



Private Healthcare Australia
Better Cover. Better Access. Better Care.



Budget submission 2026-27

January 2026

Contact:

Ben Harris – Director Policy and Research

0418 110 863

ben.harris@pha.org.au

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the private health insurance industry's peak representative body. We have more than 20 registered health funds throughout Australia as members and collectively represent 99% of people covered by private health insurance. PHA members fund healthcare for more than 15 million Australians.

Introduction

Medicare is a world-class health system, but it is under growing strain. While recent government investment has strengthened general practice, affordable access to specialist care is diminishing; more than one-in-five Australians referred to a specialist are not attending because of cost.¹ The consequences are serious: avoidable health deterioration, greater reliance on already-stretched public hospital emergency departments, and reduced private hospital activity that is leading to viability concerns.

Amid acute cost-of-living pressures, Australians are being asked to shoulder rising out-of-pocket costs in a system that has little transparency and often rewards low-value care. Too many consumers are being exposed to expensive yet unnecessary, ineffective and in some cases harmful interventions at a time when affordability has never mattered more. This Budget must prioritise access to high-value care, reducing waste across the health system, and actively disincentivising low-value practices to protect consumers and public finances.

Affordable private health insurance is critical to maintaining access, choice and capacity across Australia's dual public-private health system. Since mid-2020, more than a million additional Australians have joined a private health fund, including many new Australians living in fast-growing outer suburbs where public hospital access is limited. Nationally, more than 416,000 full-rate age pensioners currently rely on health insurance as a safety net for faster access to planned surgery and other essential care.

Private health care underpins the sustainability of the entire health system. More than 40% of hospital separations are funded through health insurance, with 84% occurring in private hospitals. Public hospitals – already facing record-long waiting lists – would be unable to absorb a significant decline in health insurance participation without further deterioration in access and waiting times for patients.

Yet the private system itself is facing mounting structural challenges: rising specialist out-of-pocket charges, increasing costs for private hospitals (that are largely being met by health funds, which is driving up claims and putting pressure on premiums),

¹ Patients Australia and La Trobe University (2025) [*Patient Voice: Sharing Australians' perspectives and experiences with general practice and specialist out-of-pocket costs in Australia.*](#)

mismatches between bed supply and demand, and outdated infrastructure that fails to deliver the modern, efficient care Australians expect.

Consumers are acutely aware of these pressures. Independent polling from RedBridge and Ipsos shows overwhelming concern about specialist fees and a widening gap between Australians' desire to hold private health insurance and their ability to afford it. At the same time, there remains a cohort of working-age Australians who could afford health insurance but choose not to participate, highlighting the need for renewed policy focus on value, relevance and affordability to attract and retain these consumers.

The establishment of the CEO Forum is an important step in aligning government, insurers and private hospitals around shared responsibility for system sustainability. As joint funders of private healthcare, governments and health funds must work together to contain inflation, manage emerging risks and keep premiums affordable for consumers. Incremental change will not be enough. Meaningful reform requires a decisive shift toward a system designed first and foremost around consumers, one that rewards value, improves efficiency, and delivers care in the most appropriate settings.

Strengthening Medicare has rightly been a priority for the Albanese Government, and recent investment in primary care provides a strong foundation for further reform, including expanded scope of practice and more healthcare delivered in the community where consumers prefer to receive it. Polling shows Australians strongly support government intervention. However, there is no sustainable source of funding for private healthcare beyond premiums paid by members or higher out-of-pocket costs borne directly by patients. Improving affordability, therefore, depends on driving efficiency, reducing unnecessary costs and modernising care delivery and the system. This will require direct government action including establishing appropriate timeframes for the implementation of disruptive initiatives such as the private national efficient price framework, the removal of legislative barriers that prevent innovation, and ignoring simplistic pleas for protection in the market.

Growing and sustaining health insurance participation remains one of the most effective ways to support private hospital viability and relieve pressure on the public system. This Budget should be squarely focused on lowering costs for consumers, improving access to specialist care, and ensuring Australia's health system delivers genuine value for every dollar spent, because a system that works for patients ultimately works for everyone.

Recommendations

PHA recommends the Health Portfolio Budget focus on:

- introducing a consumer-focussed private national efficient price
- cracking down on fraud, waste and low value care
- reducing the cost of medical devices to the same as New Zealand
- improving tax incentives to help with cost-of-living pressures and create medium to long-term strategies that are essential to attracting working-age individuals back into health insurance
- increasing transparency of specialist doctors' fees and eliminating surprise medical bills
- advancing innovative models of healthcare that provide consumers with choice and flexibility, while also relieving system pressures, and
- keeping Gold hospital cover affordable. Reviewing the impact and unintended consequences of product tiering.

Introducing a consumer-friendly private national efficient price

Recommendations:

- *Introduce a private national efficient price to reduce consumer costs and improve value.*
- *Overhaul default benefits for hospital services to focus on underserviced areas, such as regional Australia.*
- *Use statutory minimum benefits to drive efficiency, rather than reward inefficient services, including promoting out-of-hospital care.*

Health funds are required to pay minimum amounts to private hospitals, but these minimum payments are based on hospital locations rather than consumer need. For example, minimum benefits are higher in North Sydney than in northern Tasmania, north Adelaide or the Northern Territory. Default benefits should be based on patient service needs, not supporting private hospital business models that are outdated, or driving the supply of new beds in areas of over-supply.

Australia continues to have lengthy hospital stays for common conditions compared to comparable economies, and care continues to be predominantly delivered in hospitals rather than community-based alternatives. Part of the reason for these additional costs is outdated Commonwealth legislation that encourages in-hospital care. The current regulatory requirements for hospital categorisation, default benefits, combined with provider self-interest, mean patients are frequently treated in hospitals instead of more appropriate and effective out-of-hospital (OOH) care settings, even when this does not accord with best practice. This has led to health inflation being concentrated in hospital care and specialist care, instead of investment in more effective general practice and primary care.

PHA has welcomed the opportunity to work with government, consumers and providers to explore options for a national efficient private price. This is an important debate, as the current approach has failed to provide best-value health care to consumers with health insurance.

Consumers need affordable access to high-quality and high-value health care. Hospital viability depends on consumers being able to afford private health insurance – if premiums are too high, people will drop their insurance, and hospitals will have fewer patients. Thus, it is imperative any changes to hospital funding models are only made after careful examination of the effects on consumers and the premiums they pay. Any new system that increases the price of care to consumers will be self-defeating.

PHA has provided advice to the government on key issues that need to be addressed when considering transitioning to a potential private national efficient price, including:

- **Affordability for consumers.** The key requirement for system viability – both public and private – is that consumers can afford private health insurance. Any reforms that increase prices for consumers will not serve the system objectives. A private national efficient price should drive efficiencies.
- **Value versus cost.** Consumers need value from their health care. Most health systems are shifting focus to consumer value and health outcomes rather than provider costs as a basis for funding. A private national efficient price provides an opportunity to incentivise high value care, rather than continuing to embed low value care on a cost-plus model.
- **Transparency.** Greater transparency of hospital finances will lead to better decisions for providers, funders and consumers.
- **Modelling consumer impacts.** Modelling is vital to ensure consumers, governments, payors and providers understand the full impact of reform options.
- **Including medical devices.** The high cost of many medical devices in Australia is driving inefficiencies and costing consumers millions of dollars each week, fuelling supernormal profits for overseas medical technology companies. A private national efficient price will ensure high-value devices are easier to access for consumers, particularly where the device may decrease length of stay or otherwise improve consumer outcomes.
- **Private sector contracting improves patient outcomes.** The development of a private national efficient price should facilitate private sector bargaining and contracting to ensure that the benefits to consumers are maximised. This will include greater consistency and standardisation of some terms and conditions and allowing hospitals to be compensated for continual improvement through contracting.
- **Incentivising continual improvements.** A truly efficient private national efficient price will incentivise providers to look at improved models of care, better outcomes and improved value for consumers.

Our health system should prioritise services rather than infrastructure. Hospitals must change along with community expectations and advances to healthcare. Our health system was set up in the 1970s when acute care in hospitals was the norm. We now have millions of Australians living with chronic conditions and a move to home- and community-based care. Locking in old models of care, which can be capital-intensive, disempowering and inefficient cannot be the goal. We need to modernise healthcare, and have a firm focus on the patient in the context of their lives, rather than our traditional provider- and facility-focused system. This means ensuring the viability of every hospital is a flawed goal – we should be ensuring hospital services match the needs of the community rather than the other way round.

A national efficient private price can help move our health funding system towards a more effective, efficient and higher quality system if it is designed with a future-focus based on modern clinical guidelines and consumer expectations.

More information is available at <https://privatehealthcareaustralia.org.au/wp-content/uploads/20251124-PHA-response-to-Pricing-Framework-for-Australian-Private-Hospital-Services-Draft.pdf>.

Cracking down on fraud, waste and low value care

Recommendations:

- *Set targets to reduce length of stays in hospital to comparable countries.*
- *Remove or limit Medicare Benefits Schedule rebates for low value care.*
- *Increase compliance activities and penalties for fraudulent behaviours.*

Medicare and health funds should not be paying for medical interventions that are known to be ineffective or cause harm. During a cost-of-living crisis and with limited health funding to serve our ageing population that has more chronic conditions, we must challenge vested interests to reduce waste for consumers.

There are many examples of low value care, such as spinal cord stimulators to treat back pain, as well as hospitalising people for simple procedures that can be done in doctors' rooms at a fraction of the cost.

Where healthcare providers are found to be doing the wrong thing, there should be real consequences to deter such behaviour. A culture of tolerating healthcare fraud, waste and abuse is costing consumers millions of dollars annually. More needs to be done to prevent it.

Estimates of the prevalence of waste or low value care in Australia suggest it is a significant issue for consumers, funders and governments alike. As 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.”²

Private health insurance is particularly prone to miscoding and low value care. There can be a culture within some provider groups that health insurance and other third-party payers like workers' compensation, road injuries and other statutory compensation schemes and the Department of Veterans Affairs are cash cows to be exploited. More widely, there has been a culture in the private health sector of providers treating health funds like 'passive payers' with a sense of entitlement that does not necessarily benefit consumers.

Australian consumers and policymakers cannot tolerate this any longer. In an inflationary environment, it is critical every dollar spent in this sector adds measurable

² At <https://bmccmedicine.biomedcentral.com/articles/10.1186/s12916-020-01563-4>

value. Too often, historical funding models under the health portfolio compel expenditure in ways that are wasteful and even harmful.³

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.

We recommend that the Medicare Benefits Review section expand its brief to target disinvestment in low value items from the Medicare Benefits Schedule (MBS). The MBS has retained several procedures where the evidence is poor, and many where there is significant evidence of harm.

Further, we recommend the Medicare Benefits Advisory Committee implement an automatic review process where their estimates are proven to be incorrect. For example, cardiac catheters were estimated to cost consumers \$18.4 million over five years, but the actual figure was \$137.4 million.

PHA also recommends the Australian Government set national targets to reduce hospital length of stay to levels comparable with the top quartile of OECD countries. Australia currently performs at or below average on this measure, which is inconsistent with the standard of our medical practitioners and hospital system. A reduction in average length of stay of just 10% would generate savings of hundreds of millions of dollars each year, while improving productivity by reducing burden of treatment.⁴ These savings would be shared across the Australian Government, state and territory governments, and consumers, with flow-on benefits including downward pressure on private health insurance premiums.

Lastly, PHA recommends that all hospitals – public and private – be required to publicly report quality, safety and administrative performance data as a condition of receiving Medicare funding. Transparent reporting is fundamental to a high-performing health system and is essential to enable robust, consistent and reliable evaluation of health system reforms. Meaningful and sustained improvements are not possible without granular, high-quality data. At present, public hospitals rarely report data on private patient activity, while some private hospitals do not report quality and safety indicators at all. Requiring all hospitals to report data accurately and consistently would strengthen accountability and support measurable improvements in quality, efficiency and overall system effectiveness.

³ Last year's [PHA Budget Submission](#) contains an appendix with several examples of low value care, with over \$300 million pa available in savings.

⁴ Several examples of procedures with high length of stays can be found at <https://www.privatehealthcareaustralia.org.au/theres-no-place-like-home/>

Reducing the cost of medical devices for consumers

Recommendations:

- *Reduce the costs of medical devices in the private sector to the same level as New Zealand, saving consumers \$300 million per annum.*
- *Implement a Code of Conduct for the medical devices industry, consistent with the pharmaceutical industry.*

Nearly half the Australian population relies on the private hospital system for access to medical devices and technology, including critical and widely used items ranging from artificial knee joints to coronary artery stents. Medical device prices in the private system are regulated by the Australian Government and set at rates between 7 and 100% higher than those paid by public hospitals, around 30% higher than prices in New Zealand, and more than double the prices paid in Germany.

Reducing the costs of medical devices to internationally competitive levels would help lower health insurance premiums for Australian consumers and create headroom to better fund private hospitals as they transition to more modern models of care.

Removing the current private sector surcharge paid by consumers would deliver savings of around \$80-100 million per annum. Reducing prices to no more than paid in New Zealand would save Australian consumers and the government more than \$300 million annually. If combined with a systematic program of reducing errors, mispricing and inconsistencies across the Prescribed List of Medical Devices and Human Tissue Products (the PL), premiums for the typical family would be reduced by almost \$100 per annum.

PHA also recommends requiring the medical device industry to implement a Code of Conduct comparable to that applying to medicines. At present, medical device companies may pay secret commissions to providers and place sales representatives in surgical operating theatres without patient consent. They can also engage in a range of other sale-driven practices that are prohibited in the pharmaceutical sector, like providing benefits directly to doctors who use their products without routine disclosure. Subjecting the medical device and pharmaceutical industries to comparable regulatory regimes would strengthen trust and transparency and, most importantly, protect consumers from unethical practices and physical harm.

An enforceable medical device Code of Conduct would help ensure decisions about the use of medical devices are based solely on clinical considerations, rather than being influenced by commercial or other interests.

Improving tax incentives to relieve cost-of-living pressures and create medium to long-term strategies that are essential to attract working-age individuals back to health insurance

Recommendations:

- *Review existing incentives, such as the Medicare Levy Surcharge, its income bands and age segments to enable medium to long-term strategies be developed that will encourage greater participation from the working-age population.*
- *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 and taking pressure off the public system.*

Most Australians with private health insurance earn less than \$100,000 a year and make deliberate financial sacrifices to maintain their health cover. Research consistently shows they these consumers value the ability to choose their doctor and the private hospital where they receive 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 households and younger age groups would improve participation, affordability and equity within the system. These measures would place downward pressure on premiums and improve insurers' risk pools, providing a more stable foundation to meet the needs of a growing and ageing population. Higher participation in private health insurance would also help reduce pressure on emergency departments and public hospitals, supporting broader government economic and health system priorities.

A comprehensive review of existing incentives – including the MLS, its income bands and age-based settings – would support the development of medium- to long-term strategies to encourage greater participation in health insurance among the working-age population. Recent reforms to the age of dependents represented a positive step; however, further policy action is required to sustain participation and growth over time.

Modelling undertaken for PHA suggests a higher MLS for high-income earners would 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 cohorts aged 65 and older, including those on higher incomes. But high-income cohorts over 65 are very unlikely to withdraw from health insurance regardless of their Rebate value. In contrast, lower-income and younger working-age Australians are more likely to buy health insurance if they were given a rebate on their premiums. Further, the current settings, introduced by the Howard Coalition Government, reinforce generational wealth inequity by transferring funds from younger people to older Australians on high incomes.

Combining a higher MLS with a health insurance rebate that is better targeted to lower-income and working-age consumers 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.

Over the past 20 years, the ratio of working to non-working age health insurance participants has decreased from 4.6 working persons to every non-working person (age>60) to 2.7, which means the significant demographic age shift is contributing 3% per annum to Bronze and Basic hospital price via risk equalisation. This requires intervention. Otherwise, premiums will rise to 8% – or more – in the future (3% for calculated deficit for risk equalisation plus 5% for hospital indexation, let alone nurse wages and/or EBA-related inflation).

A thoughtful set of adjustments that grows participation, especially among younger, working-age cohorts, would improve the risk pool for health insurers, stabilise premiums, and relieve demand on stressed public hospitals. It would also reduce pressure on government 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 2025-26⁵

Threshold	Base tier	Tier 1	Tier 2	Tier 3
Single threshold	\$101,000 or less	\$101,001 - \$118,000	\$118,001 – \$158,000	\$158,001 or more
Family threshold	\$202,00 or less	\$202,001 - \$236,000	\$236,001 - \$316,000	\$316,001 or more
Medicare levy surcharge	0%	1%	1.2%	1.5%

⁵ ATO 2025, at <https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge/medicare-levy-surcharge-income-thresholds-and-rates>

By increasing participation in younger age groups, premium increases would be lower 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. Currently, private hospital beds are underutilised while Australians continue to be waiting longer than ever before for elective surgeries in public hospitals. 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 the procedure was necessary.

In addition to changes to the MLS, PHA recommends adjustments to the Rebate to provide more support to low-income earners. When combined with the proposed MLS changes, neither of the two options below involve an increase in government expenditure over the next four years.

PHA recommends reducing the Rebate for high income earners and redistributing the proceeds to lower-income earners. This increases the Rebate for more than six million people and decreases the Rebate for 1.9 million people in tier 2 and tier 3. The Rebate amounts are adjusted to whole numbers and would not need to be changed for five years. This option would save up to \$100 per annum for individuals earning less than \$101,000 and families earning less than \$202,000.

Table: proposed new Rebate rates (% of premium)

	Base Tier	Tier 1	Tier 2	Tier 3
0 to 64 – existing rates	24.288	16.192	8.095	0
0 to 64 – proposed rates	26	18	0	0
65-70 – existing rates	28.337	20.240	12.143	0
65-70 – proposed rates	28	20	0	0
70 or above– existing rates	32.385	24.288	16.192	0
70 or above– proposed rates	32	24	0	0

The Australian Government is projected to save \$1.0 billion in the first year through these measures. 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 health insurance, 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.

The document *PHI Participation Levers for PHA Budget Submission 2026-27* (Attachment 1) provides more information, including costings data and assumptions.

Making it easier to find the right doctor at an affordable cost

Recommendations:

- *Implement the promised Medical Costs Finder website upgrade as soon as possible to improve price transparency and help consumers make informed decisions about specialist care.*
- *Strengthen consumer laws by introducing ‘Surprise Billing’ amendments to ensure patients are not liable to pay medical bills if informed financial consent has been inadequate or provided under duress, such as on the day of surgery.*
- *Increase supply of specialists in areas of high need, including regional areas, to address shortages and introduce more competition so consumers can access care more quickly and easily.*

Polling commissioned by PHA shows out-of-pocket costs for healthcare are a major pain point for consumers, whether for GP visits, medicines, diagnostic services, specialist consultations or planned surgery. Research by the [Australian Bureau of Statistics](#), [La Trobe University](#) and [Patients Australia](#) show up to 20% of Australians are delaying or skipping specialist appointments due to cost.⁶ The [Grattan Institute](#) estimates more than one million people each year miss out on seeing a specialist because they cannot afford it.⁷

Despite increasing GP attendances over the past five years, fewer Australians are following through on specialist referrals. In 2018-19, there were 5.6 million attendances for initial specialist consultations nationally, representing just 3.6% of total GP attendances (157.8 million).⁸ This divergence highlights the growing financial barriers Australians face in accessing specialist care.

By 2023-24, initial specialist attendances had fallen to 5.2 million, representing just 3.2% of GP attendances (163.5 million). Over this period, GP attendances increased by 4% while initial specialist consultations declined by 8%. This equates to around 400,000 fewer people accessing an initial specialist consultation compared with 2018-19, highlighting a growing disconnect between primary care and timely specialist access. Meanwhile, consumers in the public system face wait times up to several years to see a specialist.⁹ Rising cost pressures and out-of-pocket costs are a barrier to timely

⁶ Private Healthcare Australia Media Release, [From \\$650 to \\$5,650: The steep rise in specialist doctor fees for common medical procedures](#), 17 October 2025.

⁷ Grattan Institute (2025) [Special treatment: Improving Australians’ access to specialist care](#), by Peter Breadon, Jessica Geraghty, Dominic Jones, Elizabeth Baldwin, p. 11.

⁸ PHA-Mandala (2026) [Restoring affordable access to specialist care in Australia](#), February 2026 [Attachment 2].

⁹ Australian Institute of Health and Welfare (2024) [Waiting times by intended procedure](#).

specialist access, and without intervention, this trend may result in poorer health outcomes, preventable complications, and increased strain on the healthcare system.

Evidence also suggests some medical specialists are charging exorbitant fees amounting to price gouging in certain cases. [Data released last year](#) shows some psychiatrists are charging up to \$950 and obstetricians up to \$650 for a first appointment. There have also been [credible reports](#) of anaesthetists and surgeons charging patients hidden out-of-pocket costs up to \$5,000, disguised as ‘booking’ or ‘administrative’ fees with no corresponding MBS item number attached. Such practices exacerbate financial barriers and undermine trust in the healthcare system.

Many of these specialists also claim to participate in no-gap fee schemes with health insurers, yet still charge patients directly, thereby increasing their profits. Some consumers have reported that anaesthetists requested payment in cash, or disclosed their fees on the day of, or day before, their procedure, leaving patients fearful their surgery could be postponed if they questioned the amount. Such conduct constitutes duress and clearly breaches the principles of informed financial consent (IFC).

Hyper-inflation in medical costs is also growing. There will be a need to address it, particularly in areas like the ACT where there is little competition between specialist doctors,¹⁰ and in treatment areas where the supply of specialist doctors is constrained. There is available evidence that suggests some medical specialists are working fewer hours 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. Nevertheless, these increased medical costs are a significant driver of inflation, so reducing pressure on costs would also help reduce pressure on interest rates.

Surprise out-of-pocket costs cause health insurance members considerable frustration. Consumers should be able to confidently start a course of treatment knowing how much the total cost will be, and they should not be receiving information about fees, such as anaesthetists’ fees, on the day of a procedure. This sort of “drip pricing” needs to be addressed in our health system. While many doctors and hospitals provide no-gap (or known-gap) services, some consumers experience very high out-of-pocket costs, and some patients are not made aware of these costs in advance.

Australia could learn from surprise billing legislation that has been introduced in the United States of America, with bipartisan support, to strengthen existing consumer protections. PHA released a detailed policy paper, [Combating Surprise Billing in Australia](#), which recommends the introduction of surprise billing legislation here. The proposal’s key elements are that patients should not be liable for costs above the MBS

¹⁰ Private Healthcare Australia Media Release, [Revealed: the states and territories where people face the highest out-of-pocket costs for private medical care](#), 27 March 2025.

schedule fees where they have not been informed in advance, and doctors and hospitals should face civil or criminal penalties for deceiving patients, insurers and/or governments about their charges, including by imposing hidden fees outside of Medicare and health insurance arrangements.

Another measure that could help reduce inflation is the upgrade to the Medical Costs Finder (MCF) website, which was introduced by Greg Hunt, the previous Minister for Health, in the 2019-2020 Budget at a cost of more than \$17 million. In late 2019, he announced that “In 2020, the information [available on the MCF website] will expand so people will be able to... see the fees for particular medical specialists.” This promise was repeated several times over subsequent years, but it was only in 2023 that the website was able to accept individual specialists’ fees, and only when the fees were volunteered by the doctor.

The take up by doctors to MCF has been woeful with only a handful of medical practitioners willing to post their fees. The Senate Estimates Community Affairs Legislation Committee was told on 7 November 2024 that 218 doctors were registered on the website, 73 of whom had agreed to publish their fees.¹¹ A Department of Health and Aged Care official told the committee the website had so far cost the nation \$24.2 million. The website, while with some merit in principle, has failed to deliver on the primary objective of helping consumers determine what fees their specialist is likely to charge.

Publishing all doctors’ actual fees – derived from Services Australia data – would help ensure consumers had a meaningful choice of doctor for any treatments required. It would also reduce the costs of medical care, as better market information for consumers would increase competition and encourage people to ask questions of their doctor while shopping around for affordable treatment.

PHA commends the Government for announcing last year it would compel doctors – including surgeons and anaesthetists – to disclose their fees on the website, providing consumers and their GPs greater transparency about specialist costs before appointments.¹² This represents a significant win for consumers and should be implemented by the government as a matter of urgency.

In late 2025, RedBridge was commissioned by PHA to undertake consumer research with 13 focus groups across the country. Not one participant had heard of the MCF

¹¹ Parliament of Australia Budget Supplementary Estimates 2024-25, Community Affairs Legislation Committee, Thursday 7 November 2024, Portfolio Question Number DoHAC SQ24-003240 available at https://www.aph.gov.au/Parliamentary_Business/Senate_estimates/ca/2024-25_Supplementary_budget_estimates

¹² Private Healthcare Australia Media Release, *Health funds welcome plan to reveal thousands of specialist doctors’ fees for the first time*, 17 March 2025.

website. Once it was revealed and explained to them, they were disappointed to learn that all doctors were not listed.

A related survey of consumers, also conducted in 2025, revealed 94% of Australians believe the government needs to act on improving patient choice.¹³ It found consumers believe their options are constrained by single-referral habits of GPs, and a limited local supply of specialists in certain locations, particularly outside of metropolitan areas. One-in-three (33%) in inner metropolitan areas stated they were unable to get appointments with specialists or surgeons in a timely manner, and this proportion nearly doubles in rural Australia (61%).¹⁴ Rural and regional Australians are often left with no practical alternatives but to travel further to access care, endure extended delays or forego care.

In Australia, it takes at least 12 years to train a medical specialist.¹⁵ There is a persistent undersupply. This is particularly the case in regional areas, where rural health services struggle to fill vacancies. To compound the issue, there is no comprehensive national specialist workforce planning mechanism.¹⁶ Lowering the registration barriers for overseas-trained doctors would allow Australia to increase the supply of specialists in shortage areas urgently. However, excess supply could lead to risks of overservicing and supply-induced demand.¹⁷ This is where significant information asymmetries permit doctors to exert unwarranted demand for their own service. Workforce planning must, therefore, be balanced and the supply of specialists be increased thoughtfully and to match public health needs appropriately.¹⁸

¹³ PHA Mandala (2026) *Restoring affordable access to specialist care in Australia*, February 2026.

¹⁴ Ibid

¹⁵ Grattan Institute (2025) *Special treatment: Improving Australians' access to specialist care*, by Peter Breadon, Jessica Geraghty, Dominic Jones, Elizabeth Baldwin.

¹⁶ Kruk (2023) [Independent review of overseas health practitioner settings](#).

¹⁷ Sekimoto (2015) [Supplier-induced demand for chronic disease care in Japan: Multilevel Analysis of the Association between Physician Density and Physician-Patient Encounter Frequency](#).

¹⁸ Australian Institute of Health and Welfare (1998) [Medical workforce supply and demand in Australia](#)

Advancing innovative models of healthcare that provide consumers with choice and flexibility while also relieving system pressures

Recommendations:

- *Allowing more innovative models of healthcare outside of hospital settings that improve consumer access and eliminate out-of-pocket costs, while improving the long-term sustainability of our health system.*

Australia's health financing system was designed in the 20th century, yet we are dealing with 21st century problems. Demand for our 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. But more than \$1 billion of potential efficiency is being missed due to Australia lagging well behind other countries in the uptake of out-of-hospital (OOH) care models. For many patients, OOH care is not only safe and high quality, but the best possible care for their personal circumstances.

PHA's *There's no place like home* report identifies the following archetypes for OOH or hospital substitution care as:

1. Primary prevention and coordination (e.g., coordination of cancer screening)
2. Chronic disease management and monitoring (e.g., chronic disease management, including secondary and tertiary prevention programs)
3. Triage and emergency management (e.g., telehealth triage or virtual emergency departments)
4. Mental health and substance misuse management (e.g., mental health hospital-in-the-home and rehab-in-the-home)
5. Peri-operative management (e.g., short-stay surgical models)
6. Acute care/single intervention (e.g., direct admission into hospital-in-the-home or chemotherapy at home)
7. Step down services and rehab (e.g., typical step-down hospital-in-the-home and rehab in the home), and,
8. End-of-life care (e.g., palliative care at home).

Health funds are already permitted to fund some of the above types of care in the community, but associated processes are often bureaucratic and burdensome, which limits patients' ability to access high quality care and restricts the choice of where they can receive services.

Removing regulatory barriers to allow health insurers to develop more innovative models of healthcare would offer Australian patients greater choice, reduce the load upon 'bricks and mortar' hospitals, and help cut public hospital wait times and care

bottlenecks. It would also reduce costs for all players, including consumers and governments.

The Productivity Commission has called for government reform for sectors where regulations unnecessarily impede new entrants such as in private health insurance.¹⁹ The commission indicated health insurers are well positioned to play an active role in facilitating models of care to improve prevention and long-term outcomes, including in OOH services.²⁰

Health funds want to create a more patient-centred private health system with fewer out-of-pocket costs for consumers and more options for them to receive care at home and in the community. Allowing health funds to do this would help contain rising costs across the system and take pressure off the public health system, which picks up the slack when people cannot afford to access private care.

One example of how health insurers could increase consumer access to private healthcare, while reducing pressure on public hospitals, is changing current legislation so health insurers can fund bundled private maternity care.

The costs of having a baby in Australia's private system are prohibitive. The decline in birth rates is putting pressure on providers, with several facilities struggling due to declining numbers. 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 from 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. Many obstetricians are pricing themselves out of the market by charging thousands of dollars for pregnancy management. However, for expectant parents, obstetrics services are just one of the most visible costs. When you include scans, pathology, hospital birthing services, anaesthetists, paediatricians and midwives, there are many opportunities for consumers to be slugged with additional out-of-pocket costs. Many of these costs are not disclosed at the beginning of the episode of care with a private obstetrician.

New models could help 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,

¹⁹ Productivity Commission. 5-year Productivity Inquiry Report. March 2023.

²⁰ Ibid

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 out-of-hospital costs and health funds are legally unable to contribute. Out-of-pocket costs for 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 selected by the patient (the obstetrician, midwife or GP) to coordinate all the services required and manage the care. The lead practitioner would negotiate the remuneration with other medical providers to present a single invoice to the patient that covered all services they required.²¹

Such an approach would eliminate the “drip pricing” currently experienced by consumers, ensuring they are aware of the total out-of-pocket costs before they start their private maternity care journey. Such a model, where a lead practitioner coordinates both the health and the financial aspect of care, would be a genuine innovation in the Australian context, and one that would be warmly welcomed by patients who want more affordable maternity options with greater price certainty.

PHA recommends medical practitioners, midwives and GPs be able to coordinate care in this manner. Offering expectant parents with a wider range of practitioners to lead their care would 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 would get more certainty and, ultimately, a better deal.

To compensate lead practitioners for the administrative burden and reduce overall out-of-pocket costs for consumers, PHA recommends health funds and the Australian Government each provide a minimum of \$3,000 to lead practitioners who agreed to

²¹ The package would include a standard range of services. Should the birth be especially complex and require an extraordinary range of services, the lead practitioner may charge the patient more under strict conditions.

undertake the task of coordinating care and providing a single bill to the patient. The Australian Government would only provide \$3,000 on the condition the health fund provides no less than \$3,000 towards out-of-pocket costs.²² The health fund would also provide a package of funding equal to the existing legislative requirements for median medical rebates. Lead practitioners who wished 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.

The financial impact to the Australian Government is estimated at \$246 million over four years.²³

²² 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.

²³ Estimates assume legislation is passed to allow a 1 January 2026 commencement, with births covered by the scheme being 5000 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.

Keeping Gold hospital cover affordable

Recommendations:

- *Undertake a full review of the measure introduced by the previous government to categorise health fund products into strict tiers – Gold, Silver, Bronze and Basic.*
- *Simultaneously look at risk equalisation options to try and take the pressure off Gold.*

The former government introduced a strict system of tiering health insurance products based on value (treatment areas covered) in the belief this would help consumers choose an appropriate product. It has had the effect of creating a risk pool for top hospital cover (“Gold”), which only consists of people who know they are going to claim.

By its very nature, Gold covers the most expensive admission types, e.g., mental health, pregnancy and birth, joint replacements and weight loss surgery. The rate of inflation of the underlying cost of Gold has been catastrophic – in the order of 20-30%. The sector warned the government this would be a consequence of legislated product tiering when it was introduced. It has led to the following outcomes:

- health funds not promoting Gold products to consumers, or not offering them at all because of the high cost and risk of adverse selection
- health funds closing existing Gold products to protect current members from large premium increases, and then relaunching them at a higher price (illegal under ‘phoenixing’ legislation currently being drafted)
- all but the highest risk consumers abandoning Gold products, and
- the Australian Prudential Regulation Authority (APRA) putting pressure on health funds to review Gold products that are loss-making.

Unless something changes, Gold hospital cover is unsustainable at a time when the health insurance sector needs to offer customers value for money. In addition to the cost-saving measures described elsewhere in this document, the policy outcomes and unintended consequences of product tiering should be reviewed as a matter of urgency.

The impact of including maternity and mental health in risk equalisation should also be modelled to determine the impact of spreading the risk of these high-cost admissions.