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

Empowering through choice: How a bundled model can transform private maternity care

JULY 2025

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Executive summary

Australian mothers are limited to expensive private obstetric care in the private system, where out-of-pocket costs approach $4,000

Mothers who choose to give birth in the private system are only covered for in-hospital care by an obstetrician. This limited approach is challenging for consumers, private hospitals, and insurers, as the market shifts to more accessible models of care.

Consumers face average out-of-pocket costs of close to $4,000 for low-risk, uncomplicated pregnancies, but these costs are often opaque and can be more than double the national average in major cities. The opacity of the system and limited availability of data means that this is likely a significant underestimate of the true cost.

The cost of the current system is driving consumer demand away from private care and towards the public system, where there are affordable (in some cases free), more diverse care models on offer, and low risk pregnancies are often managed by midwives (midwife-led care). Reduced demand for private care is making it difficult for insurers and private hospitals to maintain their current offerings.

The Government's suggestion to expand maternity cover to Silver and Bronze tiers would increase access to private maternity care, however it would come at the cost of increased premiums for consumers. This in turn lowers participation and destabilized the private health insurance risk pool.

Mothers have more choice and better access to private maternity care with bundled care, with savings to the average cost of a low-risk, uncomplicated pregnancy of 29%

A model of practitioner-led care with a bundled payment (bundled care) involves a lead practitioner (obstetrician, GP, or midwife) coordinating care and negotiating a single, up-front price for the mother.

Bundled care can reduce total and out-of-pocket costs through savings from practitioner substitution, bundled pricing, and contracting efficiencies. Additional savings can be created through insurer contributions to out-of-hospital services, and new administrative costs can be offset by a government contribution.

The lead practitioner will have greater coordination and negotiation capacity through the antenatal, labour and birth, and postnatal phases of care. Consumers will have greater choice of practitioner and will know the costs upfront, making them less vulnerable to bill shock.

Bundled care can be led by an obstetrician, a GP, or a midwife. Midwife-led care is the norm in peer countries such as New Zealand, the UK, and Canada, and is the main model of care for low-risk pregnancies in the public system in Australia. The total cost of bundled midwife-led care could be 29% cheaper than the current private model.

Midwife-led care is popular in the public system. To encourage take-up of private care, bundled care could be included in Gold policies, with expanded cover of out-of-hospital services.

A bundled care model has significant benefits for mothers, the private system, and the health workforce, with private hospital births predicted to increase by 25%

Consumers will save close to $3,500 in out-of-pocket costs, which will ease cost-of-living pressures on women, who are more adversely affected by rising costs. Consumers are also likely to experience increased access and choice, report greater satisfaction, and have superior clinical outcomes.

Private bundled care offers women in the private system a proven model of care available in the public system, alongside the extras coverage people value from their private health insurance.

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.

The job satisfaction of midwives is expected to increase, alongside their earning potential, which could rise to close to $200,000. There are sector-wide benefits on offer through improvements in workforce productivity resulting from enabling practitioners to work to their full scope of practice. With government support for lead practitioners to assist in absorbing administrative costs of coordinating care, the cost to implement would be $258M over four years.

1 **Australian mothers are limited to expensive private obstetric care in the private health system**

2 Bundled care offers mothers greater choice in the private system

3 Bundled care has significant benefits for mothers, the private system, and the health workforce

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The current model of private maternity care is no longer working for consumers, private hospitals or insurers

Expensive out-of-pocket costs for private maternity care are becoming unaffordable, especially in a cost-of-living crisis

Over the course of the average pregnancy in the private system a woman can expect to pay close to $4,000 in out-of-pocket costs.

80% of these out-of-pocket costs are for consultations and imaging, which private health insurers cannot cover.

Consumers lack choice in the private system, which does not offer midwife-led and shared-care models available in the public system.

Private hospitals are struggling to keep maternity wards open with less demand and growing costs

Australia, like many nations, has seen birthrate declines over the last 7 years, falling from 1.8 births per woman to 1.5.

At the same time, hospitals fixed costs to delivery maternity services have not changed, with limited productivity growth and increasing labour and other costs.

The viability of the current private obstetric model is declining. New models of maternity care are needed to guarantee the success of private obstetric care in Australia.

Insurers are limited in what they can cover, particularly for out-of-hospital services

Insurers are limited in what services they can deliver, especially for out-of-hospital services; consumer relief must therefore come from lowering costs.

Simply expanding maternity cover from Gold tier policies to Silver and Bronze will not improve affordability, and instead drive up premiums for all.

Addressing the overall costs of private maternity care will increase the utilisation of both private hospitals and insurance.

Private obstetric care is the primary model in the private system, while midwife-led and shared care models are more common in the public system

Characteristics of the four major models of maternity care

Private system Public system

Model of maternity care	Description	Arrangement of care: *Led by midwife*	*Shared*	*Led by obstetrician*
Private obstetrician specialist care	Care is led by a private obstetrician, with assistance from hospital midwives during intrapartum services.			●
Public hospital maternity care	Care is managed between obstetricians and midwives depending on the level of risk and demand for maternity services.		●	
Midwifery group practice caseload care	Care is managed by a primary midwife or a group of midwives, with involvement from doctors where risk is higher.	●		
Shared care	Care is shared between a community doctor (e.g., GP), midwife and/or hospital doctor.		●	

Most aligned with First Nations centric care. Offered in public hospitals.

More common in rural areas.

Source: AIHW (2024), Healthdirect (2025)

Private obstetric care is expensive, costing consumers close to $4,000 out-of-pocket for a low risk, uncomplicated pregnancy

Private obstetric care in Australia costs families close to $4,000 out-of-pocket for an uncomplicated pregnancy. The total cost reaches approximately $15,800 per birth, split between Medicare ($2,780), private insurers ($9,150), and consumers ($3,870), with 77% of consumer costs occurring outside hospitals, primarily during antenatal care.

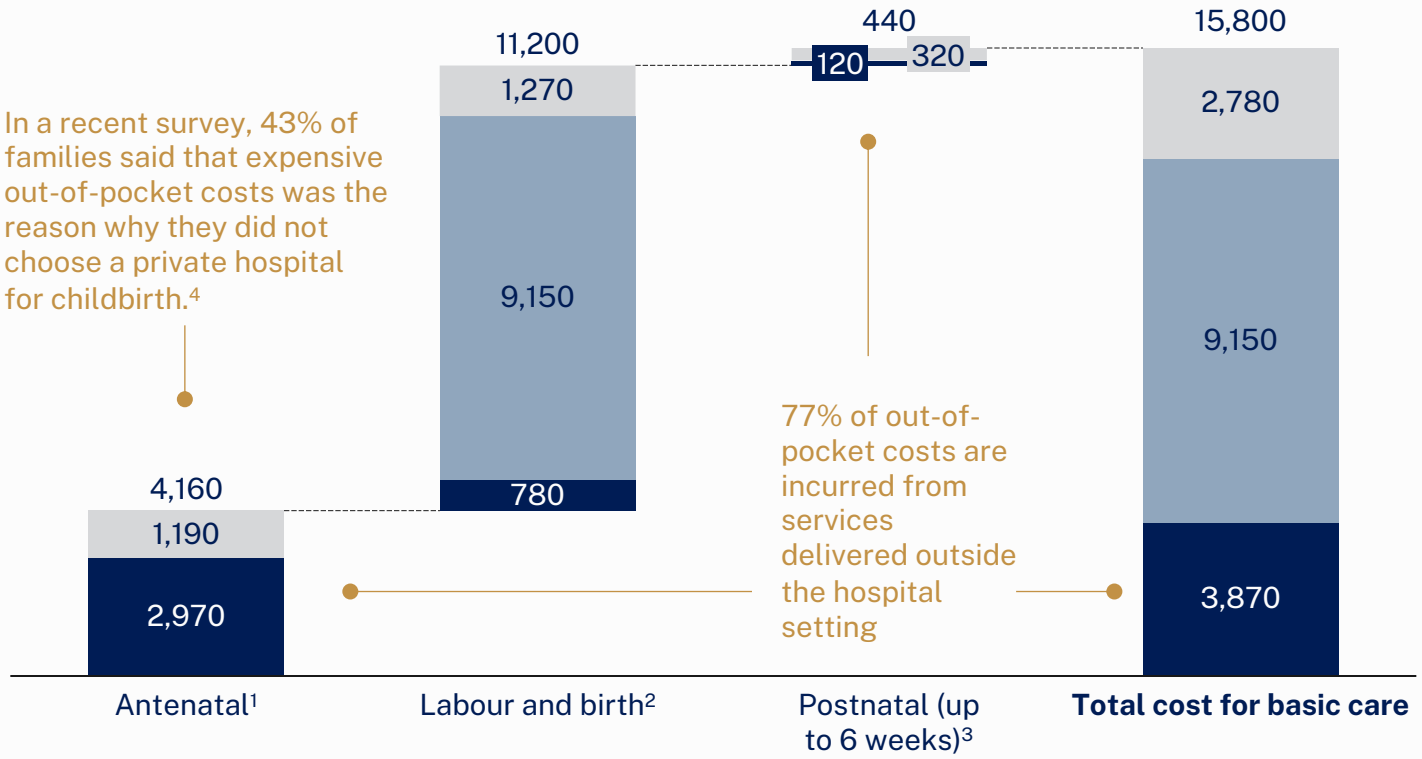
The private system offers choice of obstetrician, shorter waiting times, and private accommodation, but cost remains a major access barrier. With 43% of families avoiding private facilities due to expenses, significant equity issues exist in maternal healthcare, particularly affecting those unable to afford upfront costs despite having insurance that primarily covers in-hospital expenses.

Private obstetric care suffers from poor cost transparency, especially for out-of-hospital services. While in-hospital data from health funds is reliable, specialist fees remain difficult for consumers to access beforehand. Medical Cost Finder offers limited insights, but with widely varying fees and no standardised disclosure requirements, expectant parents often discover the full extent of costs only after beginning care.

Notes: Costs exclude complications. See appendix for information on additional costs for complications.

Total average costs of basic services provided by private maternity care

$, per birth



Notes: 1 Medical Costs Finder (2023a); Medical Costs Finder (2023b); Skinner (2024); Medical Costs Finder (2023c); Queensland Government (2025); Medical Costs Finder (2023d); NSW Government (2023a); Australian Government (2025a); Australian Government (2025b); Australian Government (2025c); Branley (2022); NSW Government (2023b); ACT Government (2024). 2 PHA data; Medical Costs Finder. 3 Medical Costs Finder (2023e). Assumed five post natal checkups. 4 IPSOS, Health Care and Insurance Australia (2023) Report 4.
Source: healthdirect.gov; Callander et al. (2023); Mandala analysis

Out-of-pocket costs can vary significantly by provider and region however publicly available information is limited

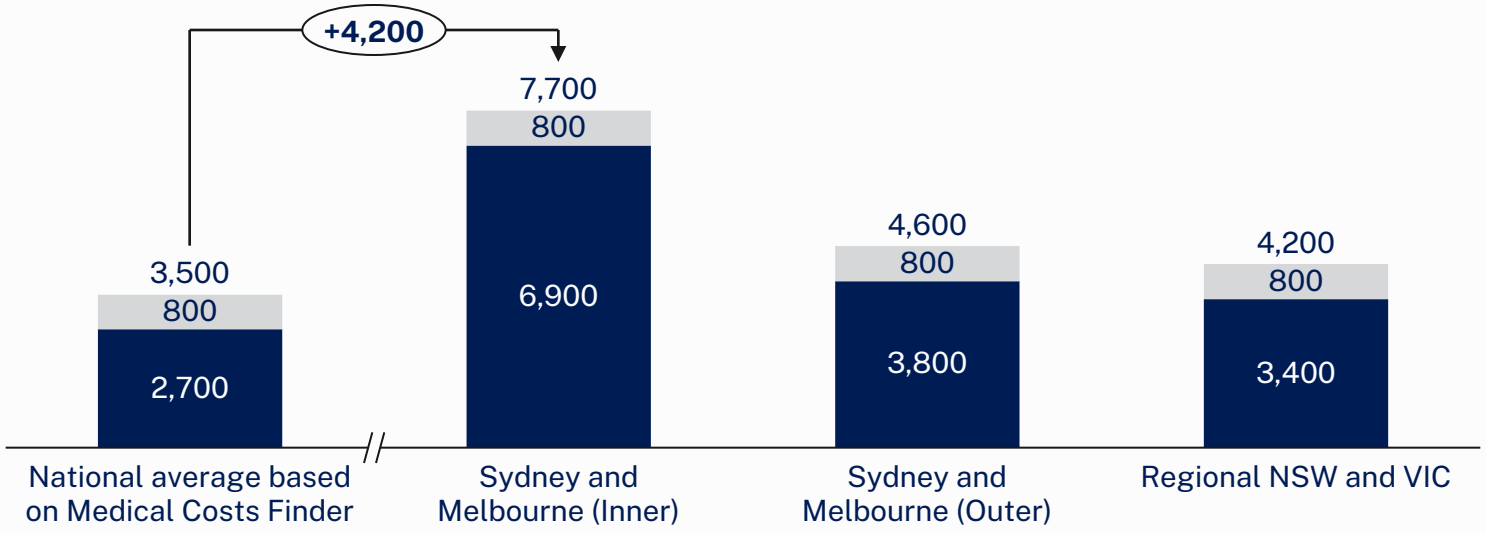
Out-of-pocket costs for obstetric consultations in Australia show large regional variations, with inner Sydney and Melbourne consumers paying $6,900 compared to regional areas where costs average around $3,400. This difference represents a $4,200 premium for city centre care despite Medicare's consistent contribution of $800 across all regions. The national average out-of-pocket expense sits at $2,700, masking geographical disparities that impact healthcare accessibility.

The lack of transparent fee schedules compounds this regional inequality, with few obstetricians publicly disclosing their charges before consumers commit to care. This opacity makes informed decision-making difficult for expectant parents, who may face substantially different costs for identical services based solely on location. In some areas prices are more than double those of regional providers, creating a system where comprehensive cost information remains inaccessible precisely when mothers need it most for financial planning.

Variability in obstetrician costs for antenatal consultations by region

Median antenatal costs by region, based on most recent fee schedules, $

While few obstetricians publish their fee schedule, a sample from practices in different regions highlights a broad range of potential out-of-pocket costs that consumers can face for antenatal services. They also indicate that our estimates, based on national figures from Medical Cost Finder website, are likely an underestimate of actual costs. With access to better data from the Department of Health, Disability and Aging this analysis could be improved.

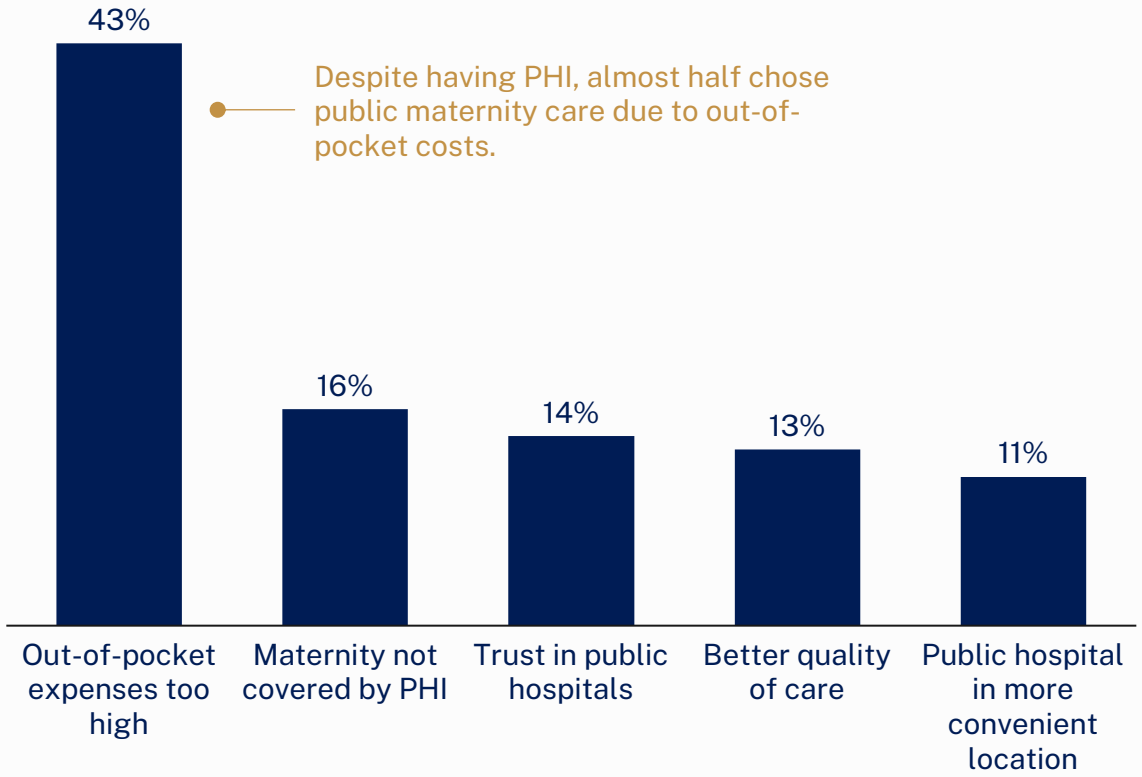


Note: Obstetricians are classified as 'Inner' city if their rooms are located less than 15km from the capital city's CBD, 'Outer' city if their rooms are located more than 15km from the capital city's CBD, and 'Regional' if their rooms are located more than 100km from the capital city's CBD.
Source: Skinner (2024), Hatziokostas (2025), Owen (2025), Buist (2025), Alana Obstetrics (2025), Wood (2024), Roessler (2025), Medical Costs Finder (2023), Robinson (2024); Mandala analysis

Cost is the primary factor preventing consumers with PHI having a baby in a private hospital ...

Factors leading to not having a baby in a private hospital

Proportion of those with PHI who chose to have a baby in a public hospital
2023, n = 159



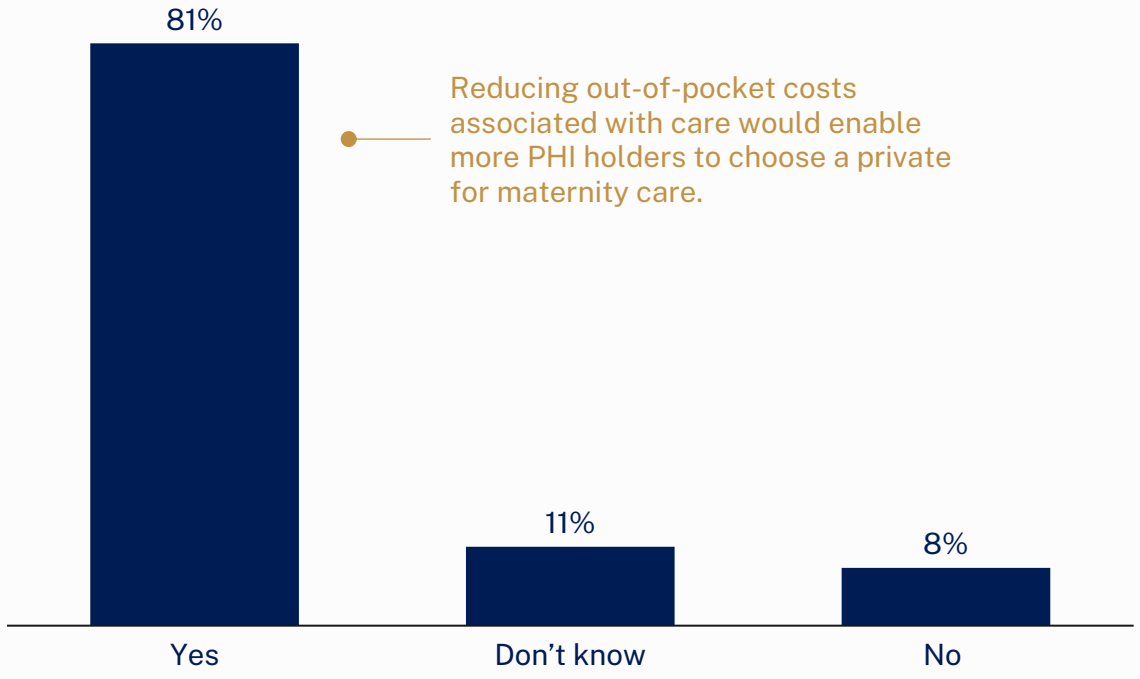
Despite having PHI, almost half chose public maternity care due to out-of-pocket costs.

Source: Ipsos (2023) Health Care and Insurance Australia 2023 – Report 4L Population Attitudes. Question E4a(iv); Mandala analysis

... and if out-of-pocket costs were not a factor, most consumers with PHI would choose private over public maternity care

Choice of private over public if no out-of-pocket obstetric fees

Proportion of those with PHI who would choose private if not for out-of-pocket fees
2023, n= 159



Reducing out-of-pocket costs associated with care would enable more PHI holders to choose a private for maternity care.

Source: Ipsos (2023) Health Care and Insurance Australia 2023 – Report 4L Population Attitudes. Question E6c; Mandala analysis

The proposal to expand maternity cover from Gold to all tiers would increase premiums for Bronze and Silver policies

The proposal to extend maternity coverage from Gold tier to all insurance tiers would trigger substantial premium increases, with Bronze policyholders facing the largest jump of 13.3% (from $1,474 to $1,670 annually). Silver premiums would rise by 3.5% to $2,312, while the average increase across both tiers would be 6.5%.

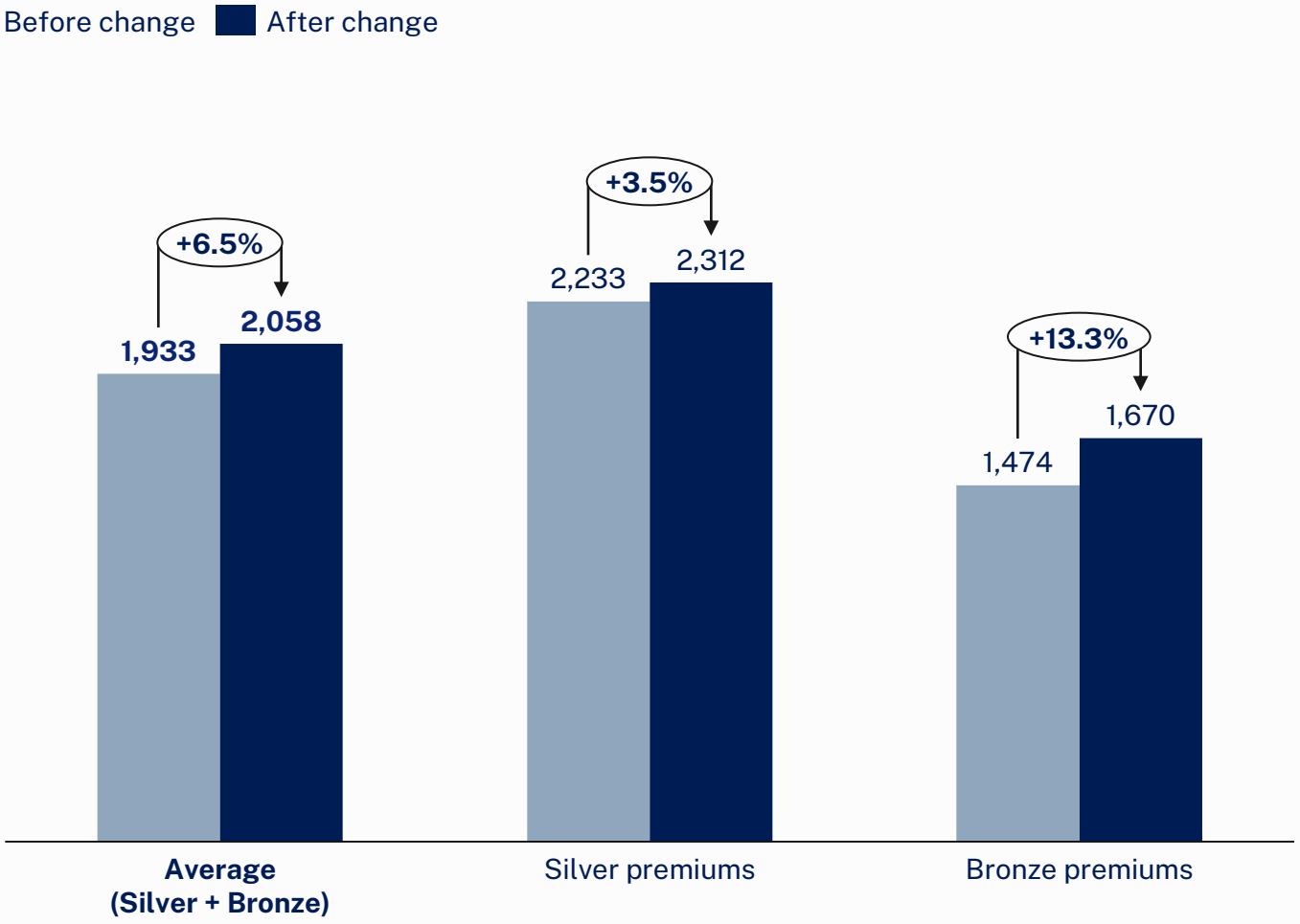
This policy, developed in response to the Hospital Viability Review, attempts to broaden access but fails to address the primary barrier of out-of-pocket costs.

Our modelling indicates approximately 580,000 Australians would drop their private health insurance due to these premium increases, particularly affecting younger policyholders in Bronze and Silver tiers. This exodus would likely undermine the policy's intent to improve hospital viability, instead potentially worsening participation, with declining membership leading to further premium increases.

In this way, higher premiums and expensive out-of-pocket costs risks making private maternity care inadvertently less accessible.

Annual premiums before and after expansion of maternity cover

$, p.a.



Source: PHA data, APRA, ABS, AIHW (2024), HILDA, Compare The Market, Medical Costs Finder; Mandala analysis

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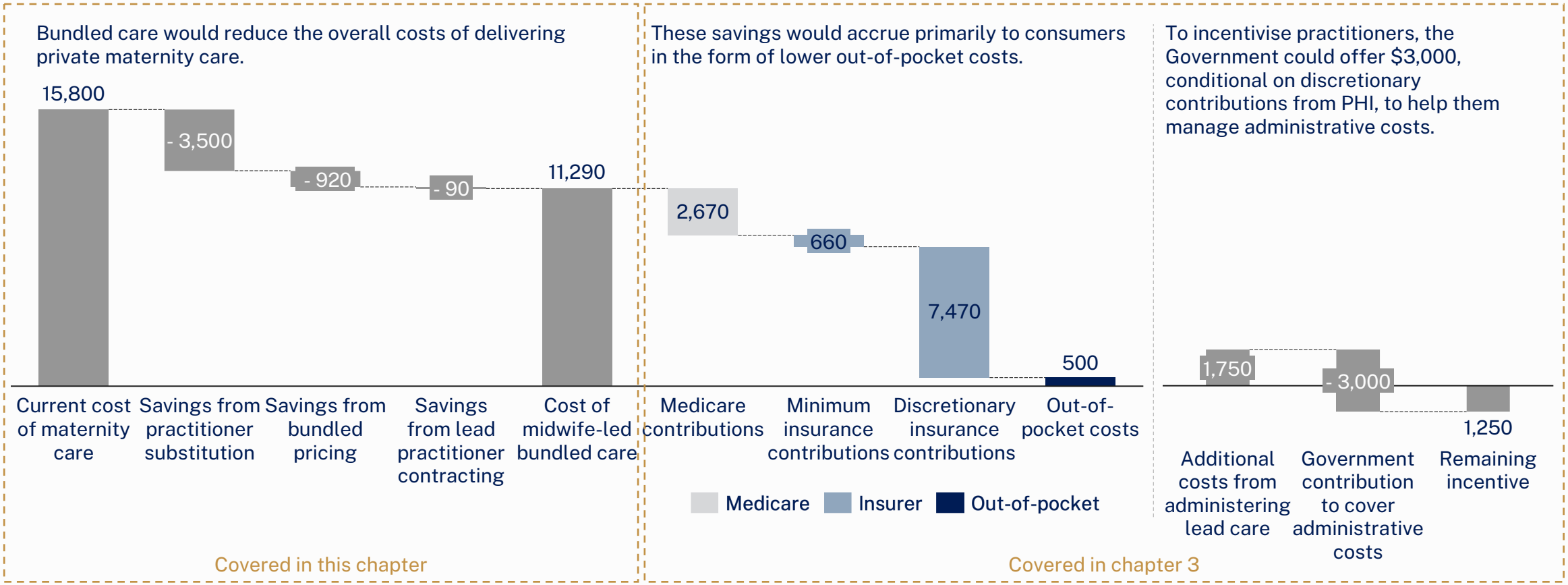
Introducing practitioner-led care with a bundled payment (bundled care) would reduce the total cost of private care and out-of-pocket costs for consumers

Distribution of cost savings and payers from the proposed bundled model of maternity care with a midwife as lead practitioner

$, per patient



Note: Subtotals may not sum to totals due to rounding.
Source: Private Healthcare Australia (2024), Department of Health, Disability and Aging (2025); Mandala Analysis

Consumers pay less under bundled care as a lead practitioner can coordinate care costs efficiently and negotiate on prices with providers

Overview of bundled care and drivers of cheaper costs

Care organised and coordinated by a lead practitioner, enabling price negotiation

- **Coordinate care.** Lead practitioner coordinates all the maternity services on behalf of the mother, delivers services and oversees the end-to-end journey.
- **Negotiate on price.** In the same way insurers and hospitals form agreements for 'no gap' or 'known gap,' lead practitioners would do the same, negotiating lower costs for mothers.

Choice of lead practitioner based on preference and risk assessment

- **Proven model of care.** There are international examples of maternity care led by practitioners other than obstetricians.
- **Choice of lead practitioner.** Mothers can choose to receive care from obstetrician, general practitioner or midwife.
- **Choice based on preference and risk assessment.** Low-risk pregnancies can be supported by a midwife, but mothers can still opt to receive care from an obstetrician.
- **Potential of lower cost practitioner options.** Midwife-led maternity care may be lower cost than obstetrician-led care.

Single bundled payment, avoiding bill shock and overservicing

- **One up-front payment.** The lead practitioner offers a single, up-front price to the consumer.
- **Avoiding bill-shock.** Consumers have certainty around the total price they will be charged with no unexpected costs along the journey.
- **Reduces inefficiency and overservicing.** Changing to one up front fee removes the incentive to overservice and may lower the overall cost.

Under bundled care, lead practitioners coordinate care, enabling price negotiation on behalf of consumers

The Commonwealth government's Scope of Practice Review recommends bundled payments for maternity services, including in the private sector. This could include midwifery continuity of care, traditional midwife plus medically led model, or GP shared care models.

Bundled care works through a lead practitioner who organises and coordinates the care for the mother. This provides the mother with continuity of care throughout their pregnancy and birth journey.

The lead practitioner also delivers services under bundled care. The same services would be delivered at the same standard of care regardless of the profession of the lead practitioner. The lead practitioner would deliver the antenatal and postnatal visits, support labour and birth and manage referrals to other practitioners throughout the pregnancy and birth journey.

A lead practitioner can negotiate on behalf of the mother to ensure they receive the best price available. Lead practitioners can act in a similar way to hospitals and health funds, forming agreements to keep out-of-pocket costs low. This saves mothers money.

Studies which have attempted to quantify the cost savings from bundled payments have found savings of 5 to 10%.[1] A similar cost savings are expected when bundling is applied to maternity care.

[1] Mathematica et al. (2014), Bundled Payment Demonstrations

Source: Department of Health, Disability and Aging (2024) Unleashing the Potential of our Health Workforce - Scope of Practice Review

Bundled care under a lead practitioner - model of care

Antenatal

Initial consult with lead practitioner
An expecting mother attends initial consultation with the lead practitioner of their choice. This could be a **midwife, GP or obstetrician.** A risk assessment is undertaken to determine if a mother is low-risk and eligible for midwife or GP-led care.

Care planning
Lead practitioner negotiates prices on behalf of the mother and has agreements with hospitals and other practitioners keeps prices down. Medicare and PHI contribution for bundled maternity care is the same regardless of lead practitioner.

Regular appointments
Mother attends regular consultations with the same lead practitioner.

Labour and birth

Hospital care
Lead practitioner supports labour and delivers baby, with support of other healthcare professionals if necessary.

Hospital stay
Mother is admitted to a private hospital of her choice for labour and birth.

Pathology and imaging
Lead practitioner organises scans and screening and recommends mother to selected services.

Postnatal

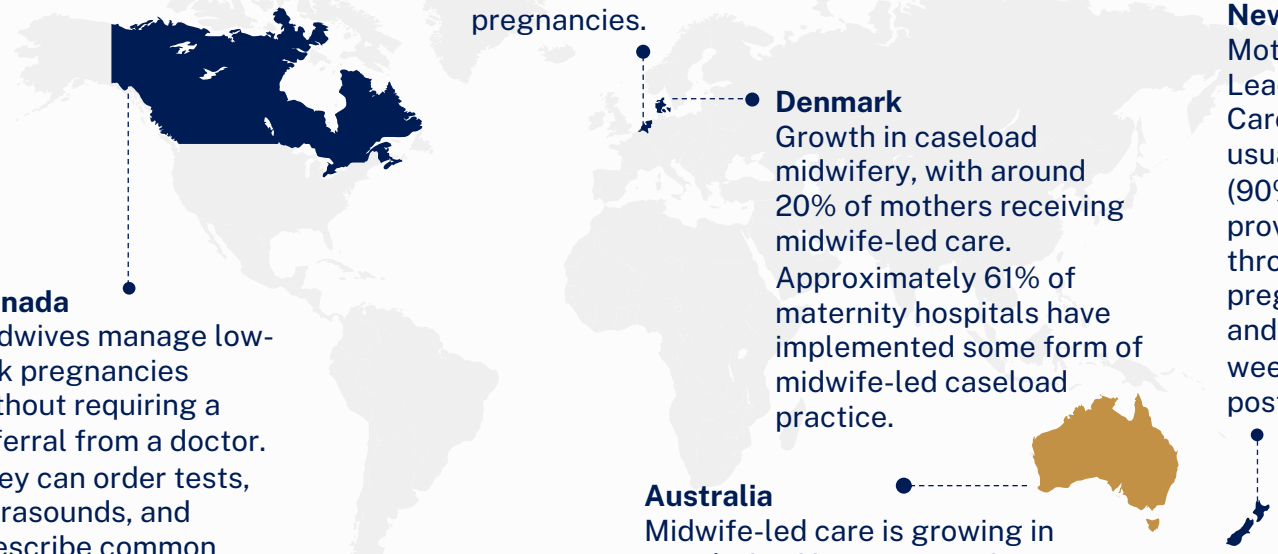
Midwife visits
Up to 6 weeks after birth, the mother receives postnatal care from the lead practitioner.

Other care
Mothers may required other support and medical services such as physiotherapist or lactation consultants. The lead practitioner organises these services.

Source: Medicare Benefits Schedule Review Taskforce (2019) Post Consultation Report from the Participating Midwife Reference Group

Midwife-led approaches to maternity care exist internationally with proven outcomes

Examples of countries which have midwife-led maternity care



Netherlands
Midwives are the primary care providers for low-risk pregnancies.

Denmark
Growth in caseload midwifery, with around 20% of mothers receiving midwife-led care. Approximately 61% of maternity hospitals have implemented some form of midwife-led caseload practice.

New Zealand
Mothers choose a Lead Maternity Carer (LMC), usually a midwife (90%). The LMC provides care throughout pregnancy, birth, and up to six weeks postpartum.

Canada
Midwives manage low-risk pregnancies without requiring a referral from a doctor. They can order tests, ultrasounds, and prescribe common medications.

Australia
Midwife-led care is growing in popularity. However, service availability is restricted, with only an estimated 8% of mothers able to access.

- Bundled care allows mothers to choose a lead practitioner, who can be an obstetrician, general practitioner or midwife.
- Midwife-led maternity care is delivered across the world, including with some limited offerings in Australia's public system.
- Midwife-led care is an evidence-based model of maternity care, with studies pointing to mothers experiencing greater satisfaction, lower use of interventions, and lower use of neonatal admission in intensive care units.
- Australia and other countries with midwife-led care models have similar processes for identifying high-risk pregnancies involving a comprehensive risk assessment at the initial appointment. If risk factors are identified, the mother is referred to an obstetrician for obstetrician-led care.
- The mother is continuously assessed throughout pregnancy, and if she becomes high-risk at any stage, she will be referred to an obstetrician.

Source: NZCM (2025), AUT (2019), Dawson et al. (2016), NHS (2023), CMO (2025), Chaibekava (2023), Jepsen (2017), Little et al. (2019), Ekelund (2015), Niessink-Beckers et al. (2023), Government of Cananda (2023), Health New Zealand (2023), Talukdar, Dingle & Miller (2021)

Consumers receive one up-front fee, preventing bill shock...

Timing of payments in private bundled care

	Services	Payer		
Antenatal	Initial consult with lead practitioner	Consumer	Medicare	PHI
	Lead practitioner appointments			
	Pathology and imaging			
Labour and birth	Hospital care			
	Hospital stay			
Postnatal	Lead practitioner appointments			
	Other care			

A shift to a single upfront price will reduce overservicing. It also prevents bill shock as the total cost is known upfront.

Note: Other care refers to services such as physiotherapy or appointments to see a lactation consultants

...unlike the current model, where surprise out-of-pocket costs accumulate at each stage of pregnancy

Timing of payments in current private maternity care

	Services	Payer		
Antenatal	Initial consult with obstetrician	Consumer	Medicare	
	Obstetrician appointments	Consumer	Medicare	
	Pathology and imaging	Consumer	Medicare	
Labour and birth	Hospital care	Consumer	Medicare	PHI
	Hospital stay	Consumer		PHI
Postnatal	Obstetrician appointments	Consumer	Medicare	
	Other care	Consumer	Medicare	PHI (extras)

Note: Other care such as physiotherapy or appointments to see a lactation consultants are often delivered out of hospital. These services may be covered by PHI if included as Extras on a policy.
Source: Department of Health, Disability and Aging (n.d.) What Medicare covers, Department of Health, Disability and Aging (n.d.) What private health insurance covers

Bundled care would be included in Gold policies, with funds able to contribute to out-of-hospital services

Bundled care would be incorporated into Gold tier private health insurance policies, offering a transformative alternative to the current fragmented approach to private maternity coverage. Currently, Gold policies cover in-hospital birth and related services but leave significant gaps for out-of-hospital costs.

This model creates a comprehensive care package that spans the entire pregnancy journey instead of just the hospital stay. By allowing health funds to contribute toward out-of-hospital costs when part of a bundled package, it removes the artificial boundaries that have historically contributed to rising out-of-pocket expenses.

Health funds should cover at least 15% of the Medicare Benefits Schedule fee for out-of-hospital services. For funds, this model offers greater predictability in costs and creates opportunities to demonstrate enhanced value to members considering starting families. For consumers, it delivers the continuity of care, provider choice, and financial transparency that has been missing from private maternity care, all while maintaining the private hospital experience they expect from their Gold cover.

Eligibility of payers to contribute to services in delivered in different setting

		Proposed bundled private model			Current private system		
		Insurer	Medicare	Consumer	Insurer	Medicare	Consumer
Lead practitioner coordination payment		✓	✓	✓			
Out-of-hospital	Prenatal appointments	✓	✓	✗	✗	✓	✓
	Imaging	✓	✓	✗	✗	✓	✓
	Pathology	✓	✓	✗	✗	✓	✓
In hospital	Medical care	✓	✓	✗	✓	✓	✓
	Hospital services	✓	✗	✗	✓	✗	✓
Out-of-hospital	Postnatal appointments	✓	✓	✗	✗	✓	✓

Allowing health funds to contribute toward out-of-hospital costs when part of a bundled package would reduce the out-of-pocket costs for consumers

Insurers cannot currently cover out-of-hospital services

Source: Private Healthcare Australia (2025) *Budget submission 2025-26 Maternity services*

The costs to deliver midwife-led bundled care are 29% lower than the current cost of private maternity care

Bundled care reduces the cost of private maternity care regardless of the type of lead practitioner. Bundled care with a midwife as the lead practitioner costs 29% less than the current private maternity care offering. It costs $11,290, compared to $15,800. The cost savings are lower when an obstetrician is the lead practitioner, but costs are still 8% lower, at $14,530[1].

Bundled care led by a midwife drives savings in three ways. The first, and major mechanism for cost reduction, is the ability for mothers to elect for care to be delivered by midwives or a GP instead of obstetricians. Care delivered by a midwife costs less than the same care delivered by an obstetrician.

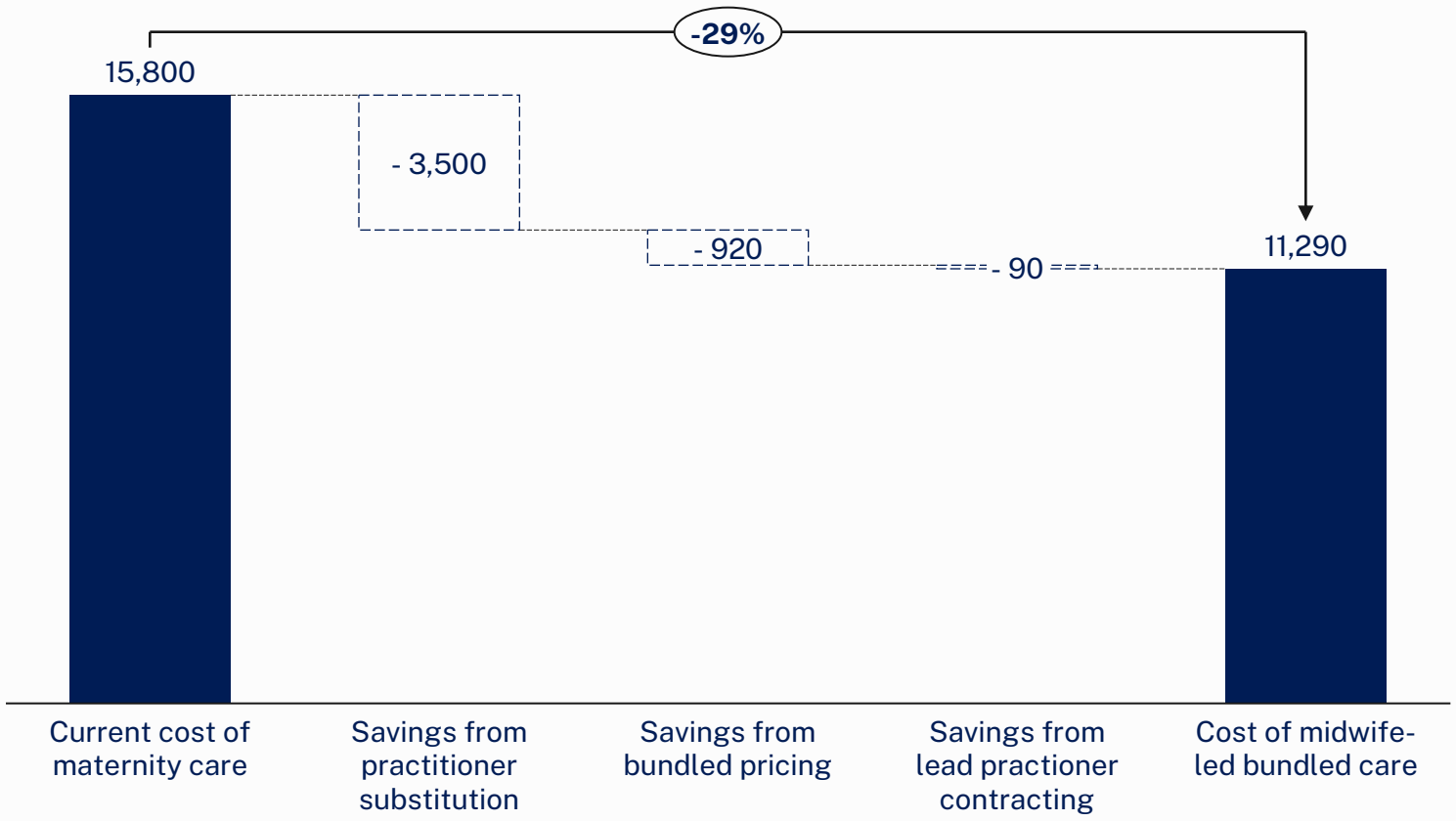
The second is through the mechanism of bundled pricing rather than fee-for-service pricing. This increases efficiency and limits over-servicing. Bundled pricing reduces costs by between 5 to 10%[2]. There is evidence that bundled pricing does not negatively impact the quality of care.

The third mechanism is through the lead practitioners negotiating better prices for services such as ultrasounds through contracting arrangements. This functions in the same way private health insurance agreements with hospitals drives down out-of-pocket costs of in-hospital services.

1. See appendix. 2. Damberg et al. (2014); Cavalieri et al. (2013)

Cost of bundled care, with a midwife as lead practitioner

$, average cost



Note: The cost of bundled care with an obstetrician as the lead practitioner can be found in the appendix. Cost rounded to the nearest 10. Savings from lead practitioner contracting is limited to services which are not currently fall under contracts between hospitals and insurers. It also does not apply to bulk billed services.
Source: Private Healthcare Australia (2024), Department of Health, Disability and Aging (2025); Mandala Analysis

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4 Appendix

There are benefits on offer for consumers, the private system, public hospitals, and the medical workforce through bundled care

Benefits of the bundled maternity care model

Consumer	Cost savings	Families can save approximately $3,400 on out-of-pocket expenses for private maternity care, making quality healthcare more affordable for expecting parents.
	Enhanced satisfaction	Mothers report higher satisfaction levels with their overall birth experience, including better continuity of care throughout pregnancy, labour, delivery and postnatal periods.
	Improved health outcomes	Bundled care models demonstrate better clinical outcomes for both mothers and babies, including reduced intervention rates and improved recovery times.
	Increased access	Families in regional and remote areas gain better access to private maternity services, reducing the need to travel long distances or relocate temporarily for birth.
Private system	Growth in private births	A 25% increase in births occurring in private maternity hospitals from mothers who would have otherwise used public facilities, creating a more balanced healthcare system.
	Increased insurance uptake	More mothers are likely to purchase Gold-tier private health insurance policies that cover comprehensive maternity care, strengthening the private health insurance sector.
Public hospitals	Reduced system pressure	Public hospitals experience relief from overcrowding as low-risk births shift to the private system, with 9% of public system births shifting to the private system. This will allow public resources to be directed towards complex cases and emergency care.
Medical workforce	Financial advantage for midwives and GPs	Midwives experience improved financial security through more predictable income streams and better remuneration structures under the bundled payment model.

Bundled care reduces out-of-pocket costs, saving consumers $3,370

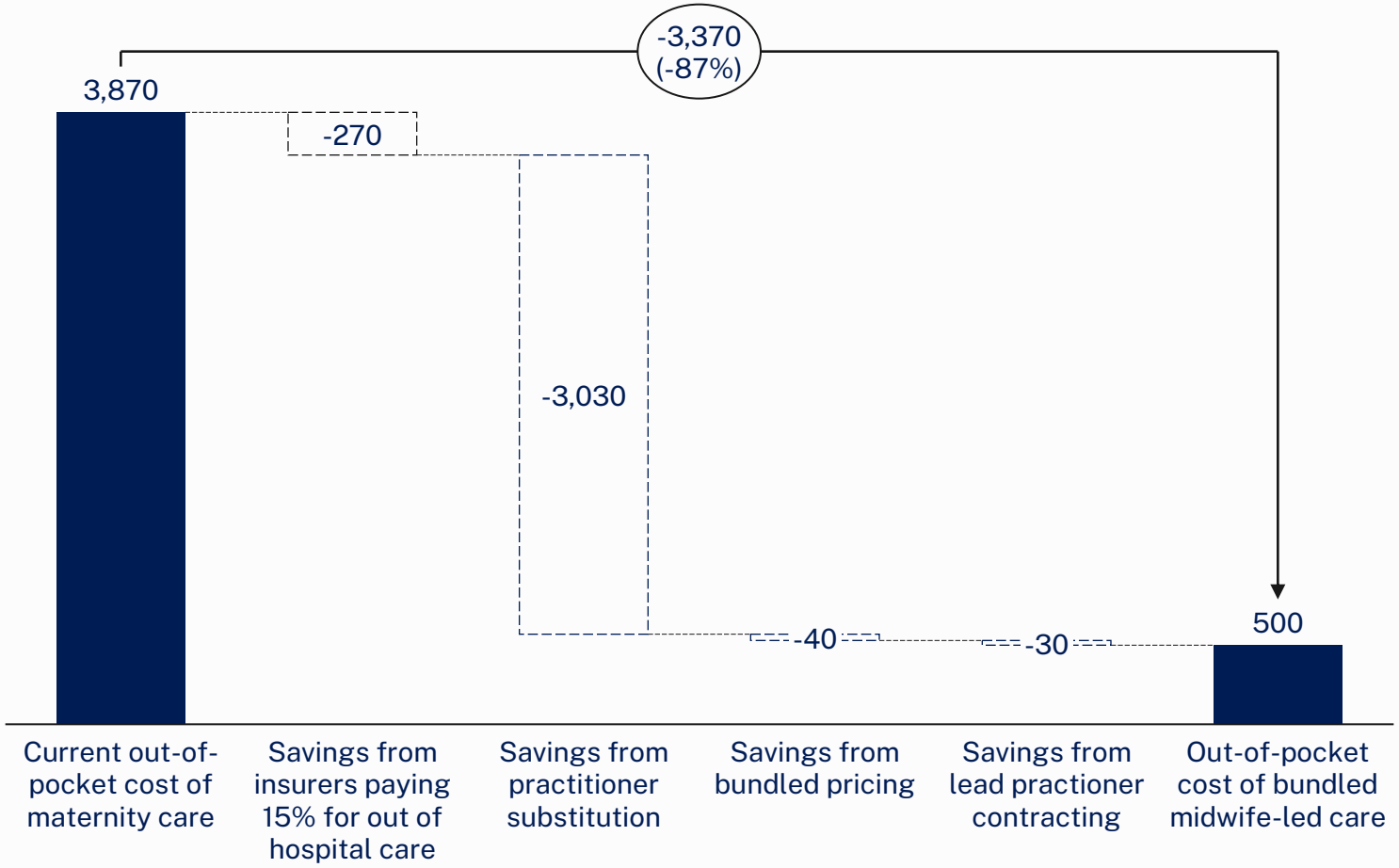
Bundled care offers substantial financial relief for families, potentially reducing out-of-pocket expenses by $3,370 compared to traditional private obstetric services. The most significant savings occur when consumers choose a midwife as their lead practitioner, with out-of-pocket cost decreasing from $3,870 to $500 — a saving of $3,370 or 87%. This midwife-led model represents the most cost-effective option within the bundled care approach.

The three drivers of out-of-pocket savings are practitioner substitution, savings from bundled pricing and savings from lead practitioner contracting. The lower cost of midwife services is the key driver of out-of-pocket savings in bundled midwife care.

Currently the consumer pays the remining 15% of the Medicare Benefits Schedule (MBS) Fee and any gap charged by the provider. Under the bundled model of maternity care, the insurers will cover at least 15% of the Medicare Benefits Schedule Fee for out of hospital services. The insurer and consumer will both contribute to any gap charged by the lead practitioner in addition to the MBS Fee. This contributes to consumer savings of $270.

Out-of-pocket costs of bundled care, with a midwife as lead practitioner

$, per patient



Note: The cost of bundled care with an obstetrician as the lead practitioner can be found in the appendix. Cost rounded to the nearest $10. This does not include the hospital excess which would be payable in addition to the out-of-pocket costs.
Source: Private Healthcare Australia (2024), Department of Health, Disability and Aging (2025); Mandala Analysis

More affordable private maternity care will support women amidst cost-of-living pressures

Women are more likely to be affected by cost-of-living pressures, spending a greater portion of their income on living expenses

Housing

- **Surging rents.** Rental costs have surged 48% since mid-2020 due to low vacancy rates, nearly five times faster than the previous four years.
- **Mortgage repayments up.** The average Australian homebuyer now needs to dedicate 50% of their income to mortgage repayments as of June 2024, up from 30% in 2020.

Food

- **Prices rising.** Food prices have risen 17% since 2020, though inflation has slowed in recent months.
- **Fresh produce remains particularly expensive**, with fruit and vegetable prices 6% higher in December 2024 compared to the previous year.

Childcare

- **Out-of-pocket childcare costs have jumped** by up to 16% since 2019 as providers pass higher operating costs to families.
- **Low-income households** spend up to 21% of their disposable income on childcare services.
- **High charges for full-time childcare in major cities** like Sydney, exceeding $200 per day (over $54,000 annually) at some centres.

Healthcare

- **Private health insurance premiums** will increase by an average of 3.7% for 2025/26 to cover rising claims and costs.
- **Healthcare inflation above average,** is running at 4%, significantly above the overall inflation rate of 2.5%, with medical and hospital services showing 4.4% price growth.
- **Costs to see a GP have risen over time.** Non-bulk-billed GP attendances cost individuals $43 out-of-pocket. Bulk-billing rates have fallen from the 2020 peak of 89% to 78% in 2024.

Source: Department of Health, Disability and Aging (2024); Medicare Benefits Schedule Review Taskforce (2019); Homer (2016); International Conference of Midwives (2017); Cummins et al. (2020); Sandall et al. (2024); Whitburn et al. (2024); Fikre et al. (2023), National Health Workforce Dataset (2023); ASIC (2024); NSW Government (2023); Ludlow et al. (2024); AIHW (2024); AIHW (2024)

There are also clear non-financial benefits, with better satisfaction, better clinical outcomes, and better access and choice from bundled care

Non-financial benefits of bundled maternity care

Greater satisfaction

- **Greater satisfaction levels** reported by mothers
- **Improved sense of control** through respect for the mother's experience
- **Improved flexibility** through care tailored to the mothers' circumstances and needs
- **Improved sense of connection** with the lead practitioner
- **Greater continuity of care;** for example, mothers are nine times more likely to be attended at birth by a known midwife

Superior clinical outcomes

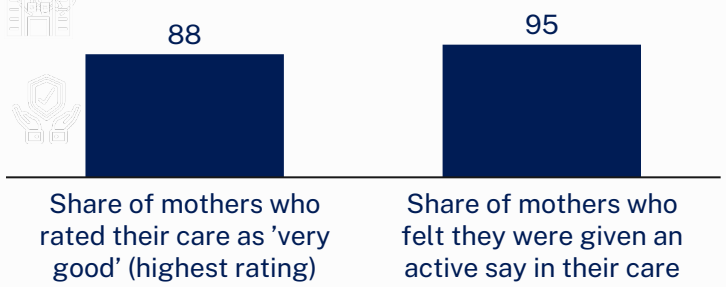
- **Lower rates of intervention** such as episiotomy, instrumental births, caesarean sections, induction, and epidurals
- **Improved clinical outcomes for babies**, notably, reduced preterm birth and foetal and neonatal death
- **Mitigation of the effects of high levels of stress** on postnatal maternal mental health
- **Successful breastfeeding** more likely

Increased access and choice

- **Rural and remote** access to care likely to be improved, with a higher ratio of midwives to population in remote and regional areas than major cities
- **Greater choice of lead practitioner** (obstetrician, GP or midwife)
- **Birthing on country** models potentially enabled
- **At-home care** more easily facilitated

Selected satisfaction outcomes under midwife-led care

Share of mothers surveyed, %[1]

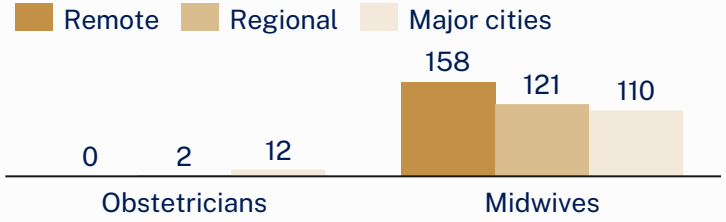


Selected clinical outcomes under midwife-led care

Change in likelihood compared to other care models ppt change[2]

Practitioners by region

Practitioners per 100,000 people, 2023[3]



1 Whitburn et al. (2024) *Women's views and experiences of a new Midwifery Group Practice model in rural Australia*
2 Sandall et al. (2024) *Midwife continuity of care models versus other models of care for childbearing women*
3 National Health Workforce Dataset (2023) *Health Workforce Data*
Note: Regionality classification based on Australian Statistical Geography Standard (ASGS) Edition 3 Remoteness Areas
Source: Department of Health, Disability and Aging (2024); Medicare Benefits Schedule Review Taskforce (2019); Homer (2016); International Conference of Midwives (2017); Cummins et al. (2020); Sandall et al. (2024); Fikre et al. (2023),

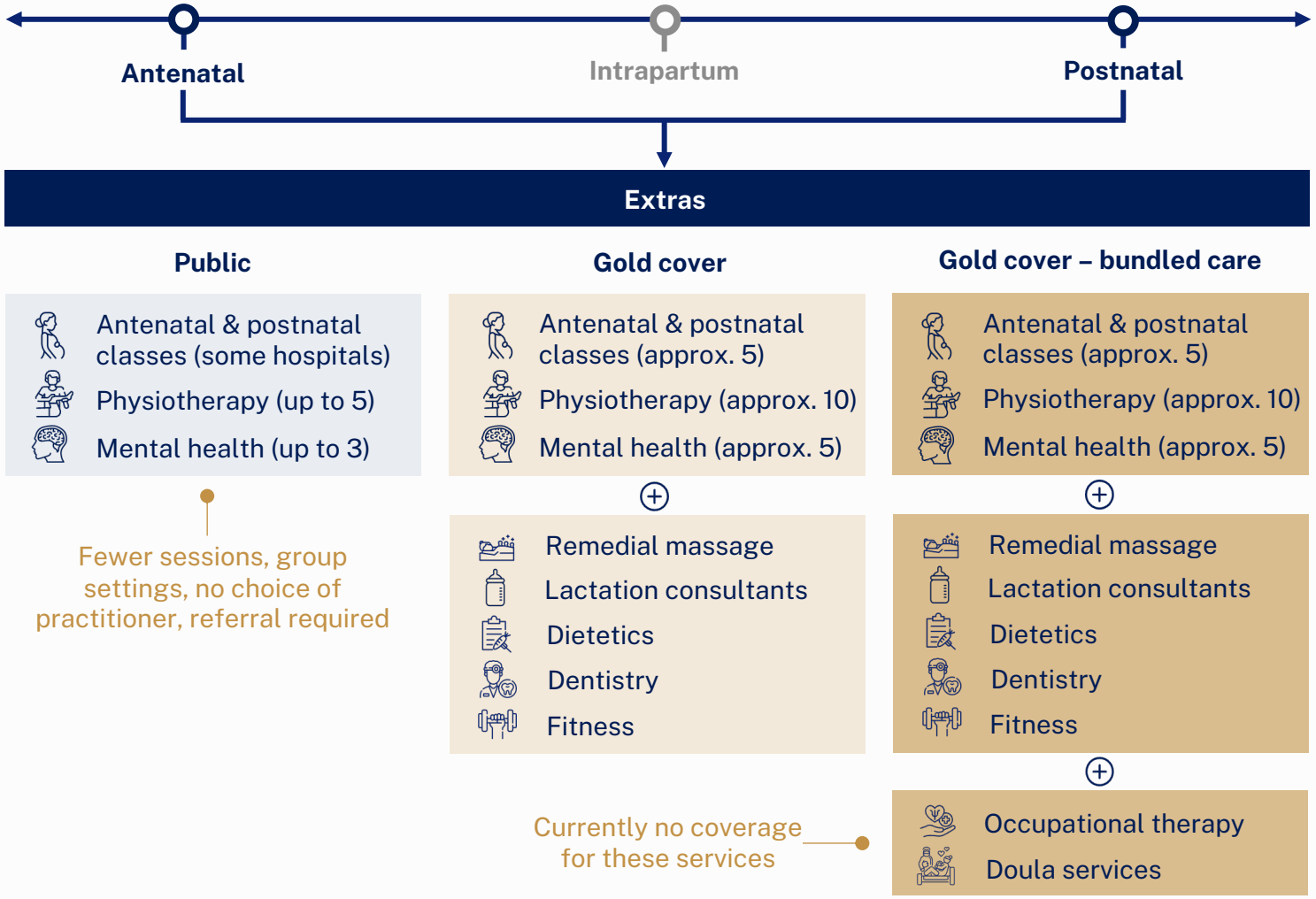
Private bundled care offers a proven safe model of care available in the public system, with the extras people value from the private system

Services such as antenatal and postnatal classes, physiotherapy, and psychology can be included in public care, but there are fewer sessions, which are often provided in group settings, and mothers have no choice of practitioner. Mothers always require a referral to access Medicare-subsidised allied health like physiotherapy and psychology.

Beyond antenatal and postnatal classes, physiotherapy, and psychology, gold-tier private health insurance includes additional extras which can benefit mothers, such as remedial massage and dietetics. Services accessed through private health insurance do not require a referral, are more frequent, and allow mothers to choose their practitioner.

The introduction of bundled care creates opportunities for private health insurers to cover additional services. For example, mothers who choose to access services such as occupational therapy or doula services would be covered for them. Moreover, out-of-pocket savings generated by bundled care will free-up financial resources for mothers to redirect to these additional services they need.

Antenatal and postnatal extras, public, current private and with bundled care



Source: Medibank (2025); iSelect (2025); Health Direct (2025); Department of Health, Disability and Aging (2025); APS (2025); Bupa (2025); Medibank (2025); Compare the Market (2025)

Births in private hospital could increase by 25%, reducing public hospital pressure

By significantly reducing out-of-pocket costs associated with private maternity care, while also enabling more choice, bundled care would significantly increase the uptake of private hospital births.

Analysis of the sensitivity of consumers to in-hospital out-of-pocket costs suggests that the savings unlocked by bundled care could increase the uptake of private care by 25% by 2030. This equates to an additional 14,000 private hospital births relative to business as usual (BAU) projections.

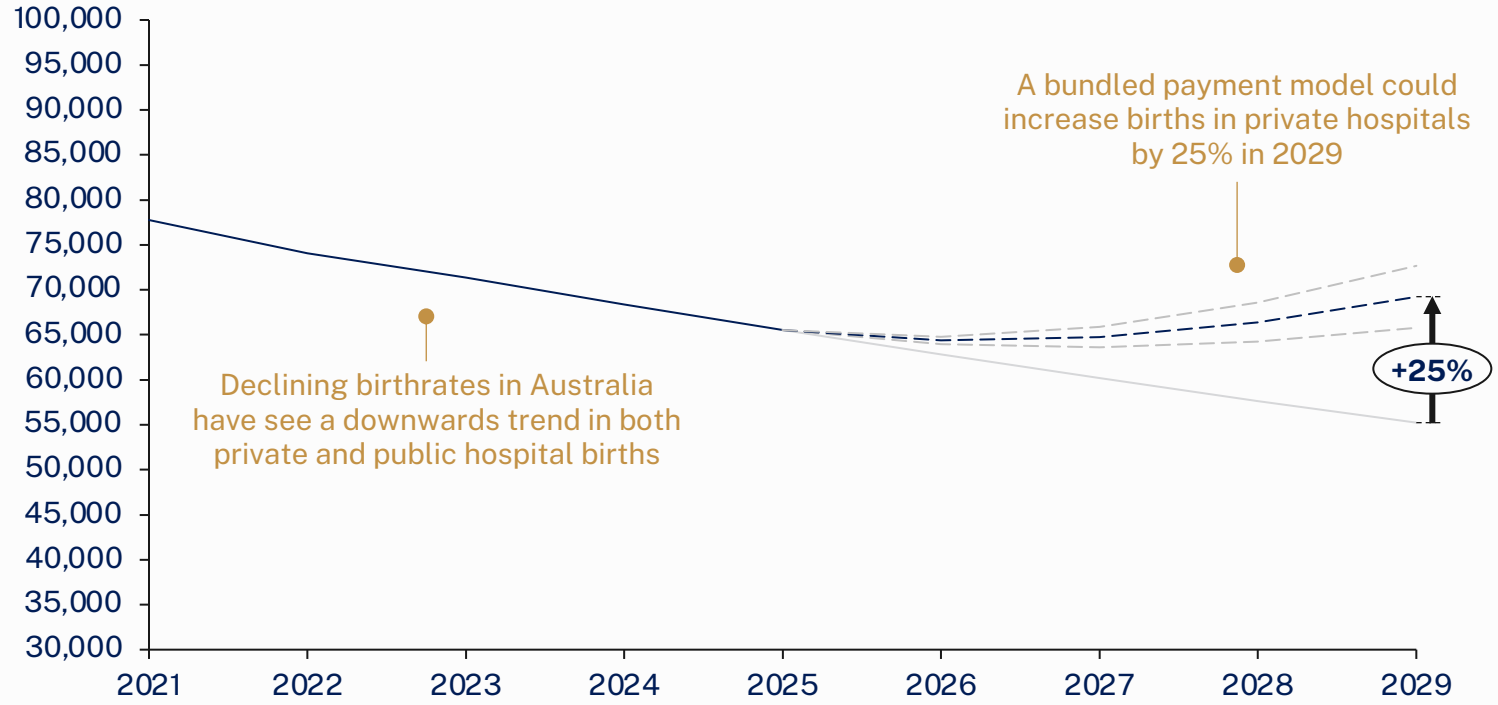
The shift would significantly alleviate pressure on public hospitals while expanding the private healthcare sector. This projected increase stems from reduced financial barriers, with the bundled payment model substantially lowering out-of-pocket costs for private maternity care.

Consumer sensitivity analysis confirms that more affordable private options with practitioner-led care would drive this transition. The historical decline in private hospital births could be arrested through this model, creating a more balanced distribution between public and private healthcare systems and potentially improving overall maternal care access and quality.

Note: See appendix for further detail on modelling of private births

Number of private hospital births over time (modelled)

#, per year



Source: PHA data; AIHW (2024); AIFS (2024); McCrindle (2013); Drago et al. (2009); Mandala analysis

By increasing the uptake of private maternity care, the public hospital system will benefit from reduced demand

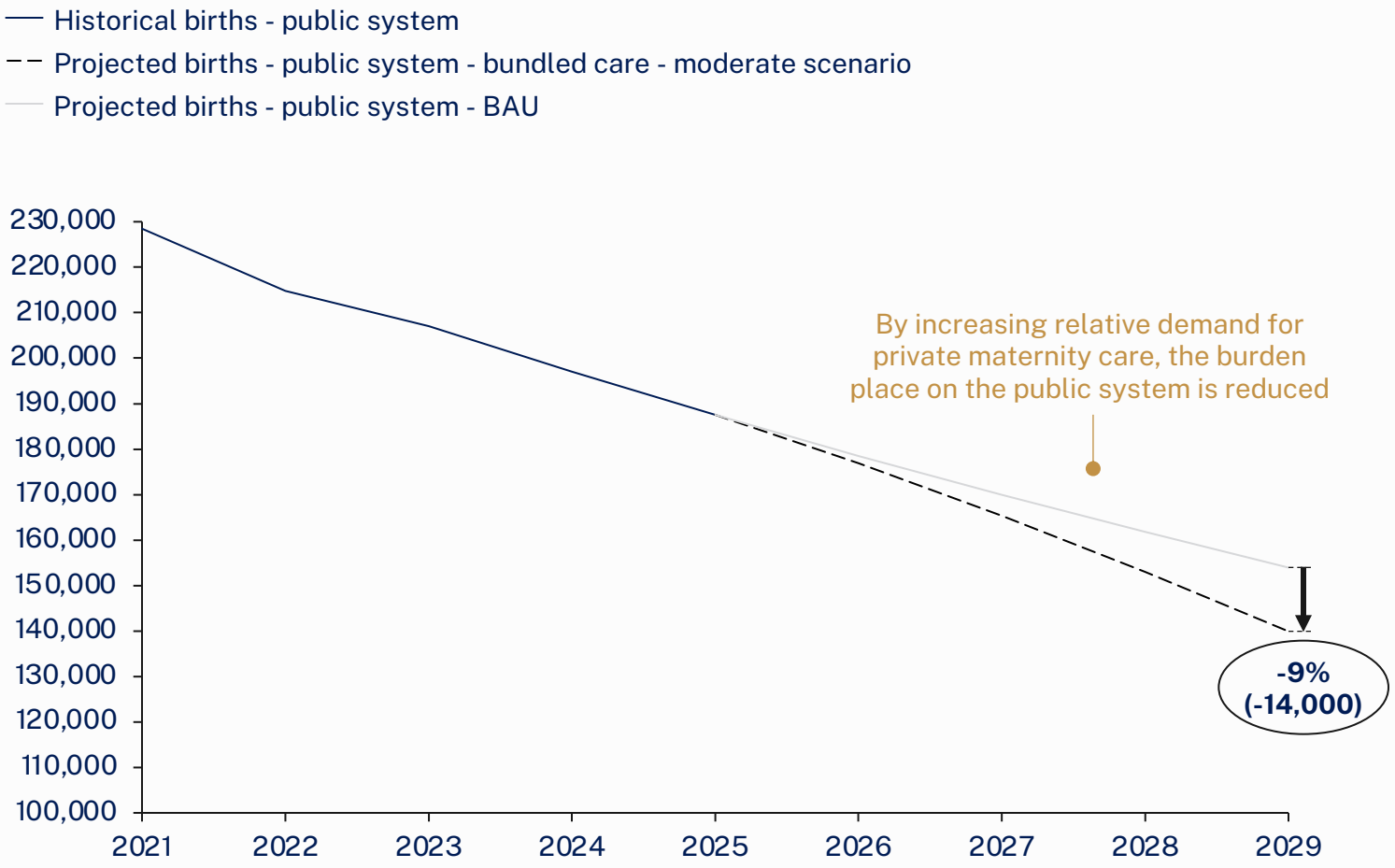
The public system currently delivers around 70% of all births that occur in Australia each year. Based on current trends, the number of public system births is projected to be around 150,000 in 2029.

Under the introduction of private bundled care, reduced out of pocket costs associated with private maternity care would see many patients switch from using the public system to the private system. This is estimated to constitute a 9% reduction in total public system births in 2029, or 14,000 births.

By shifting some low-risk patients from the public to the private sector, private bundled care can reduce pressure on public hospital wards, and deliver savings for government budgets, which need to service fewer public births.

Number of public hospital births over time (modelled)

#, per year



Source: PHA data; AIHW (2024); AIFS (2024); McCrindle (2013); Drago et al. (2009); Mandala analysis

Lower out-of-pocket costs would attract more mothers to upgrade to a Gold policy or take out PHI for the first time

Introducing bundled care which is covered under the Gold tier of PHI could incentivise those without PHI to chose a Gold policy for maternity care or those with a Bronze or Silver policy to upgrade to a Gold policy for maternity care.

Several factors influence a consumer's decision to take out a Gold tier policy. The first is price. The proposed bundled model of maternity care would not increase the price of Gold premiums. The bundled care model will remove maternity care as a driver of cost in Gold premiums.

Out-of-pocket costs prohibit many mothers using their Gold policy for maternity cover or taking out a Gold policy. Out-of-pocket costs have been cited as the most common reason for those with PHI choosing a public hospital rather than a private hospital for childbirth. This policy reduces out-of-pocket costs. There is likely to be an increase in participation as well as utilisation of Gold tier policies as a result.

Those holding a Gold policy are likely to view it as higher value. This is because premiums remain constant but out-of-pocket costs decrease. This is likely to attract more mothers to take out a Gold policy or utilise it for private maternity care. Bundled care is likely to have a net positive impact on PHI participation in the Gold tier.

Impact of bundled care on drivers of participation in Gold tier PHI

Driver	Impact of policy	Participation impact
Cost of annual premiums	Maternity care removed as a driver of cost of gold premiums. Other factors (for example mental health claims, rising costs) will still lead to premium increases.	—
Out-of-pocket costs	Out-of-pocket costs reduce. Those who were deterred from taking out Gold cover for maternity care due to cost are more likely to take out a Gold policy.	^
Perceived value of PHI	Greater choice, along with lower out-of-pocket cost at the same premium price is likely to be seen is higher value to the consumer.	^
Participation incentives	No change to the PHI Rebate.	—

Introducing bundled care to the private system is likely to have a **net positive impact on PHI participation in the Gold tier.**

Note: Without elasticities for out-of-pocket costs, the magnitude of the impact on participation cannot be modelled. The impact on PHI is based on likely directional impact of reducing out-of-pocket costs.
Source: Ipsos (2023) Health Care and Insurance Australia 2023 Report 4: Population Attitudes

Midwives could earn almost $200,000 working as a lead practitioner in a group practice

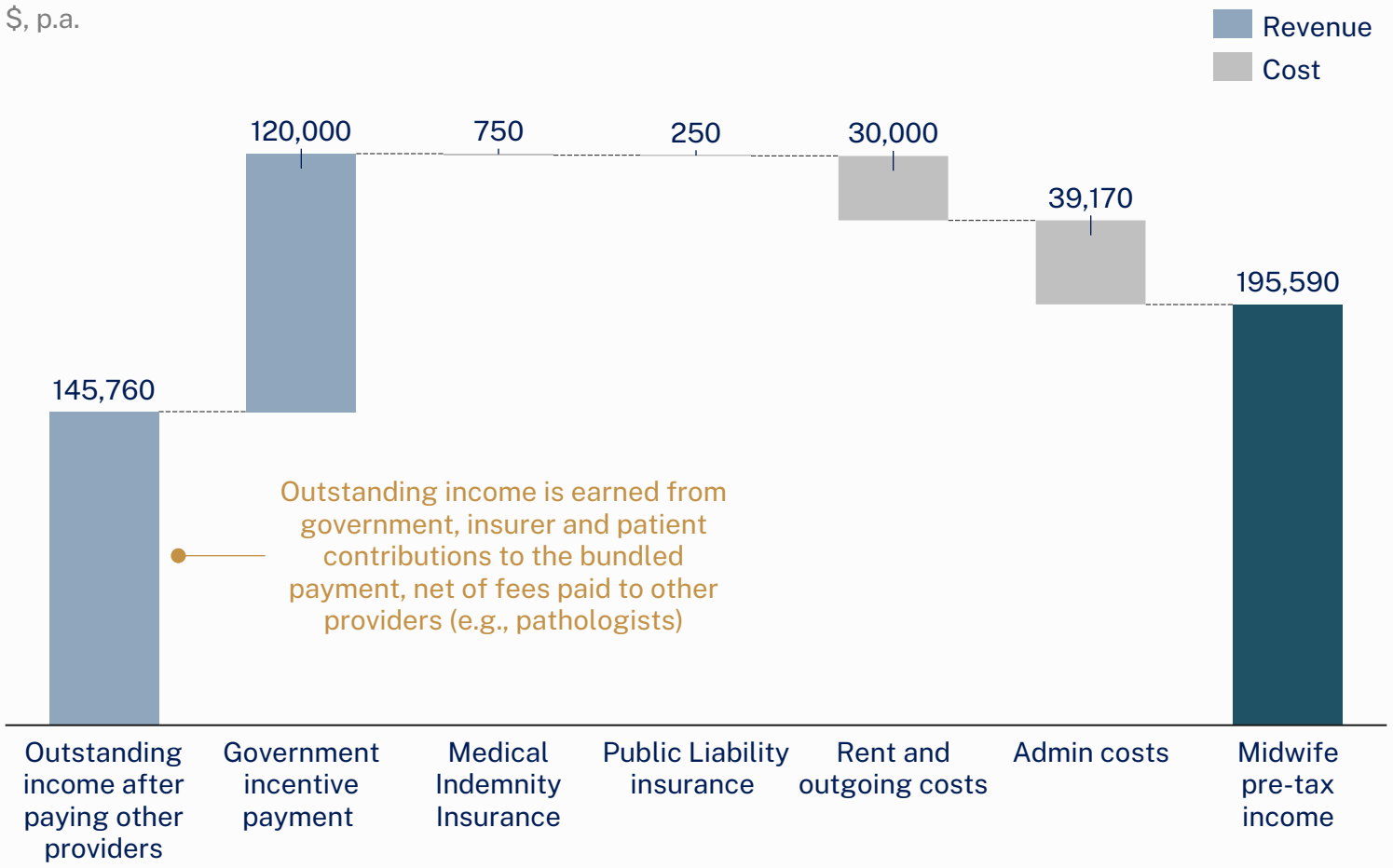
Midwives are likely to work in group private practices when delivering the bundled care model. 90% of GPs and 70% of non-GP specialists work in group practices.[1] If a midwife works in a group practice with a total of four midwives which is common, they could earn $200,000 in pre-tax income.[2] This accounts for medical indemnity insurance, which would continue to be supported under the Federal Government's Midwife Professional Indemnity Scheme (MPIS). This helps indemnity insurers with the cost of claims against midwives in private practice. This also accounts for rent, outgoing, admin costs and public liability insurance to run a private practice. These costs are shared across the group practice.

Currently a salaried midwife working as a clinical midwife earns around $103,000.[3] Midwives working in a group practice offering bundled care could earn almost twice as much as if they worked as an employee in a private hospital.

Alongside the increased earning capacity, practitioners report enhanced autonomy, knowledge, skills development, and stronger professional identity from acting as a lead practitioner. It is also associated with lower rates of burnout and lower anxiety and depression scores than their peers in noncontinuity models.

1 ANZ and the Melbourne Institute (2022), 2 Women's healthcare Australasia (n.d.), 3 Seek (2025)
Source: Barnett et al. (2016); Dawson et al. (2018); Fenwick et al. (2018); Newton et al. (2014); Sheehy (2019); Collins et al. (2009)

Potential income from delivering bundled care, with a midwife as lead practitioner



Note: Assumes rent, outgoings, admin costs and public liability insurance is divided over four midwives in a group practice. Assumes each midwife in the group practice supports 40 mothers each year. See Gilkinson, A, et al. (2018). General Practitioners earn approximately $200,000 each year. See Melbourne Institute (2021)
Source: Realcommercial.com.au (2025A); Realcommercial.com.au (2025B); Realcommercial.com.au (2025C), RACGP (2018), Bizcover (n.d.), MIGA (n.d.), Payscale (2025) Private Healthcare Australia (2024), Department of Health, Disability and Aging (2025); Mandala analysis

A government incentive payment of $3,000 per pregnancy to lead practitioners would cover costs

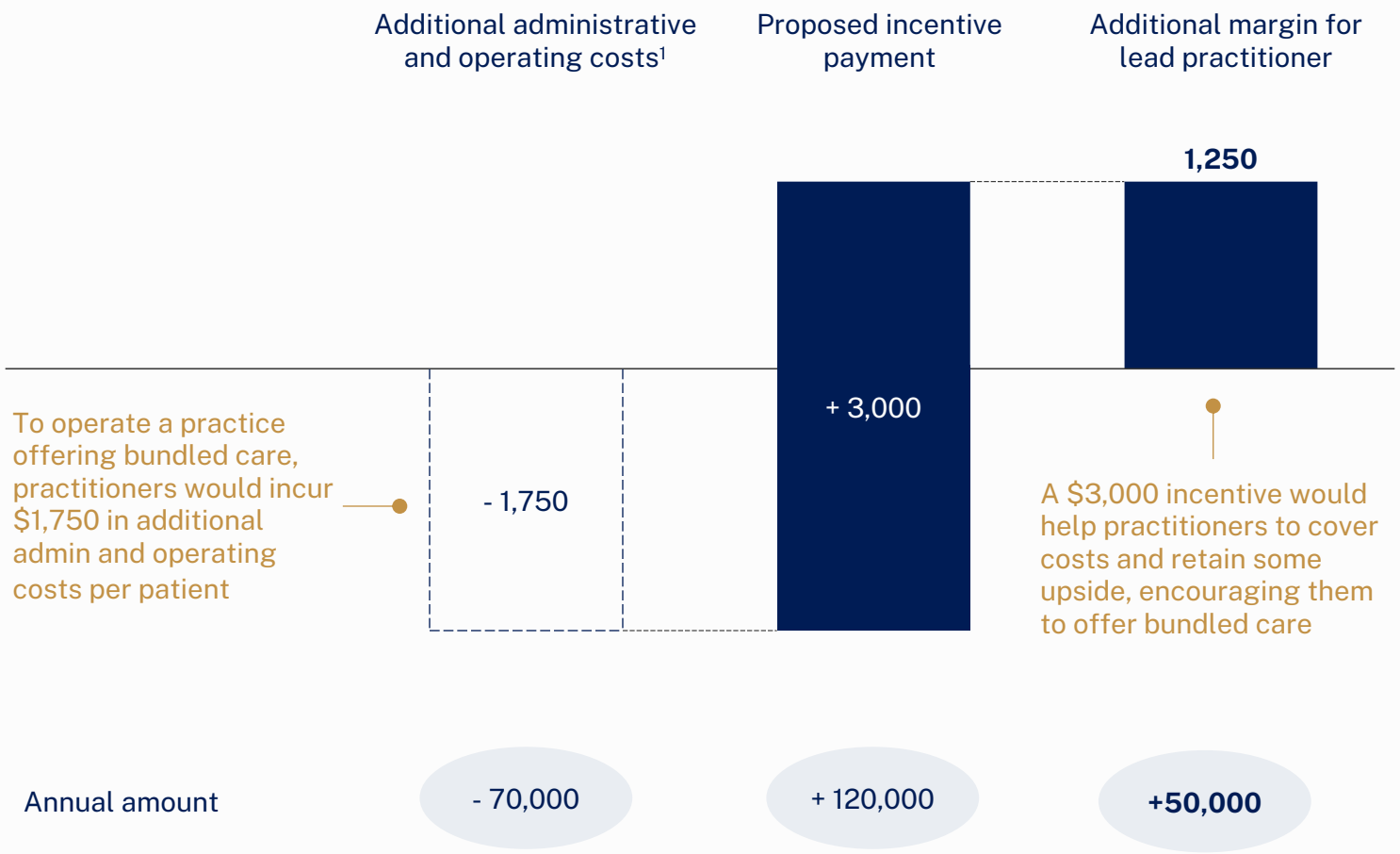
To achieve a core objective of this policy –expanding the range of choice available to mothers in the private system – bundled care needs to sufficiently compensate lead practitioners to encourage them to offer this form of care.

Under the current modelling of the policy, an incentive payment of $3,000 per patient could provide lead practitioners an extra $120,000 in revenue each year, helping them to cover the additional administrative and operating costs that would be incurred from providing lead care.

The proposed $3,000 incentive is designed to strike the right balance of encouraging practitioners to take on a lead care role and minimising costs to government. This incentive could be adjusted as further details of the policy are developed.

Proposed incentive payment to encourage uptake of bundled care relative to additional costs

$, per patient p.a.



1 Based on estimated administrative, rental and insurance costs associated with running a private practice. Assumes that practitioners will manage 40 patients per year, as per Gilkison et al. (2015)

An incentive payment encouraging the uptake of bundled care would incur a cost to government that would depend on both population trends and relative demand

Factors determining the likely adoption and fiscal cost of bundled care

Category	Sub-category	Description	Impact on fiscal cost	Modelling approach
Population trends	Fertility rates	Fertility rates in Australia have been declining as less people choose to have children. All else equal, this will reduce the adoption of bundled care over time.[1]	↓	Trends in the use of private maternity care over time (excluding the price effect from bundled care) were maintained at historical growth rate of -4% p.a., reflecting the current combination of declining fertility rates and growing population.
	Population projections for potential mothers	The number of women of childbearing age is expected to grow by 1% p.a. from 2024-25 to 2028-29.[2] This puts upwards on the adoption of bundled care and the subsequent fiscal cost of incentive payments.	↑	
Relative demand	Relative demand for private maternity care	Greater relative demand for private care will see more people take up bundled care in the short-term, increasing fiscal costs. As a second-round effect, this reduces relative demand for public care, reducing fiscal costs.	—	The direct impact of demand for private maternity care was estimated using a fixed effect regression of private hospital births on OOP costs.[3] The second-round savings from reduced public care were assumed to be zero.
	Relative demand for bundled care	Greater relative demand for bundled maternity care will see more people switch from traditional private care to bundled care, increasing the volume of incentive payments.[4]	↑	The degree to which consumers who would otherwise have used traditional private care switched to bundled care was challenging to estimate. For simplicity, and to estimate an upper bound of the fiscal cost, this was assumed to be 50% in the short-term.[5]

1 ABS (2024). 2 Centre for Population (2024). 3 See Appendix for further details. 4 It is also possible that despite high relative demand for bundled care, limited uptake from lead practitioners could constrain the adoption of bundled care in the short to medium term. 5 A sensitivity test of this assumption can be found in the Appendix.
Source: Mandala analysis

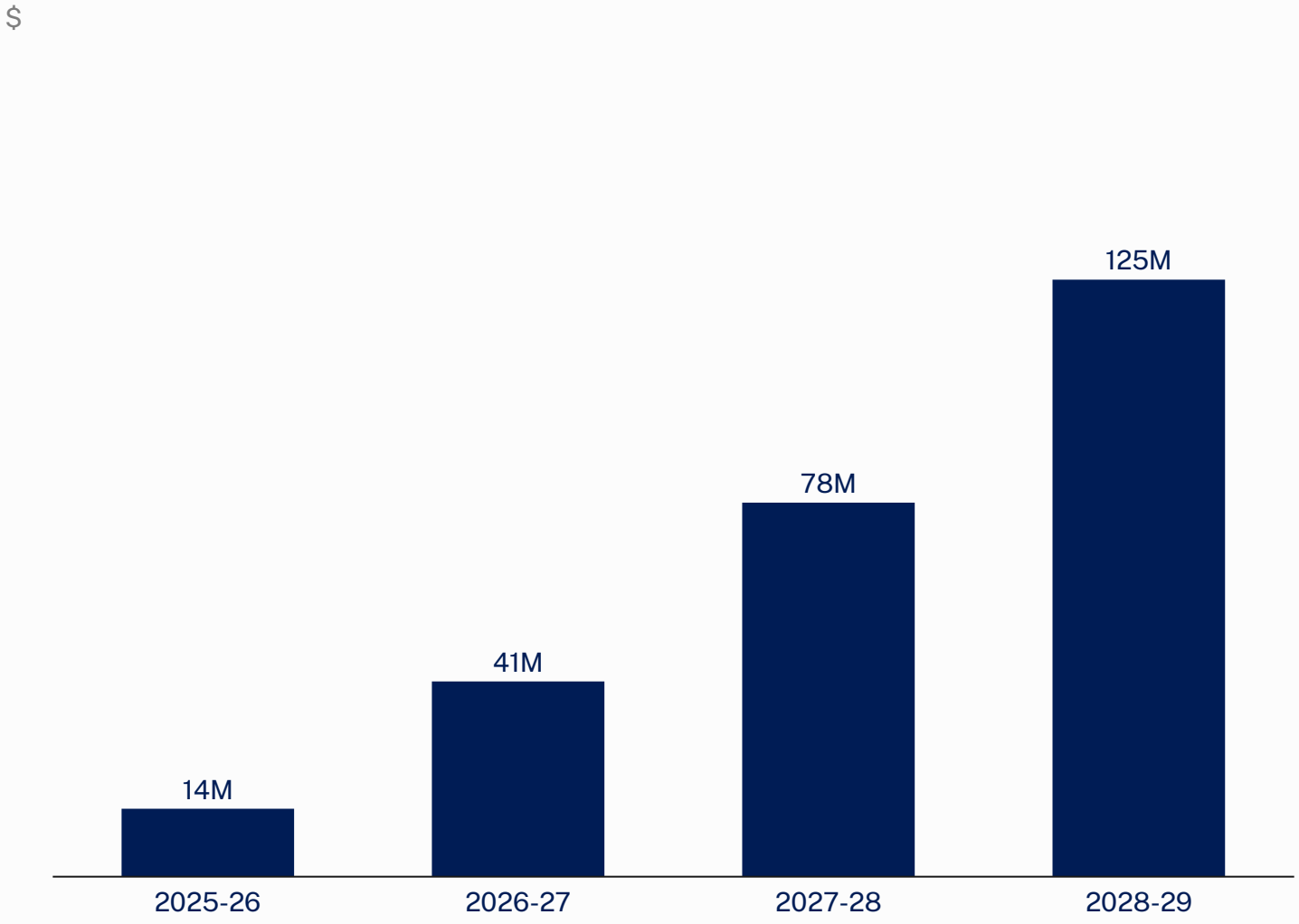
Implementing this model of bundled care would cost the Government an estimated $258M over 4 years

The implementation of bundled care for private maternity services represents a significant but worthwhile investment, costing the Australian Government $258 million over four years for $3,000 incentive payments to lead practitioners. This funding would be matched by private health insurers committing to cover at least an equivalent amount ($3,000) of out-of-pocket costs for consumers.

This investment addresses a critical gap in maternity care options. While the public system already offers models of midwife-led care and GP shared care arrangements, mothers in the private system have been largely limited to specialist obstetrician models with significant out-of-pocket costs. The bundled payment approach would finally provide mothers in the private system the same choice of care models that mothers in the public system currently enjoy, but with the added benefits of private hospital accommodation and continuity of care.

The value of this investment extends beyond just financial considerations. By expanding provider options to include midwives and GPs as lead practitioners, the model directly addresses the ongoing decline in birth rates and the financial viability of private maternity services. This model puts mothers at the centre of their care, allowing them to select the practitioner and model that best suits their individual needs and preferences, while simultaneously addressing the affordability crisis in private maternity care.

Cost to Government to implement a bundled care model for the private system



Source: Private Healthcare Australia (2025) *Budget submission 2025-26 Maternity services;* Mandala analysis

Medical indemnity insurance premiums vary significantly by practitioner, and will change under bundled care

Medical Indemnity Insurance for obstetricians and gynaecologists is expensive compared to other medical practitioners. The median premium was $50,000 in 2019, but premiums can be as high as $92,000. The median premium equated to 8.5% of private practice income in 2019. Premiums for GPs with specialist obstetric capabilities are much lower, with a median premium of $18,000. The median cost of medical indemnity insurance for privately practicing midwives was $3,000 in 2019, and as of 2025, premiums were capped at $7,500 for the highest earning midwives.

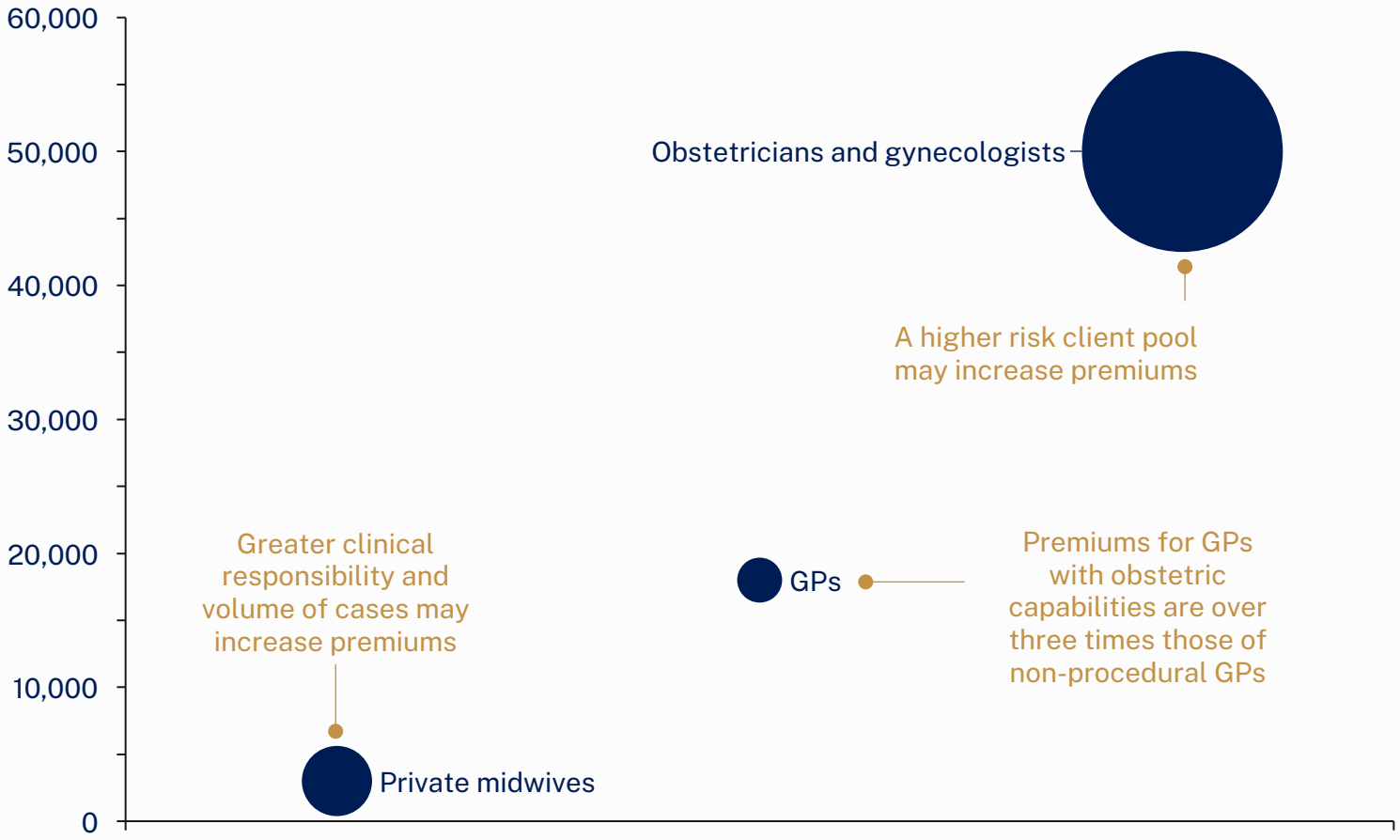
If bundled care were to be implemented, the clinical responsibility of private midwives will increase, along with their volume of cases, which will likely drive up their premiums. For obstetricians, the mothers they care for will likely be higher risk, which will also drive up their premiums. The extent to which premiums will change is a complex actuarial question.

Government intervention may be required in a bundled care scenario. However, intervention already exists in the markets for both private midwife and obstetrician indemnity insurance via the Midwife Professional Indemnity Scheme (MPIS) and the Premium Support Scheme (PSS). Any need for ongoing intervention should not be taken as indicative of the viability of the proposed bundled care solution.

Source: Australian Government Actuary (2020); MIGA (2025): Experien (2024)

Median indemnity insurance premiums and number of practitioners, by practitioner category

Premium $, 2019



Note: Premium values and number of practitioners covered by indemnity policies are based on the most recent data available (referring to 2019). Size of bubble indicates number of insured practitioners. Current premiums and policy numbers are likely to be higher.
Source: Australian Government Actuary (2020)

Concerns about bundled care in the private system can be overcome with careful consideration of the evidence and design of the policy

Concerns

- **Concerns about safety.** Some argue that only obstetricians possess the specialised training and expertise necessary for safe maternity care. Some claim that expanding lead practitioner roles to GPs and midwives would compromise clinical safety, particularly for managing complications that require specialist intervention.
- **The cost of liability.** There are arguments that taking on the coordination of all aspects of maternity care exposes lead practitioners to increased liability, which could result in higher insurance premiums that would ultimately be passed on to consumer, negating any cost benefits of the bundled model.
- **Concerns over a lack of realised savings.** The policy may be implemented without meaningfully reducing out-of-pocket costs for consumers, resulting in no real financial benefit to consumers.
- **No difference between public and private care**. There is insufficient differentiation in care provided in the public and private systems for the cost of private care to be justifiable for mothers.
- **Feasibility.** Such a change would be significant from the way current private maternity services operate and would be challenging to implement in a widespread manner.

Evidence

- **Proven model.** Research supports the safety of midwife-led and GP care for low-risk pregnancies, with proper risk assessment and specialist referral pathways. This model enhances safety by offering mothers more provider options, improving access and care continuity.
- **Incentives to participate.** The bundled care model may reduce risk through better coordination between providers, addressing a major factor in adverse outcomes. The $3,000 incentive contribution from Government absorbs marginal insurance increases without affecting consumer fees.
- **Improved competition.** Transparent pricing creates a competitive marketplace where practitioners must compete on quality and cost, driving down out-of-pocket expenses. Eliminating "drip pricing" ensures consumers can make informed financial decisions when choosing providers.
- **Private care offers significant extras benefits.** Mothers have access extras which are unavailable in the public system. More extras can be made available under bundled care as well, all while continuing to offer mothers choice of provider and hospital.
- **Pilot in thin markets.** Regional areas of Australia are struggling to keep private maternity wards open. These locations are ideal to implement the bundled care model initially with providers who are interested in testing new care and payment models to ensure care for those who need it.

1 Australian mothers are limited to expensive private obstetric care in the private health system

2 Bundled care offers mothers greater choice in the private system

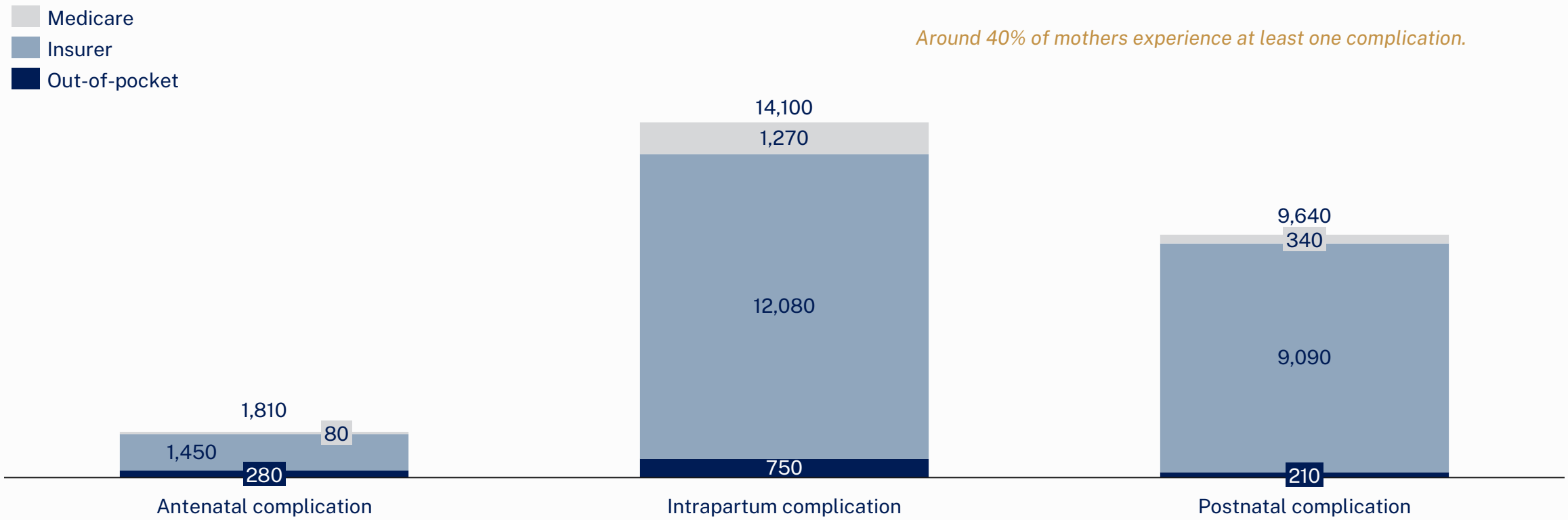
3 Bundled care has significant benefits for mothers, the private system, and the health workforce

4 **Appendix**

Complications from pregnancy can add additional out-of-pocket costs to mothers, from between $210 to $750 depending on the stage of pregnancy

Total cost of private maternity care complications

$, per birth



1 Example complication, based on an antenatal hospital admission. 2 Example complication, based on a catastrophic or severe complication during childbirth. 3 Example complication, based on a neonate admission to hospital. 4 Due to aggregation and deidentification of data, the joint probability of a woman experiencing multiple complications cannot be directly observed. This is instead is estimated based off the observed probabilities for each individual event.

Source: PHA Data; Mandala analysis

Cost to deliver obstetrician-led bundled care is 8% lower than the current cost of private maternity care

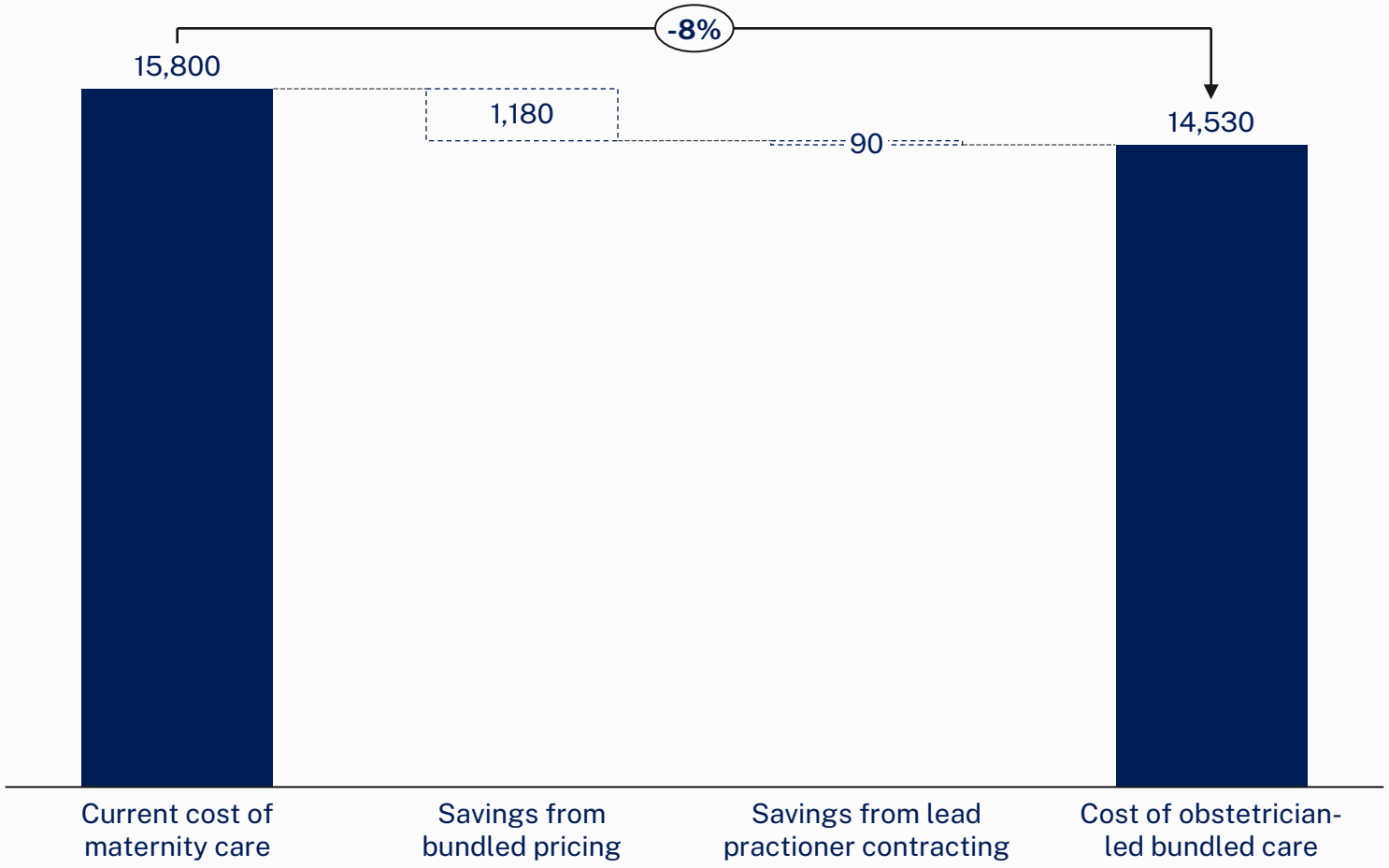
Bundled care reduces the cost of private maternity care regardless of the type of lead practitioner. Bundled care with an obstetrician as the lead practitioner costs 8% less, at $14,530.

Bundled care drives savings in two ways for obstetrician-led care. The first is through the mechanism of bundled pricing rather than fee for service pricing. This increases efficiency and limits over-servicing. Bundled pricing reduces incentives for overservicing, reduces costs by between 5% to 10%.[1] There is evidence that bundled pricing does not negatively impact the quality of care.

The second mechanism is through the lead practitioners negotiating better prices for services like scans and tests through contracting arrangements. This functions in the same way private health insurance agreements with hospitals drives down out-of-pocket costs of in-hospital services. Unlike with midwife-led care, there is no savings from substitution to a lower cost practitioner.

Cost of maternity care under current model and bundled care with an obstetrician as lead practitioner

Median cost



Source: Private Healthcare Australia (2024), Department of Health, Disability and Aging (2025); Mandala Analysis

1. Damberg et al. (2014); Cavalieri et al. (2013)

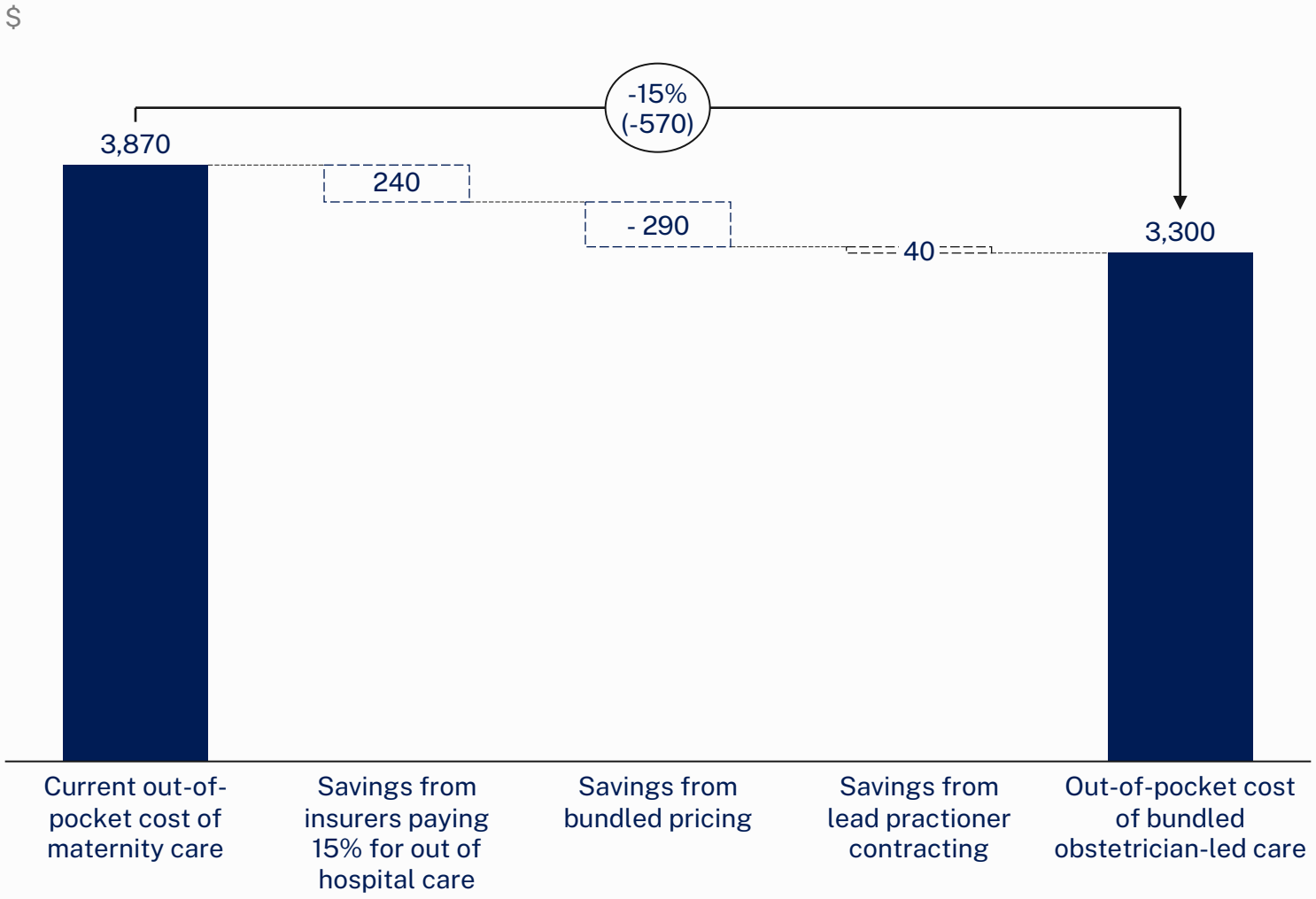
Bundled care led by an obstetrician saves consumers $570 in out-of-pocket costs

Mothers who choose an obstetrician as the lead practitioner will still save money under a bundled model. While the savings are not as large as under the midwife-led bundled model, mothers can save $570 in out-of-pocket costs.

The three drivers of out-of-pocket savings for the consumer. The first is savings from the insurers covering 15% of the MBS. Currently the consumer pays the remining 15% of the Medicare Benefits Schedule (MBS) Fee and any gap charged by the provider. Under the bundled model of maternity care, the insurers will cover at least 15% of the Medicare Benefits Schedule Fee for out of hospital services. The insurer and consumer will both contribute to any gap charged by the lead practitioner in addition to the MBS Fee. This contributes to consumer savings of $240.

The second saving comes from bundled pricing which saves 5 to 10% of the cost of all services delivered. The final is savings from lead practitioner contracting. This is the smallest saving as it only affects imaging as these are the only services not already part of PHI and hospital agreements.

Out-of-pocket costs of bundled care, with obstetrician as lead practitioner



Source: Private Healthcare Australia data; Medical Costs Finder (2023); Department of Health, Disability and Aging (2025); Mandala Analysis

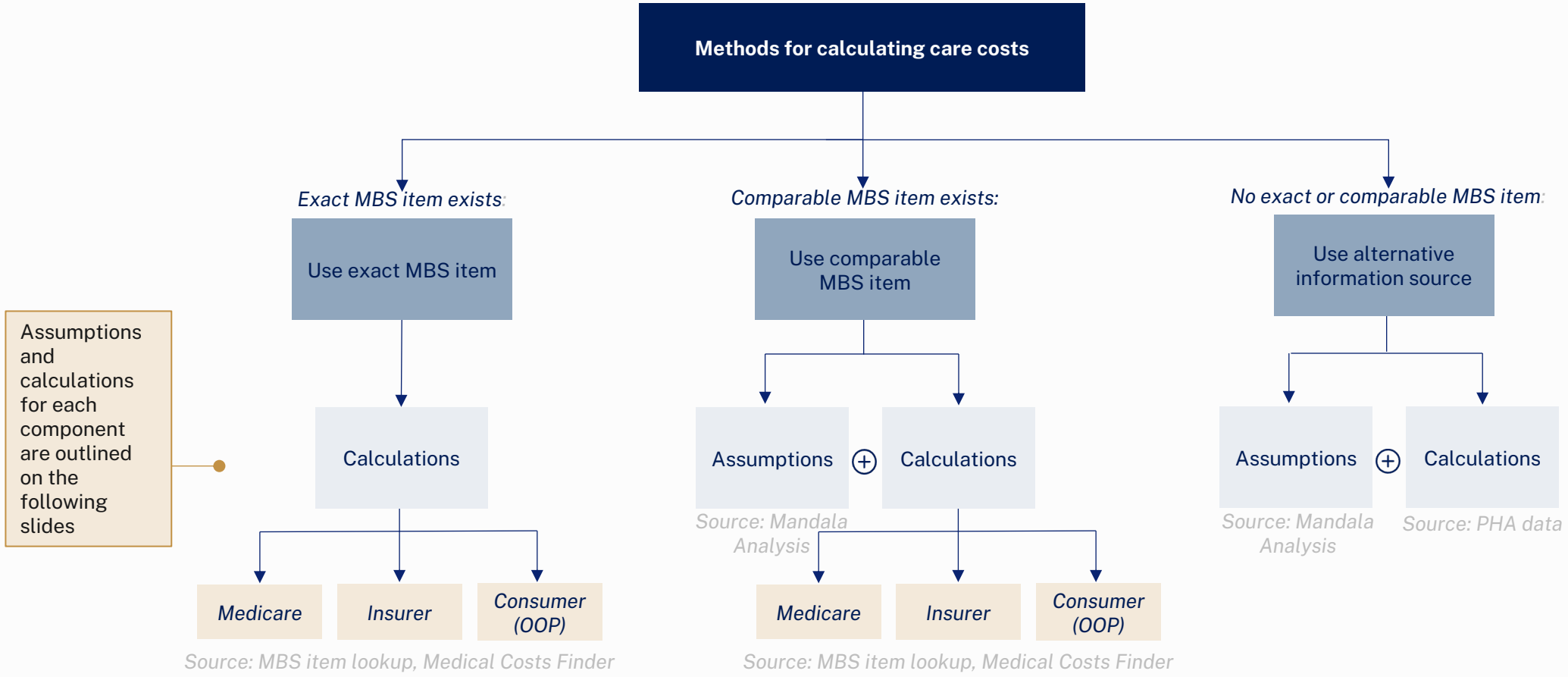
Methodological differences between obstetrician-led and midwife-led cost models

	OBSTETRICIAN-LED	MIDWIFE-LED
Costs reality or theory	**Based on current model** where cost divisions between payers are already established	**Based on theoretical model** where cost divisions between payers remain to be seen • Assumes insurers will contribute to both in and out-of-hospital expenses
Major data source	Medical Costs Finder	MBS items and PHA data
Standard formula	*Total ($) = F * (MBS + (P * OOP) + I)* *F* = Frequency; *MBS* = Medicare Benefits Schedule contribution ($); *P* = proportion with *OOP; OOP* = out-of-pocket contribution ($); *I* = insurer contribution ($)	*Out-of-hospital: T = F * (MBS Benefit + Insurer MBS + Insurer Gap + Consumer Gap) = F * ((0.85*MBS Fee) + (0.15*MBS Fee) + (0.19*MBS Fee) + (0.04*MBS Fee)* *In-hospital: T = F * (MBS Benefit + Insurer MBS + Insurer Gap + Consumer Gap) = F * ((0.75*MBS Fee) + (0.25*MBS Fee) + (0.19*MBS Fee) + (0.04*MBS Fee)*

Medical Cost Finder includes data on average gap payments (covered by consumers and insurers). This data is not available in public-system MBS data. Mandala has used PHA data to determine Insurer Gap and Consumer Gap coefficients based on PHA data of average total cost and insurer benefit for a specialist care episode.

Model map for obstetric-led and midwife-led care cost calculations

Calculation methods and inputs for care cost calculations



Private obstetrician-led care - Assumptions

Assumptions overview

Care model structure based on essential (occur in effectively all pregnancies) care phases and services identified by Mandala analysis.
Modelling assumes a low-risk, uncomplicated pregnancy.

Care phase	Service	MBS item	Alternative information	Assumptions	Sources
Antenatal	Pregnancy management fee	16590			Medical Costs Finder (2023a)
	Initial consultation	16401			Medical Costs Finder (2023b)
	Follow-up obstetrics appointment	16404			Medical Costs Finder (2023c); Skinner (2024)
	Pathology	Various		Includes urine, blood and diabetes tests, as identified by the NSW Government Assume all pathology bulk-billed	NSW Government (2024); DHAC (2025c); Healthdirect (2025); DHAC (2025d); Branley (2022); ACT Government (2024)
	Ultrasounds	55706			Queensland Government (2025); Medical Costs Finder (2023d)
Labour and birth	Birth services		PHA data	Based on Mandala analysis of PHA data (combines DRG procedures data from a selection of funds)	PHA data; Medical Costs Finder (2023e)
Postnatal (up to 6 weeks)	Postnatal obstetrics appointment	16407			Medical Costs Finder (2023f)

Private obstetrician-led care - Costings

Costings overview

Standard formula (where exact or comparable MBS item exists): Total ($) = F * (MBS + (P * OOP) + I)
F = frequency; MBS = Medicare Benefits Schedule contribution ($); P = proportion with OOP; OOP = out-of-pocket contribution ($); I = insurer contribution ($)

Care phase	Service		MBS item or alternative	Frequency	MBS	Proportion with OOP	OOP	Insurer contribution	Total	Sources
Antenatal	Pregnancy management fee		16590	1	$335	92%	$2,615	$0	$2,740.80	Medical Costs Finder (2023a)
	Initial appointment		16401	1	$77	66%	$173	$0	$191.20	Medical Costs Finder (2023b)
	Follow-up obstetrics appointment		16404	10	$39	36%	$61	$0	$609.60	Medical Costs Finder (2023c); Skinner (2024)
	Pathology	Urine	65066	11	$8.80	0%	$0	$0	$97.20	NSW Government (2024); DHAC (2025c); Healthdirect (2025); DHAC (2025d); Branley (2022); ACT Government (2024)
		Blood	65060	2	$6.70	0%	$0	$0	$13.30	
		Diabetes	66545	1	$13.40	0%	$0	$0	$13.40	
	Ultrasounds		55706	3	$88	49%	$155	$0	$491.90	Queensland Government (2025); Medical Costs Finder (2023d)
Labour and birth	Birth services		PHA data	1	$1,266.90	100%	$782.09	$9,149.40	$11,198.50	PHA data; Medical Costs Finder (2023e)
Postnatal (up to 6 weeks)	Postnatal obstetrics appointment		16407	5	$64	43%	$56	$0	$440.40	Medical Costs Finder (2023f)

Theoretical midwife-led care – Assumptions (part 1)

Assumptions overview

Care model structure based on care phases and services to be included in a midwife-led bundled payment funding model, as identified by the Medicare Benefits Schedule Review Taskforce (2019)
Mandala categorises services as essential if they are included in the basic private obstetric care model
Modelling assumes a low-risk, uncomplicated pregnancy

Care phase	Service	Exact MBS item	Comparable MBS item	Alternative information	Assumptions	Sources
Antenatal - essential	Call cover		16590		No specific MBS item - new type of service Assume MBS item 16590 - A consultation with a specialist for a pregnancy which has passed 28 weeks Midwife fee calculated through summing MBS benefit, Insurer MBS contribution, Insurer gap contribution, and OOP contribution, making use of PHA data on gaps and insurer contributions (ends up less than average obstetrician fees)	Seek (2025a); Seek (2025b; Medical Costs Finder (2023a)
	Booking (initial visit)	82100				DHAC (2025a)
	Pregnancy care visits		82105		Assume MBS item 82105 - Short antenatal professional attendance by a midwife (up to 40 minutes)	DHAC (2025b)
	First trimester screenings	Various			Includes urine, blood and diabetes tests, as identified by the NSW Government Assume all pathology bulk-billed	NSW Government (2024); DHAC (2025c); Healthdirect (2025); DHAC (2025d); Branley (2022); ACT Government (2024)
	Morphology scans	55706				Queensland Government (2025); Medical Costs Finder (2023b)

Theoretical midwife-led care – Assumptions (part 2)

Assumptions overview

Care phase	Service	Exact MBS item	Comparable MBS item	Alternative information	Assumptions	Sources
Antenatal - essential	Labour management up to 30hrs		82120		No MBS item for labour management up to 30 hours. Only up to 12 hours (MBS item 82120).	DHAC (2025e)
	Conduct birth if occurs				Although 'labour management' and 'conduct birth' listed separately in taskforce framework, both covered under MBS item 82120.	
	Immediate postpartum care				No separate MBS item – assuming covered under MBS item 82120	
	Private hospital fees			PHA data	Based on Mandala analysis of PHA data of average total cost and insurer benefit for a specialist care episode	PHA Data
Postnatal - essential	Support visits	82130				DHAC (2025f)

Theoretical midwife-led care – Costings (part 1)

Costings overview

Standard out-of-hospital formula: T = F * (MBS Benefit + Insurer MBS + Insurer Gap + Consumer Gap) = F * ((0.85*MBS Fee) + (0.15*MBS FEE) + (0.19*MBS Fee) + (0.04*MBS Fee)
Standard in-hospital formula: T = F * (MBS Benefit + Insurer MBS + Insurer Gap + Consumer Gap) = F * ((0.75*MBS Fee) + (0.25*MBS FEE) + (0.19*MBS Fee) + (0.04*MBS Fee)
Insurer Gap and Consumer Gap coefficients based on PHA data of average total cost and insurer benefit for a specialist care episode

CARE PHASE	SERVICE		MBS ITEM OR ALTERNATIVE	*T*	*F*	*MBS FEE*	*MBS BENEFIT*	*INSURER MBS*	*INSURER GAP*	*CONSUMER GAP (OOP)*	FURTHER SUPPORTING ASSUMPTIONS	SOURCES
Antenatal - essential	Call cover		16590	522.3	1	424.7	361	63.7	80.7	17		Medical Costs Finder (2023a); DHAC (2025a)
	Booking (initial visit)		82100	104.2	1	84.7	72	12.7	16.1	3.4		DHAC (2025b)
	Pregnancy care visits		82105	453.3	10	36.9	31.3	5.5	7	1.5		DHAC (2025c)
	First trimester screenings	Urine	65066	97.2	11	10.4	8.8	0	0	0		NSW Government (2024); DHAC (2025d); Healthdirect (2025); DHAC (2025e); Branley (2022); DHAC (2025f)
		Blood	65060	13.3	2	7.9	6.7	0	0	0		
		Diabetes	66545	13.4	1	15.8	13.4	0	0	0		
	Morphology scans		55065	491.9	3	N/A	88	13.2	0	62.75	Alternative formulae (calculated with Medical Costs finder for obstetrician cost continuity): Insurer MBS = 0.15 * Medicare *Consumer Gap = (Proportion with OOP * Average OOP) – Insurer MBS*	Queensland Government (2025); Medical Costs Finder (2023b)

Theoretical midwife-led care – Costings (part 2)

Costings overview

Care phase	Service	MBS item or alternative	*Frequency*	MBS *fee*	MBS *benefit*	*Insurer* MBS	*Insurer gap*	*Consumer gap (OOP)*	*Total*	Further supporting assumptions	Sources
Labour and birth - essential	Labour management up to 30hrs	82120	1	$1,716.450	$1,287.30	$429	$326.10	$68.70	$2,111.20		DHAC (2025g)
	Conduct birth if occurs										
	Immediate postpartum care										
	Private Hospital fees	PHA data	1	N/A	N/A	N/A	$7,480.60	$263.60	$7,744.20	Alternative to standard formula: Observed division between OOP and insurer contribution based on PHA data Assume no MBS contribution to private hospital fees	PHA Data
Postnatal - essential	Support visits	82130	10	$60.60	51.7	$9.10	$11.60	$2.40	$748.50		DHAC (2025h)

Method and assumptions: Cost savings from the bundled care model

Component	Rationale	Calculation and assumptions	Source
Practitioner substitution	• Cost reduction from substituting out obstetrician for a midwife as lead clinician in a bundled model. • Savings from reductions in pregnancy management, consultation, and birth fees at antenatal, labour and birth, and postnatal maternity phases	• Cost of current private maternity care estimated based on Medical Cost Finder and MBS data. • Cost of potential private midwife care estimated based on MBS data and fund data provided by Private Healthcare Australia to estimate the gap applied in addition to the MBS. • Savings from practitioner substitution calculated by subtracting the cost of potential private midwife care from the cost of the current private maternity care.	Private Healthcare Australia (2024);
Bundled pricing	• Cost reduction relative to non-bundled, fee-for-service midwife-led care models • Savings from adherence to protocols; shifts to team-based care; greater degree of care coordination; educed waste and errors; development of organisational capability; development and utilisation of data systems; and greater transparency and accountability	• Bundled pricing in alternative markets reduces costs by 5 to 10%. • A mid-point of 7.5% has been used. • 7.5% cost reduction has been applied to all services.	Damberg et al. (2014); Cavalieri et al. (2013)

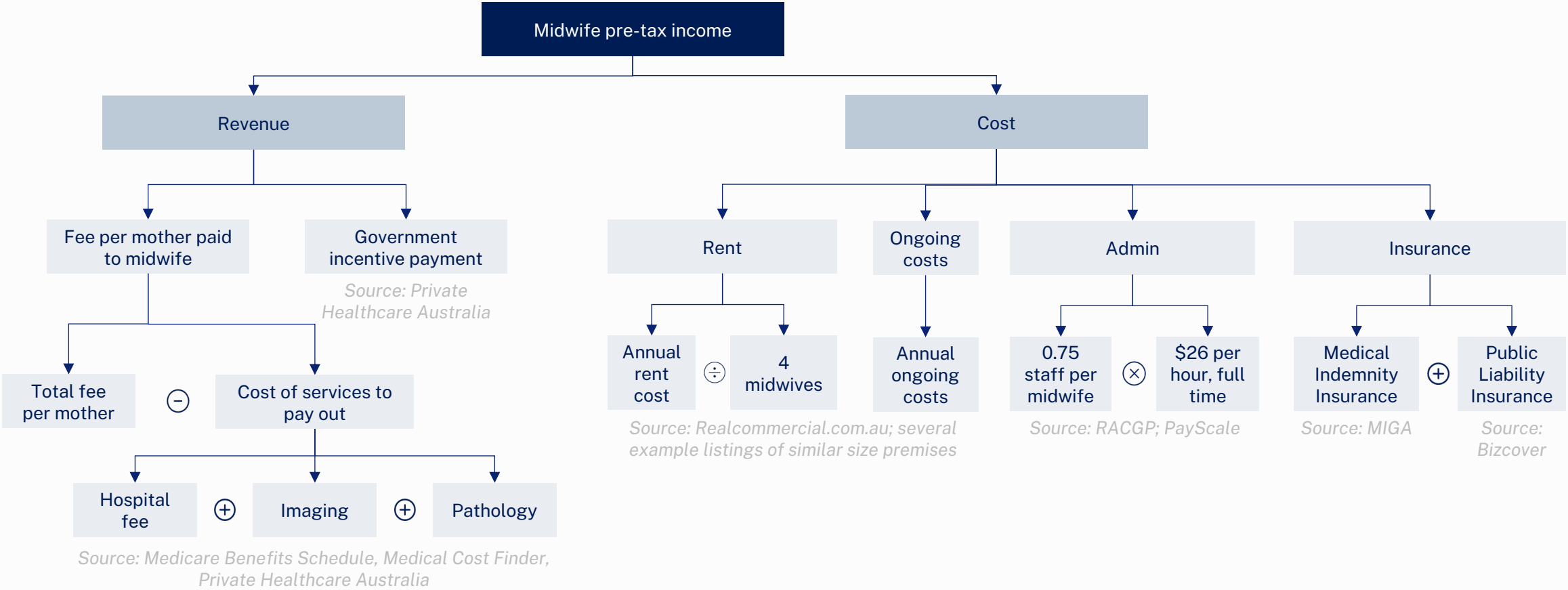
Practitioner contracting	• Cost savings in imagining and pathology via increased bargaining and purchasing power of the lead-clinician	• Assumes that lead practitioners would develop agreements with service providers in the same way private health insurers form agreements with hospitals.
		• Out-of-pocket costs for medical services vary based on whether an agreement is in place:
		  • Known gap agreement: $267 average out-of-pocket cost.
		  • No agreement: $135 average out-of-pocket cost.
		• Agreements save 49% in out-of-pocket costs
		• In the case of a lead practitioner forming agreements with service providers, asses a 20% saving in out-of-pocket cost to account for the size difference between a large insurance company and a lead practitioner.
		• 20% saving applied to services not covered by existing insurer-hospital agreements. Saving is only applied to imaging services as a result.
			APRA (2024) Medical Gap Statistics; Friedberg et al. 2015; De Bakker 2012; Charlesworth 2012; Eapen 2011; Harris (2025)

Method and assumptions: Potential earnings for midwives

Component	Rationale	Calculation and assumptions	Source
Current midwife salary	• Salary would align to a Clinical Midwife Specialists (CMS) as this role would have the necessary skills for midwife-led care.	• Assumes 35 hours per week across 47 working weeks per year. • Assumes figures are before tax, excluding superannuation contributions. • Uses an example job advertisement from Seek.com for a Clinical Midwife – Antenatal Care which has an advertised salary of $54.45 - $58.30 per hour, plus super. Used the upper bound of this salary to be conservative. Other job advertisements also in private hospitals reflected similar pay scales.	Department of Health (2024), Australian Nursing and Midwifery Association (2023).
Potential earnings	• Midwives in Australia would provide care to the same number of mothers as is provided in comparable systems overseas.	• Midwives in New Zealand see 40 to 50 mothers a year. • Lower bound of 40 mothers is used here to provide conservative estimate of earning potential.	Gilkinson, A, et al. (2018)
	• Midwife group practices typically are made up of 4 midwives	• Rent, ongoing costs, admin costs and public liability insurance divided over 4 midwives in an example group practice	Women's Healthcare Australasia (n.d.)
	• Midwives would continue to access medical indemnity insurance under the current offering from MIGA which is the sole provider of professional indemnity insurance to eligible privately practicing midwives under the Federal Government's Midwives Insurance Scheme.	• The maximum annual cost of insurance for a full time privately practicing midwife is fixed by agreement with the Commonwealth of Australia at $7,500 (for midwives earning $90,000 or more).	MIGA (2025)
	• Cost of public liability insurance will be divided across the midwives within the group practice.	• Cost of health and medical public liability insurance of $84 per month, to a cost of $252 per annum	Bizcover (n.d.)
	• A midwife group practice would require similar space (in square metres) as a General Practice which according to the RACGP would require approximately 50 square metres per GP.	• Approximately 200 square meter medical and consulting practice would cost between $90,000 to $100,000 including GST per annum according to listings with prices on Realcommercial.com.au. $100,000 assumed as rent cost for calculations. • Outgoings add an additional 20%, based on advertised outgoings on property listings. This amounts to approximately $20,000.	Realcommercial.com.au (2025A); Realcommercial.com.au (2025B); Realcommercial.com.au (2025C)
	• According to the RACGP, approximately 1.5 practitioners per admin staff member is sufficient.	• Assume 0.75 admin staff per midwife • Median hourly income for a medical office administrator is $26.43 • Assumes 38-hour, 52-week year for admin staff	RACGP (2018)

Income for midwives working as lead practitioners delivering bundled care is determined based on revenue earned from payers less costs of running a business

Driver tree of midwife income, when working in a four-midwife group practice



We used a log-log regression model with fixed effects to estimate the impact of lower OOP costs on private births

Using regional data on hospital births and costs by electorate over time, provided by PHA, and ABS data on populations and income by LGA, the effect of out-of-pocket costs on the uptake of private births could be estimated with a fixed effects regression.

Using digital boundary files provided by the ABS, hospital data recorded at the electorate level was mapped back to LGAs, using the 2021 standards. The number of births in an electorate were divided proportionally among component LGAs based on the area of overlap. The average out of pocket cost per birth in a hospital was applied equally across all LGAs. This mapping enabled a regression of the number of births in an LGA per regional population, on the average out-of-pocket cost per birth, controlling for other factors.

Since only in-hospital out-of-pocket costs were available at this level of granularity, an implicit assumption in this model is that out of hospital out-of-pocket costs scale proportionately by region and year with in-hospital out-of-pocket costs. This is a distinct limitation of the model

Using this approach, the model estimates that a 1% increase in out-of-pocket costs reduces the uptake of private births by 0.86%. This result was robust to variations in the control variables and choice of fixed effects.

Summary of the model and regression outputs

$$For\ each\ LGA\ (i) and\ year\ (j),$$

$$ln(Births\ p.c.)_{ij} = \beta_1 * ln(OOP\ costs\ per\ birth)_{ij} + \beta_2 * ln(Income\ p.c.)_{ij} + \beta_3 * (Women\ aged\ 20\ to\ 40\ as\ \%\ of\ pop)_{ij} + \alpha_i + \gamma_j + \varepsilon_{ij}$$

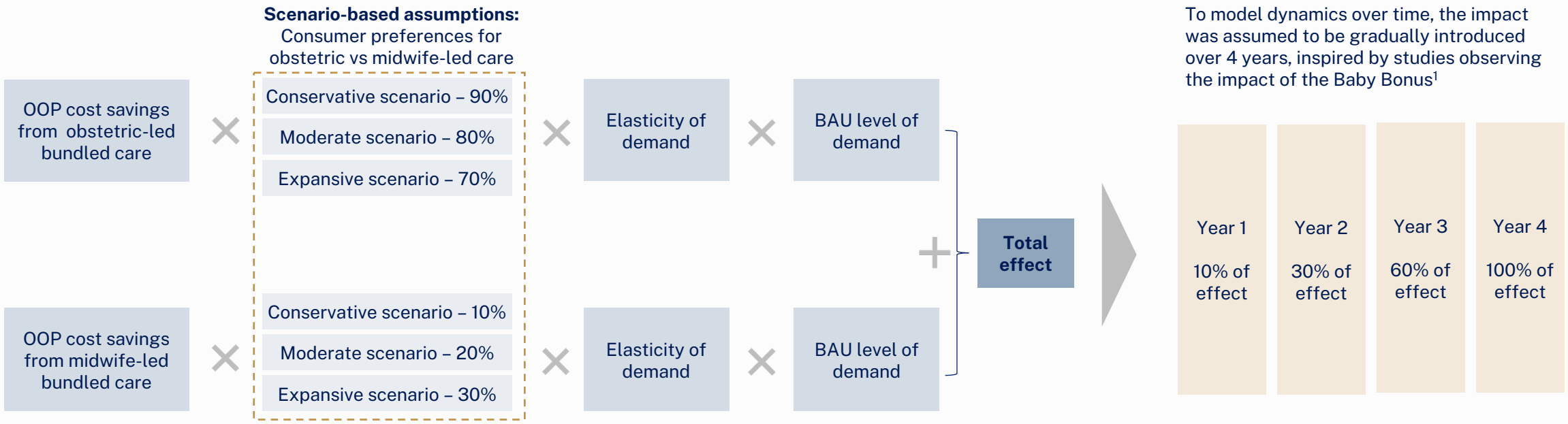
$$Where:$$
$$\gamma_j\ represents\ time\ fixed\ effects, and$$
$$\alpha_i\ represents\ regional\ fixed\ effects^1$$

VARIABLE	CATEGORY	COEFFICIENT	P-VALUE	STD ERROR	DATA SOURCE
$ln(OOP\ costs\ per\ birth)$	-	-0.862***	0.000	0.134	PHA data
$ln(Income\ p.c.)$	-	-0.499	0.198	0.387	ABS (2024)
$Women\ aged\ 20\ to\ 40\ as\ a\ \%\ of\ pop$	-	-2.208**	0.031	1.021	ABS (2024)

1 Despite the subscript, regional fixed effects were aggregated to just five regions: Inner metropolitan, Outer metropolitan, Provincial and Rural. This was done after conducting sensitivity analysis, to generate a more parsimonious model and to reduce multicollinearity with other control variables.

The model provided an estimate of the elasticity of demand for private maternity care, enabling an estimate of the impact of bundled care on demand

Driver tree of the uptake of private maternity care under bundled care

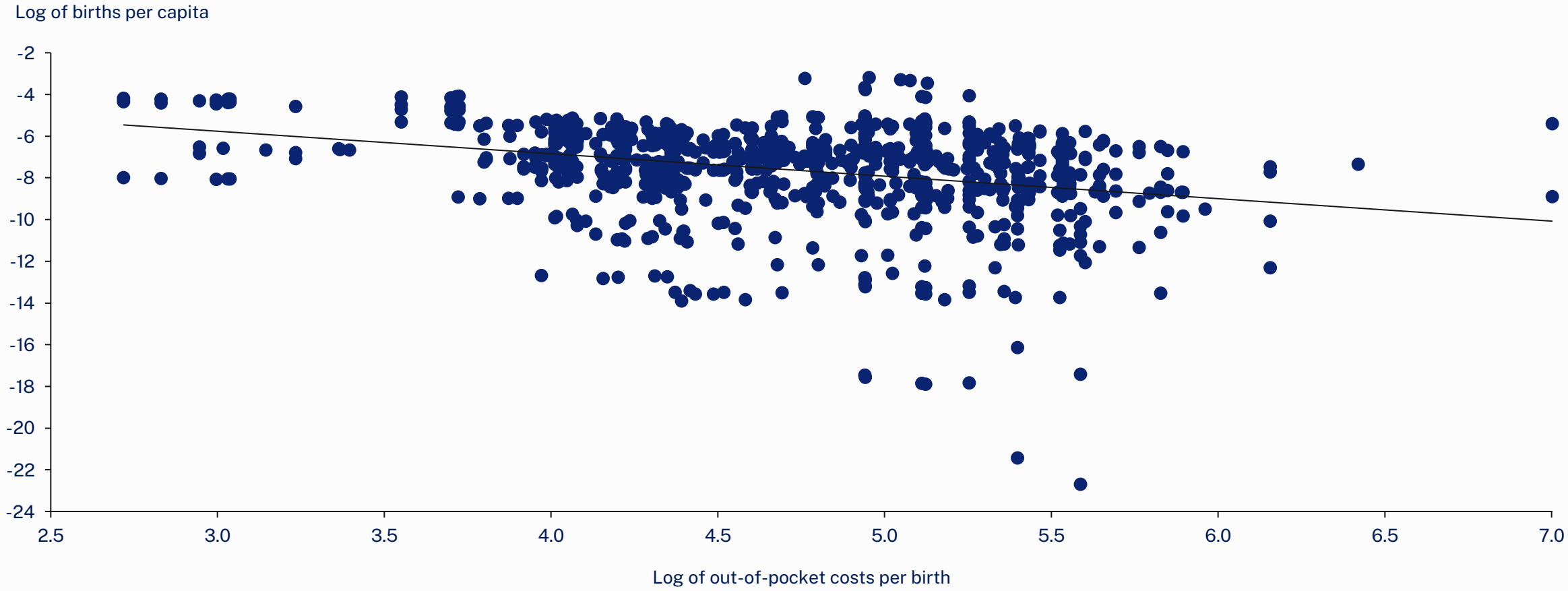


1 McCrindle (2013); Drago et al. (2009)

The relationship between the uptake of private maternity care and out-of-pocket costs display an intuitive negative trend

Log of private births per capita versus log of out-of-pocket costs per hospital birth

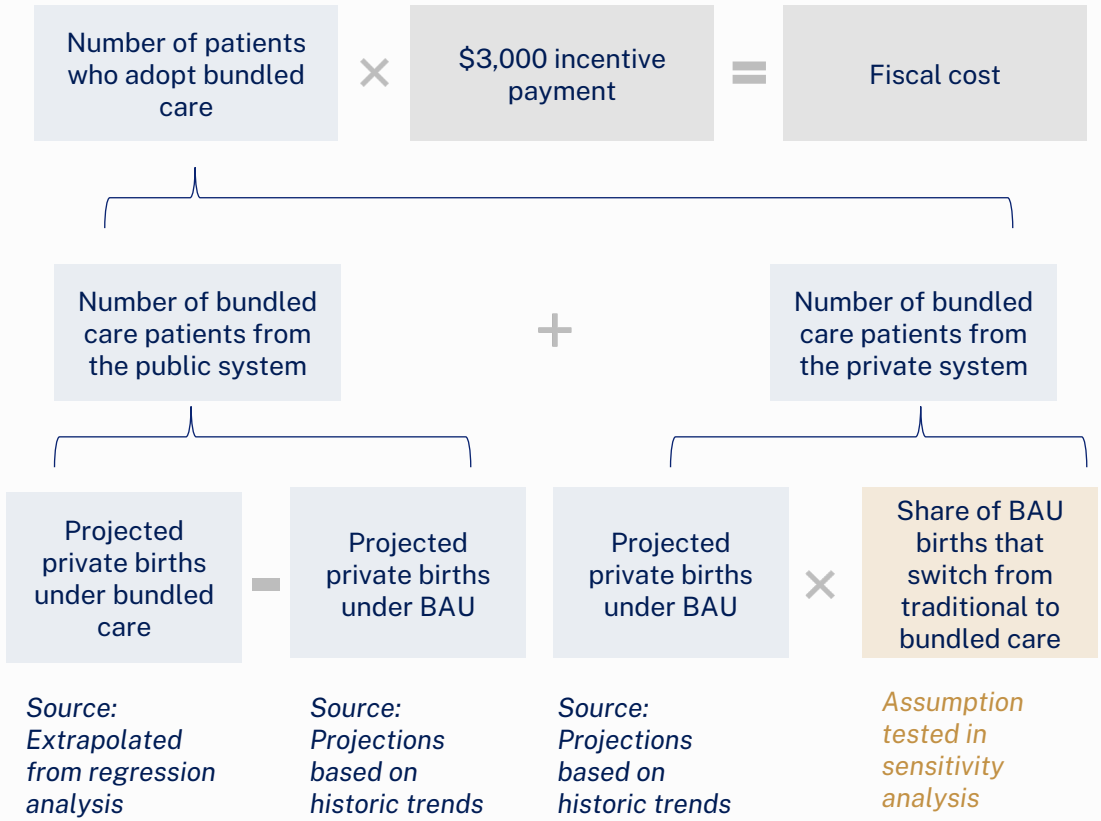
By LGA



Source: PHA data; Mandala analysis

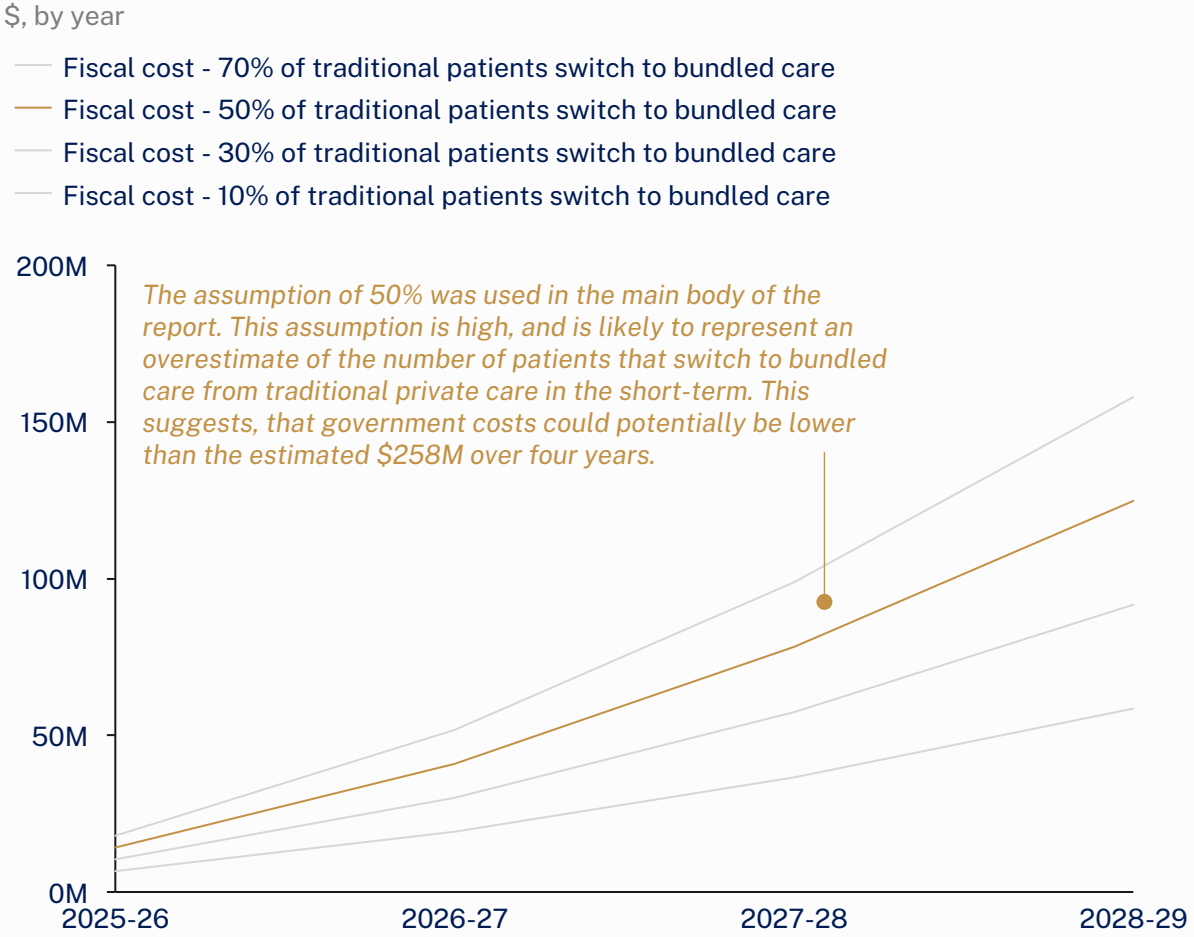
The fiscal cost of bundled care is sensitive to the number of patients that actively switch from traditional private care models, to bundled care

Calculation for estimating fiscal cost of bundled care



Source: Mandala analysis

Fiscal cost of bundled care – sensitivity analysis



Source: Private Healthcare Australia (2025) *Budget submission 2025-26 Maternity services*; Mandala analysis

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