



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



Private health sector reform

August 2026

Contact:

Ben Harris, Director Policy and Research

0418 110 863

ben.harris@pha.org.au

About Private Healthcare Australia (PHA)

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

Introduction

Private Healthcare Australia (PHA) welcomes the opportunity to provide a submission responding to the Department's paper on private health sector reform.

PHA represents the interests of 15 million Australians with private health insurance and the health funds that cover them.

While it can be tempting to generate a laundry list of problems and reform targets in a particular sector, regulatory reform of the private health sector should have a strategic focus and not get distracted by Band-Aid measures and quick fixes.

We need to develop a clear understanding of the role our sector plays in the funding and delivery of healthcare, what role we want it to play, and what needs to change to achieve this.

The potential impact of a package of reforms is thus more important than individual initiatives. There needs to be a strong unifying, consumer-focussed narrative about the role private health plays in Australia's world-class health system.

While reform objectives are contested and providers, consumers and payors have different lenses for success, there is strong interdependence across the sector. The private health sector needs to work collaboratively to deliver accessible, high-quality care, and not rely too heavily on government intervention.

PHA has tested the reforms in the consultation paper against the following four consumer-focussed principles which are fundamental to the success of any reform program in the private health sector.

- Will the measure improve the affordability of private health cover?
- Will it enhance equity?
- Will it drive increased efficiency in the sector?
- Will it lead to better health outcomes for Australians?

Several key issues have not been addressed in the paper – the glaring example is medical devices. Addressing the relatively high costs of generic medical devices in Australia compared with similar countries would allow many of these initiatives to be funded at no net additional cost for consumers.

Collectively, we can use health funding to move towards a more effective, efficient and higher quality system, designed with a future-focus based on modern clinical guidelines and consumer expectations. This will require significant adjustments from all stakeholders. Health funds are ready to lean into a modern fit-for-purpose system on behalf of their members.

A strong, more efficient and effective private health system will help buttress the public system, improving access to healthcare for the entire community.

Summary of recommendations

Adopt a strategic approach to private health reform

- Develop a clear long-term vision for the role of private health care in Australia.
- Assess reform options against four consumer-focused principles:
 - affordability
 - equity
 - efficiency
 - health outcomes.
- Avoid piecemeal reforms and focus on integrated system-wide change.

Mental health

- Support targeted migration pathways for psychiatrists, nurses and other mental health professionals.
- Allow nurse practitioners to admit and manage patients in private hospitals within their scope of practice.
- Permit nurse practitioners to provide Medicare and insurer-supported consultations in private hospitals.
- Reform legislation to support hospital avoidance programs, community-based care, multidisciplinary team support and outpatient mental health services.
- Make funding eligibility dependent on clinical need rather than treatment location.
- Expand insurer-funded mental health programs to include other clinical leads.
- Allow multiple psychiatrist case conferences during admissions where clinically appropriate.
- Review legislative definitions of hospital treatment and hospital substitute treatment.
- Remove default benefits for inpatient alcohol and drug treatment.
- Remove restrictions that prevent nurse practitioners, mental health nurses, practice nurses and similar professionals participating in Chronic Disease Management Programs.
- Reconvene the Private Mental Health Alliance.

Maternity care

- Develop bundled maternity care models, coordinated by obstetricians, general practitioners and midwives.
- Expand insurer support for out-of-hospital maternity services.
- Increase transparency and reduce out-of-pocket costs.
- Do not shorten waiting periods for pregnancy and birth.
- Do not extend maternity cover into Silver or Bronze products.
- Allow health funds to fund specialist and nurse practitioner services for newborns in the first three months after birth, regardless of whether care is delivered in hospital or community settings.

Hospital in the Home

- Only support minimum benefits where:
 - supported by clinical evidence
 - supported by guidelines
 - minimum service standards exist.
- Evaluate reforms after three years.
- Create separate reporting of out-of-hospital care within HCP1 data collections.

- Monitor utilisation, quality and outcomes.
- Reduce second-tier benefits for equivalent inpatient services as Hospital in the Home (HITH) expands.
- Introduce MBS telehealth items for specialists, GPs and nurse practitioners providing oversight of HITH patients.
- Create a new Prescribed List category allowing selected devices to attract PHI benefits when used in doctors' rooms.

Type C certification

- Retain Type C certification requirements unless strong evidence supports removal.
 - Age-based exemptions are not appropriate.
 - Anaesthesia exemptions are appropriate, other than for IV sedation.

Regional hospitals and default benefits

- Increase second-tier benefits in genuinely underserved rural and remote areas to 90-95%.
- Reduce metropolitan second-tier benefits to 75%.
- Restrict second-tier eligibility for new metropolitan services that do not improve access.
- Require hospitals receiving default benefits to limit excessive patient out-of-pocket costs.
- Replace current location-based methodology with a nationally consistent dollar-based default benefit.

Product simplification

- Retain consumer choice.
- Do not eliminate Basic, Basic Plus or Plus products.
- Review product tiers and clinical categories to improve consumer understanding.
- Seek national consistency for ambulance arrangements through National Cabinet processes.
- Remove Lifetime Health Cover loading barriers affecting dependants with disability.
- Allow funds to continue waiving excesses in appropriate circumstances.

Risk equalisation

- Develop a strategic implementation roadmap.
- Move towards a prospective risk equalisation model, including maternity and mental health.
- Undertake detailed modelling before implementation.

Additional recommendations

- Reduce Australian medical device prices to internationally competitive levels.
- Eliminate unwarranted Prescribed List price premiums.
- Introduce an enforceable medical device Code of Conduct similar to medicines regulation.
- Target waste, fraud, misuse and ineffective care.
- Expand MBS review processes to identify low-value services.
- Introduce automatic reviews where utilisation exceeds forecasts.
- Set national targets for reduced hospital length of stay.
- Require public reporting of hospital quality, safety and performance data.
- Increase the Medicare Levy Surcharge and utilise the increased participation in private health insurance to strengthen risk equalisation and affordability.

Prioritising contemporary models of care

Mental health care

Across Australia, mental health reform is increasingly focused on prevention, early intervention, recovery-oriented practice and the delivery of care in community settings wherever clinically appropriate. State and territory mental health strategies consistently emphasise:

- prevention and earlier intervention
- care delivered closer to home
- alternatives to emergency department and inpatient treatment
- integration of health, housing and social supports
- greater involvement of people with lived experience, and
- culturally responsive and place-based approaches.¹

Internationally, similar trends are evident. Many jurisdictions are seeking to reduce reliance on institutional care and strengthen community-based services in line with contemporary evidence that increasingly demonstrates many consumers can achieve equivalent or better outcomes through community-based and multidisciplinary treatment models, while maintaining family, employment, education and community connections. The European Union has even endorsed the closing and downsizing of mental health facilities as part of a shift to community-based care.²

In contrast, PHA is concerned that the mental health reforms proposed in this consultation are directed towards sustaining and expanding access to inpatient services, rather than addressing the legislative and regulatory barriers that limit access to contemporary models of care.

Current private health insurance legislation was developed around historical concepts of hospital-based treatment. As a result, consumers often face funding arrangements that depend on where care is delivered rather than what care is clinically required. For example, a day program delivered through a hospital may be eligible for private health insurance funding, while a comparable service delivered through an outpatient or community setting may not be.

The consultation paper correctly identifies growing demand for mental health services. However, the solution should not be limited to expanding inpatient capacity. Reform should also ensure that private health insurance can support hospital avoidance, multidisciplinary care, community-based treatment and other contemporary models that better align with current clinical practice.

Despite substantial reform efforts over many years, private mental health care remains heavily dependent on inpatient treatment. Data shows overnight mental health hospitalisations in private

¹ See: <https://www.health.nsw.gov.au/mentalhealth/reform/pages/default.aspx>
<https://www.health.vic.gov.au/mental-health/prevention-and-promotion/wellbeing-strategy>
<https://www.health.qld.gov.au/system-governance/strategic-direction/plans/better-care-together>
<https://mhaod.mhc.wa.gov.au/>
<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/publications+and+resources/plans/sa+mental+health+services+plan/sa+health+mental+health+services+plan>
<https://www.health.tas.gov.au/health-topics/mental-health/mental-health-projects-and-initiatives-priorities/next-tasmanian-mental-health-strategy>
<https://www.chnact.org.au/about-us/publications/actmhsppl/>
https://health.nt.gov.au/_data/assets/pdf_file/0004/1080328/NT-Mental-health-strategic-Plan-2019_2025.pdf

² <https://doi.org/10.1016/j.healthpol.2024.105081>

hospitals have remained broadly unchanged on a population basis between 2016-17 and 2023-24. Over the same period, the average length of stay increased from 18 to 19 days, and total overnight patient days increased from 916,148 to more than 1.04 million.³

By contrast, same-day psychiatric hospitalisations increased by more than 15 per cent, from 164,320 to 189,837, suggesting gradual movement towards less intensive models of care.⁴ There has also been a substantial increase in the proportion of same-day specialist psychiatric services delivered in public hospitals that are funded through private health insurance, which has more than doubled since 2018-19.⁵

These trends suggest that change is occurring, but slowly. The current reform process provides an opportunity to accelerate the transition towards contemporary models of care by removing legislative barriers that prevent insurers from supporting treatment in the most clinically appropriate setting.

With rising demand for mental health care across the community, improving access to care is a major priority. PHA supports expanding the range of services available to privately insured consumers so that more treatment gaps can be addressed and care can be delivered in settings most appropriate to individual needs. Similar issues exist in alcohol and other drug (AOD) treatment, where the evidence increasingly supports a broader range of community-based treatment options.

Several health funds have trialled innovative models of care for people living with mental health conditions. Many of these programs have demonstrated significant potential to improve outcomes and consumer experience. However, their scope is constrained by the *Private Health Insurance Act 2007* (the Act), the *Private Health Insurance (Complying Product) Rules* and the *Private Health Insurance (Health Insurance Business) Rules*.

These legislative and regulatory frameworks were developed around traditional concepts of hospital-based care and place significant restrictions on the types of services that can be funded through private health insurance. In particular, the current definitions of hospital treatment and hospital-substitute treatment do not adequately reflect contemporary mental health care, which is increasingly delivered through multidisciplinary and community-based models.

The private mental health system should operate on a "no wrong door" principle, where consumers can access clinically appropriate care without unnecessary funding or regulatory barriers. Access to private health insurance funding should be driven by clinical need and evidence-based care, rather than the physical location in which a service is delivered.

Reform of these legislative settings would enable insurers, clinicians and service providers to develop more flexible models of care, improve access to treatment, and better align private mental health services with contemporary clinical practice.

³ Australian Bureau of Statistics (2025), *Admitted patient mental health-related care: National data*, Table AC1, Available at <https://www.aihw.gov.au/mental-health/topic-areas/hospital-based-services/admitted-patients>

⁴ Ibid.

⁵ Ibid, Table AC8.

Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals

PHA supports measures to strengthen the mental health workforce and improve access to care, including targeted migration pathways for psychiatrists, nurses and other mental health professionals.

All practitioners working in private mental health settings should be appropriately trained, credentialled and supervised where required. International medical and nursing graduates make an important contribution to Australia's health system and can help address workforce shortages across the mental health sector.

However, workforce reforms should be considered in the context of changing models of care. As mental health treatment increasingly shifts towards multidisciplinary and community-based settings, workforce shortages are not confined to inpatient facilities. PHA therefore encourages the Government to consider how workforce initiatives can support access across the continuum of care, rather than focusing solely on private inpatient services.

Internationally trained practitioners also require appropriate support to navigate Australia's health system, including Medicare arrangements, private health insurance settings, professional obligations and clinical governance frameworks. In particular, it is important that doctors whose visas may be conditional on employment know this does not give the employer any rights to determine a doctors' care – this remains a clinical decision. Good training and support will assist practitioners to integrate successfully into the Australian workforce and deliver safe, high-quality care.

Nurse practitioners

PHA recommends the Government considers allowing nurse practitioners to admit and manage patients in private hospitals within their scope of practice. Expanding the role of Nurse Practitioners would increase workforce capacity, improve access to care and align with broader Government objectives to enable health professionals to work to their full scope of practice.

Allowing nurse practitioners to provide Medicare and health fund-supported consultations in private hospitals provides a short-term option that can complement the proposed expansion of access for overseas-trained psychiatrists and provide an additional pathway to increase the clinical workforce available to private mental health services.

Initiative 2: Increased access to contemporary models of mental health care.

Mental health care is increasingly delivered outside of traditional inpatient settings. Over the past two decades, clinical practice has evolved towards shorter inpatient stays, greater use of multidisciplinary care, and increased provision of treatment in community settings wherever clinically appropriate.

Hospitals are not the only providers capable of delivering high-quality out-of-hospital care. A broad range of providers, including specialist outpatient services, primary care providers, community mental health services and allied health professionals, can contribute to effective treatment and recovery. While the consultation paper acknowledges the benefits of out-of-hospital care, the proposed reforms remain focused on hospital-based providers delivering hospital-substitute services.

A notable gap in the consultation paper is the absence of hospital avoidance programs. Consumers, families, employers and the broader community all benefit when people can access effective treatment without requiring hospital admission. Advances in community-based care, digital health,

self-management supports and multidisciplinary treatment models have enabled many health systems to reduce reliance on hospital care while maintaining or improving outcomes.

Australia's private health insurance legislation has not kept pace with these developments. Current arrangements limit insurers' ability to support hospital avoidance programs and other community-based models of care. Addressing these barriers would improve consumer outcomes, expand access to treatment and better align private mental health care with contemporary clinical practice.

Promoting out of hospital mental health care

PHA supports a significant policy focus on expanding access to out-of-hospital mental health care and removing regulatory barriers that prevent care being delivered in the most appropriate setting.

Of the options canvassed in the paper, PHA supports modernising guidelines to allow non-psychiatrist specialists including general practitioners, nurse practitioners, mental health nurses and allied health professionals to participate in insurer-funded mental health programs. This should extend to hospital programs, hospital-substitute services, hospital avoidance initiatives and chronic disease management programs.

PHA also supports amendments to the MBS that would allow consultant psychiatrists to undertake multiple funded case conferences during a patient's admission where clinically appropriate. Effective mental health care increasingly relies on multidisciplinary teams and ongoing care co-ordination, and funding arrangements should reflect contemporary practice.

For example, expanded access to a range of day programs incorporating a range of practitioners, prior to any hospital admission, would provide greater access to care in the community. Other examples may include:

- intensive outpatient programs
- group-based treatment programs
- step-up / step-down residential services
- crisis alternatives to hospital
- Mental Health in the Home
- psychosocial recovery services, and
- care navigation.

This ties in with the mental health reform work being undertaken, which needs to ensure that contemporary clinical practice is promoted and prioritised over maximising pathways into hospital. While hospitalisation is a necessary option for short term crises and/or escalation management, it should not be the mainstay of treatment.

Models like this exist in the public sector. The private sector needs to encourage these models.

More fundamentally, PHA recommends the Government review the legislative definitions of hospital treatment and hospital-substitute treatment within the private health insurance framework. Funding eligibility should be based on clinical need and evidence-based models of care rather than the physical location in which care is delivered. Doing so would create greater flexibility for consumers, clinicians and insurers to develop innovative approaches that improve access and outcomes.

Removing default benefits for alcohol and drug services

Evidence reviews, World Health Organisation guidance and international treatment standards increasingly recognise that residential and inpatient services should not be regarded as the default

pathway for AOD conditions. Instead, most people with substance use problems can be treated effectively in community settings, with inpatient care reserved for those with higher acuity, significant medical complexity, severe withdrawal risk or unstable social circumstances.⁶

Current private health insurance legislation restricts arrangements largely to hospital treatment, hospital substitute treatment, and Chronic Disease Management Programs (CDMPs). As a result, insurers have limited capacity to support treatment delivered through primary care, specialist outpatient clinics and other community-based settings.

Research suggests that for many people with AOD conditions, outcomes from Intensive Outpatient Programs (IOP) are comparable to residential treatment, particularly where there is no significant withdrawal risk, severe psychiatric comorbidity, or unstable living situation.⁷ The Substance Abuse and Mental Health Services Administration's review concluded: "IOP outcomes are comparable to those seen with residential services for clients with minimal risk of acute intoxication/withdrawal, health conditions, and psychological symptoms."⁸

In addition to costing less, community-based care may also improve accessibility, support ongoing participation in employment and family life, and strengthen connections with local support networks. The evidence is particularly strong for opioid dependence.⁹

PHA recognises that inpatient and residential services remain important for some individuals, including those with severe dependence, significant withdrawal risks, co-occurring mental illness or unsafe housing circumstances.¹⁰ However, inpatient treatment is often a stabilisation intervention rather than a complete treatment pathway. Long-term outcomes depend heavily on access to ongoing treatment, recovery supports and continuity of care following discharge.¹¹

With the weight of evidence against inpatient care for AOD treatment, PHA recommends removing default benefits for AOD services and allowing health insurers greater flexibility to fund evidence-based treatment in the most clinically appropriate setting, including community-based care. This would better align funding arrangements with contemporary evidence and support consumers to access the right care at the right time.

Chronic Disease Management Programs

Health insurers offer CDMPs to assist people living with ongoing health conditions. The objective of these programs is to help members maintain their health, improve quality of life and reduce costly and preventable hospitalisations. These programs benefit consumers while also supporting the long-term sustainability of the health system. PHA outlined the many benefits of out-of-hospital care in its 2023 report, [There's no place like home](#).

CDMPs have significant potential to support people living with mental health conditions. However, current regulatory settings constrain the development of innovative models of care and create unnecessary restrictions on the scope of practice for many health professionals.

⁶ For example, [\[ncbi.nlm.nih.gov\]](https://ncbi.nlm.nih.gov), [\[who.int\]](https://who.int), [\[unodc.org\]](https://unodc.org)

⁷ For example, [\[library.samhsa.gov\]](https://library.samhsa.gov), [\[ncbi.nlm.nih.gov\]](https://ncbi.nlm.nih.gov)

⁸ At [\[library.samhsa.gov\]](https://library.samhsa.gov)

⁹ For example, [\[ncbi.nlm.nih.gov\]](https://ncbi.nlm.nih.gov), [\[who.int\]](https://who.int)

¹⁰ See [\[ncbi.nlm.nih.gov\]](https://ncbi.nlm.nih.gov), [\[nida.nih.gov\]](https://nida.nih.gov)

¹¹ See [\[library.samhsa.gov\]](https://library.samhsa.gov), [\[link.springer.com\]](https://link.springer.com)

For example, a CDMP led by a nurse practitioner or a practice nurse working in a primary care clinic could provide stronger coordination between allied health and medical providers, ensure the patient is well informed about their options, provide the necessary physical health checks, and in the case of nurse practitioners, manage prescriptions.

The *Private Health Insurance (Health Insurance Business) Rules 2018* (the Business Rules) currently limit the type of practitioners who can provide services through CDMPs. In particular, the Business Rules exclude a range of nursing professionals, including nurse practitioners, practice nurses and mental health nurses. The defined list of eligible providers no longer reflects contemporary workforce models or best practice approaches to team-based care.

There is strong evidence supporting the value of nurse practitioners, practice nurses, mental health nurses, and other appropriately trained professionals in supporting people with mental health conditions. Expanding participation in CDMPs would also align with broader Australian Government policy objectives, including:

- The [Productivity Commission Mental Health Inquiry](#) (November 2020) which recommended “The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions.”
- The [Nurse Practitioner Workforce Plan](#) (2023) which has a goal “to remove barriers affecting the [nurse practitioner] workforce.”
- The [Strengthening Medicare Taskforce](#) Report (2023) which articulates a vision where “health care professionals work to their full scope of practice.”
- The [Unleashing the Potential of our Health Workforce](#) (2024) review which is identifying opportunities to remove the barriers stopping health professionals working to their full scope of practice.

PHA recommends removing the prescriptive workforce definitions within the Business Rules and replacing them with a more flexible framework that supports evidence-based care using the most appropriate workforce available. This would provide greater flexibility for insurers to develop effective CDMPs and encourage broader sector engagement in innovative models of care.

PHA considers that removing these restrictions would support the development of more effective CDMPs and improve health outcomes for thousands of Australians living with mental health conditions.

Initiative 3: Private health sector to reconvene the Private Mental Health Alliance (PMHA).

PHA supports reconvening the PMHA. Historically, the PMHA provided a valuable forum for collaboration between hospitals, health insurers, clinicians, consumer representatives and the Department of Veterans’ Affairs (DVA). Through this work, the sector developed shared guidelines, common approaches to service delivery and a stronger understanding of the respective roles and responsibilities of participating organisations.

The PMHA also played an important role in maintaining and updating sector guidelines, supporting consistency across the private mental health system and providing a mechanism for addressing emerging issues collaboratively. These processes helped reduce unnecessary disputes, improve transparency and promote a shared understanding of best practice.

PHA can see value in re-establishing a structured forum to support implementation of contemporary models of mental health care. In particular, a reconvened PMHA could:

- oversee the ongoing review and maintenance of sector guidelines
- support the development of contemporary models of care, including community-based and multidisciplinary services
- facilitate collaboration between hospitals, insurers, clinicians, consumers and carers
- identify regulatory and funding barriers to innovation, and
- provide advice to government on emerging policy and implementation issues.

While these arrangements fell into disuse for a range of reasons, PHA considers that a carefully designed governance framework, including appropriate departmental involvement and clear processes for managing competition law issues, would enable the PMHA to make a valuable contribution to ongoing mental health reform.

Initiative 4: Review of risk equalisation arrangements

PHA supports the inclusion of mental health costs in a prospective risk equalisation scheme, with important caveats. See page 40.

Further reading

Private Healthcare Australia, [Expanding the list of practitioners able to provide services under private health insurance chronic disease management programs](#), August 2024.

Private Healthcare Australia, [Private health reform options](#), January 2025.

Private Healthcare Australia, [Draft Pricing Framework for Australian Private Hospital Services](#), November 2025.

Maternity care

The cost of having a baby in the private system is becoming prohibitive for many Australian families. At the same time, declining birth rates are placing increasing pressure on private maternity providers, with a growing number of services facing lower demand and declining economies of scale. This creates a challenging cycle: lower volumes increase costs, which can contribute to higher out-of-pocket expenses for consumers, reducing demand further and placing additional pressure on service viability. Left unaddressed, these trends threaten the long-term sustainability of private maternity services in many parts of Australia.

The most common concern raised by families is the level of out-of-pocket costs and lack of certainty about those costs. Consumer research has found 43% of families with private health insurance cite out-of-pocket expenses as the reason for not choosing a private hospital for childbirth.¹² Throughout pregnancy and birth, consumers may incur costs associated with obstetric consultations, scans, pathology, hospital birthing services, anaesthetists, paediatricians and midwifery care. In many cases, the total expected costs of care are not disclosed at the outset of the pregnancy. As a result, families can face significant and unexpected expenses at a time when they are reluctant or unable to change providers.

In the context of ongoing cost-of-living pressures and declining birth rates, reforms aimed at increasing access to maternity care must address the affordability and transparency of pregnancy and birth services. Changes to private health insurance settings alone are unlikely to improve access if the underlying drivers of consumer costs remain unaddressed.

New models of care offer a pathway to a more sustainable private maternity system, delivering improved choice and potentially better outcomes at lower costs. PHA supports Recommendation 11.1. of the [Scope of Practice Review: Unleashing the potential of our health workforce](#), which recommends the development of bundled payments for maternity services. The review “supports a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and private hospital settings”.

PHA has previously proposed a bundled care model in [Empowering through Choice](#) (April 2025). Under this approach, health insurers and the Australian Government would provide greater support for providers outside the hospital setting, while participating providers would reduce or eliminate out-of-pocket costs and provide families with upfront certainty regarding the cost of care. Greater transparency and predictability would improve consumer confidence and support informed choice.

Maintaining safe, effective and accessible maternity services in the private sector is an important public policy objective. The private maternity system currently relies on a range of direct and indirect supports, including public and private funding arrangements, hospital cross-subsidies, risk equalisation and insurer contributions. However, the current mix of subsidies and incentives has evolved over time and may no longer be aligned with contemporary policy objectives.

There is a strong case for continued support of private maternity services, including the use of cross subsidies where appropriate. However, these arrangements should be deliberate, transparent and designed around clear policy objectives. While individual reform proposals may appear attractive in

¹² IPSOS, Health Care and Insurance Australia (2023) Report 4, pp 83-88.

isolation, the challenges facing private maternity care require a coordinated and comprehensive reform strategy.

As a starting point, PHA recommends the Government articulate clear objectives for the future of private maternity care. These objectives should include improving choice and affordability for women and families, increasing transparency of costs, supporting innovative models of care, and increasing the proportion of births that can be safely and sustainably undertaken in the private sector.

Initiative 1: Sector education

PHA supports this initiative as it is a low-cost measure that may help address misconceptions and knowledge gaps across the sector. In particular, education and guidance could assist providers, hospitals and insurers to better understand existing opportunities within the current regulatory framework.

To be effective, however, this initiative should be preceded by clear, authoritative advice from government on key policy and regulatory questions. This includes matters such as the ability of midwives to bill Medicare in private hospitals, the respective roles of different practitioners within maternity care teams, and the interactions of funding and billing arrangements across models of care.

Greater clarity of these issues would reduce uncertainty and provide stakeholders with greater confidence to explore and implement innovative models of maternity care.

However, PHA does not expect sector education alone to drive significant system change. While improved understanding of existing arrangements may be beneficial, meaningful reform is likely to require changes to funding arrangements, incentives and models of care in addition to education and guidance.

Initiative 2: Increased access and choice to different models of maternity care

PHA supports increasing access to, and choice within, private maternity care.

At present, maternity care in the private system is overwhelmingly centred on obstetrician-led models of care. While this model remains appropriate and preferred for many women, the limited availability of alternative models restricts consumer choice and contributes to high out-of-pocket costs.

Consumers who choose private maternity care often face significant financial barriers. Average out-of-pocket costs for low-risk, uncomplicated pregnancies approach \$4,000, with considerably higher costs in major cities. These costs are frequently opaque, making it difficult for expectant parents to understand the likely financial commitment at the outset of their pregnancy. Given the limited availability of comprehensive data, current estimates are likely to understate the true cost of care.

The affordability challenges associated with the current model are contributing to a shift in demand away from private care and towards the public system. Public maternity services offer a broader range of care models, including midwifery-led care for low-risk pregnancies, often at little or no cost to consumers. Declining demand for private maternity care is creating significant sustainability challenges for private hospitals, insurers and maternity providers.

PHA has modelled a range of options in our paper, [Empowering through Choice](#) (April 2025). A central feature of this work is the development of bundled maternity care models that enable care

to be delivered both inside and outside of the hospital setting, supported by greater investment from health funds and government.

The current Medicare pregnancy management fee of \$446.15 provides only limited support for coordinated maternity care. While additional investment from insurers and government may be required, any increase in funding should be accompanied by measures that reduce consumer out-of-pocket costs and improve price transparency.

PHA supports a practitioner-led bundled care model, under which a lead practitioner - obstetrician, GP, or midwife - coordinates care across antenatal, labour and birth, and postnatal phases of pregnancy, reducing uncertainty and the risk of unexpected costs.

Bundled payment models have the potential to reduce both total system costs and consumer out-of-pocket expenses through:

- more efficient care coordination
- appropriate use of the maternity workforce
- reduced administrative duplication
- greater pricing transparency, and
- targeted insurer support for out-of-hospital services.

Importantly, bundled care does not prescribe a single model of maternity care. Rather, it can support a range of clinically appropriate approaches, including obstetrician-led, GP-shared care and midwife-led models.

For low-risk pregnancies, midwife-led care is well established internationally, including in New Zealand, the UK, and Canada, and widely used within Australia's public health system. The total cost of bundled midwife-led care could be 29% cheaper than the current private model. To encourage take-up of private care, bundled care could be included in Gold policies, with expanded cover of out-of-hospital services.

PHA's modelling suggests that bundled maternity care could substantially reduce out-of-pocket costs, improve consumer certainty regarding the cost of care, increase participation in private maternity services and support better utilisation of the available maternity workforce. Broader uptake of private maternity services would also help support the sustainability of private hospitals while easing pressure on public maternity services.

PHA encourages the Government to support further development of bundled maternity care models as part of a broader strategy to improve affordability, increase choice and strengthen the long-term sustainability of private maternity care.

Births in private hospitals could increase by 25% by 2030, increasing private hospital revenues. Pressure will also ease on the public maternity system, with a 9% decline in births in the public system.

Insurers will benefit through greater Gold policy uptake.

PHA would be happy to lead discussions of these and other proposals with other stakeholders across the sector, including government. PHA would welcome the opportunity to work with government, providers, hospitals and other stakeholders to further develop and implement these reforms.

Initiative 3: Shorter PHI waiting periods for pregnancy and birth

PHA does not support this proposal.

Reducing private health insurance waiting periods for pregnancy and birth would create strong incentives for consumers to upgrade to Gold cover shortly before a planned maternity event, make substantial claims, and subsequently downgrade their cover once those services are no longer required. This would weaken the principle of risk pooling and increase costs across the broader insured population.

While there may be a legitimate policy rationale for supporting access to private maternity services, reducing waiting periods is neither a targeted nor transparent mechanism for achieving that objective. The costs of such a change would ultimately be borne by other policyholders through higher premiums, particularly older Australians and those maintaining comprehensive Gold cover over the long term.

PHA considers that any cross-subsidies within the PHI system should be deliberate, transparent and linked to clearly articulated policy objectives. Policymakers should be able to identify who benefits from the subsidy, who bears the associated costs, and why the proposed redistribution represents an appropriate and efficient use of community-rated insurance arrangements.

More fundamentally, shortening waiting periods does not address the key barriers affecting participation in private maternity care. The evidence suggests that affordability, unpredictable out-of-pocket costs, and limited access to diverse models of care are the primary factors discouraging consumers from choosing private maternity services. Addressing these underlying issues would be more likely to improve access and participation than changes to waiting periods alone.

PHA therefore considers that reducing waiting periods for pregnancy and birth is unlikely to materially improve affordability, increase private maternity activity, or support the long-term sustainability of private maternity services. More comprehensive reforms focused on cost transparency, reducing out-of-pocket expenses and expanding access to innovative models of care would provide a more effective response to the challenges identified in the consultation paper.

Initiative 4: Review of product tier structure

PHA does not support expanding maternity coverage from Gold products into Silver or Bronze tiers.

While the proposal is intended to improve access to private maternity services, it would do so by increasing premiums across a substantial proportion of the private health insurance market. This would reduce affordability for many consumers and risks accelerating declines in private health insurance participation.

Modelling commissioned by PHA indicates that adding in-hospital maternity services to lower-tier products would increase premiums by an average of 6.5% across affected policies. The impact would vary by tier, with Silver premiums increasing by around 3.5% and Bronze premiums by approximately 13.3%. Given Australia's community-rated private health insurance system, these costs would be spread across a broad membership base, including many consumers who are unlikely to utilise maternity services.

The implications of these premium increases could be significant. PHA's modelling ([available here](#)) estimates that approximately 580,000 Australians would leave private health insurance in response to higher premiums. A reduction in participation of this magnitude would weaken risk pooling, place

additional upward pressure on premiums for remaining members, and increase demand on already constrained public hospital services.

More fundamentally, the proposal does not address the primary barriers to private maternity care identified elsewhere in the consultation paper. Expanding maternity coverage into lower-tier products would increase insurance premiums without addressing these underlying issues.

PHA is also concerned that the costs and benefits of the proposal have not been clearly established. Changes to product tier requirements have the potential to affect millions of policyholders and should therefore be supported by robust economic analysis and detailed assessment of the impacts on premiums, insurance participation, consumer behaviour and public hospital demand.

PHA recommends the Government undertake detailed independent modelling of the proposal before progressing any changes to the product tier structure. At a minimum, the Department should assess and respond to the modelling previously provided by PHA so stakeholders can better understand the likely consequences of the reform.

Improving access to private maternity care requires reforms that directly address affordability, transparency and models of care. Expanding maternity cover into Silver or Bronze products is unlikely to achieve these objectives, will increase premiums for millions of families, and ultimately reduce affordability across the broader private health insurance system.

Initiative 5: Review of risk equalisation arrangements

PHA supports the inclusion of maternity costs as part of a move to a prospective risk equalisation scheme, with important caveats. See page 40.

Initiative 6: Review of MBS items for paediatricians

PHA supports reforms that improve access to care for newborns and provide greater certainty for families during the immediate postnatal period. However, rather than limiting support to specific new MBS items delivered by paediatricians in private hospitals, PHA recommends amending private health insurance legislation to allow health funds to pay benefits for specialist care provided to newborns during the three months following birth, regardless of whether the care occurs in a hospital or community setting.

PHA recommends health insurers be permitted to pay benefits for non-general practitioner specialist services and nurse practitioner services provided to newborns during the neonatal period following birth, where the mother has delivered under the care of a private obstetrician or privately practising midwife. This would enable families to access funded specialist care for their newborn, whether the service is delivered in a private hospital, specialist's consulting rooms, or other appropriate outpatient setting.

This approach would provide more meaningful support for new parents than the proposal outlined in the consultation paper, which focuses on extending coverage for particular paediatric services delivered in private hospitals. By adopting a setting-neutral approach, the reform would improve flexibility for families, support continuity of care, and avoid creating incentives for care to be delivered in one setting over another.

Importantly, the proposal would recognise that clinically appropriate newborn care can occur across a range of settings and may be delivered by a variety of specialist practitioners. Allowing health funds to support this care regardless of location would be simpler for consumers, better aligned with

contemporary models of care, and provide greater value for families during the critical period immediately following birth.

Should government adopt this option, PHA recommends the Commonwealth make it a condition of service for these amended MBS items that consultants cannot bill both the patient and the insurer. In practice, this means that if the doctor accepts the insurer benefit (in addition to the MBS rebate), they cannot bill the patient an out-of-pocket cost. This will help provide peace of mind for consumers and ensure this initiative does not simply lead to an increase fee paid to the doctor with no reduction in out-of-pocket costs.

PHA considers this approach to be a more practical and consumer-focused alternative to the proposal under consideration, while remaining agnostic as to where care is delivered and supporting access to timely specialist services for newborns.

Further reading

Mandala and Private Healthcare Australia, [Empowering through Choice](#), April 2025

Hospital in the Home

In 2023, PHA released a paper, [There's no place like home](#), which highlighted the need for reform to support and expand out-of-hospital care. This was followed by the Australian Medical Association's (AMA) [Out-of-hospital models of care in the private health system](#), which recognised that "For some patients, out-of-hospital care can deliver the same outcomes as in-hospital care while also providing patients with other benefits such as the ability to recover in the comfort of home."

More recently, BUPA and Catholic Health Australia (CHA) strengthened the case for reform through their joint paper, [Patient-centred care: Making hospital in the home a reality](#) (May 2026).

Australia is falling behind international best practice because out-of-hospital care remains inaccessible to too many patients. As a result, Australians are not consistently receiving healthcare supported by the best available evidence, and clinicians are often unable to deliver the most effective and innovative models of care because current funding and regulatory settings do not adequately support them.

Australia's health financing system was largely designed for the healthcare challenges of the 20th Century, yet it is now confronting demands of the 21st Century. Demand for healthcare continues to grow at an unsustainable rate, driven by a rapidly ageing population and the growing prevalence of chronic disease. The pressure is being felt across the system, reducing access to care, increasing healthcare costs through higher out-of-pocket expenses, and placing growing burden on taxpayers.

The opportunity cost of inaction is significant. Australia's private healthcare system is estimated to be leaving \$1.3bn in potential efficiency unrealised by lagging behind comparable countries in the adoption of out-of-hospital care models. For many patients, care delivered in the home or community is not only safe, high quality and clinically effective, it is often the best possible care.

The limited uptake of these models is not due to a lack of clinical evidence, but rather funding arrangements, incentive structures and regulatory barriers that have constrained their growth. Expanding access to Hospital in the Home (HITH) and other out-of-hospital models would deliver better patient experiences, reduce the burden of treatment, ease pressure on hospital infrastructure, and help address waiting times and care bottlenecks.

Importantly, greater adoption of evidence-based out-of-hospital care has the potential to moderate growth in both private health insurance premiums and patient out-of-pocket costs, supporting the affordability and sustainability of Australia's healthcare system.

To realise these benefits, reform should focus on:

- addressing misalignment of incentives within existing funding models
- enabling sufficient supply of out-of-hospital care providers to improve access at scale
- supporting greater uptake through better use of data, digital health and technology, and
- establishing consistent quality and safety standards across out-of-hospital models of care.

Success measures should include evidence of improved patient outcomes, reduced inpatient activity, hospital bed days and overall treatment costs, rather than measuring HITH growth in isolation.

Initiative 1: Minimum benefit for select HITH services

PHA does not support the introduction of mandatory minimum benefits for HITH services unless they are underpinned by robust clinical evidence, recognised clinical guidelines and clearly defined minimum service standards. Any expansion of minimum benefit requirements should be targeted to services where safety, quality and patient outcomes have been demonstrated to be equivalent or superior to inpatient care.

If minimum benefits are introduced for selected HITH services, they should form part of a broader reform agenda that actively shifts incentives towards clinically appropriate out-of-hospital care. This should include a gradual reduction in minimum benefits for equivalent in-hospital services over time, where supported by evidence, to address longstanding distortions in funding arrangements that favour inpatient treatment.

Without corresponding changes to in-hospital funding settings, the introduction of minimum benefits for HITH services risks increasing system costs while failing to drive meaningful changes in models of care. Reform should instead be designed to encourage the adoption of evidence-based, patient-centred alternatives that deliver high-quality care in the most appropriate setting.

A rebalanced funding framework would support greater uptake of HITH models, improve patient choice and experience, reduce pressure on hospital infrastructure, and deliver better value for patients, insurers and the broader health system.

Clinical guidelines and minimum service definitions

PHA supports the recommendation of BUPA and CHA to “establish minimum service definitions for different HITH models to ensure patient safety, reliability, and equivalence with inpatient care, while allowing flexibility to meet individual clinical needs.”¹³

The introduction of minimum benefits for HITH services should be underpinned by clear clinical guidelines and minimum service standards. These safeguards are essential to ensure patients receive safe, high-quality care and that insurers, providers and consumers have a common understanding of the services that qualify for reimbursement.

A strong foundation already exists on which private sector clinical guidelines can be developed. Relevant resources include Hospital in the Home frameworks and guidelines developed by state and territory health services, accreditation standards from the Australian Council on Healthcare Standards, and the clinical care standards produced by the Australian Commission on Safety and Quality in Health Care. These resources could be adapted to support nationally consistent standards for priority HITH services, including intravenous (IV) therapies, complex wound management and palliative care.

Minimum service standards are equally important. They provide transparency regarding the components of care that must be delivered to qualify for a minimum benefit and give patients, health funds and providers certainty about service expectations. In many cases, these standards can be derived directly from the relevant clinical guidelines.

The absence of clinical guidelines and minimum service standards would create significant risks for both patients and payers. Where publicly funded schemes have introduced entitlement-based funding without sufficiently robust service definitions, there have been challenges relating to quality

¹³ BUPA (May 2026) [Patient-centred care: Making hospital in the home a reality](#)

assurance, inappropriate claiming, fraud and waste. The experience of the National Disability Insurance Scheme (NDIS) highlights the importance of establishing strong governance and service standards before introducing new funding arrangements. Evidence presented to a parliamentary inquiry in 2026 indicated around 8.3 per cent of the \$45 billion of NDIS expenditure in the previous financial year was attributable to so-called “integrity leakage”, including fraud and inadvertent non-compliance.¹⁴ Beyond the financial implications, inadequate oversight can result in poor-quality services and poorer outcomes for consumers.

Establishing minimum service standards and clinical guidelines at the outset would also help minimise these risks and support confidence in the expansion of HITH models. It would also facilitate more effective contracting between health funds and providers of hospital-substitute services, including non-hospital providers, by providing a consistent framework for service design, quality assurance and payment management.

PHA also notes that some HITH and hospital-substitute services may provide substantial benefits to patients without meeting the threshold required for legislated minimum benefits. For example, lower-intensity or step-down services may be clinically appropriate for patients transitioning from acute episodes of care but may not satisfy the minimum service requirements established for benefit eligibility. The existence of clearly defined service standards would nevertheless assist health funds and providers to contract for these services, supporting innovation and patient choice.

Reporting and evaluation

Currently, reporting for HITH services is consumed within the existing HCP1 database for inpatient services with little visibility for policy makers. PHA recommends reporting for out-of-hospital services be clearly differentiated in the HCP1 database. This will allow insurers, providers, regulators and policy makers to determine the scope of out-of-hospital services, track any changes in utilisation, and keep an eye on broad quality indicators such as readmission rates.

Further, PHA recommends an evaluation of minimum benefits for out-of-hospital services after three years to determine the successes or otherwise for patient care outcomes, viability, ‘stickiness’ from inpatient providers, and access and affordability for consumers.

Minimum benefit setting

The consultation paper proposes a minimum HITH benefit of \$360 per day. However, the methodology and supporting data underpinning this figure has not been provided. PHA would welcome access to the modelling, assumptions and costing methodology to assess the proposed benefit to properly evaluate its appropriateness and potential impacts.

PHA notes that the three proposed clinical categories – IV therapies, complex wound management and palliative care – have very different care requirements, workforce needs and cost structures. A single minimum benefit across all three areas is therefore unlikely to reflect a consistent proportion of the costs associated with delivering each service.

Significant variation also exists within each clinical category. For example, wound care patients may need their wounds tended to three times a day, or once every three days. Similarly, the resource

¹⁴ See <https://www.abc.net.au/news/2026-05-01/ndis-funding-integrity-leakage-parliamentary-hearing/106630496>

requirements for palliative care of IV therapies can differ markedly depending on the patient's condition, complexity and duration of treatment.

PHA recognises a default benefit is intended to act as a market signal and provide a foundation for contracting, but in the absence of supporting information on how the proposed amount was derived, it is difficult to assess. We are uncertain about whether the benefit is appropriately calibrated, whether it would encourage uptake of HITH services, or whether it may unintentionally distort incentives and contracting arrangements.

There is also a risk that a single mandated benefit may overcompensate some services and undercompensate others, creating inequities across providers and clinical disciplines and potentially discouraging innovation in service design. Consideration should therefore be given to whether differentiated benefits, or a framework that better reflects the intensity and complexity of care, would be more appropriate.

PHA further notes that the Private Health Insurance framework already recognises the need for adjusted payment arrangements for extended hospital stays through the use of step-down rates after prescribed lengths of stay. If minimum benefits are introduced for HITH services, comparable arrangements should be considered for patients requiring longer-term care. This would help ensure funding remains aligned with expected costs over the course of treatment and supports the efficient delivery of care while maintaining appropriate patient protections.

Further work is required to establish an evidence-based approach to minimum benefit design, including transparency regarding the proposed benefit calculation, assessment of costs across different HITH models, and consideration of appropriate payment structures for longer-duration episodes of care.

[Realigning incentives by reducing in-hospital benefits](#)

Patients in the private system should have greater access to high-quality out-of-hospital care, including HITH services. The existing hospital funding arrangements however create a significant barrier to reform. In particular, the current second-tier default benefit arrangement continues to favour traditional inpatient models of care, even where clinically appropriate and evidence-based alternatives can be delivered safely and effectively outside the hospital setting.

The current funding framework provides strong incentives for investment in, and utilisation of, inpatient hospital capacity. High minimum funding levels for inpatient care can support models of care that are more resource-intensive than necessary and may discourage the adoption of innovative alternatives. Over time, this has contributed to substantial growth in inpatient capacity and reinforced commercial incentives to direct patients towards hospital-based services, even where out-of-hospital models may provide equivalent or better outcomes.

To support a transition towards contemporary, patient-centred models of care, the introduction of HITH minimum benefits must be accompanied by a reduction of second-tier inpatient benefits for these services. For the first three years of the HITH minimum benefit, PHA recommends the second-tier rate for these services in an inpatient setting be reduced from 85% to 80% (or five percentage points should the benefit rate change). Following the initial three-year period, the minimum benefits should be aligned between HITH and inpatient care.

Aligning financial incentives with contemporary models of care is essential if Australia is to realise the benefits of HITH services, including improved patient experience, reduced pressure on hospital

infrastructure, greater system efficiency and more sustainable growth in healthcare costs. Ultimately, funding arrangements should support the delivery of the right care, in the right place, at the right time, and at the lowest cost consistent with high-quality patient outcomes.

Initiative 2: Introduce a telehealth item for HITH services

PHA supports the introduction of MBS telehealth items for medical specialists, general practitioners and nurse practitioners providing care to patients admitted to hospital substitute services, including HITH.

Access to timely clinical oversight is fundamental to the safe and effective delivery of HITH services. Regardless of the model of care, a suitably qualified health professional must assume clinical responsibility and accountability for managing a patient's care. Where that clinician is required to provide advice, review a patient's condition, adjust treatment, or otherwise intervene, they should be appropriately remunerated for their clinical expertise and responsibility.

Introducing MBS telehealth items that enable medical specialists including GPs and nurse practitioners to provide services to HITH patients at the equivalent in-hospital rebate rate (75 per cent of the MBS schedule fee), would support the sustainability and scalability of hospital substitute services. It would also improve access to clinical expertise, particularly when an in-person consultation is not required, while providing reassurance to patients, families, carers and clinicians delivering care in the home setting.

This reform would help reduce barriers to clinical engagement, facilitate timely intervention when required, and strengthen the capacity of HITH services to deliver safe, high-quality care outside traditional hospital settings.

Private health insurers would continue to be responsible under existing legislative arrangements for covering the gap between the MBS rebate and the MBS schedule fee for eligible in-hospital services. Insurers could also enter contractual arrangements with medical practitioners and nurse practitioners to provide benefits above the minimum required level, enabling no-gap arrangements and minimising out-of-pocket costs for patients.

These proposed new MBS items should include support for participation in case conferences led by substitute providers (similar to the existing item 880), multidisciplinary telehealth consultations, and out of hours escalation to treating practitioners.

Other issues: Expand Prescribed List arrangements to support care in doctors' rooms

A number of Prescribed List (PL) medical devices are currently only eligible for private health insurance benefits when provided as part of a hospital admission. However, advances in clinical practice mean some of these devices can now be safely and effectively implanted or administered in a doctor's rooms, avoiding the need for a hospital admission while maintaining high standards of patient care.

Examples include implantable cardiac loop recorders, coils used in the treatment of varicose veins, and certain ophthalmic devices. Restricting benefits for these devices to hospital settings can create unnecessary costs and administrative complexity, while limiting opportunities to provide care in lower-cost, more convenient settings.

PHA recommends the Australian Government work with the medical technology industry and relevant clinical stakeholders to identify specific PL devices for which the evidence demonstrates

treatment can be provided safely and effectively in doctors' rooms. These devices should be included in a new Part X of the Prescribed List.

Devices listed in Part X should be required to satisfy the same clinical effectiveness, safety and assessment requirements that apply to devices listed in Part A of the Prescribed List. Importantly, these devices should remain eligible for benefits when provided as part of a hospital admission, consistent with current arrangements. In addition, private health insurers should be permitted to pay benefits for Part X devices when they are provided in a doctor's rooms or other appropriate non-hospital setting.

This reform would support clinically appropriate care in lower-cost settings, improve patient convenience and access, reduce unnecessary hospital admissions, and help ensure that funding arrangements keep pace with contemporary models of care and technological advancements.

Other issues: Chronic disease management programs

Out-of-hospital care reforms should also consider the role of Chronic Disease Management Programs (CDMPs), which can enable health funds to cover care that supports patients outside hospitals, including substitute and preventative services. Expanding the scope of these types of programs by removing the restrictions on the types of health practitioners whose services can be funded would increase access to multidisciplinary care, support earlier intervention, and provide patients with a broader range of clinically appropriate out-of-hospital treatment options. Currently nurse practitioners, mental health peer support workers and others are excluded from receiving PHI funding under the current PHI legislation. This would help reduce avoidable hospital admissions and improve continuity of care for people living with chronic conditions.

Further reading

Private Healthcare Australia, [There's no place like home](#), May 2023.

Type C certification exemptions

Across the world, health systems are seeking to reduce the burden of treatment on patients, improve safety and outcomes, take advantage of advances in technology, and shift appropriate care from hospitals to community-based settings.

Australia appears to be doing the opposite by buttressing policy settings that seek to increase the proportion of care undertaken in hospitals, locking in old-fashioned, lower quality models of care. This provides lower quality care at a higher price for consumers, as well as adding to the burden on patients.

PHA recommends governments consider the international evidence and promote policy settings that encourage access to day hospitals, procedures performed in medical practices, and other community-based care options where these are clinically safe, effective and efficient. Such settings can often provide high-quality care while reducing costs and inconvenience for patients.

Type C certification arrangements serve an important policy purpose by requiring medical practitioners to consider whether a procedure that can be safely performed outside a hospital should nonetheless be undertaken in a hospital setting. The certification process requires the practitioner to determine that hospital treatment is reasonable and necessary in the circumstances of the individual patient.

While the administrative burden associated with Type C certification appears relatively modest, the requirement provides an important clinical and regulatory safeguard. It encourages consideration of less intrusive models of care and supports decision-making that is proportionate to patient need. Removing the certification requirement may reduce an important prompt for clinicians to consider whether a lower-acuity setting would be appropriate.

The certification process also provides assurance that admission to hospital reflects a clinical need rather than organisational or financial considerations. This remains important given ongoing changes in healthcare markets, including increased consolidation and the growing role of more services being owned by private equity and other commercially minded operators. In both public and private systems, pressures to increase activity can influence service delivery decisions, making clinical safeguards particularly valuable.

Governments should be cautious about implementing policy changes that may unintentionally encourage the use of higher-cost care settings where equivalent outcomes can be achieved elsewhere. Increasing healthcare costs without a corresponding improvement in quality or patient outcomes is ultimately detrimental to consumers, health funds and the long-term sustainability of the private health system.

Hospital admission, even for relatively low-risk procedures, carries inherent risks including healthcare-associated infections, medication errors and falls among other dangers. Accordingly, hospital treatment should be reserved for situations where it is clinically justified and provides a clear benefit to the patient.

The proposal to remove Type C requirements from certain Medicare Benefits Schedule (MBS) items has the potential to reduce administrative burden for hospitals, clinicians and health funds. However, any reduction in administrative requirements must be carefully balanced against the risk of increased utilisation of higher-cost care settings and the potential for higher costs to consumers and government.

In the absence of certification requirements, there is an increased risk that more patients will be admitted to hospital for procedures that could safely be provided in alternative settings. Where hospital admission occurs, health insurers are generally required to pay benefits for the hospital component of care, with resulting implications for premiums and government expenditure through the Private Health Insurance Rebate.

PHA has observed examples where providers have sought to deliver services in hospital settings despite the availability of clinically appropriate alternatives. For instance, some providers have promoted intravitreal eye injections in hospital settings despite evidence that many such services can be delivered safely in community-based facilities and notwithstanding the current Type C requirements.

The risks associated with these proposals, therefore, warrant careful consideration. While PHA supports efforts to reduce unnecessary administrative burden, any reform should be supported by clear evidence demonstrating that existing certification requirements no longer provide a meaningful safeguard.

Rather than encouraging greater use of hospital-based care, governments should continue to explore opportunities to expand access to clinically appropriate out-of-hospital services. This includes enabling health funds to support a broader range of community-based treatments, reducing incentives that favour hospital delivery, and providing patients and clinicians with greater choice regarding where care is delivered.

More broadly, the consultation paper tends to rely on proxy indicators such as age, anaesthetic modality, or current treatment setting rather than directly assessing the patient characteristics and clinical risk factors that determine whether hospital-based care is appropriate. Any exemption framework should be based on demonstrated clinical risk and evidence of patient benefit rather than broad demographic or procedural proxies.

Initiative 1: Exemption if patient is over 75 years

While the consultation paper correctly notes that multimorbidity, frailty and anaesthetic risk increase with age, the evidence presented supports a risk-based assessment rather than an age-based categorisation. Contemporary perioperative literature consistently identifies frailty, functional status and comorbidity burden as stronger predictors of adverse outcomes than chronological age alone.

The consultation paper does not provide evidence demonstrating that age ≥ 75 independently predicts the need for hospital-based care for procedures otherwise suitable for lower-acuity settings. Nor does it justify the selection of 75 years as the threshold for exemption. The proposal appears to rely primarily on an association between increasing age and higher risk, rather than evidence that age itself is an independent determinant requiring hospital-based management.

A recurring theme in contemporary perioperative and geriatric-surgery literature is that chronological age alone is a poor risk stratifier. Recent reviews emphasise that risk is better predicted by:

- frailty
- functional status
- cognition
- nutritional status
- comorbidities, and

- physiological reserve.

Canales et al (2025) explicitly state that "age alone is not a sufficient indicator of risk".¹⁵

The available evidence supports the exercise of clinical judgement based on recognised risk factors such as frailty, comorbidity, ASA score and other relevant clinical considerations. However, the evidence presented in the consultation paper does not appear sufficient to justify a blanket exemption based solely on age.

In particular, the paper does not demonstrate:

- that 75 is the optimal threshold for exemption
- that age predicts adverse outcomes independently of frailty and comorbidity
- that all, or most, patients over 75 benefit from hospital-based management for the relevant procedures; or
- that alternative risk-based criteria, such as ASA class, frailty score, multimorbidity measures, would perform worse than the proposed age criterion.

PHA supports evidence-based healthcare policy. On the evidence presented, the proposed age-based exemption does not appear to meet that standard. A risk-based approach centred on clinical assessment would be more consistent with contemporary evidence and patient-centred care.

Initiative 2: Exemption associated with anaesthesia use

The consultation paper provides more compelling rationale for anaesthesia-related exemptions

than for demographic-based exemptions, as the administration of general anaesthesia, regional anaesthesia and some forms of intravenous (IV) sedation carry recognised requirements for staffing, patient monitoring, recovery facilities and emergency preparedness. However, the evidence presented does not establish that the use of these anaesthetic techniques necessarily requires treatment in a hospital setting in every case.

The Australian and New Zealand College of Anaesthetists (ANZCA) principles cited in the consultation paper emphasise a risk-based assessment that considers the procedure, anaesthetic technique, patient characteristics and facility capability. These principles are directed towards matching the level of care to clinical risk rather than applying a universal exemption based solely on the type of anaesthesia administered.

While general anaesthesia and some higher-risk forms of sedation may justify treatment in facilities with greater capability, the proposal does not demonstrate that certification requirements provide limited benefit whenever general anaesthesia, regional anaesthesia or IV sedation is used. Nor does it provide evidence that all procedures involving these techniques are unsuitable for accredited non-hospital settings.

In particular, the inclusion of IV sedation is not adequately supported by the evidence presented. A wide range of procedures involving IV sedation are routinely and safely performed outside traditional hospital settings, including endoscopy, dental procedures, ophthalmic procedures, and interventional radiology. These services are commonly provided in accredited facilities operating under established requirements for patient selection, monitoring, staffing, recovery and emergency management. The

¹⁵ Canales C, et al. *Perioperative risk assessment in older adults* (2025). Available at: <https://pubmed.ncbi.nlm.nih.gov/41044779/>

consultation paper does not appear to demonstrate that certification is ineffective in managing the risks associated with these procedures or that hospital-based care is required in all cases where IV sedation is administered.

Similarly, the use of regional anaesthesia encompasses a broad spectrum of techniques and risk profiles. The proposal does not distinguish between lower-risk and higher-risk applications, nor does it explain why all procedures involving regional anaesthesia should attract an exemption irrespective of patient characteristics, procedural complexity or facility capability.

Modern anaesthesia is generally safe and effective when delivered within appropriately accredited settings by suitably qualified clinicians. Contemporary anaesthetic practice emphasises individualised risk assessment and the selection of the most appropriate setting based on the patient's overall risk profile. This approach aligns with ANZCA guidance, which focuses on matching the patient, procedure, anaesthetic technique and facility capability.

Accordingly, while anaesthesia-related factors are relevant considerations in determining procedural risk, the evidence presented supports a risk-based and capability-based assessment framework rather than a blanket exemption based solely on the use of general anaesthesia, regional anaesthesia or IV sedation. Additional evidence would be required to demonstrate that certification does not adequately mitigate risk in accredited non-hospital facilities, or that all procedures involving these forms of anaesthesia warrant automatic exemption from the proposed requirements.

PHA supports evidence-based healthcare policy. On the evidence presented, a more proportionate approach would be to assess exemption criteria based on clinical risk, patient factors and facility capability rather than the use of specific anaesthetic techniques alone.

[Initiative: Reclassify MBS item 14245](#)

The consultation paper identifies legitimate clinical risks associated with the administration of immunomodulating agents, including the potential for infusion-related reactions and anaphylaxis. However, the evidence presented does not demonstrate that these risks necessarily require treatment in a hospital setting, nor that accredited non-hospital infusion centres are unable to safely meet the supervision, monitoring and emergency response requirements specified under MBS item 14245.

The item descriptor already requires administration under the supervision of a medical practitioner, together with appropriate arrangements for the recognition and management of adverse reactions. These requirements are not unique to hospitals and can be met in accredited non-hospital facilities that are appropriately staffed, equipped and governed.

Importantly, departmental data indicate that approximately 38% of services billed under item 14245 are already delivered outside hospital settings. This suggests a substantial proportion of patients can currently be managed safely in alternative facilities. If such services are being provided safely in non-hospital settings under existing regulatory framework, further evidence is required to demonstrate why reclassification is necessary.

In particular, the consultation paper does not provide evidence regarding:

- rates of anaphylaxis
- infusion-related reactions requiring intervention
- hospital transfers

- emergency department presentations
- unplanned admission, or
- other clinically significant adverse events

A more clinically appropriate approach may be to differentiate patients according to individual risk factors. For example, hospital-based treatment may be justified for patients with:

- first-dose administration
- a history of severe infusion reactions
- significant cardiopulmonary disease
- unstable multimorbidity
- complex clinical circumstances requiring multidisciplinary management, or
- treatment with high-risk biologic agents known to have a higher risk of serious infusion-related adverse events.

By contrast, non-hospital treatment may be entirely appropriate for patients who:

- have an established treatment history
- have previously tolerated infusions without complication,
- are clinically stable, and
- are treated in facilities with appropriate medical supervision, monitoring capabilities and immediate access to emergency management protocols and equipment, consistent with the requirements of the MBS item.

The consultation paper does not appear to consider whether these patient-level risk factors are more predictive of adverse outcomes than the treatment setting alone. Nor does it assess whether a risk-based model could achieve equivalent or better safety outcomes while preserving patient access and service flexibility.

Consideration should therefore be given to alternative approaches that distinguish between:

- first and subsequent infusions
- the specific medicine being administered
- the known risk profile of the treatment
- previous adverse reactions, and
- individual patient risk factors.

Such an approach would be more consistent with contemporary risk-based healthcare regulation than a uniform classification applied to all services billed under item 14245, regardless of patient characteristics or clinical complexity.

PHA supports evidence-based healthcare policy. On the evidence presented, the case for reclassifying all services under MBS item 14245 has not been established. Further evidence regarding comparative safety outcomes in hospital and accredited non-hospital settings should be provided before a blanket reclassification is adopted. A targeted, risk-based approach would be more proportionate and better aligned with patient-centred care.

[Initiative: Other possible exemption criteria](#)

PHA remains committed to engaging constructively in proposals that reduce unnecessary administrative burden and improve regulatory efficiency. However, any exemption framework should

be based on robust clinical evidence and demonstrated risk rather than broad demographic characteristics or criteria that are susceptible to inconsistency, unintended consequences or gaming.

Of the four options identified in the consultation paper, PHA makes the following observations:

Younger patient criteria

A younger-age exemption is a demographic criterion rather than a clinical one. While younger patients may, on average, have fewer comorbidities and lower procedural risk, the consultation paper does not provide evidence demonstrating that age alone is an appropriate proxy for clinical complexity or the need for certification. As with proposals relating to older patients, any age-based exemption should be supported by evidence showing that age independently predicts relevant clinical outcomes and performs better than established risk-based measures.

Travel requirements

Travel burden can be a legitimate consideration in healthcare policy, particularly for patients in rural, regional and remote areas. However, a simple distance-based exemption may not appropriately reflect the realities of healthcare access. Travel burden is influenced by a range of factors, including transport availability, travel time, socioeconomic circumstances, mobility limitations and local service availability. A solely geographic threshold risks creating arbitrary distinctions and may not accurately identify patients who face the greatest barriers to care.

Co-claiming with higher classified items

PHA notes that a Type C certificate is generally not required where an item is co-claimed with a higher-classified item. To the extent that existing arrangements already recognise and address the higher-risk service through the classification of the accompanying item, the clinical and policy rationale for any additional exemption appears limited. Any proposed changes should clearly demonstrate that they address a genuine regulatory gap rather than duplicating existing mechanisms.

Time of admission

PHA does not support exemption criteria based on the time of admission or scheduling of a procedure. Time of day is not inherently related to clinical risk and does not represent a meaningful indicator of patient complexity, procedural difficulty or facility capability. Such an approach would also be highly susceptible to gaming and could create incentives for scheduling decisions that are driven by administrative considerations rather than clinical need. Exemption criteria should be based on objective and clinically relevant factors rather than operational variables that can be readily manipulated.

Overall, PHA considers that exemption criteria should, wherever possible, be linked to demonstrable clinical risk factors, patient complexity, procedural requirements and facility capability. Criteria based primarily on demographic characteristics, administrative arrangements or operational timing are unlikely to provide a sufficiently robust evidentiary basis for exemption and may create unintended distortions within the system.

PHA encourages the development of evidence-based, risk-adjusted exemption criteria that are transparent, clinically relevant and capable of being applied consistently across settings and patient populations.

Further reading

Private Healthcare Australia, [Type C delisting](#), October 2025

Delivering better value to consumers

Improving access to regional private hospitals

Default hospital benefits are a policy mechanism developed in the 1990s in response to market conditions that no longer exist. While originally intended to safeguard patient access and choice by providing a safety net for hospitals without contractual arrangements with private health insurers, the current framework is no longer effectively serving those objectives.

The existing arrangements increasingly function as a subsidy for hospitals operating in already well-served metropolitan markets.

Current settings produce outcomes that are difficult to justify on equity or consumer-interest grounds. In some instances, hospitals in affluent metropolitan areas receive higher default benefit payments than hospitals serving regional and remote communities in other jurisdictions with greater healthcare access challenges. At the same time, a small number of non-contracted hospitals are able to receive second-tier default benefits while also imposing substantial out-of-pocket costs on patients, effectively benefiting from both the regulatory safety net and direct patient contributions.

Second-tier default benefits operate as a partial price control, setting a price floor. They provide a safety net for providers that do not hold contractual arrangements with insurers, while preserving scope for insurers and hospitals to negotiate contracts that deliver value to consumers. However, the current settings distort incentives and redirect resources away from areas of greatest need.

Under the current framework, second-tier default benefits can disproportionately benefit:

Hospitals with limited demonstrated value

- Hospitals that are unable to secure contracts due to quality, performance or value concerns may still receive 85 per cent of the average contracted rate regardless of the quality of services provided.

Providers in oversupplied markets

- Hospitals operating in highly competitive metropolitan markets can continue to receive substantial default payments regardless of local service saturation or levels of unmet need.

Conversely, the current arrangements can disadvantage:

Consumers and their health funds

- Consumers ultimately fund higher payments for services that have not demonstrated sufficient value to secure a contractual arrangement, contributing to higher system costs.

High-performing hospitals

- Resources directed towards lower-value services reduce the capacity for health funds to reward providers that demonstrate higher clinical quality, better patient outcomes and stronger value for money.

Hospitals in undersupplied areas

- Payments directed towards providers in oversupplied markets reduce the resources available to support hospitals serving communities with genuine access challenges.

Providers facing higher operating costs

- Rural, remote and other higher-cost locations often experience elevated workforce, transport and infrastructure costs. Current settings do not adequately recognise these differences.

Innovative models of care

- Emerging service models, including hospital-in-the-home and other innovative delivery approaches, require flexible funding arrangements and a degree of investment risk. The current framework reduces the capacity to support and expand these models, as there is no incentive to take a chance on change.

Taxpayers

- The administration of the existing system imposes costs that generate limited public benefit and may not represent an efficient use of resources.

Market distortions and capital allocation

The current arrangements create incentives for providers to establish low-cost services in oversupplied metropolitan markets where second-tier default benefits provide a relatively secure revenue stream. This incentive structure is compounded by the well-documented information asymmetries present in healthcare, where consumers may find it difficult to evaluate service quality and value.

Research has also identified the risk of supplier-induced demand, whereby service utilisation may increase beyond clinically optimal levels in response to financial incentives.^{16 17}

The result is a distortion of investment decisions. Capital investment and facility development are encouraged in already well-served urban locations, while regional, rural and remote communities continue to experience lower levels of investment and fewer healthcare options.

Furthermore, recent data released by the Australian Bureau of Statistics indicates that the overwhelming majority of private hospitals – 88.1% – were profitable or broke even in 2024-25.¹⁸ This profit rate is a significant increase from 2022-23 and remains significantly higher than the average profitability rate across industries. There is limited evidence to demonstrate that increasing default benefit payments across broad categories of hospitals would effectively address financial sustainability concerns or materially reduce the risk of hospital closures.

Where specific hospitals are experiencing viability challenges, blanket increases in default benefits are unlikely to represent the most efficient policy response. In sectors facing demographic and workforce pressures, increasing payments per patient does not necessarily address underlying structural issues where demand volumes remain constrained. A more targeted and transparent approach would better support access, value and sustainability.

¹⁶ Richardson JRJ & Peacock SJ (2006), *Supplier-induced demand*, Applied Health Economics and Health Policy, 5(2).

¹⁷ Willcox S (2005), *Buying best value health care: Evolution of purchasing among Australian private health insurers*, Australia and New Zealand Health Policy, 2(6).

¹⁸ Australian Bureau of Statistics (2026), *81550DO001_202425 Australian Industry, 2024-25*, Table 4 Industry performance by industry division and subdivision, available for download from <https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry/latest-release#data-downloads>.

Initiative 1: Increase the second-tier benefits for established regional private hospitals

Proposals to increase second-tier default benefit rates for all regional hospitals risk applying a broad solution to a highly varied market.

Regional hospital performance is not uniform. Available evidence suggests that some regional hospitals are financially strong while others face challenges. Similarly, the degree of service availability varies considerably across regional Australia. For example, certain Modified Monash Model (MM2) locations, such as Geelong, Hobart and the Sunshine Coast, are relatively well serviced compared to more remote communities.

Accordingly, any reform should focus on addressing genuine market failures rather than broadly increasing subsidies across all non-metropolitan areas.

PHA recommends:

- increasing second-tier default benefit rates in genuinely underserved rural and remote areas to between 90 and 95 per cent of the reference rate
- reducing second-tier default benefit rates in oversupplied metropolitan markets to 75 per cent, and
- restricting access to second-tier default benefits for new hospital services established in oversupplied metropolitan markets, unless those services demonstrably improve consumer access or expand service availability.

PHA does not support only increasing benefits for established regional hospitals. This would simply support incumbents and not encourage new or innovative services.

Rebalancing incentives

Simply increasing default benefits in regional areas while maintaining existing metropolitan rates would be inflationary and would do little to alter investment decisions. A more effective approach would combine:

- higher default benefit rates in undersupplied areas, and
- lower rates in oversupplied metropolitan markets.

This would create meaningful incentives for providers to establish services where they are most needed while improving the allocation of healthcare resources across the system.

The evidence indicates that reliance on second-tier default benefits is concentrated in oversupplied markets. In many cases, these are providers that have either chosen not to contract with insurers or have been unable to demonstrate sufficient value to secure contractual arrangements. Continued subsidisation of such providers does little to improve consumer outcomes. PHA notes a 75% default benefit rate would significantly increase the pressure on urban hospitals in oversupplied areas to contract with the majority of health funds.

PHA further recommends setting the maximum regional default benefit rate below 100 per cent. A 100 per cent rate would remove incentives for providers to enter contractual arrangements with insurers.

Contracting delivers important consumer benefits, including:

- lower or no out-of-pocket costs

- quality improvement initiatives
- participation in clinical registries and safety programs
- enhanced patient experience, and
- greater accountability for outcomes.

Removing incentives to contract would weaken these benefits and risk poorer outcomes for consumers.

Targeting new services

PHA recommends that new hospitals or services established in MM1 and MM2 locations should only be eligible for second-tier default benefits where they demonstrably improve consumer access to services not currently available in the local market.

Examples may include:

- innovative models of care
- specialised services that are not otherwise available locally, or
- service models designed to reduce consumer out-of-pocket costs.

Conversely, hospitals offering services that are already readily available in the local area should not automatically attract public policy support through second-tier default benefits.

No equivalent restrictions are recommended in rural or regional locations, where increasing provider participation and consumer choice should remain a policy priority.

Initiative 2: Volume Weighting and Consumer Protections

Any reform to the methodology used to calculate second-tier default benefits should be assessed against a simple test: whether it delivers measurable consumer benefits through improved access, affordability or quality.

Changes that merely increase default benefit payments without improving consumer outcomes would represent a transfer of resources from consumers to providers, adding to healthcare costs without delivering corresponding public benefit.

If the Government chooses to revise the methodology, PHA recommends that reforms be accompanied by measures that directly benefit consumers, including:

- prohibiting hospitals receiving second-tier default benefits from charging excessive out-of-pocket costs, and
- replacing the current location-based percentage approach with a nationally consistent, flat dollar-based default benefit rate (see below).

Protecting consumers from excessive charges

The existing framework establishes a payment floor through second-tier benefits but imposes no effective ceiling on patient charges. As a result, some of the largest out-of-pocket costs in the private health system arise from services provided by hospitals operating outside contractual arrangements.

PHA recommends access to second-tier default benefits be conditional on providers agreeing not to charge more than a prescribed amount above the relevant default benefits price. There is precedent for this approach. Prior to 2015, Medicare benefits for optometry services were linked to

participation arrangements that limited patient charging. A similar undertaking could readily be adapted to the second-tier default benefit system.

[Establishing a national default benefit rate](#)

The current arrangements produce significant inconsistencies. It is difficult to justify a system in which default benefit payments can be higher in well-served metropolitan areas than in regions facing clear shortages of private healthcare services.

PHA recommends replacing the existing percentage-based methodology with a nationally consistent dollar-based default benefit rate determined by the Department of Health, Disability and Aged Care. The national rate could be calculated using existing contracted hospital payment data and benchmarked at the lower quartile of current second-tier rates. Once established, the rate should be indexed annually by the lower of:

- the Consumer Price Index, or
- the average annual increase in private health insurance premiums.

This approach would improve transparency, reduce inflationary pressures, strengthen incentives for contracting, and better align funding with consumer interests and health system objectives.

[Further reading](#)

Private Healthcare Australia, [Private health reform options](#), January 2025.

Private Healthcare Australia, [Draft Pricing Framework for Australian Private Hospital Services](#), November 2025.

Private Healthcare Australia, [Reforming default hospital benefits](#), September 2022.

PHI product simplification

It is very clear from research that consumers value choice. Consumers also value clear, simple options and the capacity to easily compare products. Product tiering reforms should support:

- people having affordable and equitable access to private care
- products providing meaningful choice and value for money
- consumers understanding and comparing products with confidence
- community rating and risk pooling remaining sustainable
- membership remaining broad and stable
- competition supporting consumer value and long-term system sustainability.

The introduction of product categories in 2019 has made it easier to compare products (although these need to be improved). However, the poor design of the Basic, Bronze, Silver and Gold product categories in 2019 has resulted in unnecessary complications for consumers.

Introducing clinical categories and product tiers has had a very significant impact on insurer product design. Product development centred on consumer life stages and value in that stage has been replaced with an approach based on body system and the expense of procedure. For example, Gold products just include all the most expensive procedures, regardless of whether they are relevant to the customer's life stage. Cataracts and joint replacements sit alongside pregnancy/birth and assisted reproductive services.

We need to aim to keep the positive aspects of the clinical categorisation for consumers, in terms of it being easy to understand and compare, while introducing more flexibility for insurers to tailor or differentiate products and give consumers more choice.

The Department should take the results of the 2024 Clinical Categories review to make amendments to the clinical categories to improve clarity and understanding. Resurrecting this process should help address any consumer confusion.

The Basic, Bronze, Silver and Gold product categories need to be reviewed to make the hierarchy more sensible and more sustainable. PHA will continue to work with government to improve this system. However, reducing choice is simply a penalty on consumers and should not be supported.

The assertion in the paper that there are 5000 hospital products available for consumers to choose from is misleading. Australia is a federation, so eight sets of product suites are required to comply with state and territory laws. From there, funds have versions of their policies for families, couples, singles and single parents. Most funds have fewer than ten base products available, and with these, offer a range of options to consumers to vary, for example, excess levels. These options are a feature of our system, allowing consumers to make choices about their preferred level of cover, to suit their particular circumstances.

For example, a single person in Victoria may choose from 262 policies from 29 health insurers, including duplicates sold by the same insurer under different brandings (for example, RT Health is now part of HCF). These options include policies in a range of policy tiers, with a range of excesses, and in some cases, hospital copayment options.¹⁹

¹⁹ Search conducted on privatehealth.gov.au on 28 July 2026.

The assumptions made in the paper that consumers' understanding of products is poor and that smaller product cohorts are inherently harmful are not proven. Further, the assumption that simplification would reduce these concerns is also not demonstrated. The transaction costs are significant, and it is not clear that consumers would consolidate into the remaining products without materially reducing their level of cover or leaving private health insurance.

PHA's emerging research also suggests consumers are making deliberate product choices. They consider the services they expect to use, affordability and the broader peace of mind provided by protection against significant health risks. Some members, particularly in the lower tiers, also question whether product inclusions align with the services they are most likely to need and provide sufficient value.

This suggests consumers are responding to the current product architecture in a deliberate way. Rather than focusing narrowly on the number of products, a better focus for consultation would be whether the current architecture best aligns products with consumer needs while supporting affordability and sustainability.

Our emerging analysis suggests that some of the strongest claims and premium pressures are associated with particular products, consumer cohorts and clinical categories. Understanding the relative contribution of consumer behaviour, product architecture, claims experience and the concentration of particular high-cost services - including maternity and mental health within comprehensive products - will be important in determining the most effective reform pathway.

Initiative 1: Simplify PHI product structure

The premise of these proposals – that consumers value simplicity over choice – is not borne out by the research. PHA seeks advice from government on any substantial evidence that consumers would prefer not to be allowed to purchase a range of insurance products in the market. PHA does not accept the premise that consumers are getting it wrong; consumers are the best judge of their own needs.

Wherever the paper suggests removing the option for insurers to offer a product, the actual effect is removing the option for consumers to purchase a product. Stopping consumers exercising choice is a poor policy option and should be rejected.

Basic products

Basic products are an important part of private health insurance, providing an affordable entry-level option for consumers. Around 10% of the market is Basic and Basic Plus products, with more than three times as many Basic Plus products as base tier Basic products.²⁰ These products provide real value to consumers, particularly for those with emergency cover. In response to consumer demand, health funds offer Basic Plus policies which include other clinical categories. Further, some Basic products provide restricted coverage for clinical categories but cover more clinical categories than higher-tier products. This outcome may provide greater cover than a comparable product with outright exclusions, yet is classified at a lower tier.

Removing the option for consumers to purchase Basic and Basic Plus health insurance would reduce the incentives to take out private health insurance to avoid the Medicare Levy Surcharge. This may

²⁰ Representative member fund survey, June 2026.

reduce coverage and remove significant funding from the Risk Equalisation pool, which puts upwards premium pressure on other contributors.

PHA notes that recommended increases in the Medicare Levy Surcharge (see below) may increase the take up of private health insurance, including Basic and Basic Plus products where the only deciding factor is the cheapest policy available to avoid the surcharge.

Plus products

Consumers are voting with their feet. There has been significant growth in both Silver Plus and Bronze Plus categories over the past five years. Around two thirds of policy holders are now on Plus products. Outside of Gold cover, which has declined in recent years, there are fewer than five per cent of members on base tiers – nearly every customer is choosing either a Plus product or Gold cover.²¹

Partly, this is a result of the poor initial design of the product categories. In most cases, it is a sensible and considered decision for consumers who want more than is offered by the base level of the tiers, and/or don't need coverage for particular services (such as pregnancy).

Removing the capacity for consumers to purchase Plus products would require more than eight million people to change their cover – this would be a significant impost on the community. Further, the government would be telling people that their choices were wrong, and they would be forced to reconsider their cover choices.

Remove or consolidate some product tiers

PHA is open to considering changes to the product tiers and has commissioned work to contribute to the policy discussion. The market has not settled on the four tiers set by government in 2019, with more than two thirds of people now on Plus products. Consumers have comprehensively rejected the base products in Basic, Bronze and Silver, preferring to choose added coverage.

PHA will continue working towards considering the market, the demand from consumers, and the feedback from representative surveys and other research data. These data will need to be considered alongside modelling on the effects of any proposed changes on premiums, as affordability and access to care are the paramount concerns of consumers.

PHA looks forward to continuing work on this issue with the Department and other stakeholders.

Clarify communication about product type

PHA agrees consumers need clarity on the products they choose, and this information should be clearly available in product description documents produced by health funds. PHA is unaware of any examples where adequate information about what consumers are covered for is not provided, and asks the Department for any examples of concerns they have.

Policy settings on ambulance, emergency department and hospital-substitute

PHA considers the existing Rules as clear on these issues but would welcome a discussion with the Department about any areas of concern.

PHA notes that ambulance coverage varies significantly state by state, and this causes confusion among consumers, including people with private health insurance. This is a particular issue for people who move between jurisdictions, or people living in border regions. PHA would welcome

²¹ Representative member fund survey, June 2026.

consistency between jurisdictions on access to ambulance services and recommends the Australian Government seek consistency through National Cabinet processes.

Initiative 2: standardising the age threshold and associated eligibility for dependants

The paper is right to point out issues with the implementation of the 2021 legislation.

In August 2023, Dr David wrote to the Minister on the implementation of the dependents with a disability aspect of the legislation being severely compromised by the drafting of the rules by the previous government requiring application of the Lifetime Health Cover (LHC) to dependents with a disability. This means that customers who wish to add their dependent children to their policy face significant and unnecessary financial barriers.

Funds have been reluctant to introduce new products for families with a dependent with a disability due to the additional, unnecessary, costs. Consumers have understandably been reluctant to pay more for their family health insurance simply because their dependent family member is over 30 years old. Thus, there are very few products in the market, and families including adults with a disability have not had access to private health insurance as envisaged by the Amendment Act in 2021.

PHA recommended removing the LHC loading as a requirement for dependent persons with a disability and presented two legislative options to achieve this objective.

We remain disappointed that this issue has yet to be resolved three years later. It seems unreasonable that the paper would consider an option forcing funds to offer a product for this group without addressing the significant problem with the legislation as implemented by the department which unnecessarily increases the cost of these products and is the primary reason they are not offered.

On the issue of variation on how insurers apply the age threshold for dependants, PHA recommends no change and expects the market will stabilise to provide greater consistency. Variation does not equal complexity, and the paper provides no evidence of an actual problem to be addressed. Consumers can change funds to take advantage of differences in the age of dependants covered.

Initiative 3: excess and co-payment standardisation

The industry is restricted with the amounts that can be applied for excesses and/or copayments though the Complying Product Rules. It is unclear from the paper what the issue to be addressed is.

PHA would welcome further clarification as to what the department is concerned with, and any evidence for the asserted confusion or perceptions cited.

The product Rules appear clear, and PHA would welcome any advice on the suggestion that there are inconsistencies in the Rules between the maximum excess payable and any daily co-payments, and/or if department considers any existing practices inadvertently breach the Rules.

PHA recommends that insurers be allowed to waive excesses as customers' individual circumstances may vary. These should be considered in the same manner as ex-gratia payments. Funds will often provide benefits for procedures, devices or services to which the customer is not entitled under their policy for a range of reasons. This practice provides a public good and should be maintained.

Initiative 4: ensuring consistency across premium structures

Again, the department has asserted perceptions of inconsistency and unfairness without providing the basis for these assertions. PHA would welcome any evidence of these concerns being expressed by consumers.

PHA notes the paper suggests identical products are being offered at different premiums, and highlights to the department that this is not legal. However, we acknowledge that many people are on older products (predominantly in the Gold category), with very similar products currently available to new customers at a different price. Seeking to normalise the premiums for these similar products would significantly disadvantage older customers on closed products – at the same time the Australian Government planning to reduce the Private Health Insurance Rebate for these customers by up to \$602 for a couple.

There is already a cap in discounts that funds may offer. Removing the capacity of health insurers to waive waiting periods or offer discounts within this cap will result in a substantial lessening of competition. The economic case for lessening competition must be strong for there to be a public benefit. PHA notes it is normally industry which seeks to limit competition for consumers, not government. If the industry suggested this approach, it would fail to be approved by the ACCC.

However, PHA notes concern within the industry that some current practices may fall outside the current guidelines. For example, brokers are not bound by the current guidelines and may fund discounts outside the cap. Further, some current discounts are implemented over two years, which allows the cap to be utilised twice. PHA recommends the government consider limiting the use of promotions for both brokers and funds to a total of one years' worth of discounts (which may then be spread over more than one year).

The concerns that single parents pay more for a policy with multiple people covered than a single person with one person covered seems not to understand the nature of insurance. Covering more people will cost more. PHA supports community rating principles and welcomes funds' flexible approaches to serve customers who are single parents, those with shared custody, and those experiencing family violence and financial coercion. PHA does not support changes to community rating principles that could penalise different types of family configurations.

Further reading

Private Healthcare Australia, [Clinical categories review](#), January 2025

Risk equalisation

Risk equalisation needs changes to meet the new realities of the private health insurance sector. Over time, the importance of the risk equalisation pool to the sector has increased simply by default, as successive governments have not properly engaged in this vital part of our system. PHA welcomes the government's willingness to consider reform options.

The objectives of risk equalisation should be clearly articulated. PHA recommends the objectives be supporting community rating, improving efficiency, and promoting participation. PHA further recommends ensuring the size of the risk equalisation pool per single equivalent unit.

The initiatives listed are sound in principle, with settings needing to be modelled to determine whether the stated objectives of risk equalisation are achieved (or at least improved), as well as the impact of on any winners and the losers. However, implemented in isolation they will simply increase the flagfall, resulting in more unaffordable products and higher premiums across the sector.

PHA recommends instead a strategic approach to risk equalisation changes, rather than tinkering at the edges. We need to commit to a prospective risk equalisation pool and chart a path to a prospective pool that achieves the stated objectives of community rating and efficiency and better reflects the costs of maternity and mental health. Simply adding to the pool to redistribute funds without a vision to improve equity and efficiency would be a wasted opportunity.

Implementation can be based on a platform with an extended range of risk adjustment factors, including demographic factors, health indicators, and possibly socioeconomic impacts. Several of these factors can be set to zero for the initial implementation phase. Risk adjustment factors to be considered as part of the platform include the customer characteristics identified in previous reports, as well as product tiers and clinical categories. Learnings from international risk equalisation systems (both in design and administration) will be important to help develop an optimal and sustainable pathway for our system.

By highlighting the factors to be considered for future implementation – a roadmap for the future with clear timeframes – funds will be able to undertake more sophisticated modelling on the effects of future changes and provide better advice to government. The work to date provides the case for building the platform, but funds have insufficient information on the two specific proposals in this paper to make a fully informed assessment.

PHA notes that the risk equalisation rates for maternity and for mental health may need to differ and looks forward to contributing to modelling options. For example, a measurable proportion of mental health claims are made by older customers, and there are some claims in both areas which meet the thresholds for the high-cost claims pool.

Adjustments to risk equalisation are essentially a zero-sum game – changing the settings produces winners and losers – highlighting the importance of any changes resulting in a measurable improvement in supporting community rating and efficiency. PHA recommends the government seek to also grow private health insurance participation to ease pressure on the public system, with changes to the Medicare Levy Surcharge (MLS). Increasing the MLS will help encourage a significant number of people taking out private health insurance and becoming net contributors to the pool. That would allow changes to be made while minimising the negative effect on existing policyholders.

Further reading

Private Healthcare Australia, [Response to the Private Health Insurance Actuarial Study into Risk Equalisation](#), December 2022.

Areas not covered by this consultation

There are a number of important areas of reform not covered by this consultation, which would improve care, reduce costs and build the sustainability of the industry for private hospitals, medical professionals, insurers and consumers.

Reducing the cost of medical devices

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.

Low value care

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, and this includes 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 this 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.”²²

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.

In an inflationary environment, it is critical every dollar spent in this sector adds measurable value. Too often, historical funding models under the health portfolio compel expenditure in ways that are wasteful and even harmful.²³

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 the burden of treatment for consumers.²⁴

These savings would be shared across private hospitals, 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

²² At <https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-020-01563-4>

²³ PHA’s [Budget Submission 2023-24](#) contains an appendix with several examples of low value care, with over \$300 million pa available in savings.

²⁴ Several examples of procedures with high length of stays can be found at <https://www.privatehealthcareaustralia.org.au/theres-no-place-like-home/>

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.

Increase the Medicare Levy Surcharge

Many of the issues considered in this reform process would be eased by encouraging more of the 900,000 Australians on high incomes paying the Medicare Levy Surcharge (MLS) to take out private health insurance.

Increasing the MLS to 1.5% for tier 1 earners, and 3% for tier 2 and 3 earners could see participation increase by 383,000 people, with the majority of these (277,000) aged under 50. This influx of new participants would make a significant impact on the risk equalisation pool, providing the flexibility to undertake some of the recommended reform options.

In addition, these changes would provide a net \$410 million to government in additional revenue, which could be used for other purposes such as reducing the impact of the proposed Private Health Insurance Rebate on pensioners and other low income earners over 65 years.

These policy changes - supported by health funds, by private hospital groups, and the Australian Medical Association - would improve participation, affordability and equity within the system. It 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.

Conclusion

Private Healthcare Australia and our member funds are committed to working with government, consumers, private hospitals and clinicians to improve our private health system. PHA looks forward to detailed discussions across the sector to improve affordability, enhance equity, increase efficiency and improve health outcomes for Australians.