Private Healthcare Australia

Better Cover. Better Access. Better Care.

# Delivering quality care more efficiently

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# 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 collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for more than 15 million Australians.

# Introduction

PHA welcomes the opportunity to assist the Productivity Commission to improve the efficiency of health care.

Quality healthcare helps us live longer, more comfortable and productive lives, which is why an effective and efficient health system is vital for all Australians.

The re-elected Albanese Government was returned to power with an increased majority based on, among other things, sound economic management and a genuine commitment to strengthen Medicare, the cornerstone of Australia's world-class health system.

The focus on improving the affordability and accessibility of healthcare over the past three years should be commended, as should improvements in primary care and urgent care that will provide great benefits for our community while taking pressure off our busy public hospital system. But there is still work to be done.

There is an opportunity to take ownership of the role the private sector is increasingly playing in Australia's dual health system. 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.

The 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 five 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.

Health fund members are also getting access to new models of care, such as mental health treatment in the community, and 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 in-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.

During May, 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.

The transformation we are experiencing in healthcare is necessary to address consumer preferences for more convenient, affordable care. Healthcare is rapidly becoming more expensive for governments, health funds, and consumers, and all payers are facing higher costs to meet the needs of our ageing population living with more chronic disease and complex illness.

The last Intergenerational Report in 2023 predicted health spending will rise faster than any other Government expenditure over the next 40 years. But this can be addressed without compromising care and choice. To start creating a smarter health system that ensures our limited health funding goes further, Australia needs to:

- Ensure health insurance remains affordable for Australians who want it as a safety net by improving tax incentives to relieve cost-of-living pressures. 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.

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

- Introduce 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 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.

- Tackle 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. For example, 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.

- Reduce wasteful spending via the Prescribed List of medical devices 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.

- Cut 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 have been shown by gold standard medical research to be no better than placebo and frequently cause harm, cost about $50,000. Low value care must be addressed, particularly where there are strong financial incentives for clinicians to continue using ineffective, harmful interventions.

- Review 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.

- Reset estimates of how much technology is improving productivity in the health sector. The last Productivity Commission review of the health sector overestimated the impact of technology on productivity. This has resulted in a conclusion the sector is more

productive than reality. The pandemic and its second-order economic effects has negatively impacted productivity in the private health sector. This will will be felt for years to come unless it is urgently addressed. This means looking closer at the health sector's severe workforce constraints, substitution, and scope of practice, and modifying Medicare Benefits Schedule (MBS) incentives over time to favour initial consultations.

- Urgently address the lack of transparency and competition leading to market failures and perverse incentives created by outdated or ill-considered regulations.

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.

This submission will concentrate on the following three of the five pillars of productivity:

**1. Creating a more dynamic and resilient economy**

**2. Building a skilled and adaptable workforce**

**3. Harnessing data and digital technology**

**4. Delivering quality care more efficiently**

**5. Investing in cheaper, cleaner energy and the net zero transformation**

# Response

## The cost of healthcare

Australia's health sector has experienced hyperinflation in recent years, especially in relation to non-GP specialist out-of-pocket costs. This is placing real pressure on consumers during a cost-of-living crisis. It is also creating barriers to accessing the health system, which is limiting what we can achieve from prevention and early intervention in healthcare.

Hyper-inflation in medical out-of-pocket costs is growing, and it is particularly bad in some pockets of 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 surveys conducted by Patients Australia and La Trobe 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.

An analysis of patient experiences by the Australian Bureau of Statistics suggests 7% of people who needed to see a GP delayed or did not see one when needed in 2022-23 due to cost. A separate study by Australian National University academics, published in the journal Health Policy last month, found a third of people living with chronic diseases are not attending specialist appointments due to cost. Both upfront costs and out-of-pocket costs were identified as a major barrier to care.

There is also huge variation in cost around Australia for the same procedure, with some areas and medical specialties disproportionately affected. This is particularly apparent in the ACT, Queensland's Gold Coast, parts of the NSW Hunter region and Victoria's Mornington Peninsula. Doctors can set their own fees in Australia and research shows they charge based on competition in their area and the wealth of people living around them, so people living in areas with fewer doctors tend to face higher fees.

There is also anecdotal evidence of medical specialists working less and seeing fewer patients since the pandemic yet charging more so their incomes remain the same or increase.

Non-GP medical specialists are among the highest income earners in Australia. This is important because of the rigorous training and tough working conditions many endure, but it should not exclude them from consumer law, and their patients from reasonable consumer protection.

Medicare data analysed by PHA shows there has been a 10% decrease in initial specialist consultations over the past five years, with some specialist doctors charging more than $900 for an appointment. Combined with population growth of 7% during that time, this is a massive change in community access to specialist care. The decline in initial specialist consultations is choking the pipeline of patients for private hospitals, increasing sickness across the community and driving more use of public hospital emergency departments. While out-of-pocket costs are not the sole driver of this change, they are a significant factor.

The federal government's commitment to improve transparency for specialist doctor costs by publishing fees on the Medical Costs Finder website is a great start to assist GPs and consumers to shop around for a specialist in their price range. There is no evidence patients receive better treatment from a doctor that charges more. We need greater transparency as soon as possible so people can compare doctors' fees, but this will only partially address problems with consumer access.

There have also been increased reports of 'side-billing'. This is when large fees are demanded from patients outside the billing processes of the Medicare Benefits Schedule (MBS) or private health insurance (PHI). These fees are not attached to any MBS item number, do not contribute to the Medicare Safety Net and are not captured by official statistics for bulk-billing or out-of-pocket medical costs. These fees, often described as 'administration fees', 'booking fees' or 'subscription fees', do little more than increase the wealth of the health provider charging them.

Patients continue to be subjected to 'drip-pricing' – receiving separate bills from different medical providers such as surgeons, anaesthetists, surgical assistants and pathologists, all of which may also generate an out-of-pocket cost. Many patients only find out about some of these fees (such as anaesthetic costs) via text message within 48 hours of a procedure, when they are unlikely to challenge the amount out of fear the procedure may be delayed or cancelled. This raises questions about whether proper informed financial consent is being obtained from patients in these circumstances.

PHA acknowledges these are difficult problems for the Government and/or health funds to fix in an inflationary environment with widespread workforce shortages. But increased medical costs are also a significant driver of inflation, so reducing pressure on costs will also help reduce pressure on interest rates and the economy.

## Recommendations:

- Immediate implementation of the pre-election commitment to publish MBS data on the government's Medical Costs Finder website to improve transparency for specialist costs. 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.

- Undertake regular surveys in partnership with health funds to detect and address side-billing fees. All co-payments to be processed through MBS or private health insurance 'no gap' or 'known gap' arrangements.

- Strengthen Australian consumer law protections for patients by:

    - Introducing '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. Read more in

PHA's 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.

    - Eliminating 'drip-pricing' by requiring doctors to provide a written pre-operative quote. Patients should not be liable for any additional costs thereafter.

    - Prohibit obtaining informed financial consent under duress e.g. within 48 hours of surgery, or where threats are made that surgery could be cancelled.

- Simplify and streamline penalties for breaches of the law to deter these behaviours rather than undertake lengthy, detailed and costly prosecutions. Administrative fines should be the preferred sanction for these kinds of offences.

- Put one regulator in charge of medical billing infractions rather than multiple, which is currently resulting in a 'passing the buck' mentality.

- Where workforce shortages are reducing competition, this should be addressed by using the accelerated pathways recommended in the Kruk review (2023), increasing the scope of practice of other qualified health workers as recommended by the Cormack Review, and in the long run, reaching agreement with the states and territories on funding additional training positions for medical professionals.

## Outdated regulatory constraints preventing health funds from properly supporting models of care outside hospital

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.

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.

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.

***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."*

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.

## Maternity care

Reforms are urgently needed in obstetrics given the costs of having a baby in the private system are becoming prohibitive. Further, the decline in birth rates is putting pressure on providers, with several facilities struggling due to the falling number of births. This leads to higher cost structures with higher out-of-pocket costs and the potential for a spiral, which threatens private maternity care in several places across the nation.

The most common complaint of new parents in the private system is high and unknown out-of-pocket costs, particularly for managing the pregnancy, which mostly occurs as an outpatient. Obstetricians are pricing themselves out of the market. However, obstetrics services are only the most visible cost. From initial and follow-up consultations, scans, pathology, hospital birthing services, anaesthetists, paediatricians and midwives, there are many opportunities for consumers to be slugged with out-of-pocket costs. Many of these costs are not disclosed at the beginning of the episode of care. Many people feel powerless to challenge these unexpected costs.

New models of care can shift private maternity care to a more sustainable path with improved outcomes at lower costs. PHA supports the Scope of Practice Review: Unleashing the potential of our health workforce recommendation to introduce a bundled payment for maternity services (rec 11.1). The report "supports a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and private hospital settings."

Currently health funds can only pay claims for in-hospital care. Health funds provide around 88% of the costs incurred for in-hospital maternity care, with Government contributing 11%. Government and consumers pay all of the out of hospital costs and health funds are unable to contribute. Out-of-pocket costs to consumers typically add up to thousands of dollars.

PHA recommends developing options for bundled packages by changing the current legislation to allow health funds to pay for maternity services out of hospital under strict conditions with a wider range of practitioners. This would require a lead practitioner (the obstetrician, midwife or GP) selected by the patient to coordinate all the services required, managing the care of the patient. This would also include negotiating remuneration with other medical providers, with the lead practitioner providing a single invoice to the patient covering all the services required. The package would include a standard range of services, and should the birth be especially complex and require a range of other services, the lead practitioner may charge the patient more under strict conditions. Such an approach would eliminate the drip pricing currently experienced by

consumers and ensure parents were aware of the total out-of-pocket costs before they started the private maternity care journey. It would also open new high-quality care options for parents and offer medical providers models with more sustainable cost structures for a wider pool of people.

Such a model, where a lead practitioner coordinates both the health and the financial aspect of care, is an innovation in the Australian context, but one that would be warmly welcomed by patients. It is also consistent with the recommendations of the Cormack Review.

PHA recommends specialist obstetricians, midwives or specialist general practitioners be the only people able to coordinate care in this manner. Offering expectant mothers with a wider range of practitioners to lead their care will require legislative changes. Coordinating care should be the responsibility of the clinician, yet currently, clinicians do not take on this role with respect to patients' costs.

The additional administrative costs of managing patients' care are significant. Lead clinicians would need to negotiate prices and arrangements with a range of providers, such as anaesthetists, sonographers and others in advance. The lead clinicians' increased purchasing power should reduce overall costs from other healthcare providers, but the out-of-pocket costs are still likely to be significant. However, the total costs will be known up front, meaning consumers will get more certainty and a better deal.

To compensate lead practitioners for the administrative burden and to reduce overall out-of-pocket costs for consumers, PHA recommends health funds and the Australian Government each provide a minimum of $3000 to lead practitioners who undertake the task of coordinating care and providing a single bill to the patient. The Australian Government would only provide funding of $3000 on the condition the health fund provides no less than $3000 towards out-of-pocket costs. Funds typically already provide more than twice this amount, and this provision is to ensure that funds continue current levels of funding for maternity services. The health fund would also provide a package of funding equal to the existing legislative requirements for median medical rebates.

Lead practitioners who wish to participate in the scheme would then compete for patients, with obstetricians, midwives and some GPs building practice networks to bring in and fund other healthcare providers out of the bundled care package. This competition would be transparent on both price and the services offered, providing greater choice to consumers.

PHA has had modelling done on the financial impact to the Australian Government, which is estimated at $246 million over four years.[1]

[1] Estimates assume legislation is passed to allow a 1 January 2026 commencement, with births covered by the scheme being 5,000 in 2025-26 ($15 million); 12,000 in 2026-27 ($36m); 25,000 in 2027-28 ($75m) and 40,000 in 2028-29 ($120m). Recurrent costs stabilise at $120m per annum. PHA has not modelled any impact on the Extended Medicare Safety Net.

## Out-of-hospital care

Reforms that promote out-of-hospital care in Australia must be encouraged. In 2023, PHA released a paper, *There's no place like home*, which highlighted the need for reform to promote out-of-hospital care. Following this, the Australian Medical Association drew attention to the issue with the publication of *Out-of-hospital models of care in the private health system*, which noted: "For some patients, out-of-hospital care can deliver the same outcomes as in-hospital care while also providing patients with other benefits such as the ability to recover in the comfort of home."

Australia is falling behind global best practice because of the limited accessibility of out-of-hospital care. Australian patients are not receiving healthcare supported by the best available evidence. Doctors are unable to support the most effective and innovative models of care because our system does not support them to provide best practice.

Our health financing system was designed in the 20th Century, yet we are dealing with 21st Century health problems. Demand for Australia's healthcare system is growing at an unsustainable rate, driven by the dual burdens of a rapidly ageing population and the growing prevalence of chronic disease. This unsustainable growth is placing pressure on access to care and healthcare costs, especially for patients bearing out-of-pocket costs, and taxpayers more broadly.

We are not rising to the challenge. Australia's private healthcare system is leaving $1.3 billion of potential efficiency on the table by lagging well behind other countries in the uptake of out-of-hospital care models. For many patients, out-of-hospital care is not just safe, high quality and clinically proven, it is the best possible care.

We have not developed these alternatives to cost-intensive inpatient care due to incentive structures and regulation that impede their growth. Increasing adoption of these models of care will provide better care with less burden of treatment, reduce the load upon 'bricks and mortar' hospitals, and reduce wait times and care bottlenecks. Adopting best practice care, including out-of-hospital options, will also reduce growth in private health insurance premiums and out-of-pocket costs, supporting overall access and affordability of care for patients.

We need to:

- address misalignment of incentives in existing funding models
- enable sufficient supply of out-of-hospital care providers to improve consumer access at scale
- enable increased uptake through better use of data and technology, and
- standardise quality and safety of out-of-hospital care models.

The first issue with this proposal is a dearth of well-established programs with clinical guidelines. The first task must be to develop guidelines for agreed clinical areas where out-of-hospital care is appropriate. This requires clinical leadership, with the medical profession providing advice on modern best practice. This should be informed by, but not led by, health funds, hospitals and other out-of-hospital care providers.

Clinical areas that would benefit from early work on guidelines include services which are predominantly provided outside of hospitals in other jurisdictions (such as rehabilitation and some cancer treatment) and services which are inadequately managed in hospital (such as palliative care). While provider preferences are important, improving access to care for consumers should be a high priority.

Minimum default benefits for out-of-hospital care are favoured by providers because they superficially provide certainty, but this is a bad option for consumers. Experience with second-tier default benefits for inpatient care has proven such approaches are cost inflationary, stifle innovation and promote low-value care. This approach will inflate premiums. In the out-of-hospital setting, application of blanket minimum default benefits would also reduce the scope for funds and other stakeholders to effectively monitor the quality of such services. The Government need only look at the experience of minimum benefits in the National Disability Insurance Scheme, which has seen the proliferation of poor-quality care, fraud and mismanagement.

A 2024 Cochrane review – considered the gold standard in systematic reviews of medical research – found home hospitals were comparable to traditional hospitals in clinical outcomes and reduced length of initial hospital stays. But a separate Cochrane review also found that for a major expansion of home hospitals to be effective, health service managers, health professionals and policymakers needed more evidence about implementing and sustaining them.

More attention is also needed to develop a shared approach to the efficient discharge of nursing home-type patients from acute hospital beds. This needs to include health funds, as well as Commonwealth, State and Territory governments.

## Further issues

PHA has also recommended nurse practitioners be allowed to admit and treat patients in private hospitals, as per our position paper in November 2024. This would reduce costs for private hospitals as it would increase the available workforce. The Australian College of Nurse Practitioners and the Australian Private Hospitals Association have also backed this change. The proposal is consistent with other Government policy directions, including Strengthening Medicare, and Scope of Practice changes.

In addition, PHA has called for a roundtable of all Australian governments, private health insurers, private hospitals and aged care providers to help find solutions to aged care type patients remaining in hospital and blocking beds for other patients who need admission. This would focus on out-of-hospital care and affordable models and address an increasing problem for private and public hospitals. With an ageing population this is becoming a serious and intractable issue across the whole sector, not just for public hospitals. One single health insurance claim for an elderly patient awaiting discharge to an aged care facility came to a staggering $753,362 in 2024.

A strategic solution is required which involves engagement by all Australian governments with the private health and aged care sectors. PHA is prepared to commit resources to this.

### Recommendations:

- Implement PHA's GP, Obstetrician and Midwife shared care maternity model as a case study by allowing health funds to offer an end-to-end care package for maternity services with fixed out-of-pocket costs. Where clinicians agree to lead a team and take responsibility for all aspects of care, the Australian Government and health funds each provide at least $3,000 to reduce out-of-pocket costs.

- Remove the list of health professionals that health insurers are permitted to fund in the PHI Act. At the very least nurses of all types should be included if the above is considered a step too far by the left of politics.

- Consider bundled payments for additional treatment areas to create the right incentives for length of stay and discharge to hospital in the home (HITH). An alternative would be to capture incentives for reduced length of stay and increased home care using a National Efficient Price (NEP) model for how Australian public hospital services are funded.

- Work on a shared approach to efficient discharge of nursing home type patients from acute beds. This needs to include health funds, Commonwealth, State and Territory governments.

## Poor co-ordination and occasionally hostile relationships between governments and private sectors leading to poor decision-making, which causes economic waste and unsatisfactory consumer outcomes

A lack of understanding about how health insurance works, along with hostile relations between the Commonwealth, States and private sectors has resulted in poor decision-making, leading to economic waste and poor consumer outcomes.

### NSW seeking to increase funding from private patients

The Minns Government announced in its 2024-25 Budget that it planned to raise an additional $490 million over four years by getting health funds to pay nearly $900 per night for a single room in a public hospital – double the Commonwealth regulated rate that all funds were paying. In addition, single rooms in public hospitals are not routinely available for private patients. Health funds also argued the move would create a massive incentive for public hospital staff to prioritise 'private patients' over public patients when there are plenty of private hospital beds sitting empty across the state.

NSW is the only state in Australia that taxes people contributing to their own healthcare via health insurance. This is despite 65 per cent of the four million people in the state who have health insurance having a taxable income of $90,000 or less, and 38 per cent having an income of $50,000 or less. The ACT also taxes private health insurance.

This case study highlights growing concern about the trend to increase private patient admissions in public hospitals. This practice was called out in the mid-term review of the National Healthcare Reform Agreements conducted by Rosemary Huxtable last year. She said:

> *Some LHNs [local health networks] see private health insurance (PHI) income as an important source of own source revenue, potentially at the expense of public patient admissions. Instances were noted of patients feeling pressured to use their private insurance following an admission from the ED and/or public hospital stay, and then facing out-of-pocket costs. The extent of those costs was not always clear at the point of private patient election.*

## Consumer access to health records

MyHealthRecord requires an urgent upgrade to provide seamless access to patient data across all points of care in the health system regardless of the funder, and to genuinely transfer this tool into patients' hands.

The Australian Government has begun this process, with legislation passed to ensure that pathology and diagnostic imaging results are available to consumers.

Better information for consumers and their clinicians will drive better health decisions, and improved outcomes. For example, the lack of access to test results is cited as one of the reasons that Australians have so many repeat colonoscopies.

Estimates of unnecessary repeat testing are commonly between 7-20%, but PHA is unable to verify these estimates. It is clear a significant proportion of testing is unnecessary; being a simple repeat of an existing test without clinical need. It is very likely that the lack of access to previous test results through MyHealthRecord is a contributing factor to these repeated tests being conducted. Even if only one per cent of tests can be avoided, this would save private health fund members over $2.7 million per annum for diagnostic imaging and pathology testing, in addition to saving the Commonwealth over $4.8 million, in private hospitals alone. More importantly, it would reduce the burden of treatment for thousands of Australians – for example, Australians in private hospitals alone would receive at least 10,000 fewer venepuncture needles to collect pathology tests. Across the community sector, Australians will save thousands of hours waiting for pathology and diagnostic imaging. This will increase productivity and reduce burden of treatment.

There is no reason consumers should not have access to their own health information. Patients being able to moderate their own behaviour with access to their test results show clear benefits to the consumer, to their health providers, and to the community as a whole. Arguments that patients should be kept ignorant of their test results are lacking. Better information results in more comprehensive discussions between patients and their health providers, more ownership of health decisions (where patients are co-designers of their own health care) and will reduce the stresses of receiving health information without preparation.

Further improvements to information being available to consumers is necessary, with PHA recommending all medical records are required to be copied to MyHealthRecord over the next four years.

## Funding models and regulation which poorly target preventive health initiatives in private health

The internal underwriting of PHI under the community rating principles called risk equalisation has the unintended consequence of penalising health funds that invest in preventive care. This is poor public policy and reduces productivity both in healthcare and across the economy.

Despite these disincentives, funds are implementing a range of initiatives aimed at helping members stay healthier, including providing information, heart health checks, and funding clinical prevention services.

At least some of the pooled risk equalisation funding should be allocated on a prospective basis to incentivise investment in prevention and hospital avoidance.

The Australian Government began work on changing risk equalisation arrangements in 2022, but this work has not progressed substantially since PHA published our submission in December 2022. PHA outlined a range of principles for changes to risk equalisation arrangements, including a prospective model and allowing prevention initiatives to be included in the pool. These proposals will increase the incentives for health funds to promote better health care to their customers, with consumer benefits over time. PHA would be concerned if short term changes to maternity and obstetrics coverage came at the expense of more substantive changes with greater consumer benefit.

We did ask that the Commonwealth Government to model the effects of such changes, and if implemented, put in place guard rails with limits on net claims changes over 3% per annum to ensure changes do not overly affect health funds' operations. The Government is yet to publish the results of further modelling.

### Recommendation:

- Implement changes to improve risk equalisation that will shift the cost burden among consumers rather than decrease that cost burden.

## Multiple perverse incentives caused by overpricing the Prescribed List and the second-tier default benefits

### Medical devices

As highlighted in the 2023 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, and significantly higher than countries such as New Zealand, France and South Africa.

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 alone 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."[2] 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.

## Low value care, fraud, waste and abuse

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.

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

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."

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. PHA welcomed the establishment of a unit in the Department of Health and Aged Care in July 2023, 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.

## Default benefits for hospitals

Second-tier default benefits for hospitals have been a policy failure, as explained in PHA's policy paper. Second-tier default benefits act as a floor price for hospital contracts, but there is no ceiling. It means any hospital that can't secure a contract with a health fund is automatically paid 85% of the average contract price for hospitals in that state. This is not only anticompetitive, but it has fuelled the creation of private hospital beds in areas of oversupply and spreads the health fund dollar far too thinly. In the meantime, regional areas continue to struggle to attract private doctors and hospitals.

Designed in the 1990s as a political fix when vastly different market dynamics applied, the policy is no longer serving its intended purpose of safeguarding access and choice for consumers. Nor is it supporting smaller hospitals and those in under-serviced areas, including Australia's rural, remote and regional areas where more healthcare options are needed.

Instead, the default benefits policy has become a hospital subsidy program, particularly for small day hospitals in over-serviced, wealthy urban areas. For example, the current settings provide higher subsidies in affluent northern Sydney than in northern Tasmania, the northern fringe suburbs of Adelaide, and the Northern Territory.

It is untenable that default benefits can be higher in overserviced states than underserviced states. This is entirely unfair and based on hospital location rather than consumer need. The existing percentage-based default benefit varying by location should be removed, and a dollar figure based on the lowest quartile of existing second tier rates should replace it so it is set as a national rate (subject to a rural loading, see below). This national rate would be determined by the Department of Health and Aged Care based on every fund's contractual rates.

Hospital default benefits are also linked to higher out-of-pocket costs for consumers, with a small number of hospitals eschewing health fund contracts, pocketing the second-tier benefit

and charging very high out-of-pocket costs, double-dipping through default benefits and patient contributions. It is unfair to consumers, health funds and contracting hospitals that non-contracting hospitals have a high floor price with no limits on what they can charge consumers.

PHA recommends that to access second-tier default benefits, providers should be required to sign an undertaking that stipulates services receiving default benefits are prohibited from charging more than 100% of the reference price. There is a legislative precedent; prior to 2015, Medicare only paid benefits for services provided by 'participating' optometrists who had signed a Common Form of Undertaking for Participating Optometrists with the Australian Government. The optometry Common Form of Undertaking required that optometrists charge no more than the Medicare Benefits Schedule standard fee. This model could easily be adopted for default benefits.

There is no case for a second-tier benefit based on other contracts, as this fuels health inflation. Once these new rates are set by the department, they should automatically increase each year by the Consumer Price Index, or the average rate of health fund premium increases, whichever is the lower.

Default benefits should be abolished and a revised approach adopted.

## Recommendations:

- Expand the Department of Health and Aged Care's unit to address fraud and miscoding in Medicare.

- Abolish default benefits and explore a National Efficient Price for private health care as a baseline for contracting between private hospitals and health insurers, which bundles the cost of medical devices and surgical supplies into the procedure. Should the Government consider this revised approach, an appropriate trade off to benefit consumers would be:
    - ensuring any hospital claiming second-tier default benefits is not able to charge consumers out-of-pocket costs above a prescribed rate, and
    - default benefits to be standardised at a consistent dollar rate rather than according to a percentage that varies by location.