or with what rate of error. A practitioner cannot point to any of it, because none of it is produced. Whether that reflects an absence of oversight or merely an absence of visible oversight is not something I can determine from outside — but from a prudential standpoint the distinction may matter less than it first appears, since a Board that receives no reporting on a function is in much the same position as I am. That is the concern this submission brings to APRA, and Sections 6.1A and 6.9A propose the means of addressing it.

One feature of my own experience illustrates the point, and I set it out fully at Section 4.2. The material an insurer assembled in an audit of my practice was notified by it to the Dental Board of Australia. The Notifications Committee considered that same material and determined to take no further action. The insurer's own determination against the practice, resting on the same material, was not reconsidered, and the statutory outcome was not engaged with in the determination of the appeal some six months later. I do not say the insurer was bound by the National Board's conclusion: an insurer may reach its own view on a contractual or benefit question that the statutory process did not decide. The concern is narrower and, I think, properly prudential — nothing in the process indicates the determination was considered at all.

1.2 Why this submission is provided

This submission is provided because the substantive concerns that draft CPS 510 addresses — board governance, conflicts management (including intragroup conflicts), fitness and propriety of directors and senior executives, and the governance of vertically integrated group structures — arise in an especially acute form in the Australian private health insurance sector. That sector has, over the past decade, evolved through vertical integration, with the major APRA-regulated private health insurers now operating provider-side subsidiaries (dental, allied health, hospital and primary care) that compete commercially with the independent health practitioners whose services those same insurers audit, contract with, and can effectively remove from the insured segment of their professions.

The governance concerns that arise from this configuration have real consequences for AHPRA-registered health practitioners, for the continuity of care of insured patients, and for the authority of the National Registration and Accreditation Scheme itself. Those consequences are directly relevant to the policy questions on which APRA is consulting. This submission offers a worked example of how the concerns manifest in operation, and identifies specific provisions of draft CPS 510 where the standard could be strengthened to address them.

1.3 Sources of the factual material, and de-identification

The substantive policy analysis in this version is unchanged from the version provided to APRA. Dates have been generalised where their precision served identification rather than the argument. Where the worked example at Section 4 requires a chronology to be intelligible, the sequence of events and the intervals between them have been preserved.

I understand that submissions may be the subject of Freedom of Information requests and that section 56 of the Australian Prudential Regulation Authority Act 1998 protects information about APRA-regulated entities that is not in the public domain. I confirm that the factual material in this submission draws only on: (a) documents that are on the public record; (b) documents that are in my own possession as a party to the matters described; and (c) documents that have been the subject of my own contemporaneous correspondence with the entities concerned.

2. Executive summary — six key policy propositions

This submission develops six key policy propositions for APRA's consideration in finalising CPS 510. Each is summarised below and developed in the sections that follow.

Proposition 1 — The intragroup conflict that vertical integration has created in the private health insurance sector is not reached by the draft standard. The provisions that would otherwise reach it, at paragraphs 63 to 71, are excluded from private health insurers by paragraph 4(d) and rest on group machinery that does not exist for them. The direct remedy is an express intragroup limb in paragraph 74, which does apply to private health insurers.

Paragraphs 63 to 71 contain the standard's group governance architecture: the obligation to maintain governance arrangements for the group (paragraph 63); the obligation to ensure those arrangements support each regulated entity's Board to exercise independent judgement in practice (paragraph 64); the requirement that they be designed to support the identification and management of actual or potential conflicts arising from intragroup roles, reporting lines or other group arrangements (paragraph 65(b)); escalation and resolution of matters raised by the entity's board, including on group-wide decisions (paragraph 65(c)); the group internal audit function (paragraph 66); the group Board committees (paragraph 67); and — most directly relevant here — the obligation, where an institution within the group that is not a regulated entity engages in business activities that may pose a material risk to the group, to ensure those activities comply with the group governance arrangements (paragraph 69).

The vertically integrated private health insurers are the segment of the APRA-regulated population in which non-regulated provider-side subsidiaries — dental, allied health, primary care — sit inside the group and transact commercially in the same market as the counterparties the regulated entity audits and can remove from its network. Paragraph 69 is the closest group-governance analogue to that configuration. Paragraph 4(d) removes it from the entities to which it is most obviously directed.

I do not suggest the exclusion is an oversight. There appears to be a structural reason for it, and it is one that bears directly on what APRA should be asked to do. Paragraphs 63 to 71 operate through the concept of the "Head of a group", and CPS 001 defines that term only for authorised deposit-taking institutions and general insurers, by reference to a Level 2 Head or Level 3 Head. There is no private health insurer equivalent, and no Level 2 or Level 3 group framework for private health insurers. Paragraph 72 is consistent with this: it refers to a "corporate group" in the case of a private health insurer, using the term CPS 001 does define for them. Simply lifting the paragraph 4(d) exclusion would therefore import an operative term that has no meaning for the entities it was lifted for. The exclusion is also stated in APRA's own consultation paper: the structure table at section 2.1.2 describes the group governance provisions as applying to an APRA-regulated head of a group, and footnote 4 records that this section does not apply to RSE licensees or private health insurers. I note also that section 2.6 of the consultation paper records that APRA has not provided detailed commentary on areas where requirements have not substantively changed, and lists the Head of a group among them. The exclusion has accordingly been carried forward from a framework designed before this sector integrated vertically, rather than examined against the sector as it now stands. That is not a criticism of the review's conduct; it is the reason the point is worth raising now.

That the machinery does not fit is a reason the machinery does not fit. It is not a reason the conflict does not exist. The more direct remedy is available in Part B, which does apply to private health insurers, and which this draft extends to insurers for the first time. Paragraph 74(a) already requires identification and assessment of conflicts arising from structural arrangements, expressly including intragroup arrangements. What it does not do is say what that means where the related body corporate competes in the same market as the provider counterparties whose participation the insurer determines. An express limb in paragraph 74 would say so, and would do it without new artefacts: the register is already required by paragraph 74(f), the policy by paragraph 75, and the annual independent review by paragraph 74(j). A drafting proposal is at Section 6.2.

If APRA prefers instead to bring private health insurers within paragraphs 63 to 71, that route remains open, but it requires a companion amendment to CPS 001 defining "Head of a group" for private health insurers. Both formulations are set out at Section 6.2. The Part B route is the cheaper and, in my submission, the better one.

Proposition 2 — Decisions affecting a registered health practitioner's access to insured patient populations should be governed by a tiered oversight model: Board approval of the framework, risk appetite and materiality thresholds; an independent decision-maker for high-impact cases; and exception reporting to the Board Risk Committee. The Board should not make these decisions, but it should be in a position to see them.

An earlier formulation of this proposition asked that provider-network decisions be added to the non-delegable responsibilities at paragraph 13. On reflection that is the wrong instrument, and inconsistent with the direction of this review. Sections 2.2.2 and 2.2.3 of the consultation paper make clear that APRA is seeking to clarify a short list of core prudential responsibilities and to give boards confidence to delegate everything else, so that board time goes to strategy, risk, culture and challenge. A proposal to lengthen the non-delegable list cuts against that objective, and would in any event be impractical: an entity may make many hundreds of provider decisions a year, the overwhelming majority of which are routine and properly made at an operational level.

The governance outcome sought does not require board decision-making. It requires that the framework within which such decisions are made is board-approved, that genuinely high-impact decisions receive independent review before they take effect, and that the Board and its Risk Committee see enough to exercise the challenge paragraph 13(h) requires of them. Paragraphs 15 to 17 already provide the architecture: delegation is permitted, but must be documented, risk-based, consistent with risk appetite, monitored, conflict-controlled and regularly reviewed. What is missing is any indication of what that means for a function of this character.

A tiered model, capable of expression in CPG 510 rather than in the standard, would operate as follows:

- The Board approves the provider-audit and network governance framework, the associated risk appetite, the delegations under paragraph 17, and the materiality thresholds at which a decision escalates.
- Decisions meeting a materiality threshold are determined by a senior decision-maker or committee independent of the investigation. Thresholds would sensibly include: removal of multiple practitioners or a bulk or prospective declaration; removal affecting a material number of policyholders; a characterisation expressed in terms of fraud, dishonesty or professional misconduct; an actual or potential conflict involving a related provider business; a determination inconsistent with a finding of a court, regulator or National Board; and any matter in which a whistleblower or retaliation concern has been raised.
- The appeal or review of a determination is conducted by a person who did not conduct the audit, gather the evidence, make the determination or issue the notice.
- The Board Risk Committee receives exception reporting on threshold decisions and periodic aggregated reporting on the function, in the terms proposed at Section 6.1A.
- Internal audit periodically samples determinations and tests the framework, consistently with paragraphs 42 and 43.
- The full Board is notified of systemic issues or individually exceptional matters.

Where a decision of this kind warrants legal input, the appropriate formulation is independent legal, risk or compliance review proportionate to the nature of the decision. I have not proposed oversight by the Chief Legal Officer specifically: that officer advises the entity and may be responsible for defending its position, and is therefore not necessarily an independent reviewer of it.

Proposition 3 — Fitness and propriety assessments for accountable persons at PHI insurers should include consideration of how the accountable person has discharged responsibilities in relation to whistleblower disclosures and adverse conduct notifications concerning the entity's operational conduct.

The proper handling of whistleblower disclosures under Part 9.4AAA of the Corporations Act is a core indicator of the integrity, judgement and prudential conduct of accountable persons. The fitness and propriety framework at Part C should ensure that entities are required to consider, in reasonable-steps assessments under paragraph 77, how their accountable persons have engaged with whistleblower and adverse-conduct disclosures.

Proposition 4 — Conflicts management frameworks under CPS 510 should specifically address the use of external legal advisers for investigations into whistleblower disclosures and adverse conduct concerning the entity itself, and paragraph 35(e) appears to contain a drafting error that undermines the only provision presently addressing the independence of such engagements.

The current national conversation, including the Parliamentary Joint Committee on Corporations and Financial Services' examination of KPMG's engagement of external law firms for whistleblower investigations, has surfaced substantial concerns about the use of legal-advice engagement architectures to close down whistleblower engagements. Paragraph 35(e) requires that a Board committee engaging third-party experts do so in a manner ensuring the engagement is "independent of the Board" — which appears not to be the intended requirement. This is developed at Section 5.3.

Proposition 5 — Board oversight of contractual frameworks that affect the practical operation of statutory frameworks (such as the National Law) should be a specifically identified prudential responsibility.

PHI insurers operate fund rules and provider agreements that deploy the National Law's conduct terminology, permit the disregard of statutory Board findings, and can effectively determine which registered practitioners may practise in the insured segment of their profession. The prudential oversight of such contractual frameworks is a governance question for the boards of APRA-regulated entities, and CPS 510 should expressly recognise this.

Proposition 6 — Alignment between CPS 510 and the Financial Accountability Regime should ensure that accountable persons at PHI insurers face genuine personal accountability for the discharge of their responsibilities in relation to registered health practitioners.

The Financial Accountability Regime commenced for insurance entities on 15 March 2025 and creates personal legal accountability for accountable persons at PHI insurers. Paragraph 8(b)(i) already makes an Accountable Person, as defined in section 10 of the Financial Accountability Regime Act 2023, a responsible person for the purposes of this Prudential Standard. The interaction between the two regimes should ensure that reasonable-steps obligations and open-cooperative-conduct obligations under FAR are supported by the fitness and propriety framework in Part C and by the board oversight requirements in Part A.

3. The governance concern in private health insurance

This section sets out the structural features of the Australian private health insurance sector that make governance a matter of specific and heightened concern, and that make draft CPS 510's treatment of intragroup conflicts, board oversight, and fitness and propriety directly relevant to APRA's oversight of PHI insurers.

3.1 The Australian private health insurance sector's evolution to vertical integration

Over approximately the last ten years, the Australian private health insurance sector has undergone a significant structural transformation. The major APRA-regulated private health insurers — Bupa, Medibank, HCF, NIB and HBF — have evolved from pure insurance entities to vertically integrated groups that now include, in most cases, provider-side subsidiaries operating in commercial competition with the independent health practitioners whose services those same insurers audit, contract with, and can effectively remove from their provider networks.

This vertical integration is publicly documented in the annual reports of the major insurers. One such insurer, taken as an example, established a dental subsidiary and has publicly described it as among the fastest-growing dental groups in its home State, with a stated target in the order of 100 practising dentists. That insurer acquired an allied health group as a wholly-owned subsidiary during the 2022

financial year. Its FY2024 Annual Report reports that combined dental and physiotherapy consultations were approximately 400,000 in that year, a 15 per cent increase on the prior year. The chief executive's statement in the same year referred to the leveraging of the group's investments in its dental and physiotherapy clinics. Analogous vertical integration configurations exist in other major PHI insurers.

Whether a given private health insurer is a significant financial institution materially changes which of the standard's obligations bind it. CPS 001 defines a significant financial institution, for private health insurers, as one with total assets in excess of A$3 billion, or one determined as such by APRA having regard to matters such as complexity in its operations or its membership of a group. SFI status triggers separate Audit and Risk Committees (paragraph 37), a Board Remuneration Committee (paragraph 36(c)), and a triennial external independent assessment of Board, Board committee and director performance (paragraph 53). For a vertically integrated fund operating non-regulated health services subsidiaries, the complexity limb of the SFI definition is directly engaged, and CPG 510 should indicate how APRA proposes to apply it to funds in that configuration.

The commercial logic of vertical integration is intelligible and does not, in itself, engage prudential concerns. Insurers may legitimately operate provider-side services. The prudential concern arises from a specific structural feature of the resulting groups: the personnel making audit and network-removal determinations affecting independent providers sit within a corporate structure where their operational leadership also has strategic and commercial responsibility for the growth of the provider-side subsidiaries that benefit commercially from the removal of those independent providers from the insured patient flow.

3.2 The specific structural configuration

Within the Insurer, a single executive line carries organisational responsibility for both the payment integrity function — which conducts audits and provider network decisions affecting independent providers — and the group's provider-side operations, being its dental subsidiary and an acquired allied health group. The point is structural rather than personal: it concerns where responsibility for the two functions sits within the organisation, not the conduct of any individual occupying the role. The configuration is evident from the Insurer's correspondence and from public sources including industry and professional media.

The dual oversight configuration means that decisions affecting independent providers' ability to practise in the insured segment of their profession are made by personnel whose operational leader has direct commercial responsibility for the growth of the group's competing provider subsidiaries. I emphasise that this is a conflict of the kind paragraph 74(a) addresses, and not merely a perceived one. Whether it is characterised as an actual conflict or as a material potential structural conflict that becomes actual on the facts of a particular decision is not a question this submission needs to resolve: paragraph 74(a) requires the identification and assessment of both. APRA has decided, for reasons set out in its response to feedback, that perceived conflicts will be addressed in guidance rather than in the standard, and nothing in this submission depends on that category. Common ownership of an entity competing in the same market as the counterparties whose network participation the regulated entity determines is a conflict between an Interest of the entity and its duty to policyholders as a matter of fact, whatever any observer perceives. It is a structural configuration in which the same executive leadership benefits commercially from decisions to remove independent providers from the network and to expand the group's own provider subsidiaries.

Similar structural configurations exist across the vertically integrated PHI sector. Where a major insurer operates provider-side subsidiaries and simultaneously operates provider audit and network-removal functions, the intragroup conflict identified in this section arises in similar form.

3.3 Why this is a governance question, not merely a commercial one

A commercial competition between an insurer's provider subsidiary and an independent provider is a matter for competition law and, potentially, for the Australian Consumer Law. The Australian Competition and Consumer Commission's June 2025 proceedings against Bupa, resulting in the $35 million penalty ordered in December 2025, demonstrate the ACCC's active enforcement in this space.

The concern this submission raises is different. It is not that vertical integration is commercially competitive. It is that the governance framework of the APRA-regulated insurer, as the entity within which both the audit function and the provider subsidiaries operate, must be adequate to identify, manage and mitigate the intragroup conflict this configuration produces. Absent adequate governance:

- The reliability of audit-and-network-removal determinations against independent providers is affected by the commercial interest in the growth of the group's own provider subsidiaries.
- The board's oversight of the entity's conduct toward independent providers is compromised by the internal reporting lines through the executive whose dual oversight sits at the heart of the conflict.
- The public interest served by prudential regulation — the sound and prudent management of the insurer, the protection of policyholder interests, and the identification and management of the operational, legal and reputational risks arising from the insurer's dealings with provider counterparties — is not adequately protected.
- The insurer's own long-term prudential standing is affected by the reputational, legal and regulatory risk arising from adverse conduct against independent providers that may not have received appropriate board-level oversight.

3.4 Draft CPS 510's treatment of intragroup conflicts

Draft CPS 510 addresses intragroup conflicts explicitly. Paragraph 31 requires that, where a director also serves on the Board of a parent or other entity within the same group, independence be assessed with specific regard to any potential or actual conflicts arising from, or associated with, intragroup arrangements, such as structural, funding or remuneration relationships. Paragraph 74(a) requires a regulated entity to identify and assess all actual and potential conflicts in connection with its business operations, including those arising from structural, funding or remuneration arrangements and expressly including intragroup arrangements.

Part B extends conflicts management requirements previously confined to RSE licensees under SPS 521 to banks and insurers. The obligations include identification and assessment of all actual and potential conflicts (paragraph 74(a)); implementation of appropriate controls having regard to the associated risks and potential impacts on the interests of, or duties owed to, policyholders (paragraph 74(b)); avoidance of conflicts where the entity reasonably concludes that a conflict cannot be effectively managed to protect policyholder interests (paragraph 74(c)); assessment and monitoring of control effectiveness and remediation where the risk or impact changes (paragraph 74(e)); maintenance of a current register of potential and actual conflicts together with the associated controls (paragraph 74(f)); recording in the minutes of Board and Board committee meetings of conflicts disclosed and the action taken (paragraph 74(g)); monitoring of compliance with the conflicts management policy (paragraph 74(i)); and annual review of the policy's appropriateness and effectiveness by operationally independent, appropriately trained and competent persons (paragraph 74(j)). Paragraph 75 requires a conflicts management policy applying to the entity, all responsible persons and all employees.

These provisions are directly relevant to the PHI sector configuration described above. The extension of RSE licensee-style conflicts management to insurers, if properly calibrated for the specific character of insurer-provider vertical integration, would address the governance concern this submission identifies. Two calibration questions arise: whether paragraph 74 says enough about the intragroup conflict that vertical integration creates, given that the group governance provisions which would otherwise address it

are excluded from private health insurers and rest on machinery that does not exist for them — addressed at Proposition 1 and Section 6.2; and a definitional limit on the reach of Part B, addressed immediately below.

3.4A A definitional limit on the reach of Part B

A related limitation arises from the definition of "conflict" at paragraph 8(f)(ii). For all regulated entities other than RSE licensees, a "conflict" is defined as a conflict between a duty or an Interest and the interest of, or duty to, depositors or policyholders as relevant. The conflicts obligations in Part B are anchored to that definition, and paragraph 74(b) likewise frames the required controls by reference to "the interests of, or duties owed to its policyholders, depositors or beneficiaries".

On its terms, therefore, Part B does not reach a conflict that operates against a provider counterparty of the regulated entity. It reaches such a conflict only where the policyholder limb is independently engaged.

In the matter described in Section 4, the policyholder limb plainly was engaged: approximately 2,600 insured members of a single private health insurer lost access to their treating practitioners as a consequence of a determination made within the structural configuration described in Section 3.2. But that is a factual conclusion about one matter, not a drafting outcome the standard secures.

Two adjustments would close the gap without expanding Part B beyond its intended scope:

- Confirmation in CPG 510 that, for private health insurers, a decision affecting the composition of the provider network engages the interests of policyholders for the purposes of paragraphs 8(f)(ii) and 74(b), because the policyholder's practical access to benefits is determined by it; or
- Extension of the paragraph 8(f)(ii) definition, for private health insurers only, to conflicts between a duty or Interest and the interest of, or duty to, providers with whom the insurer has contracted — reflecting that the private health insurance model uniquely places the regulated entity in a contractual relationship with the professionals whose services its policies pay for.

3.5 The public-interest dimensions engaged

The prudential concern is not confined to the reliability of the insurer's internal governance. It has direct public-interest consequences that engage APRA's own statutory mandate under section 8 of the Australian Prudential Regulation Authority Act 1998, which requires APRA to balance the objectives of financial safety with efficiency, competition, contestability and competitive neutrality, and to promote financial system stability.

The specific public-interest dimensions engaged include:

- Continuity of care for insured patients. When an independent provider is removed from a PHI network through determinations affected by intragroup conflicts, the insured patients of that provider face disrupted therapeutic relationships. In the matter described in this submission, approximately 2,600 patients of the practice were affected. Similar disruption arises whenever comparable determinations are made across the sector.
- Public confidence in the private health insurance system. If provider network decisions are perceived to be affected by the commercial interests of the insurer's competing provider subsidiaries, public confidence in the insurer's independence as a neutral payer of benefits is affected.
- The authority of the National Registration and Accreditation Scheme. Where PHI insurers use language capable of being understood by practitioners and patients as a professional-conduct characterisation, notwithstanding that no statutory determination of unprofessional conduct or professional misconduct had been made in private determinations, apply that vocabulary through

non-registered personnel, and communicate resulting determinations to insured patients as if they were regulatory findings, the practical authority of AHPRA and the National Boards is affected.

The jurisdictional character of this concern is not contentious. AHPRA's Pathway Navigator service has confirmed in writing, in response to a concern of the character described in this submission, that its work is guided and at times limited by the Health Practitioner Regulation National Law; that AHPRA has jurisdiction to review individual registered health practitioners but not the conduct of a private health insurer; that concerns of this character therefore fall outside its regulatory scope while being recorded on its system in the event patterns of conduct emerge; and that the appropriate insurer-side avenue is the Private Health Insurance Ombudsman. The regulator with jurisdiction over the practitioner has no jurisdiction over the entity whose determination carries the professional consequence.

This is a considered institutional response from the national health-practitioner regulator, and it illustrates the specific gap in the current regulatory architecture that CPS 510 has the opportunity to address at the prudential end. AHPRA can regulate the practitioner; AHPRA cannot regulate the insurer whose conduct affects the practitioner's standing. PHIO can inquire about the insurer but is not a prudential regulator of the insurer. The prudential governance framework that CPS 510 establishes — particularly paragraph 13 (board oversight), Part B (conflicts) and Part C (fitness and propriety) — is directly relevant to closing this gap.

- Contestability and competitive neutrality. APRA's statutory mandate expressly includes competitive neutrality. Where a vertically integrated insurer's audit and network-removal decisions can operate to remove independent competitors from the insured patient flow, the competitive neutrality of the insurer's market position is directly engaged.
- The sustainability of the registered health workforce. Where registered health practitioners can be removed from the insured segment of their profession by processes that operate outside the National Law framework's procedural protections, the willingness of qualified persons to enter and remain in independent professional practice may be affected.

3.6 The current national conversation on external law firm investigations

The prudential relevance of governance and conflicts management in APRA-regulated entities has been sharpened, in 2026, by the Parliamentary Joint Committee on Corporations and Financial Services' examination of KPMG's engagement of external law firms (Ashurst and Allens) for investigations of whistleblower disclosures. That examination has produced parliamentary characterisation of the pattern in unusually direct terms.

On 10 August 2026, the Committee released six legal documents that had been protected by KPMG's assertion of legal professional privilege, on the basis of "compelling public interest." On 14 August 2026, KPMG's deputy general counsel James McClelland told the Committee under parliamentary examination that his earlier internal investigation had been "fundamentally undermined" by responses that were "misleading, if not directly deceptive," and by restrictions on scope. On 17 August 2026, Allens partners appeared before the Committee and defended their Project Magenta investigation work.

The Committee's examination has established, on the parliamentary record, that Allens' Project Magenta investigation for KPMG consisted of 14 interviews with senior KPMG partners and directors (12 of which lasted approximately 30 minutes); that Allens did not interview the whistleblower, junior staff, affected clients or other external witnesses; that no comprehensive review of digital records was conducted; and that the scope of the investigation was controlled by a KPMG board subcommittee. KPMG's own evidence to the Committee has established that Allens advised KPMG that the narrow scope was reasonable and proportionate at the time.

Committee chair Senator Deborah O'Neill questioned during the 17 August 2026 hearing how the current system allows lawyers to be engaged and named as investigators when what they are asked to do is at odds with what ordinary Australians would understand an investigation to be.

This parliamentary attention on the specific pattern of external law firm investigations conducted under legal-advice engagement parameters is not confined to KPMG. It engages the general question of how APRA-regulated entities, including PHI insurers, use external legal advisers to investigate whistleblower disclosures and adverse conduct concerning the entity itself. The conflicts management framework at Part B, the non-constraint requirements at paragraphs 95 to 101, and paragraph 35(e) are, in this context, directly relevant to how PHI insurer boards are expected to oversee such engagements.

3.7 Concurrent regulatory developments in the private health insurance sector

Several concurrent regulatory developments in the PHI sector heighten the specific relevance of CPS 510 to APRA's oversight of the sector:

- The Department of Health, Disability and Ageing has confirmed that it is progressing reform work through the Private Health CEO Forum, including work towards a code of conduct for private health insurers. That work and this consultation are directed at overlapping conduct, and the prudential and conduct instruments should be read together.
- The Australian Competition and Consumer Commission instituted proceedings against Bupa HI Pty Ltd in the Federal Court on 30 June 2025. In December 2025 the Court ordered Bupa to pay $35 million in penalties and granted an injunction restraining the contravening conduct for five years. The Court declared that between May 2018 and August 2023 Bupa engaged in misleading or deceptive conduct and made false or misleading representations to members, hospitals and medical providers as to entitlement to benefits, and that between June 2020 and February 2021 it engaged in unconscionable conduct in connection with its incorrect assessment of certain Mixed Coverage Claims. Bupa had earlier given the ACCC a court enforceable undertaking to complete a remediation program compensating affected members, hospitals and medical providers. Two features of the ACCC's account of the admitted conduct bear directly on this submission and are developed at Sections 5.9 and 6.9A: the incorrect assessments were generated by automated claims assessment systems programmed to reject the claims in question, and the period of admitted unconscionable conduct was one in which the insurer had ceased manual review of claims that those systems had automatically assessed as attracting no benefit.
- The Australian Broadcasting Corporation's national coverage of provider audit conduct in the private health insurance sector, including on 13 August 2026, has documented what the Australian Private Hospitals Association CEO characterised as "rogue behaviour" — audits with a strong focus on minor technical compliance issues and punitive outcomes for deviations. The Australian Physiotherapy Association has formally documented instances of insurers threatening to exclude physiotherapists from HICAPS where providers do not supply clinical notes even where patients have denied consent.
- The Financial Accountability Regime commenced for insurance entities on 15 March 2025. Under FAR, accountable persons at PHI insurers have personal legal obligations to act with honesty and integrity and with due skill, care and diligence, and to take reasonable steps to prevent matters that would result in material contraventions. Paragraph 8(b)(i) of draft CPS 510 makes an Accountable Person, as defined in section 10 of the Financial Accountability Regime Act 2023, a responsible person for the purposes of the Prudential Standard.

Read together, these concurrent regulatory developments indicate that the PHI sector is presently the subject of substantive, converging regulatory and policy attention across ASIC, ACCC, DoH, APRA and AHPRA. The finalisation of CPS 510 in this context is an opportunity for APRA to ensure that the prudential governance framework it establishes is calibrated to the specific structural features and public-interest concerns of the vertically integrated PHI sector.

3.8 Federal Court authority on the composition of insurer audits

The prudential relevance of the fitness and propriety of personnel making insurer audit decisions affecting registered health practitioners is not a novel proposition. It has been considered by the Full Court of the Federal Court of Australia.

In Bupa HI Pty Ltd v Chang [2019] FCAFC 180, the Full Court dismissed an appeal by Bupa arising from its audit of a Sydney ophthalmologist with vitreoretinal subspecialist expertise. The primary judge had declared that Bupa breached its contract with Dr Chang, and had dismissed Bupa's claims under the Australian Consumer Law in respect of allegedly overpaid amounts. The appeal was dismissed and Bupa was ordered to pay Dr Chang's costs. The litigation ran for approximately three years and concluded in 2019, and the insurer was ordered to pay the practitioner's costs.

The contractual question was whether Bupa had formed a "reasonable opinion" that the practitioner's conduct "may adversely impact" its "goodwill, reputation or business", so as to entitle it to deregister him from its Medical Gap Scheme. Among the material before the Court was correspondence from Dr Chang's solicitors advancing the criticism that "it does not appear that an ophthalmologist peer with vitreoretinal subspecialist expertise, has had input into BUPA's audit". The Court confirmed that the point was well made.

I do not put Chang higher than it goes. It is not authority for a general procedural requirement that insurer audits obtain peer input, and the peer-expertise criticism was one element in a case decided on the reasonableness of the insurer's contractual opinion. What Chang does establish is that the composition and expertise of an insurer's audit function bears on whether the opinion the insurer forms on the strength of that audit is a reasonable one — that is, it is a matter of legal consequence and not merely internal operational choice.

The concern the Full Court addressed in 2019 has continued to manifest across the sector. In the Australian Broadcasting Corporation's coverage of 13 August 2026, the Australian Private Hospitals Association CEO characterised the current audit environment as "rogue behaviour," and the University of Sydney Law School's Bashi Hazard stated on the public record that insurer conduct in the audit context can, in appropriate circumstances, engage questions of contract voidness. Merv Saultry of the Independent Dentist Network confirmed that dentists affected by comparable audit conduct have often been unwilling to speak publicly. These public statements do not extend the position reached in Chang; they indicate that it remains live.

For the purposes of the present consultation, Chang is relevant to CPS 510 in three specific ways. First, it demonstrates that the composition and expertise of insurer audit personnel bears on the legal validity of the determinations that follow. Second, it supports the proposition that the fitness and propriety framework in Part C should address the competencies of personnel exercising functions that affect the professional standing of AHPRA-registered practitioners — a matter paragraph 82 already requires to be defined and documented for responsible person positions. Third, it indicates that prudential oversight of an APRA-regulated PHI insurer's audit function is properly a matter for the insurer's board, exercising the non-delegable responsibilities at paragraph 13.

3.8A The pattern is documented across the sector and across professions

This submission uses a single worked example, and I am conscious that a proposal for a change of general application should not rest on one instance. It does not. On 12 August 2026 the ABC published an investigation into private health insurer audit practices which documents, across several professions, the features this submission identifies: audits conducted by personnel whose qualifications the audited practitioner disputes, information demands that exceed what the practitioner may lawfully provide, financial consequences threatened where the practitioner declines, and practitioners unwilling to be identified for fear of insurer retaliation. I set out the publicly reported material below. I do not put any individual account as established fact; none has been tested, and the accounts of two of the practitioners

concerned are anonymous. What I put is that a pattern reported by named industry bodies, in a national broadcaster's investigation, in more than one profession, is a pattern APRA is entitled to take into account when settling the governance framework for the entities conducting the audits.

Dentistry. The Independent Dentist Network told the ABC of a case, before the pandemic, in which a large insurer asserted that a Western Australian dentist had submitted approximately $1 million in questionable claims. The auditors sent by the insurer were, on the dentist's account, dental practice managers or nurses rather than registered dentists, and they recommended that treatments be reclassified. Following negotiation and legal threats the asserted amount was halved and ultimately abandoned with a warning. The Network reported that the dentist remained affected by the experience and was unwilling to speak publicly. That case is independent of mine, arose in the same State and the same profession, and turns on the same question: the competence of the persons conducting a clinical audit to make the clinical judgements it requires.

Physiotherapy. A physiotherapist reported being subject to two audits by a major insurer, in one of which he was asked for the entire clinical history of that insurer's patients at his practice. He wrote to those patients seeking consent and two-thirds declined. On informing the insurer, he received correspondence stating that it required the records irrespective of patient consent and relying on his preferred provider agreement. AHPRA advised him that he could not release the records absent consent. He reported that the insurer then raised the prospect of repayment of up to $300,000 in benefits, and that the matter was resolved only after he approached the Commonwealth Ombudsman. He asked not to be identified for fear of retribution by insurers.

Private hospitals. The Australian Private Hospitals Association reported that its members have experienced comparable demands for entire clinical histories, that complaints about aggressive audits are increasing, and that audits are focused on minor technical compliance matters with punitive consequences for departures. Its chief executive characterised the conduct as "rogue behaviour". A University of Sydney Law School academic who has studied the sector expressed the view that an insurer cannot write into a contract a term that requires a practitioner to act contrary to law, and that a demand for patient records outside an episode of care and without consent should render the term unenforceable.

Professional associations. The Australian Physiotherapy Association has, on published reporting, formally documented multiple instances of insurers threatening to exclude physiotherapists from the Health Industry Claims and Payments Service — the real-time claiming system through which patients receive benefits at the point of care — where the practitioner does not supply clinical notes, including where patients have refused consent. The Association has put to insurers that the practice subordinates patient consent and requires practitioners to act unlawfully. That mechanism warrants particular attention here: exclusion from real-time claiming is a network-access consequence of the same character as the declaration described at Section 4, applied as leverage in an information dispute rather than as the outcome of a determination on the merits. The Australian Private Hospitals Association has made corresponding representations to government.

The trend in complaints. Published reporting records that the Australian Competition and Consumer Commission received 186 contacts concerning private health insurance in 2024–25, an increase of approximately 22 per cent on the previous year, and that the Commonwealth Ombudsman received 4,241 private health insurance complaints in 2023–24, an increase of approximately 23.7 per cent. I do not suggest those figures are attributable to audit conduct; complaint volumes capture the whole of the sector's dealings with members and providers. I record them because they indicate a rising, not settling, level of friction in the sector whose governance framework APRA is now setting for the period from 2028.

The reform context. In March 2026 the Australian Private Hospitals Association and Catholic Health Australia jointly called for a mandatory code of conduct governing insurer-hospital contracting, overseen by the ACCC. That proposal is directed at contracting conduct rather than at prudential governance, and I

do not ask APRA to duplicate it. I note it because a code of that kind would operate alongside CPS 510 rather than instead of it: a code can regulate what an insurer may require of a counterparty, while CPS 510 governs whether the insurer's Board has approved, and can oversee, the framework under which its personnel decide such matters. The two instruments answer different questions, and the prudential one is not answered by the conduct one.

The industry position. In fairness to the insurers, Private Healthcare Australia told the ABC that health funds are responsible for managing approximately $27 billion of healthcare payments annually, that most claims and providers are legitimate, that audits nonetheless uncover fraud, inappropriate claiming and billing error involving substantial sums, and that funds follow the privacy procedures the law requires and use audit information only for payment integrity. Funds estimate that up to three per cent of claims are over-billed each year. I do not dispute any of that, and nothing in this submission asks APRA to constrain payment integrity activity. The proposition is narrower and, I think, common ground: a function of that importance, operating at that scale, with those consequences, should be conducted under a governance framework that the entity's Board has approved and can oversee.

One feature of the ABC's account bears directly on why this is APRA's question rather than someone else's. The report records that the legality of some audit conduct is unclear because health laws overlap, and gives as an example that prudential standards require an insurer to ensure payment integrity while the terms of insurance permit auditing of any funded service. In other words, the prudential framework is already being relied upon in this sector as the source of authority for audit conduct. If APRA's standards are the authority for the function, APRA's standards are the right place to set the governance conditions under which it is exercised. At present they require the outcome without addressing the conduct.

The anonymity itself is evidence. Two of the practitioners whose accounts appear in that investigation declined to be identified because they feared insurer retaliation, and a third declined to comment at all. Whatever the merits of any individual matter, a state of affairs in which contracted health practitioners will not speak publicly about an APRA-regulated entity's conduct toward them is the state of affairs paragraphs 99 to 101 are directed at, and it is addressed at Section 5.7.

3.9 The bulk Unacceptable Provider Declaration mechanism and the fitness-and-propriety question

A specific corporate mechanism used by APRA-regulated private health insurers to remove providers from the insured segment of their profession — the bulk Unacceptable Provider Declaration — illustrates the fitness-and-propriety question that Part C is directly designed to address. The mechanism warrants specific consideration in the finalisation of the standard.

A bulk Unacceptable Provider Declaration is a corporate determination, made under a private health insurer's own fund rules, that a group of AHPRA-registered health practitioners at a particular practice are to be treated as "unacceptable" for the purposes of the insurer's provider network. In the matter documented in Section 4, one such Declaration was made on 8 April 2024 against ten AHPRA-registered dental practitioners at a single practice. The Declaration was framed in the National Law's conduct terminology ("improper and unprofessional") — vocabulary that in the National Law framework is reserved for statutory determinations by AHPRA and the National Boards. The Declaration extended prospectively to any future AHPRA-registered practitioner joining the practice, effectively creating a corporate designation of the practice itself as one from which no registered practitioner would be recognised in the insured network.

The determination was signed at operational level within the payment integrity function, by a person who was not, on the searches available, registered under the National Law as a dental practitioner. The same operational role had conducted the audit, collated the evidence provided to the insurer's internal delegated executive committee, participated in the network-removal decision-making, signed the network-removal notice, acted as gatekeeper to the appeal pathway, participated in the appeal review,

and signed the appeal-rejection notice. What matters for this submission is the concentration of those functions in one operational role and the absence of a registration requirement attaching to it, not the performance of any individual who held it. The determination was subsequently maintained even after the statutory Board's own determination of November 2024 had concluded that the underlying conduct did not warrant regulatory action.

The fitness-and-propriety questions that a mechanism of this character engages under draft CPS 510 include the following:

- Whether the entity is exercising the skill, care, diligence and judgement contemplated by paragraph 84(a) when it makes determinations characterising the conduct of AHPRA-registered practitioners in language capable of being understood as a professional-conduct finding, through personnel whose education, technical qualifications and experience would not satisfy paragraph 84(b) for a position of that consequence.
- Whether the accountable persons at the insurer, having received notice of the determination and of the affected practitioners' response, are discharging the reasonable-steps obligation under the Financial Accountability Regime — and, under paragraph 77, the all-reasonable-steps standard for fitness and propriety — when they permit or ratify the determination without their own documented oversight.
- Whether the concentration in a single unregistered operational employee of the audit function, the evidence collation, the decision-making, the notice-issuing, the appeal-gatekeeping, the appeal-reviewing and the appeal-rejecting is consistent with paragraph 17(d), which requires that conflicts arising from or in connection with a delegation be identified and appropriately managed, and with paragraph 21, which requires that conflicts be considered and recorded in all relevant decision-making.
- Whether the maintenance of the determination after the statutory Board's contrary determination is consistent with paragraph 86(c), which requires consideration of the findings of any court, tribunal, regulator, board, arbitrator, public inquiry or other body whose responsibility it is to make findings of the relevant kind.

The accountability architecture around such determinations is a matter of specific significance. In the matter documented in Section 4, the Insurer confirmed in formal correspondence that neither its chief legal officer nor its non-executive Chair was involved in the audit of the practice or in the decision to remove the practice from its provider network. That is recorded not as a criticism of either — there is no requirement in the current framework that they be involved — but because it locates where the decision was in fact made. If a determination affecting the professional standing of ten registered practitioners and the provider access of approximately 2,600 members was taken without engagement at that level, the question the framework should answer is who within the entity was accountable for it, and whether that accountability was commensurate with the consequences.

Paragraph 13 identifies as non-delegable the Board's responsibilities to oversee culture, including risk culture, and to set a clear tone from the top (paragraph 13(b)); to oversee governance and risk management frameworks (paragraph 13(c)); to ensure that directors and senior managers collectively have the skills needed for the effective and prudent operation of the entity (paragraph 13(g)); and to constructively challenge senior managers (paragraph 13(h)). Where accountable persons at Chair or chief legal officer level are documented as not having been involved in a determination of the character of a bulk Declaration against ten registered practitioners, the determination is shown to have been made at a level of the entity that was not commensurate with its consequences, engaging the Board's responsibility under paragraph 13(c) for oversight of the governance framework and its continuing responsibility under paragraph 16 for delegated obligations.

Whether the bulk Declaration mechanism warrants formal legislative adjustment is a policy question that goes beyond APRA's remit and engages the Department of Health, Disability and Ageing's reform work,

the National Law framework, and potentially the Corporations Act 2001. My considered view, offered for APRA's information rather than as a determination this submission asks APRA to make, is that formal adjustment is warranted in at least three respects:

- The use of professional-conduct terminology drawn from the National Law in private corporate determinations should require, at a minimum, that the person making the determination be registered under the National Law in the relevant profession. This adjustment could be made at the National Law level, at the Private Health Insurance Act 2007 level, or through a code of conduct for insurers.
- Bulk determinations affecting multiple registered practitioners simultaneously should require documented board-level oversight commensurate with their consequences. This adjustment could be made at the prudential level through CPS 510, or through a code of conduct for insurers, or both.
- Corporate determinations that maintain adverse characterisations of registered practitioners after the relevant statutory Board has determined that no regulatory action is warranted should engage specific reasonable-steps obligations under FAR and specific obligations under paragraphs 86(c), 88 and 89.

For the immediate purposes of the CPS 510 consultation, the most direct contribution APRA can make is through the second and third of these adjustments.

4. Worked example: the matter documented

This section provides a worked example, drawn from my own documented experience with the Insurer (an APRA-regulated private health insurer), of how the governance concerns identified in Section 3 manifest in operation. The material is offered as illustration of the specific governance concerns CPS 510 addresses. It is not offered as a request for APRA determination in relation to the Insurer specifically.

4.1 The audit and bulk designation

In April 2024, the Insurer signed a bulk Unacceptable Provider Declaration against ten AHPRA-registered dental practitioners at the practice. The Declaration was made under the relevant fund rule. It characterised the underlying conduct as "improper and unprofessional" — language capable of being understood by practitioners and patients as a professional-conduct characterisation, notwithstanding that the National Law defines the distinct terms "unprofessional conduct" and "professional misconduct" and that no statutory determination of either had been made. The Declaration was signed at operational level within the Insurer's payment integrity function, by a person who was not, on the searches conducted, registered under the National Law as a dental practitioner. The Declaration extended prospectively to any future AHPRA-registered practitioner joining the practice.

The Declaration was based on findings made within the same operational payment integrity role that had conducted the audit, collated the evidence provided to the Insurer's internal delegated executive committee, participated in the network-removal decision-making, signed the network-removal notice, acted as gatekeeper to the appeal pathway, participated in the appeal review, and signed the appeal-rejection notice. The concentration of investigator, assessor, decision-maker and appellate functions in a single unregistered operational role is documented in the Declaration and subsequent correspondence. It is that concentration, and the absence of any framework requirement preventing it, that this submission is concerned with.

One feature of the audit warrants separate mention, because it bears on the conflicts analysis at Section 5.2 and on the proposal at Section 6.1D. The audit was accompanied by a demand for unfettered access to the practice's clinical and practice management system, rather than for the records relating to the claims under audit. No limitation on scope, no restriction on use, no undertaking as to retention or destruction, and no safeguard of any kind was offered or, so far as I could establish, existed. Access of that character

does not obtain the audited claims. It obtains the practice: the full patient list, the treatment and recall history of every patient whether or not they were the subject of a claim under audit, fee structures, referral sources, appointment and utilisation patterns, and clinician-level records.

4.2 The National Board's determination and its treatment

The Notifications Committee of the Dental Board of Australia, via AHPRA, determined in November 2024 to take No Further Action in respect of the underlying conduct that the Insurer had notified. The determination is the National Law's formal outcome on the underlying conduct the Insurer had alleged.

The Insurer did not, on the material available to me, notify me of the AHPRA determination. The Insurer did not modify or reconsider the Unacceptable Provider Declaration in light of the statutory Board's determination. The appeal against the Declaration was rejected in May 2025 — approximately six months after the AHPRA determination — without the appeal-rejection correspondence engaging with the statutory Board's contrary finding. The Insurer's fund rule expressly permits the Insurer to disregard the view of the relevant statutory Board ("the Insurer may have regard to, but is not obliged to have regard to, how a court, relevant statutory board or tribunal or professional association may view the facts under consideration").

Three points follow, and I put them as governance propositions rather than as complaints. First, the statutory Board and the Insurer were considering the same material: the conduct the National Board assessed was the conduct the Insurer had itself notified, arising from the same audit. Second, the Insurer was not bound by the outcome. A National Board determination to take no further action resolves the statutory professional-conduct question; it does not determine every contractual, billing or fund rule question that an insurer may separately consider, and an insurer may legitimately reach a different conclusion on a different question. Third, and this is the prudential point, nothing in the material available to me indicates that the entity identified what different question it was deciding, recorded reasons for departing from the statutory outcome on the shared material, obtained independent clinical or legal review before doing so, or revisited the Declaration at all. The determination was simply maintained, and the appeal determined without reference to it.

The distinction matters because the first two points are unremarkable and the third is not. An entity that considers a contrary statutory determination and gives reasons for reaching a different conclusion on a different question is exercising judgement, and its Board can see that it has. An entity whose process produces no record of having considered it at all leaves its Board unable to know whether judgement was exercised or the determination was simply never read. CPG 510 should indicate that where a court, regulator or National Board has made a determination on conduct that an entity has itself notified, and the entity maintains an adverse determination of its own on the same material, the entity is expected to document the distinct question it says it is deciding, its reasons for the different conclusion, the independent review obtained, and the steps taken to ensure its communications do not imply that the statutory body made an adverse finding.

4.3 The corporate structure context

The Insurer is the corporate parent of a group that includes a dental subsidiary operating multiple clinics, an allied health group acquired as a wholly-owned subsidiary in FY2022, the group's physiotherapy business, an acquired regional health fund, and a second insurance brand. The Insurer's own Annual Reports over the period covered by this matter document the strategic character of this configuration, including CEO statements describing the dental subsidiary as among the fastest-growing dental groups in its home State and referring to the leveraging of the group's investments in its dental and physiotherapy clinics.

The executive line with organisational responsibility for the payment integrity function that conducted the audit and the network-removal determination also carries responsibility for the group's dental and allied

health subsidiaries. That configuration is evident from the Insurer's correspondence and from public sources. It has not, on my review of the public record, been identified in the Insurer's annual reporting as an intragroup conflict requiring specific management under the existing prudential standards. The observation concerns the entity's disclosure and management of a structural configuration, not the conduct of any person within it.

It is directly material to Proposition 1 that this configuration — a non-regulated institution within the corporate group engaging in business activities in the same market as the regulated entity's provider counterparties — is the configuration paragraph 69 addresses, that paragraph 4(d) excludes private health insurers from it, and that on the present drafting nothing in Part B says expressly what paragraph 74(a) requires of an insurer in it.

4.4 The handling of the subsequent disclosures

Following the events described above, disclosures were made to the Insurer under Part 9.4AAA of the Corporations Act concerning the conduct described. The features of the Insurer's handling of those disclosures that bear on this submission are structural rather than particular to the matter, and are set out below without the detail that would identify it.

The Insurer engaged an external law firm to investigate the concerns, on terms framing the engagement as obtaining legal advice in relation to the alleged conduct, and asserted legal professional privilege over the resulting advice including the investigation materials and any investigation report. The interview scope proposed through the Insurer was limited to a small number of the Insurer's own senior personnel. It did not include the discloser, the operational employee whose conduct was the primary subject of the disclosures, or any of the other registered practitioners at the practice.

Response windows allowed for complex forensic questions spanning the audit and network-removal period were consistently between one and five business days. The disclosures recorded contemporaneously that those deadlines amounted to procedural unfairness and to detrimental conduct within the meaning of the Corporations Act. The Insurer rejected that position the following day, the firm proceeded on the information then available, and the Insurer's Chair subsequently wrote to close all further engagement with the disclosures on the basis that the investigation was complete.

4.5 What this worked example illustrates

The matter documented in this section illustrates, in operational form, the specific governance concerns Section 3 identifies:

- The intragroup conflict configuration operates in practice. The audit and network-removal determinations were made within a corporate structure where the same executive oversight extended to the group's competing provider subsidiaries — the configuration paragraph 65(b) addresses and from which paragraph 4(d) excludes private health insurers.
- Board oversight of decisions affecting the National Scheme's authority appears to have been minimal at the point of the original Declaration, which was signed at operational level within the payment integrity function. The Board became engaged only after sealed disclosures were sent to individual directors in late 2025, approximately twenty months after the original Declaration.
- Fitness and propriety questions arise. The personnel making clinical-outcome and professional-conduct determinations about registered practitioners were themselves not registered under the National Law. The senior personnel accountable for the audit function's operational conduct also had oversight of the competing provider subsidiaries.
- The conflicts management framework did not, on the material available to me, operate to identify and manage the intragroup conflict inherent in the corporate structure. The Insurer's Annual Reports do not disclose the dual oversight as an intragroup conflict requiring specific management.

- The use of external legal advisers to investigate the whistleblower disclosures followed the pattern the Parliamentary Joint Committee has since documented at KPMG. The engagement was framed as legal advice; the investigation materials were protected by asserted legal professional privilege; the scope excluded the whistleblower and the personnel most centrally connected to the operational conduct at issue; and the investigation outcome was used to close down all further engagement.

5. Response to specific provisions of draft CPS 510

This section responds to specific provisions of draft CPS 510 that are directly relevant to the governance concerns identified above.

5.1 Core prudential responsibilities that boards may not delegate (paragraphs 13 to 17, 21)

Paragraph 13 identifies the Board's prudential responsibilities that cannot be delegated: setting and monitoring strategic objectives, business plan and risk appetite (paragraph 13(a)); overseeing culture, including risk culture, and values, and setting a clear tone from the top (paragraph 13(b)); overseeing governance, remuneration and risk management frameworks and making the annual risk management declaration (paragraph 13(c)); overseeing financial and operational resilience (paragraph 13(e)); setting and monitoring Board, Board committee and director performance objectives (paragraph 13(f)); ensuring that directors and senior managers collectively have the skills needed for the effective and prudent operation of the entity (paragraph 13(g)); and constructively challenging senior managers (paragraph 13(h)).

Paragraph 15 provides that, subject to paragraph 13, where a prudential standard imposes a Board obligation other than those in paragraphs 13(a) to 13(h), the authority to fulfil it may be delegated to a Board committee or to senior managers. Paragraph 16 preserves the Board's responsibility for overseeing delegated obligations, and paragraph 17(d) requires that conflicts arising from or in connection with a delegation be identified and appropriately managed.

For PHI insurers, the paragraph 13 list should include explicit reference to the Board's oversight of decisions and frameworks that affect the practical operation of the National Law framework in respect of registered health practitioners. Where a PHI insurer's contractual framework can produce consequences equivalent in practical effect to adverse professional-conduct determinations by AHPRA and the National Boards, board-level oversight of that framework is a core prudential responsibility. It should not be delegable under paragraph 15 to operational personnel or to internal committees whose composition and criteria are not board-approved.

This proposal does not require APRA to prescribe the detailed content of PHI insurer provider agreements or fund rules — those matters are properly for the insurer's own operational determination. It requires that the framework itself, and the entity's operation of it, be subject to board-level oversight commensurate with the framework's actual consequences for registered practitioners, insured patients, and the public interest.

Paragraph 21 is also directly engaged. It requires a locally incorporated regulated entity to have processes in place to ensure that management information, strategy, risk appetite and conflicts are considered and recorded in all relevant decision-making. A determination that removes a group of registered practitioners from an insurer's provider network is a relevant decision for this purpose. Where the entity operates provider-side subsidiaries competing with those practitioners, paragraph 21 requires that the conflict be considered and recorded at the point of decision. CPG 510 should confirm that this is so.

5.2 Conflicts management — intragroup conflicts (paragraphs 31, 74, 75)

Paragraph 74 establishes the conflicts obligations for all regulated entities, and paragraph 75 requires a conflicts management policy applying to the entity, all responsible persons and all employees,

proportionate to and consistent with the entity's strategic objectives, risk profile, size, business mix and complexity. Paragraph 31 requires that intragroup conflicts be given specific regard in assessing director independence.

For PHI insurers with vertically integrated provider-side subsidiaries, the intragroup conflict framework should specifically require:

- Documentation of the specific intragroup conflict that arises when the same executive oversight extends to both the group's audit and network-removal functions and the group's competing provider subsidiaries, as an intragroup arrangement within the meaning of paragraph 74(a).
- Board-level identification of the conflict as an intragroup conflict requiring specific management, and assessment against paragraph 74(c), which requires avoidance where the entity reasonably concludes that a conflict cannot be effectively managed to protect policyholder interests.
- Documented conflict management measures, including separation of executive oversight where appropriate, or documented reasons why such separation is not required — as controls for the purposes of paragraph 74(b), with effectiveness assessed and monitored under paragraph 74(e).
- Register entry and board minute recording of how the intragroup conflict is managed in specific decisions affecting independent providers, under paragraphs 74(f) and 74(g) respectively.
- Disclosure in the entity's public governance reporting of the existence of the intragroup conflict configuration and the management framework applied to it. This has no counterpart in the current draft and is offered as an addition.

There is a further point on calibration, and it arises from a choice APRA has already made. The consultation paper states that APRA intends the conflicts requirements to be consistent with existing conflicts management obligations in legislation and with ASIC's Regulatory Guide 181 on managing conflicts of interest. That alignment is useful here, because RG 181 is organised around a distinction the draft standard uses but does not explain: the distinction between controlling a conflict, avoiding it, and disclosing it. Paragraph 74(b) requires controls; paragraph 74(c) requires avoidance where the entity reasonably concludes the conflict cannot be effectively managed to protect the interests of depositors, policyholders or beneficiaries; and paragraph 74(a) requires the identification and assessment on which any such conclusion must rest.

The question this submission raises is where, in that structure, the provider-side conflict of a vertically integrated private health insurer belongs. It is not self-evidently a controls case. Where the same corporate group both determines which independent practitioners may participate in the network and owns businesses that gain when they do not, it is at least arguable that no arrangement of reporting lines, declarations and delegations within a single group can eliminate the incentive; that is a structural feature rather than a procedural one. I do not press the conclusion, which will depend on the facts of each fund. I press the question, because paragraph 74(c) requires the entity itself to reach a view on it, and nothing in the draft or in the consultation paper suggests any private health insurer has been asked to.

CPG 510 should therefore indicate, by reference to the RG 181 framework APRA has adopted, what factors bear on whether a vertically integrated private health insurer's provider-side conflict falls to be avoided under paragraph 74(c) rather than managed under paragraph 74(b). Relevant factors would include the materiality of the related provider business to group revenue or strategy; whether the same executive line has responsibility for both the provider audit and network function and the performance of the related businesses; whether remuneration in either function is linked to outcomes in the other; the extent to which affected practitioners compete directly with the related businesses in the same geographic and clinical market; and whether the entity has any means of testing, after the fact, whether its determinations have in practice favoured the group's own businesses. Guidance of this kind would give paragraph 74(c) practical content in the one configuration where it is most likely to be engaged, and would do so using an analytical structure the sector already knows.

This calibration would ensure that the general framework in Part B operates effectively in the specific configuration of vertically integrated PHI insurers. It should be read with Proposition 1: the intragroup limb proposed for paragraph 74 at Section 6.2 and the confirmation proposed at Section 3.4A are directed at the same gap from different sides, and either would improve the position on its own.

5.3 Conflicts management — external legal advisers, and an apparent drafting error at paragraph 35(e)

Draft CPS 510 addresses third-party expert engagement only obliquely, and in a form that appears to contain a drafting error. Paragraph 35(e) provides that a Board committee with delegated authority to fulfil a board obligation must, if choosing to engage third-party experts, have the power to do so "in a manner that ensures that the engagement, including any advice received, is independent of the Board."

Independence of the Board appears not to be the intended requirement. A Board committee is a creature of the Board; advice procured to assist the Board in discharging its oversight function is not improved by being independent of it. The evident purpose of the provision — and of the analogous provision at paragraph 121(f), which requires only that the engagement "is independent", without the qualifier — is to secure independence from senior managers, whose conduct the committee may be examining. I respectfully suggest that paragraph 35(e) should read "is independent of senior managers of the entity", or words to that effect.

The correction is not merely technical. Paragraph 35(e) is the only provision in the draft standard that addresses the independence of an external engagement procured to inform a Board committee. In its current form it does not secure independence from the management whose conduct is under examination, which is precisely the risk the current national conversation on external law firm investigations has surfaced.

Beyond that correction, the conflicts management framework should require that where an external legal adviser is engaged to investigate whistleblower disclosures or adverse conduct concerning the entity, the engagement architecture is considered as a potential conflict-of-interest matter. Specifically:

- The engagement of an external legal adviser under a legal-advice engagement parameter for such investigations should be identified in the entity's conflicts register under paragraph 74(f).
- The scope of the engagement should be reviewed by the Board or a Board committee for consistency with the investigation's stated purpose.
- Where the investigation's scope excludes categories of witnesses that would ordinarily be considered central to a genuine investigation — including the whistleblower and the personnel most directly connected to the alleged conduct — the exclusion should be specifically justified in board records, and the justification minuted under paragraph 74(g).
- The interaction between the assertion of legal professional privilege over the investigation outcome and the entity's obligations under Part 9.4AAA of the Corporations Act should be documented and reviewed by the Board.

These requirements connect directly to paragraphs 95 to 101. Paragraph 99 prohibits a regulated entity, and requires it to ensure its subsidiaries do not, constrain, impede, restrict or discourage — whether by confidentiality clauses, policies or other means — any person from disclosing information or providing documents to APRA about the matters referred to in paragraphs 95 and 96. Paragraph 100 extends the prohibition to prospective, current and former officers, employees and contractors, expressly including professional service providers. Paragraph 101 requires that internal policies and contractual arrangements do not explicitly or implicitly restrict or discourage auditors or other parties from communicating with APRA.

CPG 510 should address the interaction between an assertion of legal professional privilege over an investigation report and the non-constraint obligations at paragraphs 99 to 101, and should confirm that paragraph 93(g)(i) — which requires processes, systems and controls to encourage any person to disclose information that may be relevant to a fit and proper assessment to the entity or to APRA — is not satisfied by a disclosure channel that is closed following a privileged investigation.

These provisions would not prevent legitimate use of external legal advice. They would ensure that the specific configuration identified as a pattern of concern in the current national conversation is subject to the conflicts management discipline that Part B is designed to establish.

5.4 Fitness and propriety — assessment criteria (paragraphs 77, 82, 84 to 87)

Paragraph 77 requires a regulated entity to take all reasonable steps to ensure its responsible persons are fit and proper. Paragraph 82 requires the entity to clearly define and document the competencies required for each responsible person position. Paragraph 84 sets the criteria — skill, character, care, diligence, honesty, integrity and judgement (paragraph 84(a)); suitable education, technical qualifications and experience (paragraph 84(b)); and, for a director or SOOA role, time and capacity (paragraph 84(c)). Paragraph 86(c) requires consideration of the findings of any court, tribunal, regulator, board, arbitrator, public inquiry or other body whose responsibility it is to make findings of the relevant kind. Paragraph 87 requires the entity to demonstrate a rigorous process and verified information, including making all reasonable enquiries and collecting sensitive information as defined in the Privacy Act 1988.

Paragraph 86(c) is, in my submission, already wide enough to capture most of what is needed. What is missing is not the criterion but the guidance. CPG 510 should confirm that, for private health insurers, paragraph 86(c) extends to:

- The accountable person's discharge of responsibilities in relation to whistleblower disclosures under Part 9.4AAA of the Corporations Act, the proper handling of which is a core indicator of the character, integrity and judgement criteria at paragraph 84(a).
- Adverse conduct notifications concerning the entity's operational conduct, including notifications from ASIC, the ACCC, PHIO and AHPRA, and from professional bodies.
- Determinations of AHPRA and the National Boards under the Health Practitioner Regulation National Law, which are findings of a "board … whose responsibility it is to make findings of the relevant kind" within the ordinary meaning of paragraph 86(c), and which should be treated as such where the entity has itself made or maintained a contrary characterisation of the same conduct.
- Findings of parliamentary inquiries, which fall within the "public inquiry" limb of paragraph 86(c).

A distinct question arises as to whose fitness is assessed. Paragraph 8(b) defines "responsible person" by reference to Accountable Persons under the FAR Act, the CRO or equivalent, the auditor, the actuary and, for RSE licensees, the secretary — a list that does not reach operational personnel exercising provider-facing determinative functions. Paragraph 8(b)(vi), however, permits APRA to determine that a person is a responsible person where APRA is satisfied that the person makes, or participates in making, decisions that affect the whole or a substantial part of the business of the regulated entity, or has the capacity to significantly affect the entity's financial standing. Where an individual exercises the audit, evidence-collation, determination, notice-issuing, appeal-gatekeeping and appeal-review functions in relation to an entity's provider network, that discretion is available. CPG 510 should indicate the circumstances in which APRA would consider exercising it.

I note for completeness that "auditor" throughout the draft standard means the appointed financial auditor within the meaning of paragraph 8(i), and that the internal audit function at paragraphs 42 to 44 evaluates the adequacy and effectiveness of the entity's financial and risk management frameworks. Neither reaches clinical or payment-integrity audit of provider claims. The absence of any prudential provision governing that function is itself the gap this submission identifies.

One further point on Part C, and it answers an objection I anticipate. It may be said that the competence of operational personnel conducting provider audits is not a Part C question at all, since those personnel are not responsible persons and the narrowing of the cohort at paragraph 8(b) puts them further outside it. That is correct as far as it goes, and I do not argue otherwise. But it does not follow that the question is outside Part C. It follows that the question arrives in Part C one level higher up.

The chain is short and rests entirely on provisions already in the draft. Paragraph 13(g) makes it a responsibility the Board may not delegate to ensure that directors and senior managers collectively have the skills needed for the effective and prudent operation of the entity. Under the Financial Accountability Regime, the accountable person in whose accountability area a function sits must act with due skill, care and diligence and take reasonable steps in relation to it. Paragraph 8(b)(i) makes that accountable person a responsible person for the purposes of this Prudential Standard, and paragraph 84(a) requires the entity to be satisfied that a responsible person possesses the skill, care, diligence and judgement to perform properly the duties of the position. Paragraph 77 requires the entity to take all reasonable steps to ensure that is so.

Put those together and the position is this. Whether an entity permits determinations characterising the conduct of registered health practitioners to be made by personnel without the professional qualification the characterisation calls for is not merely an operational matter. It is evidence going to whether the accountable person in whose area that function sits has exercised due skill, care and diligence, and to whether the Board has discharged its paragraph 13(g) responsibility. The competence of the function travels upward to the persons who are in scope, even though the personnel conducting it are not. CPG 510 should say so, because on the present drafting an entity could reasonably read the narrowed cohort as putting the whole subject beyond Part C, which I do not think is what APRA intends.

I should be precise about what I do not say. The National Law does not prohibit an insurer from forming a view about whether treatment was clinically appropriate for the purpose of paying a benefit, and nothing in this submission suggests otherwise. What the National Law does is confer on the National Boards the function of determining whether a practitioner has engaged in unprofessional conduct or professional misconduct, as those terms are defined, through a process carrying notice, a right to respond, an impartial decision-maker and reasons. The governance concern is not that a private entity has trespassed on a statutory jurisdiction. It is that where a private determination is expressed in language a practitioner or patient would read as a professional-conduct finding, it produces the practical consequence of one without any of the procedure that attends the statutory version — and that the entity's Board is presently not required to know that this is happening.

5.5 Fitness and propriety — reassessment triggers (paragraphs 88 to 92)

Paragraph 88 requires a regulated entity that becomes aware of information which may result in a responsible person no longer meeting the fit and proper criteria to take all reasonable steps, in a timely manner, to determine whether a material fitness and propriety concern exists, and to conduct a reassessment where it does. Paragraph 89 sets the minimum triggers: reasonable grounds to believe the individual may not be meeting minimum fitness or propriety expectations (paragraph 89(a)); is the subject of allegations of misconduct or has behaved in a manner inconsistent with the entity's code of conduct (paragraph 89(b)); or has been subject to adverse findings in criminal, civil or professional proceedings (paragraph 89(c)). Paragraph 90 preserves APRA's power to require a reassessment. Paragraph 92 requires notification to APRA within 10 business days of an adverse assessment.

Paragraphs 89(b) and 89(c) already reach much of what follows. What CPG 510 should confirm, for private health insurers, is that the triggers extend to:

- Adverse findings by another Commonwealth regulator against the entity or the accountable person.
- Parliamentary examination findings adverse to the entity or the accountable person.

- Judicial findings adverse to the entity or the accountable person in proceedings involving the entity's conduct toward providers, insured patients, or whistleblowers.
- Formal notifications by professional bodies — such as the Australian Dental Association, Australian Medical Association, Australian Physiotherapy Association or Australian Private Hospitals Association — concerning the entity's conduct.
- Notifications under Part 9.4AAA of the Corporations Act that concern the accountable person's own responsibilities.

5.6 Interaction with the Financial Accountability Regime

The two regimes are already interlocked at the definitional level. Paragraph 8(b)(i) makes an Accountable Person, as defined in section 10 of the Financial Accountability Regime Act 2023, a responsible person for the purposes of this Prudential Standard, and footnote 5 confirms that a CRO or equivalent may also be an Accountable Person. Paragraph 81 requires annual validation of a responsible person's fitness and propriety following appointment, which for directors must have regard to directors' performance objectives and the Board skills matrix.

The alignment between CPS 510 and FAR should ensure that:

- The reasonable-steps obligations under FAR are supported by the all-reasonable-steps standard at paragraph 77 and the assessment criteria at paragraphs 84 to 87, so that failure to take reasonable steps in the discharge of accountable person responsibilities engages both frameworks.
- The obligation under FAR to deal with APRA and ASIC in an open, constructive and cooperative way is supported by paragraph 14 (directors and senior managers available to meet APRA on request) and by the non-constraint requirements at paragraphs 95 to 101.
- The obligation under FAR to prevent matters from arising that would adversely affect the prudential standing or reputation of the entity is supported by the conflicts framework at paragraph 74, so that intragroup conflict configurations giving rise to reputational and prudential risk are subject to identified oversight.

5.7 Non-constraint and provider agreements — paragraphs 99 to 101

Paragraphs 99 to 101 are, in my submission, among the most consequential provisions of the draft standard for the private health insurance sector, and their reach into contractual arrangements with providers warrants specific attention in CPG 510.

Paragraph 99 requires that a regulated entity must not, and must ensure that its subsidiaries do not, constrain, impede, restrict or discourage any person — whether by confidentiality clauses, policies or other means — from disclosing information or providing documents to APRA about the matters at paragraphs 95 and 96. Paragraph 100 extends the prohibition to prospective, current and former officers, employees and contractors, expressly including professional service providers. Paragraph 101 requires that internal policies and contractual arrangements not explicitly or implicitly restrict or discourage communication with APRA.

Provider agreements in this sector routinely contain confidentiality provisions, restrictions on standing to bring proceedings, and arbitration requirements. A contracted health practitioner may fall within paragraph 100 as a contractor or professional service provider of the entity, though the classification will turn on the particular arrangement. Paragraph 99, which applies to any person, and paragraph 101, which applies to contractual arrangements, do not depend on that classification. Where such terms operate to constrain or discourage a practitioner from raising matters with APRA — including matters going to whether a responsible person is fit and proper (paragraph 95) or whether the entity has complied with this Prudential Standard (paragraph 96) — paragraphs 99 to 101 are engaged on their face.

Two things follow. First, board-level oversight of provider agreement terms that affect a practitioner's ability to communicate with APRA or seek external remediation should be treated as a governance framework matter under paragraphs 11 and 12, not left to commercial contracting. Second, CPG 510 should confirm that a contracted health practitioner falls within paragraph 100, and should indicate what review of standard-form provider agreements APRA expects entities to undertake against paragraph 101 before commencement.

5.8 Responses to APRA's consultation questions

APRA has posed six questions. I respond to each in turn, from the perspective of a provider counterparty of an APRA-regulated entity rather than that of a regulated entity itself. Where a question falls outside what I am positioned to answer, I say so rather than pass over it.

Question 1 — Proportionality and transition. The draft achieves proportionality principally through the significant financial institution distinction and through the industry carve-outs at paragraph 4. In the private health insurance sector the carve-out at paragraph 4(d) is, in my submission, the wrong instrument: it operates by entity class rather than by structural complexity, and so exempts precisely the vertically integrated funds whose structures generate the conflicts the group governance provisions address. The paragraph 74 limb proposed at Section 6.2 delivers proportionality more accurately, because it attaches to the structure rather than to the class. On transition, I do not consider any transitional arrangement necessary for that proposal: an entity that already maintains a conflicts register and policy can accommodate the limb within its existing annual review cycle before the 1 January 2028 commencement.

Question 2 — Reviews and assessments. The scope of the annual and independent performance assessments at paragraphs 51 and 54 is, in my submission, appropriately drawn, and the flexibility to combine reviews is sensible. I raise one caution about combination. Paragraph 74(j) permits the annual review of the conflicts management policy to be incorporated into the board performance assessment or, for entities other than RSE licensees, into the review of the risk management framework. Paragraph 94(d) permits the annual review of the fit and proper policy to be folded into the same exercise. Where an entity combines all three, the conflicts review is conducted by whoever is conducting a board performance assessment. Paragraph 74(j) requires that reviewer to be operationally independent, appropriately trained and competent, but a reviewer selected for competence in board effectiveness is not necessarily competent to evaluate whether an intragroup conflict has been correctly identified and controlled. CPG 510 should confirm that where reviews are combined, the competence requirement in paragraph 74(j) is assessed against the conflicts subject matter and not satisfied by the reviewer's general governance credentials.

Question 3 — Fit and proper streamlining and FAR alignment. I do not oppose the removal of routine fit and proper reporting where FAR reporting covers the same individuals, and the narrowing of the responsible person cohort is a defensible simplification. I raise one unintended consequence. The narrowed cohort — accountable persons, auditors, actuaries and RSE licensee secretaries — excludes operational personnel who exercise determinative functions over third parties. The individuals whose conduct this submission describes are captured by neither regime: not Accountable Persons under FAR, and not within paragraph 8(b). Streamlining that reduces duplication between two regimes does not reach a function that sits outside both, and narrowing the cohort moves the boundary further from it. Paragraph 8(b)(vi) preserves the remedy, and CPG 510 should indicate when APRA would exercise it.

Question 4 — Areas where further detail in guidance would assist. In order of priority: whether a provider-network decision engages policyholder interests for the purposes of paragraphs 8(f)(ii) and 74(b); the circumstances in which APRA would exercise the paragraph 8(b)(vi) discretion; the application of the complexity limb of the significant financial institution definition in CPS 001 to vertically integrated private health insurers; whether a contracted health practitioner falls within paragraph 100; the

interaction between asserted legal professional privilege and the non-constraint obligations at paragraphs 99 to 101; and the competence question at Question 2 above.

Question 5 — Compliance costs and net impact. I am not a regulated entity and cannot produce a Regulatory Burden Measurement Framework estimate on the industry side. I can, however, be specific about the marginal burden of what I propose, measured against APRA's own inventory. Every artefact the paragraph 74 limb would touch already appears in Attachment B to the consultation paper: the register of actual and potential conflicts together with the associated controls; the conflicts management policy; the board and committee minutes documenting conflicts and how they were avoided or managed; and the annual review of the conflicts management policy, which Attachment B records as an existing requirement under CPS 220 and SPS 521. The limb creates no new artefact, no new policy, no new register and no new review. Its marginal cost is the assessment itself, incurred only by those private health insurers that in fact own entities providing services claimable against their own policies — a small subset of the class — and arguably already required by paragraph 74(a) as drafted. The proposal creates no new prescribed artefact. It is likely to impose limited and incremental implementation and assurance costs — mapping the related provider businesses and decision pathways, revising the existing conflict assessment, and any consequential change to Board reporting — on the subset of private health insurers with relevant provider businesses. Those entities are best placed to quantify them, and I would expect an affected entity to be able to confirm or correct my assessment from its own cost base. APRA records in the consultation paper that initial estimates suggest the reform is, in aggregate, broadly cost-neutral for industry. Nothing in this proposal is intended to disturb that assessment: it adds no prescribed artefact to the inventory at Attachment B, and applies only to the subset of private health insurers that own provider businesses. As APRA requests, I state the limitations of my own assessment: I am not a regulated entity, I have no visibility of insurers' internal cost structures or existing conflicts processes, and I have not applied the Regulatory Burden Measurement Framework methodology, which I am not positioned to apply meaningfully from outside the regulated population.

Question 6 — Artificial intelligence governance. This is, in my submission, the question on which the private health insurance sector presents the most immediate and least examined risk, and I address it at Section 5.9 below rather than briefly here.

5.9 Automated and algorithmic decision-making in provider integrity functions

APRA's consultation paper identifies artificial intelligence as an area where technology is increasingly embedded in decision-making and operations, and asks whether the draft requirements adequately support its oversight and use. I offer one application that I do not expect to be raised by other respondents, because it is visible principally from the receiving end.

Payment integrity and provider audit functions in this sector operate at a scale that makes case-by-case human selection impractical. Where analytic or algorithmic methods are used for that purpose — and I do not assert that every entity uses them — claims data is compared across a provider population and outliers identified by reference to peer billing patterns, item number frequency, treatment mix or patient demographics. A practitioner selected in this way is then audited, and may be the subject of a determination affecting their participation in the network. The selection layer is automated; the determination that follows is characterised as a human decision. I do not suggest that analytic selection is improper. It is a rational response to volume, and no doubt detects genuine irregularity. The governance question is what sits between the flag and the determination.

Four matters warrant treatment in CPS 510 or CPG 510:

First, model validation and its ownership. Where an outlier model informs decisions with consequences for a registered professional's livelihood, the entity should be able to demonstrate that the model has been validated, that its error characteristics are understood, and that a false-positive rate is known and monitored. A clinically atypical practice — a practice serving an unusual patient population, or with an

unusual case mix — is by construction an outlier. A model that cannot distinguish atypical from improper may generate disproportionate false-positive flags, and adverse outcomes for practitioners whose only distinguishing feature is an unusual but legitimate practice profile. This engages paragraph 13(c), oversight of the risk management framework, and paragraph 45(a), the Risk Committee's oversight of internal control systems.

Second, the substance of human review. Where the material presented to a decision-maker consists of a model output and the evidence gathered to substantiate it, the decision is human in form and automated in substance. CPG 510 should indicate that a governance framework satisfying paragraphs 11 and 12 requires a documented point at which a person exercises independent judgement on the merits, with access to material capable of displacing the model's inference and not only material supporting it.

Third, the competence of the reviewer. The concern at Section 6.8 — that clinical and professional-conduct characterisations should be made by persons registered under the National Law in the relevant profession — is sharper where the input is statistical. A statistical deviation is not a clinical finding, and the translation from one to the other is a matter of professional judgement. Paragraphs 82, 84(a) and 84(b) provide the framework for requiring that the person making it is competent to do so.

Fourth, disclosure to the affected practitioner. A practitioner told that an audit arose from a review of their claiming, but not that the review began with an algorithmic comparison against a peer population, cannot meaningfully respond to the basis of the concern. Where an automated process initiated a determination, the affected person should be told so. This is a natural justice point of the kind developed at Section 6.9, and it costs the entity nothing but the disclosure.

This is not a speculative risk profile. It has already materialised in this sector. In the proceedings described at Section 3.7, the ACCC's statement of the conduct admitted by an APRA-regulated private health insurer records that its automated claims assessment systems were programmed in a way that incorrectly rejected claims of two identified categories, generating representations to members, hospitals and medical providers that no benefit was payable when benefits were payable for the covered component. The conduct ran from May 2018 to August 2023. The conduct the Court declared unconscionable was narrower and more instructive: for a period of some eight months the insurer ceased conducting the manual review of claims that the automated system had assessed as attracting no benefit, in circumstances that included its knowing manual review was necessary to identify claims the system had assessed wrongly. The human layer was removed from an automated adverse determination process known to produce incorrect outcomes. I note that the insurer concerned is the second largest in the Australian market, with an approximate 25.5 per cent share and some 4.5 million members: this was not a small entity with thin controls.

I do not suggest the facts are the same as those at Section 4. That case concerned claims assessment affecting members; this submission concerns audit and network determinations affecting practitioners. The affected class differs. The mechanism does not: an automated process generates an adverse determination, the review layer that would catch its errors is absent or nominal, and the error propagates at scale before anyone external to the process detects it. The consequences in that case included members who delayed, cancelled or went without treatment for which they were at least partly covered, and providers and hospitals who did not receive payments to which they were entitled — a concrete illustration of why a systems failure of this kind engages policyholder interests for the purposes of paragraphs 8(f)(ii) and 74(b), and falls within the non-financial limb of the CPS 001 definition of material risks. The governance controls proposed above are directed at the conditions that allowed it to run for five years.

These matters are not peculiar to provider integrity functions, and APRA may prefer to address them at a level of generality that captures other applications of automated decision-making by regulated entities affecting third parties. The private health insurance case is offered because it is one where the consequences of an unexamined model fall outside the entity, on persons who are not its customers and

have no visibility of the process, and who are therefore unlikely to appear in the entity's own risk reporting.

6. Suggested strengthenings and drafting proposals

This section sets out specific drafting suggestions for the final CPS 510 and for the accompanying prudential practice guide CPG 510. The suggestions are directed at ensuring that the general framework CPS 510 establishes operates effectively in the specific configuration of vertically integrated PHI insurers.

6.1 Suggested guidance on paragraphs 15 to 17 — tiered oversight of provider-affecting decisions

Rather than an addition to the non-delegable list at paragraph 13, CPG 510 should indicate what paragraphs 15 to 17 require of a delegation covering decisions that materially affect a third party's capacity to practise their profession in the insured segment of the market. The tiered model at Proposition 2 sets out the elements. In drafting terms, the guidance would confirm that a delegation of this character is one in which paragraph 17(b) requires materiality thresholds to be set by reference to the consequences for affected third parties as well as to the entity's own exposure; paragraph 17(c) requires monitoring sufficient to identify patterns rather than only individual escalations; and paragraph 17(d) requires that conflicts arising from or in connection with the delegation — including conflicts arising from the group's ownership of competing provider businesses — are identified and managed at the point the delegation is made, not only when an individual decision is challenged.

6.1A Suggested guidance on paragraphs 20 to 22 — management information on provider-affecting functions

Paragraph 20 requires a policy setting out the Board's expectations for management information, covering expected content, quality and frequency. Paragraph 21 requires processes ensuring that management information, strategy, risk appetite and conflicts are considered and recorded in all relevant decision-making. Paragraph 22 requires senior managers to brief the Board effectively with succinct and relevant information. These provisions are, in my submission, among the most useful in the draft for the concern this submission raises, because the Board's inability to challenge a function it cannot see is a reporting problem before it is anything else.

For a private health insurer with material provider-audit and network functions, CPG 510 should indicate that Board and Risk Committee reporting sufficient to satisfy paragraphs 20 to 22 would ordinarily include, in aggregate and by exception:

- Audits initiated, and the basis on which providers were selected, including whether selection was analytic or referral-driven.
- Determinations made, recoveries sought and recovered, and network removals — including any bulk or prospective declarations and the number of practitioners covered.
- The number of policyholders affected by removal decisions, and the continuity-of-care consequences identified.
- Appeals lodged, and outcomes — upheld, reversed or modified.
- Referrals to and determinations by courts, regulators and National Boards, and any inconsistency between those outcomes and the entity's own determinations.
- Complaints concerning procedural fairness, privacy or clinical autonomy arising from the function.
- Where the group owns competing provider businesses, any observable redirection of affected members to those businesses following a removal.

- Conflicts declared in connection with the function and how they were managed.
- Disclosures made under the entity's whistleblower arrangements concerning the function.
- Legal proceedings, settlements and their trend.
- Where automated systems contribute to selection or determination, model performance and error rates (see Section 5.9).

The proposition this supports is narrow and, I think, difficult to argue with: a Board cannot constructively challenge senior managers under paragraph 13(h) about a function whose outputs it does not receive.

6.1B Remuneration as a conflicts category — paragraphs 74(a) and 46

Paragraph 74(a) requires identification and assessment of conflicts arising from structural, funding and remuneration arrangements. This submission has so far relied on the structural limb. The remuneration limb warrants separate treatment, because remuneration is ordinarily the mechanism by which a structural conflict becomes an operative one. A conflict that exists on an organisation chart changes behaviour when it is priced.

CPG 510 should indicate that a private health insurer's conflicts assessment under paragraph 74(a) examines whether remuneration, incentive or performance measures applying to personnel in provider-audit, payment-integrity or network functions, or to the executives to whom they report, are linked to:

- Claims savings, avoided benefit outlay, or amounts recovered from providers.
- Audit volumes, or audit "success" rates measured by determinations made rather than by determinations sustained.
- The number of providers removed from, or declined entry to, the network.
- Growth, revenue, patient volume or profitability of a provider business within the group.
- Member conversion or referral to a provider business within the group.

Paragraph 46(b) already requires the Board Remuneration Committee to consult the Risk Committee and the CRO through a documented process so that risk outcomes are appropriately reflected in remuneration outcomes, and paragraph 46(d) requires guidance to senior managers on the level and timing of risk adjustment. CPG 510 should confirm that, for entities in this configuration, the risk outcomes to be reflected include determinations subsequently overturned on appeal or inconsistent with a later regulator or National Board finding; substantiated complaints of procedural unfairness or privacy breach; and conflicts identified as having been unmanaged. Where a measure of the kind listed above applies without such adjustment, the entity is paying for an outcome it has no mechanism to verify was correctly reached.

6.1C Internal audit and Board skills — paragraphs 42 to 44 and 47 to 49

Paragraph 42 requires an independent and adequately resourced internal audit function evaluating the adequacy and effectiveness of the entity's financial and risk management frameworks, and paragraph 43 gives it unfettered access to business lines and support functions. Where provider-audit and network decisions represent a material risk, CPG 510 should indicate that periodic internal audit coverage of the function would ordinarily examine sample selection and data integrity; the qualifications of those conducting reviews and making characterisations; segregation of investigation, determination and appeal; compliance with the delegations approved under paragraph 17; conflict declarations; the treatment of contrary external findings; member communications; record retention and document-change controls; and the implementation of accepted remediation.

Paragraphs 47 to 49 require the Board to document required skills in a matrix with clear assessment criteria, and to demonstrate how it is addressing current and future capability gaps, having regard to the entity's business mix and complexity. For a private health insurer that owns provider businesses and

makes determinations affecting registered practitioners, the collective capability required plainly includes healthcare delivery and provider contracting, clinical governance, privacy and health-record governance, and the technology capability relevant to automated decision-making discussed at Section 5.9. This is a more natural and more proportionate response to the concerns in this submission than treating operational reviewers as responsible persons.

6.1D Lawful information demands and system access in provider audits — paragraphs 12, 17 and 74

The material at Section 3.8A discloses a governance failure mode distinct from those addressed elsewhere in this submission, and one that CPG 510 can address without any amendment to the standard. Where an insurer's audit protocol requires a contracted practitioner to produce patient records beyond the episode of treatment under audit, or without patient consent, it requires the practitioner to do something the Privacy Act 1988 and their obligations of confidence under the National Law and the National Boards' shared Code of Conduct may prohibit. The practitioner is placed between a contractual demand and a legal obligation, with financial consequences attached to choosing the latter. That is not a conflict the practitioner created; it is one the entity's own governance framework has produced.

It is also a policyholder matter, and not incidentally. The records being sought are the members' own health records, and they are being sought beyond the scope to which the member has consented. Paragraph 74(b) requires conflicts controls calibrated to the potential impacts on the interests of policyholders, and the CPS 001 definition of material risks for private health insurers extends to non-financial impacts on policy holders' interests. A protocol that obtains members' clinical histories beyond consent engages both.

A second and, in my submission, more serious question arises where the entity demanding that access is a vertically integrated insurer. Information obtained in an audit does not remain with the audit function; it enters the entity, and in a vertically integrated group the entity owns businesses competing with the practitioner from whom it was obtained. Patient lists, treatment and recall patterns, fee structures, referral sources and utilisation data are confidential business information of direct commercial value to a competitor in the same market. The concern is not that any entity has misused such information — I make no such allegation, and I am not in a position to know. It is that the ordinary controls for conflicts of this kind, being separation of function, reporting lines and declarations, do not address it. Once information of that character is inside the group, no arrangement of internal reporting can restore the position that existed before it arrived. That is the character of a conflict that paragraph 74(c) contemplates avoiding rather than managing, and it is a concrete instance of the question I raise at Section 5.2.

The policyholder dimension is equally direct. System-level access exposes the records of every patient in the practice, including patients who were not the subject of any claim under audit and who have consented to nothing. Many of those patients are the entity's own members. Paragraph 74(b) requires controls calibrated to the potential impacts on the interests of policyholders, and the CPS 001 definition of material risks for private health insurers extends to non-financial impacts on policy holders' interests. A demand of that scope engages both, and does so at a scale unrelated to the matter under audit.

CPG 510 should accordingly indicate that a governance framework satisfying paragraphs 11 and 12, and a delegation satisfying paragraph 17, would ordinarily include a Board-approved audit protocol that: limits information requests to what is reasonably necessary to verify the claim under audit; identifies the lawful basis for each category of information sought, whether valid patient consent or another basis authorised under the Australian Privacy Principles; does not require or induce a practitioner to act inconsistently with their obligations under the Privacy Act or the National Law; records the consent position for each request; specifies the mode of access, and in particular whether the entity seeks the production of identified records or access to the practitioner's clinical or practice management system, the latter requiring separate justification, scope limitation, and undertakings as to use, retention and destruction; and provides an escalation path where a practitioner declines on stated legal grounds, rather than a financial

consequence. Where the entity or a related body corporate provides services in competition with the practitioner, the protocol should further address what information obtained in the audit may be retained, who within the group may access it, and how the entity satisfies itself that it is not used for any purpose beyond verifying the claim under audit. Where an entity relies on a provider agreement term to obtain information a practitioner cannot lawfully provide, that reliance should be identified and assessed as a conflict under paragraph 74(a) and recorded under paragraph 74(f).

6.2 Suggested amendment to paragraph 74 — an intragroup limb for private health insurers, and an alternative route through paragraph 4(d) and CPS 001

The primary proposal is an addition to paragraph 74, which applies to all regulated entities including private health insurers, to the following effect:

> *(k) where the regulated entity is a private health insurer and the insurer, or a related body corporate of the insurer within the meaning of section 50 of the Corporations Act 2001, provides health services for which benefits may be payable under a complying health insurance product of the insurer, identify and assess any actual or potential conflict between the commercial interests of that provider business and the interests of, or duties owed to, policyholders arising from the insurer's audit, contracting and network-participation decisions affecting non-related providers of comparable services, and manage or avoid that conflict in accordance with paragraphs (b) and (c).*

This formulation is deliberately narrow. It attaches only where a fund actually owns entities competing with its own provider counterparties, and leaves unintegrated funds unaffected. It does not require APRA to prescribe the content of provider agreements or audit methodology. It imposes no new artefact: conflicts identified under the limb are recorded in the register already required by paragraph 74(f), managed under the policy already required by paragraph 75, minuted under paragraph 74(g), and reviewed annually under paragraph 74(j). The marginal compliance cost is the assessment itself, which paragraph 74(a) arguably already requires and which this limb makes explicit.

If APRA prefers to address the matter through the group governance provisions instead, the exclusion at paragraph 4(d) can be narrowed, but a companion amendment to CPS 001 is required. Paragraph 4(d) would read to the following effect:

> *(d) paragraphs 63 to 71 (Part A) apply only to locally incorporated regulated entities except for RSE licensees and, subject to paragraph 4(f), private health insurers;*
>
> *(f) paragraphs 64, 65 and 69 apply to a private health insurer that is the head of a corporate group in which an institution that is not a regulated entity provides health services for which benefits are payable under the private health insurer's complying health insurance products.*

CPS 001 would require a corresponding entry, since "head of a group" is presently defined only for authorised deposit-taking institutions and general insurers by reference to a Level 2 Head or Level 3 Head. A formulation to the following effect would suffice, though APRA will have its own preference:

> *[PHI] head of a corporate group means the private health insurer that is not itself a subsidiary of another company within the corporate group of which it is a member.*

This route is coherent but more expensive, both for APRA in drafting and for entities in implementation, because it brings with it the group internal audit function at paragraph 66 and the group Board committees at paragraph 67. It also requires APRA to revisit a provision that section 2.6 of the consultation paper identifies as substantively unchanged from the current framework. The Part B limb achieves the conflicts outcome this submission is concerned with at materially lower cost, sits inside a Part APRA is already redrafting for private health insurers, and is the proposal I would urge.

6.3 Suggested amendment to paragraph 35(e) and additions on external legal adviser engagements

Paragraph 35(e) should be corrected to require independence from senior managers rather than from the Board, for the reasons set out at Section 5.3. In addition, the conflicts management framework should include express reference to the engagement of external legal advisers for investigations of whistleblower disclosures and adverse conduct concerning the entity itself, requiring:

- Identification in the conflicts register maintained under paragraph 74(f).
- Board or committee review of the engagement scope.
- Specific justification of exclusions from the investigation scope where those exclusions relate to categories of witnesses — including the whistleblower and personnel most directly connected to the alleged conduct — that would ordinarily be considered central to a genuine investigation, minuted under paragraph 74(g).
- Documented consideration of the interaction between asserted legal professional privilege over the investigation outcome and the entity's obligations under Part 9.4AAA of the Corporations Act and under paragraphs 99 to 101.

6.4 Suggested guidance on paragraph 86 — fitness and propriety assessment criteria

Paragraph 86(c) already requires a regulated entity, in assessing fitness and propriety, to consider the findings of any court, tribunal, regulator, board, arbitrator, public inquiry or other body whose responsibility it is to make findings of the relevant kind. I do not propose adding to that list; it is comprehensive. The gap is a mechanism rather than a criterion. Where an adverse finding concerns the conduct of the entity rather than naming an individual — as is commonly the case with regulator findings, court judgments and parliamentary inquiry conclusions — nothing in the draft requires the entity to work out whose accountability the finding engages. CPG 510 should confirm that in such a case the entity is expected to identify the responsible persons whose accountability areas encompassed the conduct, assess what those persons knew or ought reasonably to have known, and determine whether the finding gives rise to a material fitness and propriety concern requiring reassessment under paragraph 88. Guidance should equally confirm the converse: an allegation, complaint or disclosure is not itself evidence of unfitness, and what paragraph 88 requires is a documented and timely assessment of materiality and credibility, not an outcome.

6.5 Suggested additions to CPG 510 — practical guidance for PHI insurers

The accompanying prudential practice guide should include specific practical guidance for PHI insurers on:

- The application of the paragraph 74 conflicts framework, and (if paragraph 4(d) is amended) paragraph 65(b), to vertically integrated PHI groups with provider-side subsidiaries.
- Whether and when a decision affecting the composition of the provider network engages the interests of policyholders for the purposes of paragraphs 8(f)(ii) and 74(b).
- The circumstances in which APRA would consider exercising the discretion at paragraph 8(b)(vi).
- The application of the complexity limb of the significant financial institution definition in CPS 001 to vertically integrated private health insurers.
- The application of paragraph 12(b) (formal charters) and paragraph 13 (board oversight) to contractual frameworks — including fund rules and provider agreements — that deploy the National Law's conduct terminology or that permit disregard of statutory Board determinations.

- The interaction between the standard and the reform work being undertaken by the Department of Health, Disability and Ageing through the Private Health CEO Forum, including any code of conduct for insurers that emerges from that work.

6.6 Suggested guidance on paragraphs 88 and 89 — reassessment triggers

CPG 510 should confirm that the triggers at paragraphs 89(b) and 89(c) extend to the matters set out at Section 5.5, and that paragraph 88's "timely manner" requirement is engaged from the point at which the entity receives a protected disclosure concerning an accountable person's own conduct, not from the conclusion of any investigation the entity commissions into it.

6.7 Interaction with concurrent regulatory reform

The final CPS 510 will take effect from 1 January 2028. In the intervening period, several concurrent regulatory reform processes will progress, including the Department of Health's reform work through the Private Health CEO Forum, ASIC's sector-wide review of Big Four whistleblower handling announced on 9 July 2026 under compulsory information-gathering powers, and any legislative reform arising from the Parliamentary Joint Committee's ongoing examination of external law firm investigation methodologies.

APRA's finalisation of CPS 510 in late 2026 is an opportunity to ensure that the prudential governance framework it establishes is coordinated with these concurrent reforms. The specific interactions worth considering include how the paragraph 13 board oversight requirements interact with any code of conduct for insurers; how the Part B conflicts framework interacts with FAR's individual accountability regime; and how Part C interacts with any legislative reform arising from parliamentary examination of external law firm investigation methodologies.

6.8 Specific reform proposals within APRA's remit

The proposals in this subsection are offered as substantive policy input on reforms that can be addressed in the finalisation of CPS 510 and CPG 510. A coherent reform program in this area also requires coordination with the Department of Health, Disability and Ageing, the Ministerial Council on Health and the National Boards, and with Parliament. Proposals engaging those other remits are set out separately at Annexure A, so that they can be considered — or set aside — without affecting the proposals in this section.

Proposals directly within APRA's CPS 510 remit:

- A documented tiered escalation framework for provider network decisions, approved by the Board under paragraph 17, with materiality thresholds, a determination made independently of the investigation above those thresholds, and an appeal separated from both. Delegated executive structures operating without a Board-approved framework, documented thresholds and reporting back to the Board should not be recognised as adequate governance of decisions of this consequence. Set out at Proposition 2 and Section 6.1.
- A governance charter section on provider auditing. Paragraph 12(b) requires formal charters setting out the roles, responsibilities and objectives of the Board and Board committees. CPS 510 or CPG 510 should require that, for private health insurers, the governance framework addresses the governance of the provider audit function — the personnel entitled to make audit determinations, the escalation pathway, the board's oversight role, and the interaction with statutory determinations by AHPRA and the National Boards.
- Transparency of decision-makers. The identity and professional qualifications of personnel making determinations affecting the professional standing of registered practitioners should be documented, disclosed to the affected practitioner, and subject to board oversight. Paragraph 82

already requires competencies to be defined and documented for each responsible person position; read with paragraph 8(b)(vi), the framework is available.

- Structural independence of the audit function. Provider audit functions should be structurally independent of the entity's provider-side subsidiaries, with documented separation of executive oversight. This engages paragraph 74(a) to (c) and, if the paragraph 4(d) exclusion is removed, paragraph 65(b).
- Individual assessment of each provider. Determinations affecting the professional standing of registered practitioners should be made on the basis of individual assessment, and bulk determinations — including declarations extending prospectively to future practitioners at a practice — should engage specific board oversight and documented individual justification for each practitioner named. Paragraph 21 requires that conflicts be considered and recorded in all relevant decision-making; the same discipline should apply to the individual basis for each determination.
- Fit and proper personnel making clinical characterisations. Determinations characterising the conduct of AHPRA-registered health practitioners in clinical terms, or in terminology drawn from the National Law's conduct provisions, should be made only by personnel who are themselves registered under the National Law in the relevant profession. This engages paragraphs 82, 84(a) and 84(b). Dental nurses, dental practice managers, or other operational personnel who are not registered dental practitioners should not be entitled to make clinical determinations or declarations of professional misconduct concerning registered dentists. Analogous requirements should apply for other professions.
- Non-overrideability of statutory Board determinations. Where AHPRA or a National Board has made a formal determination on conduct that a PHI insurer has separately assessed, the insurer's board should be required to document its consideration of the statutory determination, consistently with paragraph 86(c), and should not be permitted to disregard or override it in ongoing corporate determinations against the practitioner.

I note expressly that the term "audit" in these proposals refers to clinical and payment-integrity audit of provider claims. It is not the financial audit function addressed at paragraphs 41 to 44 and defined at paragraph 8(i). The absence of any prudential provision governing clinical and payment-integrity audit — notwithstanding that its determinations can end a registered practitioner's participation in the insured segment of their profession — is the gap these proposals are directed at.

6.9 Prevention and remediation of natural justice violations

A foundational principle that runs through the specific reform proposals set out above, and that warrants specific treatment in CPS 510 in its own right, is the prevention of natural justice violations by APRA-regulated entities in the exercise of their functions affecting third-party registered professionals, and the remediation of such violations when they occur.

The principles of natural justice — the hearing rule and the rule against bias — are foundational principles of Australian administrative and equitable jurisprudence. Their application to private corporate decision-making that has substantial public consequences has been developed in the courts, and their engagement in the context of decisions affecting the professional standing of registered health practitioners is direct.

APRA-regulated private health insurers make determinations that have substantial and often career-affecting consequences for AHPRA-registered health practitioners. Those determinations include audit findings, network-removal decisions, bulk Unacceptable Provider Declarations, appeal-rejection decisions, and communications to insured patients characterising practitioners in terms drawn from the National Law's statutory vocabulary. Each such determination engages the prudential governance of the entity making it.

Prevention. CPS 510 should require that the governance framework maintained under paragraphs 11 and 12 includes documented natural justice protections for determinations affecting the professional standing of registered health practitioners. Specifically:

- The affected practitioner must receive adequate notice of the substance of the concerns before any determination is made, including the specific evidence relied on and the specific allegations to be considered.
- The affected practitioner must receive a reasonable opportunity to respond, calibrated to the complexity of the matter and the seriousness of the potential consequences.
- The decision-maker must be genuinely independent of the investigation and evidence-gathering functions. The concentration in a single person of the investigator, decision-maker and appellate functions is inconsistent with the rule against bias and should not be recognised as an acceptable governance arrangement. Paragraph 17(d) already requires that conflicts arising from a delegation be identified and appropriately managed.
- Where the potential consequences are substantial, face-to-face engagement between the decision-maker and the affected practitioner should be the default position, with reasons for departing from it documented.
- The appeal pathway must be independent of the initial decision-making pathway. Personnel who participated in the initial determination should not participate in the review of an appeal against it.
- Bulk determinations affecting multiple practitioners simultaneously must engage individual natural justice protections for each affected practitioner. The efficiency of a bulk process does not displace the individual right of each practitioner to be heard and to have their matter determined by an impartial decision-maker.

Remediation. CPS 510 should require that where a natural justice violation has occurred — whether identified by the entity itself, by the affected practitioner, by another regulator, by a tribunal or court, or by a professional body — the entity's governance framework provides for documented remediation. Specifically:

- The Board or an appropriate Board committee must be notified of any identified natural justice violation and must consider what remediation is required.
- Where the violation affected a determination that remains operative, the entity must consider whether the determination should be reversed, modified, or reconsidered.
- Where a statutory Board has subsequently made a determination on the same underlying conduct that differs from the entity's private determination, the entity's Board must document its consideration of that determination, consistently with paragraph 86(c), and must consider whether its own determination should be reconsidered in light of it.
- Where the violation caused financial or professional loss to the affected practitioner, the entity must consider what compensation or restoration is appropriate.
- The consideration of remediation, and the reasons for any decisions taken, must be documented in board records and available to APRA on request.

The presence or absence of natural justice violations in the entity's determinations affecting registered health practitioners, and the entity's response to such violations when identified, are directly relevant to the fitness-and-propriety assessment of the accountable persons responsible for the governance framework under which those determinations are made. CPS 510 should make that connection explicit: a pattern of natural justice violations without documented remediation is, in my submission, evidence of a failure of the all-reasonable-steps standard at paragraph 77.

I do not put this on the basis that administrative-law procedural fairness duties attach to private contractual decision-making; whether and when they do is contestable, and this submission does not need the point. I put it on prudential grounds. Given the seriousness and the public consequences of these determinations, procedural fairness safeguards — adequate notice, a genuine opportunity to respond, an impartial decision-maker, an independent appeal and documented reasons — are properly treated as governance and risk controls, whether they are required by law, by contract, or by good governance practice alone. Their inclusion in CPG 510 would formalise, within the prudential governance framework of APRA-regulated private health insurers, protections that registered health practitioners reasonably expect when their professional standing is the subject of an adverse corporate determination.

6.9A Why this is a prudential matter — unmeasured legal risk

It may be asked why procedural fairness in an entity's dealings with its provider counterparties is a matter for the prudential regulator rather than for the courts and the conduct regulators. The answer is not that the entity ought to be sued. It is that where determinations of this kind are made without written standards, without documented reasons, and without an appeal pathway independent of the original decision-maker, the entity accumulates a contingent liability that it has no means of measuring, and that its Board therefore has no means of overseeing.

An adverse determination against a contracted health practitioner is capable of giving rise to claims in contract and in tort, and to regulatory exposure under the unfair contract terms regime in the Australian Securities and Investments Commission Act 2001 and the Australian Consumer Law, which since November 2023 has attached civil penalties to the proposal, application or reliance on an unfair term in a standard-form small business contract. An independent dental or allied health practice is a small business for those purposes, and a provider agreement is a standard-form contract. Whether any particular claim would succeed is a question for a court and is not one this submission asks APRA to answer. The prudential point is anterior to it: an entity that does not record the basis of its determinations cannot assess the strength of the claims they may attract, cannot aggregate that exposure across the affected population, and cannot report it. That this exposure is real rather than theoretical in this sector is illustrated by the proceedings at Section 3.7, in which a claims assessment systems failure produced a $35 million penalty, a five-year injunction and a court enforceable remediation undertaking under which more than $14.3 million had been repaid across more than 4,100 claims. Those are measurable figures, and they became measurable only once a regulator compelled the assessment. The prudential objective is for an entity to know the size of such an exposure before that point.

That gap engages the draft standard at several points. Paragraph 13(e) makes oversight of financial and operational resilience a responsibility the Board may not delegate. Paragraphs 45(b) and 45(c) require the Risk Committee to advise the Board on the entity's current and future risk appetite and to monitor its risk position relative to that appetite — which cannot be done for an exposure that is not quantified. Paragraph 74(b) requires conflicts controls calibrated to the associated risks and potential impacts on the interests of policyholders, and CPS 001 defines material risks for private health insurers as risks capable of material impact, financial and non-financial, on the institution or on the interests of policy holders. Reputational and continuity-of-care consequences for insured members are squarely within that definition.

Three practices, in my submission, are what convert an ordinary commercial risk into an unmeasured one, and each is capable of being addressed through the governance framework required by paragraphs 11 and 12:

- The absence of a written audit standard. Where the criteria against which a provider is assessed are not documented in advance, neither the entity nor its Board can determine after the fact whether a determination was soundly based, and the entity cannot demonstrate consistency across providers.

- The absence of recorded reasons for network removal. Reasons recorded at the time are the only reliable evidence of the basis on which a determination was made. Their absence transfers the evidentiary burden to the entity in any subsequent proceeding, and deprives the Board of the material it would need to review the decision on its merits.
- The absence of an appeal pathway independent of the original decision-maker. Where the same person or function determines the matter and reviews the determination, the review adds no assurance, and the entity forgoes the opportunity to identify and correct an unsound determination before its consequences crystallise.

I note that CPS 001 defines legal risk to include exposure to fines and penalties, ordinary damages in civil litigation, related legal costs and private settlements. That definition is presently tagged to authorised deposit-taking institutions alone. Legal risk of this character is not peculiar to banking, and APRA may wish to consider whether the definition should be extended across the regulated industries in the CPS 001 amendments accompanying this standard.

The proposals at Section 6.9 should therefore be understood not as importing administrative-law standards into commercial dealings, but as the means by which an entity makes an existing and otherwise invisible exposure legible to its own Board. That is a governance outcome, and it is one CPS 510 is the appropriate instrument to secure.

6.10 Structural pathways for provider dispute resolution

A further reform principle concerns the structural pathways available to registered health practitioners affected by insurer conduct — particularly where that conduct has occurred in circumstances of undisclosed or unmanaged intragroup conflict, has operated as a retaliatory measure against a practitioner who raised concerns, or has otherwise produced unnecessary harm to the practitioner or to insured patients. The current architecture leaves affected practitioners with substantial structural barriers to remediation. The prudential dimension of those barriers is addressed here; the proposals engaging other remits are at Annexure A.

The structural barriers include provider agreement terms that limit standing to bring civil proceedings or require confidential arbitration; the financial cost of private litigation against an APRA-regulated insurer with substantial legal resources; the information asymmetry between the insurer, which holds the audit records and internal decision-making documentation, and the practitioner, who typically has only the outcome correspondence; the absence of a standing complaint pathway that can independently investigate rather than merely inquire; and the exclusion of registered health practitioners from protective frameworks that apply to consumers or to employees.

Proposals directly within APRA's CPS 510 remit:

- Governance framework requirements for provider dispute resolution. The governance framework maintained under paragraphs 11 and 12 should include documented arrangements for provider dispute resolution, including mediation pathways available before contested determinations are enforced, independent internal review pathways, and documented processes for the entity's response to third-party findings or recommendations by regulators or professional bodies.
- Fitness-and-propriety consideration of the entity's response to adverse third-party findings. Where a regulator, tribunal, court or professional body has made findings adverse to the entity in relation to its conduct toward a provider, the entity's Board should consider whether the accountable persons responsible for the relevant governance framework have discharged their obligations under paragraph 77, and whether the entity's response has been consistent with those obligations.

The prudential concern is direct. APRA's statutory mandate includes competitive neutrality and contestability, and requires APRA to promote financial system stability. An architecture in which affected providers cannot practically access remediation for adverse insurer conduct affects the competitive

neutrality of the sector, reduces contestability by concentrating market power in the insurers, and, over time, affects the long-term prudential standing of insurers whose conduct is not effectively constrained.

7. Closing

I appreciate the opportunity to contribute to APRA's consultation on draft CPS 510. The perspective of an AHPRA-registered health practitioner whose profession is directly affected by the governance frameworks of APRA-regulated PHI insurers is one that may otherwise be under-represented in the consultation process, and I offer this submission in that spirit.

The governance concerns identified in this submission are not confined to the specific matter documented in Section 4. They arise from structural features of the vertically integrated PHI sector that engage specific provisions of the draft standard — the exclusion at paragraph 4(d), the definition at paragraph 8(f)(ii), the non-delegable responsibilities at paragraph 13, the conflicts obligations at paragraph 74, the fitness and propriety framework at paragraphs 77 to 94, and the drafting of paragraph 35(e). If those provisions can be strengthened in the finalisation of CPS 510 and in the accompanying prudential practice guide, the resulting standard will better serve APRA's statutory mandate and the public interest that mandate exists to protect.

I am willing to provide further information to APRA on any aspect of this submission if that would assist the consultation process. This submission is lodged to PolicyDevelopment@apra.gov.au, addressed to the General Manager, Policy and Frameworks, Policy and Advice Division, in accordance with the request for submissions at section 3.2 of the consultation paper.

Yours sincerely,

A registered dental practitioner

Principal and owner of an independent dental practice, Western Australia

Name, registration number and practice details supplied to APRA in the identified version

Contact details supplied to APRA in the identified version

Correspondence may be directed to me via APRA

August 2026

Annexure A — Proposals engaging other regulatory remits

The proposals in this Annexure are provided for coordination rather than as requests directed to APRA. Each engages a remit other than APRA's — principally the Department of Health, Disability and Ageing's reform work and the code of conduct for insurers under development, the National Law framework administered through the Ministerial Council on Health and the National Boards, or Commonwealth legislation. They are recorded here because the prudential, conduct and professional-regulation instruments in this sector operate on the same conduct, and a reform in one is more effective where the others are aligned. Nothing in this Annexure is necessary to the proposals in the body of this submission.

A.1 Provider audit standards and personnel

- Registration requirements for insurer audit personnel. This engages the National Law framework and would require amendment through the Ministerial Council on Health and the National Boards, or amendment of the Private Health Insurance Act 2007. It should be pursued in coordination with the Department of Health's reform work.

- A provider audit rule book with written appeal pathways and standards. This engages the Department of Health's reform work and the code of conduct for insurers being developed. CPS 510 can support it by requiring board oversight of the provider agreement architecture; the substantive rulebook is for the code of conduct.
- Remediation before network removal. This engages the code of conduct reform work. CPS 510 can support it by requiring that the entity's governance framework include documented remediation processes before network removal.
- A face-to-face meeting requirement in audit processes. This engages the code of conduct reform work; CPS 510 can support it through the governance framework requirements at paragraphs 11 and 12.
- Fraud characterisations. Billing error, contractual non-compliance, suspected fraud, civil fraud and alleged criminal fraud are distinct, and are not interchangeable in communications to a practitioner or to third parties. Where an entity communicates that a registered practitioner has engaged in fraud or dishonesty, that characterisation should rest on appropriately qualified legal review, be supported by identified evidence, be clearly distinguished from billing error or contractual disagreement, and be referred to an appropriate authority where the entity considers it warranted.

A.2 Dispute resolution and provider protection

- Expanded PHIO jurisdiction, including formal mediation of provider disputes with binding recommendation powers and standing to bring proceedings on behalf of affected providers where systemic conduct is identified. This engages the Ombudsman Act 1976 and would require legislative reform.
- Provider protection legislation analogous to the whistleblower protections under Part 9.4AAA of the Corporations Act, providing standing, confidentiality protection and remedies for practitioners who have raised concerns about insurer conduct. This engages the Private Health Insurance Act 2007 or a new dedicated framework.
- Contractual clause review through the Department of Health's reform work, addressing terms in provider agreements that inhibit access to remediation.

Taken together with the proposals in Section 6, these would produce a reform architecture in which the governance frameworks of APRA-regulated private health insurers, the code of conduct for insurers under development, and the statutory frameworks under the National Law and the Private Health Insurance Act 2007 operate consistently to protect the position of AHPRA-registered health practitioners, insured patients, and the public interest.