



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



Senate Select Committee on Women's Health

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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

PHA welcomes the opportunity to provide advice to the Senate Select Committee on Women's Health.

Private health insurance is a significant funder of health care for women, including the areas identified within the Select Committee's terms of reference. Health funds support women who require hospital care, and a range of non-medical services through extras cover. This includes, but is not limited to, physiotherapy, access to pharmaceutical items not covered by the PBS, lactation support, mental health support and more.

However, current legislation prohibits health funds from supporting a range of services which would help support women, and we would welcome the Select Committee considering recommendations to free up legislative barriers to best practice care.

Response

Best practice pregnancy and postpartum care models to support long-term maternal physical and mental health

Recommendations:

- *Allow health funds to offer an end-to-end care package for maternity services with fixed out of pocket costs.*
- *These should be able to be managed by obstetricians, midwives or general practitioners to give women more choices.*
- *Where clinicians agree to lead a team and take responsibility for all aspects of care, the Australian Government and health funds each provide at least \$3000 to reduce out of pocket costs.*

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

The most common complaint of new parents in the private system is high and unknown out of pocket costs, particularly for managing the pregnancy, which mostly occurs as an outpatient. Obstetricians' costs are pricing themselves out of the market. However, obstetrics services are only the most visible cost. From initial and follow up consultations, scans, pathology, hospital birthing services, anaesthetists, paediatricians and midwives, there are many opportunities for

consumers to be sluggish with out-of-pocket costs. Many of these costs are not disclosed at the beginning of the episode of care. Many people feel powerless to challenge these unexpected costs.

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

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

Last year, PHA put a paper to government and the sector on developing options for bundled packages by changing the current legislation to allow health funds to pay for maternity services out of hospital under strict conditions with a wider range of practitioners. This would require a lead practitioner (the obstetrician, midwife or GP) selected by the patient to coordinate all the services required, managing the care of the patient. This would also include negotiating remuneration with other medical providers, with the lead practitioner providing a single invoice to the patient covering all the services required.¹

Such an approach would eliminate the drip pricing currently experienced by consumers and ensure parents were aware of the total out of pocket costs before they started the private maternity care journey.

It would also open new high-quality care options for parents and offer medical providers models with more sustainable cost structures for a wider pool of people.

Such a model, where a lead practitioner coordinates both the health and the financial aspect of care, is a new innovation in the Australian context, but one that would be warmly welcomed by patients.

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

The additional administrative costs of managing patients’ care are significant. Lead clinicians would need to negotiate prices and arrangements with a range of providers, such as anaesthetists, sonographers and others in advance, in addition to ensuring strong clinical governance. The lead clinicians’ increased purchasing power should reduce overall costs from other healthcare providers, but the out-of-pocket costs are still likely to be significant. However,

¹ The package would include a standard range of services. Should the birth be especially complex and require an extraordinary range of services, the lead practitioner may charge the patient more under strict conditions.

the total costs will be known up front, meaning consumers will get more certainty and a better deal.

To compensate lead practitioners for the administrative burden and to reduce overall out of pocket costs for consumers, PHA recommends health funds and the Australian Government each provide a minimum of \$3000 to lead practitioners who undertake the task of coordinating care and providing a single bill to the patient. The Australian Government would only provide funding of \$3000 on the condition the health fund provides no less than \$3000 towards out-of-pocket costs.² The health fund would also provide a package of funding equal to the existing legislative requirements for median medical rebates.

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

Full paper [HERE](#)

² Funds typically already provide more than twice this amount, and this provision is to ensure that funds continue current levels of funding for maternity services.

The cost and accessibility of postpartum healthcare, including:

- infant feeding supports,
- mental health supports and services,
- physiotherapy services, including pelvic health services, and
- related allied health services

Recommendations:

- *Remove the legislative barriers to health funds supporting care by nurses, nurse practitioners and other health providers as part of Chronic Disease Management Programs*

Private health insurance is the leading funding source for many allied health services, through extras coverage. Private health funds provide the largest contribution to allied health funding, other than patient contributions, across Australia. Health funds covered more than 50 million consultations in 2022-23 and provided more than \$2.7 billion in patient benefits, while Medicare contributed to 27 million consultations, paying \$1.8 billion in benefits.³

Women often need significant physical recovery after childbirth, in addition to mental health support. Common postnatal issues such as pelvic floor dysfunction, urinary incontinence, prolapse, recovery from perineal trauma or caesarean section, and pregnancy-related musculoskeletal conditions can have a significant impact on a woman's long-term health and wellbeing.

Women seeking postpartum healthcare are able to use their health insurance for common allied health services such as physiotherapy and psychology, including for specialised services such as pelvic floor assessment and rehabilitation. Many products also offer support for consultations with lactation consultants, massage therapy, dietetics and nutrition support, and occupational therapy for new mothers. Some funds offer specific extras packages aimed to support new mothers.

There is scope for health funds to play a larger role in supporting access to allied health services. For example, health funds want to be able to pay all allied health professionals for Chronic Disease Management Plan (CDMP) services, which could be better utilised for postpartum care.

However, health funds are currently limited to paying a list of designated health professionals for CDMP services under the *Private Health Insurance (Health Insurance Business) Rules 2018* (the Business Rules). These Rules currently prohibit health funds from providing CDMP services involving, among others, counsellors, social workers, nurses, lactation consultants and many more.

The defined list of health professionals listed in the Rules as eligible to provide these services only includes the registered allied health professions and is out of step with current best

³ See <https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care#:~:text=Allied%20health%20services%20subsidised%20by,the%20Department%20of%20Veterans'%20Affairs>

practice and should be removed altogether. PHA wants the list eliminated altogether so health funds can choose which health professionals they will pay for CDMP services.

Antenatal and postpartum reproductive health support and education, including contraceptive care

Health funds support their members during pregnancy, postpartum and early parenthood through a range of services, including specific programs, providing information and virtual care options. Some examples are highlighted below.

However, programs such as this should complement, not replace, a sustainable maternity care system. For example, the expansion of the St Lukes service into Tasmania's North West followed the loss of local private maternity services, illustrating how gaps in service provision can emerge when care options reduce. If private maternity services are removed by providers, there is a risk that demand for pregnancy, birth and postpartum care will increasingly shift to an already constrained public system.

Medibank

Medibank supports women during pregnancy, postpartum and early parenthood through a range of services focused on improving access to care, providing timely support and helping members navigate the health system. Eligible members can access their Health Concierge service, which provides personalised support and guidance throughout pregnancy and parenthood, including prenatal and postpartum check-ins. Medibank members also offer 24/7 Medibank Nurse Support and 24/7 Mental Health Support, providing access to registered nurses and mental health professionals for advice, reassurance and service navigation.

Additional services include Virtual Psychology delivered through Amplar Health, Online Doctor virtual GP consultations, and a Sleep and Settling Support Line operated by Tresillian nurses to support parents during the early years of parenthood.⁴

Beyond direct services, Medibank invests in research and advocacy to better understand and address the factors affecting women's health and wellbeing. They have partnered with Mum Walk on the [Mums Need Mums](#) report, which explored motherhood loneliness, social connection and wellbeing, and with Women's Agenda on the [Beyond the Village](#) report, which examined loneliness, social isolation, workforce participation and access to support among mothers in the early years of parenthood. In addition, Medibank supports employee's women's health and wellbeing through initiatives such as its partnership with VIV Health to improve menopause education and awareness.

St Lukes

St Lukes' experience in Tasmania demonstrates the important role that flexible, community-based postpartum services can play in improving access to care, particularly in regional areas where maternity services have reduced or closed.

The St Lukes Private Postnatal Service was established in Northern Tasmania following the closure of private postnatal services in Launceston, and was later expanded into the North West following changes to private maternity service availability in the region. Over the past decade, the program has supported more than 1,000 babies and their families across northern and north-west Tasmania.

⁴ More information can be found at [Medibank member pregnancy support services | Medibank](#)

The service provides families with access to specialist midwifery and lactation support, either in-home or through a supported accommodation model, alongside physiotherapy, practical household assistance and referral pathways to ongoing care where required. Importantly, the model focuses on continuity of care during the transition from hospital to home, a period commonly identified as one of the most challenging for new parents.

St Lukes' program evaluations show families value:

- timely access to clinical advice and reassurance
- breastfeeding and infant feeding support
- early identification of emerging physical or mental health concerns
- navigation to additional services when required, and
- care models that are tailored to individual family circumstances.

Accessible postpartum support services are very important, particularly in regional and rural communities where women often face additional barriers to care. St Lukes' experience demonstrates that community-based models can strengthen continuity of care after birth, provide earlier access to clinical support and referrals, and help families navigate the transition from hospital to home.

BUPA

Bupa's Parent and Baby Wellbeing Program supports eligible members and their partners during pregnancy and after birth, until their child turns two. The program offers psychological therapy for members experiencing anxiety, depression, difficulty adjusting to parenthood, bonding concerns, premature birth or pregnancy loss. It is provided by the Parent-Infant Research Institute (PIRI) – a not-for-profit research institute which conducts international research and develops rigorously evaluated early intervention programs that enhance perinatal mental health and improve early parent-infant relationships.

The program is delivered nationally through telehealth, offering:

- Confidential consultation with a clinical psychologist to assess the member's needs
- Assessment for depression, anxiety and other perinatal mental health concerns
- If suitable, PIRI connects the member with a specialist perinatal psychologist, and
- Up to 18 sessions delivered nationally via telehealth.

More details are available at [Parent and Baby Wellbeing Program | Bupa](#).

Barriers to effective pain management, including the range and affordability of available treatments

Recommendations:

- *Improve access to multidisciplinary pain management programs, including pain clinics*
- *Remove the legislative barriers to health funds supporting care by nurses, nurse practitioners and other health providers as part of Chronic Disease Management Programs*
- *Reduce the incentives for poor-quality care, including by reducing the prices of medical devices for spinal cord stimulation and spinal fusion*
- *Consider further research into gender differences for clinical procedures used for pain management.*

Millions of Australians live with pain, yet the range of effective treatments is limited. Access to comprehensive, multimodal pain management is both hard to access and expensive. In particular, access to specialised pain clinics can be very difficult for many affected patients.

Private health funds support both multidisciplinary care programs and access to individual professionals to assist with pain management. In particular, private health insurance covers consultations from allied health professionals such as physiotherapists, psychologists and occupational therapists.

PHA sees significant potential for Chronic Disease Management Programs for pain management, should the Australian Government amend the legislative barrier to working with nurse practitioners under CDMs. Being able to work with prescribing practitioners able to coordinate care and take a holistic view of pain management would make these programs much more useful to patients.

While legislative, cost and access barriers are preventing patients receiving high-quality care, access to some ineffective and, in many cases, harmful modes of care is relatively easy in the Australian private system – particularly for surgical care.

Health funds are obligated to pay for any intervention where there is a Medicare Benefits Schedule item billed, with legislation requiring health funds to pay towards medical costs, hospital charges and medical devices.

Partly due to the very high prices mandated by the Australian Government for medical devices, surgery rates for many procedures are very high compared to international benchmarks. Two key examples include implanting spinal cord stimulators, and spinal fusion. Both surgeries are more common for women than for men.

Spinal cord stimulators are devices implanted into the back during surgery to send low levels of electricity directly into the spine to attempt pain relief. People with chronic back pain pay on average \$58,000 for the surgery, which has no sustained benefits that outweigh the costs and risks, according to two respected [Cochrane Reviews](#).⁵

⁵ See https://www.cochrane.org/evidence/CD014789_spinal-cord-stimulation-low-back-pain

PHA data from 5,852 patients over a 10-year period to 2021 found 41% required surgical reintervention within three years.⁶ For comparison, the revision surgery rate for hip and knee replacements is 2.7% and 2.4% within three years.

Spinal cord stimulators are being implanted in the Australian private system at 20 times the rate of New Zealand, and despite the difference in population, more than triple the number of procedures in Australia than the United Kingdom. Data examined in the Cochrane Reviews and reported to the TGA reveal many patients receiving new and more significant harms than prior to surgery including paraplegia.

Other surgical interventions for pain management, including spinal fusion, also demonstrate significantly higher rates of intervention in Australia than comparable countries⁷ despite the evidence of effectiveness being limited.

Australian health funds hold a wealth of information on surgery rates across a range of procedures and would welcome working with the Select Committee to help define the areas where women are more or less likely to be operated on. In combination with clinical advice, this may help identify areas of concern.

⁶ See <https://www.mja.com.au/journal/2025/223/5/spinal-cord-stimulation-patterns-care-re-interventions-and-costs-private-health>

⁷ For example, see <https://www.unsw.edu.au/newsroom/news/2018/02/spinal-fusion-surgery-for-lower-back-pain--it-s-costly-and-there>

Access and affordability issues relating to fertility and assisted reproduction treatments

Under current legislation, health funds are only allowed to cover the hospital component of assisted reproductive treatments. Examples include day surgery accommodation, theatre fees, and doctor/anaesthetist fees when admitted as a private patient for egg collection (oocyte pick-up) or gamete transfer. Health funds are unable to cover outpatient services such as consultations, scans, ultrasounds, some diagnostic procedures and pathology services. There are also additional costs associated with pharmaceuticals, egg transportation, testing and freezing that are generally not covered. Even with private health insurance, total out of pocket costs can be significant.

Assisted reproductive treatment services are generally only available through Gold Cover, as these procedures are expensive and are likely to be planned (meaning claims are more likely).

The regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting

The role of relevant regulators and other agencies in responding to complaints regarding medical devices

Recommendations:

- *Require all providers – medical practitioners, hospitals and device companies – to report adverse events*
- *Introduce provisions to immediately remove suspect devices from sale pending assessment*
- *Introduce significant penalties for medical device companies that do not report adverse events*

Prices for many medical devices are set by the Australian Government through the Prescribed List, and often at rates that are often are inflated to global markets. Evidence across many specialties shows the high prices for medical devices in Australia results in doctors and patients being aggressively targeted for surgeries by global suppliers.

Australian patients, clinicians and health funds should not have to rely on media reports to trigger the removal of ineffective and harmful medical devices and technologies from the private health system. Health funds continue to be forced to pay for poorly performing and harmful devices despite knowing they don't work and can cause harm.

Doctors should be legally obliged to report adverse events involving medical devices to the Therapeutic Goods Administration to help protect patients from harmful products and procedures.

The Australian Government should also introduce tougher measures to ensure dangerous and ineffective medical devices are swiftly taken off the Medicare Benefits Schedule (MBS) and Prescribed List of Medical Devices. This would take them off the market for doctors and private hospitals, so they can't be used.

The two most significant medical device disasters of the last 25 years, the ASR hip and pelvic floor mesh, disproportionately harmed women. Both of these disasters could have been substantively avoided through more robust device regulation, device testing and effective monitoring.

In both situations devices were approved by the Therapeutic Goods Administration (TGA) under "substantial equivalence" (material composition) claims, as opposed to robust clinical trials on what were in both cases new technologies or applied in previously untested approaches.

Both resulted in pain and debilitation, with ASR hips releasing toxic metals into the blood stream (with the effects yet to be fully observed), the other causing erosion through pelvic floor tissue layers on devices often impossible to fully remove causing permanent irreconcilable damage and ongoing endless pain.

A review of the TGA's Database of Adverse Events (DAEN) records relatively low numbers of complaints by suppliers, hospitals and clinicians in both failed device categories, despite thousands of life-impacting revisions having taken place over the last two decades. A review by

PHA taken on the DAEN in early 2024 found fewer than 225 complaints were recorded for both the Boston Scientific and J&J devices pelvic floor devices from 2012 through 2023. This rate of reported adverse events is significantly lower than the actual harm from these devices.

In the case of the Johnson & Johnson ASR hip component, it was the Australian Orthopaedic Association's National Joint Replacement Registry (NJRR) which identified patient complications – not the TGA and not the supplier reporting complaint to the regulator. The [BMJ](#) noted the NJRR raised issues with the device supplier (J&J Depuy) 17 times from 2007 through 2009, yet no action was taken by the supplier, as they continued to profit from the sale of the device. The NJRR is the only comprehensive registry of its type in Australia – if the same issues had appeared in other clinical areas, it may not have been picked up.

PHA remains concerned that some suppliers do not appear to be meeting their obligations to report adverse events to the DAEN. PHA has previously identified low rates of reporting for adverse events for Medtronic spinal cord stimulators (devices which since have been removed from the market). The Age and the Sydney Morning Herald have recently reported similar issues, in a story “‘Impossible to give consent’: Medtech giant hid bad data from patients, doctors.”⁸ PHA recommends significant penalties should apply where a supplier does not disclose safety or performance data to the regulator.

It is critical that suppliers, hospital and clinicians are legally mandated to report complaints. Early identification of the issues with pelvic mesh and the ASR hip would have reduced the harms to Australian women.

⁸ Available at <https://www.theage.com.au/national/impossible-to-give-consent-medtech-giant-hid-bad-data-from-patients-doctors-20260825-p60rfj.html>