

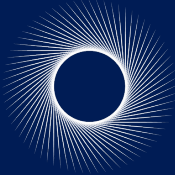


Restoring affordable access to specialist care in Australia

FEBRUARY 2026

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MANDALA

This document is intended for general informational purposes only. The analysis in this report was commissioned by Private Healthcare Australia and prepared by Mandala.

Mandala is a research firm with offices in Melbourne, Canberra, Sydney and Perth. Mandala specialises in combining economics, data analytics, and policy knowledge to study the challenges facing businesses and government.

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Note: All dollar figures are Australian dollars unless indicated otherwise.

The Government is advancing broader economic and health reforms for all Australians ...

... yet out-of-pocket costs continue to rise, exacerbating cost-of-living pressure on consumers

4.9% health inflation

despite easing cost-of-living pressures

8% fewer specialist consults

despite more GP attendances between FY19 and 24
(10% fewer for in-person visits between CY19 and 24)

\$270 out-of-pocket costs

for in-hospital services in FY24

Without change, consumers could find themselves paying \$1.7B in out-of-pocket costs by 2030

\$322 out-of-pocket costs

if costs continue to grow at 3% to 2030

1.2M consumers delay care

due to expensive specialist costs

A targeted package of measures will ensure that consumers can access high quality care, of their choosing, provided at a fair and transparent cost

Implement Medical Costs Finder

- 1 in 2 are stressed about medical costs and unaware of fees
- 94% believe the Government should improve patient choice
- Upgrades to Medical Costs Finder will improve transparency, choice, and referral processes

Improve regional specialist supply

- 61% of rural Australians cannot get timely appointments
- ACT residents pay \$335 higher costs than the national average
- Overseas-trained doctors could alleviate shortages in accessing quality care in regional areas

Encourage scope of practice reform

- Midwives leave their profession at 2.3x higher rates than Medical Practitioners
- Reforming scope of practice can improve workforce capacity and flexibility

Fix billing practices

- Over 1 in 2 receive unexpected bills and 29% are charged often illegal fees for 'booking' and 'admin'
- Withdrawals from super for medical care are rising, inflating health costs
- Consumer protections can prevent surprise billing and hidden costs



1

Out-of-pocket costs continue to rise; reform will be needed to keep healthcare affordable for all Australians

2

Implementing Medical Costs Finder can improve price transparency and help consumers make informed decisions

3

Increasing the supply of specialists in regional areas can address shortages and improve equitable access to care

4

Encouraging scope of practice reform can maximise health workforce capabilities and improve medical service supply

5

Fixing inappropriate billing practices can improve consumer protections and reduce inflationary forces

While cost of living pressures across the economy in general have eased, health inflation remains high at 4.9%

The steep rise in inflation since 2020 placed real pressure on consumers. The health group of CPI in particular rose significantly by 10.0 index points, while all groups of CPI excluding health rose by 5.7 index points since June 2023. This means that consumers are facing disproportionate cost increases in healthcare services, with health inflation growing faster than the general rate.

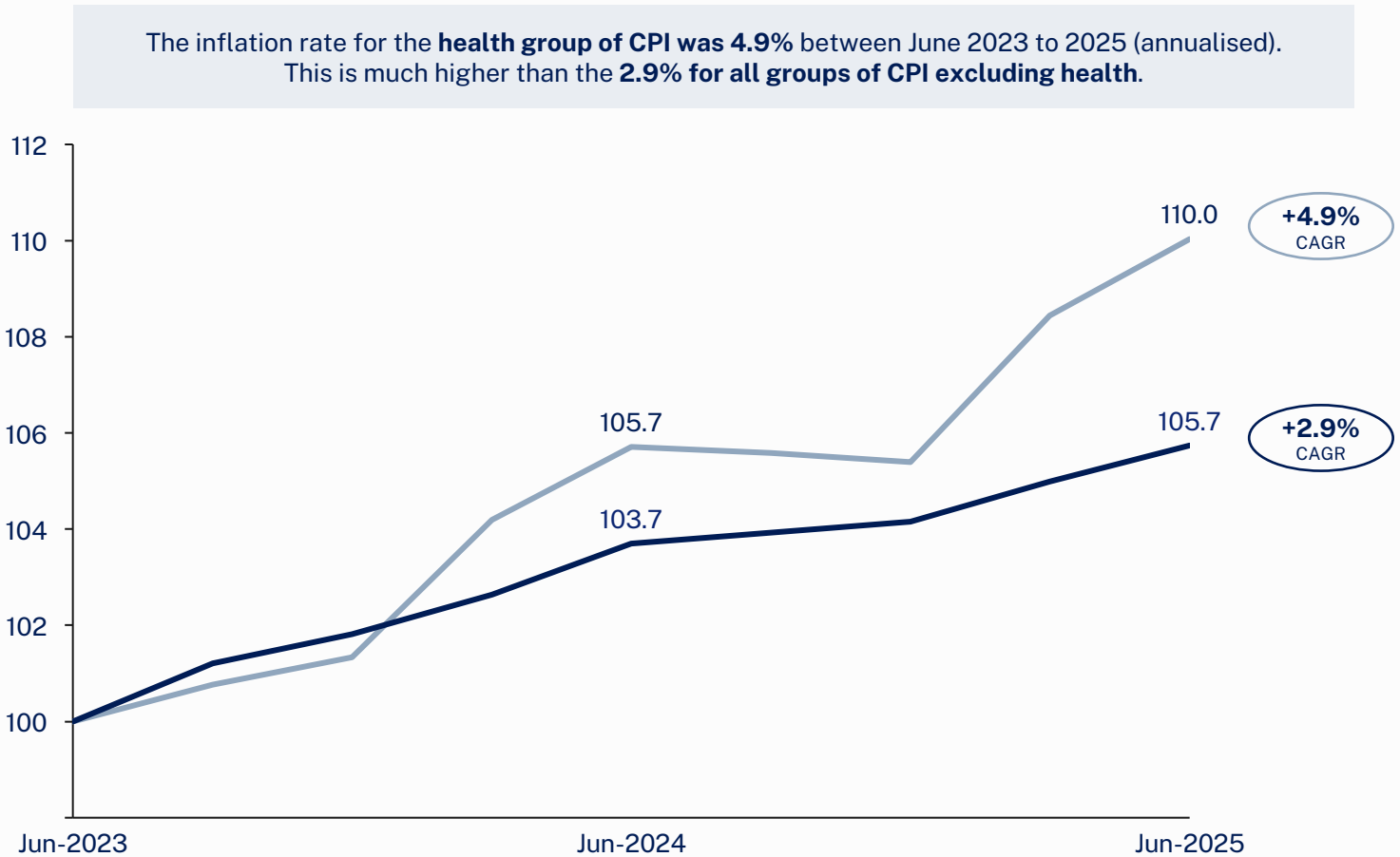
Further breaking down components that make up the health group of CPI, the medical and hospital services component had the highest inflation rate between June 2023 to 2025¹:

- Overall health group of CPI: 4.9%
- Medical and hospital services: 5.9%
- Pharmaceutical products: 1.6%
- Dental services: 3.2%

Source: 1. Australian Bureau of Statistics (2025) Consumer Price Index.

Quarterly Consumer Price Index (CPI) increase

Index points, % CAGR, indexed to June 2023² — Health group of CPI — All groups of CPI excluding health



Notes: The health group of Consumer Price Index is one of 11 groups which is the first level of disaggregation of CPI (ABS, 2017).

Source: 2. Australian Bureau of Statistics (2025) Consumer Price Index.

Government is advancing broader economic and health reforms to ease inflationary pressures among other challenges

SUMMARY OF CURRENT HEALTH AND ECONOMIC REFORM INITIATIVES

Productivity reform	Private Hospital financial assessment	NHRA negotiations	Other reforms
Australia’s labour productivity growth is amongst the lowest in the OECD since 2015, with 6.5 ppt less growth relative to the OECD average.¹ The Federal Government’s Economic Reform Roundtable² focused on improving Australia’s productivity, particularly solving for the following challenges: ▪ Declining levels of private investment ▪ Declining productivity amidst a fast-growing non-market sector ▪ A growing need for workforce adaptability and reskilling ▪ Low adoption of emerging technologies ▪ Meeting emission targets at a low cost	Private hospitals are an important part of the Australian health system but face long-term financial challenges, with costs outpacing revenue in recent years. The Private Hospital Financial Viability Health Check³ found that: ▪ Private hospitals account for 40% of all hospital admissions and ~70% of elective surgery. ▪ The private hospital sector have faced several financial shocks - such as the COVID-19 pandemic and the associated restrictions on elective surgery. ▪ Inflationary pressures and workforce challenges are driving continued financial volatility.	The National Health Reform Agreement (NHRA)⁴ is undergoing negotiations on a new Addendum, following a 12-month extension. There is pressure for these negotiations to address the following identified issues⁵: ▪ Current models drive care toward inpatient settings, rather than an integrated care approach that would better suit the increasing prevalence of chronic conditions. ▪ Current funding arrangements are seen as growing too slowly, which impact the capacity for hospitals to respond to demand pressures. ▪ There are a lack of provisions to address market failures in rural and remote areas.	The Government is also advancing several other reforms, signalling commitment to health and broader economic reform: ▪ Strengthening Medicare⁶ initiatives to modernise and improve access to primary care ▪ National Medical Workforce Strategy⁷ to build a stronger and sustainable medical workforce ▪ Aged Care Act 2024⁸ to implement a person-centred and rights-based approach to care ▪ The Digital Health Blueprint⁹ to encourage innovation in Australia’s digital health systems

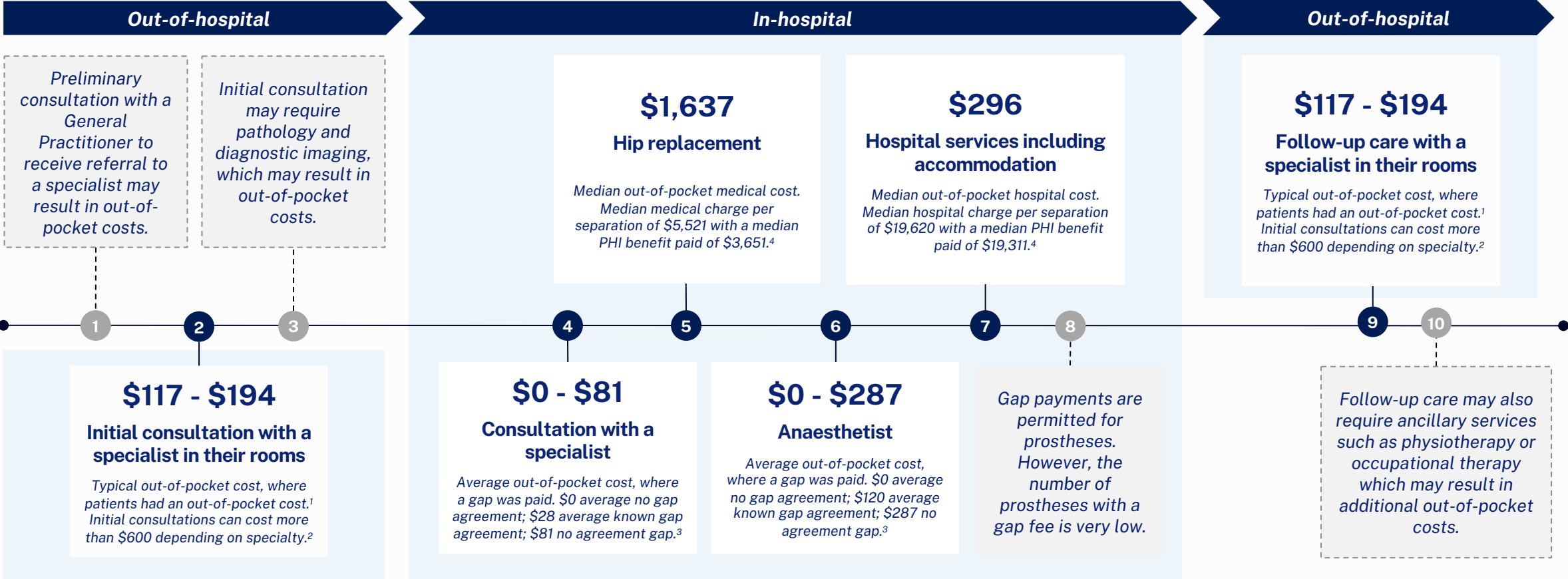
Source: 1. OECD (n.d.) GDP per hour worked (Index, Constant prices, 2020) 2. The Treasury (2025) *Economic Reform Roundtable – Productivity*. 3. Department of Health, Disability and Ageing (DHDA) (2024) *Private Hospital Financial Viability Health Check – Summary*. 4. DHDA (2025) *National Health Reform Agreement (NHRA)*. 5. DHDA (2023) *Mid-term review of the National Health Reform Agreement Addendum 2020-2025 – Final Report* 6. DHDA (2025) *About the Strengthening Medicare measures*. 7. DHDA (2024) *About the National Medical Workforce Strategy 2021-2031*. 8. DHDA (2025) *About the new rights-based Aged Care Act*. 9. DHDA (2023) *The Digital Health Blueprint and Action Plan 2023-2033*.

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Consumers face out-of-pocket costs across the healthcare journey; in-hospital and specialist costs are the most expensive

Illustrative healthcare journey for a consumer undergoing a hip replacement without complication or comorbidity

\$AU24, FY24



Notes: AR-DRG used: Hip Replacement W/O Catastrophic CC (I03B).
Source: 1. Department of Health, Disability and Ageing (2024) Medical Costs Finder – Initial specialist appointment. 2. Grattan Institute (2025) Special treatment – Improving Australians access to specialist care. 3. APRA (2024) Quarterly Private Health Insurance Medical Services June 2024. 4. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

Visible out-of-pocket costs have grown significantly in the last two years, as consumers paid a median \$270 per service in FY24

In a period of rising cost-of-living pressures, out-of-pocket costs for medical services have increased significantly. The cost increase in real dollar terms means the average consumer is paying more in 2024 than they would have in 2014 for the same medical service, after adjusting for inflation.

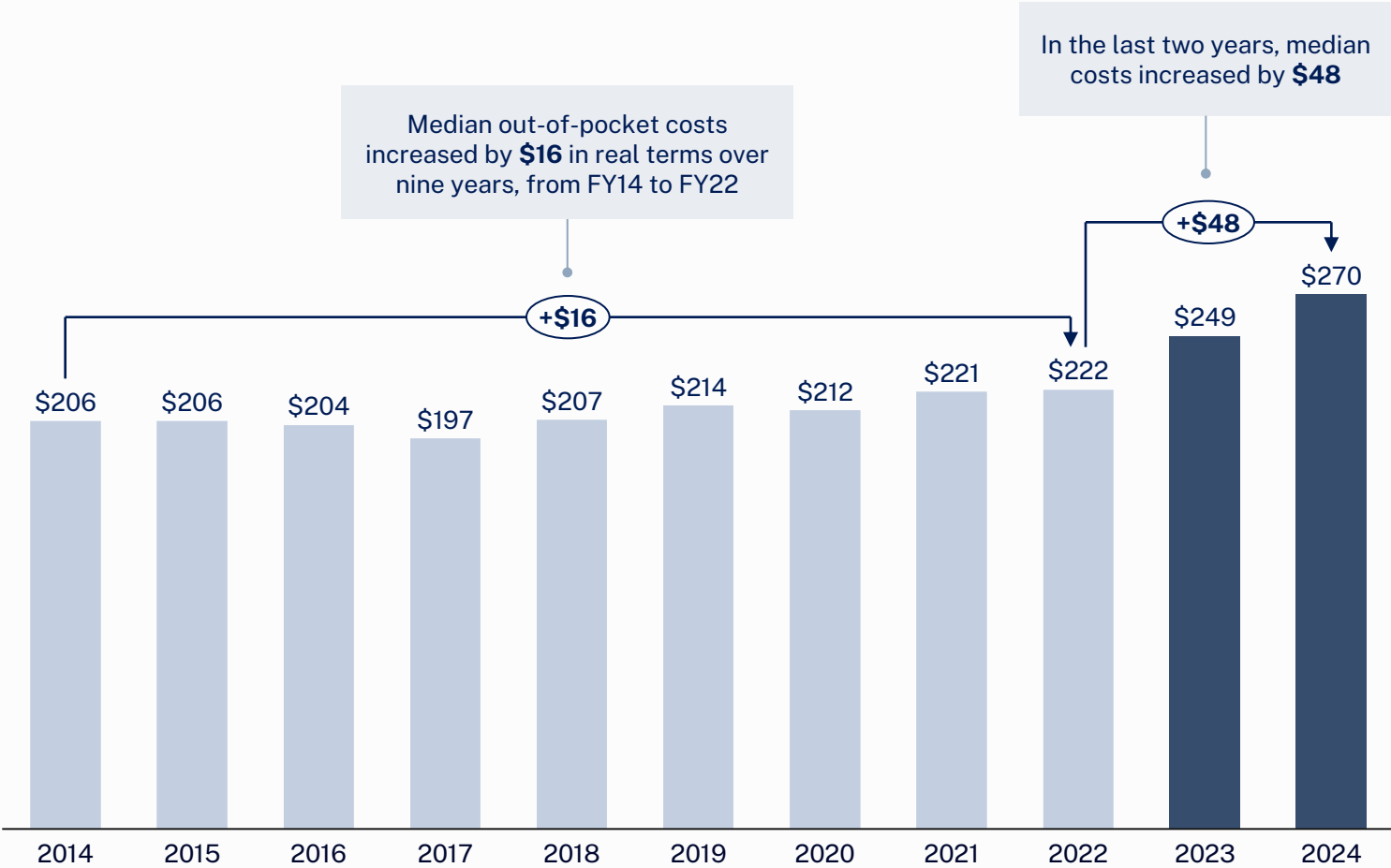
The recent rise in costs is significant in the broader context of the last eleven years. Between FY14 to FY22, median out-of-pocket costs rose by \$16 over nine years. However, in just two years, from FY22 to FY24, costs increased from \$222 to \$270. This \$48 increase is triple the increase of the preceding nine-year period.

This cost increase follows a period of relative stability. Real costs declined slightly between 2014 to 2017 and rose gradually between 2017 to 2022. Cost growth per service was \$27 between FY22 and FY23 and \$21 between FY23 and FY24.

Notes: Costs are calculated as the weighted average of the median medical gap payment for all procedures classified under AR-DRG v.7.0. The costs are weighted by the number of total separations for that procedure in that year.

Median out-of-pocket cost for in-hospital medical services

\$AU24, FY14 to FY24



Notes: Data from public hospitals excluded. Procedures with Catastrophic or Severe Complications and Comorbidities (CC) were removed to exclude rare and high complexity procedures.
Source: APRA (2024) Quarterly Private Health Insurance Medical Services December 2023. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

Consumers will face \$322 in median out-of-pocket costs per procedure if costs continue to grow at trend, adding up to \$1.7B in 2030

If out-of-pocket costs continue to grow at 3% to 2030, median out-of-pocket cost will grow from \$270 in 2024 to \$322 by 2030. In real terms, this is \$52 higher than the current median out-of-pocket cost.

This increase will contribute to a total of \$1.7 billion in additional out-of-pocket costs for consumers by 2030.¹

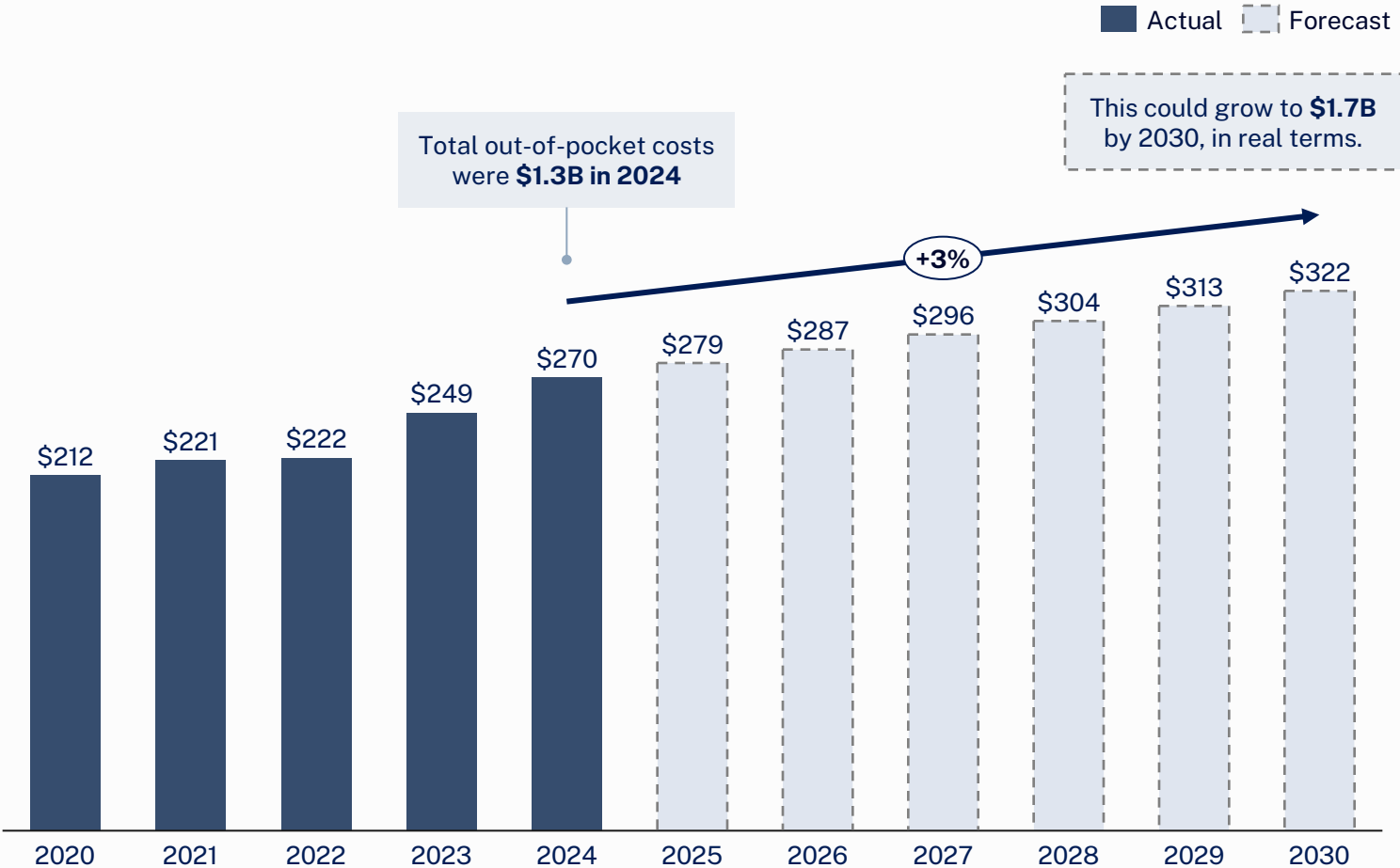
Out-of-pocket growth will continue to be a product of key drivers including inflation, limited supply of medical specialists and a lack of price transparency. If left unchanged, these drivers will continue to place upward pressure on out-of-pocket costs.

Based on historical changes in out-of-pocket costs for specific procedures, it is anticipated that out-of-pocket growth will not be consistent across all areas of the private healthcare market. The median out-of-pocket cost across all procedures is low when compared to the out-of-pocket cost for many of the high-cost procedures.

1. The \$1.7 billion estimate is based on projected out-of-pocket costs and the projected number of separations, maintaining the current cost distribution between medical specialists and other related expenses.

Out-of-pocket cost for in-hospital medical services

Median cost per separation for in-hospital medical treatments, \$AU24, FY20 to FY30²



2. Data from public hospitals excluded; see appendix for methodology and assumptions.
Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data.
Mandala analysis.

Initial specialist consultations declined by 8% in the last 5 years as consumers face increasing cost barriers

Despite increasing GP attendances, fewer Australians are following through with specialist referrals, with cost identified as the primary barrier. In FY19, there were 5.6M attendances for initial specialist consultations across Australia, equivalent to 3.6% of GP attendances (157.8M). By FY24, initial specialist attendances fell to 5.2M, equivalent to 3.2% of GP attendances (163.5M).

In that period, GP attendances rose by 4% while initial specialist consultations decreased by 8%. This represents about 420,000 fewer people attending initial specialist consultations.

When measured in calendar years, the decline in in-person initial specialist consultations between 2019 and 2024 is 10%. Data from FY25 suggests that these initial consultations are yet to recover to pre-pandemic levels, with the decline estimated at 7% from FY19.

The widening gap between GP visits and specialist consults from FY19 to FY24 suggests that consumers are seeking primary care and receiving appropriate referrals, but do not attend specialist consultations in the private system. Meanwhile, consumers in the public system face wait times up to several years to see a specialist.¹

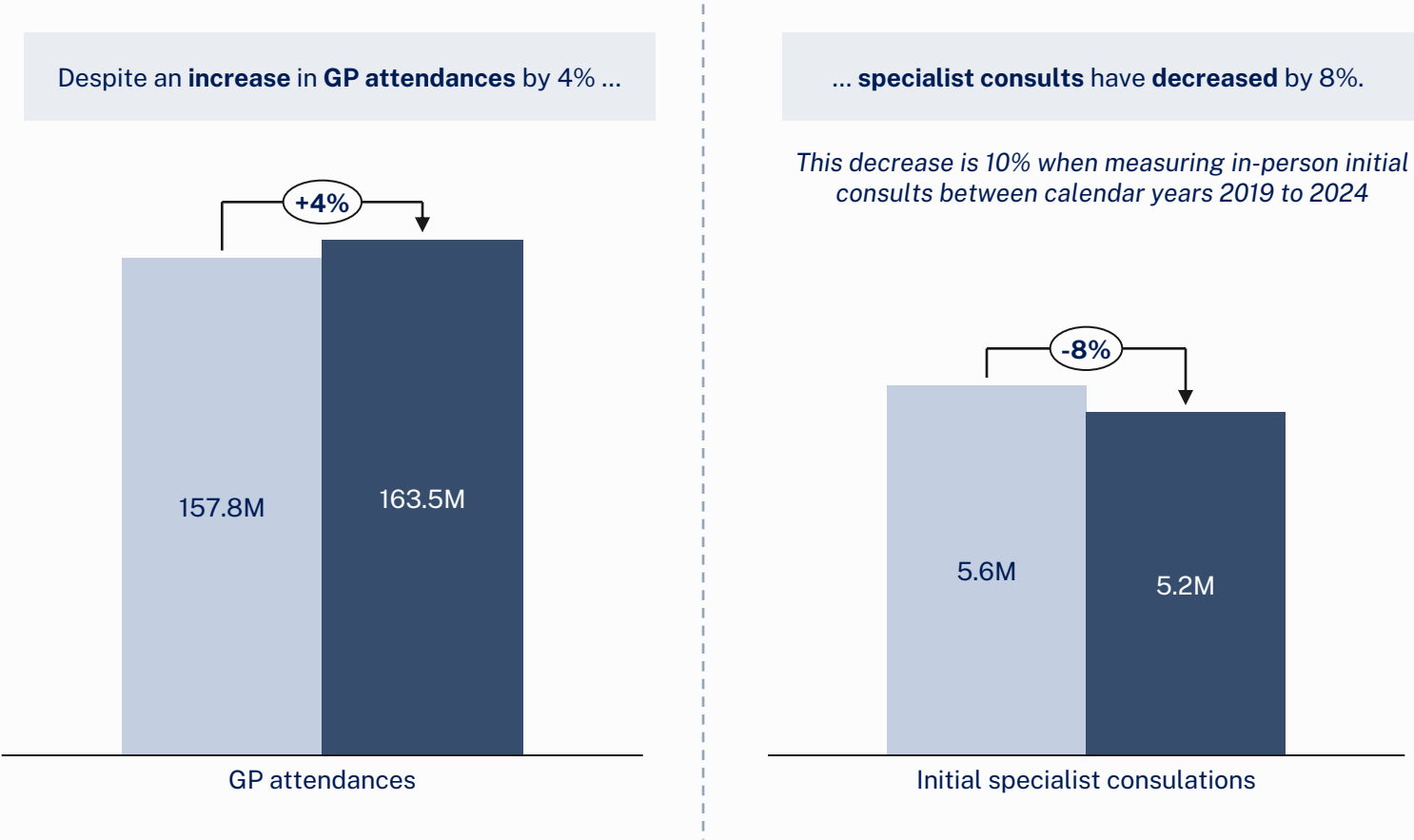
Rising cost pressures and out-of-pocket costs is a barrier to timely specialist access. Without intervention, this could lead to worse health outcomes, preventable complications, and a greater strain on the healthcare system.

1. AIHW (2024) *Waiting times by intended procedure*.

Medicare-subsidised GP attendances and initial specialist consultations

Number of total Medicare-subsidised services in Australia, FY19 to FY24^{2,3}

FY19 FY24



Notes: Initial specialist consultations data includes MBS item 104 (Specialist, Initial attendance, Face-to-face) and MBS item 91822 (Specialist, Initial attendance; Telehealth equivalent of 104); Introduced since COVID-19). Source: 2. Services Australia (2018-2025) *Statistics – Medicare Item Reports*. 3. AIHW (2019-2024) *Medicare-subsidised GP, allied health and specialist health care services across local areas*.

As costs rise, 1.2M consumers will delay or avoid accessing specialist care by 2030, an additional 330,000 from 2024

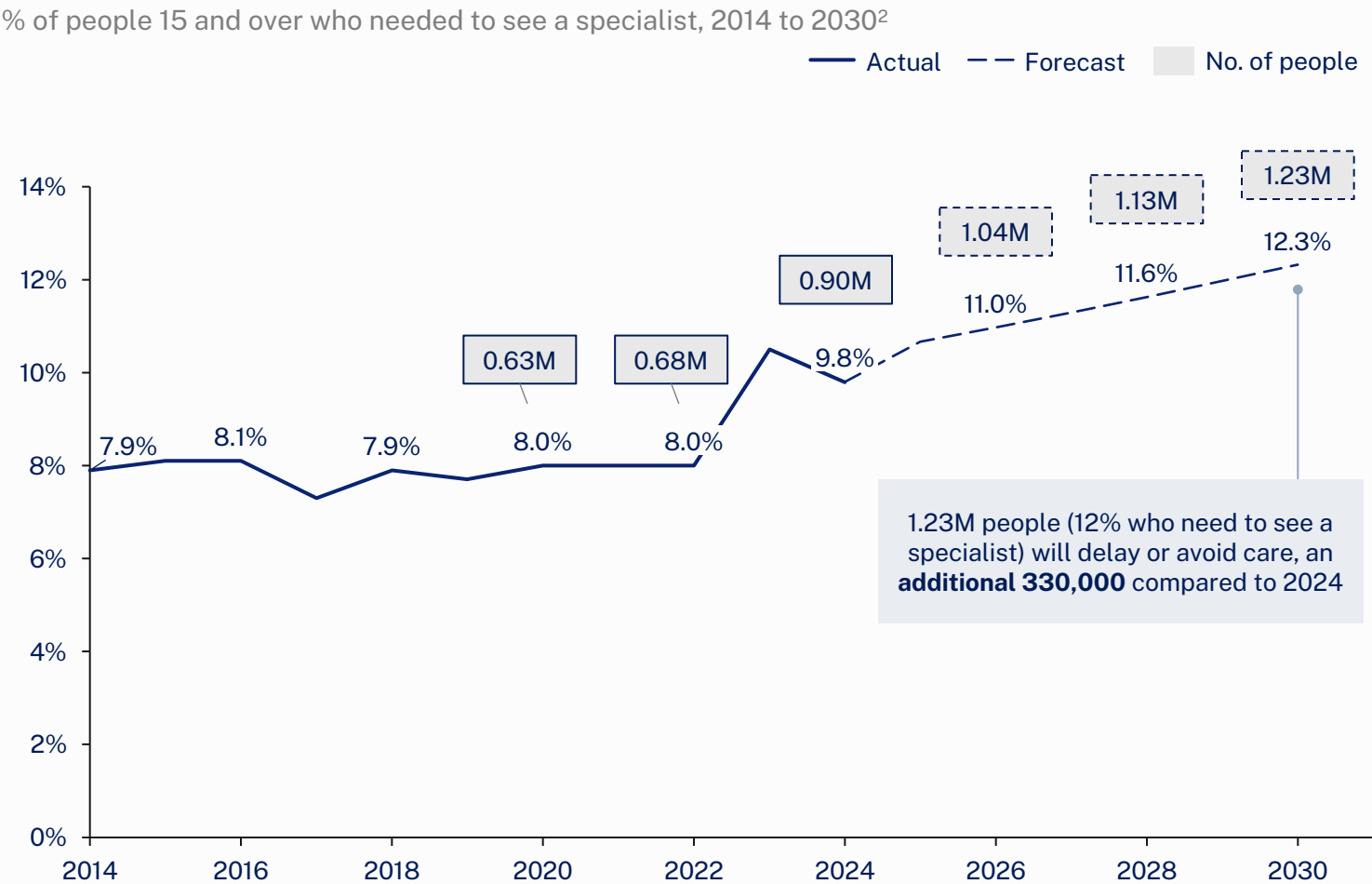
In 2024, 9.2M people aged 15 and over in Australia needed to see a specialist. However, 1 in 10 of those consumers delayed or did not see a specialist and cited cost as a reason. This is equivalent to 0.9M people delaying or avoiding specialist care because fees were too costly.

As costs rise, there will be more consumers delaying or avoiding care. With out-of-pocket costs expected to increase at 3% annually to 2030, it is estimated that 12.3% of consumers will delay or avoid care due to cost. This represents 1.23M people who need specialist care in 2030, an additional 330,000 people compared to those delaying or avoiding care in 2024.

Consumers cited consultation fees being too high (15%) and out-of-pocket expenses being too much (14%) as the top two reasons for delaying or cancelling an appointment in the past 12 months.

Source: 1. Commonwealth Bank (2024) CommBank Patient Experience Insights 2024.

Proportion of people who needed to but delayed or did not see a specialist due to cost



Notes: Assumed population growth rate of 1.4% each year. Data from 2021 was excluded as an outlier due to a rise in specialist attendance from post-COVID catch up; see appendix for full methodology and assumptions.
Source: 2. Australian Bureau of Statistics (2024) Patient Experiences, 2023-24, Table 10 and Table 12.2. Mandala analysis.

Young people are more likely to avoid seeing a specialist as costs rise, with an additional 10,000 set to miss out on care by 2030

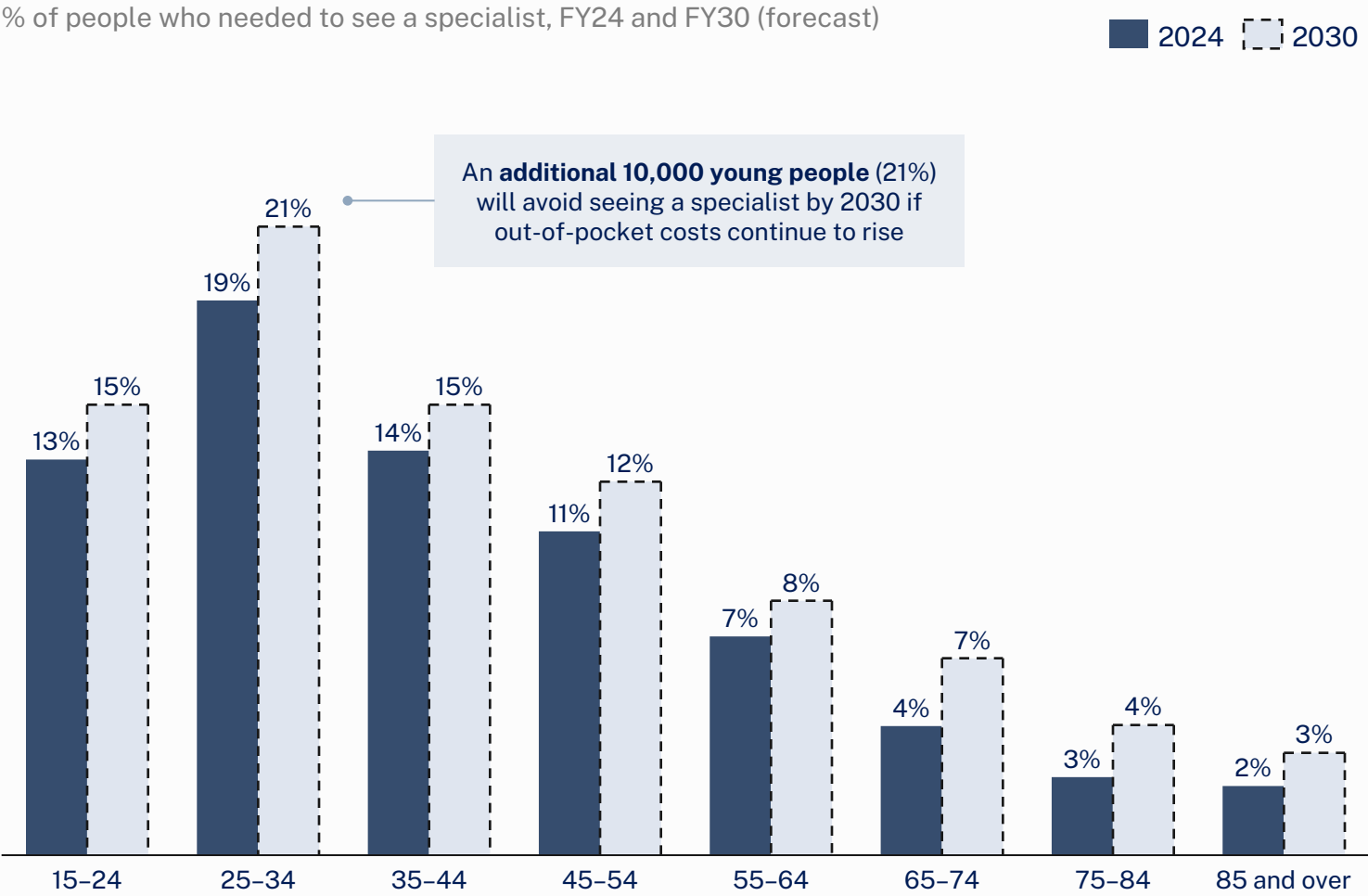
Cost pressures will affect consumers differently. The share of people delaying seeing a specialist due to cost is highest in younger age groups, with up to 21% of 25–34-year-olds potentially foregoing or delaying care in FY30 due to cost.

The proportion of people who needed to but did not see a specialist is higher for individuals who live in more disadvantaged areas (11%) compared to the least disadvantaged areas (8%). Consumers in inner regional areas are also more likely to avoid seeing a specialist due to cost than consumers in other areas.

In the intersection of these groups; young people in disadvantaged, inner regional areas, these impacts will compound, and it is expected that the proportion of people who will avoid or delay care in this cohort to be even higher.

Source: Australian Bureau of Statistics (2024) *Patient Experiences, 2023-24*.

Proportion of people delaying or avoiding seeing a specialist by age group



Notes: Assumed population growth rate of 1.4% each year. Data from 2021 was excluded as an outlier due to a rise in specialist attendance from post-COVID catch up; see appendix for full methodology and assumptions.
Source: Australian Bureau of Statistics (2024) *Patient Experiences, 2023-24*. Mandala analysis.

When it comes to healthcare, consumers care about quality, cost, transparency and choice



The four main drivers shaping consumers’ experience and decisions in healthcare are **quality, cost, transparency** and **choice**.

While Australia has established frameworks for quality, significant challenges remain in the other three dimensions. Addressing these gaps will ensure equitable access to healthcare and reduce difficult trade-offs that consumers face when choosing between health and financial wellbeing.

DOMAIN	 QUALITY	 COST	 TRANSPARENCY	 CHOICE
CONSUMER EXPERIENCE	Consumers perceive a weak link between price and quality in healthcare. This disconnect means that consumers cannot confidently determine whether paying more results in better services and treatment outcomes. However, this report does not examine the quality of healthcare as Australia has robust and established frameworks for safety and quality in health care.	Out-of-pocket costs are increasing each year. High costs lead to consumer sacrifices including: ▪ Using debt to fund treatment ▪ Cancelling other spending ▪ Delaying or foregoing appointments ▪ Prioritising children’s needs over parents, and ▪ Withdrawing superannuation for non-terminal healthcare.	Consumers are often unaware of full medical costs up-front. ‘Bill shock’ is common when facing payments that are unexpected or difficult to navigate, such as: ▪ Surprise or late invoice ▪ Up-front deposits, and ▪ Complex and multi-line bills. This also leads to embarrassment when asking for fees, loss of agency from the inability to plan, and deferral of care.	Choice in healthcare is constrained, with consumers unable to access their preferred specialists and treatment options. The main reasons are: ▪ Single-referral habits by GPs limit the range of specialists available to a consumer ▪ Limited local health workforce reduces consumer choice, especially in regional areas.

Top reform opportunities include improving MCF, growing specialist supply in regional areas, acting on scope of practice reform, and fixing billing practices

Government measures and its impact on health consumers and the health system

	Description	Impact on health consumers	Impact on system
1 Implementing Medical Costs Finder (MCF) including automated referral processes	MCF is a price transparency mechanism that helps patients find the typical cost of medical services in Australia and can be expanded to assist GPs in referring patients.	Supports consumers to prepare for treatment costs in advance and lead cost discussions with medical specialists.	Helps to reduce out-of-pocket costs and assists patients in making informed healthcare decisions, which can reduce rates of deferred care.
2 Improving the supply of specialists in regional areas	The specialist shortage in regions can be improved by increasing the intake of overseas-trained doctors whilst safeguarding quality.	Reduces waiting times for health consumers in regional areas and increases access to quality care.	Addresses shortages and introduces more competition - which can lower prices and relieve pressures on the public system from deferred care.
3 Encouraging scope of practice reform	Ensuring medical professionals work at the top of their scope of practice, especially in the areas of maternity, mental health, and chronic disease management.	Expands accessibility for health consumers by improving service supply and maximises the capabilities of the workforce.	Addresses shortages and introduces more capacity and flexibility in the workforce, which allows consumers to access care more quickly and easily.
4 Fixing billing practices	Current policies allow for 'surprise billing' practices, which can be fixed by introducing penalties for inappropriate billing and mandating upfront quotes.	Reduces hidden costs and uncertainty when accessing specialist services, allowing consumers to prepare for and make informed decisions.	Reduces risk of billing fraud and waste , which can reduce unnecessary costs to taxpayers and consumers as a result of leakages and price markups.

Together, these measures can address the challenges faced by consumers of cost, transparency and choice

Government measures should address the three main challenges consumers face when accessing specialist services - cost and sacrifice, transparency and choice.

To do this, we propose a coordinated package of measures – implementing Medical Costs Finder, improving the supply of specialists in regional areas, encouraging scope of practice reform and fixing billing practices - that together address all three challenges.

At a baseline, each measure works to either reduce information asymmetries or correct supply-demand imbalances. This can alleviate the cost and sacrifice challenges consumers face when accessing specialist care. Additionally, implementing Medical Costs Finder and fixing billing practices reduce the effects of ‘surprise billing’ and opaque price discrepancies, which can address the transparency challenges consumers face. Improving the supply of specialists in regional areas also provide consumers with a wider pool of specialists, which can address the choice challenges that consumers are experiencing.

Proposed package of government measures and challenges addressed

	Challenges facing consumers		
	Cost	Transparency	Choice
1 Implementing Medical Costs Finder	✓	✓	✓
2 Improving the supply of specialists in regional areas	✓		✓
3 Encouraging scope of practice reform	✓		✓
4 Fixing billing practices	✓	✓	

Coordination across the sector will be necessary for this package to be successful

Actions and coordination needed to successfully deliver proposed package

LEGEND
● High involvement
● Medium involvement
● Low involvement

Proposed measures	Actions	Stakeholders			
		Parliamentarians, government departments and regulators	Health industry bodies and unions	Medical providers (e.g. specialists)	Patients and consumers
1. Implementing Medical Costs Finder	1. Incentivise specialists and patients to engage in Medical Costs Finder ¹	●	●	●	●
	2. Include procedural complexity, patient reviews and other quality factors to contextualise costs ^{1 2}	●	●	●	●
2. Improving the supply of specialists in regional areas	3. Increase the intake of overseas-trained medical specialists, particularly in regional areas ³	●	●	●	●
	4. Fast-track credentials whilst maintaining rigorous standards verification and quality safeguards (including communication skills) ^{2 3}	●	●	●	●
3. Encouraging scope of practice reform	5. Ensure medical professionals work at the top of their scope of practice, especially in the areas of maternity, mental health, and chronic disease management.	●	●	●	●
4. Fixing billing practices	6. Introduce administrative penalties for inappropriate billing	●	●	●	●
	7. Mandating upfront quotes	●	●	●	●
	8. Increase the scrutiny of ‘booking/administrative’ fees	●	●	●	●



1

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New survey data shows 51% of consumers are stressed due to medical costs

More than half of consumers (51%) experience stress due to medical costs, including 78% of those under significant financial strain and 21% of those under no financial strain at all.

Some of this stress is exacerbated by a lack of price transparency. Consumers who cannot access information about fees up front are unable to plan adequately or make informed decisions about their care.

The Medical Costs Finder is incomplete and offers limited guidance to consumers looking for cost information for different treatments or locations (e.g. ACT and NT). Consumers often attend appointments without knowing the full costs, and this uncertainty causes stress even among those who could afford the care if costs were clear upfront.

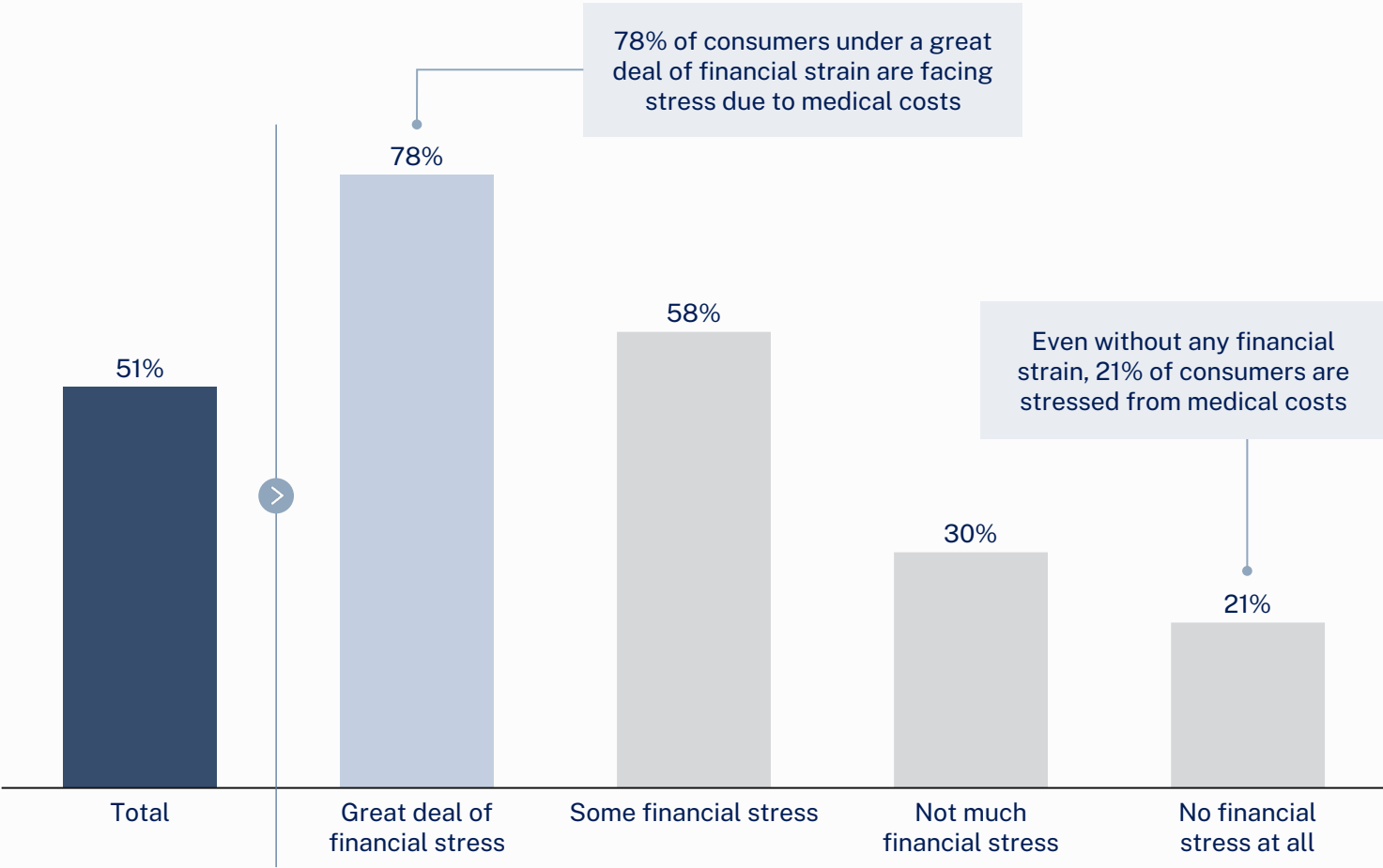
Without straightforward access to information on the typical costs of medical services, consumers lose agency in planning for financial and healthcare decisions. Price transparency for all treatment types in all regions is important in ensuring equitable and informed choice.

Source: Redbridge (2025) Medical Experiences Survey.
Department of Health, Disability and Ageing (2025) Medical Costs Finder.

Consumers experiencing stress due to medical costs, by financial strain levels



% of survey respondents, n=4,014, 2025¹



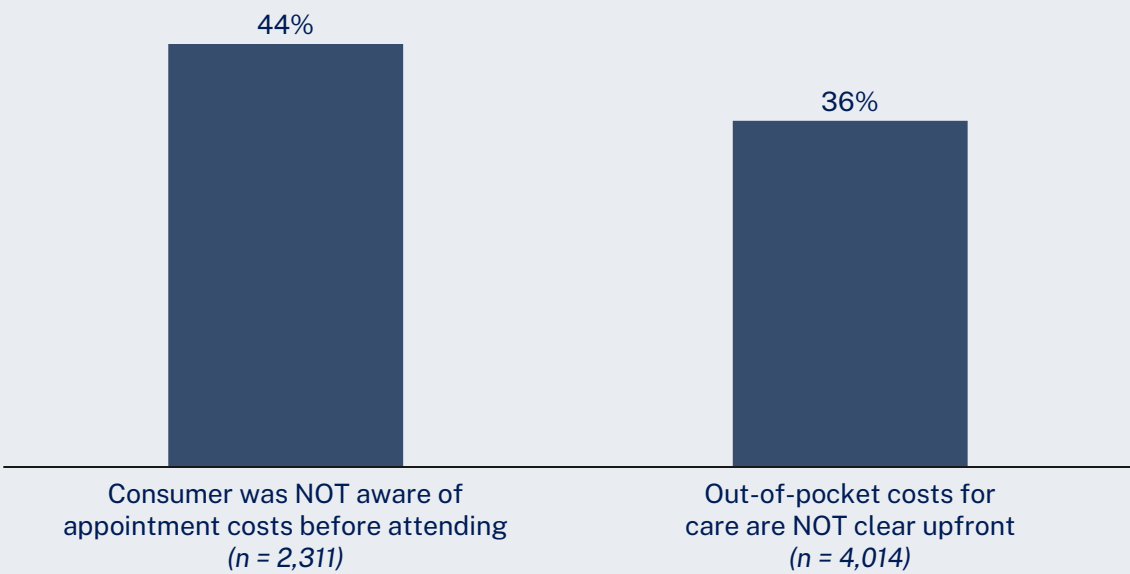
1. Respondents were asked: "If you or someone in your immediate family were referred to a medical specialist or surgeon today, to what extent would the following be true? Medical costs do not cause me any stress". They could respond: Very true, Somewhat true, Not true, Not sure, or Prefer not to say. Chart displays the proportion who answered Not true. Source: Redbridge (2025) Medical Experiences Survey.

Almost 1 in 2 consumers are not aware of fees prior to their appointment with a specialist ...

Consumer awareness of appointment costs and out-of-pocket costs

% of survey respondents, n=2,311 and 4,014, 2025¹

Almost **1 in 2 (44%)** are **unaware** of appointment costs and **over 1 in 3 (36%)** **lack clarity**. The **lack of transparency** around out-of-pocket costs causes uncertainty, leaving consumers unable to plan for treatment expenses or make informed decisions.



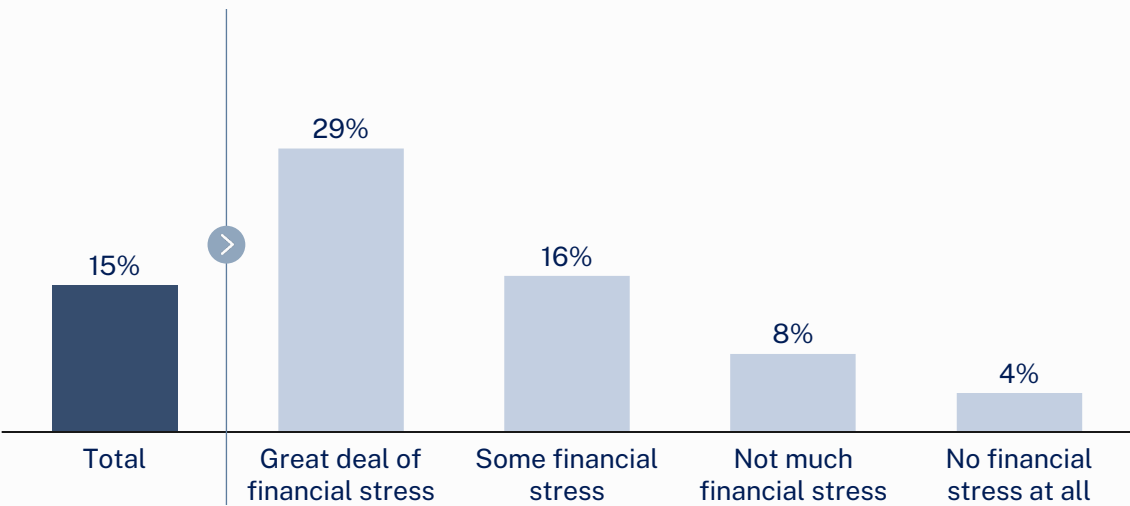
1. Respondents were asked: “Before your most recent referral to a medical specialist or surgeon, did you or your family member know the cost of the appointment before attending?” 2. Respondents were asked: “Do you agree or disagree that the out of pocket costs for specialist care (e.g. appointments, tests, treatments and procedures) are usually made clear to patients upfront?”. Source: Redbridge (2025) Medical Experiences Survey.

... and consumers who do not understand their bills are also under greater financial stress

Consumers who do not understand their bills, and financial stress levels

% of survey respondents who rarely or never understand their medical bills, n=4,014, 2025²

15% of people “Rarely” or “Never” understand their bills from a specialist or surgeon. **Complex medical billing** particularly affects those under **high financial stress (29%)**, compared to those **without financial stress (4%)**.



2. Respondents were asked to rate their experience with bills from a medical specialist or surgeon. They could respond: “Always understand”, “Usually understand”, “Rarely understand”, “Never understand”, or “Not applicable”. Source: Redbridge (2025) Medical Experiences Survey.

Health consumers are also frustrated by a lack of choice, with 94% believing that the Government should act on improving patient choice

Consumers value choice in healthcare, yet their options are often constrained by GP single-referral habits and limited local supply of specialists, particularly in regional areas. Even with available and transparent pricing, consumers are unable to make informed choices and act on information regarding costs.

We need to make things easier for GPs to know what specialists near them charge, in a way that they can share it transparently and quickly with their patients in the consulting room. This would allow patients to quickly view the local range of costs without the stigma or embarrassment of having to request an alternative due to price.

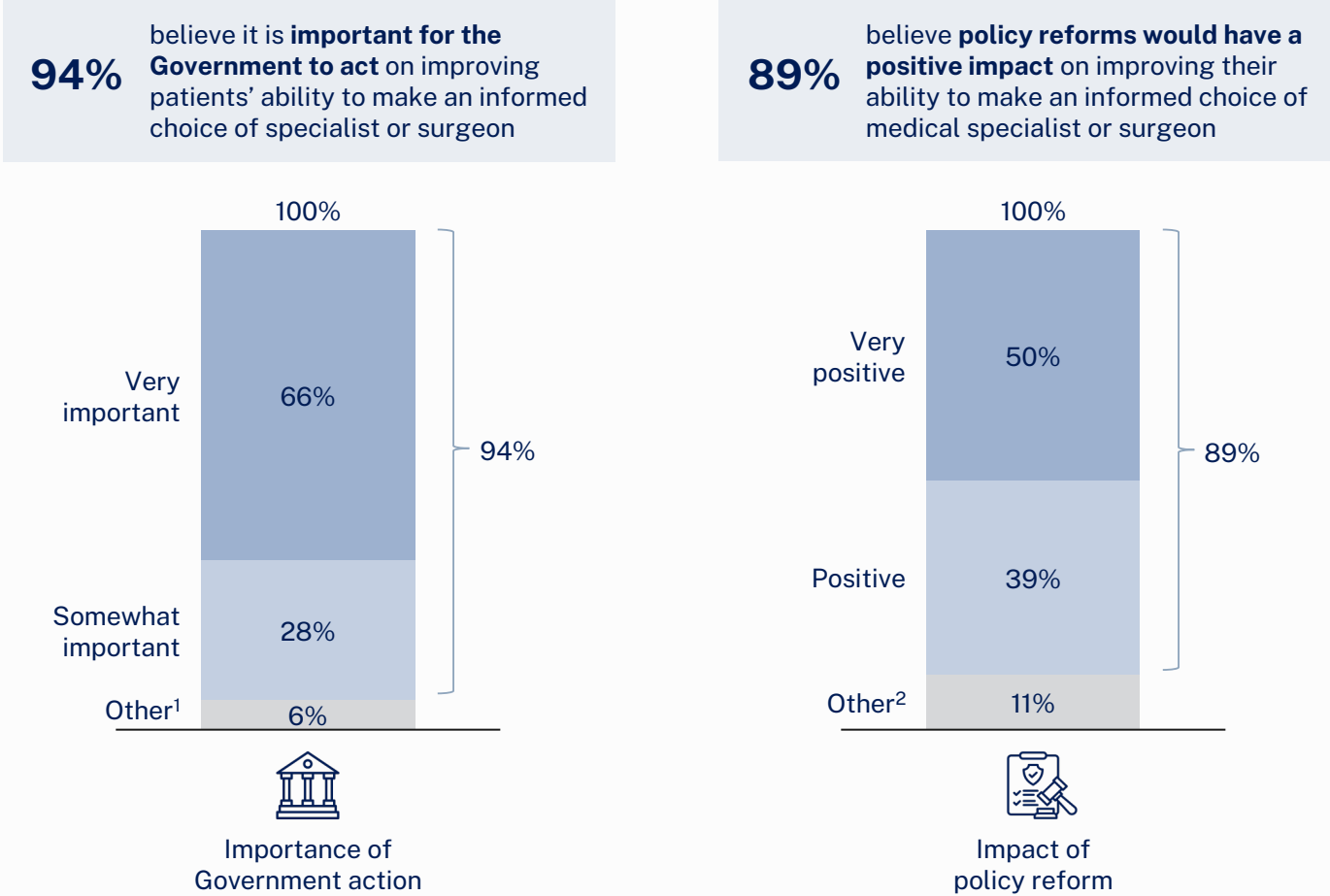
Narrow referral pathways limit the ability to compare and choose medical professionals based on cost, location, or expertise. Consumers in regional and rural areas may also face disadvantages due to the limited availability of specialists, and extended waiting periods may force them to accept the most readily available options.

Almost all consumers (94%) believe it is important for the Australian Government to act on improving patient choice, and 89% believe policy reforms would have a positive impact on choice.

Perceived importance of Government action and impact of policy reform on consumer choice



% of survey respondents, n= 4,014, 2025



1. Includes respondents who selected *Not important* or *Not sure*. 2. Includes respondents who selected *Neither positive nor negative*, *Somewhat negative*, *Very negative*, or *Not sure*.
Source: Redbridge (2025) Medical Experiences Survey.

Medical Costs Finder is a tool for consumers to find and understand typical costs for procedures, but experiences vary across Australia

Information available on the Medical Costs Finder website for hip replacement

Medical Costs Finder (MCF) is a **tool to find and understand costs** for GP and medical specialist services. Consumers can:



- Find typical medical costs in different locations
- Locate medical specialists for select services
- View a typical patient journey for select procedures
- Anticipate and plan for costs before appointments

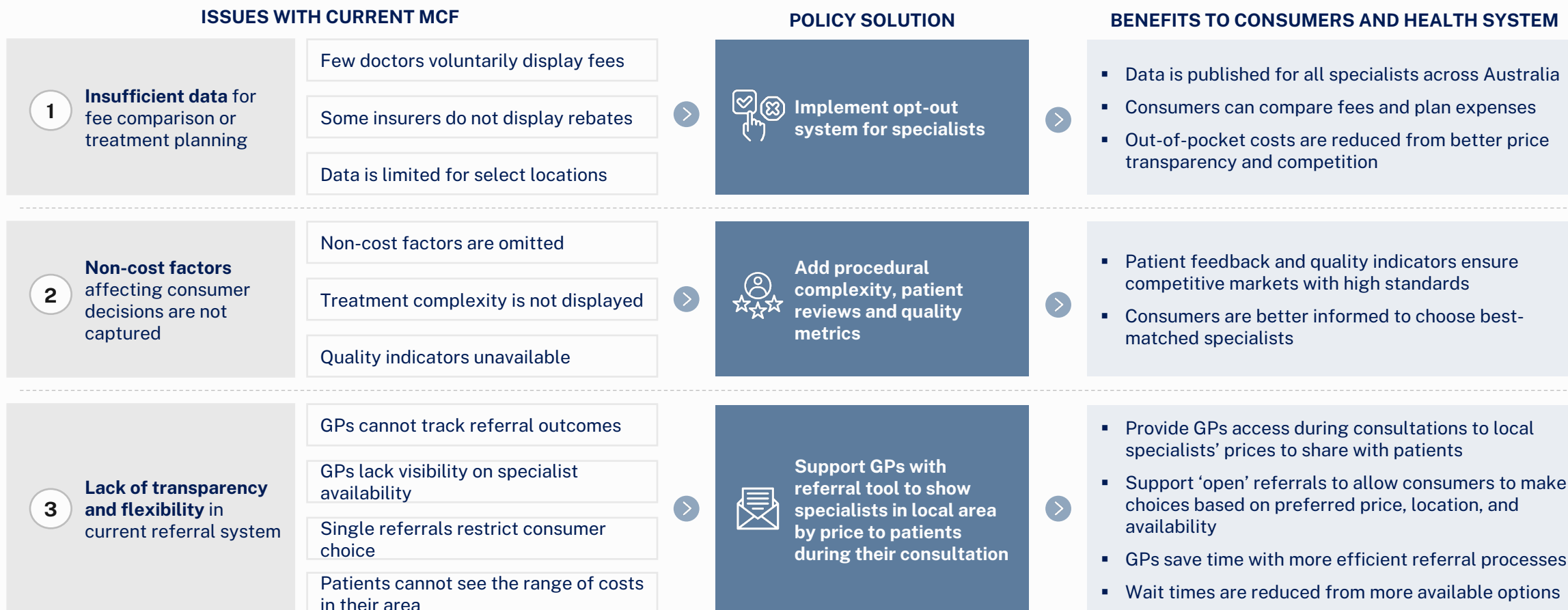
Australians in different states and territories can look for relevant information regarding out-of-pocket costs for different procedures. However, areas like **NT and ACT provide little to no information**, and available data may not be an accurate representation of most experiences.

	 Consumers who paid out-of-pocket	 Typical out-of-pocket costs	 Number of specialists listed	
Australia (total)	16% have no out-of-pocket costs	\$1,000	14 specialists listed with fee information	In FY24, the actual medical gap ranged from \$1 to \$9,976 in NSW , and \$1,515 to \$5,849 in NT , depending on treatment complexity. However, cost ranges or procedure complexities are not displayed on MCF.
New South Wales	16% have no out-of-pocket costs	\$2,900	10 specialists listed with fee information	
Northern Territory	No data available	No data available	No specialists listed	

Note: Information available on Medical Costs Finder website as of October 2025.
Source: Department of Health, Disability and Ageing (2025) Medical Costs Finder – Hip replacement.

Upgrades to Medical Costs Finder can improve price transparency and help consumers make informed choices, while streamlining referrals

Benefits of upgrades to the Medical Costs Finder tool





1

Out-of-pocket costs continue to rise; reform will be needed to keep healthcare affordable for all Australians

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Implementing Medical Costs Finder can improve price transparency and help consumers make informed decisions

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Medical specialist shortages disproportionately affect the regions, with 61% of people in rural areas unable to get timely appointments

Medical specialist shortages are worse in rural areas, resulting in longer wait times.

1 in 3 surveyed consumers (33%) in inner metropolitan areas are unable to get appointments with specialists or surgeons in a timely manner, and this proportion nearly doubles in rural areas (61%).

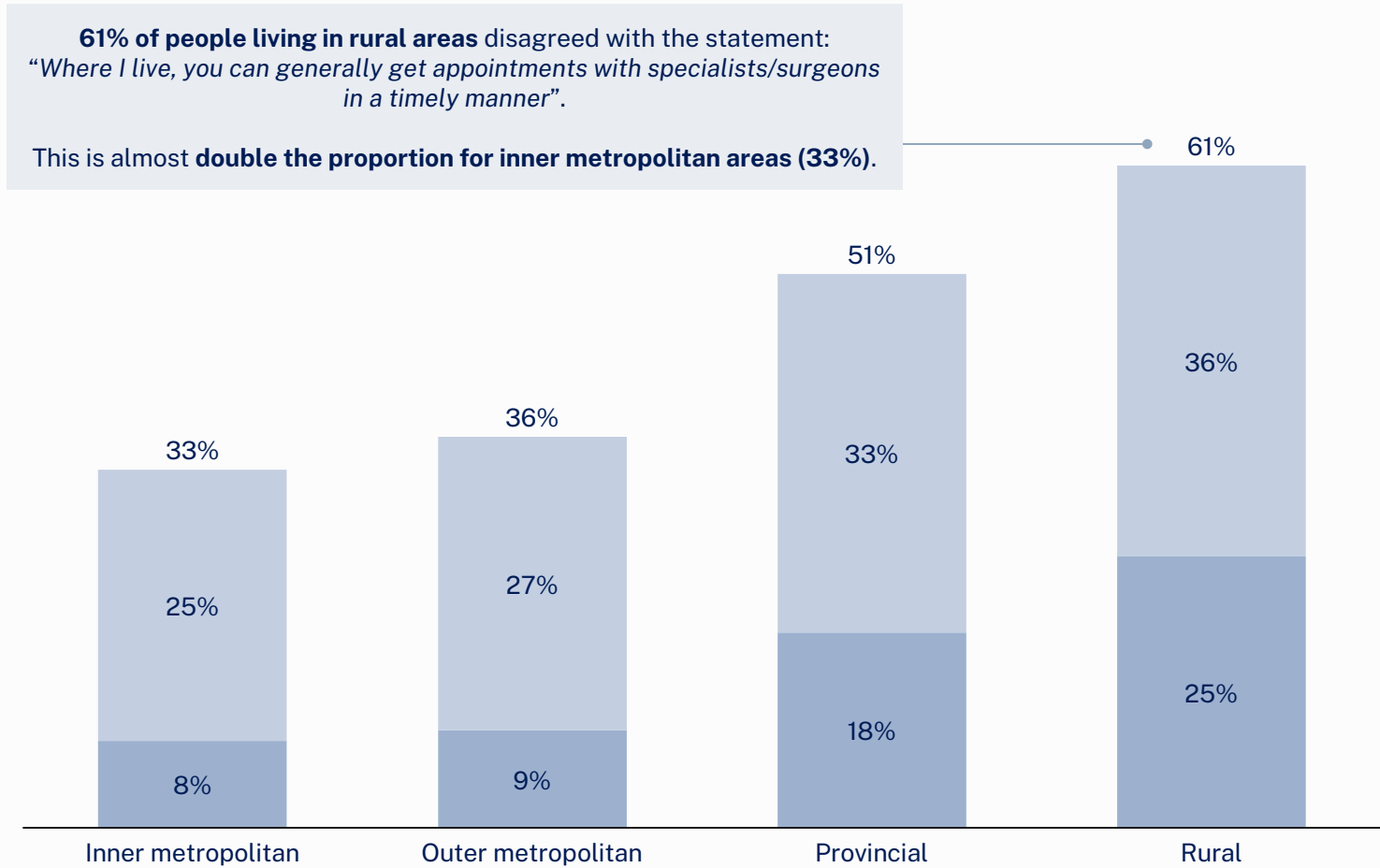
Survey participants were also asked to rate whether they agreed or disagreed with the statement “Where I live, we are well served by different types of specialists/surgeons”. Only 14% of consumers in inner metropolitan areas disagreed, while more than half (51%) of consumers in rural areas disagreed.¹

Rural and regional Australians are often left with no practical alternatives but to travel further to access care, endure extended delays or forego care.

1. % of survey participants, n=4,014. Respondents could select: *Strongly agree, Agree, Not sure, Disagree, or Strongly disagree.*
Source: RedBridge Medical Experiences Survey, Sep 2025.

Proportion of consumers unable to get timely appointments with specialists or surgeons redbridge

% of survey participants who disagreed with statement², n= 4,014, 2025 Disagree Strongly disagree



2. Respondents could select: *Strongly agree, Agree, Not sure, Disagree, or Strongly disagree.*
Source: Redbridge (2025) Medical Experiences Survey.

ACT residents pay the highest out-of-pocket costs of \$605 per service, \$335 higher than the national average

Visible out-of-pocket costs vary significantly across the country. In the ACT, the median visible out-of-pocket cost for a medical service is \$605. This is 2.2 times, or \$335, higher than the national average of \$270. Within states and territories further variation exists with discrepancy in prices between electorates.

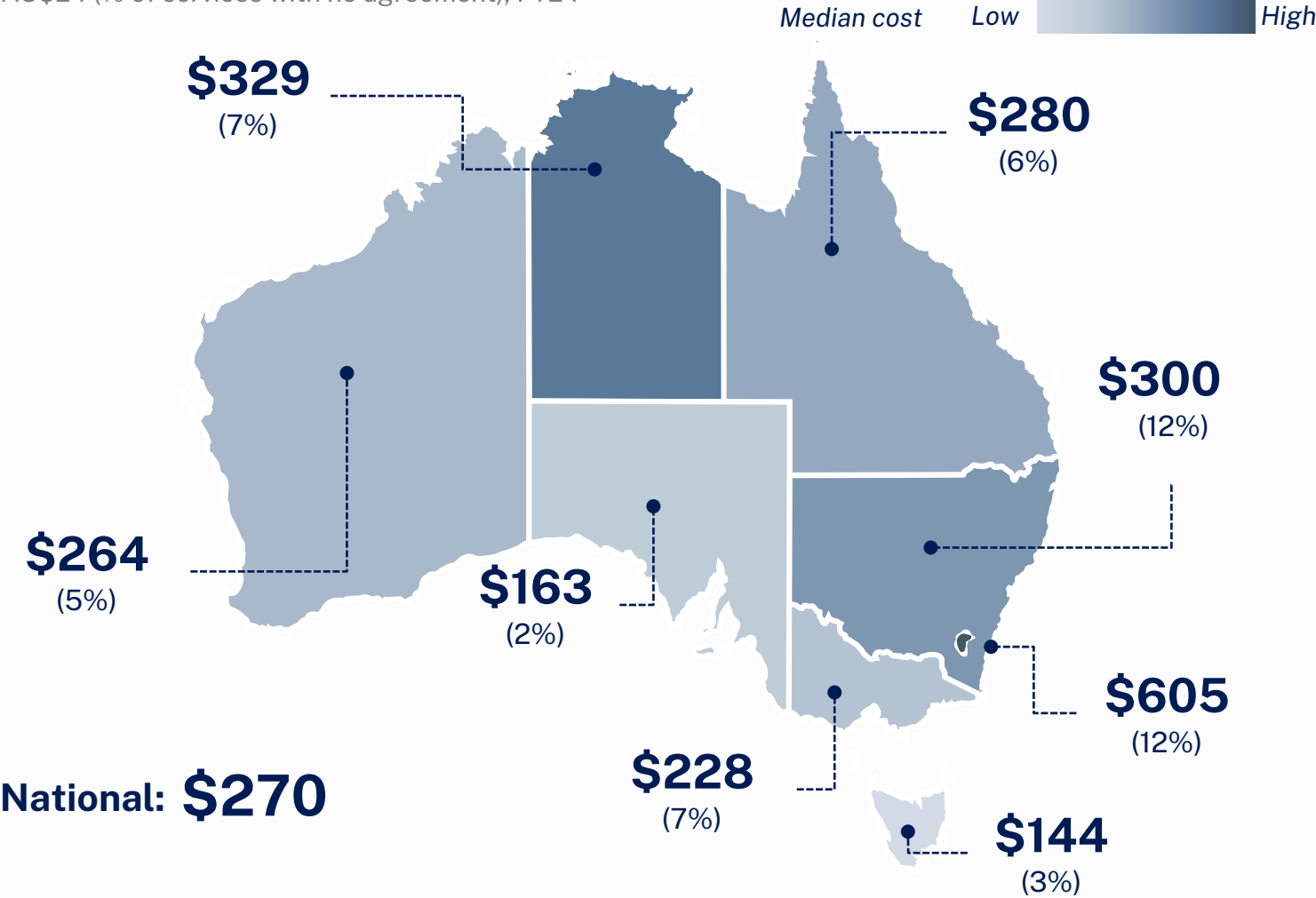
The inconsistency between states creates issues of health equity. An ACT consumer is worse off than a TAS consumer, as they incur higher out-of-pocket costs. Some consumers may be priced out of the private healthcare market in their home state, resulting in deferred care or further pressure being placed on the public system. Some consumers report travelling to other states to receive care at a lower cost.

The ACT and NT are smaller healthcare markets with fewer specialists. The lack of competition and price transparency likely contributes to the high average out-of-pocket costs in these territories.

The ACT, followed by NSW, has the highest proportion of services which are not covered under an agreement between private health insurers and the practitioner. Consumers in these markets are likely to pay higher out-of-pocket fees as a result.

Median visible out-of-pocket costs by state and territory

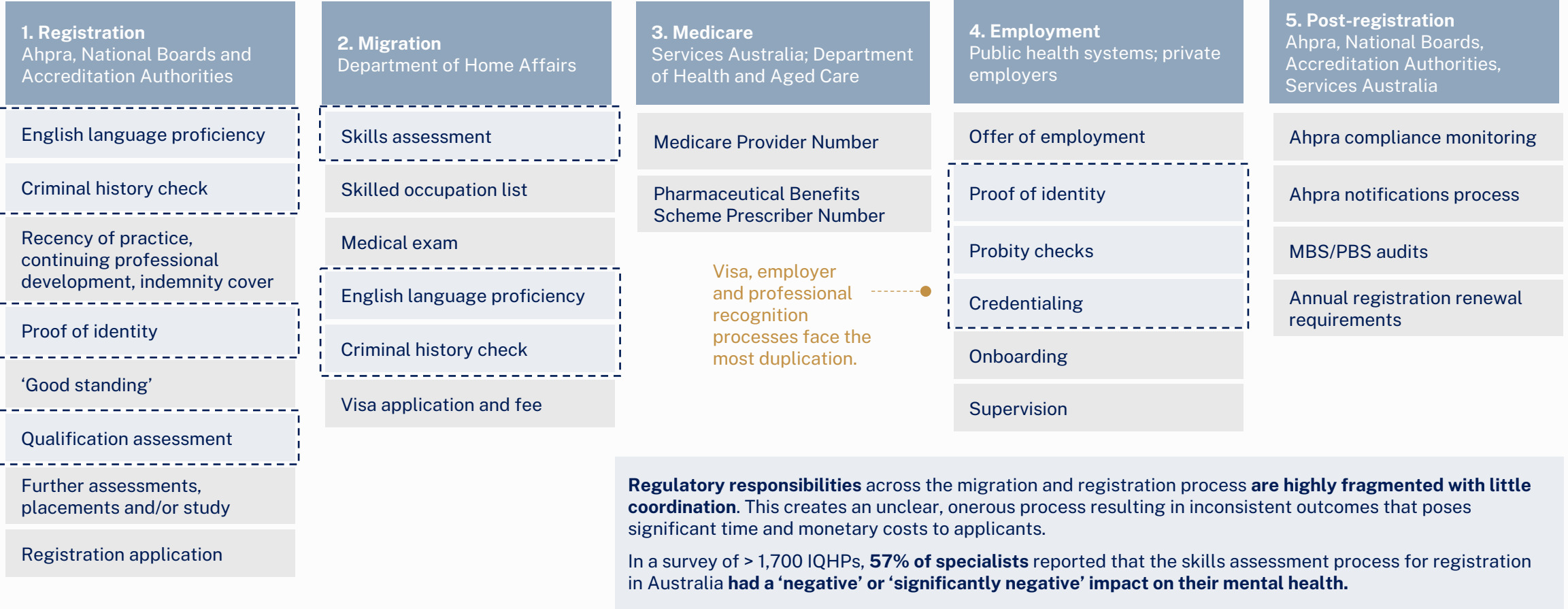
AU\$24 (% of services with no agreement), FY24^{1,2}



Notes: Public hospital data excluded from the median visible out-of-pocket cost.
Source: 1. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data.
2. APRA (2024) Quarterly Private Health Insurance Medical Services Jun 2024. Mandala analysis.

Overseas-trained specialists registering in Australia need to comply with multiple requirements and regulators, which is a duplicative, slow and expensive process

Example process for an internationally qualified health professional (IQHP) seeking registration in Australia Identified duplications



Lowering the registration barriers for overseas-trained specialists will improve Australia’s competitiveness and increase supply

Overseas-trained doctors play an important role in improving the distribution of our health workforce and filling vacancies where there is insufficient domestically-trained workers.

In Australia, it takes at least 12 years to train a medical specialist.¹ 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

Lowering the registration barriers for overseas-trained doctors will allow Australia to increase the supply of specialists in shortage areas urgently. However, excess supply can lead to risks of over-servicing and supply-induced demand.^{3,4} 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.

1 Grattan Institute (2025) Improving Australians’ access to specialist care. 2. Kruk (2023) Independent review of overseas health practitioner settings 3. Sekimoto (2015) Supplier-induced demand for chronic disease care in Japan 4. AIHW (1998) Medical workforce supply and demand in Australia

Proposed policy recommendations to improve the supply of overseas-trained specialists

POLICIES	RATIONALE	IMPACT
1 Introduce expedited registration pathways for specialists in acknowledged areas of shortage	IQHP non-GP specialists report registration can cost up to \$45,200, with a median cost of \$23,425.	International medical graduates who are eligible for expedited pathways would save \$7,700.
2 Remove duplication across regulators and move to a single portal	The end-to-end journey for IQHP non-GP specialists takes between 26 to 105 weeks, averaging 56 weeks.	Improves applicant experience and reduces time and cost. A central portal for uploading documents, would reduce processing time by 3 to 8 weeks. ³
3 Broaden the age exemption on skilled visas	Many experienced professionals have valuable competencies in key skill shortage areas but face age caps on permanent residency.	Raising the age cap to 55 could lead to an additional 4,500 experienced practitioners gaining registration over 5 years.
4 Reduce the IELTS test standard for written English to 6.5 and recognise programs in English⁴	Other countries competing with Australia for medical talent provide greater flexibility on assessments, e.g. lower IELTS standards.	Enables ~ 2,750 additional health practitioners to be registered over 5 years. Those who won’t need an IELTS test could save up to \$410.
5 Legislate recognition of skills and experience, in addition to qualifications and training.	Experienced and junior overseas health practitioners are largely assessed similarly despite differences in risk.	Attracts more mid-career and specialised health practitioners, by valuing skills and experience.

3. Depending on health profession. 4. The International English Language Testing System (IELTS) is a test that measures English language proficiency.
Source: Kruk (2023) Independent review of overseas health practitioner regulatory settings



1

Out-of-pocket costs continue to rise; reform will be needed to keep healthcare affordable for all Australians

2

Implementing Medical Costs Finder can improve price transparency and help consumers make informed decisions

3

Increasing the supply of specialists in regional areas can address shortages and improve equitable access to care

4

Encouraging scope of practice reform can maximise health workforce capabilities and improve medical service supply

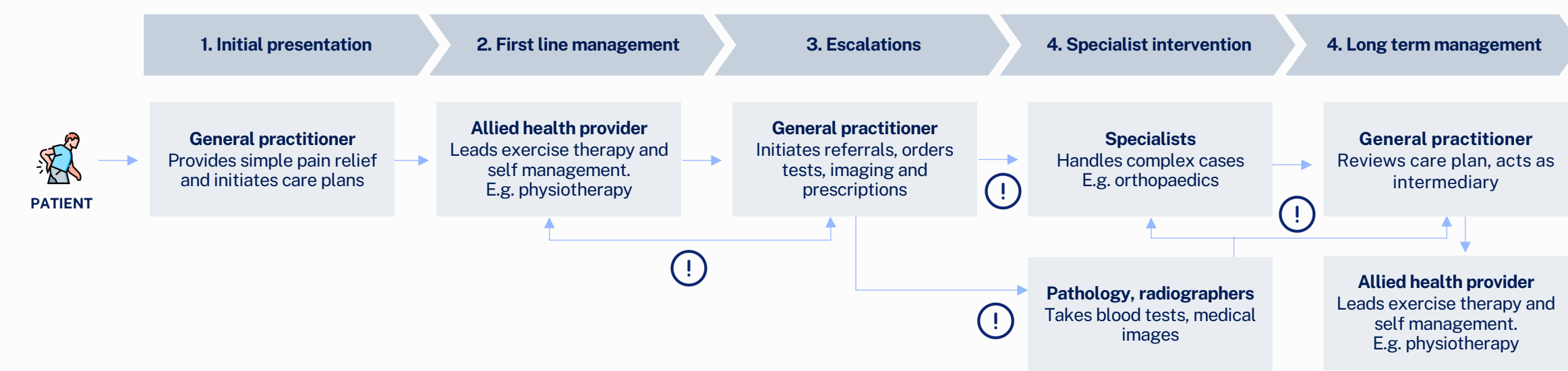
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Fixing inappropriate billing practices can improve consumer protections and reduce inflationary forces

Health professionals are not working to their full scope of practice, which is leading to an increased burden on GPs and unnecessary specialist referrals

Example care pathway for chronic back pain and associated challenges

⚠ Barriers from scope of practice



1 Regulatory settings place restrictions on allied health scope of practice, which increases strain on GPs. For example, physiotherapists are unable to order imaging or refer patients to specialists without a GP, leading to ‘double’ consultations.

2 Lack of clear pathways for a second opinion are leading to unnecessary referrals. GPs are referring patients when they could manage their care themselves with a quick second expert opinion. However, there are no secondary consultation systems in place. This adds time and costs for patients who don’t need a referral and wait times for those who do.

3 Funding and payment mechanisms restrict scope of practice in primary care. Health professionals are mostly paid via a ‘fee-for-service’ payment model, which does not remunerate for extra time spent discussing complex care with other doctors.

Health professionals facing significant barriers leave more frequently, with a 2.3x higher exit rate for Midwives than Medical Practitioners

The exit rate for Medical Practitioners, which includes General Practitioners and Specialists, was 4.7% on average. This was much higher for professionals in Nursing and Midwifery, Allied Health, and Aboriginal and Torres Strait Islander (ATSI) Health.

Professions with the highest exit rates are also experiencing significant barriers to working to their full scope of practice. If exit rates in other primary care professions were on par with Medical Practitioners, the workforce would retain thousands of health practitioners each year.¹

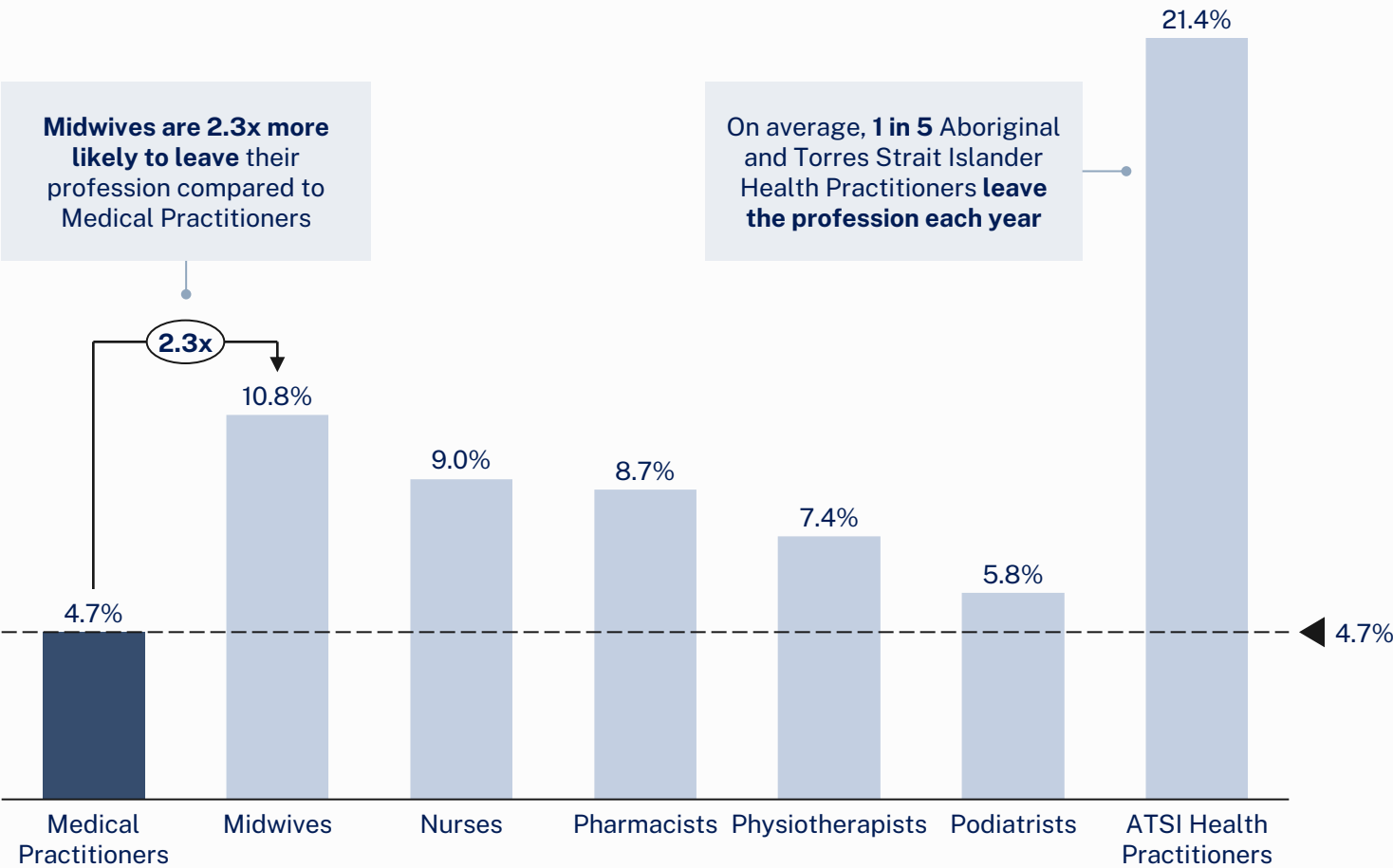
Research from the Australian Health Practitioner Regulation Agency shows that more than one in ten health practitioners (12%) contemplate leaving their profession. Top reasons for leaving other than retirement included: mental burnout (33%); feeling undervalued/unrecognised (29%); lack of professional satisfaction (28%); and work no longer being fulfilling (25%).²

Encouraging health professionals to work to their full scope of practice can both boost sector productivity and strengthen health workforce retention.

Source: 1. Department of Health, Disability and Ageing (2024) *Unleashing the Potential of our Health Workforce – Scope of Practice Review*. 2. Australian Health Practitioner Regulation Agency (2025) *Trends in retention and attrition in nine regulated health professions in Australia*.

Workforce exits from different primary health professions

Mean annual exit rate (%), 2023²



Notes: Data is provided for whole of workforce, not limited to primary care professionals. An exit rate is calculated for each workforce, which is the mean annual rate of permanent exits since the commencement of the NRAS in 2010. Source: 2. Department of Health, Disability and Ageing (2024) *Unleashing the Potential of our Health Workforce – Scope of Practice Review*. Mandala Analysis.

There are 5 important reforms that can improve capacity and flexibility in the workforce by allowing medical practitioners to work to their full scope of practice

Proposed reforms for encouraging full scope of practice

Policy settings	Description	Impact on health professionals
1 Direct referral pathways supported by technology	- Introduce referral pathways for consumers to non-GP specialists - For example, allowing direct referrals from Physiotherapists to Orthopaedic surgeons, Audiologists to ENT surgeons, Midwives to Obstetricians, Psychologists to Psychiatrists, etc.	- Fewer duplicate consultations for referrals by GPs - Fewer barriers for consumers to be eligible for MBS items when referred outside of specific named professions
2 Funding models to incentivise multidisciplinary care	- Develop block funding, bundled funding, and blended funding for multidisciplinary care teams to work collaboratively - Establish access requirements for blended payments including being registered or part of a clinical network	- Improved continuity of care across health disciplines - Better recognition of multidisciplinary care teams and their contributions to primary care
3 Set up secondary consultation systems for primary care	- Set up secondary consultation systems that enable GPs to access timely, high-quality specialist advice (in the private system) - Secondary consultations should be delivered by specialists (private) with funding from the federal government to compensate GPs for using the system.	- Fewer unnecessary referrals and specialist consultations - Improved quality of care and health outcomes - Improved wait times for consumers and time savings for health practitioners
4 Mandate use of My Health Record for continuity of care	Mandate the use of My Health Record so all health professionals involved in care have oversight of important patient information	Improved patient continuity of care and reduced need for and time spent on manual information sharing and administrative tasks
5 Activity-based regulation for scope of practice	- Progress activity-based regulation of scope of practice to complement the status quo protection of title approach - Review Drugs and Poisons, Radiation Safety, and Mental Health Acts which exclude health professionals from providing services	- Consolidated activities of overlapping scope between practices - Fewer restrictions for carrying out activities that fall within the scope of medical professions - Better recognition of skills and ability rather than title

Source: Department of Health, Disability and Ageing (2024) *Unleashing the Potential of our Health Workforce – Scope of Practice Review*. Grattan Institute (2025) *Improving Australians' access to specialist care*.



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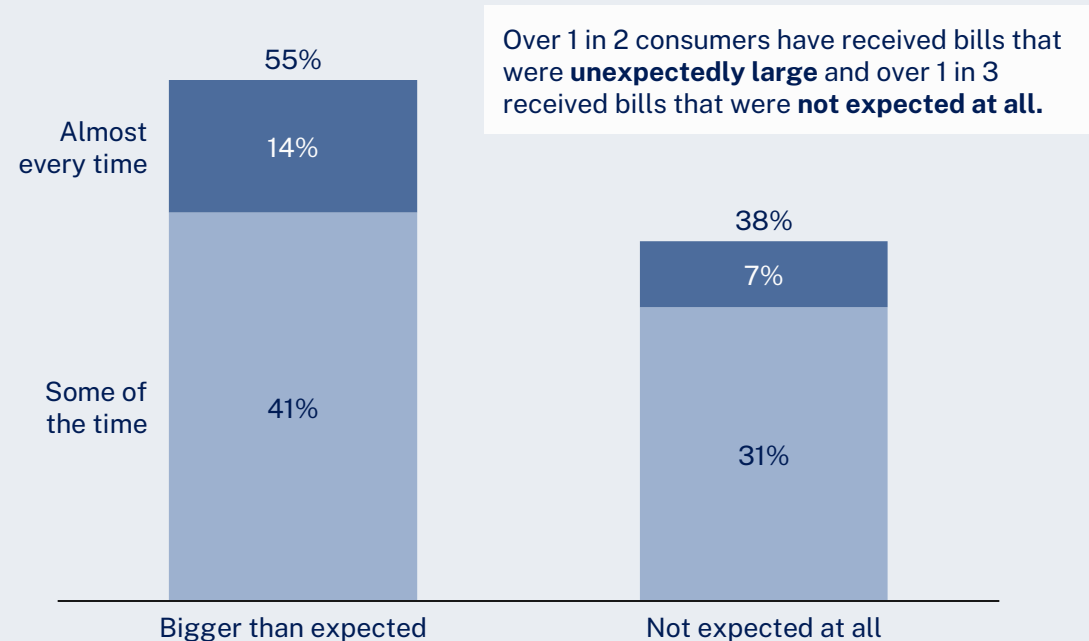
5

Fixing inappropriate billing practices can improve consumer protections and reduce inflationary forces

Over 1 in 2 consumers received unexpected bills for medical services...

Unexpected bills from medical specialists or surgeons

% of survey respondents¹, n= 4,014, 2025



1. Respondents were asked: “Have you ever received a bill from a medical specialist or surgeon that was bigger than you expected?” and “Have you ever received a bill from a medical specialist or surgeon that you were not expecting?”
Source: Redbridge (2025) Medical Experiences Survey.

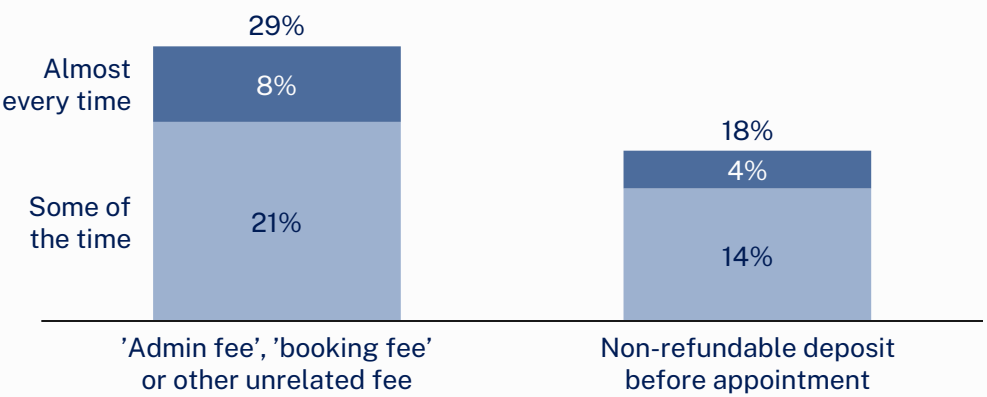
... and 29% have been charged ‘admin’ or ‘booking’ fees, frequently illegal

Other fees and payments to medical specialists or surgeons

% of survey respondents, n= 4,014, 2025²

Many consumers pay for costs unrelated to care, with **29% paying ‘other fees’** and **18% paying non-refundable deposits** before medical appointments.

Consumers could be paying **\$20M in hidden fees and upfront deposits** (3% of total out-of-pocket costs in FY24), though the full magnitude of hidden costs is unknown.³



2. Respondents were asked: “Have you ever received a bill from a medical specialist or surgeon that included an ‘admin fee’, a ‘booking fee’, or any other fee that seemed unrelated to your care?” and “Have you ever had to pay a non-refundable deposit to secure an appointment with a specialist or surgeon?”
3. Assumed 5% ‘admin’ fee, 10% non-refundable deposit, for services with median cost of \$270. Source: Redbridge (2025) Medical Experiences Survey.

Current consumer protections do not prevent ‘surprise billing’ resulting in consumers facing hidden costs of an unknown magnitude

Current consumer protections are limited, with bodies including the Australian Medical Association (AMA) recommending the practice of informed financial consent. Informed financial consent is where practitioners and consumers collaborate to ensure a consumer is provided with information about medical fees prior to treatment. However, this is a recommended practice and there are no consequences for not adhering to this procedure.

In circumstances where informed financial consent is not practiced, consumers may experience surprise billing or split billing. Surprise billing refers to an unexpected medical bill or any charge that is not expected by patients. Split billing is where the full cost of the service is not disclosed to various payers including the consumer, their health fund, and Medicare. These are hidden expenses which contribute to out-of-pocket costs beyond official reporting.

To effectively bring down costs to consumers, policy measures must address both visible and hidden costs in the private health system.

Causes of bill shock and policy solution

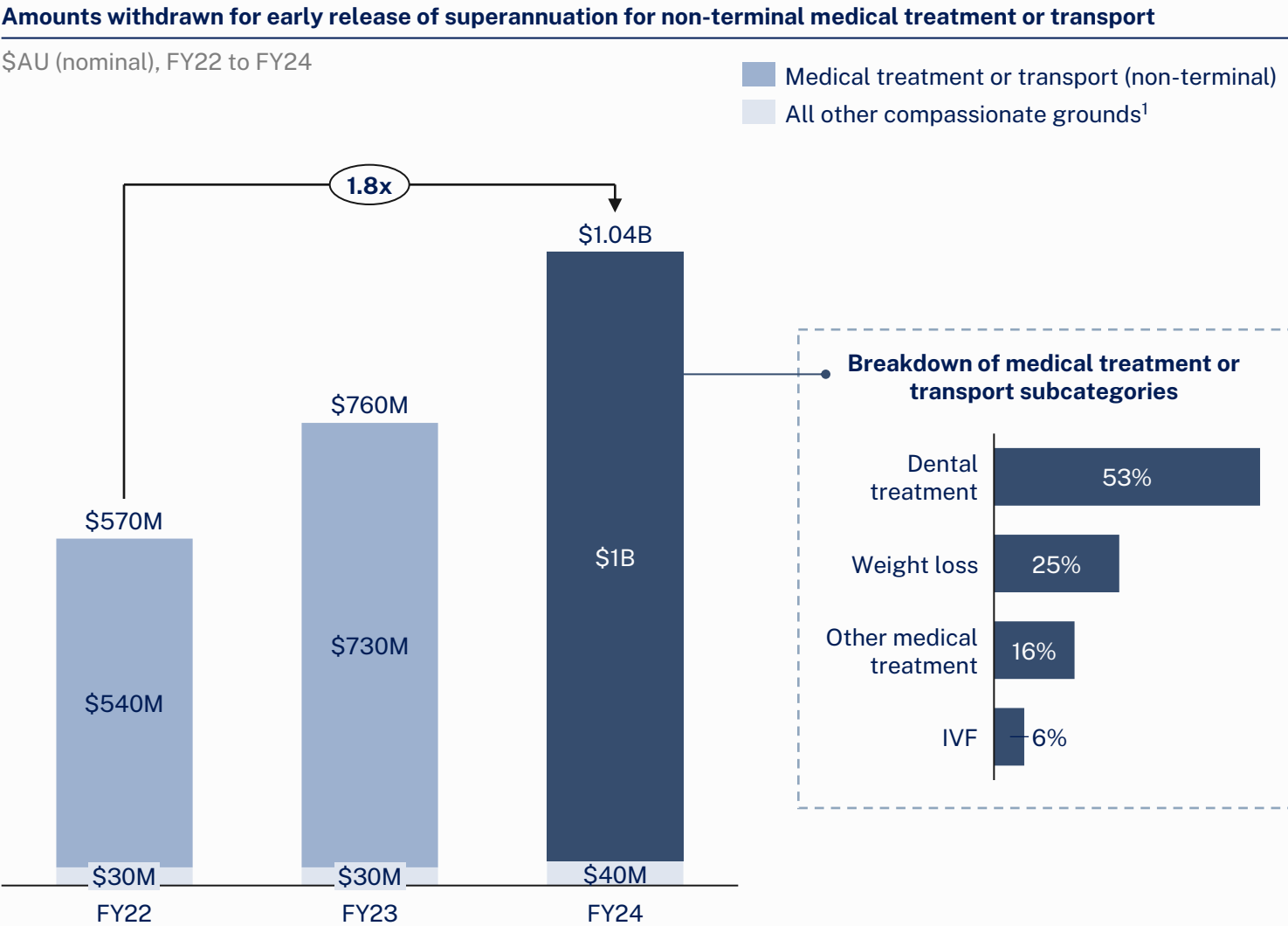
TYPES OF BILL SHOCK	DESCRIPTION	POLICY SOLUTION
 Lack of disclosure of high out-of-pocket costs prior to treatment	Patient may not be aware of the additional charges associated with assistance in surgery or pathology services which may come with high out-of-pocket costs	Legislated informed financial consent: • Consumers are not liable for costs which are not disclosed prior to receiving treatment • Penalties apply where split billing occurs, and full costs are not disclosed to all payers
 Split billing	Not disclosing the full cost of the service to various payers by billing Medicare, the health insurer and the patient separately without each other's knowledge	
 Charging a booking or administrative fee	Claiming these charges as separate services, avoids the requirements under contractual obligations to charge no-gap or a known gap	
 Unexpected change in the scope during treatment	Surgical complications may result in unexpected costs for additional services. While complications are rare, consumers need to be aware of the possible complications and associated costs.	

Withdrawals from super to fund medical treatment have almost doubled in two years

The total amounts withdrawn for early release of superannuation increased by 1.8x from \$570M in FY22 to \$1.4B in FY24. Although the proportion withdrawn for non-terminal medical treatment or transport stayed constant at 96%, total approvals for early release of superannuation increased.

In FY24, 50,000 applications were approved for early release of super, up from 34,000 applications approved in FY22. The average amount withdrawn for medical treatment and transport was \$21,000, while the amount for all other compassionate grounds was \$14,600. Dental treatment makes up more than half (53%) and weight loss makes up 25% of withdrawals for medical treatment.

The ability to access superannuation for non-terminal medical treatments can have an inflationary impact on healthcare prices. Increased access to funds allows consumers to pay higher prices for specialist care. Specialists may charge higher fees that would otherwise be unaffordable to consumers without access to retirement savings. As a result, a cycle emerges where higher fees drive more frequent superannuation withdrawals, which in turn increases prices further.



1. All other compassionate grounds include: accommodating a disability, palliative care for a terminal illness, preventing foreclosure or forced sale of a home, and funeral expenses for a dependant.
Sources: Australian Taxation Office (2024) *Compassionate release of super - applications received and approved.*

Tightening access to superannuation could save each consumer \$48,000 in superannuation by retirement

Eligibility for an early compassionate release of superannuation (CRS) is currently too broad, with reports that most individuals are withdrawing early for non-terminal medical treatment.

In 2023-24, the average individual approved for CRS for medical treatment purposes, withdraws \$21,000 at age 42. At this age, the median superannuation balance in Australia is \$93,000 and an early withdrawal would reduce this to \$72,000.

By age 65, retirement age, the average individual approved for CRS will have saved \$446,000. In the scenario where they did not access their superannuation early, their balance would be significantly higher at \$494,000. The gap from withdrawal would widen by 2.3x to \$48,000 by retirement age due to compounding interest.

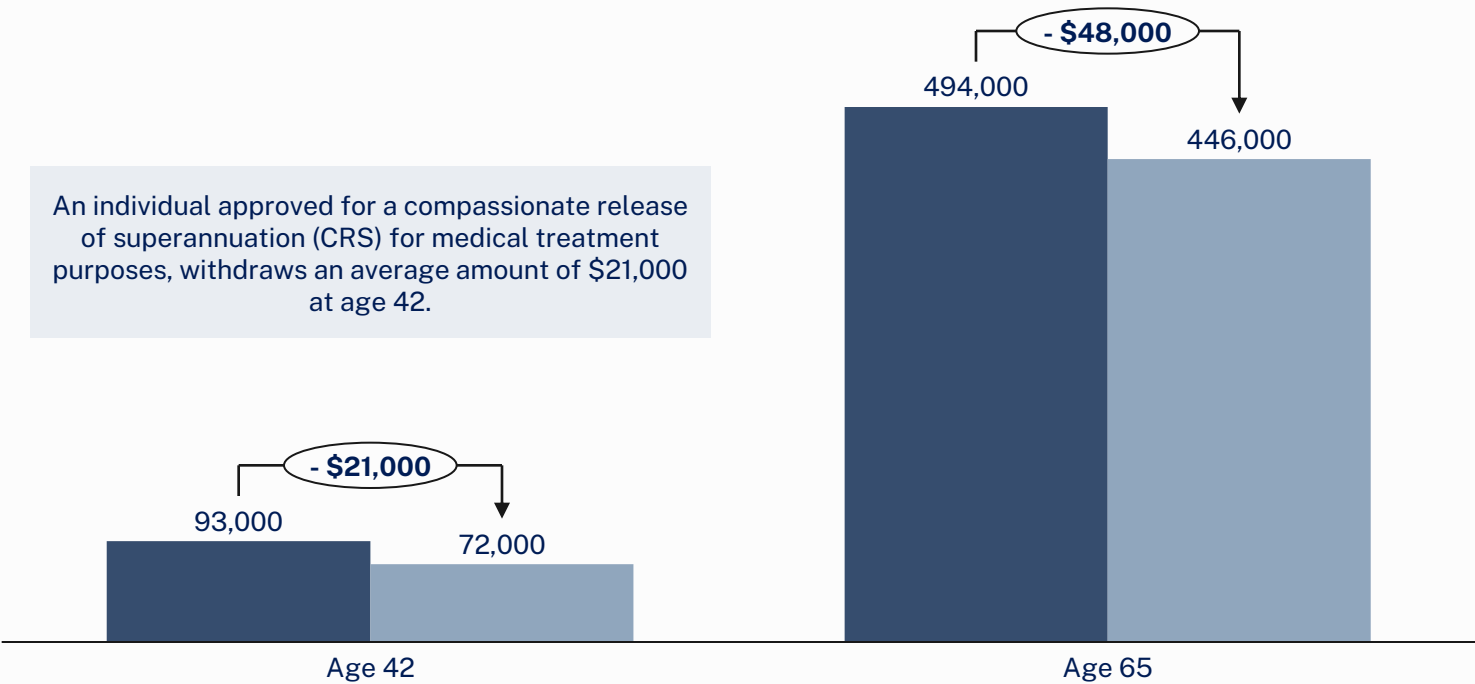
Tightening access to superannuation to only fund care in terminal cases, will help protect \$48,000 of each consumers' retirement savings. Furthermore, consumers retiring with higher superannuation balances will have less reliance on government-funded age pensions, easing pressure on the government budget.

Forecasted median superannuation balance from the average age of CRS to retirement age

\$AU (real), FY24

No withdrawal Early withdrawal

By retirement age, the average individual approved for CRS will have saved \$446,000, which is \$48,000 less compared to if they did not access their superannuation early.



Note: Superannuation balances have been rounded to the nearest thousand. Original values can be found in the appendix.

Source: Australian Taxation Office (2024) Compassionate release of super - applications received and approved. Mandala analysis.



Appendix

a

Glossary and additional context

b

Key inputs and assumptions

c

Methodology

Glossary

TERM	DEFINITION
Australian Refined Diagnosis Related Groups (AR-DRG)	A classification that provides a clinically meaningful way to relate or group the number and type of patients treated in admitted acute episodes of care to the resources required in treatment.
Bulk billing	Consumers do not pay for a service and a health practitioner will bill Medicare for the service, accepting the Medicare benefit as full payment for the service.
Invisible costs	The payments consumers make that are not captured in official statistics such as private health insurance and Medicare records.
Known gap agreement	When an insurer has an agreement with the hospital, a consumer will pay an agreed amount according to the insurance policy.
Medicare Benefits Schedule (MBS)	Lists a wide range of consultations, procedures and tests, and the Schedule fee for each of these items. The Schedule fee is the amount the Government considers appropriate for one of these services.
No agreement	When an insurer does not have an agreement with the hospital, a consumer will pay the out-of-pocket cost set by the practitioner, which may be high.
No gap agreement	When an insurer has an agreement with the hospital, a consumer will pay no out-of-pocket cost for hospital charges.
Out-of-pocket costs	The difference between the amount a doctor charges for a medical service and what Medicare and any private health insurer pays. Out-of-pocket costs are also called gap or patient payments.
Private Health Insurance premiums	Fees a consumer pays to the insurer in exchange for health insurance cover.
Private patient	Person admitted to a private hospital, or person admitted to a public hospital who decides to choose the doctor(s) who will treat them or to have private ward accommodation. This means they will be charged for medical services, food and accommodation.
Public patient	A patient treated at no charge in a public hospital (or provided with care by a private hospital on behalf of a public hospital).
Separation	An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.
Specialist Medical Practitioner	Doctor who received further training in a medical specialty, such as surgery or psychiatry. Medical Specialists are accredited by the Professional Associations. General Practitioners are not included within the specialist medical practitioner group for this report.
Visible costs	Costs for health services which are captured through private health insurance and Medicare records.

Australia has a dual public-private healthcare system, where privately insured consumers receive choice and quality care, but often incur out-of-pocket costs

Components of cost within Australia’s healthcare system

System	Location	Payer	Description
 Public healthcare system	In hospital	MEDICARE	Medicare will pay the Medicare Benefits Schedule fee for a service.
		CONSUMER	Consumers will pay for ancillary services and medication costs.
	Out of hospital	MEDICARE	Medicare will pay the Medicare Benefits Schedule fee for a service, meaning the consumer does not pay for the services covered by Medicare. This includes both medical and hospital services (such as accommodation).
		CONSUMER	General Practitioners who do not bulk bill will charge consumers an out-of-pocket fee for a service.
 Private healthcare system	In hospital	MEDICARE	Medicare will pay 75% of the Medicare Benefits Schedule fee for consumers receiving care in a private hospital.
		PRIVATE HEALTH INSURANCE (PHI)	PHI benefits will cover at least the remaining 25% of the Medicare Benefits Schedule fee, for consumers with PHI cover. Insurers negotiate on behalf of consumers to secure lower fees for services covered by PHI.
		CONSUMER	Consumers will pay any additional fees for medical and hospital services charged by practitioners above the Medicare Benefits Schedule fee. Consumers will pay for ancillary services provided within specialist rooms as a part of their hospital stay.
	Out of hospital	MEDICARE	Medicare will pay 85% of the Medicare Benefits Schedule fee for consumers receiving care from a private specialist.
		CONSUMER	PHI cannot provide a benefit for out-of-hospital private services, meaning consumers are responsible for the additional cost above the Medicare Benefits Schedule fee.

Key inputs and assumptions for analysis

Variable	Value	Source
Annual inflation rate forecast from June 2025	2.6%	RBA (2025) <i>Statement on Monetary policy</i> .
FTE Medical Practitioners, annual growth rate from 2025	3%	AIHW (2024) <i>Health Workforce</i> .
Number of hospital beds, annual growth rate from 2025	-0.6%	AIHW (2024) <i>Hospitals at a glance</i> .
Total number of private hospital separations in Australia, annual growth rate from 2025	1.5%	Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. <i>Average growth rate from 2013 to 2024</i> .
Population in Australia, annual growth rate from 2025	1.4%	ABS (2023) <i>Population Projections, Australia</i> .
Average age of retirement	65	ABS (2023) <i>Retirement and Retirement Intentions</i> .
Average age for early withdrawal of superannuation	42	ATO (2024) <i>CRS age demographics</i> .
Median superannuation balance at age 40-44	\$93,351	ATO (2023) <i>Taxation Statistics – Snapshot – Table 5</i> .
Median annual income	\$67,600	ABS (2023) <i>Employee earnings and hours</i>
Mandatory superannuation contributions	12%	ATO (2025) <i>How much super to pay</i>
Average real 10-year return on superannuation balance in Australia	3.6% (annual)	APRA (2024) <i>Annual superannuation bulletin</i> .

Methodology 1: Forecasting out-of-pocket costs for consumers

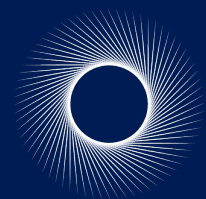
Inputs and data cleaning	▪ Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Data from public hospitals excluded.			
Methodology steps	Forecasting median out-of-pocket costs per service (2025 to 2030)			
	1. Obtained hospital data for 2013 to 2024 to run a regression.			
	2. Obtained regression results and forecasted time-variant variables (CPI_t , $Bedst$, $Practitionerst$), based on assumptions listed, for $t = 2025$ to 2030 .			
Methodology steps	3. Predicted the average <i>MedicalGap</i> for $t = 2025$ to 2030 using forecasted variables and coefficient estimates from regression.			
	Regression formula:			
	$\log(MedicalGap_{i,t}) = \beta_0 + \beta_1(CPI_t) + \beta_2(Beds_t) + \beta_3(Practitioners_t) + \beta_4(Complication_i) + \sum_{j=1}^n \alpha_{i,j}(Cluster_i) + \sum_{k=1}^m \rho_{i,k}(Cluster_i * MCF_i)$			
Methodology steps	where:			
	▪ <i>MedicalGap_{i,t}</i> is the median medical gap for AR-DRG procedure i in year t .			
	▪ <i>CPI_t</i> is the inflation rate in year t .			
Methodology steps	▪ <i>Beds_t</i> is the number of available public hospital beds per 1,000 population in year t .			
	▪ <i>Practitioners_t</i> is the number of FTE Medical Practitioners per 1,000 population in year t .			
	▪ <i>Complication_i</i> is a binary variable for whether or not procedure i is classified under Catastrophic or Severe CC			
Methodology steps	▪ <i>Cluster_i</i> is a set of binary variables for whether or not procedure i belongs to a cluster. The available clusters are: 1, 2, 3.			
	▪ <i>MCF_i</i> is a binary variable for whether or not procedure i took place in state with Medical Costs Finder data availability. Procedures in ACT and NT have $MCF_i = 0$.			
Regression results (only main variables displayed)	Variable	Estimate	p-value	Interpretation
	Intercept	5.474	<0.0001	N/A
	CPI	0.042 	<0.0001	On average, a 1 ppt increase in CPI is associated with a 0.042% increase in the median medical gap in that year.
	Beds	-0.381 	<0.0001	On average, a 1 bed increase (per 1000) is associated with a 0.381% decrease in the median medical gap in that year.
	Practitioners	-1.020 	<0.0001	On average, a 1 medical practitioner increase (per 1000) is associated with a 1.02% decrease in the median medical gap in that year.
	...	...	...	...
	...	...	...	...

Methodology 2: Forecasting consumers who delay or avoid specialist care

Inputs and data cleaning	▪ Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Data from public hospitals excluded. ▪ ABS (2024) Patient Experiences, Experience of medical specialist services. Data from 2021 was excluded as an outlier due to a rise in specialist attendance from post-COVID catch up.							
Methodology steps	<u>Forecasting total number of people delayed or avoided care</u>							
	1. Obtained ABS data for 2014 to 2024 to run a regression. 2. Obtained regression results and forecasts for median out-of-pocket costs from Methodology 2. 3. Predicted the proportion of people who delay or avoid care from 2025 to 2030. 4. Identical approach for age group breakdowns, with a separate regression and prediction for each age group							
	Regression formula:							
	$Delay_t = \beta_0 + \beta_1 (MedicalGap_t)$							
	where:							
	▪ $Delay_t$ is the proportion of people who delay or avoid seeing a medical specialist due to cost as a reason, of Australians who needed to see a medical specialist. ▪ $MedicalGap_t$ is the median out-of-pocket costs for consumers in that year.							
	<i>Note: Although this regression is not free from endogeneity, we assume variation is adequately captured and other time-variant trends remain constant.</i>							
Forecasting results		2024 (actual)	2025	2026	2027	2028	2029	2030
	Number of people who need to see a medical specialist	9,186,900	9,315,517	9,445,934	9,478,177	9,712,271	9,848,243	9,986,119
	Proportion of people who delay or avoid care	9.8%	10.7%	11.0%	11.3%	11.6%	12.0%	12.3%
	Number of people who delay or avoid care	900,316	993,419	1,036,792	1,082,114	1,129,460	1,178,907	1,230,531

Methodology 3: Forecasting superannuation balance for an individual who withdraws super early

Inputs and data cleaning	- Australian Taxation Office (2024) <i>Compassionate release of super, applications received and approved.</i> - Australian Taxation Office (2024) <i>Compassionate release of super, CRS age demographics.</i> - Australian Taxation Office (2023) <i>Taxation statistics, Snapshot - Table 5.</i> - APRA (2024) <i>Annual superannuation bulletin highlights, performance.</i> - Reserve Bank of Australia (2025) <i>Measures of inflation, consumer price index.</i> - ABS (2023) <i>Employee earnings and hours.</i>										
Methodology steps	<u>Scenario 1: No early withdrawal of superannuation</u> - Calculated the average age of individuals withdrawing superannuation early for compassionate reasons (CRS) using a weighted average method - Obtained the median superannuation balance at the average age of CRS - Calculated the real rate of return by obtaining the historical 10-year average annual rate of return and adjusting for inflation using the 10-year CPI average - Obtained the average annual income for each age category - Calculated the median superannuation balance at retirement age, adding mandatory superannuation contributions from the median income of all Australians and compounding using the real rate of return <u>Scenario 2: Early withdrawal of superannuation for medical treatment</u> - Obtained the average amount of withdrawal from superannuation for medical treatment purposes - Deducted the average amount of withdrawal from the median superannuation balance in a ‘no early withdrawal’ scenario - Calculated the median superannuation balance at retirement age, adding mandatory superannuation contributions from an average income and compounding using real rate of return										
Results	<table><tr><th></th><th>Average age of CRS (42 years)</th><th>Retirement age (65 years)</th></tr><tr><td>Scenario 1: no withdrawal</td><td>\$93, 351</td><td>\$493,732</td></tr><tr><td>Scenario 2: early withdrawal</td><td>\$72, 233</td><td>\$446,068</td></tr></table>			Average age of CRS (42 years)	Retirement age (65 years)	Scenario 1: no withdrawal	\$93, 351	\$493,732	Scenario 2: early withdrawal	\$72, 233	\$446,068
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