Private Healthcare Australia

Better Cover. Better Access. Better Care.

Health funds' statement of priorities

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Contact:

Dr Rachel David – CEO

Rachel.david@pha.org.au

0401 775 779

Ben Harris – Director Policy and Research

0418 110 863

Ben.harris@pha.org.au

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have more than 20 registered health funds throughout Australia as members and represent over 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 15 million Australians. Health funds employ more than 17,000 people.

Introduction

Dear Minister,

Congratulations on your appointment as Minister for Health, Disability and Ageing in the Albanese Labor Government. We are looking forward to working with you to improve the health of Australians and modernise the health services they rely on.

The Albanese Government has been re-elected with a strong, increased majority, based on (among other issues) sound economic management, and a genuine commitment to strengthen Medicare, the cornerstone of Australia's world-class health system.

Over the past three years, the government has focussed on improving the affordability and accessibility of healthcare. While there is still work to be done, the improvements in primary care and urgent care will provide great benefits for our community while taking pressure off our busy public hospital system.

Successive Labor Governments have recognised that a universal health scheme requires a strong, vibrant private sector to increase funding for healthcare overall, provide choice, promote equity, and ensure the public system is available to care for those who need it most.

Labor's commitment to getting this balance right continues to deliver world leading results. There are much smaller gaps in health outcomes between wealthy and disadvantaged groups in Australia compared to the privately dominated US system and publicly dominated UK system. Encouraging Australians with financial capacity to contribute towards their own health and wellness ensures our most vulnerable people are not displaced in a rationed public system.

For the past four-and-a-half consecutive years, an increasing number of Australians have invested in health insurance so they can budget for greater access to preventative

health services such as dental care and receive rapid medical treatment in a private hospital with their own choice of doctor if they need it.

Increasingly, health fund members are getting access to new models of care, such as mental health treatment, rehabilitation, chemotherapy and palliative care at home. These services are being delivered to people where and when they want them, with equivalent if not better outcomes to hospital services, at a fraction of the cost. In many cases, this has helped people continue working and spend more time with their families during challenging times.

Just this month, two of the largest private health companies in Australia, Bupa and Ramsay Health Care signed a new contract outlining the delivery of more high-quality home-based services to ensure health fund members receive more convenient care and more value for money. Both parties agree this is part of an essential transformation of the private health system to shift away from old-fashioned processes to deliver the right care in the right place at the right time. These changes are being driven by advances in technology and clinical care and are occurring around the world. If anything, Australia's private sector is lagging.

This transformation is required to address consumer preferences for more convenient, affordable care. Healthcare is rapidly becoming more expensive for governments, health funds, and consumers. All payers are facing higher costs to meet the needs of our ageing population with more chronic disease. The last Intergenerational Report in 2023 predicted health spending will rise faster than any other government expenditure over the next 40 years. Australia is at significant risk of falling short.

With enough political will, we can change this. There are many initiatives governments, health funds, health professionals, and health services can adopt to reduce waste without compromising care and choice. To start creating a smarter health system that ensures our limited health funding goes further, the Albanese Government should now focus on:

- Ensuring health insurance remains affordable for Australians who want it as a safety net. Greater participation makes health insurance more affordable and sustainable as health funds continue to pay out more every year for an older, sicker population. High participation creates the optimal mix of younger and older people and reduces demand for expensive care in the public system.
- Reviewing the Gold, Silver, Bronze, Basic tier system introduced by former Health Minister Sussan Ley. It is too rigid and not working for consumers and health funds. When health funds close products it is because they are unsustainable

and running at a loss. This needs to be addressed so consumers can choose products that truly suit their needs and health funds can provide sustainable options.

- Addressing the steep rise in specialist doctors' fees for community and hospital-based care so Australians with health insurance can access a medical specialist when they need one and use their health cover for private hospital treatment if they need it. The high out-of-pocket cost to see a specialist doctor for a first consultation is blocking the path to private hospital care for many people. This requires transparency via the Medical Costs Finder website and stronger consumer protection laws to shield patients from unexpected costs and surprise bills.
- Introducing the right incentives to secure targeted support for private hospitals and guide the transformation of private health services, so we have the right mix of cost-effective inpatient hospital care and out-of-hospital care across Australia. As outdated services are replaced by those offering more modern care, there is an opportunity to create a system that is better matched to patients' needs. Australia currently has more private hospital beds than it needs.
- Reforming private maternity care by introducing lower fixed cost options for people who cannot afford the high cost of a private obstetrician's management fee for 6-9 months before giving birth in a private hospital. This fee, which often exceeds $6,000, cannot currently be subsidised by health insurance. This will help private maternity services offer more diverse and attractive models of care for people who want to choose their clinician and private hospital accommodation.
- Tackling workforce reform to ensure health professionals are working to the top of their scope of practice, as recommended by Professor Mark Cormack's Scope of Practice Review. There is great potential for nurses, midwives and nurse practitioners to step into more responsible roles in the private health system so we can increase productivity across the health system.
- Reducing wasteful spending via the Prescribed List so Australians are not overpaying for common generic medical devices such as artificial hip and knee joints, insulin pumps and pacemakers. This would save at least $100 million a year and encourage more competition in the sector, benefiting local Australian biotechnology companies while building resilience as part of the Future Made in Australia policy.
- Cutting low value care to save up to $1 billion a year. To put downward pressure on health insurance premiums, we must stop Medicare and health funds paying for interventions that have been shown by credible scientific evidence to cause

people more harm than good. This will improve patient safety and free up funding for new technologies and treatments. The most recent case study is our campaign with leading clinician academics to stop the use of spinal cord stimulators for back pain. These procedures, which are no better than placebo and frequently cause harm, cost around $50,000 per procedure. Low value care must be addressed, particularly where there are strong financial incentives for clinicians to continue using ineffective, harmful interventions.

On behalf of 15 million Australians with health insurance, Private Healthcare Australia will continue to champion reforms to create a more modern, sustainable health system for our changing population. We will also fearlessly question vested interests standing in the way of sensible reforms to create a more effective, efficient health system that helps people stay well and receive high quality care where and when they want it. This is a critical component of helping the Albanese Government improve productivity for Australia.

Regards,

Dr Rachel David

CEO, Private Healthcare Australia

Key facts and trends

12.4 million Australians[1] (45% of the Australian population) are covered by a hospital treatment policy. 15 million Australians (55%) are covered by a general treatment policy.

In 2024, health funds paid for:

- 2/3 elective surgeries including 57% of joint replacements.
- 54% of hospital based mental health care, making mental health the top hospital claim for people aged under 60.
- dental care for half the Australian population.

Income profile of people with health insurance (PHI)

- 56.3% of individuals (8.74 million people) who submitted a tax return for the 2021-22 income year had private health insurance.
- 38% of people with PHI have an annual taxable income of $50K or less.
- 65% of people with PHI have an annual taxable income of $90K or less.
- 406,099 pensioners have PHI.
- Only 13% of people with PHI have an annual taxable income over $150K.
- 86% of people with PHI receive some form of the private health insurance rebate, with 64% of these individuals receiving the base tier rebate (i.e. the full means-tested rebate).

Polls show the cost of health insurance premiums remains a major concern for Australians. In 2024, about 300,000 people downgraded their health insurance. Most of these people were moving from Gold products to Silver products as part of a consistent trend since 2020.

Average Annual Price of Hospital Cover[2]

- Basic single cover $1024, family cover $2048
- Bronze single cover $1202, family cover $2405
- Silver single cover $1846, family cover $3692
- Gold single cover $3087, family cover $6175

[1] All figures sourced from Australian Prudential Regulatory Authority, as at 31 December 2024.
[2] Average prices quoted in line with Finder's database of health insurance policies as at March 2025. Prices are based on a single individual with less than $97,000 income and living in Sydney with a $750 excess, before any surcharges or the private health insurance rebate are applied.

Supporting private hospitals

In the past two years, health funds have provided more than $270 million in financial assistance to private hospitals outside of their standard contracts to deliver services. This follows the Federal Government's $1.5 billion Private Hospital Financial Viability Payment (FVP) to assist private hospitals during the pandemic.

Premium revenue and costs

Australians paid $30.35 billion for health insurance premiums in 2024, and health insurers paid out $25.57 billion for their members' health care in the same year.

- Health funds paid $18.73 billion for hospital treatment (up 8.1% on last year).
  - Accommodation and nursing costs benefits were over $13.53 billion.
  - Medical benefits were over $2.75 billion.
  - Medical device benefits were over $2.44 billion.
- General treatment (ancillary) benefits were over $6.55 billion.

- The overall claims ratio for the private health insurance sector exceeds 84% which is far higher than any other form of insurance. For example, the general insurance sector is 60%. The claims ratio for Australia's health insurance sector has remained stable for two decades.
- Overall profits in 2024 were 4.8% (health insurance business industry net margin).

Cost of living

Every poll conducted by PHA or publicly reported has found cost of living remains the biggest issue for Australians, regardless of where they live and how old they are. It is vitally important the second Albanese Government reduces pressure on rising costs for health care, including private health insurance premiums.

Medical devices are too expensive

The quickest way to do this is to reduce the cost of generic medical devices and surgical supplies. While consumers are struggling financially, the supernormal profits legislated for large international medical supply companies cannot be justified.

As recently highlighted in the report *Australia's Surgical Surcharge: How Australians are paying too much for medical devices through the prescribed list of medical devices*, we pay 30%-100% more than people in comparable countries for commonly used generic

medical devices, with prices set by government at higher rates than paid in Australia's public hospitals. It is unacceptable that the cost of most common medical devices in Australia is on average triple the cost charged in Germany.

Reducing the cost of medical devices is critical for sector sustainability. The current system of the Prescribed List has operated as a subsidy mechanism for device companies, rather than a consumer-focused approach to ensure medically necessary devices are available. Changes are urgently needed. This includes, in the short term, assertively addressing errors on the Prescribed List, introducing conditions on use for medical devices to reduce low value care caused by off-label use (similar to the PBS approach) and reducing the price of cardiac devices as recommended by the Medical Services Advisory Committee. These measures will save consumers over $100 million per annum.

The current Memorandum of Understanding signed by former Health Minister Greg Hunt unilaterally with the device sector has failed to deliver the promised savings, as there are no controls on volume and some consumer-friendly initiatives have been abandoned. The Department in 2022 did not recommend the MoU, which, "in the view of the Department, predominantly benefitted industry rather than providing a negotiated balance of benefits to industry and the Australian community/government."[3] The MoU expires in June 2026, providing an opportunity for the government to take a more sensible approach that prioritises the Australian public interest. Another unilateral deal with big American multinationals will not be acceptable.

It's time to start working on a new system from 1 July 2026 that combines a Diagnostic Related Group (DRG) approach for common procedures with a revamped list for less common items. PHA proposed such a system prior to the previous MoU, which was consistent with the Department's preferred approach. Such a system would deliver savings for consumers and hospitals and reduce the supernormal profits flowing to big international medical supply firms.

Medical specialists' out-of-pocket fees

Rightly described as a "barbeque stopper" during the election campaign, specialist out-of-pocket costs are blocking access to private health care for many in the community.

Hyper-inflation in medical costs is growing, and it is particularly bad in some pockets around Australia where doctor numbers are constrained, and household incomes have historically been higher than average. An analysis by Mandala has revealed a 12% increase in medical out-of-pocket costs in 2023-24 alone. Data from a Patients

[3] Department of Health and Aged Care, FoI 4046.

Australia survey undertaken in conjunction with Latrobe University in 2025 estimates 1 in 5 people referred by a GP to a non-GP specialist do not attend because of the anticipated cost.

This needs to be addressed, particularly in areas like the ACT where there is little competition between specialist doctors. There is also evidence of medical specialists working less and charging more since the pandemic. This is a difficult problem for the government and/or health funds to fix in an inflationary environment with widespread workforce shortages.

These increased medical costs are a significant driver of inflation, so reducing pressure on costs will also help reduce pressure on interest rates.

Medicare data analysed by PHA shows there has been a 10% decrease in initial specialist consultations over the past five years. Combined with population growth, this is a massive change in access to specialist care. The decline in initial specialist consultations is choking the pipeline of patients for private hospitals, driving more use of public emergency departments, and increasing sickness across the community. While out-of-pocket costs are not the sole driver of this change, they are a significant factor.

PHA welcomes the government's commitment to improve transparency for specialist doctor costs, but this will only partially address the problems with consumer access. Other policy responses that need to be explored in the health portfolio include workforce constraints, substitution and scope of practice, and modifying MBS incentives over time to favour initial consultations.

Further, the Australian Competition and Consumer Commission should be empowered to take more assertive action against doctors and groups of doctors that act in a way that substantially lessens competition, unless a clear consumer benefit can be demonstrated.

Low value care, fraud and waste

Medicare and health funds should not be paying for medical interventions that are known to be ineffective, especially those that cause harm. During a cost-of-living crisis and with limited health funding to serve our ageing population, we must be prepared to take on vested interests in health care and reduce waste for consumers.

There are many examples of low value care, such as spinal cord stimulators to treat back pain that have no proven benefit, as well as hospitalising people for simple procedures that can be done in doctors' rooms at a fraction of the cost.

Further, where healthcare providers are clearly doing the wrong thing, there should be real consequences to deter bad behaviour. A culture of tolerating health care fraud, waste and abuse is costing consumers millions of dollars each year and more needs to be done.

Estimates of the prevalence of low value care in Australia indicate a significant issue for consumers, funders and governments. Braithwaite et al (2020) notes: "While change is everywhere, performance has flatlined: 60% of care on average is in line with evidence- or consensus-based guidelines, 30% is some form of waste or of low value, and 10% is harm."[4]

While the use and misuse of Medicare is a central component of low value care, the associated expenditure (including hospital benefits and medical device benefits) is often higher and can show greater variance. The issues extend beyond Medicare; they include a range of harmful regulatory protections that lead to services that are expensive, wasteful and drive up costs for consumers.

The merging of the administration of the National Disability Insurance Scheme with the Department of Health and Ageing presents a unique opportunity to combine and streamline compliance activities, data-sharing, and interventions across the whole Care Economy.

In July 2023 PHA welcomed the establishment of a unit in the Department of Health and Aged Care to address fraud and miscoding in Medicare. We recommend this unit expand its brief to disinvest in low value items from the Medicare Benefits Schedule.

[4] At https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-020-01563-4

Right care, right place: Transforming private health services

A vibrant and modern private hospital sector operating in partnership with health funds is a key component of Australia's health system. Private hospitals, like most other Australian businesses, have suffered setbacks as a consequence of the pandemic and its second-order economic impacts, particularly inflation. PHA supports a targeted approach to assist private hospitals providing essential services, where their financial data has shown they are in genuine need of support, and where our members have few alternative choices to provide care.

It is not the role of health funds to turbo-charge the profits of large for-profit hospital groups which have maintained profitability through the crises, or to bail out finance companies that have made serious errors in their investment and management strategies for private hospitals. Nor is it our role to prop up 1980s-style businesses that are sinking because they have failed to innovate and offer attractive services.

Due to steady demand, private hospital closures continue to be offset by more new facilities opening. For every hospital that shuts down, at least one more has been established over the past decade.

Over the past 10 years to the end of 2024, 143 private hospital licenses in Australia have been revoked (closures) and 165 granted (openings). These 165 new hospitals are all still operating today. We currently have more private hospitals than we did 10 years ago and there are estimates only 64% of all private hospital beds are being used.

There has been a period of disruption and transition for private hospitals around the world, driven by changes in technology and clinical care. The current mix of services available in the private hospital sector does not match patient needs or expectations. We need to transform our hospital sector to meet the requirements of the Australian community in the 21st Century, rather than reinforcing old-fashioned models from the last century.

Length of stay in Australian private hospitals is currently average or above average overall when compared to other OECD countries, which does not match the excellence of our medical practitioners and hospitals. Reducing length of stay by just 10 per cent would save consumers hundreds of millions of dollars and improve productivity. PHA is keen to explore a National Efficient Price model as a baseline for hospital contracting that addresses this and provides incentives for efficient procurement of medical implants and surgical supplies at the same time.

Improvements are impossible without granular and robust data. Currently, public hospitals rarely report data on private patient stays, and there are some private

hospitals that do not report on indicators of quality and safety at all. Ensuring all hospitals report correctly will help improve quality and effectiveness.

Case study – Adeney Private Hospital Melbourne

In February 2025, a new private hospital opened in Melbourne offering surgery with zero out-of-pocket costs. That means no extra bills for your surgeon, anaesthetist, pathology, radiology, or pharmacy. It's all covered as part of your hospital stay which is funded by your health insurance with no one charging additional private fees on the side.

Forty-two doctors own 51% of the hospital and Medibank's health service arm, Amplar Health, owns 49%. The key to making the business model work is shorter hospital stays and more use of home-based rehabilitation, which is cheaper for the hospital and better for patients who prefer to recuperate at home if they are properly supported. This is common in Europe where people have much shorter hospital stays after surgery with equivalent if not better outcomes due to a range of factors including a lower risk of infection.

By all accounts, Adeney Private Hospital is the result of some blue sky thinking to examine costs, eliminate waste, and ensure a limited budget is spent wisely so consumers don't have to pick up the tab for old, inefficient business models and inflationary billing.

After years of negotiating with scores of doctors and other providers, the hospital's CEO, Louise O'Connor, told the ABC recently: "This is the hardest thing I've ever done, but we need a revolution in the healthcare sector otherwise it won't be sustainable. Gone are the days when we can allow medicine to get a bit more expensive every year."

Improving equity by modifying consumer incentives

Changes to the Medicare Levy Surcharge and the Private Health Insurance Rebate

An increasing number of Australians are choosing to contribute to their own healthcare via health insurance, so they have an additional safety net for timely healthcare in a private hospital with their own choice of doctor. Much of the growth in health insurance membership over the past five years has come from people living in outer suburban areas of major cities, particularly the Indian and Chinese diaspora communities in Melbourne and Sydney. Most of these people earn under $90,000 a year and make sacrifices to afford health insurance. Research shows they value the ability to choose their own experienced doctor and private hospital for care, should they need it.

At the same time, more than half a million high income earners do not have health insurance, even though they have the means to contribute to their own healthcare costs instead of relying solely on Medicare.

Increasing the Medicare Levy Surcharge (MLS) and retargeting the Private Health Insurance Rebate (the Rebate) towards lower-income and younger age groups will increase participation, affordability and equity. It would put downward pressure on premiums and improve insurers' risk pools, creating a stable foundation to cope with a growing and ageing population.

The settings recommended in the attachment, and modelling provided to previous office staff and the Department, result in increased participation, lower pressure on premiums, and reduce pressure on the public system.

Savings to government are projected to be about $4 billion in total direct financial savings over the four-year period. This growing cost saving is primarily driven by increased participation in PHI, particularly among younger cohorts. The projection incorporates first-year participation changes, along with subsequent premium adjustments reflecting the improved risk pool composition and demographic trends.

Transparency

Medical Costs Finder

PHA polling shows out-of-pocket costs for healthcare are a massive pain point for consumers, whether it be for GPs, medicines, diagnostics, specialist doctor appointments or planned surgery. Data released in 2024 by the ABS and from Patients Australia in 2025 show between one in ten and one in five Australians are putting off seeing a specialist doctor due to cost.

While many doctors and the vast majority of hospitals provide no-gap (or known-gap) services, some consumers experience very high out-of-pocket costs — and many patients are not made aware of these costs in advance.

PHA is pleased with the government's commitment to improve transparency for specialist costs, and we look forward to helping you implement this commitment.

Publishing all doctors' actual fees, derived from Services Australia data, will help ensure consumers have a meaningful choice of doctor for the treatment they require. It will also reduce the costs of medical care, as better market information for consumers will increase competition and encourage people to ask questions of their doctor and shop around for affordable treatment.

In late 2024, Redbridge undertook research with 13 focus groups across the country. Not one participant had heard of the Medical Costs Finder website, and once it was revealed to them, they were disappointed to learn it did not list all doctors' fees.

Unknown out-of-pocket costs are one of the greatest concerns for people with private health insurance. Consumers should be able to confidently start a course of treatment knowing how much it will cost them, and they should not be receiving information about fees, such as anaesthetists' fees within 48 hours of a procedure when they are under duress. This sort of "drip pricing" needs to be addressed.

Surprise billing

PHA recommends the second Albanese Government implement surprise billing legislation to ensure consumers are not held liable for costs not disclosed before treatment or disclosed under duress and introduce administrative penalties for hidden billing practices.

Other countries have introduced surprise billing legislation with bipartisan support, and Australia should learn from these consumer protections, which could be introduced

here to enhance existing consumer laws. Read more in PHA's detailed policy paper: Combatting Surprise Billing in Australia.

The key elements of the proposal are that patients should not be held liable for fees above MBS schedule costs if they are not properly informed beforehand, and doctors and hospitals should face civil or criminal penalties if they deceive patients, insurers or governments about their charges, for example, by charging hidden fees outside of Medicare and private health insurance.

Conclusion

The sustainability of Australia's health system is not just a matter of clinical care — it is an economic imperative. Health spending is projected to outpace all other areas of government expenditure over the next 40 years. Without action, rising costs will place increasing pressure on public finances, household budgets, and national productivity.

The private health sector plays a critical role in absorbing demand, expanding choice, and delivering cost-effective care. But to continue fulfilling this role, key economic reforms are required: modernising funding models, reducing unnecessary expenditure, improving competition, and ensuring incentives align with value and outcomes.

By making strategic changes now — including reforming outdated pricing mechanisms, improving transparency, and shifting to more efficient models of care — we can bend the cost curve, drive innovation, and relieve pressure on both the public system and the broader economy. These reforms will not only improve access and equity, but also free up resources for investment in the future of Australian healthcare.

Private Healthcare Australia and its members are committed to working with you to deliver a smarter, more sustainable system — one that supports healthier Australians, a stronger workforce, and a more productive nation.

Attachment one: Improving tax incentives to relieve cost-of-living pressures

Recommendations:

- *Change the Private Health Insurance Rebate levels to reduce the cost of health insurance for people on lower incomes and make it more accessible to those who want it.*
- *Increase the Medicare Levy Surcharge to ensure people on high incomes are contributing to their health care costs via health insurance.*

An increasing number of Australians want to contribute to their own healthcare via health insurance, so they have an additional safety net for rapid healthcare in a private hospital with their own choice of doctor. Much of the growth in health insurance membership over the past five years has come from people living in outer suburban areas of major cities, particularly the Indian and Chinese diaspora communities in Melbourne and Sydney. Most of them earn under $90,000 a year and make sacrifices to be able to afford health insurance. Research shows they value the ability to choose their own experienced doctor and private hospital for care, should they need it.

At the same time, more than half a million high income earners do not have health insurance, even though they have the means to contribute to their own healthcare costs instead of relying solely on Medicare.

Increasing the Medicare Levy Surcharge (MLS) and retargeting the Private Health Insurance Rebate (the Rebate) towards lower-income and younger age groups will increase participation, affordability and equity. It would put downward pressure on premiums and improve insurers' risk pools, creating a stable foundation to cope with a growing and ageing population.

Modelling undertaken by PHA suggests a higher MLS for high-income earners will increase private health insurance participation. By growing the pool of consumers, premium prices would ease.

The Rebate complements the MLS in setting participation incentives. The current distribution of the Rebate is skewed towards older cohorts aged 65 and older, including those on higher incomes. But high-income cohorts over 65 are very unlikely to withdraw from PHI regardless of their Rebate value. In contrast, lower-income and younger cohorts are more likely to buy PHI if given a Rebate on their premiums.

Combining a higher MLS with a PHI Rebate that is better targeted to lower-income and younger age groups will lift participation, affordability and equity. Setting clear and simple Rebate values for a fixed period before regular review would also amplify the incentive to the market.

Improving participation stabilises the national health system and eases budgetary pressures.

A thoughtful set of adjustments that grows participation, especially among younger cohorts, will improve the risk pool for health insurers, stabilise premiums, and relieves demand on stressed public hospitals. It will also reduce pressure on the government's health spending.

Increasing the MLS to 1.5% for tier 1 earners, and 3% for tier 2 and 3 earners (see current income thresholds in below table), together with the recommended changes to the Rebate, could see participation increase by 326,000 people, with the majority (246,000) aged under 50.

MLS income thresholds and Rebates for 2024-25[5]

Threshold	Base tier	Tier 1	Tier 2	Tier 3
Single threshold	$97,000 or less	$97,001 - $113,000	$113,001 – $151,000	$151,001 or more
Family threshold	$194,00 or less	$194,001 - $226,000	$226,001 - $302,000	$302,001 or more
Medicare levy surcharge	0%	1%	1.2%	1.5%

By increasing participation in younger age groups, premium increases would be slower compared to what may occur under the current settings.

Ensuring the private health system is being appropriately utilised, could also see net government health expenditure grow at a slower rate than under the current settings. Currently, private hospital beds are underutilised, while Australians continue to be waiting longer than ever before for elective surgery in public hospitals, with nearly one in 10 waiting more than a year to undergo required procedures. These record waiting times would have blown out even further were it not for privately insured patients receiving surgery in private hospitals, usually within days or weeks of being advised surgery was necessary.

[5] ATO (2024) *Medicare levy surcharge income, thresholds and rates.*

In addition to changes to the Medicare Levy Surcharge, Private Healthcare Australia recommends adjustments to the Private Health Insurance Rebate to provide more support to low-income earners. When combined with the proposed changes to the Medicare Levy Surcharge, neither of the two options below involve an increase in government expenditure over the next four years.

The current rates for the Private Health Insurance Rebate are:

Table: current Rebate rates (% of premium)[6]

	Tier 0	**Tier 1**	**Tier 2**	**Tier 3**
0 to 64	24.608	16.405	8.202	0
65-70	28.710	20.507	12.303	0
70 or above	32.812	24.608	16.405	0

Option one involves reducing the Rebate for high income earners and redistributing the proceeds to lower-income earners. This increases the Rebate for 6.1 million people and decreases the Rebate for 1.9 million people in tier 2 and tier 3. This latter cohort received significant stage three tax cuts. The Rebate amounts are adjusted to whole numbers and would not be changed for five years.

The Australian Government is projected to save $1.0 billion in the first year by implementing option one. This saving comes from three sources:

1. Additional MLS revenue collected,
2. Reduced Rebate payments, and
3. Cost savings from shifting healthcare expenses from public to private systems.

When focusing only on the direct financial impacts (MLS revenue and Rebate payments), option one delivers a net saving of $840 million in the first year, excluding any system transfer costs. This is driven by $590 million in additional revenue from the MLS and a reduction in expenditure on the Rebate of $250 million.

The forecast shows $4 billion in total direct financial savings over the four-year period. This growing cost saving is primarily driven by increased participation in PHI, particularly among younger cohorts. The projection incorporates first-year participation changes, along with subsequent premium adjustments reflecting the improved risk pool composition and demographic trends.

[6] ATO (2024) *Income thresholds and rates for the private health insurance rebate.*

Table: proposed new Rebate rates, option one (% of premium)

	Tier 0	Tier 1	Tier 2	Tier 3
0 to 64	26	18	0	0
65-70	28	20	0	0
70 or above	32	24	0	0

Option two increases the Rebate for lower income Australians but does not reduce the Rebate for higher income earners (other than minor effects from rounding to whole numbers). The Rebate will increase for 6.1 million people in tier 0 and tier 1, making it easier for this cohort to retain private health insurance and keep pressure off the public system.

The Australian Government is projected to save $460 million in the first year by implementing option two. This saving comes from three sources:

1. Additional MLS revenue collected,
2. Increased Rebate payments, and
3. Cost savings from shifting healthcare expenses from public to private systems.

When focusing only on the direct financial impacts (MLS revenue and Rebate payments), option one delivers a net saving of $120 million in the first year, excluding any system transfer costs. This is driven by $350 million in additional revenue from the MLS and an increase in expenditure on the Rebate of $230 million.

The forecast shows $920 million in total direct financial savings over the four-year period. This growing cost saving is primarily driven by increased participation in PHI, particularly among younger age cohorts. The projection incorporates first-year participation changes, along with subsequent premium adjustments reflecting the improved risk pool composition and demographic trends.

Table: proposed new Rebate rates, option two (% of premium)

	Tier 0	Tier 1	Tier 2	Tier 3
0 to 64	26	18	8	0
65-70	28	20	12	0
70 or above	32	24	16	0