DeltaPearl Partners

The Value of the Australian Government Rebate on Private Health Insurance

Economic Analysis and Policy Considerations for Australia's Dual Healthcare System

Prepared for Avant Mutual

18 August 2025

Avant
By doctors for doctors

DeltaPearl Partners

DeltaPearl Partners is a professional services firm specialising in:

- ECONOMICS
- PUBLIC POLICY
- STRATEGY
- CORPORATE ADVISORY

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Preface

Avant invited DeltaPearl Partners to analyse the impacts of potential alterations to value of the Australian Government's Private Health Insurance (PHI) Rebate scheme which incentivises and subsidises PHI coverage for Australian private health insurance policy holders. Avant has a particular interest in this area given it is Australia's largest doctor-owned organisation with over 95,000 members across all GP and non-GP specialities, providing medical indemnity, PHI and a range of other services to these doctors. It has commissioned this report as a contribution to the public policy debate currently occurring regarding private hospital viability and the role of PHI in contributing to the viability of the private healthcare sector.

Australia's world-class health system represents a balance between public and private providers. The Government directly funds the public health sector and relies on the PHI rebate scheme to support the private health sector.

At present, Australian public hospitals are at historically high levels of activity, with prolonged waiting lists for specialist consultations and planned surgery. Some procedures now exceed recommended wait times by over 300 per cent. The PHI rebate is one of the Australian Government's key mechanisms for reducing pressure on the public healthcare system and for promoting individual responsibility for health. The PHI rebate scheme was originally instituted on the grounds that it would help "ensure a viable and sustainable private health sector, while also improving the capacity of the public hospital system to deliver services to the Australian community."

The Australian Government's contribution to private health insurance through the rebate effectively reduces the out-of-pocket costs borne by PHI policyholders, thereby making private health insurance more affordable and encouraging participation in the PHI system.

Private health insurance in Australia plays a significant role in the healthcare system, offering coverage for hospital treatments and ancillary services, with the majority of payments from private health insurers being for hospital treatments. Private health insurance often allows patients to choose their own doctors, access private rooms, and avoid long waiting lists for elective surgeries. Currently, around 45.3 per cent of the population hold private health insurance.

The private hospitals perform approximately more than two thirds of all elective procedures in Australia and act as a crucial 'safety valve' that alleviates pressure on the public hospital system in the context of rising public hospital waiting lists. Thus, the private hospital system plays a distinct and complementary role to the public hospital system. Public hospitals focus on emergency care, complex and acute cases, and training medical professionals, while private hospitals tend to specialise in elective procedures, maternity, and psychiatric care.

However, as this report will show, the real value of the PHI rebate is declining. Consequently, people are shifting their PHI coverage down to lower tiers of insurance coverage, and the private health sector is experiencing financial strain, as evidenced by recent closures of private hospitals.

Accordingly, this report analyses the economic and fiscal impact across Australia's health sector of four potential scenario changes to the PHI rebate.

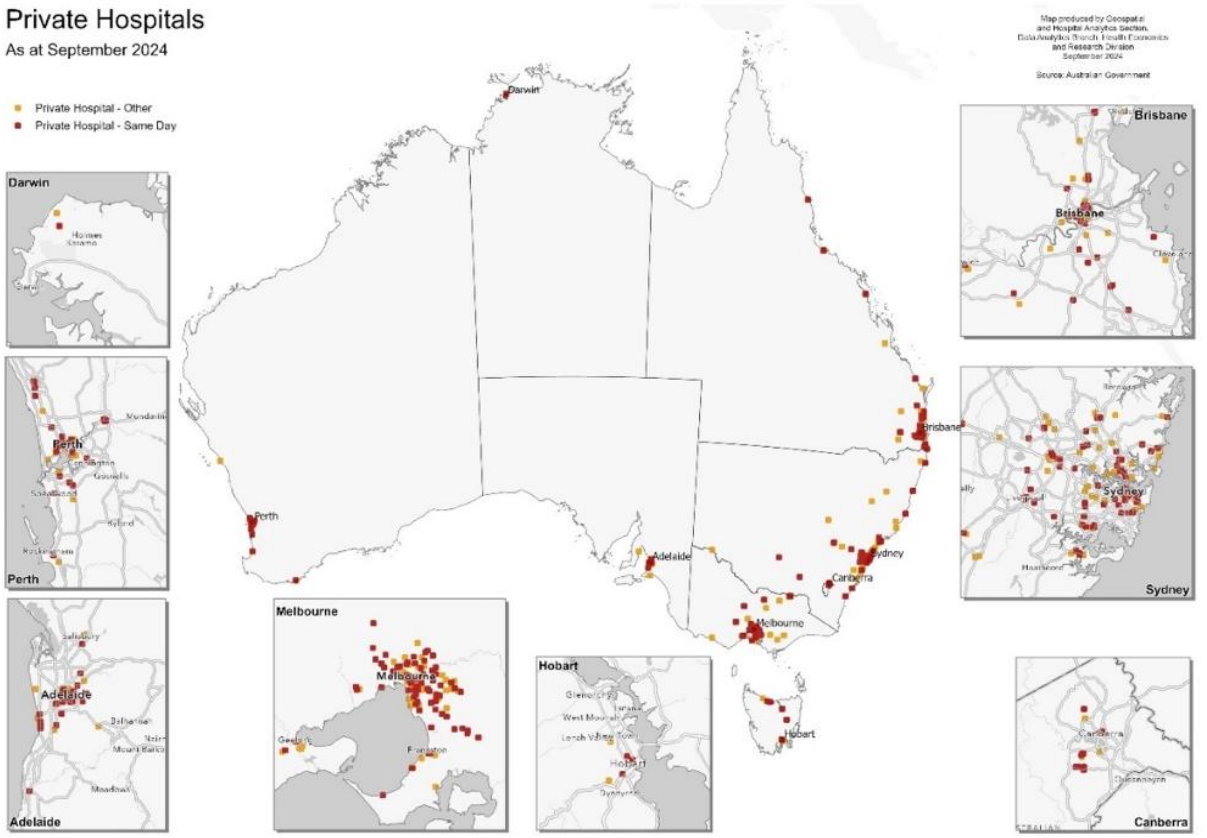
Executive Summary

The Foundation of Australia's Dual Healthcare System

A foundational principle of the Australian health system is that every Australian has timely and equitable access to the best possible care. In common with all health systems globally, the Australian system has evolved over time; its current form is a balanced model that relies on both public and private health sectors to deliver comprehensive, equitable care. This dual system is not merely a policy choice but a deliberate architecture with the overarching goal of maximising healthcare capacity, patient choice, fiscal sustainability and health outcomes. At the heart of this system lies a symbiotic relationship where private healthcare serves as an essential 'safety valve' for the public healthcare system. This structure is underpinned by a suite of incentives, penalties and transfers designed to preserve and protect this equilibrium.

The structure of the national health system has important implications for the efficient and healthy functioning of Australia's economy and society. Private hospitals perform approximately 67 per cent of all elective inpatient procedures in Australia, managing 1.8 million procedures annually that would otherwise occur in the already-strained public system. This dual system is designed to allow public hospitals to focus on emergency care, complex cases and medical training, while private hospitals specialise in elective procedures as well as maternity and psychiatric care – areas where access is becoming increasingly limited. Without this complementary structure, the public hospital system would face an insurmountable increase in demand that could not be met within existing capacity constraints.

Figure 1. Map of private hospitals in Australia[1]



[1] Department of Health, Disability and Ageing, *Private Hospital Sector Financial Health Check* (2024), https://www.health.gov.au/resources/collections/private-hospital-sector-financial-health-check-resources.

Private Health Insurance: The Cornerstone of System Viability

PHI is the financial backbone that makes private healthcare accessible to millions of Australians. Without PHI, private hospital care would be limited to only the wealthiest citizens, effectively eliminating the private sector's capacity to support the broader healthcare system. The private health insurance model spreads financial risk across the population, transforming potentially unaffordable healthcare costs – such as, for example, an individual $30,000 non-elective surgical procedure – into manageable monthly premiums.

The PHI rebate cost the Commonwealth Government approximately $7.6 billion in 2024–25, representing just 2.8 per cent of all health expenditure but generating system-wide benefits. This investment directly subsidises private healthcare participation, ensuring a substantial portion of healthcare demand is met outside the public system. Every Australian with PHI effectively reduces demand on public hospitals, shortens waiting lists for public hospital consultations and procedures, and lowers government healthcare expenditure.[2]

The regulatory framework supporting PHI policy arrangements – including community rating, risk equalisation and mandatory acceptance policies – aims to ensure the private system remains accessible and sustainable. However, this framework can only provide these system-wide benefits when supported by adequate participation rates across all age groups – particularly younger, healthier Australians whose participation balances the risk pool. Declining or unbalanced participation rates introduces greater risk to the system.

Investment Returns: The Economic Case for the PHI Rebate

The analysis contained in this report confirms PHI rebates represent a highly cost-effective investment in Australia's healthcare system. Every dollar invested in the rebate returns more than a dollar in savings on public hospital expenditure, making it an efficient mechanism for leveraging private, individual contributions to support the entire health system.

The PHI rebate serves as the ‘carrot’ to incentivise the uptake of PHI. The ‘stick” is the Medicare levy surcharge coupled with lifetime health cover loading. The ‘stick’ penalises individuals for delaying taking out PHI as well as wealthier individuals for not holding PHI. However, avoiding these penalties only requires a basic level of hospital coverage; this tends to encourage individuals to take out a bare-minimum Basic tier policy. The PHI rebate, in contrast, not only provides incentive to hold PHI but also to take out higher tiers of coverage.

The PHI rebate's economic value becomes even clearer when examining potential costs that the healthcare system would incur without it. Modelling shows without the existence of the PHI rebate an additional $74.3 billion in healthcare costs would be transferred to the public system over a decade – demonstrating that the rebate not only pays for itself but generates substantial net savings. ***Any reduction in the annual value of the PHI rebate would cost the Australian Government more than it saves – and that loss would be borne mostly by the states and territories.***

Conversely, therefore, our modelling demonstrates that increasing the value of the rebate would further enhance system-wide benefits, making it a cornerstone policy for maintaining a balanced and sustainable national healthcare system that effectively combines public and private resources. Our modelling results demonstrate the scale of the expected changes by testing four scenarios against the current situation (Base Case). The four selected scenarios are considered over a 10-year projection period, including:

- Base Case – No change to the PHI Rebate.
- Scenario 1 – Complete removal of the PHI, staggered over a 5-year period.
- Scenario 2 – Partial removal of the PHI (e.g., to fund a public dental scheme).
- Scenario 3 – Freezing PHI rebate rates at their current levels.

[2] As discussed in the report, the Medicare Levy surcharge imposes tax penalties on those above a certain income who do not hold PHI.

- Scenario 4 – Return PHI rates to their levels before the introduction of the rebate rate adjustment factor (RAF).

The results are shown in the table below. All scenarios show government are better off with the PHI rebate investment.

Table 1. Long-run annual impact of each policy scenario on net government expenditure to maintain health outcomes[3]

	Rebate Expenditure[4]	Public Hospital Expenditure	Net Governmental Expenditure[5]	Return per $1 Spent / Saved on Rebate
Scenario 1 – Full rebate removal	−$4.4 billion	+$7.9 billion	+$3.5 billion	−$1.80
Scenario 2 – Partial rebate removal	−$2.3 billion	+$3.6 billion	+$1.3 billion	−$1.57
Scenario 3 – Freezing rebate rates	+$0.8 billion	−$1.0 billion	−$0.2 billion	$1.25
Scenario 4 – Reinstating rebate rates	+$2.4 billion	−$2.9 billion	−$0.5 billion	$1.21

Over the **10-year period** from 2026–27 to 2035–36, the modelling reveals significant variations in outcomes across the four scenarios:

- **Scenario 1: Full rebate removal** would see over 8 million individuals either downgrading or dropping out of PHI, resulting in approximately 14.3 million fewer episodes treated privately and an estimated $74.3 billion in reduced private medical expenditure. While the government would save approximately $43.6 billion on rebate expenditure,[6] the need to replace this private spending would create a net negative fiscal position of $30.7 billion.
- **Scenario 2: Partial rebate removal** would see approximately 3.7 million individuals downgrading or dropping out of PHI, leading to approximately 6.5 million fewer episodes treated under private healthcare and an estimated $33.7 billion in reduced private medical expenditure. The approximately $22.6 billion in rebate savings[6] would be overwhelmed by the costs of replacing private spending, resulting in a net fiscal loss of $11.1 billion.
- **Scenario 3: Freezing rebate rates** would see over 1 million individuals upgrading or retaining PHI, leading to1.3 million additional episodes treated privately and an estimated $6.7 billion in increased private medical expenditure.[6] The additional $5.1 billion in rebate costs would be offset by reduced public hospital demand, creating a positive fiscal position of $1.6 billion, plus reduced deadweight loss from lower taxation requirements.
- **Scenario 4: Reinstating rebate rates** amplifies these benefits. Over 3 million individuals would upgrade or retain coverage, producing 4.6 million additional private episodes and $24.2 billion in increased private expenditure. Despite $19.6 billion in additional rebate costs,[6] the net fiscal position would be positive at $4.6 billion, plus the reduced deadweight loss from taxation.

[3] DeltaPearl Partners Modelling, Appendix 6.

[4] Hospital Component.

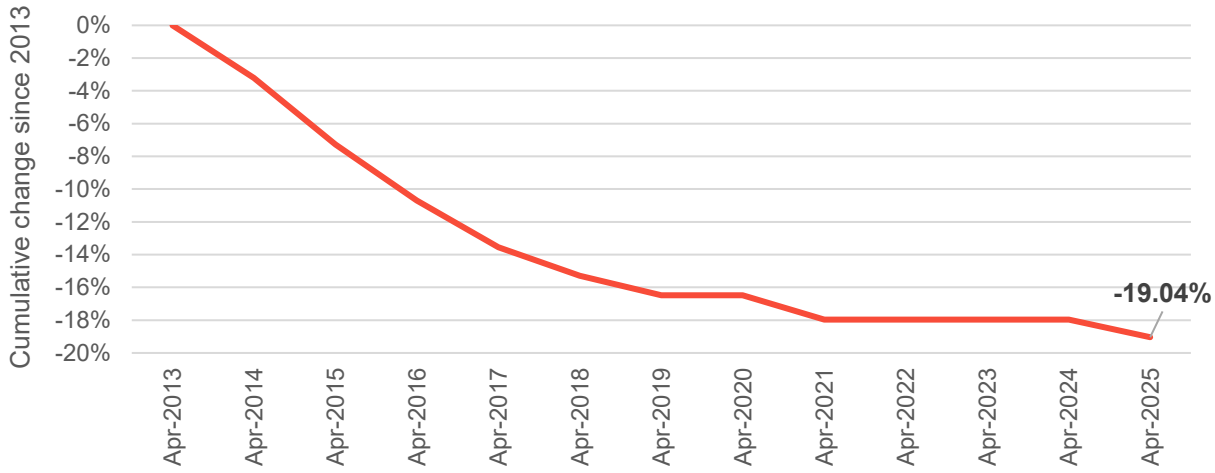
[5] Combined Commonwealth Government and State and Territory Governments' expenditure.

[6] Expenditure on the hospital component of the rebate.

The Gradual Decline in the Value of the PHI Rebate: 19 Per Cent Decline Since 2014

In 2014 the Australian Government introduced the rebate adjustment factor (RAF) which has had the effect of structurally eroding the rebate's value to each eligible PHI policyholder. Since 2013, the rebate rate paid to individuals has cumulatively declined by approximately 19 per cent, thus increasing the effective cost of health insurance premiums for policyholders. This rebate rate erosion to eligible policy holders occurs through a formula (incorporating the RAF) which caps the growth in value of the rebate below insurance premium inflation, thus ensuring that government liability is not only contained but gradually and persistently shifted costs to consumers. The RAF mechanism means that during periods of high medical and regular inflation – precisely when healthcare costs are rising fastest – consumers simultaneously face the largest increases in their out-of-pocket insurance costs.

Figure 2. Cumulative percentage change in rebate rates since 2013 [7] [8] [9]



The consequences of the decline in percentage of rebate paid to eligible PHI policy holders are already visible since 2013:

- Base tier rebate rates have fallen from 30 per cent to 24.28 per cent for those under 65 years.
- Premium affordability has decreased substantially for middle-income families.
- Younger demographics are increasingly finding PHI unaffordable.

The Commonwealth Government is reducing budget outlays through the reduced PHI rebate payments. Accounting for inflation, total Commonwealth Government spending on the PHI rebate has decreased by 6.0 per cent in real terms and decreased 4.8 per cent in real health terms when accounting for health and general inflation between 2014 and 2024, as shown in Figure 3.[10] However, as the modelling shows, these federal budgetary savings are effectively shifting costs to the state and territory governments and causing an increase in the elective surgery waiting lists.

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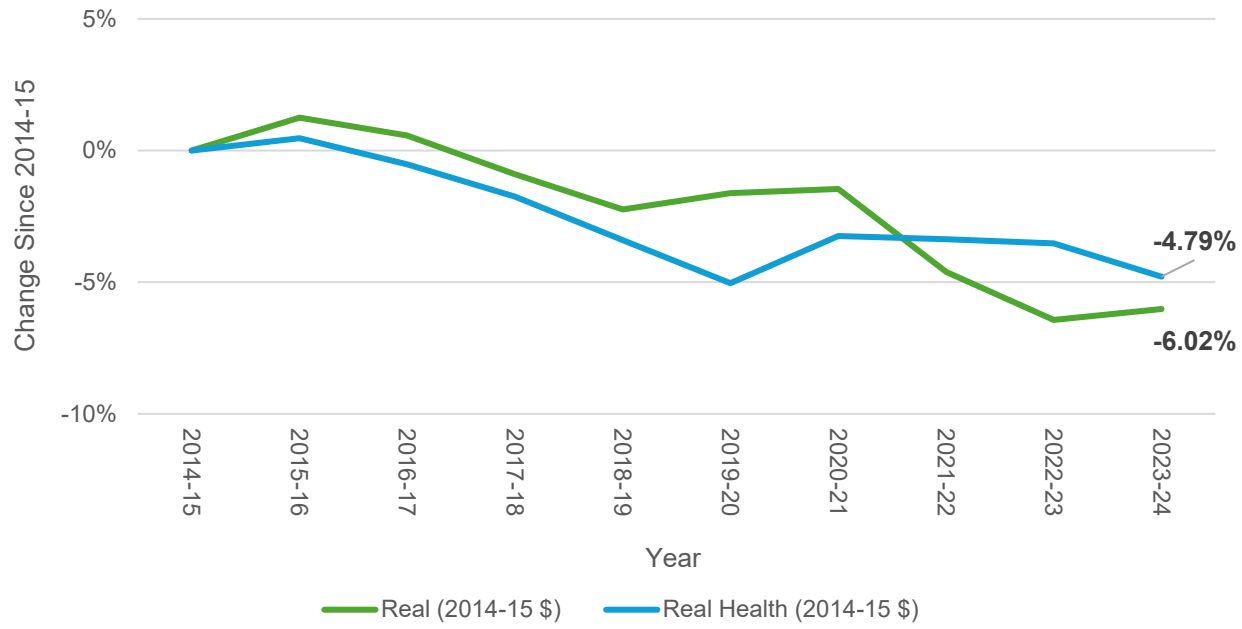
[7] Australian Taxation Office, *Income Thresholds and Rates for the Private Health Insurance Rebate* (2025), https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/private-health-insurance-rebate/income-thresholds-and-rates-for-the-private-health-insurance-rebate.

[8] Department of Health, Disability and Ageing, *Average Annual Price Changes in Private Health Insurance Premiums* (2025), https://www.health.gov.au/resources/publications/average-annual-price-changes-in-private-health-insurance-premiumsinsi.

[9] Australian Bureau of Statistics, *Consumer Price Index, Australia* (2025), https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australiahttps://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia.

[10] Over the period between 2014-15 and 2023-24, health inflation has (unusually) increased by less than general inflation. This is primarily due to a period of high general inflation following Covid between 2021 and 2023.

Figure 3. Change in Commonwealth PHI rebate expenditure in real and real health terms [11 12 13 14 15 16]



The 'Tier Slide' Phenomenon and System Destabilisation

Since the introduction of the standardised tier system for PHI in 2020, there has been a downward 'tier slide'. This means that consumers, in order to lower their monthly premiums, steadily downgrade their policy coverage from comprehensive (Gold) to lower (cheaper) PHI tiers. The downward tier slide trend is particularly pronounced among younger, healthier Australians who represent the low-risk participants essential for insurance pool stability.

Gold tier coverage has declined steadily while Bronze tier coverage has increased, fundamentally altering the national coverage profile of PHI. The tier slide shift is especially problematic for services such as maternity care, which requires Gold or Silver Plus coverage. The result is a concerning cycle where:

- Reduced health coverage leads to lower demand for private services.
- Private hospitals become financially unviable and close facilities.
- Remaining private options become more expensive due to reduced economies of scale.
- More consumers drop or downgrade coverage, thereby reducing the insurance pool.

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[11] Department of Health, Annual Reports: 2014-15 to 2021-22

[12] Department of Health and Aged Care, Annual Reports: 2022-23 and 2023-24

[13] Australian Taxation Office, Commissioner of Taxation Annual Reports: 2014-15 to 2024-25

[14] Australian Institute of Health and Welfare, Health Expenditure Australia 2022–23

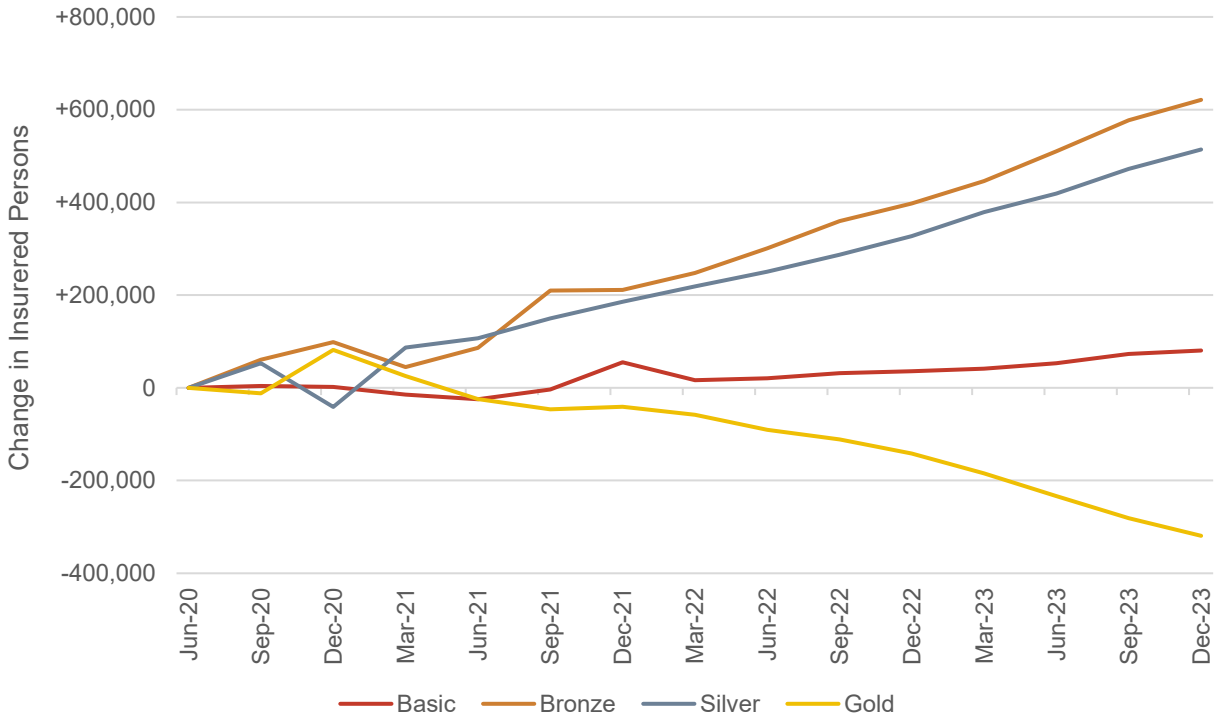
[15] Australian Bureau of Statistics, Consumer Price Index, Australia

[16] Notes:

- Real PHI rebate expenditure is adjusted for CPI.
- For health inflation: 2014-15 rebate expenditure was indexed by the Australian Institute of Health and Welfare Total Health Price Index (THPI) from 2014-15 to 2022-23. For 2022-23 to 2023-24 the CPI Health Group Index was used as the THPI was unavailable.

This tier slide threatens to reintroduce the classic insurance 'death spiral' where rising costs drive away low-risk participants, further increasing average care costs and driving away the next tier of participants until the system becomes unsustainable.

Figure 4. Cumulative change in PHI policy holders in each product tier[17]



Visible System Breakdown: Hospital Closures and Public Sector Strain

The risks of rebate erosion and tier slide are now visibly affecting the supply of private healthcare services nationally. Since 2018, at least 18 private maternity units have closed across Australia, with expert predictions that private maternity services may be extinct by 2030 without policy intervention.[18] Similar closures are emerging in psychiatric care despite rapidly increasing demand for mental health services.

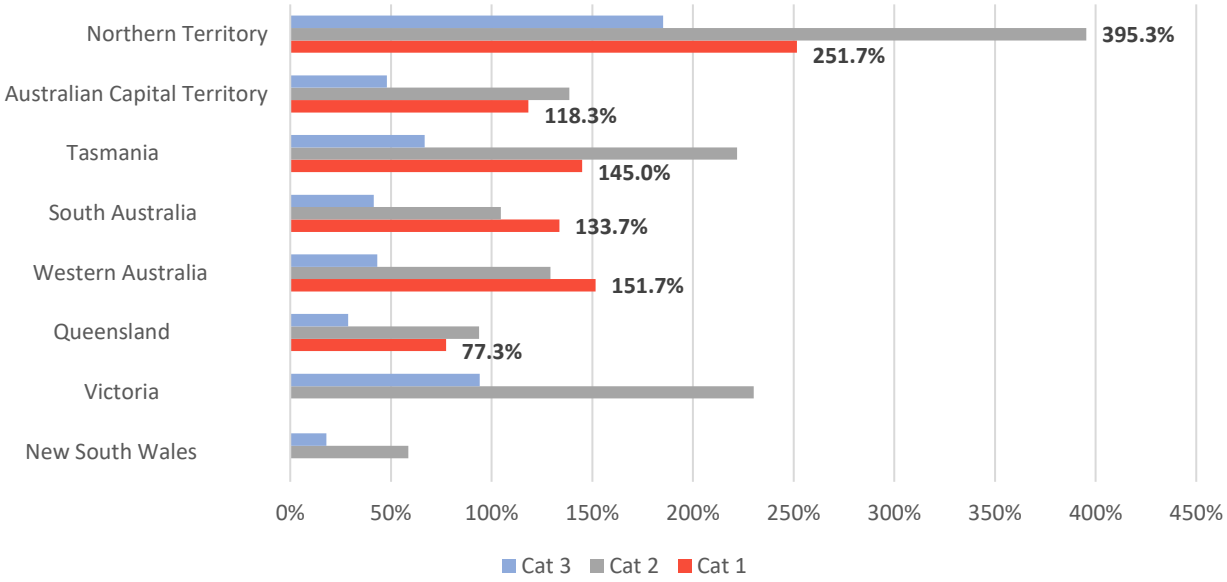
Private hospital closures create immediate pressure on public hospitals, for example:

- The Darwin Private Hospital closure of maternity services in June 2025 is expected to increase Royal Darwin Hospital's maternity load by 13 per cent.
- Regional areas are particularly affected by this trend, with some jurisdictions such as the Northern Territory and parts of Tasmania losing all private maternity options.
- Public hospital waiting lists are worsening, with some procedures exceeding recommended waiting times by over 300 per cent.

[17] Department of Health and Aged Care, Private Health Insurance Reform Data Quarterly Trends Reports

[18] Gino Pecoraro et al., *Private Maternity Hospitals: Extinct by the End of This Decade?* (InSight, 2024), https://insightplus.mja.com.au/2024/27/private-maternity-hospitals-extinct-by-the-end-of-this-decade/.

Figure 5. Average percent of time (days) public hospital elective surgery wait time over medically recommended wait times, by jurisdiction, 2023–24[19]



The pattern of hospital closures reveals the risk of private hospitals becoming unviable at a system level. In this situation, patient demand will continue to shift to the public hospitals, which in many cases lack the required infrastructure, staffing and funding to absorb the additional demand. This was the case in Darwin (June 2025) and likely too for Hobart (maternity services due to close in August 2025). The workforce implications of this change remain uncertain too. While some nursing and allied health staff might transition from the closed private facilities to public employment, many could leave the health sector entirely, exacerbating existing personnel shortages.

Hidden Public Hospital Waiting Lists

Public hospital strain is more severe than official statistics suggest due to the 'hidden waiting lists' that precede official surgical queues.

Often, patients wait:

- Weeks to see a GP for an initial assessment – over 20 per cent of patients report waiting between one and two weeks for an appointment.[20]

[19] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery* (2025), https://www.aihw.gov.au/hospitals/topics/elective-surgery.

[20] Slater Gordon Lawyers, *The Impact of Long GP Waiting Times* (2025), https://www.slatergordon.co.uk/newsroom/the-impact-of-long-gp-waiting-times/.

- Up to 6.5 years for specialist consultations in South Australia,[21] 5.3 years in Tasmania,[22] [23] 2.6 years in Victoria[24] and 1.5 years in Queensland.[25]
- Additional wait times on official surgical lists up to 2.9 years in the Northern Territory (NT), 1.9 years in Victoria, 1.7 years in Tasmania, 1.5 years in the Australian Capital Territory (ACT), 1.4 years in both South Australia (SA) and Western Australia (WA), 1.3 years in Queensland (QLD) and 1.2 years in New South Wales (NSW).[26]

In addition, patients requiring elective surgery face waits of up to 7.9 years in SA, 7 years in Tasmania, 4.5 years in Victoria and 2.8 years in Queensland — far beyond clinically recommended timeframes.[27] [28] [29] [30] As private sector hospitals close, public hospital wait times will inevitably lengthen.

Conclusion: A System at a Critical Juncture

Australia stands at a critical juncture where policy decisions will determine whether the successful dual healthcare model continues or collapses into a largely public system unable to meet demand, with minimal private services largely targeting wealthy Australians. In this context, the PHI rebate is not a luxury government expense but a fundamental investment in system sustainability, one that saves taxpayers substantially.

The analysis demonstrates that strengthening the PHI rebate represents the most cost-effective approach to Australia's healthcare system sustainability. Conversely, allowing continued rebate erosion risks triggering an irreversible decline in the viability of Australia's private health insurance system; this will, in turn, lessen service provision at private hospitals and overwhelm public hospitals and ultimately cost taxpayers far more than the cost of maintaining or increasing PHI rebate levels.

Immediate policy action is required to reverse PHI rebate decline, to arrest the tier slide phenomenon and to preserve the private sector healthcare capacity that has made Australia's healthcare system internationally acclaimed for both equity and efficiency. The choice seems clear: invest in maintaining the dual system or face the exponentially higher costs of managing its collapse.

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[21] SA Health, *Quarterly Specialist Outpatient Waiting Time Report* (2025), https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Our+Performance/Specialist+Outpatient+Waiting+Time+Report/Quarterly+Specialist+Outpatient+Waiting+Time+Report.

[22] Tasmanian Government Department of Health, *Estimated Wait Times, Outpatients* (2025), https://www.health.tas.gov.au/hospitals/outpatients/wait-times.

[23] DPP calculated the average and max from 123 data points in each urgency category.

[24] Victorian Agency for Health Information, *Routine First Appointments* (2025), https://vahi.vic.gov.au/specialist-clinics/routine-first-appointments.

[25] Queensland Health, *Specialist Appointments, Activity* (2025), https://www.performance.health.qld.gov.au/statewide-performance/planned-care/specialist-appointments-activity.

[26] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery*.

[27] Australian Institute of Health and Welfare, *Hospitals, Data Downloads* (2025), https://www.aihw.gov.au/hospitals/latest-updates-and-downloads/.

[28] Australian Institute of Health and Welfare, *Waiting Times for Surgery* (2025), https://www.aihw.gov.au/getmedia/4b7b0346-84b4-435c-bc91-a9beb65413f8/myhospitals-elective-surgery-data.pdf.aspx.

[29] Australian Medical Association, *Shining a Light on the Elective Surgery "hidden" Waiting List* (2022), https://www.ama.com.au/elective-surgery-hidden-waiting-list.

[30] Appendix 3 contains more detail on the data.

Key Metrics

- PHI rebate rates have declined by **19.04%** since 2013.
- Australian Government expenditure on the PHI rebate has decreased by **6.0%** in real terms, and decreased **4.8%** in real health terms, since 2014**.**
- The PHI rebate is estimated to cost the Commonwealth Government approximately **$7.6** billion in 2024-25, which represents **2.8%** of all health expenditure.
- Approximately **1.8 million** elective surgeries are performed by private hospitals, representing **67%** of all elective surgeries in Australia.
- There are **647** private hospitals in Australia, which handle **40%** of all hospitalisations, amounting to **5 million** hospitalisations in 2023-24.
- Without adjustment, it is estimated the PHI Rebate Adjustment Mechanism will push **1.066 million** people out of PHI or to a lower level of insurance coverage over the next 10 years.
- As of 2025, **45.3%** of the Australian population holds PHI hospital coverage.
- **18** private maternity units have closed across Australia since 2018.
- **40%** of hospitalisations in Australia are in private hospitals.
- In the last 30 years births occurring in private hospitals in Australia have fallen from **40%** to **22%**.
- Certain public hospital procedures now exceed recommended wait times by over **300%**.
- Consumers are sliding down the health insurance coverage scale: Since 2020 Gold level PHI coverage has fallen **14%** and Bronze PHI coverage has increased **24%**.
- The estimated additional healthcare costs that would shift to the public system over a decade without the PHI rebate are **$74.3 billion**. This would represent a cost of **$1.80** per **$1.00** saved on the hospital component of the rebate.
- According to the latest published State and Territory waiting list data, average waiting times for Category 2 and Category 3 elective surgeries now extend to **1.2 years** and **2.9 years** respectively, compared with the recommended wait times of within 90 days and 1 year.

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1. Introduction: Australia's unique dual healthcare system

Australia has a unique healthcare system that integrates both the public and private sectors to deliver comprehensive care to the community. It combines a taxpayer-funded universal healthcare system (Medicare and public hospitals) with a substantial private sector supported by individual contributions and targeted government policies. Australia's healthcare system is highly ranked internationally for its health outcomes and equity.[31]

Figure 6: Healthcare system performance rankings – Australia ranked no. 1 (Commonwealth Fund 2024) [32]

	AUS	CAN	FRA	GER	NETH	NZ	SWE	SWIZ	UK	US
Overall Ranking	**1**	**7**	**5**	**9**	**2**	**4**	**6**	**8**	**3**	**10**
Access to Care	9	7	6	3	1	5	4	8	2	10
Care Process	5	4	7	9	3	1	10	6	8	2
Administrative Efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	–	4	5	9
Health Outcomes	1	4	5	9	7	3	6	2	8	10

Public and private hospitals underpin the sustainability of the entire healthcare sector, supported by various funding sources and policy frameworks.

Public hospitals receive direct funding from the Commonwealth and State/Territory Governments through the National Health Reform Agreement (NHRA) and related agreements, ensuring universal access to essential health services.

Private hospitals are primarily funded through private health insurance (PHI) and individual contributions. The Commonwealth Government also supports private hospitals through measures such as the PHI rebate, the Medicare levy surcharge and lifetime health cover loading.[33] These policy tools reflect a deliberate policy choice to share responsibility for healthcare costs between taxpayers, individuals and insurers, while promoting consumer choice.

[31] See Appendix 2 for a more detailed overview of the Australian healthcare system ranking in global comparisons.

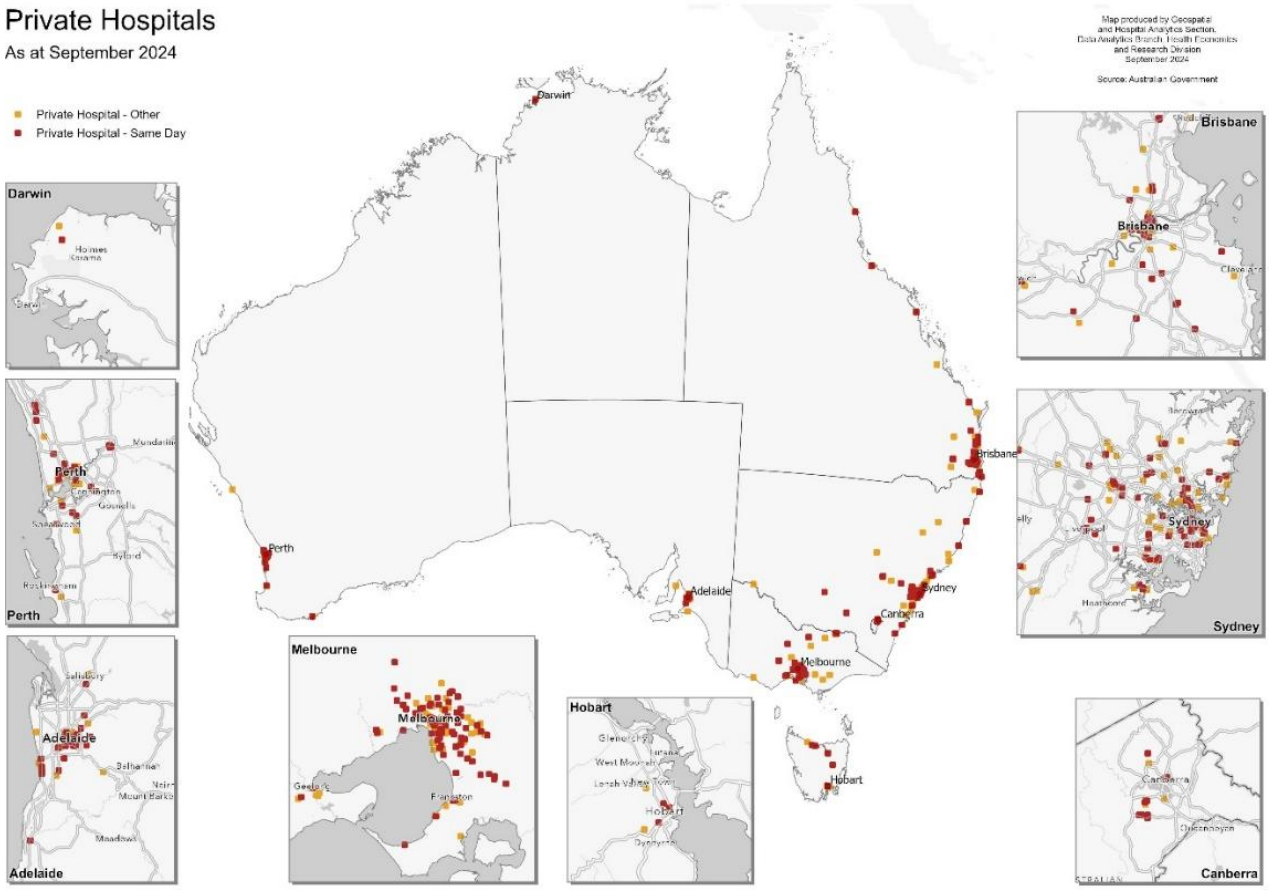
[32] David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (The Commonwealth Fund, 2024).

[33] The Commonwealth Government also contributes to the cost of medical services undertaken in private hospitals through the Medicare Benefits Scheme.

1.1. The indispensable role of private hospitals

The strength and sustainability of Australia's healthcare system relies on a complex, symbiotic relationship between public and private hospitals. In July 2024, there were 647 private hospitals in Australia providing more than 36,000 beds. A map of Australia's private hospitals is shown below.

Figure 7. Map of private hospitals in Australia[34]



Around 83 per cent of private hospitals are in metropolitan locations, 9 per cent are in regional centres and 8 per cent in rural towns. The private hospitals' share of all hospitalisations, which has remained relatively constant in recent years, is 40 per cent (5 million hospitalisations in 2023–24).[35] [36]

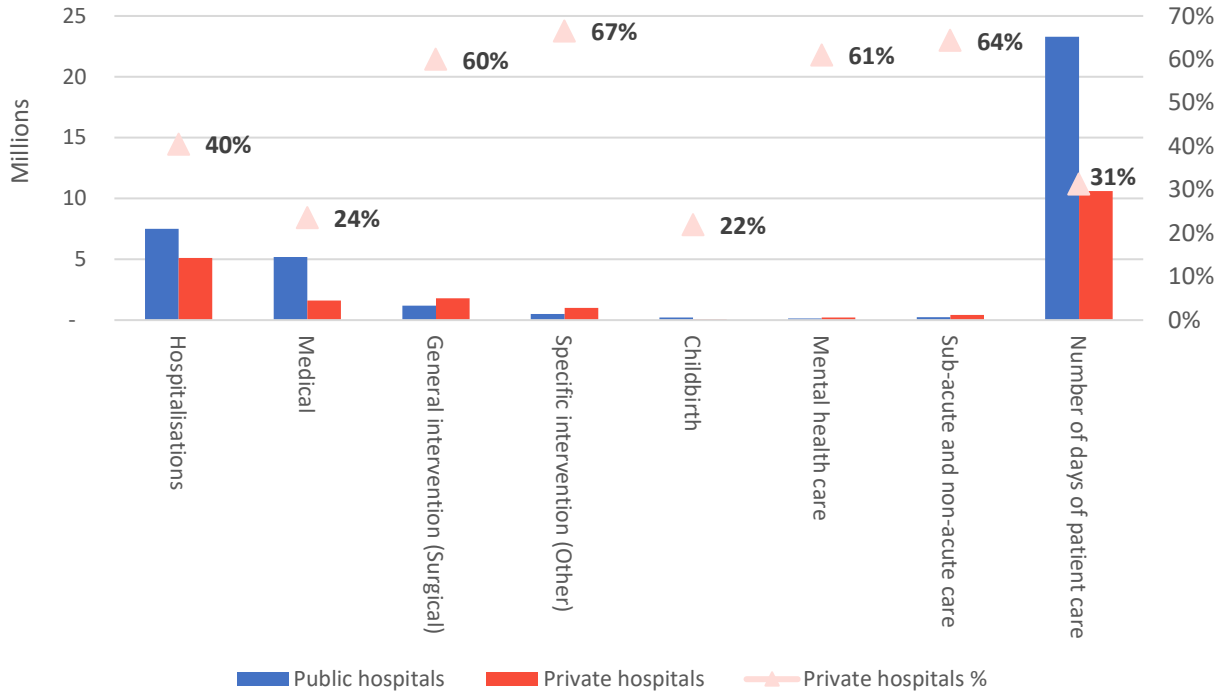
The graphic below, which provides an overview of public and private admitted care, demonstrates the division of labour between public and private hospitals. Although public hospitals manage the greater share of hospitalisations and patient care days, private hospitals are responsible for a significant part of this activity. It is evident that private and public hospitals focus on different areas of care. More specifically, private hospitals primarily handle elective/planned surgery, mental health care, maternity services, same-day procedures and specialised treatments in areas such as orthopaedics and cancer care. Conversely, public hospitals focus on emergency, highly complex and vulnerable patient care, doctor training and surgery for people who cannot afford PHI or choose to use the public system.

[34] Department of Health, Disability and Ageing, *Private Hospital Sector Financial Health Check*.

[35] Ibid.

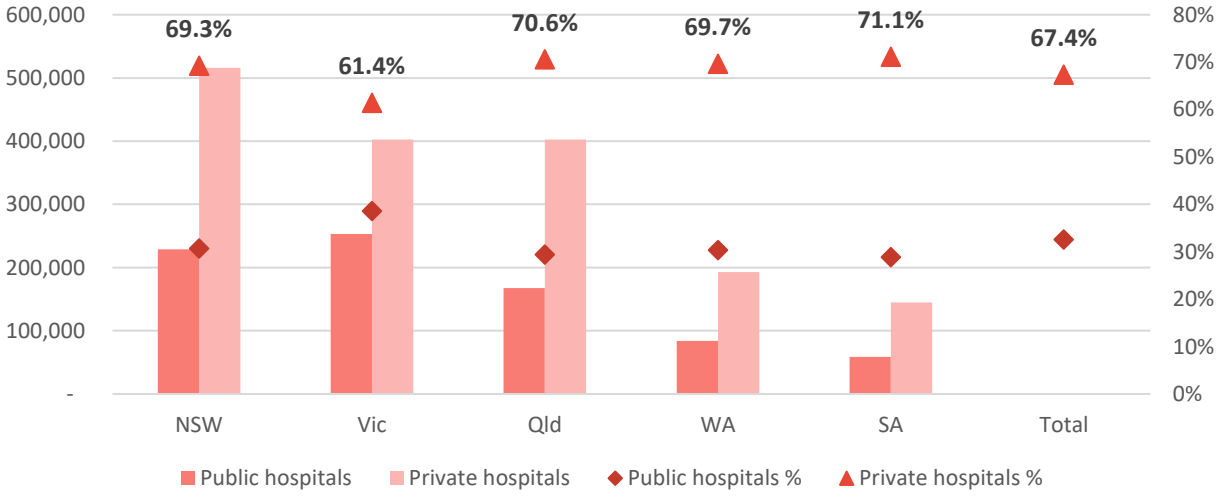
[36] Australian Institute of Health and Welfare, *Hospitals at a Glance* (2025), https://www.aihw.gov.au/hospitals/overview/hospitals-at-a-glance.

Figure 8. Characteristics of admitted patient care, public, private and all hospitals, 2023–24[37]



Notably, private hospitals perform approximately 67 per cent of elective surgeries across Australia, with some variations between the States/Territories as shown below.

Figure 9. Elective surgery public/private hospitals and per cent by State/Territory[38]



The public and private hospitals are not competitors but perform differing roles, with each relying on the other to provide comprehensive health services.

[37] Ibid.

[38] Australian Institute of Health and Welfare, *Hospitals, Data Downloads*.

1.1.1. Private hospitals act as a ‘safety valve’ for the health system

Australia’s public hospitals are operating under immense pressure, with waiting lists for essential elective surgeries increasing and now stretching out months or even years. Patients requiring treatments such as hip and knee replacements, cataract removals and hernia repairs often face prolonged delays for procedures that restore mobility, alleviate chronic pain and enable them to work, care for family and participate fully in community life. Some level of waiting for elective procedures is inevitable and, indeed, necessary as a mechanism for managing unpredictable demand for important but non-urgent care. However, when waiting times exceed clinically recommended guidelines, as they increasingly do in Australia, the consequences may extend far beyond inconvenience. Prolonged waits mean patients suffer for longer while their conditions may deteriorate, making their eventual surgery potentially more complex and costly. In addition, the waiting period may adversely affect mental health, increase reliance on pain medication and GP services and cause significant productivity loss by reducing the ability of many people to work. Thus, non-price rationing mechanisms such as waiting lists may ultimately generate greater costs across the entire health and social system when they result in wait times beyond clinically recommended periods.

In this context, private hospitals serve as a critical load-bearing component of Australia's health infrastructure; a viable private hospital sector acts as a ‘safety valve’ for the entire system, reducing demand on public hospital budgets and waiting lists, particularly for planned procedures. The broader private health sector – including non-hospital services – further supports this function by limiting GP visits and reducing ambulance callouts.

The decline or collapse of the private hospital sector would not strengthen public healthcare – it would fundamentally weaken the entire health ecosystem. Australia would lose the vital pressure valve that allows the system to function so well, creating a dangerous over-reliance on public hospitals. Rather than improving universal access, this would create an overloaded, under-resourced system that undermines the very principle it seeks to protect. The system's resilience – its ability to absorb shocks from pandemics, seasonal surges, or other crises – would be severely compromised, leaving all Australians more vulnerable.

2. Private health insurance: the cornerstone of system viability

The PHI market is essential in enabling Australians to access treatment within the private hospital system, as well as access to auxiliary healthcare services not covered by Medicare. Private hospital treatment can be extremely expensive, and, without PHI, most individuals would be unable to afford the cost of treatment. While some people could pay for minor procedures out-of-pocket, most would encounter considerable difficulties and financial strain covering the cost of major or unexpected hospital care. Health insurance spreads the financial risk of large and unpredictable medical expenses across a population. Instead of facing the possibility of paying, for example, $30,000 for a surgery tomorrow, individuals pay regular premiums so that if they do need treatment, most of the cost is covered.

PHI therefore provides a foundational function within the Australia healthcare system. The PHI system is an effective form of risk pooling which makes private care accessible to a much broader segment of the population. Without PHI, a private hospital sector would not be viable. Approximately 80 per cent of all separations[39] in private hospitals are undertaken under PHI, as shown in Figure 10 below. Only 7 per cent of private hospital separations are self-funded by patients. By improving access and enabling the functioning of the private hospital sector, PHI is essential to maintaining Australia's dual healthcare model. In turn, it strengthens the healthcare system's capacity to provide efficient and timely medical care to all Australians.

Text Box 1: Public–private patients

Public–private patients

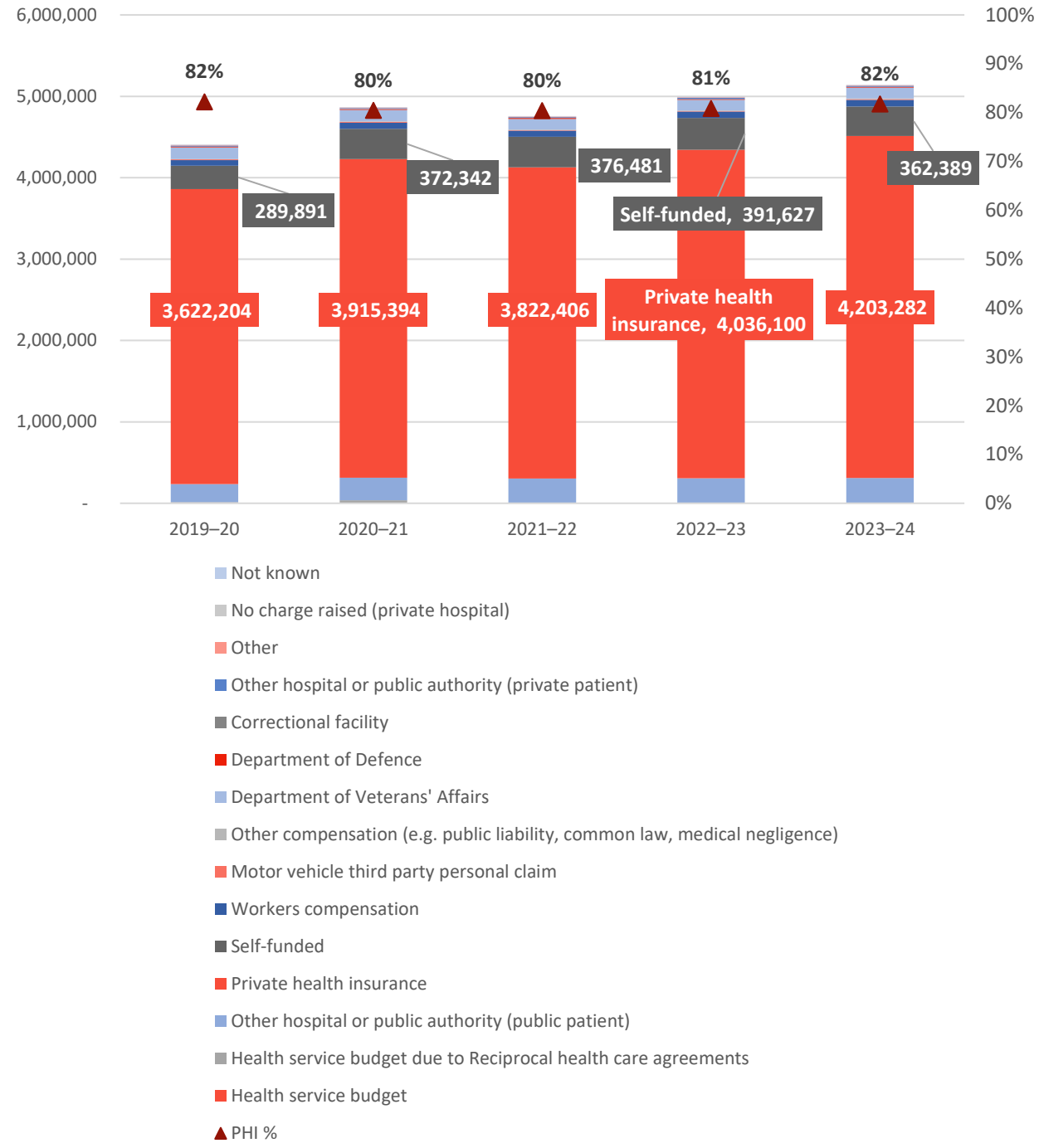
In recent years, the crossover between the public and private hospital system has increased with some private patients electing to be treated in public hospitals and some public hospitals sending patients to private hospitals. When a private hospital takes a public patient, there is a payment from the government to the private hospital. When a private patient is treated in a public hospital the health insurer pays the government. This cross-funding is working to enable patients to gain access to treatment faster through this market-clearing activity.

PHI spending on private hospital surgery enables the completion of 1.8 million procedures per year (1.7 million elective surgeries) that would otherwise be required to be completed in the public hospital system.[40] That is, approximately 67 per cent of all elective surgeries in Australia are redirected to the private hospital system. Other treatments and non-hospital services covered by PHI extras cover also take pressure off the public health system in many ways, including reduced demand on hospitals and GP visits, and reduced ambulance call outs.

[39] Completion of a patient's episode of care.

[40] Australian Institute of Health and Welfare, *Hospitals, Data Downloads*.

Figure 10. Private hospital separations by funding source, 2019–20 to 2023–24[41]



[41] Ibid.

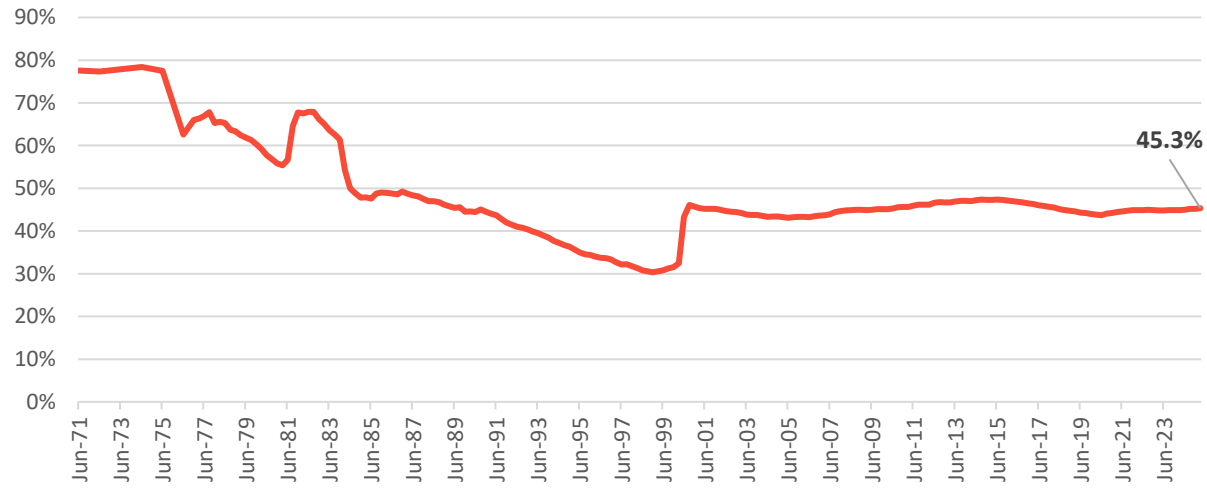
2.1. Types of PHI coverage

PHI in Australia is split into two categories: hospital treatment cover and general treatment cover (also known as extras cover). Hospital cover provides benefits for in-hospital medical treatments, including accommodation, theatre fees and doctors' fees for services received as a private patient in either a public or private hospital. General treatment cover provides benefits for a range of out-of-hospital services not covered by Medicare, such as dental, optical, physiotherapy, chiropractic and remedial massage. Insurers also offer combined policies, which package hospital and general treatment cover together.

Currently, around 45.3 per cent of the Australian population hold PHI hospital treatment cover,[42] and most payments from private health insurers are for hospital treatment.[43] Before the introduction of Medicare in 1984,[44] holders of PHI received subsidies and tax rebates on their PHI, and PHI coverage was a high proportion of the population. In the early 1980s, around 68 per cent of the population held PHI.[45]

With the introduction of Medicare, subsidies and tax rebates ceased and coverage dropped sharply to 50 per cent. PHI coverage continued to fall slowly but consistently over the next 10 years. Reforms introduced in the late 1990s to improve the viability of the PHI and private hospital sectors led to a renewed uptake of PHI. Since 2000, the proportion of the population with hospital coverage under PHI has remained relatively constant, fluctuating between 43 to 47 per cent. This steadiness, however, conceals the decline in the level of PHI coverage (to be discussed in more detail later).

Figure 11. PHI hospital coverage [46]



[42] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage* (2025), https://www.apra.gov.au/quarterly-private-health-insurance-statistics.

[43] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Benefits* (2025), https://www.apra.gov.au/quarterly-private-health-insurance-statistics.

[44] This was the second iteration of a universal publicly funded health system. The first iteration was Medibank, introduced by the Whitlam Labor Government in 1975, inspired by the implementation of similar programs in Europe during the period of post-war reconstruction. However, Medibank was subsequently dismantled by Fraser's Liberal Government. For a more detailed history, see Department of Health, Disability and Ageing, *The History of Medicare* (2025), https://www.health.gov.au/stronger-medicare/history.

[45] It had been even higher, reaching a national peak of 80 per cent in 1970, but declined with the introduction of the first iteration of a universal publicly funded health system, Medibank, introduced by the Whitlam Labor Government, as noted above.

[46] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage*.

2.2. PHI regulatory framework

Private health insurers operate within a regulatory framework established by the Commonwealth Government, the key features of which are explained below.

Community rating and risk equalisation

The cornerstones of the PHI regulatory framework are 'community rating' and guaranteed acceptance, which ensure the accessibility of PHI for all Australians. Under community rating, insurers must offer coverage to everyone[47] at the same price, regardless of their health status, age, gender or claims history.[48] In contrast with most other forms of insurance, a person cannot be charged more for their health insurance or denied coverage because they are deemed a higher risk.

To support community rating, a 'risk equalisation' scheme acts as a safety net. It redistributes money from funds with healthier, younger members to funds covering sicker, higher-claiming members. This keeps the system fair and ensures no single insurer is disadvantaged by the risk level of their members.[49]

Standardised PHI hospital product tiers

Hospital cover is classified into four standardised product tiers, Basic, Bronze, Silver and Gold.[50] Each successive tier includes coverage for a greater minimum number of clinical categories than the one below it, providing a progressive scale of coverage, with Gold cover at the top of the range.[51] Basic is the minimum level of cover, with restricted benefits. All Australian PHI hospital policies have been categorised into these four standard tiers since 1 April 2020. The standardised tier system was introduced to facilitate understanding and comparison of the different products from different insurers.

Ministerial approval of premium increases

Health funds are not permitted simply to raise their premiums whenever they wish. Private health insurers need to get approval from the Australian Minister for Health every year in order to increase premiums, with changes usually becoming operative on 1 April each year.

Exclusions

Private health insurers are explicitly not allowed to pay for out-of-hospital services already covered by the Medicare Benefits Schedule (MBS), or for drugs on the Pharmaceutical Benefits Scheme (PBS).

Oversight

Oversight of the PHI industry is undertaken by several government agencies:

- The Australian Prudential Regulation Authority (APRA) serves as the prudential regulator, ensuring insurers are financially stable and can pay out claims.
- The Private Health Insurance Ombudsman protects the interests of individuals with PHI coverage and manages complaints.
- The Australian Competition and Consumer Commission monitors anti-competitive or non-compliant behaviour that could adversely impact consumers.[52]

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[47] Restricted insurers are likewise prohibited from refusing to insure, or renew policies, to members within their eligible group.

[48] With the specific exceptions of lifetime health cover loading, and discounts for policy holders aged 18-29 years.

[49] Maternity and psychiatric care are excluded from the risk equalisation arrangements. However, it is beyond the scope of the report to discuss these implications.

[50] Private Health Insurance Legislation Amendment Bill 2018, House of Representatives 45, Cth (2018).

[51] Beyond these standard tiers, health funds can differentiate their products by adding extra clinical categories that exceed the minimum requirements for a specific tier. These are known as 'Plus' policies, e.g. Bronze Plus. By definition, Gold cover cannot be a 'Plus' policy as it already includes all clinical categories.

[52] Australian Competition and Consumer Commission, *Private Health Insurance Report 2023-24* (2024), https://www.accc.gov.au/about-us/publications/serial-publications/private-health-insurance-reports.

2.3. The rebate as a critical enabler of PHI

The Commonwealth Government encourages the uptake of PHI through several policy tools, including the PHI rebate, the Medicare levy surcharge, lifetime health cover loading and discounts for younger policy holders (see the text box below). The PHI rebate, which is the focus of this report, is a key feature of the government support.

Text Box 2: Commonwealth Government PHI policy incentives

Commonwealth Government PHI policy incentives

Medicare levy surcharge. The Medicare levy surcharge is a tax penalty (of 1–1.5 per cent depending on income level) for individuals and families who earn above a certain income threshold and do not have adequate private hospital cover. The Medicare levy surcharge is designed to incentivise higher-income earners who can afford cover to take out PHI, thereby contributing to the strength of the private health system and further alleviate demand on the public system. For many higher income earners, the cost of paying the Medicare levy surcharge is often greater than the premium for a Basic tier policy, making it a powerful financial motivator to obtain insurance.

Lifetime health cover loading. Lifetime health cover loading is a government initiative designed to encourage people to take out private hospital insurance earlier in life and to maintain it. Lifetime health cover loading acts as a penalty for delaying coverage. It works by applying a 2 per cent loading on top of the base premium for private hospital cover for each year of age over 30 years. The loading applies when a person takes out private hospital cover for the first time after they turn 31. Once a person has maintained private hospital cover continuously for 10 years, the lifetime health cover loading is removed.

Discounts for under 30s. To attract younger members, insurers can offer age-based premium discounts, making it more affordable to have PHI cover earlier in life. Since 1 April 2019, insurers have been permitted to offer discounts on premiums for hospital cover to policy holders aged 18–29 years. The amount of the discount is 2 per cent for each year that the policy holder is under 30 years of age when they first purchase cover, up to a maximum of 10 per cent. The policy holder will retain their discount if they retain the same policy until the age of 41.

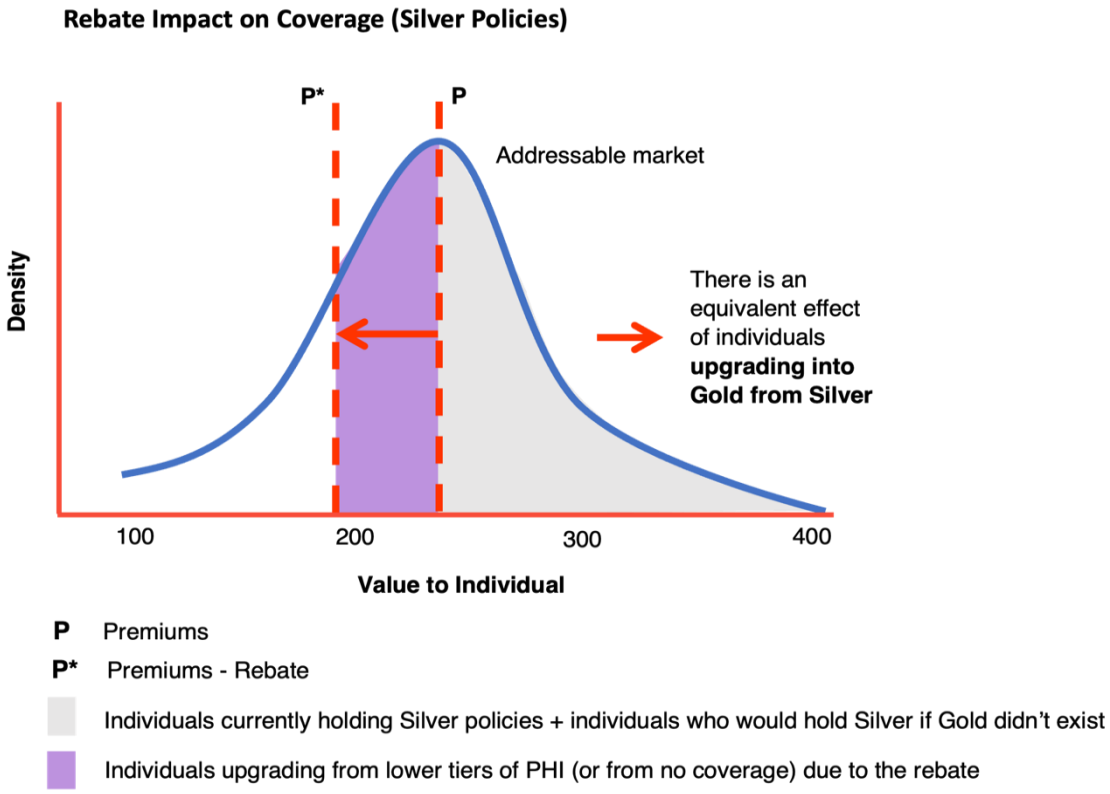
The PHI rebate. The PHI rebate is a subsidy to policy holders which lowers insurance premiums or acts as an offset in an annual tax return if the person holds PHI and their income is below a certain limit. It is means-tested and age-dependent. Higher earning individuals as well as families receive a lower rebate rate, with older individuals receiving a higher rebate rate. The current maximum rebate rate is 32.385 per cent for policy holders who are aged 70 years and older and in the lowest income tier.

The PHI rebate was introduced by the Commonwealth Government during the mid-1990s to address declining PHI coverage after the introduction of Medicare and concerns about the viability of the private healthcare sector. In the Appendix, we provide a more detailed history of its introduction. The rebate is applicable to both hospital cover and general/extras cover.

The rebate encourages individuals to hold PHI by offsetting the cost of health insurance premiums. Effectively it reduces the out-of-pocket costs for policy holders, thereby making private health insurance more affordable and, in turn, keeping younger, healthier members in the insurance risk pool. This broader participation rate helps to stabilise premiums, sustain the viability of private hospitals and protect the overall balance between public and private care.

The graph below provides an illustration of how the PHI rebate acts to reduce the effective price paid by people with PHI coverage. The effect of the rebate is that more people will choose to increase their level of PHI coverage and elect to hold higher levels of coverage than in the situation where government does not provide the PHI rebate. The more people that are captured in the purple area (below), the greater is the expected net benefit to government from investing in the PHI rebate as these people are more likely to use the private hospital system rather than the public hospital system.

Figure 12. Illustrative graph of the PHI rebate impact on Silver tier PHI[53]



The PHI rebate delivers pronounced benefits in terms of public hospital relief, industry viability and patient choice. The benefits of the PHI rebate include:

- **Encouraging PHI participation** – The PHI rebate in conjunction with other incentives, such as the Medicare levy surcharge and lifetime health cover loading, constitute a comprehensive 'carrot and stick' policy framework designed to encourage Australians to acquire and maintain PHI.
- **Incentivising higher tiers of PHI coverage** – The Medicare levy surcharge and lifetime health cover loading serve as the 'sticks' that that penalise delaying taking out PHI and wealthier individuals for not holding PHI. However, avoiding these penalties only requires a basic level of hospital coverage, encouraging individuals into a bare-minimum Basic tier policy, which provide restricted coverage for rehabilitation, hospital psychiatric services and palliative care. Restricted coverage only partially covers the costs of being treated as a private patient in a public hospital and does not cover the costs of private rooms or treatment in private hospitals. The PHI rebate acts as the 'carrot', not only incentivises individuals to hold PHI but also to take out higher tiers of coverage.
- **Reducing demand and costs of the public system** – Supporting people to access PHI reduces the demand for elective surgery in public hospitals and reduces the need for tax to fund the level of healthcare demanded by the community.
- **Cost shifting from public to private expenditure** – Government funding to incentivise PHI is an efficient and effective way to reduce the overall demand for tax revenue by leveraging individuals' funds to pay for their own healthcare, thus reducing the deadweight losses from tax collection

[53] Illustration developed by DeltaPearl Partners

activity. In addition, governments can allocate a greater portion of their available funds for other uses, potentially improving the welfare of all Australians.

- **Correcting market failure (adverse selection)** – Without government incentives for PHI, it is likely those people who would receive the greatest benefit from PHI would join preferentially – that is, there is high likelihood that this demographic would be those of higher socioeconomic status with the greatest anticipated need for inpatient care. This high-cost group would need to pay higher premiums without the younger and healthier portion of the population paying into the scheme to balance out the high-cost group. Higher PHI fees would reduce the number of people in the scheme, and many people would drop their cover and seek medical treatment in the public system. This dynamic is described as a 'death spiral', as the process of higher fees/fewer people holding PHI would continue until only the wealthy would be able to access the PHI system.
- **Consumer choice and competition** – Another consideration is that the rebate enhances choice for consumers regarding their medical provider and venue for care. Even in a private setting, there may be limited elements of patient choice, but market signals still improve the outcomes for patients and the system as a whole.

These benefits underscore the contribution of the rebate to the long-term sustainability, efficiency and overall effectiveness of Australia's dual healthcare framework. The PHI rebate mechanism helps to prevent the public system from becoming overwhelmed by the sheer volume of demand that would otherwise accrue if all care was driven to the public system.

In supporting PHI through the rebate, the Commonwealth Government provides a structured incentive enabling the healthcare market to reach a desirable equilibrium and allows individuals who prioritise factors such as timely access to medical services, choice in healthcare and access to private rooms during treatment, to obtain those services by contributing some of their own funds outside the taxation system.

The 2025–26 Commonwealth Budget estimated that the Commonwealth Government will spend $7.6 billion on the PHI rebate in 2024–25, rising over the next four years to $8.4 billion in 2028–29. [54] [55]

Table 2: Projected Commonwealth PHI rebate expenditure [56] [57]

	2024–25	2025–26	2026–27	2027–28	2028–29
PHI Rebate Expenses (billions)	$7.6	$7.8	$8.0	$8.2	$8.4

In 2022–23, the PHI rebate accounted for 6.6 per cent of all Commonwealth Government expenditure on health care and for 2.8 per cent of all expenditure on health care in Australia.[58]

[54] Department of Health and Aged Care, *Budget Related Paper No. 1.9: Health and Aged Care Portfolio*, Portfolio Budget Statements 2025–26 (2025).

[55] Treasury, *Budget Related Paper No. 1.15: Treasury Portfolio*, Portfolio Budget Statements 2025–26 (2025).

[56] Department of Health and Aged Care, *Budget Related Paper No. 1.9: Health and Aged Care Portfolio*.

[57] Treasury, *Budget Related Paper No. 1.15: Treasury Portfolio*.

[58] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

3. Investment returns: the economic and social case for the PHI rebate

Our modelling indicates that investments in the PHI rebate are of high fiscal value to the Australian Government, to the healthcare system generally and to the Australian economy.

The results of modelling the measurable fiscal gains are provided below, using a series of scenarios to demonstrate the range of impacts for various changes in the PHI rebate.[59] The modelling focuses on the hospital component of PHI because it directly reduces demand on the public hospital system, offering a quantifiable offset to government expenditure. Although the general treatment (extras) component of PHI provides benefits in the form of ancillary healthcare sector and incentives for PHI uptake,[60] [61] an analysis of direct offsets to public medical spending has not been completed as general treatment covers services that are typically outside of Medicare.

3.1. PHI represents high value

To assess the effectiveness of the PHI rebate in supporting the Australian healthcare system, we examine four counterfactual policy scenarios that evaluate how changes to the rebate would affect public hospital capacity, government health expenditure and the long-term viability of the private hospital system (see Text Box 3 below). We note it is likely that some Australians would maintain PHI even without the rebate, driven by personal preference for private care, desire for choice, tax incentives or higher-income levels.

Our analysis reveals state and territory governments derive the greatest net benefits from the PHI rebate (and conversely, the greatest losses from its removal or reduction). States and territories bear greater funding responsibility for the public hospital system. Each PHI holder represents support from the Commonwealth Government and reduced pressure on the public hospital system. For example, under the modelled Scenario 1 (full removal of the rebate), the Commonwealth Government would achieve a net saving of $845 million, but State/Territory Governments would experience a net fiscal loss of $4.345 billion. The rebate functions as an effective mechanism that reduces overall demand for taxation while maintaining system capacity, despite the vertical fiscal imbalance illustrated by this disparity in the cost-benefit between the Commonwealth and State/Territory Governments.

Beyond these direct fiscal impacts, the rebate generates broader economic benefits through faster return of patients to good and productive health. A healthier population drives higher economic growth, creating a foundation for future welfare improvements across Australia. The rebate therefore operates not merely as a healthcare subsidy, but as an investment in the nation's economic resilience and productive capacity. Higher economic growth from a healthier population is a key driver of future welfare for the Australian people.

[59] See Appendix 5 for model design.

[60] 0.1 per cent of policy holders with hospital cover hold hospital cover only.

[61] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Benefits*.

Text Box 3: Four modelled scenarios

Four scenarios modelled – 10-year projection period

- Scenario 1 – Complete removal of the PHI, staggered over a 5-year period.
- Scenario 2 – Partial removal of the PHI (e.g. to fund dental), through a 50% reduction in rebate rates, staggered over a 5-year period.[62]
- Scenario 3 – Freezing PHI rebate rates at their current levels.
- Scenario 4 – Return PHI rates their levels before the introduction of the rebate adjustment factor (RAF).

All scenarios are modelled against the base case: that is, the status quo if the government implements no changes to the current PHI rebate system. It is important to note that even under this base case, rebate rates are projected to decline over time due to the design of the RAF. The impact of this status quo decline in rebate rates is explored in Sections 4 and 5 below.

The modelling revealed clear patterns. If the rebate is removed or reduced:

- Between 3.7 and 8 million individuals would either downgrade or drop PHI, resulting in 6.6 to 14.3 million fewer episodes being treated in private hospitals. This shift would substantially increase demand for public hospitals, requiring billions in additional government funding to maintain current service levels, with pressure falling mostly to state and territory governments.
- Although the government might reduce budget outlays by reducing rebate payments, this creates an unintended subsequent flow-on cost to government. Removing the rebate entirely would save approximately $4.4 billion a year on the hospital component of the rebate, but maintaining current health standards – preventing longer waiting lists and preserving health outcomes[63] – would require an additional $7.9 billion in public hospital funding. The net result under Scenario 1 is a cost to government of $3.5 billion per annum, demonstrating how the rebate 'savings' are more than overtaken by increased public hospital expenditure.

Conversely, maintaining or increasing the rebate produces fiscal benefits. Under the scenarios where more Australians retain or upgrade their PHI coverage, more care remains within private hospitals and pressure on the public system decreases. While higher PHI rebate payments increase direct government expenditure, the savings in avoided public hospital costs exceed these outlays. For example, Scenario 4, which restores the rebate to its original percentage payment, costs an additional $2.4 billion annually but saves $2.9 billion in public hospital funding, delivering a net saving to government of $500 million.

The detailed modelling results that follow provide projections across the four alternative rebate scenarios, examining fiscal impacts, changes in PHI coverage patterns, variations in private hospital utilisation and the net effects on both rebate expenditures and overall health system costs.

[62] Even a 50% reduction in PHI rebates would only fund 25% of the Parliamentary Budget's Office estimate of the cost of completely incorporating dental into Medicare. This is covered in more detail in Appendix 6.

[63] Combined Commonwealth Government and State and Territory Governments' expenditure.

3.1.1. Key scenario outputs

Over the **10-year period** from 2026–27 to 2035–36, the modelling reveals significant variations in outcomes across the four scenarios:

- **Scenario 1: Full rebate removal** would see over 8 million individuals either downgrading or dropping out of PHI, resulting in approximately 14.3 million fewer episodes treated privately and an estimated $74.3 billion in reduced private medical expenditure. While the government would save approximately $43.6 billion on rebate expenditure,[64] the need to replace this private spending would create a net negative fiscal position of $30.7 billion.
- **Scenario 2: Partial rebate removal** would see approximately 3.7 million individuals downgrading or dropping out of PHI, leading to approximately 6.5 million fewer episodes treated under private healthcare and an estimated $33.7 billion in reduced private medical expenditure. The approximately $22.6 billion in rebate savings[64] would be overwhelmed by the costs of replacing private spending, resulting in a net fiscal loss of $11.1 billion.
- **Scenario 3: Freezing rebate rates** would see over 1 million individuals upgrading or retaining PHI, leading to1.3 million additional episodes treated privately and an estimated $6.7 billion in increased private medical expenditure.[64] The additional $5.1 billion in rebate costs would be offset by reduced public hospital demand, creating a positive fiscal position of $1.6 billion, plus reduced deadweight loss from lower taxation requirements.
- **Scenario 4: Reinstating rebate rates** amplifies these benefits. Over 3 million individuals would upgrade or retain coverage, producing 4.6 million additional private episodes and $24.2 billion in increased private expenditure. Despite $19.6 billion in additional rebate costs,[64] the net fiscal position would be positive at $4.6 billion, plus the reduced deadweight loss from taxation.

In the long run, modelling estimates that the annual impact in real terms (2026–27 dollars) of each of the scenarios, relative to the base case, is:

- **Scenario 1, Full rebate removal**: Approximately $4.4 billion saved on the hospital component of the rebate, at the cost of approximately $7.9 billion in reduced private medical expenditure (net negative $3.5 billion), with 1.7 million fewer episodes of care treated in private hospitals.
- **Scenario 2, Partial rebate removal**: Approximately $2.3 billion saved on the hospital component of the rebate, at the cost of approximately $3.6 billion in reduced private medical expenditure (net negative $1.3 billion), with 780,000 fewer episodes of care treated in private hospitals.
- **Scenario 3, Freezing rebate rates**: Approximately $800 million additional spent on the hospital component of the rebate, with approximately $1 billion in increased private medical expenditure (net positive $0.2 billion) and 230,000 additional episodes of care treated in private hospitals plus a reduced deadweight loss from reduced taxation requirements.
- **Scenario 4, Reinstating rebate rates**: Approximately $2.4 billion additional spent on the hospital component of the rebate, with approximately $2.9 billion in increased private medical expenditure (net positive $0.5 billion) and 650,000 additional episodes of care treated in private hospitals plus a reduced deadweight loss from reduced taxation requirements.

To avoid declining health outcomes and an increased size and duration of waiting lists within the public system, any reduction in private medical expenditure under each policy scenario represents the additional amount of required funding of the public hospital system.

The table below presents the long-run annual impact of each policy scenario on rebate expenditure, public hospital expenditure and net governmental expenditure required to maintain health outcomes.[65]

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[64] Expenditure on the hospital component of the rebate.

[65] Combined Commonwealth and State/Territory Governments' expenditure.

The modelling of each of these counterfactual policy scenarios demonstrates that the rebate is a sound economic investment. In each of the four scenarios, the additional or avoided public hospital expenditure consistently exceeds the corresponding rebate costs or savings, confirming the effectiveness of the rebate in reducing overall government healthcare expenditure.[66]

Table 3. Long-run annual impact of each policy scenario on net government expenditure to maintain health outcomes[67]

	Rebate Expenditure[68]	Public Hospital Expenditure	Net Governmental Expenditure[69]	Return per $1 Spent / Saved on Rebate
Scenario 1 – Full rebate removal	$4.4 billion	+$7.9 billion	+$3.5 billion	−$1.80
Scenario 2 – Partial rebate removal	−$2.3 billion	+$3.6 billion	+$1.3 billion	−$1.57
Scenario 3 – Freezing rebate rates	+$0.8 billion	−$1.0 billion	−$0.2 billion	$1.25
Scenario 4 – Reinstating rebate rates	+$2.4 billion	−$2.9 billion	−$0.5 billion	$1.21

Theoretically, from a vertical fiscal perspective, there could be an incentive for the Commonwealth Government to reduce funding for the PHI rebate (to achieve reduced outlays in its own budget) in order to encourage people to move to the public hospital system, for which the State/Territory Governments have the larger budgetary responsibility.

However, despite the incentives for the Commonwealth to reduce funding for the PHI rebate, the combined net impact across the Commonwealth and State and Territory Governments of reducing the rebate is negative, as indicated below using the scenario analysis.

If the costs or savings of the change in public hospital expenditure is shared between the Commonwealth Government and the State and Territory Governments under the current 45 per cent / 55 per cent agreement, the net fiscal impact would predominantly affect State/Territory Government budgets. The long-run annual net impact under this assumption on Commonwealth and State/Territory Government expenditure is presented in Table 4.

However, funding allocations between the Commonwealth and State/Territory Governments are based on negotiations between the two levels of government. State and Territory Government budgets are constrained by their revenue raising capacity and contributions from the Commonwealth. Significant shifts in the costs of healthcare from the private system to the public system would likely require a new agreement on how these healthcare costs are shared.

[66] There are marginal returns to the incentive effects of the rebate. As such, decreases in the rebate from current levels have a great effect than increasing the rebate.

[67] DeltaPearl Partners Modelling, Appendix 6.

[68] Hospital Component.

[69] Combined Commonwealth and State/Territory Governments' expenditure.

Regardless of the agreed division of healthcare funding, reducing the rebate while maintaining health outcomes would require increased overall taxation.

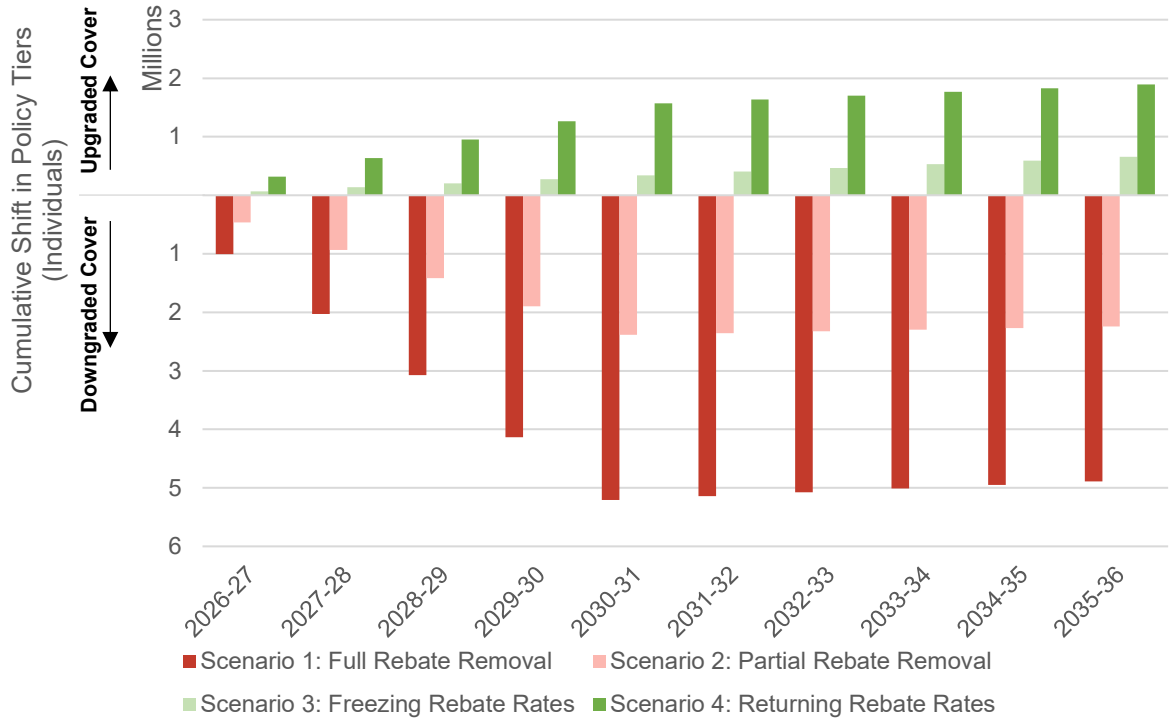
Table 4. Long-run annual impact of each policy scenario on net Commonwealth and State/Territory Government expenditure, to maintain health outcomes[70]

	Net Commonwealth Expenditure	Net State and Territory Government Expenditure
Scenario 1 – Full rebate removal	−$845 million	+$4.345 billion
Scenario 2 – Partial rebate removal	−$680 million	+$1.98 billion
Scenario 3 – Freezing rebate rates	+$350 million	−$550 million
Scenario 4 – Reinstating rebate rates	+$1.1 billion	−$1.6 billion

Figure 13 presents the impact of each policy scenario on the migration of individuals between coverage tiers. The modelling demonstrates the PHI rebate delivers clear benefits in encouraging individuals into higher tiers of coverage. Removing or reducing the rebate would lead to significant downgrading of coverage, whereas maintaining or reinstating rebate rates to their original 2013 levels would encourage upgrading to more comprehensive levels of coverage. This tier migration has particular significance for essential services provided by the private sector, such as maternity services, rehabilitation and psychiatric services, which are only covered under higher tier PHI products. The rebate therefore not only maintains overall PHI participation but ensures Australians retain access to a fuller spectrum of private healthcare services.

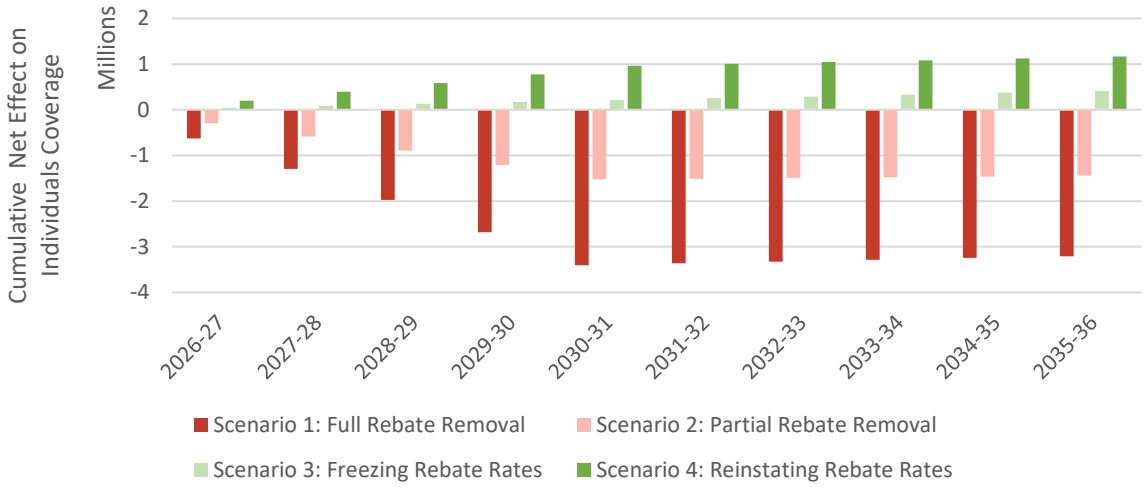
[70] DeltaPearl Partners modelling, Appendix 6.

Figure 13. Cumulative migration of individuals' PHI tiers under each policy scenario[71]



Similarly, the modelling demonstrates the role of the rebate in encouraging PHI uptake. Removing or reducing the rebate would lead to a significant number of individuals dropping their PHI, whereas maintaining or reinstating rebate rates to their original levels would lead to increased overall participation. Figure 14 presents the impact of each counterfactual policy scenario on uptake of PHI over the next decade.

Figure 14. Cumulative net effect on individuals covered by PHI each year for each policy scenario[72]

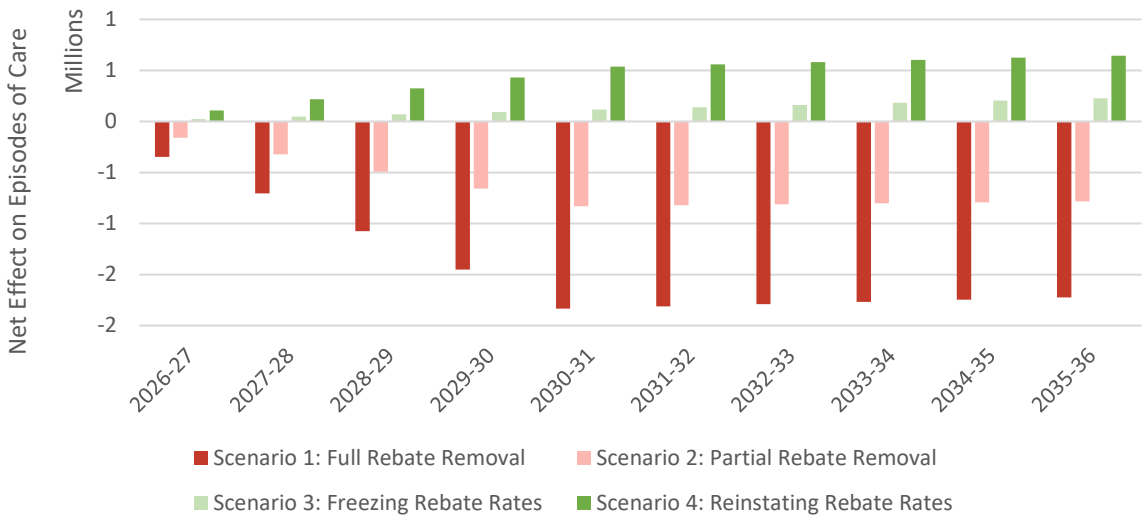


[71] DeltaPearl Partners modelling, Appendix 6.

[72] DeltaPearl Partners modelling, Appendix 6.

By incentivising PHI uptake and encouraging migration to higher tiers of coverage, the PHI rebate encourages individuals to undergo medical treatment within the private hospital sector, thus relieving pressure on the public system. Figure 15 presents the modelled net effect of each policy scenario on the annual number of episodes of care undertaken within the private hospital sector over the decade.

Figure 15. Net effect on episodes of care treated under private healthcare each year for each policy scenario[73]



Ultimately, removing or reducing the PHI rebate would lead to a significant reduction in private expenditure on medical services within the private hospital sector. The private spending reduction would shift cost of treatment to the public healthcare system and cause longer waiting times, with fewer individual receiving care within clinical recommended timeframes and consequently worse health outcomes.

The reductions in privately treated episodes would create significant financial pressure on the private sector, leading to capacity reductions, further closures of private hospitals and specialist practices, and job losses across the health and allied services industries. Hospitals specialising in clinical categories exclusively covered under higher levels of PHI policies would be especially vulnerable, particularly maternity and psychiatric care, which are only covered under Gold or certain Silver Plus policies. Conversely, maintaining or reinstating the PHI rebates to their original levels (as explained in more detail in relation to the Rebate Adjustment Factor later in the report) would lead to increased expenditure within the private system, thereby strengthening viability.

The Commonwealth Government's rebate expenditure therefore represents an attractive investment in reducing public hospital costs while maintaining a viable private system. Figure 16 presents the annual net effect over the preceding decade on private hospital expenditure alongside the yearly net effect on Commonwealth rebate expenditure for each policy scenario. The impact on private hospital expenditure represents a cost shift that would move from the private system to the public system for reductions in the rebate, and similarly to the private system from the public system when strengthening the rebate.[74] These counterfactual policy scenarios confirm that the rebate represents sound fiscal policy.

[73] DeltaPearl Partners Modelling, Appendix 6.

[74] This cost-shift would primarily impact State and Territory government budgets under the current funding agreements.

Figure 16. Net effect on rebate expenditure and private medical expenditure each year for each policy scenario[75]

[75] DeltaPearl Partners modelling, Appendix 6.

4. Gradual erosion of the PHI rebate

The effectiveness of the PHI rebate as a healthcare funding tool depends on its design and ongoing value to policyholders. However, the current rebate structure contains a fundamental element that progressively undermines its capacity to support Australia's dual healthcare system. Through the rebate rate adjustment factor (RAF) mechanism, the percentage of PHI premiums covered by the PHI rebate has declined systematically over time, gradually eroding the policy's effectiveness and threatening the viability of the private hospital sector it was designed to support.

4.1. Rebate rate adjustment factor (RAF) mechanism

The rebate rate represents the percentage of PHI premiums that the Commonwealth Government subsidises for policyholders. Since 2014, these rates have been adjusted annually on 1 April based on the RAF. The design of the RAF ensures that the rebate percentage will continue declining over time, meaning policyholders face an increasing share of premium costs, even if premium inflation does not consistently outpace general inflation. This systematic reduction gradually erodes the rebate's effectiveness in making private healthcare accessible.

Text Box 4: The rebate adjustment factor

The rebate adjustment factor

The RAF is the ratio of general inflation (increase in the Consumer Price Index (CPI)) over premium inflation (industry weighted average increase in premiums).[76]

$$Rebate\ Adjustment\ Factor = \frac{General\ Inflation\ (Consumer\ Price\ Index)}{Premium\ Inflation\ (Weighted\ Average\ Increase\ in\ Premiums)}$$

Since 2014, rebate rates are adjusted annually on April 1st based on the RAF, which is calculated by the Department of Health, Disability and Ageing (DoHDA).[77] The calculation, shown above, is the ratio of general inflation over premium inflation.[78]

The intent of the RAF is to limit Commonwealth liability by decreasing rebate rates whenever premiums increase faster than general inflation. Crucially, the formula includes an asymmetric clause – if premium inflation falls below general inflation, the RAF is capped at 1, meaning rebate rates can only decrease, never increase. This creates a ratchet effect that systematically reduces the rebate's value over time.

Before the RAF's introduction, rebate rates for the lowest income tier were 30 per cent for policyholders under 65 years, 35 per cent for those aged 65–69 years and 40 per cent for those 70 years and over. Higher-income tiers received 10 percentage point reductions, with the highest earners receiving no rebate.

Since 2014, the RAF has steadily eroded these rates, as demonstrated in the table below comparing current rebate rates with their original pre-RAF levels. This decline represents a fundamental shift in the rebate's capacity to support private healthcare participation and, by extension, the broader health system's resilience.

[76] Private Health Insurance (Incentives) Rules 2012 (No. 2), Cth (2020).

[77] Private Health Insurance Legislation Amendment Act 2014, Cth (2014).

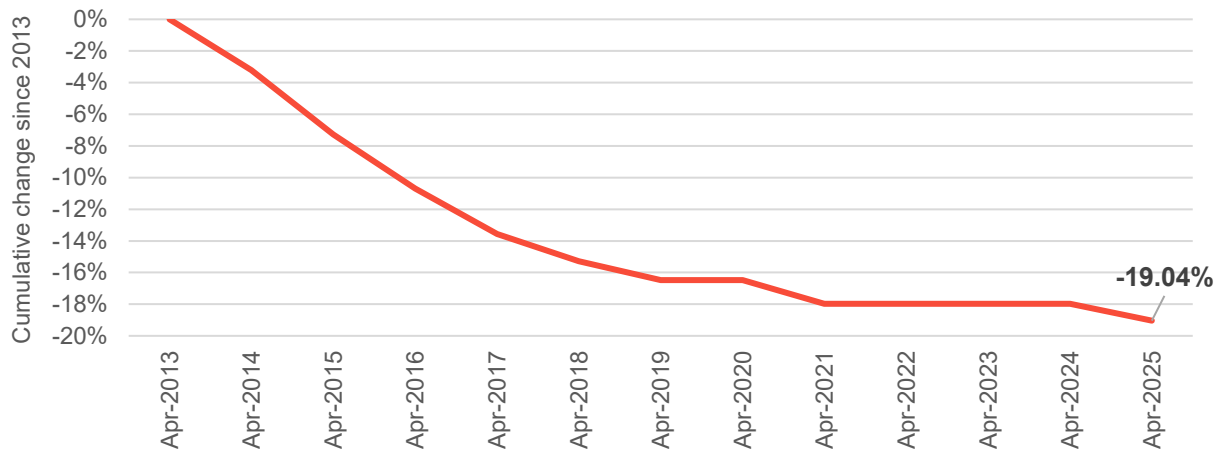
[78] To calculate the new rebate rates for a year (April–March), the rebate rates from the preceding year are multiplied by the RAF for the new year. Due to the indexing of rebate rates occurring on April 1st, a financial year contains two distinct rebate rate periods: July 1st to March 31st (using the old rates) and April 1st to June 30th (using the newly indexed rates).

Table 5: PHI rebate rates, 2012–13 and 2024–25[79]

	Rebate Rate – *Prior to Introduction of RAF* **(1 July 2012 – 31 March 2014)** *Age of oldest person covered*			**Rebate Rate** – *Current* **(1 April 2025 – 30 June 2025)** *Age of oldest person covered*		
	<65	**65–69**	**70+**	**<65**	**65–69**	**70+**
Base Tier	30%	35%	40%	24.288%	28.337%	32.385%
Tier 1	20%	25%	30%	16.192%	20.240%	24.288%
Tier 2	10%	15%	20%	8.095%	12.143%	16.192%
Tier 3	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible

The graph below presents the cumulative change in rebates over this period, which shows a reduction of 19.04 per cent.

Figure 17: Cumulative percentage change in rebate rates since 2013 [80] [81] [82]



Under the base case, the RAF effectively increases the retail cost of PHI for policyholders as rebate values decline. Rising out-of-pocket costs drive individuals, particularly younger and healthier Australians, to downgrade to lower coverage tiers or exit the system entirely. The reduction of low-risk participants weakens the overall risk pool, creating a vicious cycle where premiums rise even higher for remaining participants, threatening the fundamental sustainability of private insurance.

This dynamic of a deteriorating risk pool accelerates premium increases beyond normal health and general inflation. As fewer healthy individuals participate, the insurance pool becomes increasingly concentrated with higher-risk, higher-cost members, forcing insurers to raise premiums further to maintain viability.

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[79] Australian Taxation Office, *Income Thresholds and Rates for the Private Health Insurance Rebate*.

[80] Ibid.

[81] Department of Health, Disability and Ageing, *Average Annual Price Changes in Private Health Insurance Premiums*.

[82] Australian Bureau of Statistics, *Consumer Price Index, Australia*.

The result is a downward ‘death spiral’ where each premium increase prompts additional departures, particularly among those who can least afford higher costs but do contribute most to risk pool stability.

The implications for Australia's healthcare system are significant. As PHI becomes less affordable and fewer services are delivered privately, the burden on public hospitals intensifies systematically. Elective surgeries that currently occur predominantly in private facilities – procedures that keep public waiting lists manageable – would logically increasingly shift to an already-stretched public system. This transition would not only extend waiting times but require substantial additional government funding to maintain current service levels, with states and territories bearing the preponderance of this political and fiscal cost.

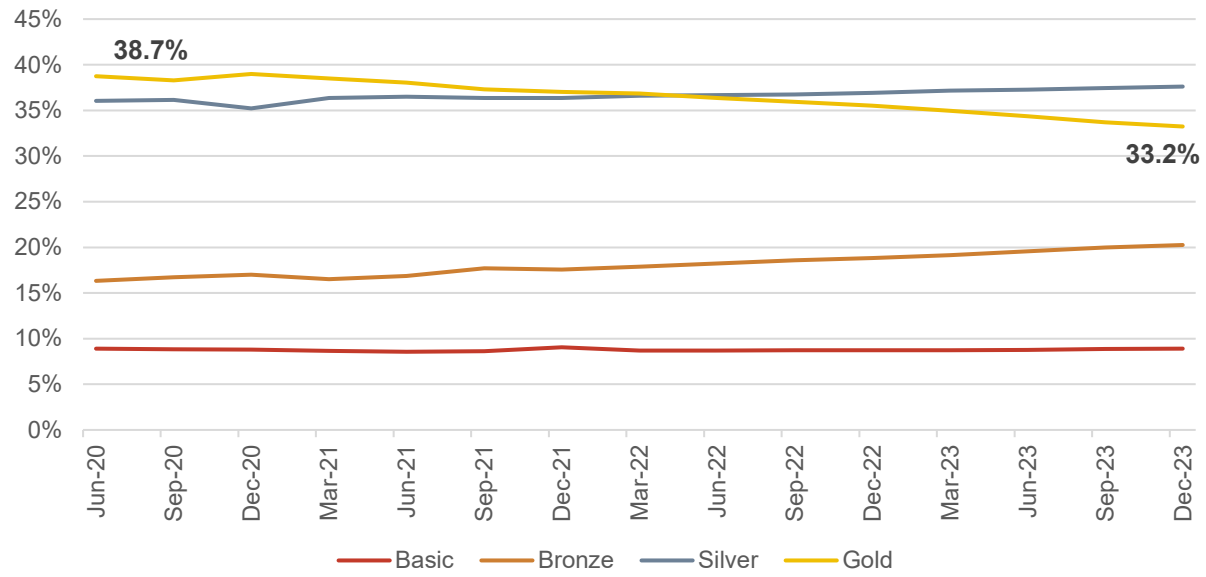
Under the status quo, this gradual erosion of PHI participation is placing steadily increasing pressure on public hospitals while undermining the foundational principles of Australia's dual-sector model.

5. The ‘tier slide’ phenomenon and system destabilisation

Since April 1, 2020, all Australian PHI hospital policies have been categorised into four standardised tiers: Basic, Bronze, Silver and Gold.[83] Basic provides a minimum level of coverage, with restricted benefits, whereas Gold offers the most comprehensive level of services at the top of the coverage spectrum.[84]

Since the introduction of the tier system, policy holders have steadily migrated to lower coverage levels as shown in Figure 18. Gold tier policies, initially the most popular, have been overtaken by Silver cover as the most common choice. This tier slide reflects consumer responses to the increasing cost of PHI driven by rising premiums and the RAF’s impact in reducing PHI rebate rates.

Figure 18. Percentage of policy holders in each PH hospital product tier[85]



The tier slide has resulted in a 14.2 per cent decline in the proportion of policy holders with Gold level cover since the introduction of the tier system in 2020. While the Silver tier absorbs some of this movement, the most dramatic growth has occurred in Bronze level cover, with the proportion of Bronze level policy holders increasing by 24.0 per cent. The downward trend means individuals are covered for fewer services under their policies, inevitably shifting treatment for these services from the private to the public sector. Clinical categories exclusive to Gold tier policies, such as maternity and psychiatric care, are currently showing significant impacts from this trend, which potentially threatens the viability of private providers, including hospitals and specialists.[86]

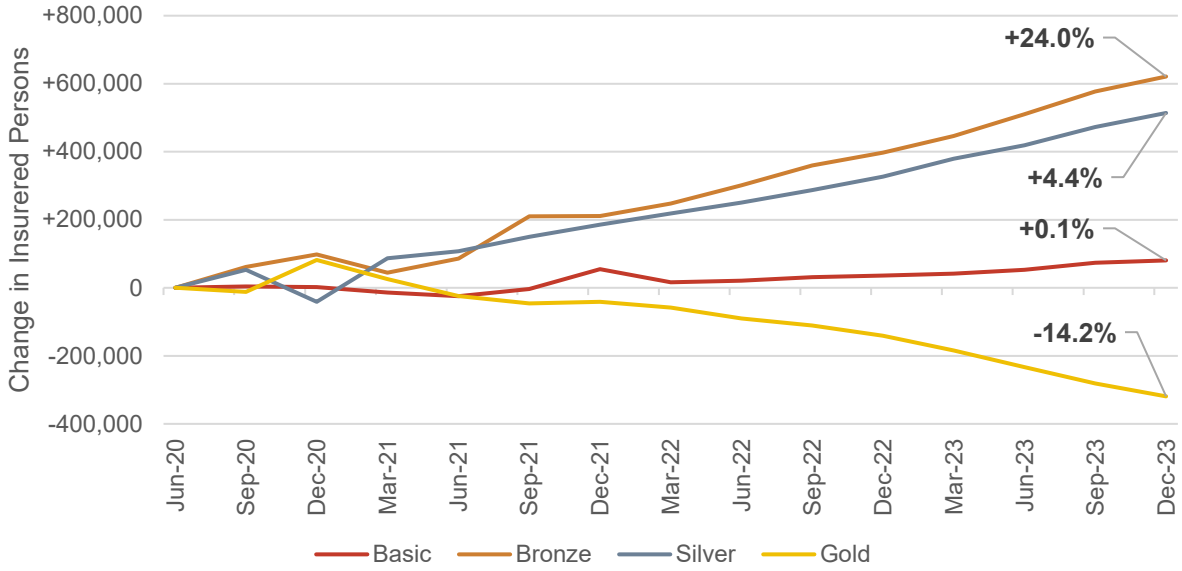
[83] Private Health Insurance Legislation Amendment Bill 2018.

[84] Beyond these standard tiers, health funds can differentiate their products by adding extra clinical categories that exceed the minimum requirements for a specific tier. These are known as 'Plus' policies, e.g. Bronze Plus. By definition, Gold cover cannot be a 'Plus' policy as it already includes all clinical categories.

[85] Department of Health and Aged Care, *Private Health Insurance Reform Data Quarterly Trends Reports*.

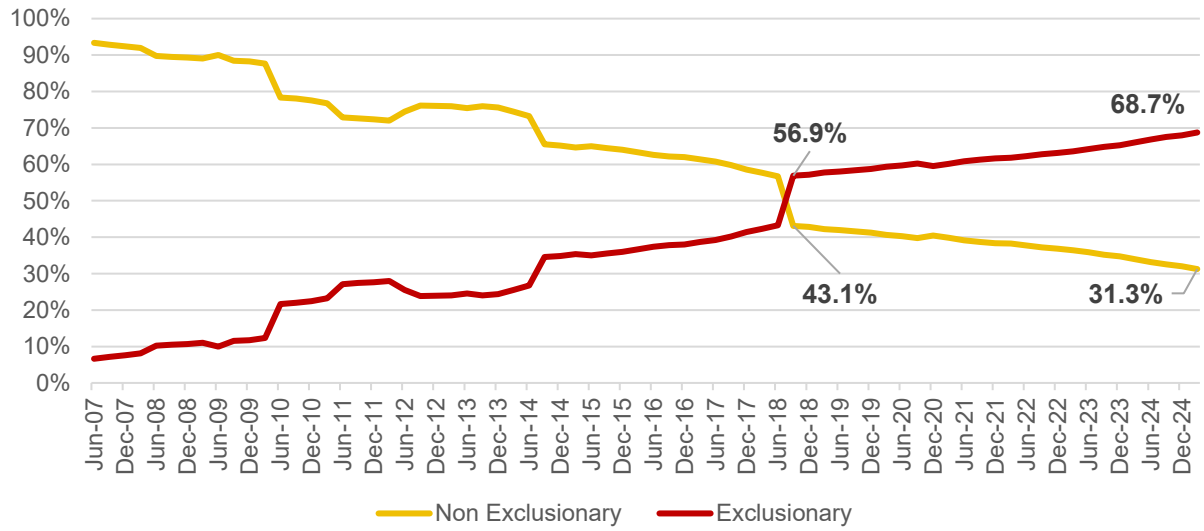
[86] In some cases, the clinical categories are covered by higher level (and more expensive) Silver Plus policies.

Figure 19. Cumulative change in PHI policy holders by hospital product tiers[87] [88]



The tier slide continues a longer pattern of coverage erosion that predates the current reforms. Historically, almost all PHI hospital policies were comprehensive, non-exclusionary policies equivalent to today's Gold tier coverage. However, there has been steady growth in policies that exclude certain medical treatments, with these exclusionary policies now accounting for 68.7 per cent of all hospital coverage – a fundamental transformation from universal comprehensive private coverage to selective, limited protection.

Figure 20. Percent of hospital treatment policy holders holding non-exclusionary vs exclusionary policies[89]



[87] Department of Health and Aged Care, *Private Health Insurance Reform Data Quarterly Trends Reports*.

[88] Percentage changes presented indicate the cumulative change in proportion of policy holders in each policy tier.

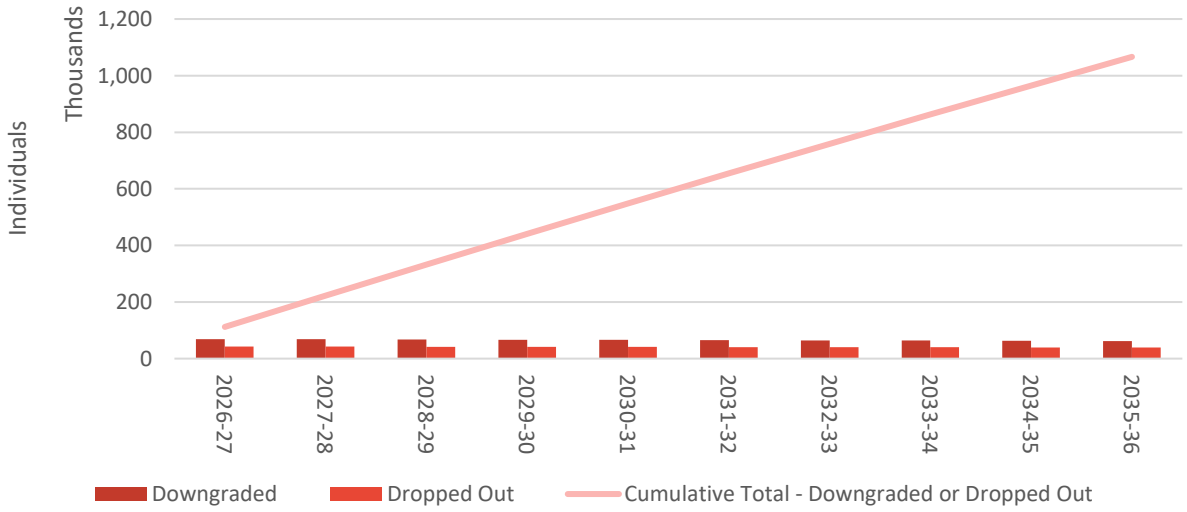
[89] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage*.

This trajectory is set to accelerate under current policy settings. As premiums continue to rise, more individuals, particularly younger and healthier Australians, are expected to downgrade further or exit the system entirely. Our modelling estimates that over the 10-year period from 2026–27 to 2035–36, the RAF will result in over 1 million additional individuals either downgrading or dropping PHI coverage completely. Under the base case scenario, which maintains current rebate policies, rebate rates will continue declining due to the RAF's design, accelerating both the tier slide and exits from PHI.

Table 6. Estimate of individuals downgrading and dropping PHI coverage due to the RAF[90]

Year	Downgraded	Dropped Out	Downgraded or Dropped Out	Cumulative Total – Downgraded or Dropped Out
2026–27	69,000	43,000	112,000	112,000
2027–28	68,000	42,000	111,000	223,000
2028–29	68,000	42,000	110,000	333,000
2029–30	67,000	42,000	108,000	441,000
2030–31	66,000	41,000	107,000	548,000
2031–32	65,000	41,000	106,000	654,000
2032–33	64,000	40,000	105,000	759,000
2033–34	64,000	40,000	104,000	863,000
2034–35	63,000	40,000	102,000	965,000
2035–36	62,000	39,000	101,000	1,066,000
Total	**656,000**	**410,000**	**1,066,000**	

Figure 21. Estimate of individuals downgrading and dropping PHI coverage due to the RAF[91]



The departure of low-risk young people from the insurance pool weakens the overall risk pool, driving premiums even higher for remaining participants and threatening the sustainability of PHI and the private hospital sector.

[90] DeltaPearl Partners modelling, Appendix 6.

[91] DeltaPearl Partners modelling, Appendix 6.

Text Box 5: The PHI 'death spiral'

The PHI 'death spiral'

A key feature of the PHI rebate is its role in encouraging younger people to access PHI. Younger people are typically healthier but earn lower incomes than older people, reducing the immediate personal benefit they derive from insurance. However, their participation is critical to the PHI system's viability given they contribute more to premiums than they consume in services, effectively keeping premiums affordable for all cohorts.

When an increasing proportion of low-risk policy holders leave the PHI system, the average net risk and cost of the PHI services increase, forcing insurers to increase their premiums. These increases create a cascade effect, driving additional price sensitive members to exit the system, which further concentrates risk among remaining participants and necessitates further premium increases.

Each round of increases pushes the next tier of healthier, more cost-conscious members out of the market, progressively shrinking the private system until it becomes a niche product accessible only to wealthy individuals with chronic conditions or anticipated surgical needs.

This self-reinforcing cycle of declining membership and rising premiums is known as a 'death spiral' – a market failure where adverse selection ultimately threatens the entire insurance system's collapse.

Without intervention to maintain broad participation across age and risk groups, the private insurance market faces systematic deterioration that would eliminate its capacity to support the private hospital sector and, by extension, Australia's dual healthcare model.

Declining PHI tier participation carries significant implications for the entire healthcare system. The scale of this impact is demonstrated in the analysis below.

Without policy intervention, the tier slide and declining coverage caused by the RAF is estimated to result in approximately 1.3 million fewer episodes being treated privately over the next decade. This reduction represents $6.7 billion in lost private medical expenditure that would otherwise support the private system. To maintain current health outcomes, the government would need to fund at least this additional $6.7 billion for the transferred hospital episodes or accept expanded public waiting lists with their associated consequences for population health.

Table 7. Reduction in medical services within the private hospital sector under the base case[92]

Year	Reduction in Episodes Treated	Reduction in Benefits Paid	Reduction in Individual Contributions	Total Lost Private Medical Expenditure
2026–27	24,000	$95,797,000	$12,308,000	$108,105,000
2027–28	47,000	$195,320,000	$25,095,000	$220,415,000
2028–29	70,000	$298,677,000	$38,374,000	$337,051,000
2029–30	93,000	$405,978,000	$52,160,000	$458,138,000
2030–31	116,000	$517,336,000	$66,467,000	$583,803,000
2031–32	138,000	$632,866,000	$81,310,000	$714,177,000
2032–33	161,000	$752,689,000	$96,705,000	$849,394,000
2033–34	183,000	$876,925,000	$112,667,000	$989,592,000
2034–35	204,000	$1,005,701,000	$129,212,000	$1,134,913,000
2035–36	226,000	$1,139,145,000	$146,357,000	$1,285,502,000
Total	**1,262,000**	**$5,920,434,000**	**$760,655,000**	**$6,681,090,000**

Moreover, this scenario would disproportionately harm the most vulnerable. While those with the financial means could still find ways to pay for private treatment out-of-pocket, the vast majority of Australians, including those the public system is specifically designed to protect, would face a healthcare landscape defined by queues and uncertainty. The quality and timeliness of care for everyone, including public-only patients, would inevitably be compromised as resources are stretched thinner and staff are placed under ever-increasing strain.

[92] DeltaPearl Partners Modelling, Appendix 6.

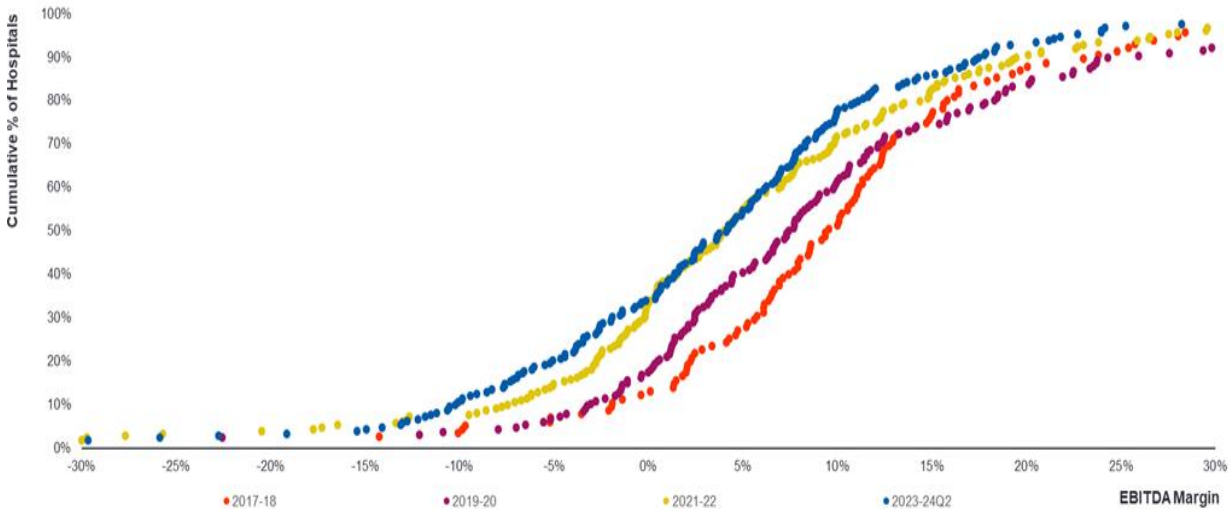
6. Visible system breakdown: private hospital closures create public sector strain

The private hospital sector in Australia is experiencing significant financial pressure. One recent sign of this pressure is Healthscope, Australia's second largest private hospital provider, entered into administration in early 2025.[93]

In response to growing concerns about private hospital viability, the Commonwealth Government in 2024 directed DoHDA to undertake a Financial Health Check of the private hospital sector.[94] The assessment examined cost structures, activity levels, pricing data, patient volumes and changes in case mix across the sector.[95] The findings revealed trends highlighting the challenges the sector is facing. Between 2018–19 and 2021–22, private hospital costs increased at a compound annual growth rate (CAGR) of 4.1 per cent while revenues grew at only 2.9 per cent.

This financial pressure is reflected in declining profit margins with weighted[96] average earnings before interest, tax and depreciation (EBITDA) margins falling from 8.7 per cent in 2018–19 to just 4.4 per cent in 2022–23 according to the Health Check.[97] DoHDA's estimate, taking into account the whole sector, is that the weighted average EBITDA margin was likely between 7 per cent and 8 per cent in 2022–23.[98]

Figure 22.EBITDA margins of private hospital sample between 2017–18 and 2023–24 Q2[99][100]



[93] The Hon Mark Butler MP, *Statement from Minister Butler – Healthscope* (Department of Health and Aged Care, 2025), https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/statement-from-minister-butler-healthscope.

[94] Department of Health, Disability and Ageing, *Private Hospital Sector Financial Health Check*.

[95] Casemix refers to the diversity and complexity of patient cases that a hospital treats.

[96] Average EBITDA margins are weighted by total operating revenue.

[97] Department of Health, Disability and Ageing, *Private Hospital Sector Financial Health Check*.

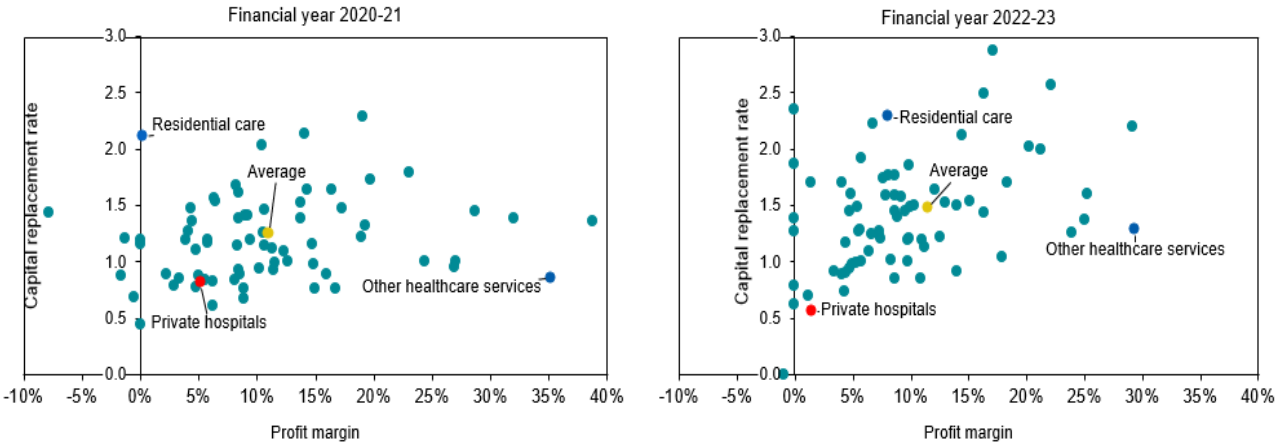
[98] The Department of Health and Aged Care stated that the financial data provided to the Health Check covered 58 per cent of private hospital separations and 63 per cent of private hospital revenue in 2022-23. Therefore, we assume the difference between the reported data and the public data provided by DoHDA is the Department's estimate of profit margins for the whole sector, including the 37 per cent of revenue not reported directly.

[99] Source: Private Hospital Sample submissions to the department.

[100] Notes: Hospital sites: 115 in 2017-18 (26 per cent of separations) growing to 209 (48 per cent of separations) in 2023-24Q2.

The DoHDA assessment identified declining profit margins alongside reduced capital replacement rates, indicating diminished investment in infrastructure and equipment. This combination suggests potential longer-term risks of asset deterioration that could compromise the private hospital sector's capacity to deliver high-quality care.

Figure 23.Capital replacement and profit margins for Australian private sector industries (ex. mining and real estate) in 2020–21 and 2022–23[101] [102]



Importantly, the DoHDA assessment indicates the private hospital market operates competitively without generating excessive profits and current pricing reflects highly efficient operations with limited scope for further cost reductions. The sector's financial viability depends heavily on PHI, which contributes over 45 per cent of their funding each year. This makes the PHI system of contracting with hospitals important to ensure the ongoing viability of the hospital sector. Although PHI payments to private hospitals experienced disruption during COVID-19, they have since recovered to exceed pre-2019 levels. However, the longer-term growth trajectory remains concerning, with PHI payments to private hospitals growing at only 2.56 per cent CAGR between 2012–13 and 2022–23 – a rate that, combined with rising costs, is compromising viability.

These DoHDA findings reinforce the critical importance of maintaining robust PHI participation and adequate rebate support to ensure the private hospital sector's continued role as a safety valve for public hospitals. However, as this analysis demonstrates, both PHI participation and PHI rebate support are declining at concerning rates, undermining sector viability and compromising the resilience of Australia's entire healthcare system.

[101] Australian Bureau of Statistics, *Australian Industry, Catalogue 8155.0* (2025), https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry/latest-release.

[102] Notes: Capital replacement measures the adequacy of replacing capital assets to cover depreciation. The average includes mining and real-estate services, although they are not shown in the scatterplot datapoints.

Figure 24. Private hospital funding by source 2022–23 (millions)[103] [104] [105] [106]

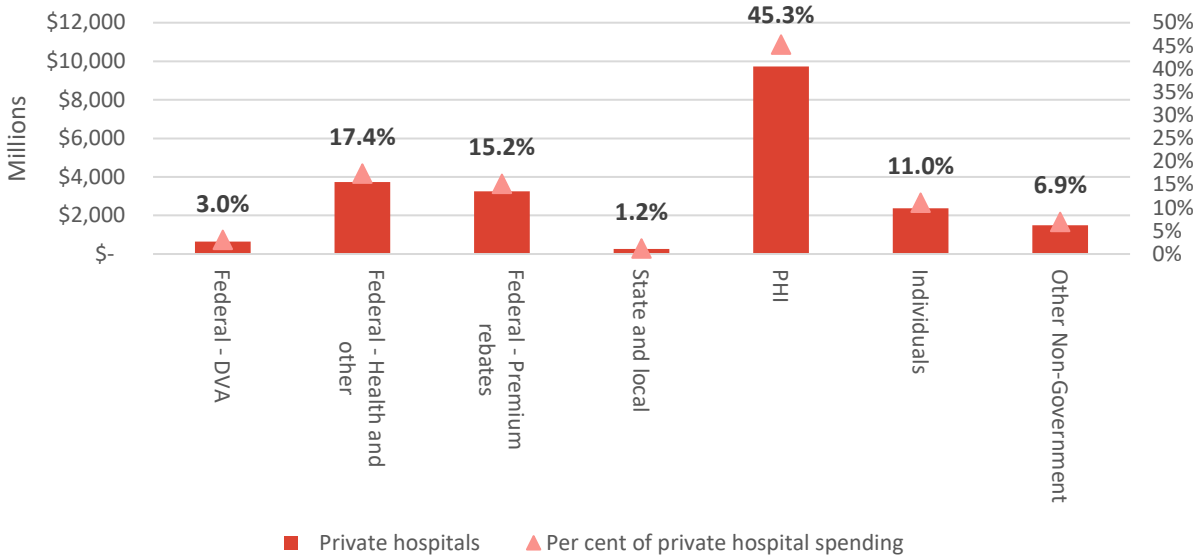
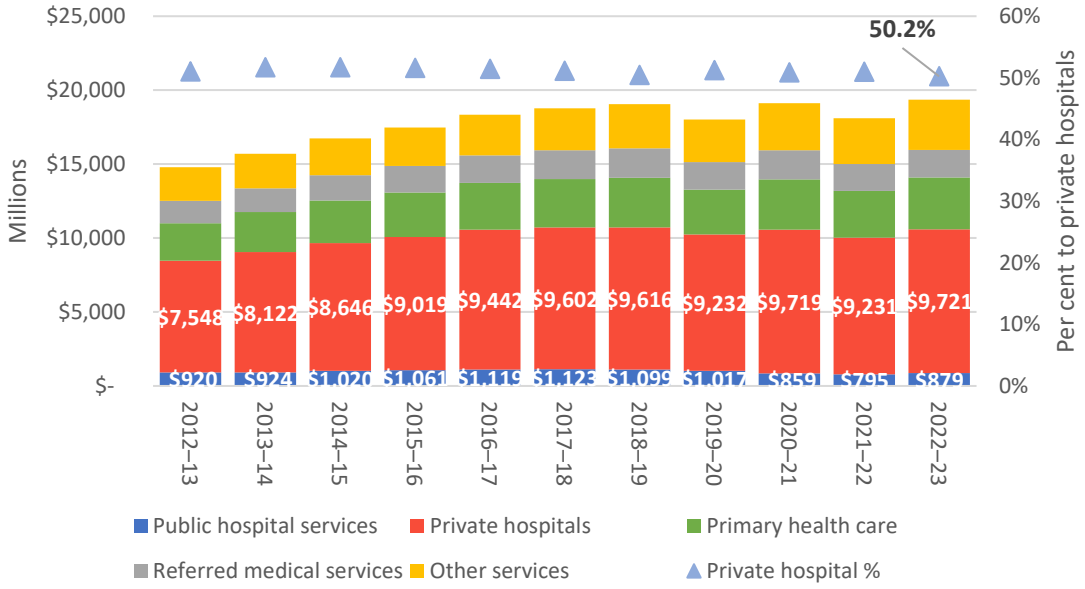


Figure 25. PHI spending by area, constant prices 2012–13 to 2022–23[107]



[103] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

[104] 'Health and other' figures include Commonwealth Government Department of Health and Aged Care's own programs, grants to states and territories (including National Health Reform grants, National Partnership of COVID-19 Response grants, PBS section 100 programs in public hospitals and other National Partnership Payments), funding by other Commonwealth Government agencies (including Department of Defence, capital consumption, and others).

[105] 'PHI' figures include health spending by Health insurance providers.

[106] 'Other' figures include health spending funded by other non-government sources (such as injury compensation insurance providers, non-government sector capital spending, non-patient revenue of private hospitals, and other private spending on health and medical research).

[107] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

6.1. Private sector closures of maternity services and hospitals

The concerning trajectory of declining PHI participation and reductions in the PHI rebate is already manifesting in tangible sector impacts, with private maternity hospital closures serving as a clear warning of the broader challenges facing the private hospital system. The maternity sector, which requires Gold tier coverage, has become particularly vulnerable to the tier slide phenomenon.

The scale of the decline in private sector maternity care is significant. Thirty years ago, nearly 40 per cent of all births occurred in private hospitals in Australia. However, in the decade from 2012 to 2023, the number of babies born in private hospitals has fallen dramatically,[108] now only around 22 per cent of births occur in private hospitals.[109] While multiple factors contribute to this reduction in births in private sector hospitals, including the declining birth rate, the reduction in private maternity cover is a key driver. The financial barriers are substantial. An analysis by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists estimated the cost of a Gold cover policy for a couple during the 12-month waiting period plus nine months of pregnancy is nearly $11,500.[110] This prohibitive expense is forcing women to abandon care even after it has commenced – a recent report by the National Association of Specialist Obstetricians and Gynaecologists published by the Medical Journal of Australia[111] found that 40 per cent of women who began antenatal care with a private obstetrician were unable to continue with private coverage. This decline in private maternity participation has translated into widespread service closures. Since 2018, private maternity hospitals and wards have been closing across Australia. At least 18 such closures have occurred since 2018, with the majority of these concentrated in the last four years[112], with health sector researchers predicting private sector maternity services may disappear completely.[113] [114] The Australian Medical Association (AMA) has described these closures as the 'canaries in the coalmine,' warning of widespread closures.[115] A recent analysis by Insight predicts that by 2030 it will no longer be viable for private hospitals to staff and run maternity services.[116] These closures place significant additional pressure on public hospital resources.

The Darwin private maternity hospital closure is expected to increase Royal Darwin Hospital's maternity load by approximately 13 per cent according to hospital data.[117] University of Technology Sydney has calculated that if every woman currently delivered privately delivered publicly, it would cost the health system an extra $1.7 billion annually.[118] The closures in the maternity sector illustrate the real-world consequences of tier slide and declining rebate effectiveness. As Gold tier coverage

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[108] Peter Day et al., *Australia's Mothers and Babies 1994* (Australian Institute of Health and Welfare National Perinatal Statistics Unit, 1997), https://www.aihw.gov.au/getmedia/e73a780e-96ca-42db-9cb3-1c1c3ae3fd58/aihw-per-4-australia-s-mothers-and-babies-1994.pdf.

[109] Around 74 per cent of births occur in public hospitals, with the remaining 3 per cent born outside hospital (birth centres, home or before arrival at hospital; Australian Institute of Health and Welfare, *Australia's Mothers and Babies* (2025), https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/place-of-birth.

[110] The estimate is $11,475.18 based on over $6,500 during the 12-month waiting period, and $4,917.93 required for a further nine months of coverage.

[111] Gino Pecoraro et al., *Private Maternity Hospitals: Extinct by the End of This Decade?*

[112] Dr Katherine Bassett, *The Collapse of Private Maternity Would Be a Public Health Disaster*, B (Catholic Health Australia, 2025), https://cha.org.au/the-collapse-of-private-maternity-would-be-a-public-health-disaster/.

[113] Gino Pecoraro et al., *Private Maternity Hospitals: Extinct by the End of This Decade?*

[114] Alison Branley, *Why HealthScope Maternity Closures Are an "absolute Crisis" and a Symptom of a Bigger Problem* (ABC News, 2025), https://www.abc.net.au/news/2025-02-21/srt-maternity-closures-insurance-private-health/104959630.

[115] Australian Medical Association, 27 February 2025, Alarm bells for private health viability following maternity closures, https://www.ama.com.au/ama-rounds/28-february-2025/articles/alarm-bells-private-health-viability-following-maternity

[116] Gino Pecoraro et al., *Private Maternity Hospitals: Extinct by the End of This Decade?*

[117] Annabel Bowles, *Northern Territory Women Delay Pregnancies, Travel Interstate as Only Private Maternity Ward Shuts* (ABC News, 2025), https://www.abc.net.au/news/2025-05-07/nt-mums-to-lose-only-private-maternity-birthing-ward/105254576.

[118] Alison Branley, *Why HealthScope Maternity Closures Are an "absolute Crisis" and a Symptom of a Bigger Problem*.

becomes less affordable and fewer women maintain this comprehensive level of insurance required for private maternity care, the viability of providing these services declines, leading to closures that cannot be easily reversed.

Table 8. Closures of private sector maternity hospitals and wards, 2018–2025 [119]

Closure date	Private hospital birthing unit	State/Territory
20 August 2025 (forthcoming)	Hobart Private Hospital (Healthscope)	Tasmania
June 2025	Darwin Private Hospital	Northern Territory
March 2025	Gosford Private Hospital	NSW
December 2024	Sydney Southwest Private Hospital (Healthscope)	NSW
June 2024	St John of God Bunbury Hospital	Western Australia
May 2024	Mater Private Hospital, Redland	Queensland
December 2023	North West Private Hospital	Tasmania
November 2023	Cairns Private Hospital (Ramsay)	Queensland
June 2023	Glengarry Private Hospital, Joondalup	Western Australia
March 2023	Epworth Hospital in Geelong	Victoria
May 2022	Sunnybank Private Hospital (Healthscope)	Queensland
July 2019	Flinders Private Hospital, Adelaide – Maternity Ward	South Australia
January 2019	Knox Private Hospital (Healthscope)	Victoria
2018	Mater Gladstone Hospital	Queensland

[119] Ibid.

Psychiatric hospitals

Similar to maternity care, psychiatric services undertaken in private facilities typically require Gold tier coverage, making them vulnerable to the same pressures. Early evidence suggests a similar trend may be affecting private sector psychiatric care, with mental health hospitals across several states/territories closing in recent years. The most recent closure was Toowong Private Hospital in Queensland (June 2025),[120] following the closures of facilities in Toowoomba, Hobart (August 2025) and Bethesda (WA)[121] between 2023 and 2025. These closures are particularly concerning given the huge demand for mental health treatment. Insurance data indicate mental health is the primary reason for patients visiting GPs and the leading cause of hospitalisation for people aged under 60 years.[122] Public hospital emergency staff report being overwhelmed with mental health cases, yet the private sector capacity to provide these services is contracting.

As fewer Australians maintain comprehensive insurance, the patient base for private mental health services shrinks, undermining the economic viability of specialised facilities and forcing closures precisely when these services are most needed.

6.2. Closures create public hospital strain

This trend creates a healthcare landscape increasingly defined by growing public hospital waiting lists that, in some jurisdictions, already exceed clinically recommended time by over 300 per cent.

Patients on official elective surgery waiting list are categorised by treatment urgency, which sets the clinically recommended timeframes:[123]

- Category 1 – within 30 days.
- Category 2 – within 90 days.
- Category 3 – within 365 days .

The figure below shows the proportion of overdue elective surgeries across all three categories by jurisdictions.

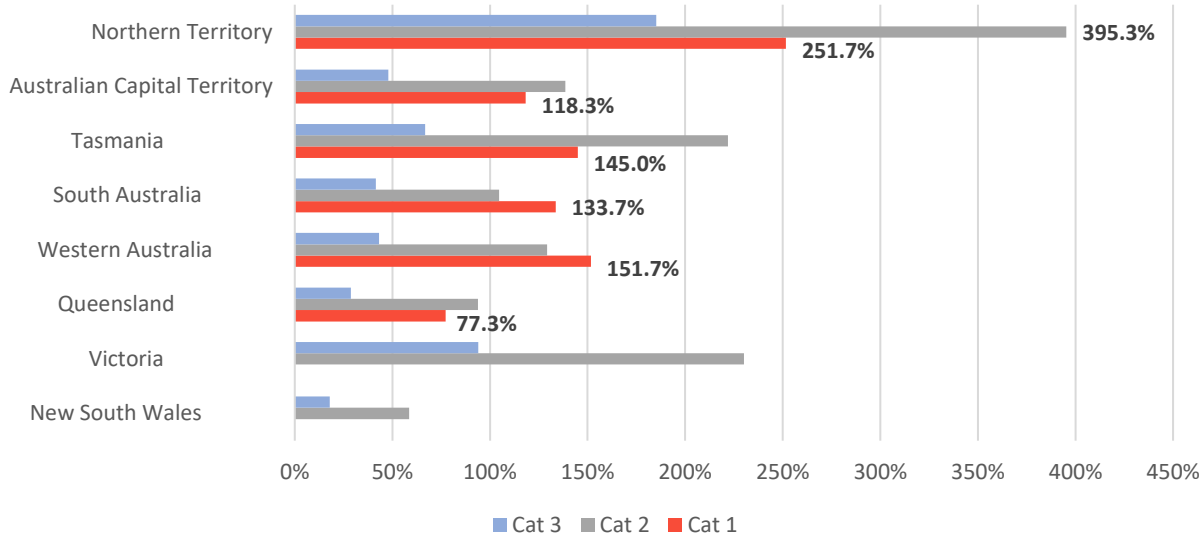
[120] Statements in an interview DeltaPearl Partners had with Christine Gee the CEO of the Toowong Hospital and President of the Private Hospitals Association https://toowongprivatehospital.com.au/about-us/our-people/; Janelle Miles, *Calls for Changes to Mental Health Funding as Toowong Private Hospital Set to Close after Nearly 50 Years* (ABC News, 2025), https://www.abc.net.au/news/2025-06-09/qld-toowong-private-hospital-closure-mental-health-insurance-/105390880. See also; Dr Katharine Bassett, *Silent Shutdowns: The Private Hospital Crisis Threatening Australia's Health System* (Catholic Health Australia, 2025), https://cha.org.au/silent-shutdowns-the-private-hospital-crisis-threatening-australias-health-system/.; Department of Health, Disability and Ageing, *Private Hospital Sector Financial Health Check*.

[121] Jo Trilling, *Perth Private Psychiatric Hospital Announces Closure after Just Nine Months Citing "Financial Unviability"* (ABC Radio Perth, 2024), https://www.abc.net.au/listen/programs/perth-drive/dr-neale-fong-bethesda-closure/103439472.

[122] Jemima Whyte and Michael Smith, *The Mental Health Crisis Gripping Australia's Private Hospitals* (Australian Financial Review, 2024), https://www.afr.com/companies/healthcare-and-fitness/the-mental-health-crisis-gripping-australia-s-private-hospitals-20240906-p5k8hp.

[123] Australian Health Ministers' Advisory Council, *National Elective Surgery Urgency Categorisation, Guideline – April 2015* (2015), https://ranzcog.edu.au/wp-content/uploads/AHMAC-National-Elective-Surgery-Categorisation.pdf.

Figure 26.Per cent of days elective surgery for public hospitals waiting time overdue on average, 2022–23[124]



According to the latest published State and Territory waiting list data, average waiting times for Category 2 and Category 3 elective surgeries now extend to 1.2 years and 2.9 years respectively, compared with the recommended wait times of within 90 days and 1 year.

These figures represent only the visible portion of the problem – the 'hidden waiting list' includes the additional time required to see a GP and then a specialist before patients even reach the official surgical queue. Including this hidden wait time extends total delays for Category 2 procedures to up to two years and Category 3 procedures to up to 7.9 years.

These delays represent far more than passive waiting periods – they constitute periods of potential active harm. Patients can experience physical decline, including prolonged pain, reduced mobility, muscle wastage and declining overall wellbeing. The deteriorating health often leads an inability to work, resulting in lost income and increased reliance on social support, worsening economic hardship for individuals and families. As conditions worsen during extended waiting periods, eventual surgery may become more complex or less effective. Importantly, although termed 'elective', these surgeries are medically necessary, as assessed by a clinical specialist, and may be required urgently. They are elective only in that they do not constitute emergency presentations.[125] [126] [127]

[124] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery*.

[125] Ibid.

[126] There are three categories of urgency for classifying elective surgery with associated timeframes within which care is required: Category 1: patients are assessed as requiring surgery within 30 days, including patients whose condition has the potential to deteriorate quickly and require emergency care; Category 2: patients are assessed as requiring surgery within 90 days, including conditions that cause pain, dysfunction or disability in patients whose condition is unlikely to deteriorate quickly and unlikely to require emergency care. Category 3: patients are assessed as requiring surgery within a year, including conditions that cause pain, dysfunction or disability in patients whose condition is unlikely to deteriorate quickly.

[127]. Examples of elective surgeries include cardio thoracic, gynaecology, neurosurgery, orthopaedic, otolaryngology head and neck surgery, paediatric, plastic & reconstructive, urological, vascular surgery. Australian Health Ministers' Advisory Council, *National Elective Surgery Urgency Categorisation, Guideline – April 2015*.

Text Box 6: 'Hidden' waiting lists

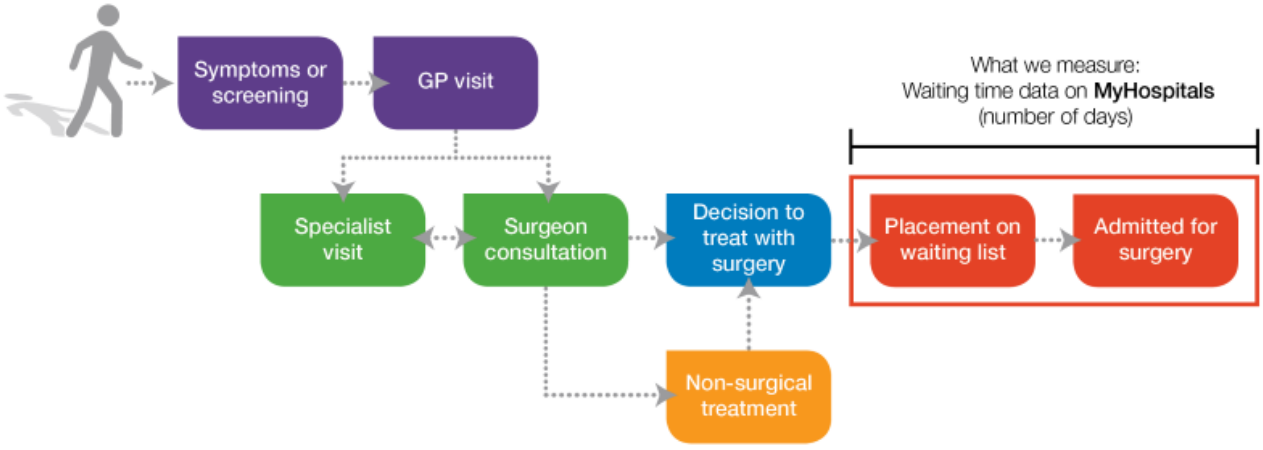
'Hidden' waiting lists

The hidden waiting list primarily comprises two waiting periods:

- waiting for a GP visit: especially in regional or underserviced areas, accessing a GP can involve delays.
- waiting for a specialist doctor appointment: this is the most significant component of the hidden waiting list. Patients often face lengthy waits – sometimes many months, or even over a year to see a specialist.

Patients are only added to the 'official' elective surgery waiting list following their specialist appointment, after they have already experienced a lengthy wait to see that specialist. Consequently, official statistics significantly under-represent the true duration of a patient's journey from initial referral to treatment, masking the full extent of demand pressures on the public health system.

Figure 27. Typical treatment pathway[128]



The AMA commented on the extent of these waiting times:[129]

> *[T]he target for urgent appointments is 30 days, however the 90th percentile wait time for an urgent gastroenterology outpatient appointment is over 150 days in both Victoria and Queensland. Those patients requiring an urgent neurosurgeon appointment can wait up to 930 days for an appointment in Victoria. For non-urgent appointments, the target is 365 days, however the 90th percentile wait time for most specialist appointments is above this. In Queensland, a patient may wait almost 700 days for an ear nose and throat appointment, and over 1,400 days in Victoria. Waiting times for ophthalmology, orthopaedic, plastic/reconstructive appointments are all over 700 days in both states.*

[128] Australian Institute of Health and Welfare, *Waiting Times for Surgery*.

[129] Australian Medical Association, *Shining a Light on the Elective Surgery "hidden" Waiting List*.

The distribution of the impacts on the public sector and patients is likely to be uneven, with more remote and lower socioeconomic regions expected to experience the largest and earliest impacts.

Already, smaller regions that have limited capacity to grow government revenues are showing significant problems in the public hospital system. The Northern Territory, ACT and Tasmania all report very long elective surgery waiting lists. Regional and remote areas face even longer delays and limited access to care. The data below show the 50th and 90th percentile waiting times by regional categorisations, revealing outer and inner regional areas represent the worst performing regions in Australia for waiting times. While both series show COVID 19 impacts from which they have not recovered, the underlying trend predates the pandemic. Remote regions experienced steady growth in waiting times for many years before COVID 19, with 90th percentile wait times increasing from 178 days in 2013–14 to 243 days in 2018–19.

Figure 28. Long-term trends of 50th percentile average elective surgery waiting days by regional categorisation 2013–14 to 2022–23[130]

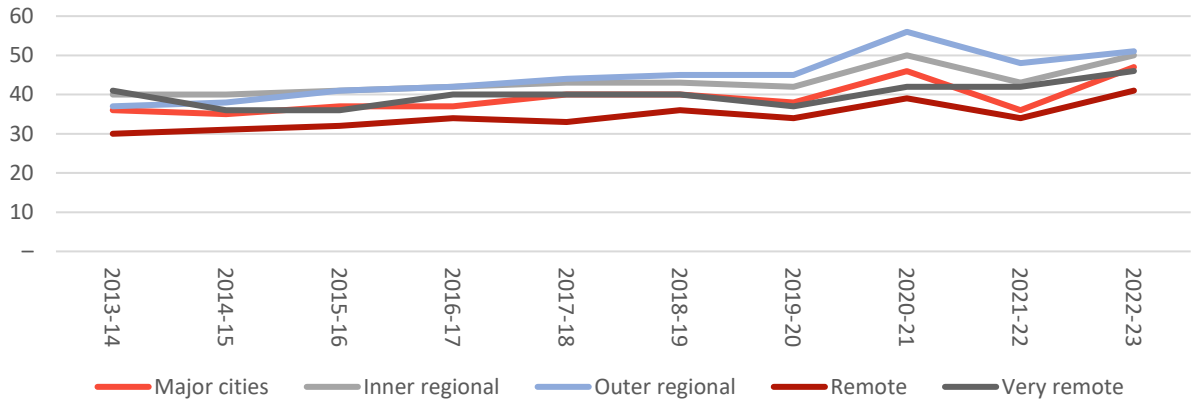
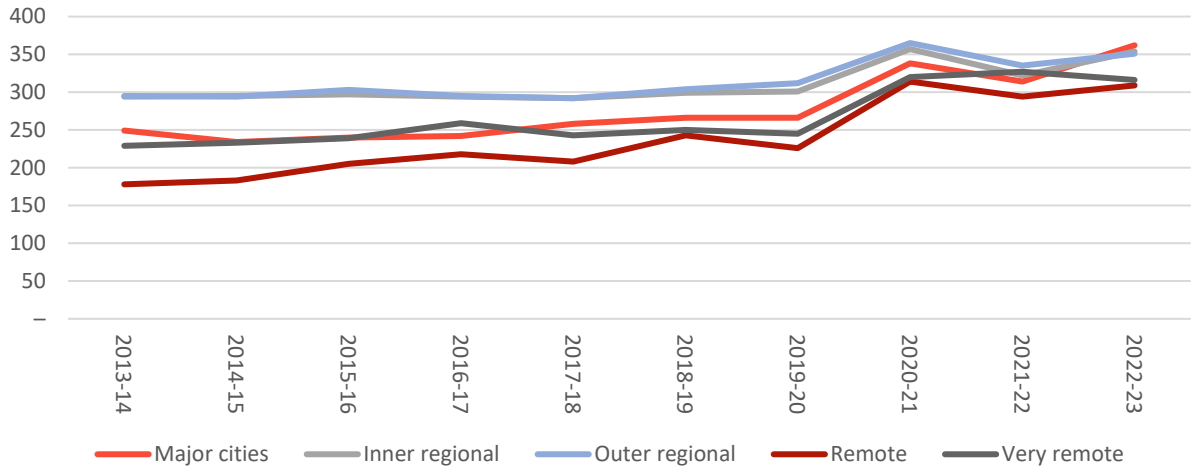


Figure 29. Long-term trends of 90th percentile average elective surgery waiting days by regional categorisation 2013–14 to 2022–23[131]



[130] Australian Institute of Health and Welfare, *Hospitals, Data Downloads*.

[131] Ibid.

6.2.1. Some other issues affecting public sector waiting lists

IHAPCA pricing

The government intervenes in the health market to set average prices for public hospital activities through the Independent Health and Aged Care Pricing Authority (IHACPA). Intervention is required because there are no natural competitive pressures in the market to set an efficient price and to balance supply and demand. Supply must be set through this process with expectations of some level of elective surgery waiting list given the demand pressures.

IHAPCA sets prices of public hospital activities at the observed average price. This then has the effect of setting the Commonwealth public hospital budget and providing a price benchmark.[132] However, the observed average price is not truly an efficient price.[133]

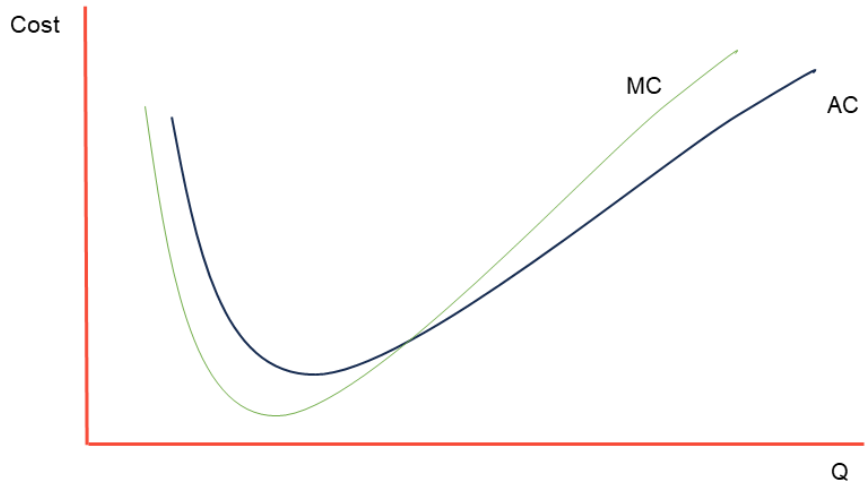
Public hospital costs are typically not linear; instead, they tend to increase per unit of delivery. That is, as demand increases and the hospitals' available capacity (supply) is used up, the cost-of-service delivery increases per unit. The observed average price ignores the impact of the increasing marginal cost of suppling hospital services.

Text Box 7: Hospital cost curves

Hospital cost curves

As illustrated in the graph below, each hospital faces a cost curve that reduces per unit for a period but then will start to increase over time as usable capacity is used. The available funding depends on IHACPA's estimates of all hospitals cost curves in Australia and the accuracy of projections of this curve.

Figure 30. Illustrative hospital cost curves – marginal cost and average cost[134]



[132] Independent Health and Aged Care Pricing Authority, *National Efficient Price Determination* (2025), https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination.

[133] For example, see Peter Breadon et al., *Special Treatment: Improving Australians' Access to Specialist Care* (Grattan Institute, 2025), https://grattan.edu.au/report/special-treatment-improving-australians-access-to-specialist-care/.

[134] Developed by DeltaPearl Partners – illustrative only, MC = marginal cost, AC = average cost, Q = quantity

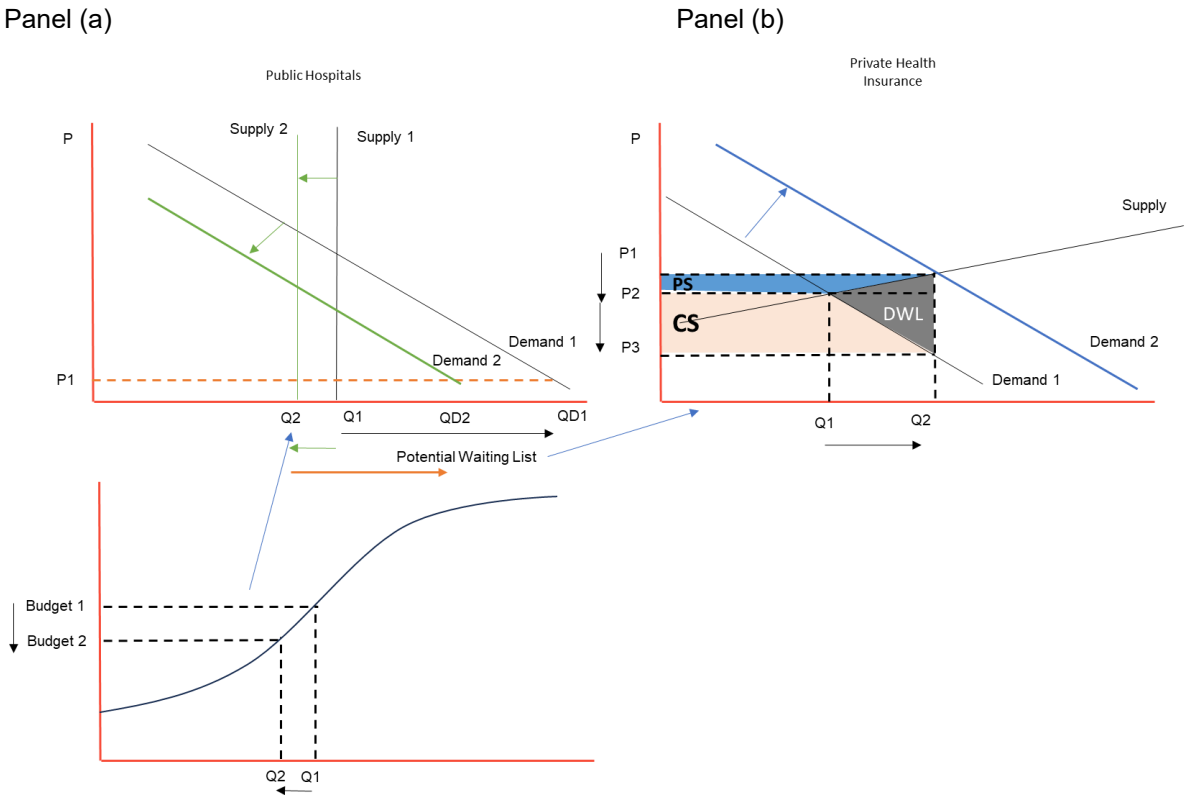
Costs of production will differ between hospitals for many reasons, with one key factor being the degree to which available capacity is utilised. Prices set by IHACPA set the budget based on demand, but limitations on the physical space and other capital items in a hospital will limit the possible throughput and increase the cost of unit production.[135] Estimating capacity and utilisation of all hospitals in Australia is not likely to be possible for the purpose of pricing, which is likely to be compounded by not including capital in the price.[136] This separation of capital from the pricing is unusual for regulatory price-setting processes in Australia. Prices set for other government and private monopolies by price regulators factor in capital costs.

Text Box 8: Supply and demand and waiting lists under IHACPA pricing

Supply and demand and waiting lists under IHACPA pricing

An illustration of the IHACPA pricing process and its impact on supply and demand (and hence on waiting lists) is provided below.

Figure 31. Public hospitals, public hospital budgets and PHI supply/demand illustrative graphic[137][138]



[135] For example, a hospital might have a theoretical capacity of 100 and be operating at 50 for a unit cost of production of $2,000. Increasing the production to 60 might reduce the unit cost to $1,950. However, as the hospital continues to increase utilisation over 80, it is likely to experience diseconomies of scale and move up the cost curve to $2,500 per unit.

[136] Furthermore, hospitals, in common with many other systems, have both 'nameplate' capacity and usable capacity. Nameplate capacity is the estimated maximum capacity of the hospital give a set of assumptions. The usable capacity is the actual throughput possible given the wide range of issues faced in the hospital daily, which causes friction and reduces the throughput.

[137] Developed by DeltaPearl Partners – illustrative only.

[138] CS = consumer surplus, PS = producer surplus, P = price, Q = quantity, QD = quantity demand, Budget = state level public hospital budget

Supply and demand and waiting lists under IHACPA pricing

Initially IHACPA pricing establishes Budget 1 (Panel (c)), which sets the quantity of services provided by public hospitals at Q1 based on Supply 1 (see Panel (a)). The quantity supplied is essentially fixed due to the budget constraint of the State/Territory Governments. At this stage, the private sector capacity is ignored.

Although quantity is set at Q1, the demand for public hospitals is much higher because price is effectively zero. Consumers demand QD1, far to the right of Q1 (Panel (a)). The potential waiting list is measured by the distance between Q1 and QD1, that is, the difference between the demand supplied through the IHACPA price/budget setting and the actual total demand at zero price to consumers.

To address demand exceeding supply, the Commonwealth Government uses some of its available budget funds to provide incentives (via PHI rebates) to the public to invest in their own health care; in Panel (a), this is shown as the shift down of the quantity of services provided at public hospitals from Q1 to Q2. The PHI incentives also shift the demand curve for public hospitals down as people move to private hospitals, which reduces the waiting list to Q2 to QD2 in Panel (a). In Panel (c), the reduced public hospital demand reduces the down to Budget 2.

Now, considering the private hospitals, Panel (b) shows the related changes in the supply and demand for those services. Supply is reasonably competitive and shown as an almost horizontal line, which remains constant in this illustration. In a normal competitive market, the price to the consumer would be P2, but this only satisfies the lower level of demand shown by Demand 1. The government rebate subsidy changes the price faced by the consumers down to P3, which then shifts the demand curve out to Demand 2. The higher demand with the rebate subsidy means that producers can secure a higher price (P1) as their fee for services.

As Panel (b) shows, the subsidy creates a producer surplus (PS), a consumer surplus (CS) and a deadweight loss (DWL). Estimate of the government subsidy is the total area of PS + CS + DWL.

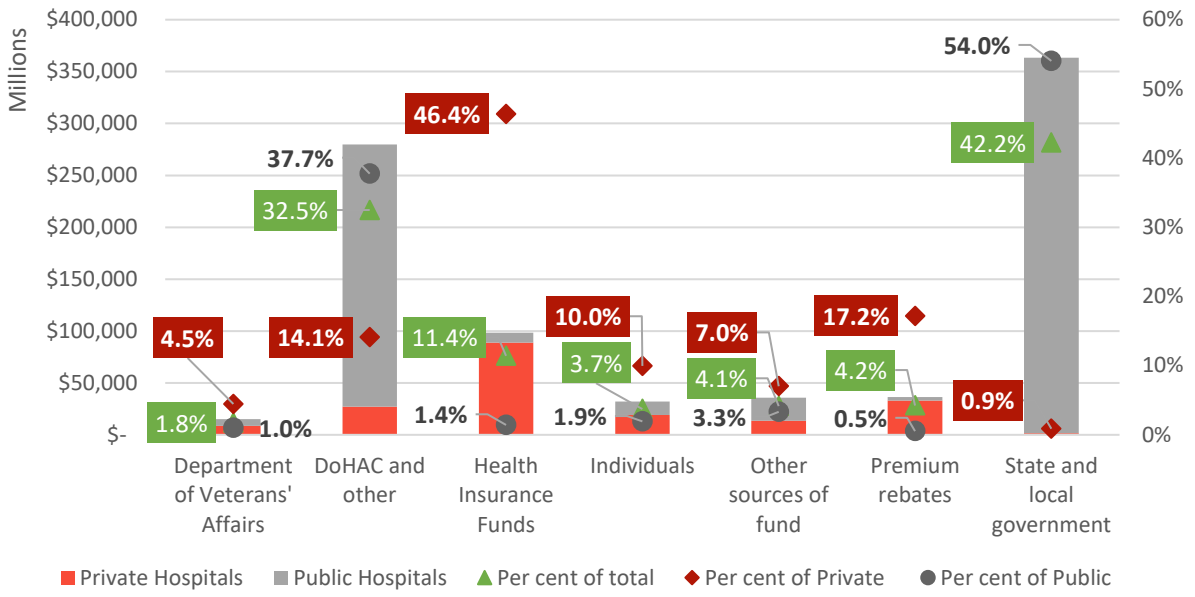
Vertical fiscal imbalance

The problem is exacerbated by the fact that the state/territories have responsibility to deliver hospital services, but the Commonwealth collects the largest portion of the tax income. To increase hospital funding, State/Territory Governments would potentially have to stop providing some other services due to their limited tax collection powers.

Funding flows from different levels of government are directed towards specific areas of hospital activity. The Commonwealth Government only funds a maximum of 45 per cent of growth in activity in public hospitals (currently estimated as 37 per cent of total public hospital funding) and the State and Territory Governments fund the remainder.

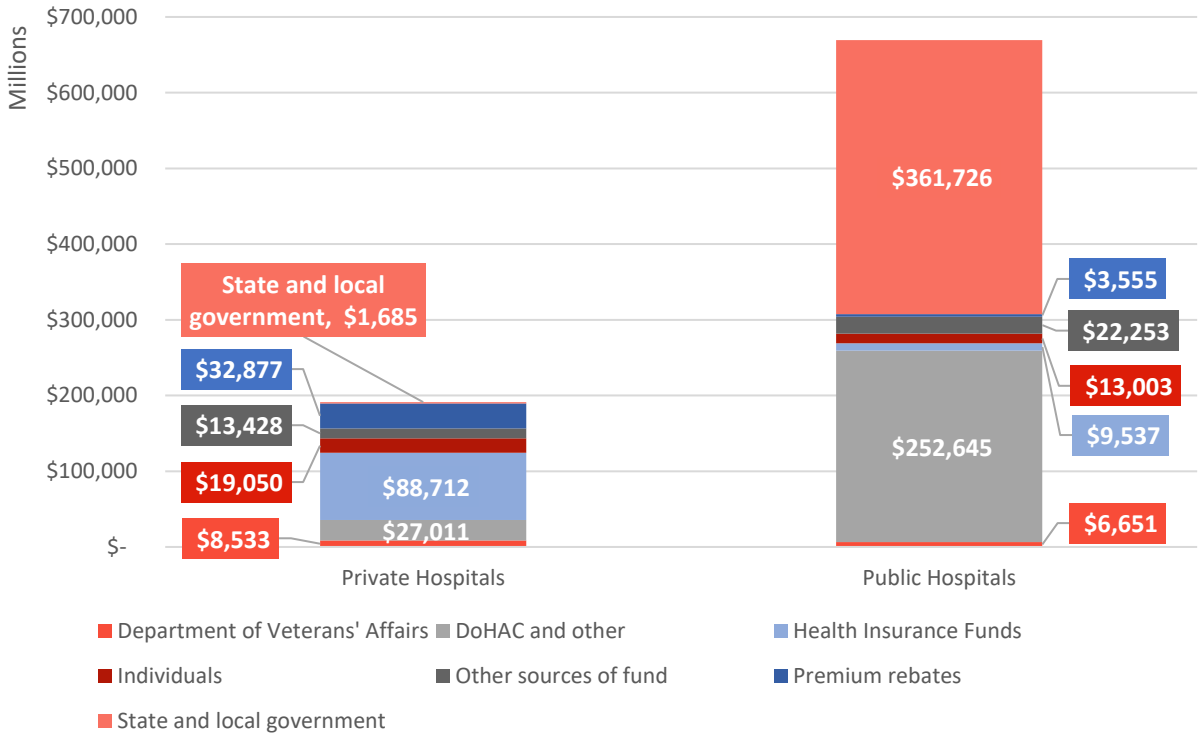
The Commonwealth Government is responsible for supporting private hospitals through the PHI rebate, while State and Territory Governments have no funding responsibility for private hospitals.

Figure 32. Public and private hospital funding source and per cent of funding for each, 2023–24[139]



Below is another view of the same funding data to demonstrate the scale difference in funding for public and private hospitals by each level of government.

Figure 33. Public and private hospital funding source, 2023–24[140]



[139] Australian Institute of Health and Welfare, *Hospitals at a Glance*.

[140] Ibid.

7. Conclusions: a system at a critical juncture

Indispensable role of private hospitals in dual health system

Australia's dual healthcare system integrates public and private sectors to deliver comprehensive community care. The private hospital sector plays an essential role by providing planned elective surgeries, maternity services and specialist treatments, allowing the public sector to focus on emergencies and complex cases. Private hospitals currently perform around 67 per cent of all elective surgeries, alleviating demand pressures and maintaining overall system efficiency. However, the current policy trajectory, driven by the declining PHI rebate and private sector closures, threatens to weaken this partnership and undermine system-wide benefits including universal public access, timely treatment and resilience to demand shocks.

PHI as cornerstone of health system

The PHI rebate is central to sustaining both public and private hospital sectors. By making PHI more affordable, the rebate keeps younger, healthier members in the insurance pool, stabilising premiums and maintaining the viability of private hospitals while protecting the balance between public and private care.

Erosion of rebate due to the RAF

Rebate rates have declined 19 per cent since 2013 due to the rebate adjustment mechanism, reducing incentives for PHI retention, particularly among younger Australians.

Tier slide

Declining PHI affordability drives ‘tier slide’ – consumers downgrading to less comprehensive policies that exclude key services such as maternity and psychiatric care. This weakens the risk pool, drives premiums higher and creates a ‘death spiral’ threatening private system sustainability.

Equity and distributional impacts

Longer waiting times not only affect patient outcomes and satisfaction but also undermine equity by disproportionately affecting those unable to afford private care. Waiting times for elective surgery in the public system have the potential to be more than an issue of health system efficiency; they could be a significant driver of inequity, creating a two-tier health system where timely access to care is often determined by socioeconomic status rather than clinical need. The impacts of this disparity could be profound and disproportionately affect the nation's most vulnerable.

The most prominent inequity is the socioeconomic divide. Australians with PHI or the capacity to pay substantial out-of-pocket costs can bypass public queues, receiving treatment in the private system often within weeks. In contrast, those reliant on the public system, typically lower-income earners, pensioners and the unemployed, have no choice but to endure waits that can stretch for months or even years. This delay is not necessarily a passive wait; it may be a period of active harm. Patients may experience deteriorating physical health, which may contribute to an inability to participate fully in the labour market, resulting in lost income and increased reliance on social support, thereby exacerbating financial hardship.

Furthermore, the burden is not shared equally across the country. A significant geographic penalty exists for those in regional, rural and remote areas. These communities already face barriers in accessing specialist consultations and have fewer local surgical services. Long waits are compounded by the additional financial and logistical burdens of travel and accommodation for treatment in metropolitan centres. The loss of private hospital in regional areas, demonstrated by the experience in the maternity sector, is evidence of the disproportionate impact expected in regional and remote areas.

The delays associated with waiting lists also have a severe impact on specific cohorts. For older Australians, a long wait can mean they become too frail or develop comorbidities that make them ineligible for surgery by the time their name reaches the top of the waiting list. For First Nations Australians, who already experience significant health disparities, the system's long waits can compound existing barriers to culturally safe and accessible care. Ultimately, long waiting times can transform a manageable health condition into a chronic, debilitating problem that erodes quality of life, mental wellbeing and economic participation, undermining the universal principle of Medicare and cementing disadvantage for those who can least afford it.

System breakdown

The private hospital sector faces significant financial strain, with declining profit margins[141] and widespread closures, most notably in maternity and mental health services. At least 18 private maternity units or hospitals have closed since 2018. Current policy settings will intensify these trends over the next decade. Maintaining or strengthening the rebate would support PHI participation, protect private hospital capacity, stabilise the dual system and preserve patient choice while containing long-term public expenditure.

Investment returns

The modelling completed for this analysis demonstrates that the government receives net fiscal gains from the PHI rebate. The four counterfactual scenarios confirm the rebate's critical role as a system enabler. Cutting or removing the rebate would force millions to drop or downgrade PHI, shifting care to public hospitals, which would require billions more in funding. Complete rebate removal would shift $74.3 billion in healthcare costs to the public system over a decade, far exceeding rebate savings. Conversely, maintaining or restoring rebate rates generates net government savings. Scenario 3 (maintaining the rebate) saves $0.2 billion annually, while Scenario 4 (restoring the rebate) saves $0.5 billion annually, as rebate costs would be offset by greater public hospital savings.

[141] Department of Health, Disability and Ageing, *Private Hospital Sector Financial Health Check*.

Appendices

Appendix 1. Features of Australia's healthcare system

Australia's healthcare system is a dual public–private model, with universal public coverage complemented by private sector provision. In essence, the publicly funded universal healthcare system Medicare ensures access to essential medical care, hospital services and affordable medicines for all eligible residents.[142]

Text Box 9: Components of Medicare

Components of Medicare:[143]

- ***Free access to public hospitals***: Medicare covers the full cost of treatment as a public patient in a public hospital.
- ***Subsidised medical services:*** Medicare covers some or all the costs of medical services provided by GPs, medical specialists and some allied health services (e.g., physiotherapy and basic dental for children).[144] The Medicare Benefits Schedule (MBS)[145] lists all the specific services subsidised by the government, with a Medicare Safety Net to reduce out-of-pocket costs for individuals who incur high medical expenses in a year.
- ***Subsidised prescription medications***: The third component of Medicare is the Pharmaceutical Benefits Scheme (PBS), which subsidises pharmaceutical costs for eligible persons.[146] The PBS covers a wide range of essential medicines, including those for cancer, mental health, pain and rare diseases. Significant subsidises make the prescription medicines much more affordable. Like the MBS, the PBS has a safety net to cap annual medicine expenses for individuals and families.

Medicare is funded by the Medicare levy, the Medicare levy surcharge and general taxation.

State and Territory Governments and the Commonwealth Government share responsibility for funding public hospitals, while subsidies under the Medical Benefits Scheme and the PBS are funded by the Commonwealth.

Individuals may also choose PHI to utilise the private sector for the provision of hospital care and ancillary services. The government encourages individuals to adopt PHI through incentives (rebates) and the Medicare levy surcharge. As discussed in the main report, the PHI system offers greater choice and coverage of additional services to those provided by the public services. The system is managed through a complex interplay of Commonwealth, State/Territory and local government and private sector responsibilities and funding.

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[142] Medicare is available to Australian and New Zealand citizens, permanent residents, and individuals from countries with reciprocal healthcare agreements.

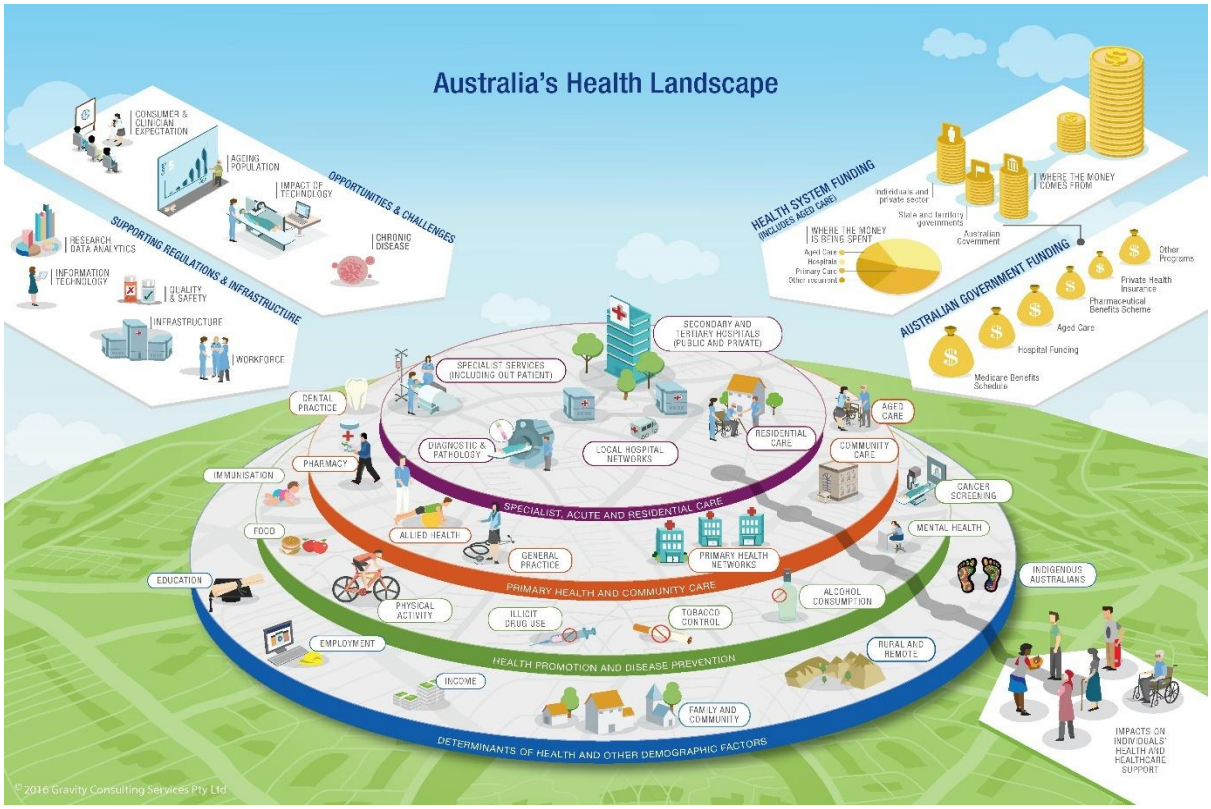
[143] Department of Health, Disability and Ageing, *The Australian Health System* (2025), https://www.health.gov.au/about-us/the-australian-health-system.

[144] Essentially the MBS covers 75 per cent of the schedule fee for treatment in private hospitals, and for private treatment in public hospitals; 85 per cent of the schedule fee for covered medical services outside of hospitals; and 100 per cent of the schedule fee for GP visits. GPs can bulk bill, receiving the Medicare benefit as full payment, though many do not do so.

[145] Department of Health, Disability and Ageing, *Medicare Benefits Schedule - Note GN.10.26* (2025), https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.10.26.

[146] Not everyone is eligible for every medication on the PBS. Eligibility depends on factors such as age, sex and medical condition and history. If an individual is prescribed a medication on the PBS list but does not qualify for the subsidy, they are liable for the full cost. See Department of Health, Disability and Ageing, *The Pharmaceutical Benefits Scheme - Explanatory Notes* (2020), https://www.pbs.gov.au/info/healthpro/explanatory-notes.

Figure 34. Infographic of the Australian healthcare system[147]



Service delivery involves a range of healthcare providers, with key players summarised below.

Text Box 10: Service delivery — Healthcare providers

Service delivery — Healthcare providers

General Practitioners (GPs): Act as the first point of contact for most health issues (primary care).

Medical Specialists: Provide specialised medical care, often on referral from a GP.

Allied Health Workers: Include professionals such as physiotherapists, psychologists and dietitians.

Nurses: Work across all sectors of the healthcare system.

Primary Health Networks (PHNs): Introduced to improve coordination and local service delivery at a regional level. PHNs operate across 31 regions. These organisations:

- Support local health providers (GPs, hospitals, community health centres).
- Coordinate care, especially transitions such as hospital discharge.
- Assess local health needs and commission extra services where required (e.g., after-hours services, mental health programs, health promotion).

Very broadly, the Australian and State and Territory Governments share responsibility for funding, operating, managing and regulating the health system.

[147] Department of Health, Disability and Ageing, *Australia's Health Landscape Infographic* (2017), https://www.health.gov.au/resources/publications/australias-health-landscape-infographic.

Text Box 11: Government responsibilities by level of government

Government responsibilities by level of government

Commonwealth Government:

- Funds and administers Medicare (MBS) and the PBS.
- Regulates PHI.
- Funds primary health care, aged care, health and medical research, veterans' health and Aboriginal and Torres Strait Islander primary healthcare.
- Manages doctor supply, national immunisation programs (vaccine purchasing), regulation of medicines/devices (through the Therapeutic Goods Administration) and coordinates national health emergencies (shares responsibility for national health emergency responses with states/territories).
- Funds public hospitals (shared responsibility with states/territories).
- Funds preventive services (shared responsibility with states/territories).

State/Territory Governments:

- Manage and administer public hospitals.
- Fund public hospitals—shared responsibility with the Commonwealth Government, as established under the National Health Reform Agreement (NHRA). The funding split is often viewed as a 45/55 split, although the actual funding arrangements are more complex and the Commonwealth share is approximately 40 per cent at present.[148]
- Fund some preventive services (shared responsibility with Commonwealth Government) and deliver public preventive services (e.g., breast cancer screening, immunisation programs).
- Fund and manage community health, mental health services, public dental clinics and ambulance/emergency services.
- Regulate health premises.

Other responsibilities that are shared between State/Territory and the Commonwealth Governments include palliative care and mental health reform.

Local Governments:

- Provide environmental and public health services.
- Offer community-based health and home care services.

[148] The funding methodology set out in the NHRA is a 'growth funding' model where only growth is funded at a 45 per cent contribution from the Commonwealth while the base is funded at the prior year's Commonwealth Contribution Rate. The Commonwealth contribution to NSW public hospital costs is currently around 40 per cent according to the latest AIHW data. see https://www.aihw.gov.au/reports/australias-health/health-system-overview. The reforms at this time included a shift from block grants to activity-based funding as detailed in the NHRA. More details are available at: Department of Health, Disability and Ageing, *2020–25 National Health Reform Agreement (NHRA)* (2024), https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra.; National Health Funding Body, *National Health Reform Agreement* (2025), https://www.publichospitalfunding.gov.au/about-us/nhr-agreement.

Health spending by source

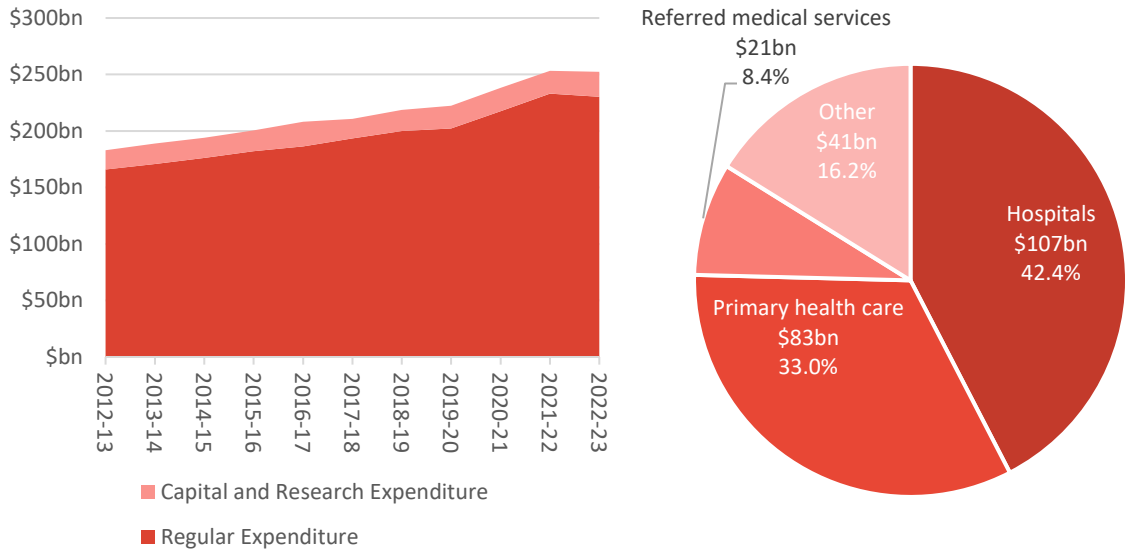
Australia's healthcare system combines public funding from Commonwealth and State and Territory Governments with private funding, reflecting the mix of public and private service provision.[149]

Table 9: Health sector funding by source of funds, 2022–23 [150][151]

Health expenditure funding	
Government	$178.7 billion (70.8% of total health spending)
Commonwealth	$101.5 billion (8.2% ↓ on previous year)
State / Territory	$77.3 billion (5.9% ↑ on previous year)
Non-government	$73.8 billion (29.2% of total health spending) (5.8% ↑ on previous year)
Individuals	$38.9 billion (52.6% of non-government health expenditure)
PHI providers	$19.3 billion (26.2% of non-government health expenditure)
Other non-government	$15.6 billion (21.1% of non-government health expenditure).

Funding for hospitals is estimated to be approximately 40 per cent of all health spending.

Figure 35. Australian health system expenditure 2022–23[152]



[149] Australian Institute of Health and Welfare, *Health System Overview* (2024), https://www.aihw.gov.au/reports/australias-health/health-system-overview.

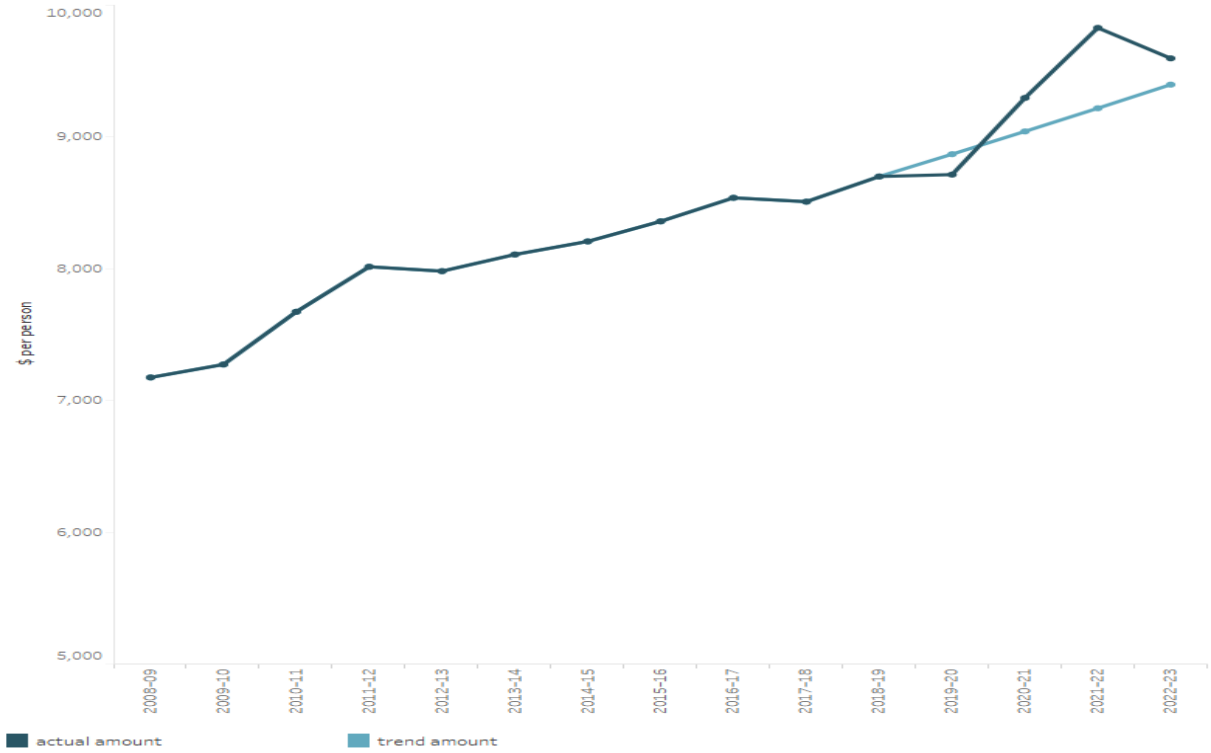
[150] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

[151] Note: Excludes funding on the NDIS, estimated at roughly $4.0 bn by the NDIA for 2022-23

[152] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

Average per capita total healthcare spending in 2022–23 was $9,597. Although the per person rate is lower than the previous year, as shown in the graph below, it is above the trend. The reduction in per person rate is part of the recovery from the COVID-19 health response.

Figure 36. Australian health spending per person, 2008–09 to 2022–23[153]

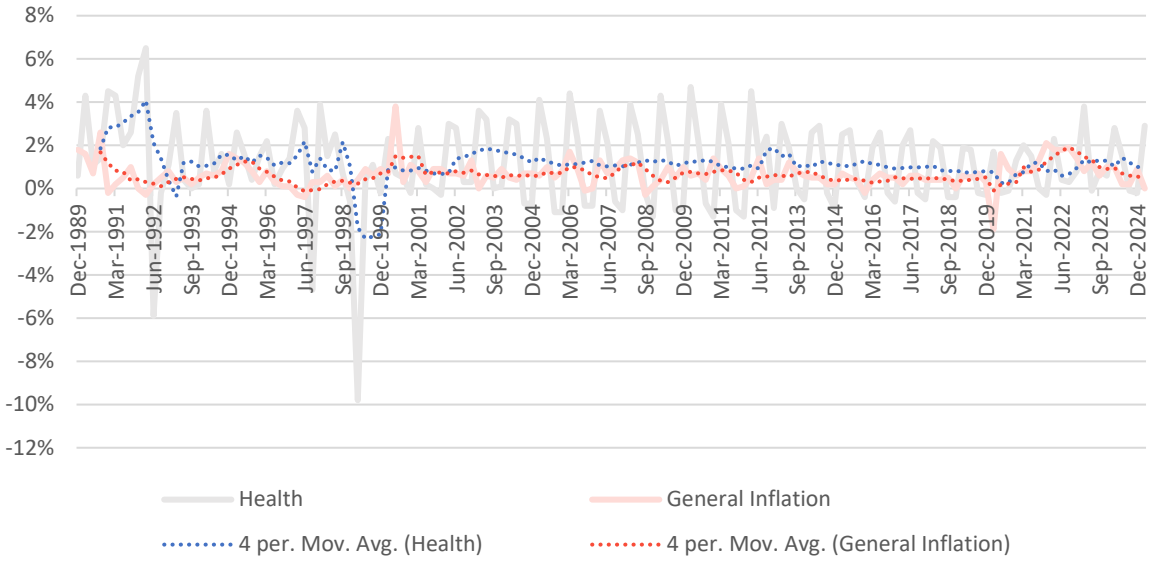


Health inflation

Historically, health inflation has exceeded general inflation in most years, although this reversed during the COVID-19 pandemic. The graph below uses a moving average to show long-term trends. Health inflation is likely to remain higher on average than general inflation, driving cost increases, although productivity gains from technology and organisational improvements may help mitigate some of these costs.

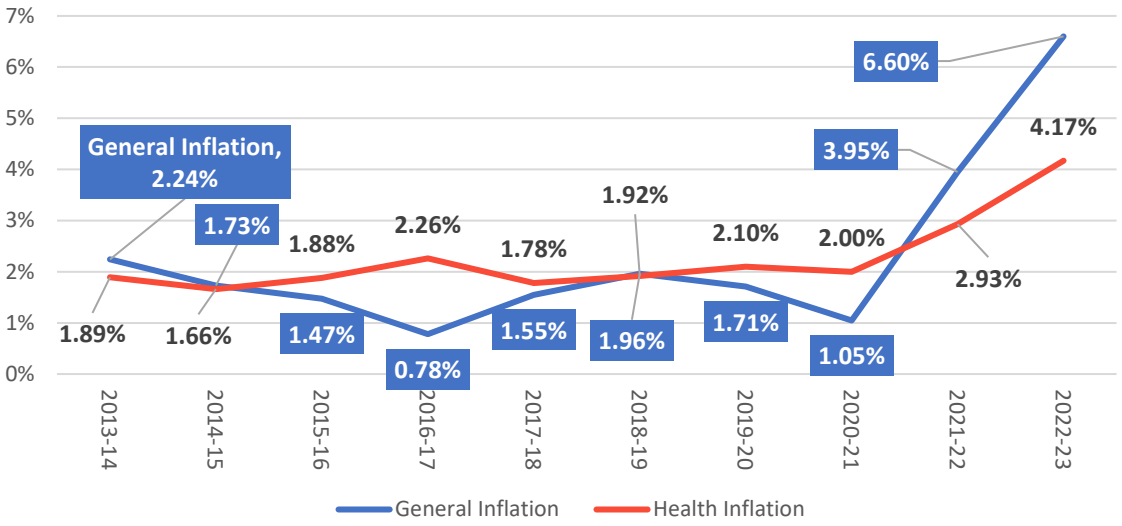
[153] Ibid.

Figure 37. Health inflation compared to general inflation, quarterly & 4 quarter moving average, 1989 to 2024[154]



The graph below, focusing on the more recent measures of inflation, shows the jump in general inflation due to the COVID-19 response.

Figure 38. Annual health inflation and general inflation 2012–13 to 2022–23[155]

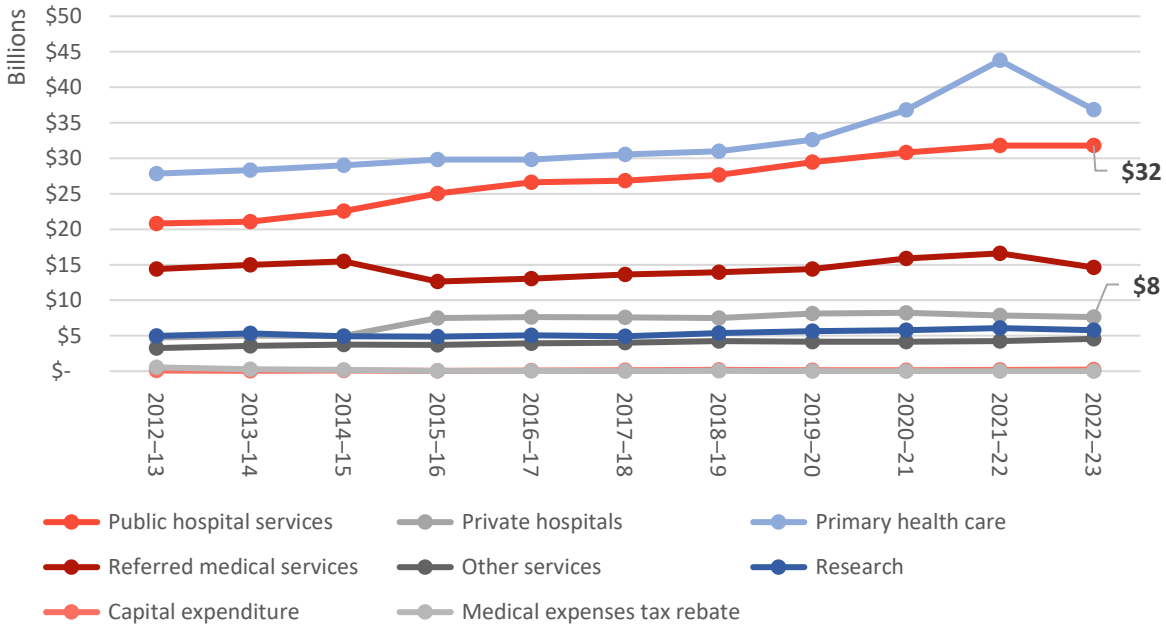


The majority of Commonwealth Government health expenditure is spent on primary health care (36 per cent) and public hospitals (31 per cent). Private hospital funding makes up approximately 7.5 per cent of the total spending in 2022–23. The total Commonwealth Government health spending is sensitive to changes in the public hospitals. Commonwealth Government public hospital spending includes an estimate for government benefits paid for in-hospital MBS services, which is between $783 million and $982 million.

[154] Australian Bureau of Statistics, *Consumer Price Index, Australia*.

[155] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

Figure 39. Commonwealth Government health spending by area of spending, constant prices, 2012–13 to 2022–23[156]



Public hospitals

The public hospital system is the foundation of Australia's universal healthcare system and is accessible to all Australian residents.

The provision and management of public hospitals is the responsibility of State and Territory Governments. However, the funding of public hospitals is shared between the State and Territory Governments and the Commonwealth, as established under the 2011 NHRA and the 2017 and 2020 addendums that set out the division of responsibilities and funding for the health system.

Public hospitals are co-funded by the Commonwealth and State/Territory Governments. The Commonwealth's contribution includes:[157]

- Activity-based funding: Payment based on the number and type of patient services.
- Block funding: Mainly for smaller rural and regional hospitals.
- Public health funding: For preventive services such as vaccinations.

This government money is pooled into a National Health Funding Pool and then distributed to Local Hospital Networks, not directly to individual hospitals. The states and territories have the flexibility to decide how to allocate funds to their networks and are responsible for managing and paying all hospital staff. Through the MBS, the Commonwealth Government also pays 75 per cent of MBS fees for procedures rendered to private patients treated in public hospitals. The IHACPA determines which hospital services are eligible for Commonwealth funding each year. States must then provide data to confirm they delivered these specific services.

For 2023–24, the services funded through this activity-based funding model include:

[156] Ibid.

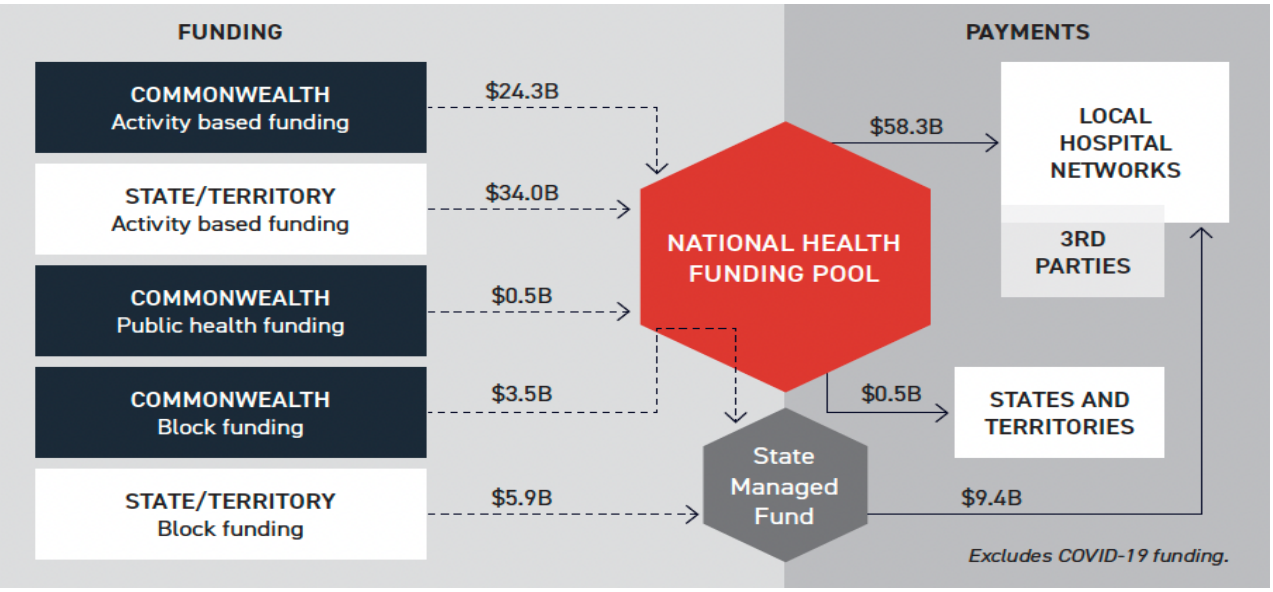
[157] National Health Funding Body, *Funding Types* (2025), https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-types.

- Emergency department services.
- Acute, sub-acute and non-acute admitted services.
- Admitted mental health services.
- Non-admitted services.

The Commonwealth pays for 45 per cent of the 'efficient growth' in these services calculated based on increases in both the price of services and the volume of services delivered.[158] The Commonwealth Government raises around 81 per cent of total tax revenue in Australia. State and Territory Governments receive 45 per cent of their revenue through transfers from the Commonwealth Government, including all goods and services tax (GST) revenue.

Importantly, the funding flows from different levels of government are directed towards specific areas of hospital activity. The Commonwealth Government only funds a maximum of 45 per cent of public hospitals (at present, it funds 37 per cent as discussed in the report) and the State/Territory Governments fund the remainder. On the other hand, the Commonwealth Government is responsible for supporting private hospitals through PHI and it funds around 35 per cent of the private hospitals. There is a large incentive for the Commonwealth Government to adjust the system to encourage people to move on to the public hospital system, where the State/Territory Governments are responsible for the delivery of services.

Figure 40. 2023–24 Public hospital funding payment flows[159]

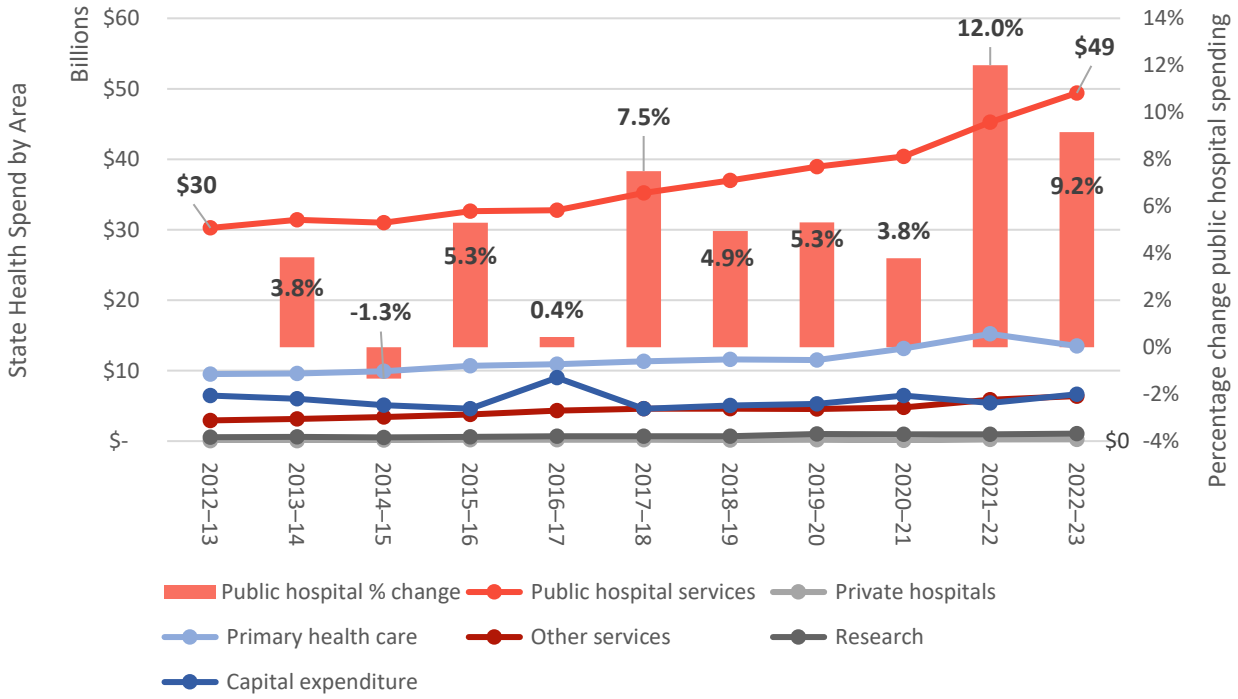


Both the Commonwealth and the State/Territory Governments spend most of their health funds on public hospitals. For 2022–23 (latest data), State/Territory Governments paid approximately 57.7 per cent of the public hospital funding and the Commonwealth Government paid approximately 36.3 per cent. Separating out the State/Territory health spending by area in the graph below, we find the public hospital spending is the largest portion of their spending (64 per cent). Public hospital spending by State/Territory Government is growing at a higher rate than all other areas of spending.

[158] National Health Funding Body, "Calculation of Commonwealth National Health Reform Funding 2020-2025," September 13, 2024, https://www.publichospitalfunding.gov.au/publications/calculation-commonwealth-national-health-reform-funding-2020-2025.

[159] National Health Funding Body, *Annual Report 2023-24 Maintenance of Effort* (2024), https://www.publichospitalfunding.gov.au/publications/annual-report-2023-24-maintenance-effort.

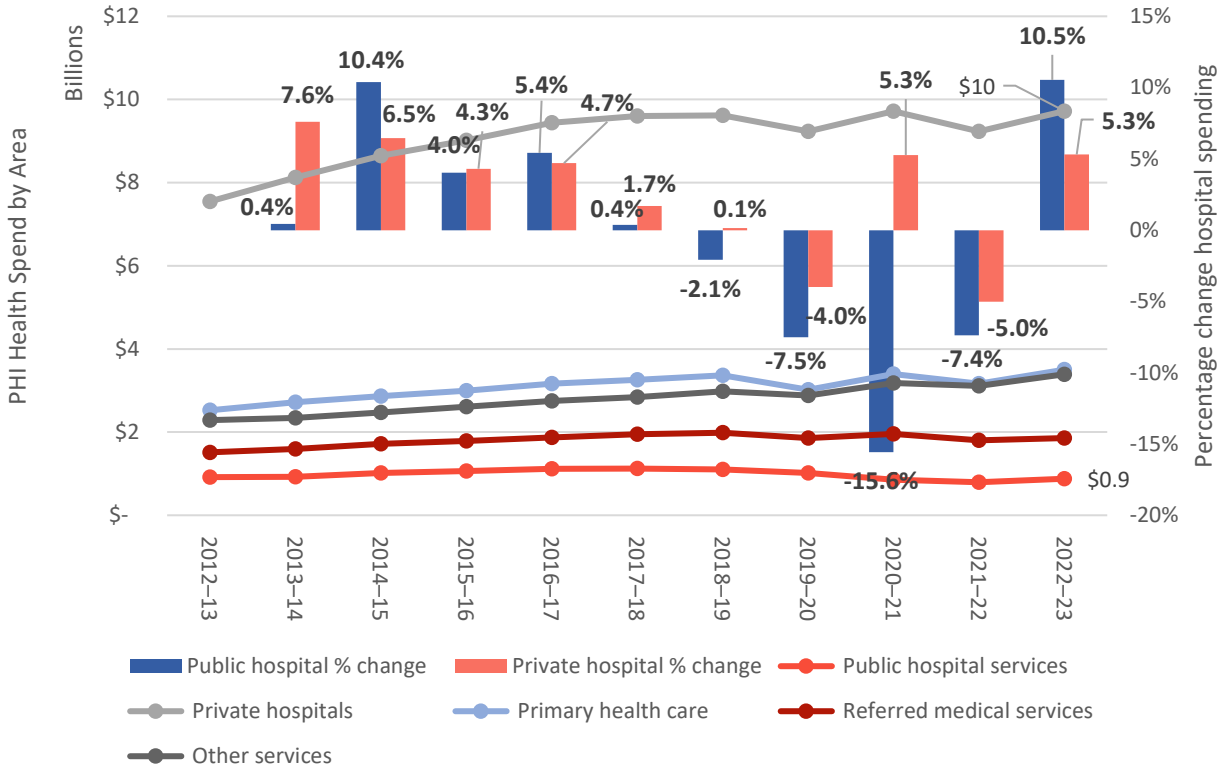
Figure 41. State and Territory Government total health spending by area of spending, constant prices and annual spending growth rate for public hospital spending, 2012–13 to 2022–23[160]



The graph below shows the PHI companies spending by area, where the majority is spent on private hospitals (50 per cent) $9.7 billion in 2022–23. The percentage change in spending on private hospitals was on a decline before COVID-19 and fell into the negative due to movement restrictions. Recently, the spending has increased again, which would be expected as part of the COVID-19 catch up. PHI spending on public hospitals is approximately $1 billion per year and is more volatile than the spending on private hospitals.

[160] Australian Institute of Health and Welfare, 20 November 2024, Health expenditure Australia 2022-23, https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2022-23/data

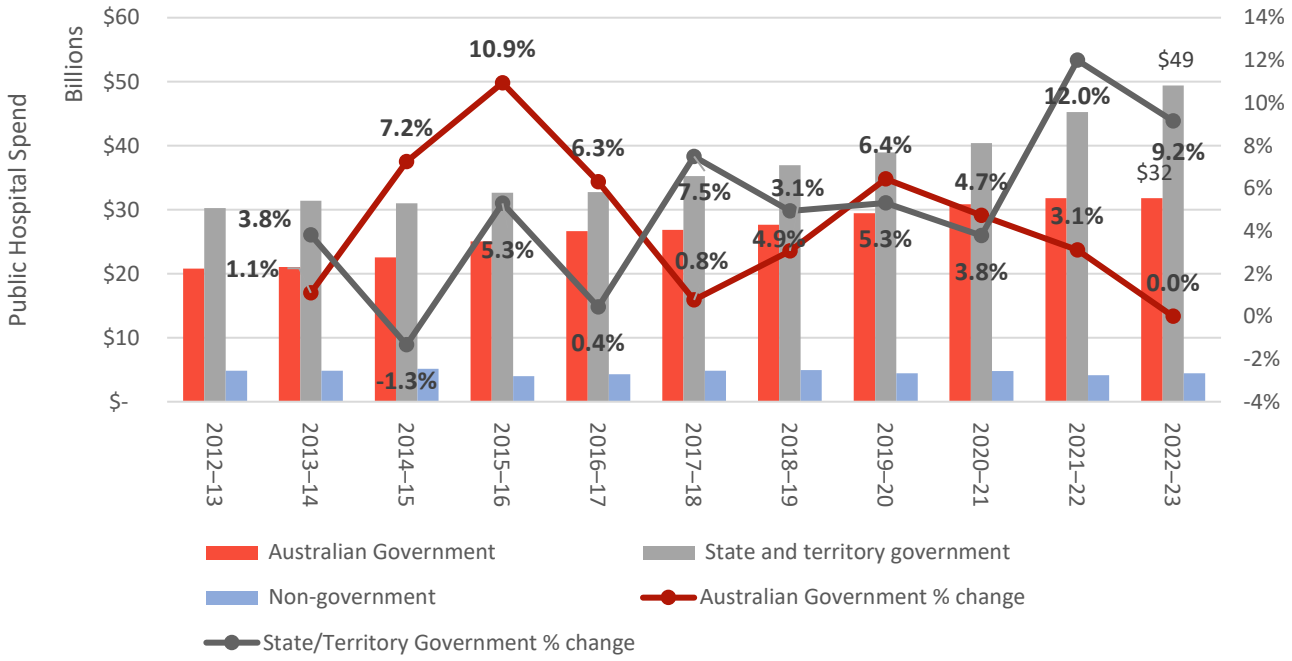
Figure 42. PHI health spending by area, constant prices and annual spending growth rates public & private hospitals, 2012–13 to 2022–23[161]



Over time, the Commonwealth Government has reduced the portion of the public hospital spending by 0.1 per cent and the non-government spending on public hospitals has reduced by 3.5 per cent. The State/Territory Governments have taken up the slack and increased their public hospital spending by 3.6 per cent (approximately $3.07 billion in 2022–23). Between 2012–13 and 2022–23, the CAGR of public hospital spending were, Commonwealth Government 4.3 per cent and State/Territory Governments 5.0 per cent.

[161] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

Figure 43. Public hospital spending by source, constant prices and annual growth rates, 2012–13 to 2022–23[162]



In 2022–23, State and Territory Governments contributed $49.4 billion (57.7 per cent). This was followed by the Commonwealth Government with $31.8 billion (37.1 per cent) and non-government entities with $4.4 billion (5.2 per cent). The Commonwealth Government spending showed no real growth, compared with a 9.2 per cent increase by State/Territory Governments and a 6.6 per cent rise by non-government sources.

In the 2022–23 period, an estimated $21.5 billion was spent on private hospitals in Australia. Most of this funding came from the non-government sector, not the government.

Funding Breakdown:

- Non-Government (63.2 per cent or $13.6 billion): This was the primary source of funding.
    - $9.7 billion from PHI providers.
    - $2.4 billion from individuals' out-of-pocket payments.
    - $1.5 billion from other non-government sources.
- Government (36.8 per cent or $7.9 billion):
    - $7.6 billion from the Commonwealth Government.
    - $0.3 billion from State/Territory Governments.
    - Government funding is typically used to contract private hospitals to treat public patients.

Recent Trends (2021–22 to 2022–23):

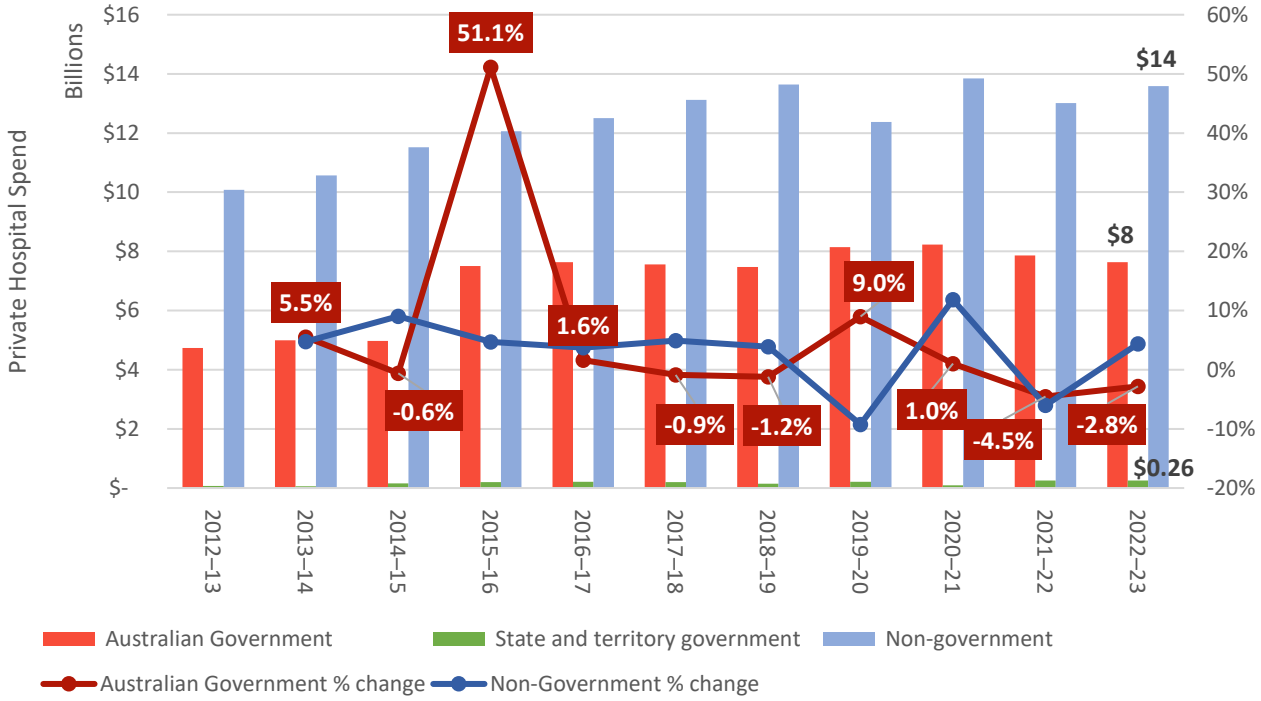
- Non-government spending on private hospitals increased by 4.4 per cent ($0.6 billion).
- Commonwealth Government spending decreased by 2.8 per cent ($0.2 billion).

[162] Ibid.

- Patient admissions to private hospitals grew by 5.0 per cent over the same period.

The approximately $14 billion per year from non-government sources is a great benefit to the national health system and takes significant fiscal pressure off government.

Figure 44. Private hospital spending by source of funds, constant prices and annual growth rates, 2012–13 to 2022–23[163]



Below is a series of charts that provide more detailed breakdown of the source of hospital funding for both public and private hospitals in Australia and by jurisdiction. All the figures are for the 2022–23 year as this is the latest reports in detail. Out of the total hospital spending of approximately $107.1 billion 80 per cent was spent in public hospitals, where on average the State/Territory Governments fund 58 per cent (range 66 per cent in the ACT to 48 per cent in QLD).

The total PHI rebates paid to hospitals is approximately $3.5 billion (51 per cent of total rebate) and the PHI payments to hospitals is approximately $10.6 billion.

[163] Ibid.

Figure 45. Total hospital expenditure (public & private), constant prices, source of funds, 2022–23[164]

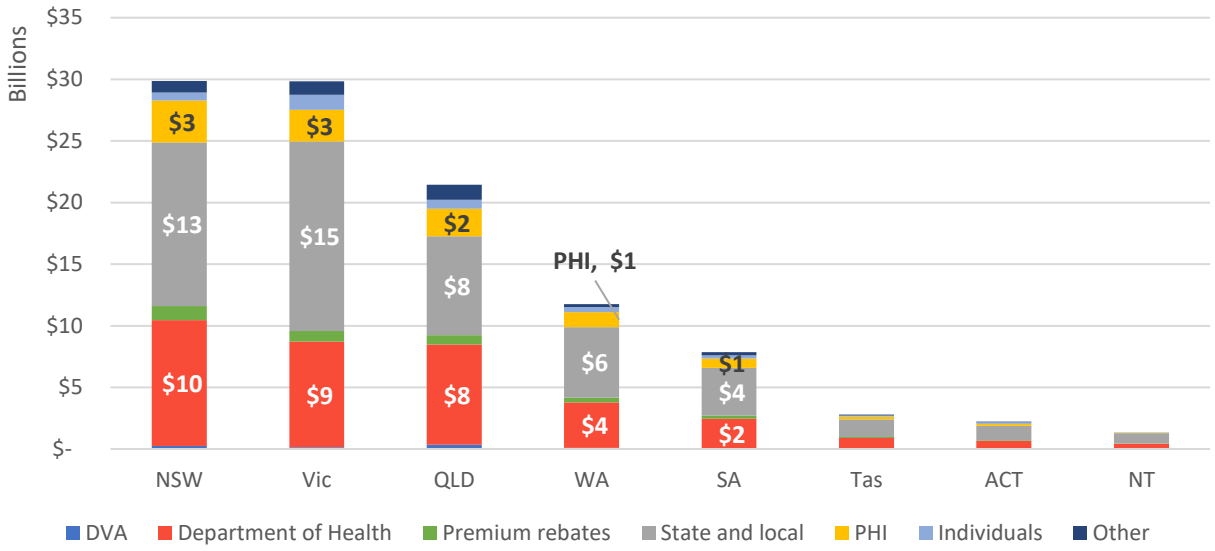
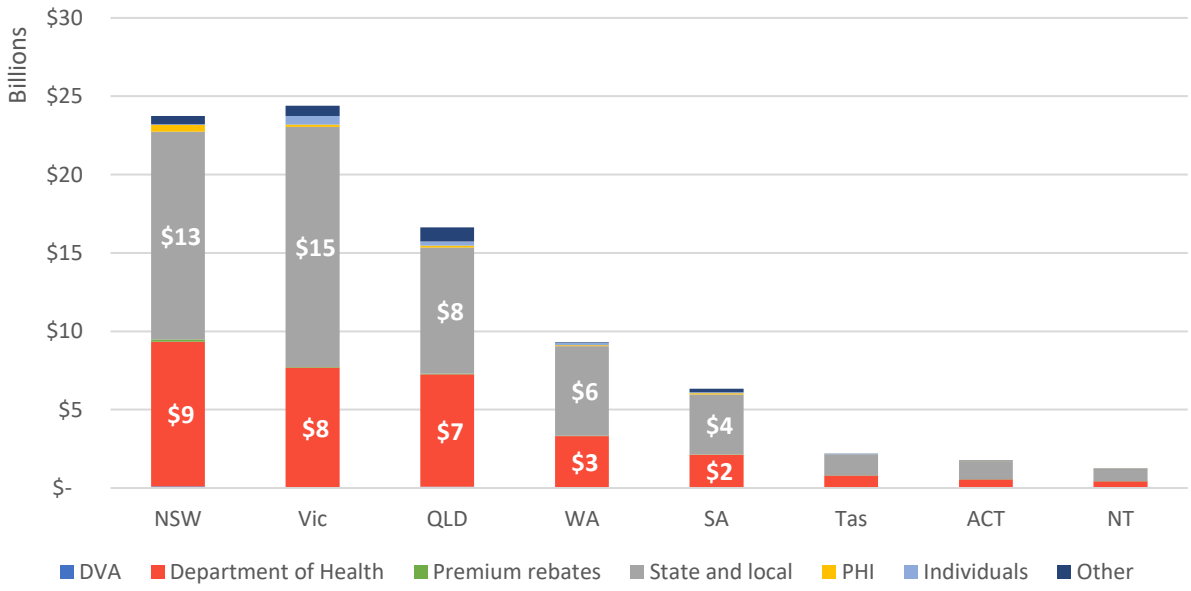


Figure 46. Total public hospital expenditure, constant prices, source of funds, 2022–23[165]

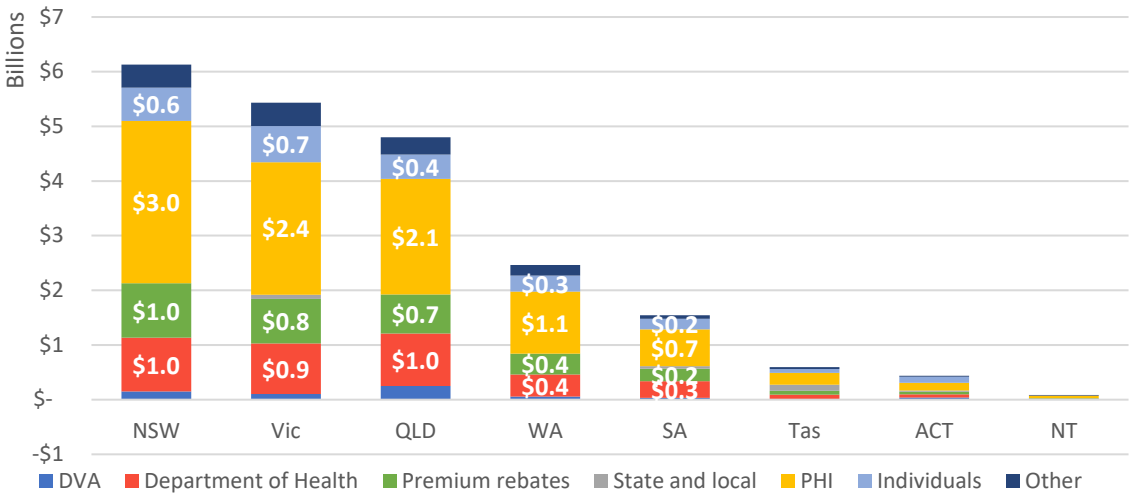


The graph below shows the private hospital expenditure is much lower than the public hospital expenditure, which is due to the limitations of the services offered. However, approximately 67 per cent of all elective surgeries are completed in the private hospital system. The PHI payments are a significant portion of the payments and individual payments are supported, which all takes pressure off the public hospitals and the wider tax system. Out of the $21.5 billion spent in private hospitals, PHI and individual spending is $12.1 billion (56 per cent).

[164] Ibid.

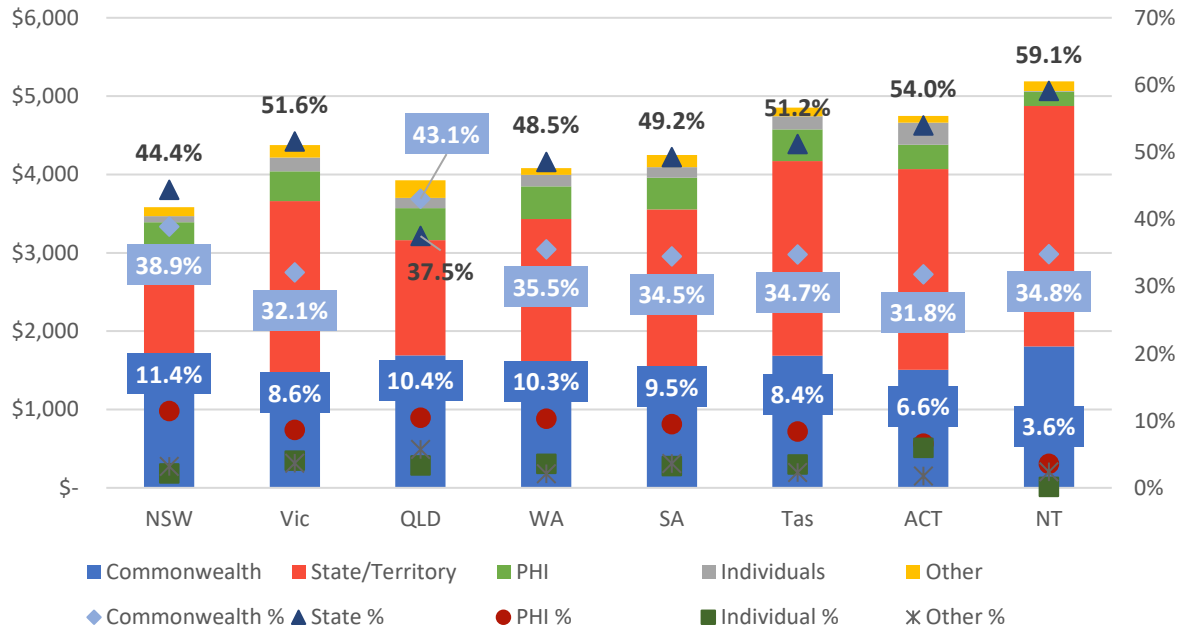
[165] Ibid.

Figure 47. Total private hospital expenditure, constant prices, source of funds, 2022–23[166]



To better understand the cost allocations, the graph below shows the total cost of hospitals per head of population in each State/Territory. In most jurisdictions, the Commonwealth Government funds the largest proportion of hospital spending, except for Queensland. The smaller population regions have a higher cost per head of population. The average cost per head of population is $4,019, the NT spend $5,188 per head of population and the lowest is in NSW where $3,581 per head of population is spent.

Figure 48. Total per head of population hospital expenditure (public & private), constant prices, source of funds, 2022–23[167]

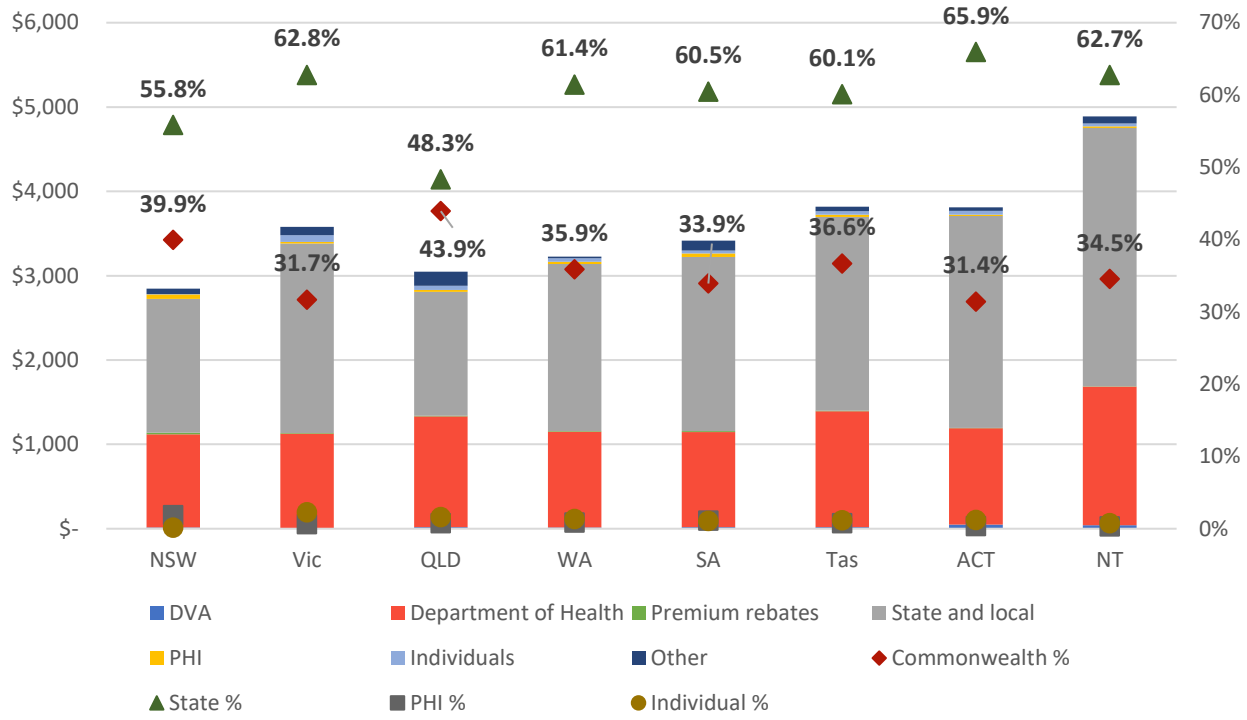


The graph below shows the funding sources for public hospitals per head of population, where the State/Territory Governments fund the majority. The Northern Territory has the highest public hospital cost per head of population at $4,888, 72 per cent higher than the lowest in NSW at $2,846.

[166] Ibid.

[167] Ibid.

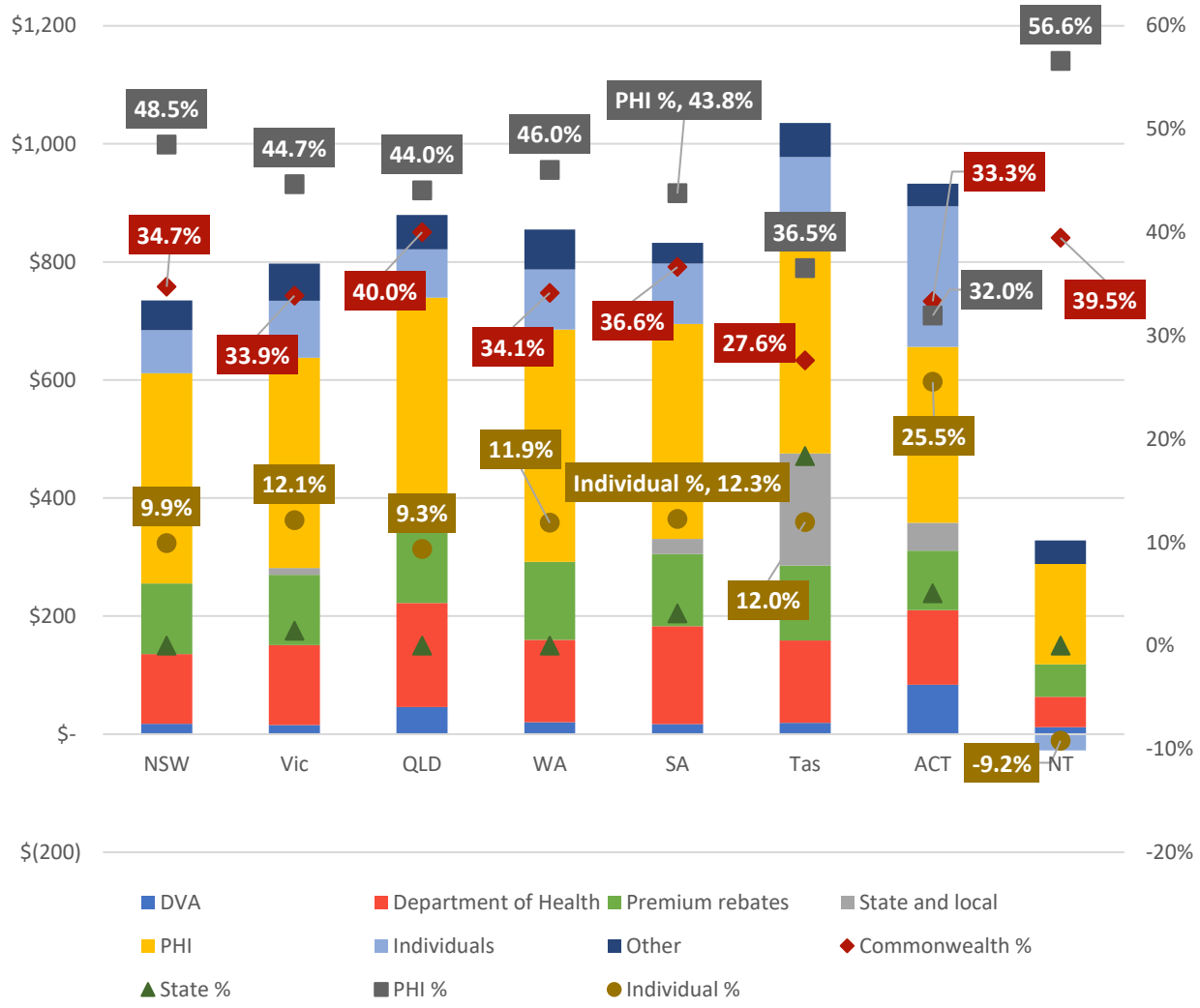
Figure 49. Total per head of population public hospital expenditure, constant prices, source of funds, 2022–23[168]



The PHI companies are the largest funder of private hospitals, ACT the lowest at 32 per cent and the highest in the NT at 56 per cent. The next highest funding source is the Commonwealth Government, Tasmania the lowest at 27 per cent and the highest in QLD at 40 per cent. The NT spend the least per head of population on private hospitals at $300 per person 71 per cent less than the highest jurisdiction of Tasmania at $1,035 per person.

[168] Ibid.

Figure 50. Total per head of population private hospital expenditure, constant prices, source of funds, 2022–23[169]

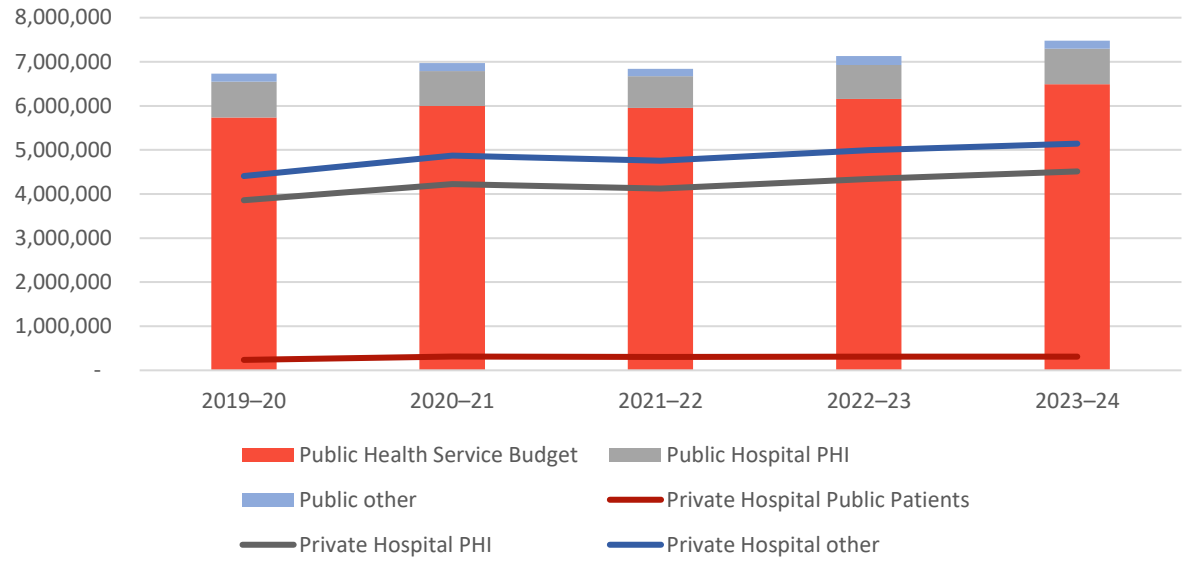


Hospital separations

As shown in the graph below, the public hospitals are the venue for most of the hospital separations each year: 59 per cent of the 12.6 million in 2023–34. Approximately 11 per cent of the public hospital separations are funded by PHI and approximately 6 per cent of private hospital separations are funded from public hospital funds. Although the public hospitals are managing most separations, the private hospitals are managing most of the surgery.

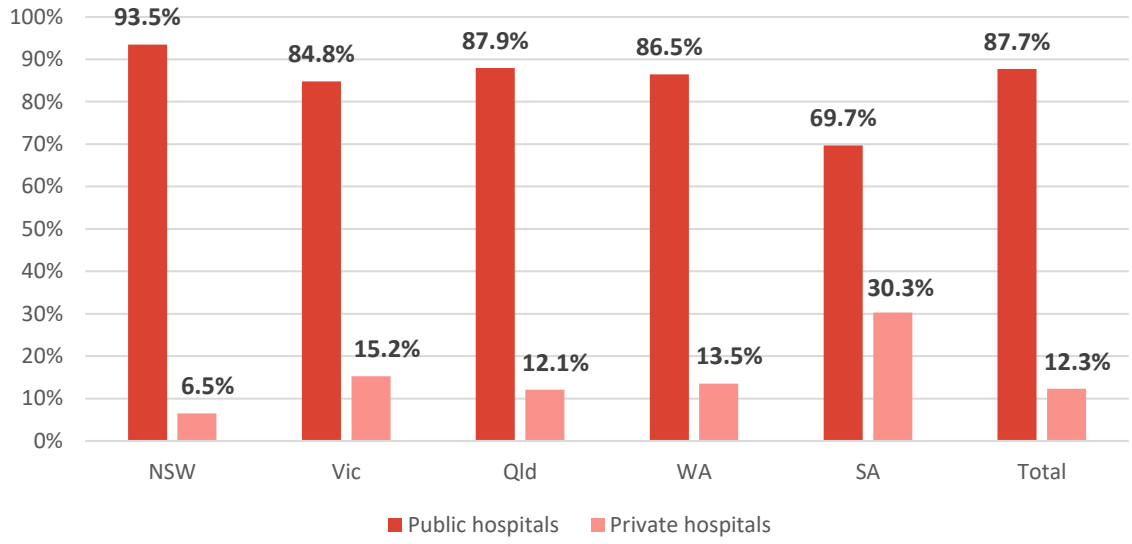
[169] Ibid.

Figure 51.Hospital separations by funding source (stacked public/private) 20219–20 to 2023–24[170] [171]



The graph below shows the public hospitals are managing the vast majority of emergency procedures, a situation recognised as disrupting their planned elective surgery. Private hospitals, on the other hand, undertake a much lower portion of the emergency care and, as a result, experience considerably less disruption to planned procedures. Emergency surgery constitutes approximately 2.6 per cent of the private hospital total surgical throughput each year, whereas for public hospitals it is over 27 per cent, or even higher (over 40 per cent in the ACT and NT).

Figure 52. Percent of emergency separations with surgical 2023–24[172]



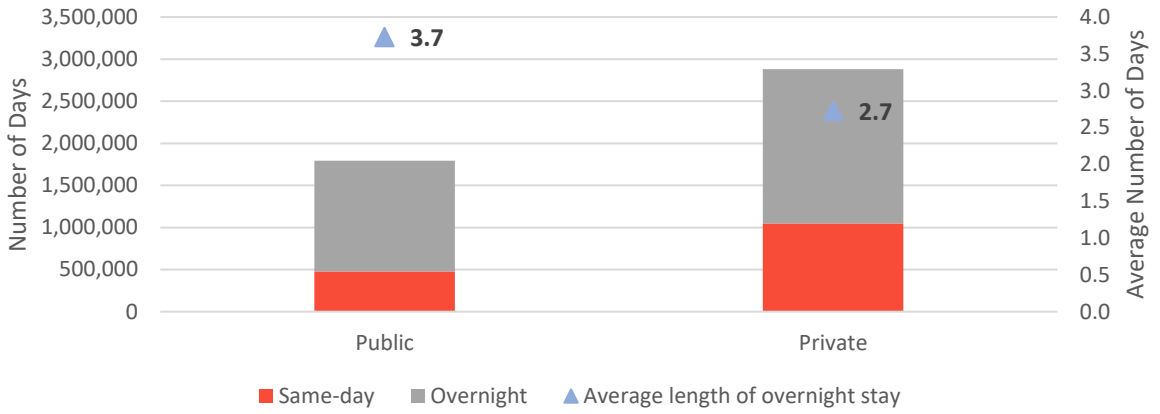
[170] Australian Institute of Health and Welfare, *Separations, by All Funding Sources, Public and Private Hospitals, 2019–20 to 2023–24* (2025), https://www.aihw.gov.au/hospitals/topics/admitted-patient-care/how-is-care-funded.

[171] Note: the public/private separations are stacked in the graph to show all separation from each funding source in public/private

[172] Australian Institute of Health and Welfare, *Separations, by All Funding Sources, Public and Private Hospitals, 2019–20 to 2023–24*.

The graph below demonstrates while private hospital admissions account for most of the hospital admitted days, they have a lower average overnight stay. The longer overnight stay in public hospitals might be related to the high level of emergency surgeries that are likely to be more complex. Private hospitals also manage more same-day treatments compared to public hospitals, which are likely to be planned and relatively simple surgeries.

Figure 53. Number of hospital days public/private & average number of overnight stay days 2023–24[173]

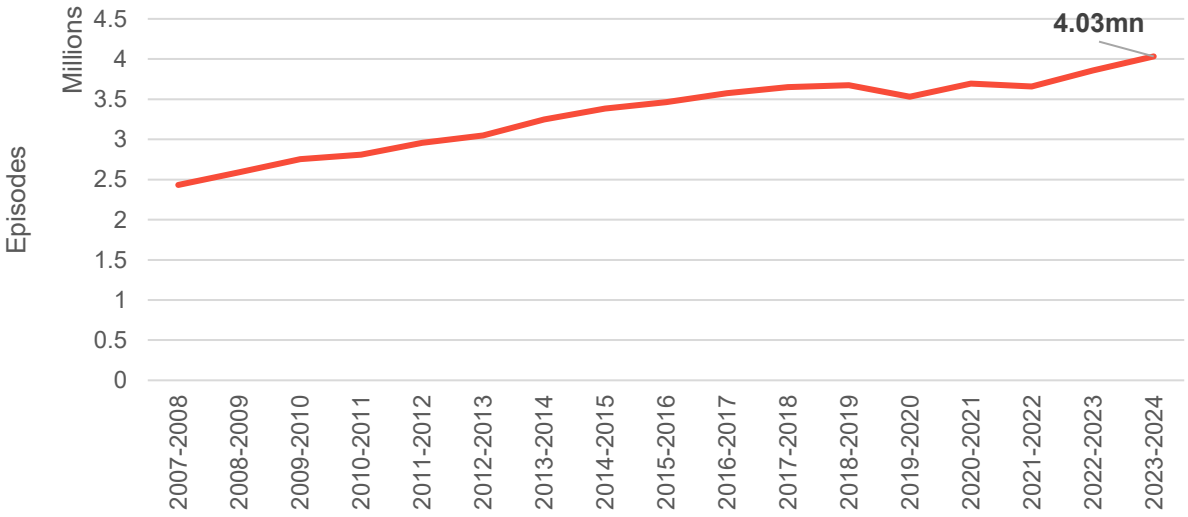


Clearly, both the public and private hospitals are meeting different medical needs for the community and have specific areas of speciality that complement each other. The government support for hospital services in both critical sectors is providing very large benefits to society.

Private health insurance

PHI plays a key role in the functioning of the private hospital system. In 2023–24, over four million episodes of care within private hospitals were treated under PHI. The number of medical episodes funded by PHI has increased steadily since 2007–08.

Figure 54: Number of episodes in private hospitals treated under PHI[174]

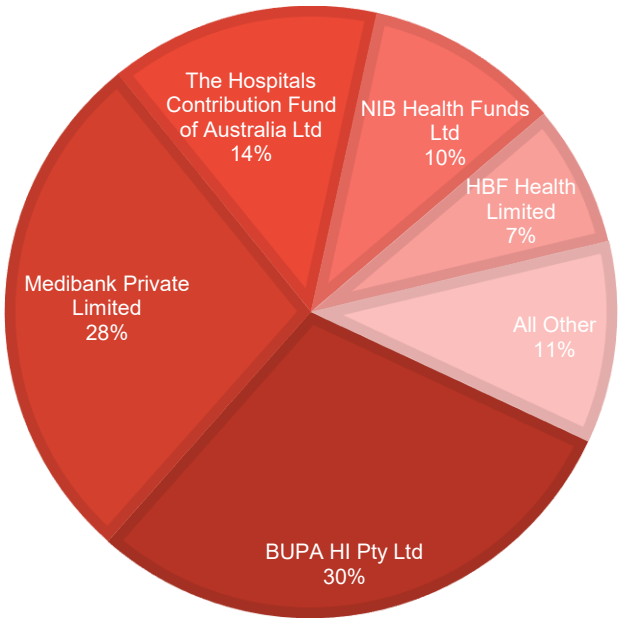


[173] Ibid.

[174] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Benefits*.

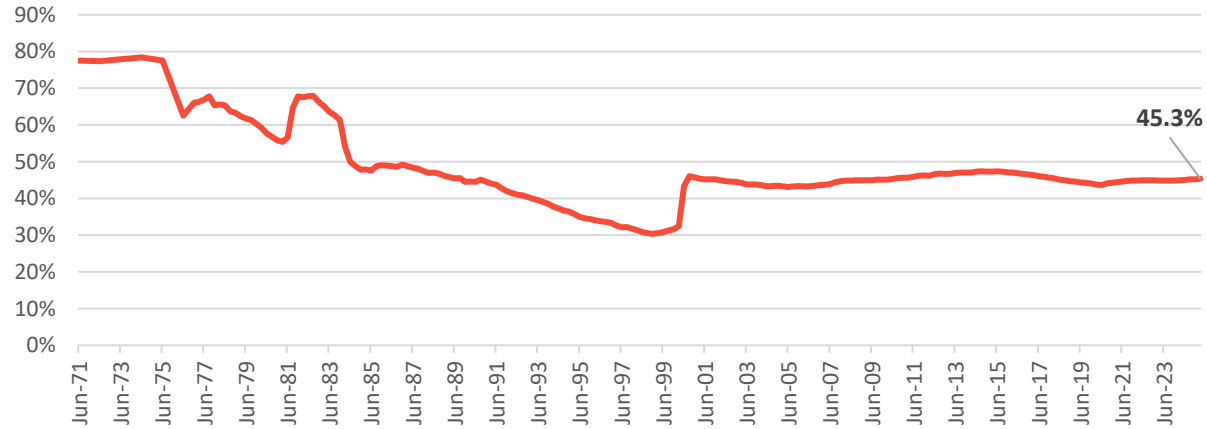
There are currently 30 private health insurers currently operating in the market. The PHI market is a competitive market, with consumers free to switch between insurers based on the product offerings and their individual needs. The five largest insurers holding a combined 89 per cent market share, with no insurer holding more than a 30 per cent market share.[175]

Figure 55. Market Share of Private Health Insurers[176]



Currently around 45.3 per cent of the Australian population hold private hospital cover. Since the Howard reforms in the late 1990s, the proportion of the population with hospital coverage under PHI has remained relatively constant, fluctuating around 43 to 47 per cent. Following the Howard reforms, after a brief period of decline, PHI hospital coverage slowly grew until 2015. The period between 2015 and 2020 saw a reversal of this growth and a decline in PHI coverage.

Figure 56. Percent of the Population Holding Hospital Cover[177]



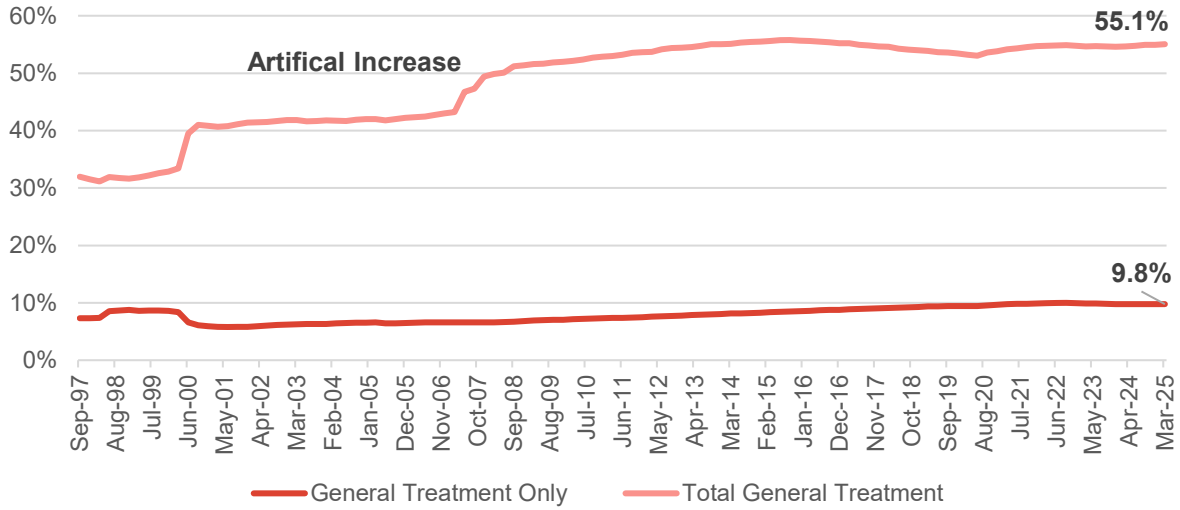
[175] Australian Prudential Regulation Authority, *Annual Private Health Insurance Statistics* (2024), https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

[176] Ibid.

[177] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage*.

Effectively all policy holders who elect to hold hospital cover elect to take out a combined hospital and general treatment policy.[178] [179] Some individuals elect to hold general treatment cover only. There has been a steady increase in the proportion of individuals holding general treatment cover since the introduction of the Howard reforms. Currently, around 9.8 per cent of the population holds general treatment only cover, with 55.1 per cent of the population holding hospital and general treatment cover.

Figure 57. Percent of the population holding general treatment cover[180]



PHI tiers and clinical category coverage

Each level of PHI coverage offers a range of services with Gold tier covering all hospital services. Many people with PHI will have a 'Plus' policy that offers all the standard services under that tier but also some specified extra services with a corresponding increase in price.

One significant part of the Gold tier is the inclusion of pregnancy and birth, which are very high cost and high quantity parts of the health system.

[178] 0.1 per cent of policy holders with hospital cover hold hospital cover only.

[179] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage*.

[180] Ibid.

Figure 58. Hospital treatment product tiers[181]

Clinical Category	Basic	Bronze	Silver	Gold
Rehabilitation	Y (R)	Y (R)	Y (R)	Y
Hospital psychiatric services	Y (R)	Y (R)	Y (R)	Y
Palliative care	Y (R)	Y (R)	Y (R)	Y
Brain and nervous system	O (R)	Y	Y	Y
Eye (not cataracts)	O (R)	Y	Y	Y
Ear, nose and throat	O (R)	Y	Y	Y
Tonsils, adenoids and grommets	O (R)	Y	Y	Y
Bone, joint and muscle	O (R)	Y	Y	Y
Joint reconstructions	O (R)	Y	Y	Y
Kidney and bladder	O (R)	Y	Y	Y
Male reproductive system	O (R)	Y	Y	Y
Digestive system	O (R)	Y	Y	Y
Hernia and appendix	O (R)	Y	Y	Y
Gastrointestinal endoscopy	O (R)	Y	Y	Y
Gynaecology	O (R)	Y	Y	Y
Miscarriage and termination of pregnancy	O (R)	Y	Y	Y
Chemotherapy, radiotherapy and immunotherapy for cancer	O (R)	Y	Y	Y
Pain management	O (R)	Y	Y	Y
Skin	O (R)	Y	Y	Y
Breast surgery (medically necessary)	O (R)	Y	Y	Y
Diabetes management (excluding insulin pumps)	O (R)	Y	Y	Y
Heart and vascular system	O (R)	O	Y	Y

[181] Private Health Insurance Ombudsman, *Product Tiers* (2025), https://www.privatehealth.gov.au/health_insurance/howitworks/producttiers.htm.

Clinical Category	Basic	Bronze	Silver	Gold
Lung and chest	O (R)	O	Y	Y
Blood	O (R)	O	Y	Y
Back, neck and spine	O (R)	O	Y	Y
Plastic and reconstructive surgery (medically necessary)	O (R)	O	Y	Y
Dental surgery	O (R)	O	Y	Y
Podiatric surgery (provided by a registered podiatric surgeon)	O (R)	O	Y	Y
Implantation of hearing devices	O (R)	O	Y	Y
Cataracts	O (R)	O	O	Y
Joint replacements	O (R)	O	O	Y
Dialysis for chronic kidney failure	O (R)	O	O	Y
Pregnancy and birth	**O (R)**	**O**	**O**	**Y**
Assisted reproductive services	O (R)	O	O	Y
Weight loss surgery	O (R)	O	O	Y
Insulin pumps	O (R)	O	O	Y
Pain management with device	O (R)	O	O	Y
Sleep studies	O (R)	O	O	Y

Notes: Y: Indicates the clinical category is a minimum requirement of the product tier;
R: Restricted cover permitted: insurers are allowed to offer cover for this clinical category on a restricted basis. A restricted benefit means you are partially covered for hospital costs as a private patient in a public hospital. You may incur significant expenses in a private room or private hospital so you should check with your insurer and hospital for details.
O: Optional for the insurer to include: insurers may choose to offer these as additional clinical categories.

Appendix 2. Australian healthcare system performance rankings

The Commonwealth Fund (2024)

A report by the Commonwealth Fund in 2024 assessed the healthcare systems of 10 high-income OECD countries, including Australia, the United States of America (USA), the United Kingdom (UK), New Zealand (NZ) and several European countries. The Commonwealth Fund ranked Australia's healthcare system at the top of these OECD countries overall.[182] Australia's healthcare system is a high performer overall, excelling in health outcomes and equity and demonstrating strong administrative efficiency.

Figure 59: Healthcare system performance rankings – Australia ranked no. 1 (Commonwealth Fund)

	AUS	CAN	FRA	GER	NETH	NZ	SWE	SWIZ	UK	US
Overall Ranking	**1**	**7**	**5**	**9**	**2**	**4**	**6**	**8**	**3**	**10**
Access to Care	9	7	6	3	1	5	4	8	2	10
Care Process	5	4	7	9	3	1	10	6	8	2
Administrative Efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	–	4	5	9
Health Outcomes	1	4	5	9	7	3	6	2	8	10

In particular, the Commonwealth Fund ranked Australia first among OECD countries based on the following factors.

Healthcare Outcomes (Rated 1st)

Australia shares the top ranking in health care outcomes with Norway and Switzerland. A key contributor to Australia's top performance is having the highest life expectancy after age 60 among the 11 countries (25.6 additional years).

Equity (Rated 1st)

Australia also ranks highest on the equity domain, alongside Germany and Switzerland. This means Australia demonstrated the smallest income-related disparities in performance across various measures in access to care, care processes and administrative efficiency. Experiences reported by people in lower- and higher-income groups on indicators including affordability, timeliness, preventive care, safe care and patient engagement are less divergent in Australia than in other countries. Australia addresses income-related equity through measures such as annual spending caps being lower for low-income individuals and incentives for primary care (in 2019, 86 per cent of Australians faced no out-of-pocket costs for primary care visits). The other factors assessed were as follows.

Administrative Efficiency (Rated 2nd)

Australia is among the top performers in administrative efficiency, ranking second. Norway, Australia, NZ and the UK are highlighted as leading in this domain. This means Australia's system is relatively successful in reducing documentation (paperwork) and other bureaucratic tasks that patients and clinicians face.

Care Process (Rated 6th)

Australia ranks 6th in care process, which includes preventive care, safe care, coordinated car and engagement/patient preferences. While not at the very top, this is a respectable mid-tier performance. The report notes that Australia (along with Switzerland, NZ, Norway and France) performs well on

[182] David Blumenthal et al., *Mirror, Mirror 2024*.

measures related to communication between primary care doctors and specialists (a part of coordinated care). Australian primary care clinicians were also high users of video consultations, which falls under engagement and patient preferences.

Access to Care (Rated 8th)

Australia ranks 8th in access to care, which covers affordability and timeliness. This is Australia's lowest-ranked domain. The Netherlands, Norway and Germany perform best here. While Australia has strong equity in access (as noted by its 1st place in equity) and 86 per cent faced no out-of-pocket costs for primary care visits in 2019, the overall access score is lower. This is supported by the finding that adults with higher incomes in Australia are as likely as, or more likely than, adults with lower incomes in five other countries to report cost-related access problems. This suggests that while out-of-pocket costs for primary care might be low for many, other aspects of affordability or timeliness across the broader healthcare system might contribute to this lower ranking.

Australian Institute of Health and Welfare

In 2024, the Australian Institute of Health and Welfare published an assessment of Australia's healthcare as measured against other similar countries.[183]

Overall Health Outcomes & Status:

Australia generally performs well in key health outcomes with the fifth lowest mortality rate from circulatory diseases and its life expectancy at birth is equal fourth highest (83.3 years), both better than the OECD average. While its infant mortality rate is mid-range (21st out of 38), it remains lower than the OECD average. Australians also have a very positive view of their health, ranking fourth highest for self-perceived 'good/very good' health. The proportion of low birthweight babies is slightly lower than the OECD average.

Long-Term Care:

Australia has a relatively high provision and utilisation of formal long-term care compared to many OECD countries ranking 11th highest for residential long-term care beds and 8th highest for formal long-term care workers and it has the 3rd highest proportion of long-term care recipients in institutions.

Health Risk Factors:

Australia performs well with the fifth lowest proportion of daily smokers. However, above the OECD average for alcohol consumption and has the 10th highest proportion of people overweight or obese. Concerningly, the fifth highest proportion of regular vapers.

Pharmaceuticals & Remuneration:

Australia's pharmaceutical sales per capita are lower than the OECD average, although this data primarily reflects PBS-dispensed medicines and excludes hospital or private sales. In terms of remuneration (adjusted for purchasing power parity), Australian self-employed GPs and specialists earn less than the OECD average (2nd and 4th lowest respectively among countries with data). Conversely, salaried hospital nurses in Australia earn more than the OECD average (5th highest).

Health Insurance & Access:

Australia ensures 100 per cent population coverage through government or social health insurance, aligning with many OECD countries and it has a high uptake of PHI (9th highest, above OECD average). Waiting times for elective surgery are mixed: shorter than the OECD average for coronary bypass and hip replacement, but longer for hysterectomies.

[183] Australian Institute of Health and Welfare, *Measures of Health and Health Care for Australia and Similar Countries* (2024), https://www.aihw.gov.au/reports/international-health-data-comparisons.

Appendix 3. Public hospital performance

Australian public hospitals are world class and highly effective at providing very high-quality healthcare. The hospital system is a cornerstone of the universal healthcare framework, striving to provide accessible and high-quality care to all citizens and permanent residents, largely free at the point of service. Generally, the system delivers a commendable standard of care, particularly for acute, emergency and complex conditions, staffed by a highly skilled and dedicated workforce. International comparisons often place Australia favourably in terms of health outcomes such as life expectancy and survival rates for major illnesses. However, the 'general performance' is a nuanced picture, marked by significant strengths alongside persistent challenges.

Key Strengths:

- Quality of Acute Care: Australian public hospitals excel in providing high-level acute and emergency medical care, including complex surgeries and trauma response.
- Skilled Workforce: The system benefits from well-trained doctors, nurses and allied health professionals.
- Universal Access (in principle): Medicare ensures that financial barriers to essential hospital care are minimised.
- Safety and Quality Standards: Robust accreditation processes and a focus on patient safety protocols are in place, although variations exist.

Significant Challenges:

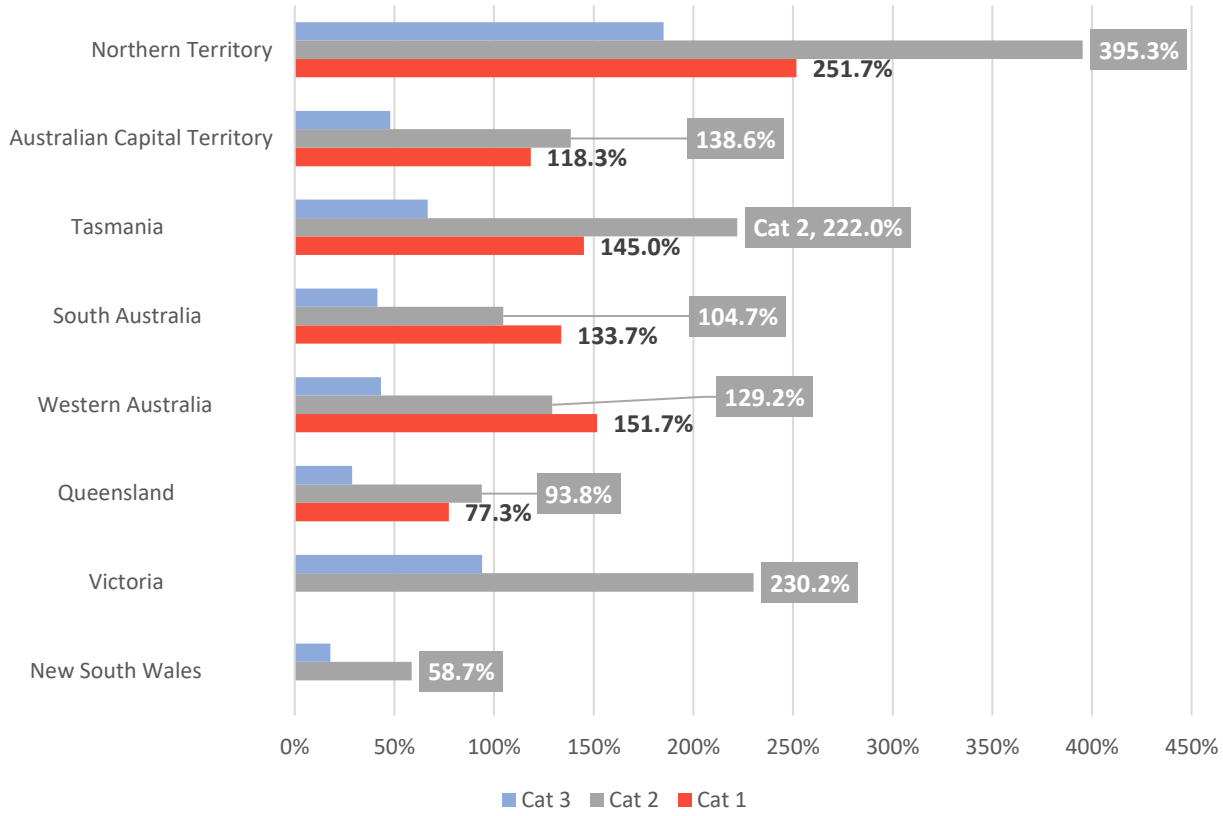
- Waiting Times: This is arguably the most prominent public concern.
    a. Elective Surgery: Many patients face extended waits for non-urgent but necessary surgeries, with significant variations between states, regions and specific procedures. This can impact quality of life and lead to deteriorating conditions.
    b. Emergency Departments (EDs): Overcrowding in EDs is a chronic issue. This leads to longer waiting times to be seen, increased 'access block' (where admitted patients wait in the ED for an inpatient bed) and ambulance ramping (where paramedics wait with patients outside full EDs).
- Bed Capacity and Flow: Insufficient inpatient bed capacity, exacerbated by difficulties in discharging patients to aged care or National Disability Insurance Scheme services, contributes significantly to ED access block and elective surgery delays.
- Workforce Pressures: Staff burnout, shortages (particularly in regional/rural areas and certain specialities) and challenges in retention are ongoing concerns, impacting service delivery and staff wellbeing.
- Funding and Efficiency: The complex Commonwealth–State/Territory funding arrangements often lead to debates about adequacy and allocation. While hospitals strive for efficiency, the increasing demand from an ageing population and rising rates of chronic disease place immense pressure on resources.
- Regional and Remote Disparities: Australians living in rural and remote areas often face poorer access to services and specialists and experience worse health outcomes compared to their urban counterparts.

In summary, while Australian public hospitals provide a high standard of medical care and act as a crucial safety net, their overall performance is often strained by demand exceeding capacity. This manifests primarily in lengthy waiting times for both planned and emergency care, alongside workforce and resource pressures. Continuous monitoring, investment and reform are essential to address these challenges and ensure the system remains sustainable and equitable for all Australians.

Elective surgery waiting lists by jurisdictions

The elective surgery waiting list in Australia is a prominent indicator of public hospital performance. The graph below shows the per cent of average days each jurisdiction elective surgery is over the recommended timeframes by category of urgency. The NT is the worst performer with high urgency (Category 1) surgery now 251 per cent over the recommended waiting time. The NT, Tasmania and Victoria are performing very poorly with Category 2 surgery waiting times now 395 per cent, 222 per cent and 230 per cent, respectively. The NT system is of particular concern with their current Category 1 surgical waiting list is the worst in the country at over 250 per cent longer than the recommended time.

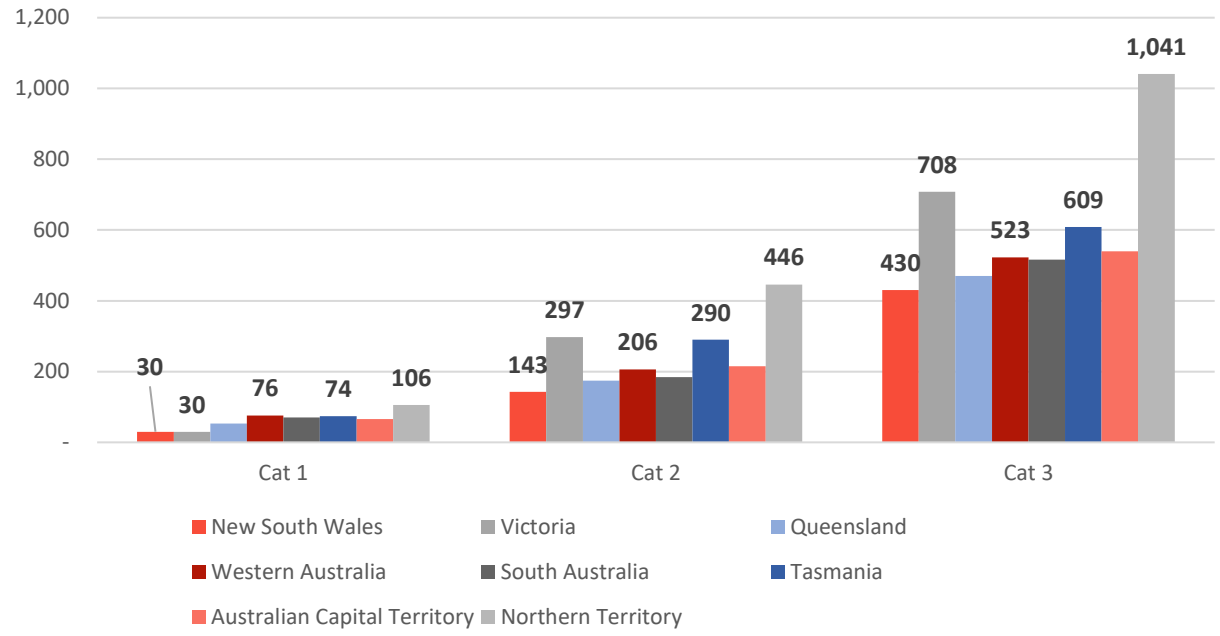
Figure 60. Average percent of time (days) public hospital elective surgery wait time over medically recommended wait times, by jurisdiction, 2023–24[184]



Translating these waiting times into average number of days waiting per category finds patients in the NT are waiting for almost three years (1,040 days) for Category 3 surgery, followed by Victoria (708 days), Tasmania (608 days) and ACT (540 days), with between 1.2 to 2.9 years waiting time. Given these numbers are averages, there are many people waiting for much longer than these reported times.

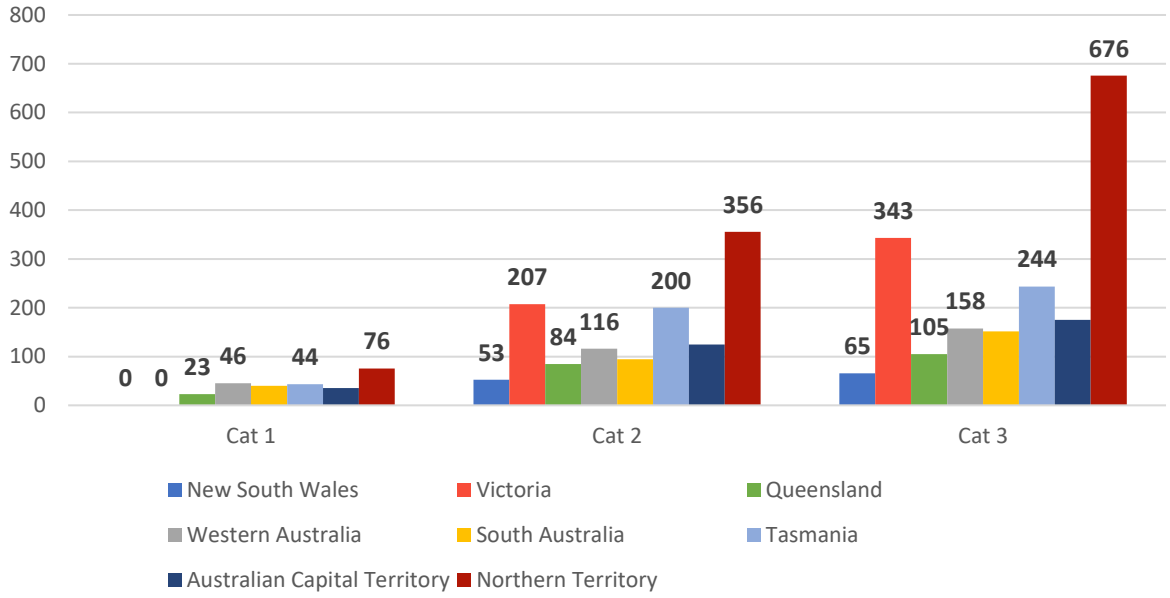
[184] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery*.

Figure 61. Average days on elective surgery waiting lists by jurisdiction and urgency category (days) 2023–24[185]



The graph below shows the average number of days overdue per jurisdiction by category. Reducing these days down to the recommended waiting times would take a huge amount of money and effort, which does not appear to be possible or a priority for government. Patients who can afford it are able to avoid these wait times through private hospital services, which indicates the issue causing these wait times is not lack of availability of hospitals, doctors and other resources.

Figure 62. Average number of days overdue elective surgery by jurisdiction and urgency category 2023–24[186]

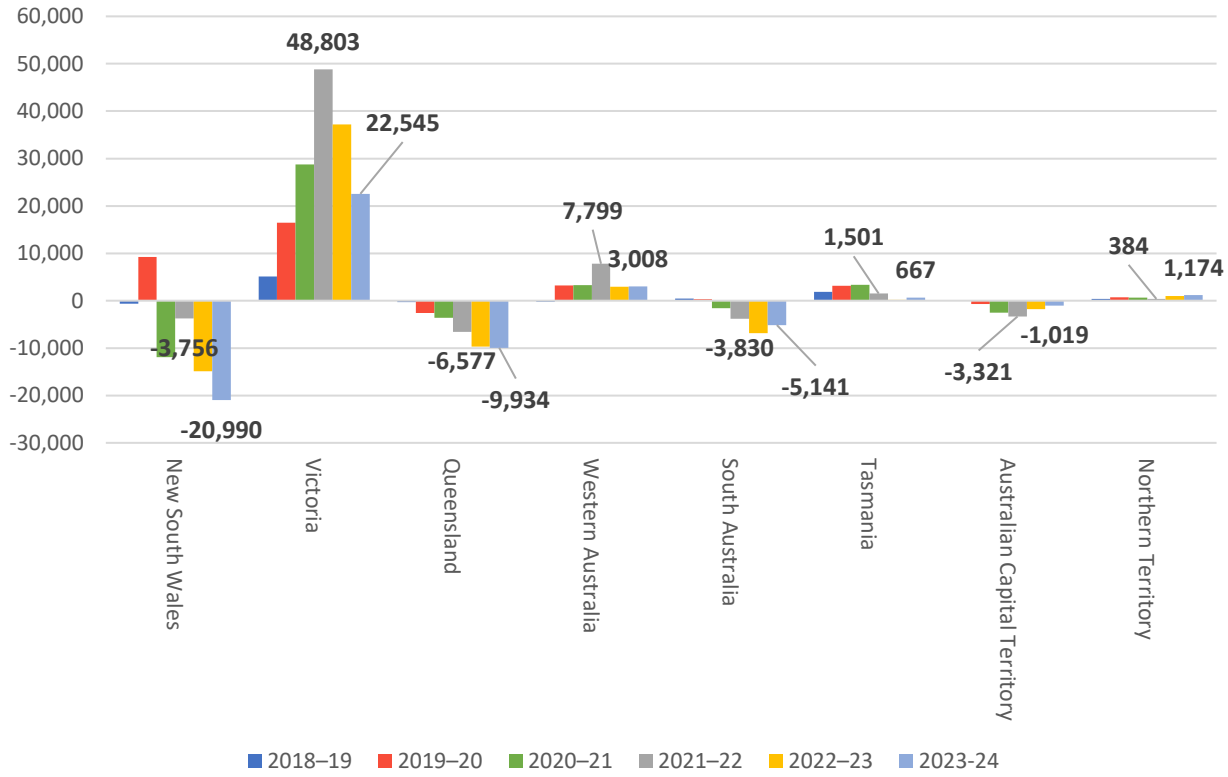


[185] Ibid.

[186] Ibid.

The graph below shows the net number of elective surgeries per year for each jurisdiction between 2018–19 to 2023–24. Some jurisdictions are reducing their wait lists each year during this period, but some jurisdictions continue to add more people to their wait lists. Victoria stands out as the largest number of additions per year to the national waiting list with over 22,500 new patients added in 2023–24, down from 48,803 peak in 2021–22.

Figure 63. Net additions/removals from the elective surgery waiting list by jurisdiction 2018–19 to 2023–24 [187] [188] [189] [190]



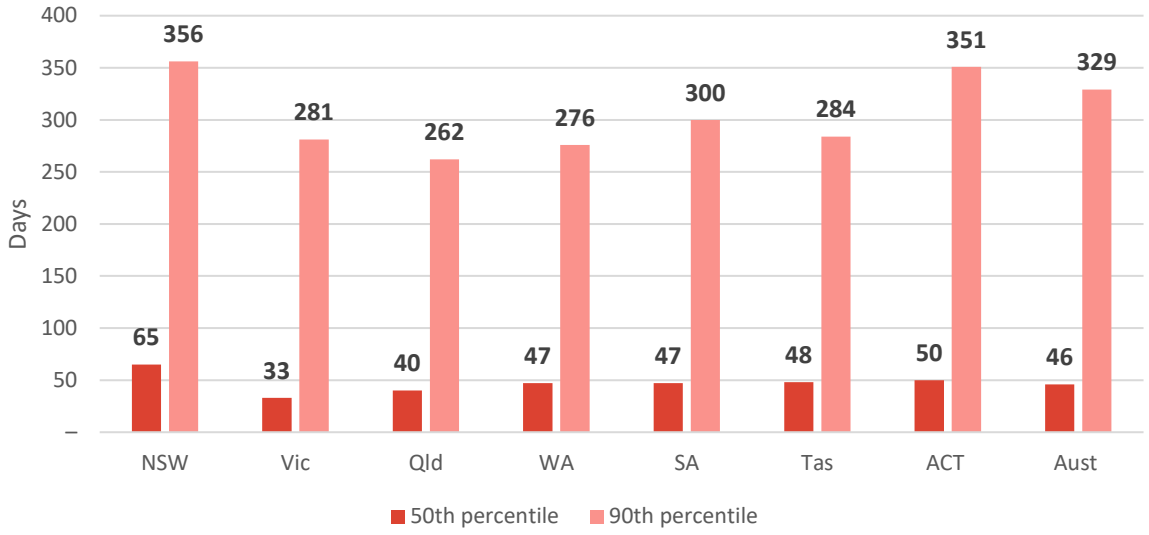
[187] Some of the removals from the elective surgery wait list are due to death, treated under different area, treated in a different hospital system, or other reasons besides having their surgery completed.

[188] NT did not have data for 2023-24, therefore an average of the past 5 years was used to maintain the graph.

[189] Australian Institute of Health and Welfare, *Hospitals, Data Downloads*.

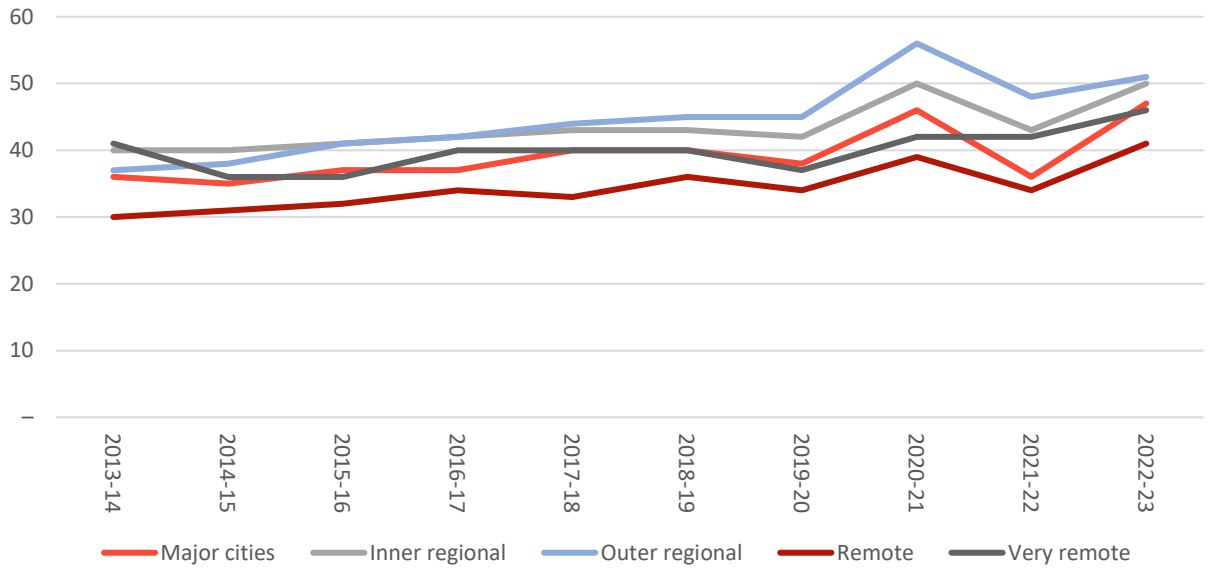
[190] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery*.

Figure 64. Elective surgery waiting times total, 2023–24[191]



Examining the longer-term average wait times indicates the issue is a long-standing trend and not a recent issue related to the COVID 19 or other wider economy issues. Since 2013–14, the average wait times have continually increased with a COVID 19 bump and now a return to the general long-term trend. Outer and inner regional areas are the worst performing areas in Australia.

Figure 65. Long-term trends of 50th percentile average elective surgery waiting days by regional categorisation 20213–14 to 2022–23[192]

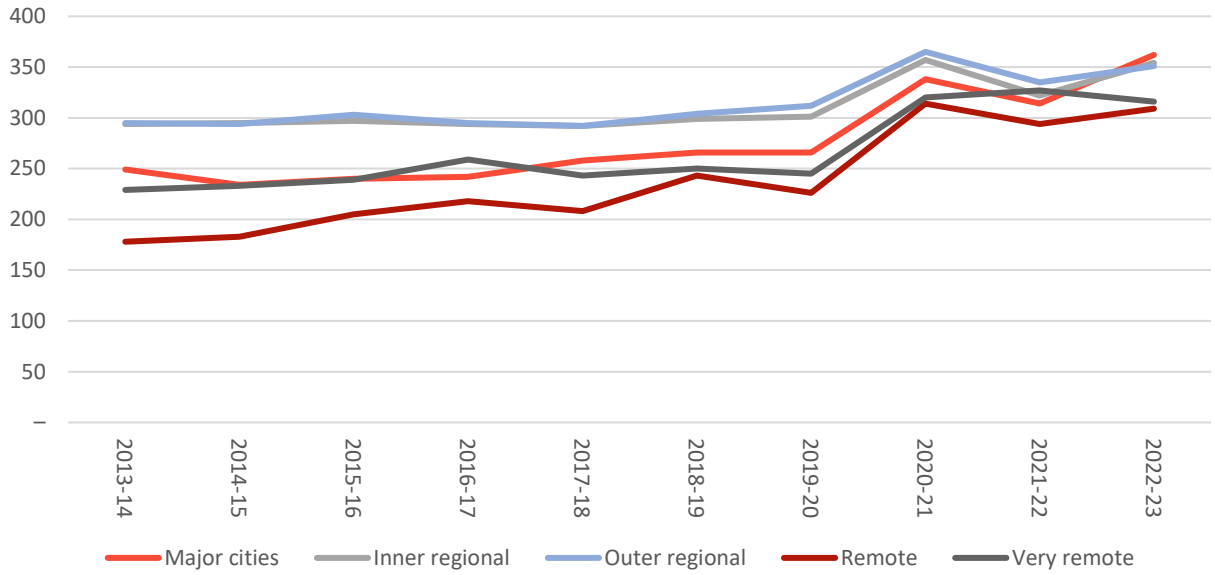


The 90th percentile waiting times by region shows a greater COVID 19 impact with a jump during the period, which has not returned to lower levels. Remote regions were experiencing growth in wait times for many years from 178 days (2013–14) to 243 days (2018–19).

[191] Productivity Commission, *Report on Government Services 2025, 12 Public Hospitals* (2025), https://www.pc.gov.au/ongoing/report-on-government-services/2025/health/public-hospitals.

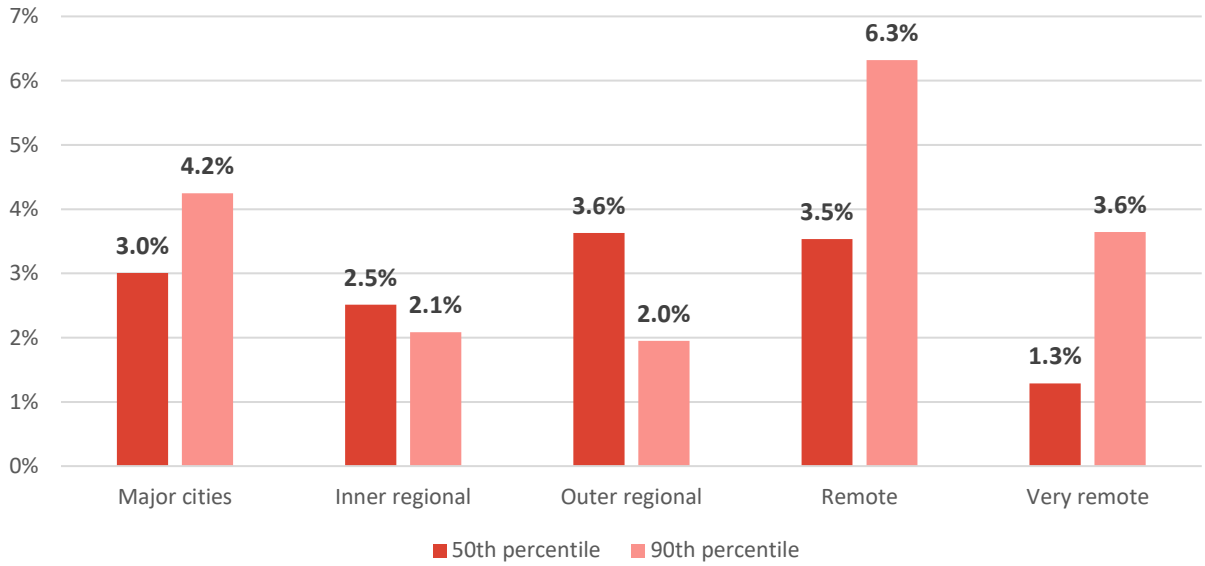
[192] Australian Institute of Health and Welfare, *Hospitals, Data Downloads*.

Figure 66. Long-term trends of 90th percentile average elective surgery waiting days by regional categorisation 20213–14 to 2022–23[193]



Between 2013–14 and 2022–23 the average waiting time increased significantly as shown in the graph below.

Figure 67. Compound annual growth rate 2013–14 to 2022–23 waiting times for elective surgery[194]



Below is a series of graphs that show each jurisdictions days waited at the 50th percentile, 90th percentile and the proportion who waited over 365 days. Almost all jurisdictions have grown in the patients waiting for more than a year, NSW is currently the worst performing with 13 per cent of patients waiting for more than a year. Most other jurisdictions are sitting around the 10 per cent mark,

[193] Ibid.

[194] Ibid.

the NT had a peak of over 19 per cent during the COVID 19 period. Clearly, the trend is increasing proportion of patients are waiting for more than a year.

Figure 68. Days waited 50th percentile by region, 2018–19 to 2023–34[195]

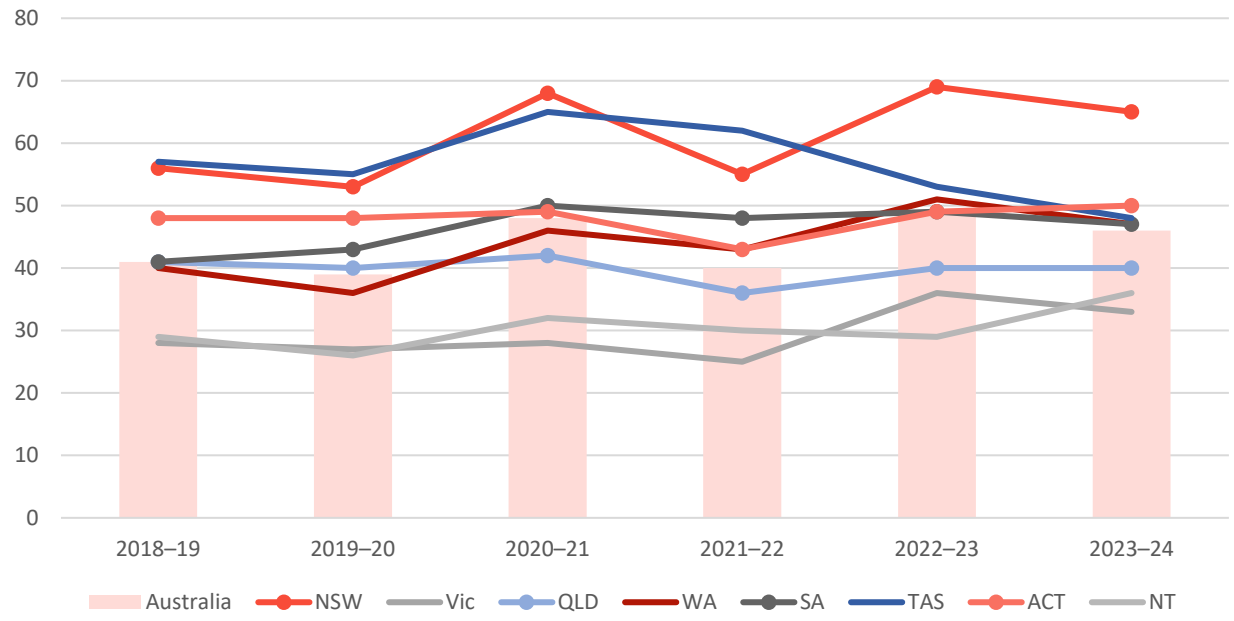
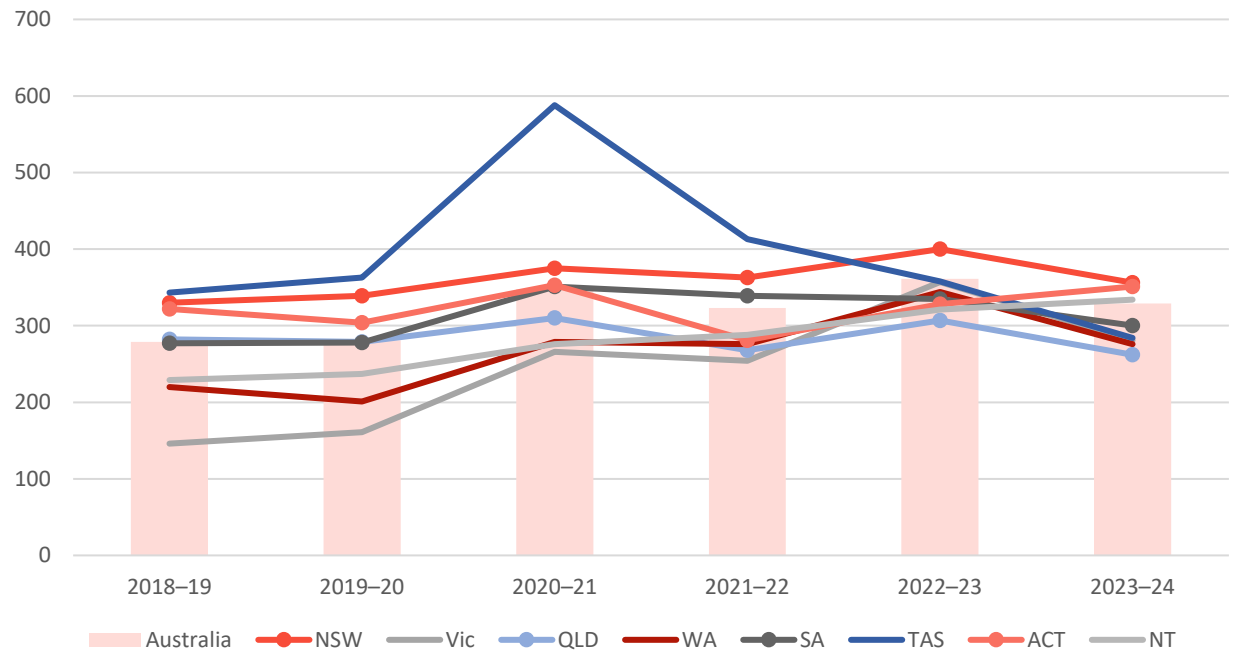


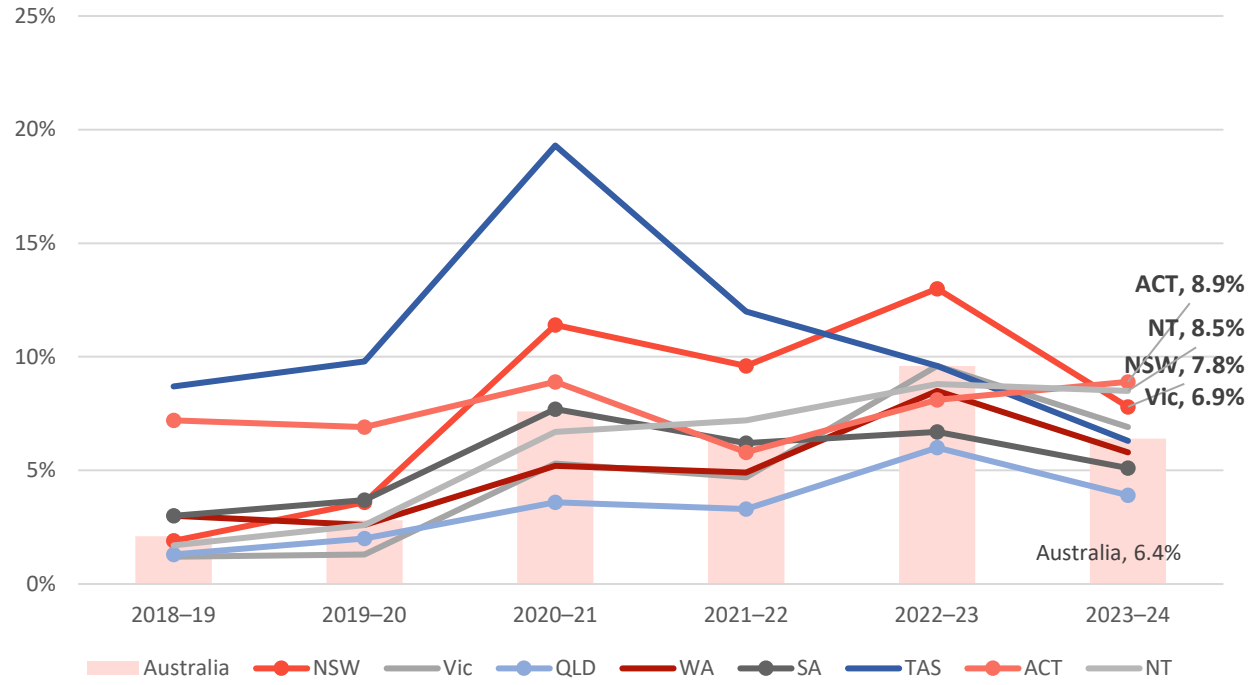
Figure 69. Days waited 90th percentile by region, 2018–19 to 2023–24[196]



[195] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery*.

[196] Ibid.

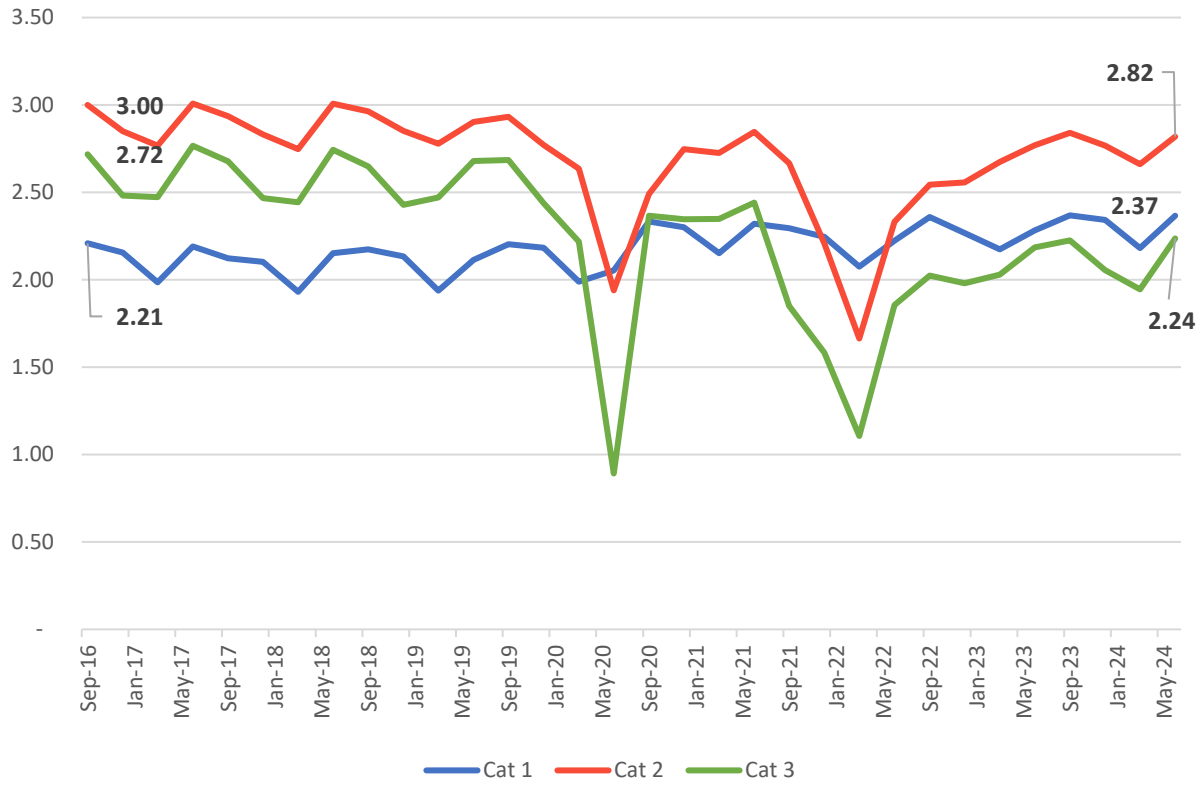
Figure 70. Proportion of patients waiting more than 365 days by region, 2019–19 to 2023–24[197]



[197] Ibid.

Examining the rate of delivery, it is evident that Category 1 surgeries have increased from 2.21 per 1,000 population in September 2016 to 2.37 per 1,000 population in May 2024 (7.2 per cent). However, the rates of Categories 2 & 3 have fallen from 3.00 and 2.72 in September 2016, respectively, to 2.82 (–6.0 per cent) and 2.37 (–17.7 per cent) per 1,000 population. While the increased rate of Category 1 surgeries is positive, that rate is still lower than the Category 2 rate. The reduced rates for Categories 2 & 3 are a concern and represent risks for many people in society.

Figure 71. Number per 1,000 population of admissions from public hospital elective surgery waiting lists by quarter 2016–2024[198]



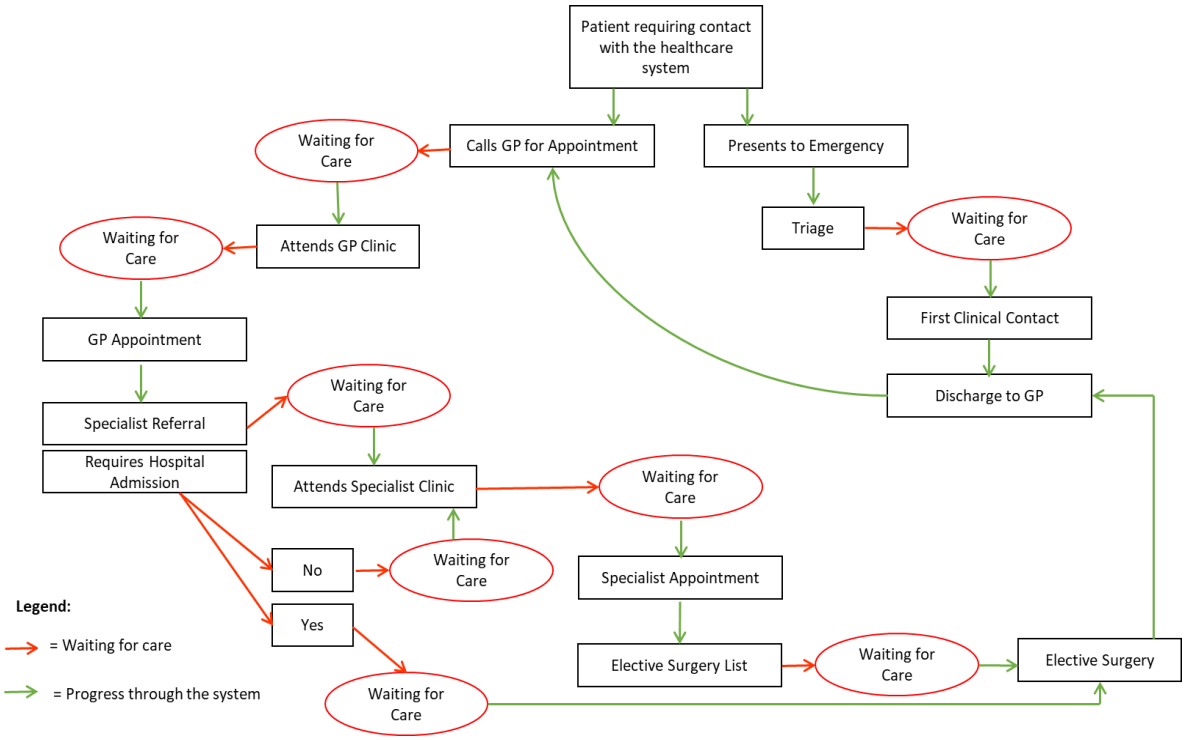
[198] Ibid.

Text Box 12: Specialist 'hidden' waiting lists

Specialist 'Hidden' Waiting Lists

Reported data on waiting times nationally is based on the time from a specialist appointment to the date of surgery. However, there is a 'hidden' waitlist because there are even longer waits from GP referral to the initial specialist appointment.[199]

Points of waiting for care through the health system[200]



A referral to a specialist – such as a psychiatrist, paediatrician, or ophthalmologist – usually means that a GP has identified that an individual has a potentially serious problem that requires further investigation or treatment.

In Australia, the clinically recommended wait time for Urgent (Category 1) patients is <30 days. Approximately 10 per cent of patients wait more than three months for a specialist appointment in many Queensland clinics and more than two months in Victoria.

Wait times for a free appointment at a public clinic are often far longer than clinical guidelines recommend. Across four capital cities (Sydney, Melbourne, Brisbane and Adelaide), there are 50 specialties where waiting times extend longer than a year. One in 10 people living in Sydney and waiting for a respiratory cystic fibrosis appointment wait more than three years for a consultation. So do one in 10 people in outer regional Victoria waiting for a neurosurgery appointment, people in inner regional South Australia waiting for an immunology appointment and people in outer regional NSW waiting for a haematology appointment.

Wait times are dependent on the number of specialists available and the hours they choose to work in public hospitals. In aggregate, 48 per cent of specialists work across both public and private sectors, 33 per cent work only in public and 19 per cent work only in private practice.

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[199] Australian Medical Association, *Shining a Light on the Elective Surgery "hidden" Waiting List*.

[200] Adapted from Daniel McIntyre and Clara K. Chow, "Waiting Time as an Indicator for Health Services Under Strain: A Narrative Review," *Inquiry* 57 (2020), https://doi.org/10.1177/0046958020910305.

Specialist 'Hidden' Waiting Lists

However, this varies by specialty. For example, orthopaedic surgeons and rheumatologists spend more than 70 per cent of their time in private practice, which generally offers higher incomes to doctors.

Patients who can afford to pay turn to private specialists; others – particularly those with poorer health (e.g., multiple conditions), lower disposable incomes, those in remote or disadvantaged areas and households with older adults – are forced to wait for the less timely care in the public system because of the greater expense of private sector specialists.

The OECD notes that a few countries (such as Finland, Norway and Spain) have implemented maximum waiting times to obtain an appointment with a general practitioner or other primary care provider.[201] In the UK, waiting times are measured based on waiting times from (GP) referral to treatment (RTT) [202] and thus better incorporate waiting times and the 'hidden wait list;' Denmark and Norway also measure waiting times in the same manner. Successfully tackling waiting lists requires the specification of an appropriate maximum waiting time, robust and reliable data combined with supply- and demand-side interventions and regular progress monitoring.

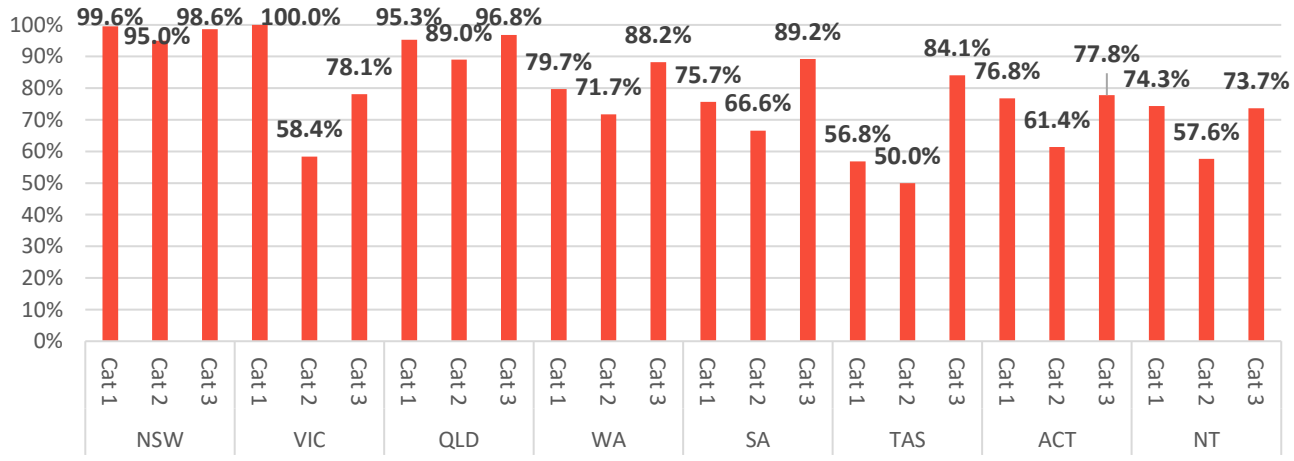
7.1.1. Waiting lists in the public hospital system

Continuous monitoring, investment and reform are essential to address these challenges and ensure the system remains sustainable and equitable for all Australians.

Addressing elective surgery delays requires looking beyond just the time spent on the official surgical list and tackling the bottlenecks in accessing specialist outpatient clinics.

Without counting the several layers of hidden waiting lists, public hospitals in Australia cannot provide the supply of services recommended by their own measures of clinically recommended waiting times. Queensland, the best performing State hospital system, is only able to provide 77.7 per cent of the elective surgeries within the clinically recommended time.

Figure 72. Proportion elective surgery patients admitted within clinically recommended time (per cent) 2023–24[203] [204]



[201] OECD, *Waiting Times for Health Services* (2020), https://www.oecd.org/en/publications/waiting-times-for-health-services_242e3c8c-en.html.

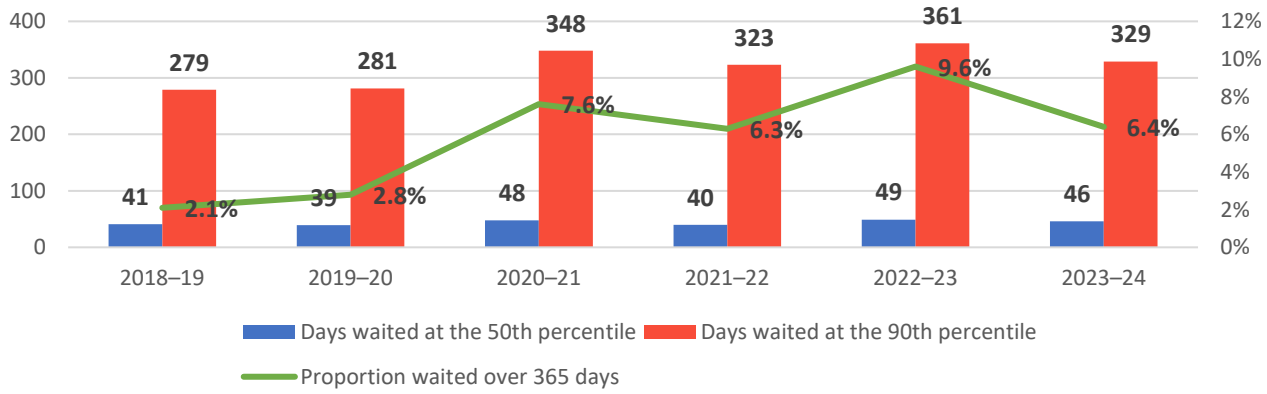
[202] McIntyre and Chow, "Waiting Time as an Indicator for Health Services Under Strain: A Narrative Review."

[203] Productivity Commission, *Report on Government Services 2025, 12 Public Hospitals*.

[204] NT did not report data for this year so an average of the past 9 years was used to show an estimate.

Between 2013–14 and 2022–23 the average waiting time increased significantly as shown in the graph below, which highlights days waited at the 50th percentile, 90th percentile and the proportion of waiting over 365 days across Australia. Appendix 3 shows almost all jurisdictions have experienced growth in patients waiting for more than a year. NSW currently performs the worst with 7.8 per cent of patients waiting for more than a year, while most other jurisdictions sit around 6 per cent. The NT peaked at over 19 per cent during COVID 19.

Figure 73. Australian average days on elective surgery waiting lists 50th & 90th percentile and portion waiting over 1 year[205]

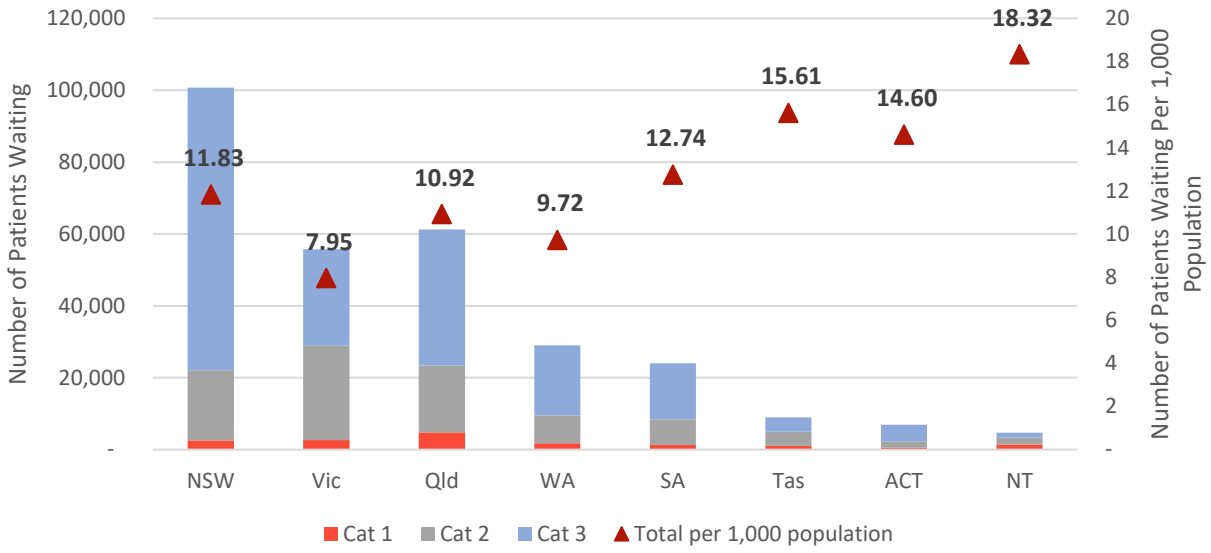


The graph below shows approximately 291,000 people (approximately 1.1 per cent of Australia's population) on elective surgery waiting lists by jurisdiction. Each State/Territory report on different dates and some are more specific than others. However, our estimates using available data show the number of patients waiting includes 16,000 Category 1, 87,000 Category 2 and 188,000 Category 3 patients. NSW has the largest absolute number (over 100,000) or 35 per cent of all patients waiting. Victoria has the largest number of patients waiting in Category 2, which is 47 per cent of their patients waiting.

When we calculate the number of patients waiting in total by 1,000 head of population, we find that the NT has the highest number of patients waiting by head of population, followed by Tasmania and the ACT.

[205] Australian Institute of Health and Welfare, *Hospitals, Elective Surgery*.

Figure 74. Number of patients on elective surgery waiting list by jurisdiction and per 1,000 population[206] [207] [208] [209] [210] [211] [212] [213] [214] [215]



[206] Legislative Assembly of the Northern Territory, *Written Question, Mr Yan to the Minister for Health* (2023), https://parliament.nt.gov.au/__data/assets/pdf_file/0003/1326036/Answer-to-Written-Question-634-Surgery-Wait-Times.pdf.

[207] Canberra Health Service, *Elective Surgery Waitlist Data* (2025), https://www.canberrahealthservices.act.gov.au/about-us/Elective-Surgery-waitlist-data.

[208] Tasmanian Government Department of Health, *Surgery* (2025), https://www.health.tas.gov.au/health-system-dashboard/monthly/surgery.

[209] SA Health, *Elective Surgery Dashboard* (2025), https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+hospital+dashboards/about+the+elective+surgery+dashboard/elective+surgery+dashboard.

[210] Government of Western Australia Department of Health, "Elective Surgery Monthly Report," May 2025, https://www.health.wa.gov.au/Reports-and-publications/Elective-Surgery-Wait-List-ESWL-reports/Elective-Surgery-Monthly-Report.

[211] Queensland Health, *Planned Surgery* (2025), https://www.performance.health.qld.gov.au/statewide-performance/planned-care/planned-surgery-activity.

[212] Victorian Agency for Health Information, *Patients Waiting for Treatment* (2025), https://vahi.vic.gov.au/planned-surgery/patients-waiting-treatment.

[213] NSW Bureau of Health Information, *Elective Surgery, Patients on Waiting List Ready for Surgery at End of Quarter* (2025), https://www.bhi.nsw.gov.au/data-portal.

[214] Australian Bureau of Statistics, *National, State and Territory Population* (2025), https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release.

[215] Number of patients by 1,000 population is calculated by DeltaPearl Partners. They populations used are September 2024 quarter.

7.1.1. Hidden waiting lists in the public hospital system

The graphs below provide a sample of the hidden waiting lists for specialist appointments in the Australian public system.

Figure 75. Queensland waiting time for initial specialist appointments in days, May 2025[216]

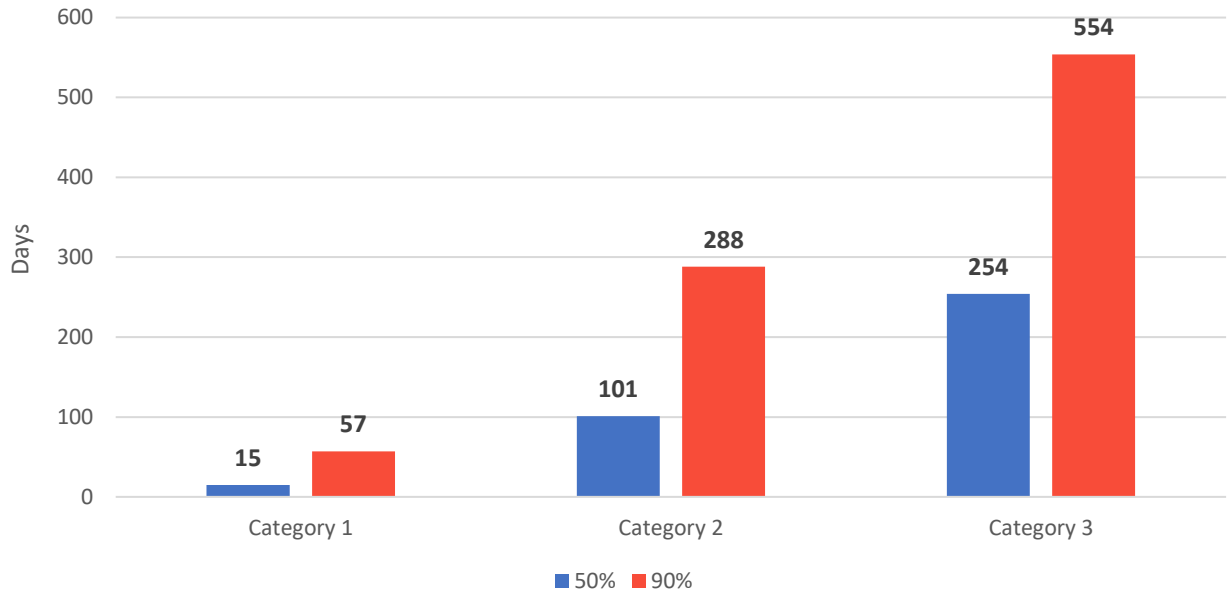
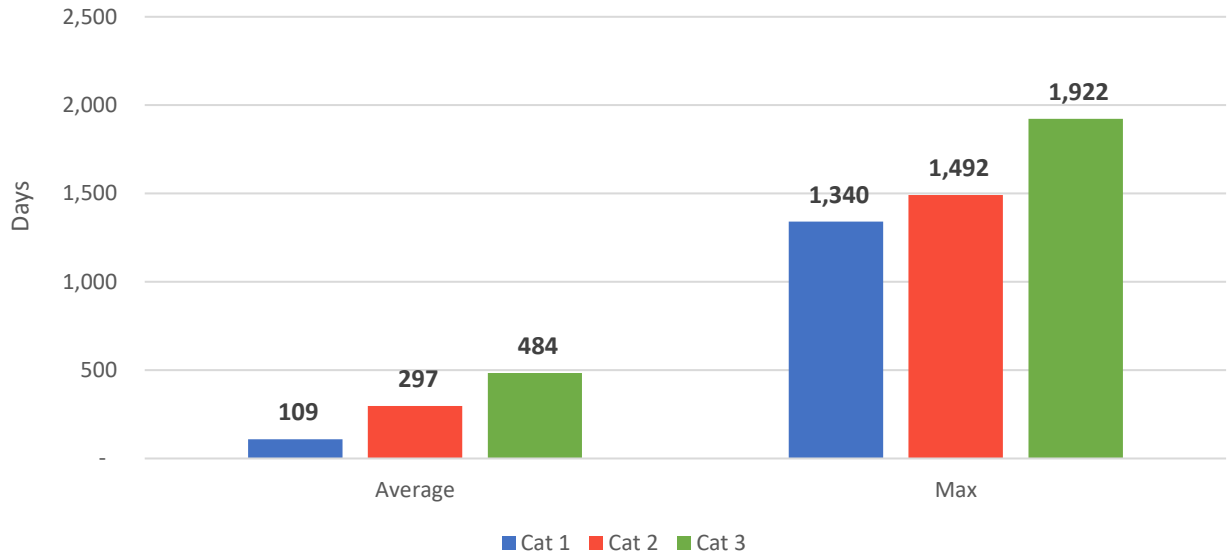


Figure 76. Tasmania outpatient wait times by urgency category, June 2025[217] [218]

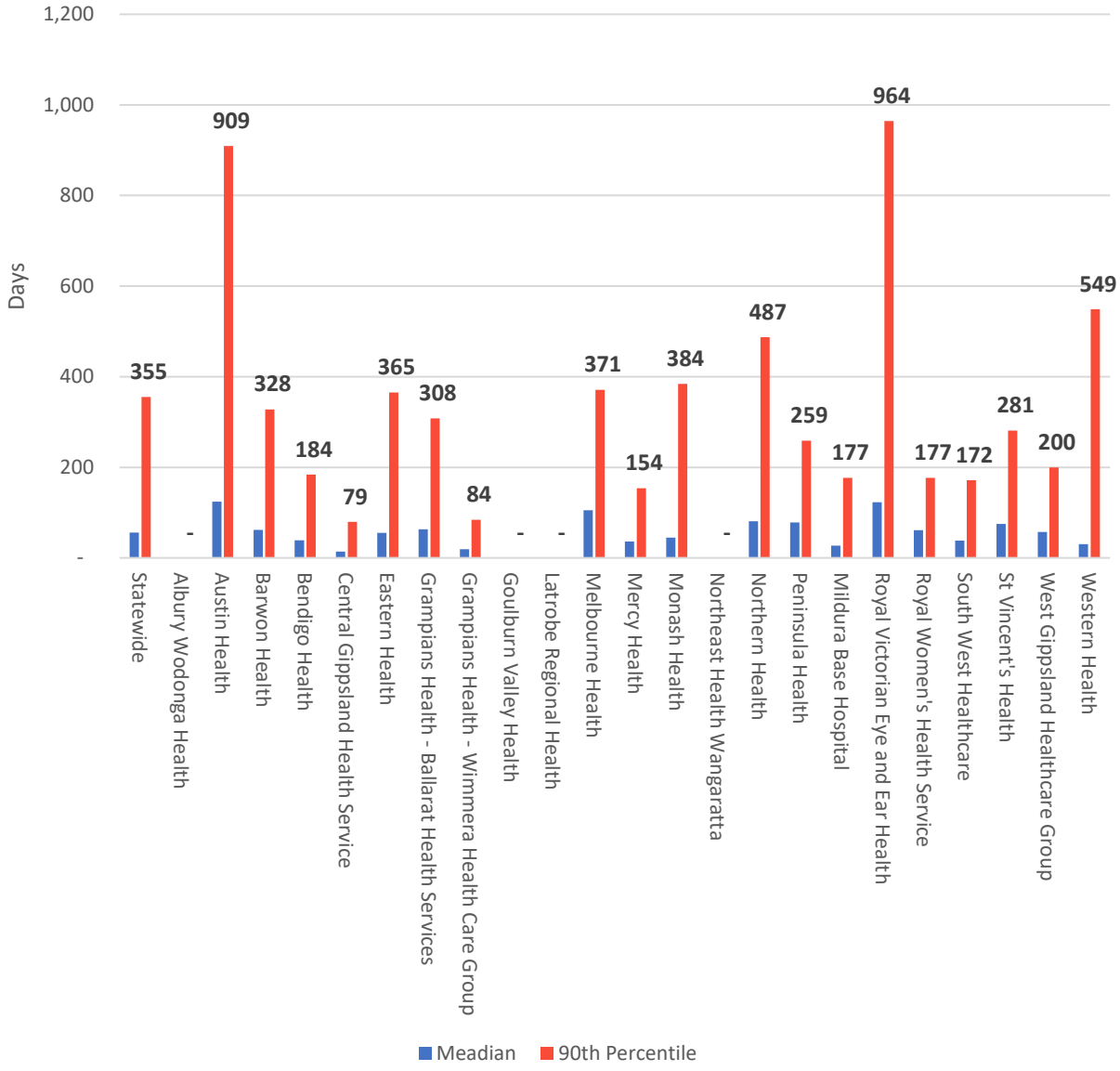


[216] Queensland Health, *Specialist Appointments, Activity*.

[217] Tasmanian Government Department of Health, *Estimated Wait Times, Outpatients*.

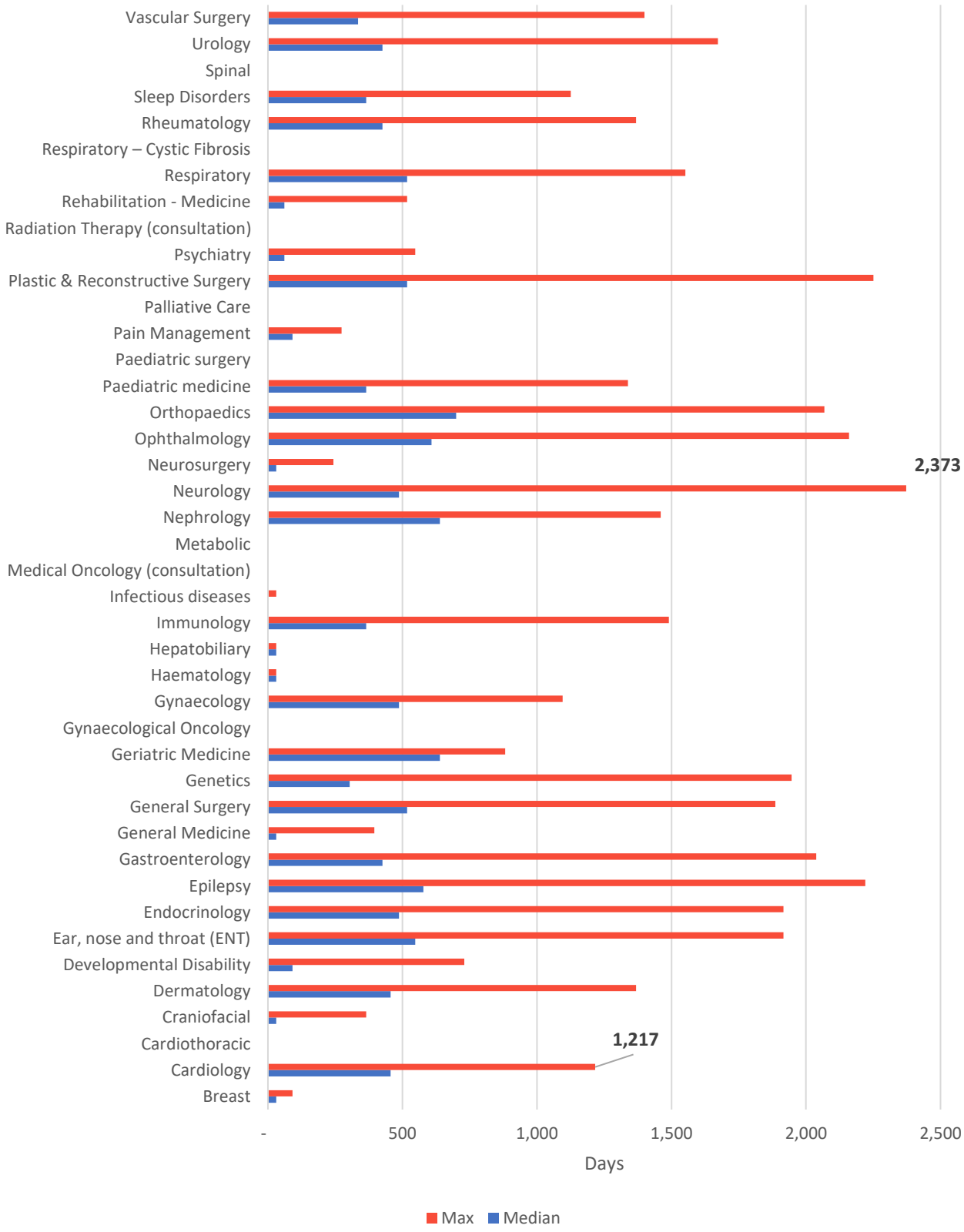
[218] DPP calculated the average and max from 123 data points in each urgency category.

Figure 77. Victorian specialist waiting times by organisation January to March 2025[219]



[219] Victorian Agency for Health Information, *Routine First Appointments*.

Figure 78. South Australia specialist outpatient waiting time, March 2025[220] [221]



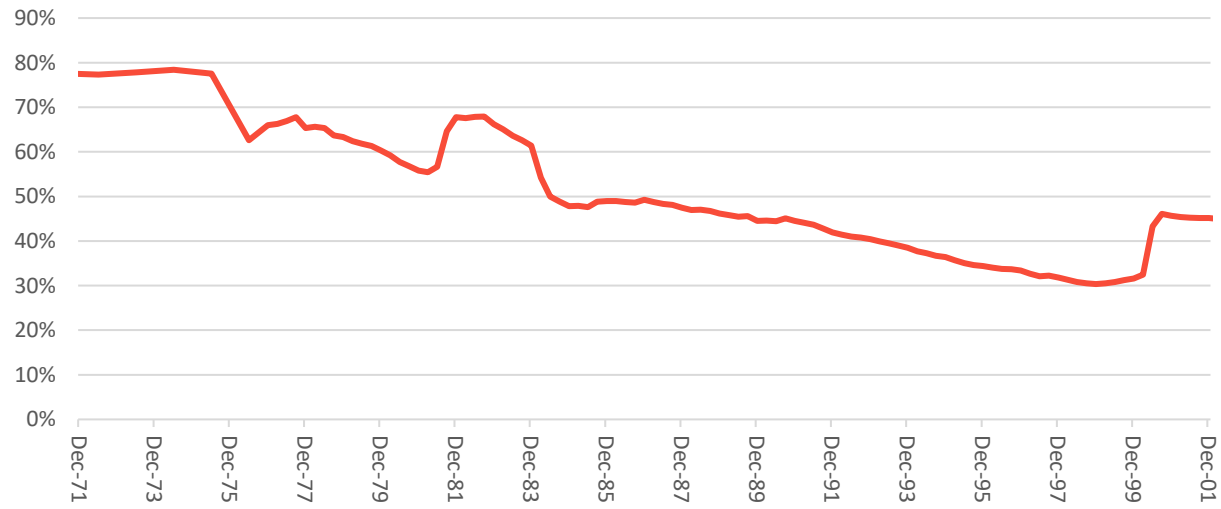
Appendix 4. Australian PHI system recent history

The origins of the current PHI system lie in the reforms introduced by the Government during the 1990s. This history focuses largely on the mid-1980s context which led to the reforms and the reforms of the 1990s onwards.[222]

Medicare and its impact on PHI

Australia adopted Medicare, a universal, publicly funded national insurance scheme in 1984.[223] In 2025, Medicare remains the major funder of Australia's health care system. Before the introduction of Medicare, holders of PHI received subsidies and tax rebates on their PHI and PHI coverage was a high proportion of the population – in the early 1980s, 55 per cent–68 per cent of the population held PHI.[224] With the introduction of Medicare, these forms of assistance ceased and PHI coverage dropped sharply to 50 per cent. PHI coverage continued to fall slowly but consistently over the next 10 years.

Figure 79. Historic decline in PHI (hospital cover)[225]



[220] SA Health, *Quarterly Specialist Outpatient Waiting Time Report*.

[221]DPP calculations: data provided as months waiting time per hospital, this graph shows the longest wait time reported for each type of treatment. Months were translated into days by dividing the months by the average number of days in a month (365/12).

[222] The early history is covered by Furnival et al (2017) and includes the beginnings of PHI in charitable institutions, mutual funds and friendly societies, and the introduction of 'voluntary health insurance' and community rating under the Menzies government in the 1950s.

[223] This was the second iteration of a universal publicly funded health system. The first iteration was Medibank, introduced by the Whitlam Labor Government in 1975, inspired by the implementation of similar programs in Europe during the period of post-war reconstruction. However, Medibank was subsequently dismantled by Fraser's Liberal Government. For a more detailed history, see Department of Health, Disability and Ageing, *The History of Medicare*.

[224] It had been even higher, reaching a national peak of 80 per cent in 1970, but declined with the introduction of the first iteration of a universal publicly funded health system, Medibank, introduced by the Whitlam Labor Government, as noted above.

[225] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage*.

Notes: The 18 per cent decline during the 1970s was in response to the introduction of Medibank, the precursor of Medicare; the decline was largely reversed when the Liberal Government unwound Medibank; PHI coverage then plummeted again with the introduction of Medicare in 1984.

Change in age distribution

Moreover, the age group distribution changed. Coverage for older persons remained relatively constant,[226] particularly among the 70 years plus group, but the incentives to hold PHI fell dramatically for younger age groups with the advent of Medicare and because there were no penalties for joining PHI later in life and younger people paid the same premium as older or sicker individuals due to community rating.227 There was little to no incentive for young healthy people to hold PHI as evidenced by the drop in coverage rates. Between 1983 and 1988, coverage by age groups fell from:

- 54.6 per cent to 16.3 per cent for 15–24 years olds.
- 75.6 per cent to 32 per cent for 35–49 year olds.[228]

Increasing risk and rising premiums

With many young and healthy people exiting the PHI system, adverse selection arose (that is, the quality of the insured pool deteriorated as low-risk healthier consumers opted out of PHI, deciding to rely on the public system and a smaller, sicker, higher-risk proportion of the population retained PHI). This increased the average risk profile of the insured pool. In response, insurance companies raised premiums.

- The Industry Commission reported that between 1990 and 1997, the average price of PHI rose at a rate of 3.5 times CPI inflation.
- The premiums of health insurers with the largest memberships in each state increased, in real terms, between 58 per cent and 173 per cent from 1984 to 1996.[229]

The rising premiums resulted in a decline in affordability, particularly among lower-income groups and a downward spiral of lower-risk cohorts dropping their PHI coverage and further premium rises occurred. There was a substantial rise in the proportion of fund members using private hospitals and an increase in average hospital admissions by private patients during this period.

Economic downturn contributed to the decline with PHI becoming largely unaffordable for average families as unemployment rose and real wages stagnated or fell. By 1997, average PHI coverage had reached a low of 30 per cent.

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[226] Coverage for 'contributor groups' (~ family unit) paid by a person in the 60-69 year age group fell from 45.3 per cent in 1983 to 39.6 per cent in 1988, while there was little change in the 70 years and over range which remained relatively constant at around 36 per cent. It may seem odd that the coverage rate was lower for these older groups. According to the ABS, this was in part due to the generally lower incomes of people in this contributor age group, and the fact that many also had access to government health concession cards. Of contributor units where the contributor was aged 65 years or more, 79 per cent were covered by government health concession cards. However, 74 per cent of those not covered by government health concession cards had private health insurance. This left about 80,000 contributor units where the contributor was aged 65 years or more with neither private health insurance nor government health concession cards. Australian Bureau of Statistics, *Health Expenditure: Private Health Insurance: Who Has It?* (1994), https://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588/dbe97f641ee74121ca2570ec00785dc6.

[227] Under community rating; health funds are required to charge all consumers the same premium regardless of health status. The objective is to address affordability through cross-subsidisation from low risk to high risk individuals. Given that individuals could join PHI funds at any point of their lives during this period, including when they were older and almost certain to lodge claims exceeding the value of their premium, community rating resulted in young people in PHI attracting premiums exceeding their true risk. Combined with the introduction of Medicare, this reduced their incentives to hold PHI.

[228] AIHW, reported in Senate Standing on Committee Community Affairs, *Healing Our Hospitals: A Report on Public Hospital Funding* (2000), https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1999-02/pubhosp/report/index.

[229] Ibid.

Quality of PHI products / industry efficiency

During the late 1980s, the Labor Government implemented some reforms to make PHI offerings more attractive.

However, they did not necessarily regard the decline in coverage as problematic, considering that a natural rate was around 30 per cent.[230] The reforms aimed at increasing efficiency and transparency in the sector and the quality of PHI offerings. They included requirements compelling funds to enable portability by recognising waiting periods already served by policy holders moving between insurers (1988), changes to minimum insolvency requirements (also 1988). In 1997, the Industry Commission had noted that unpredictable 'out-of-pocket' expenses following episodes of hospitalisation and the difficulties faced by consumers in comparing the products offered had diminished the attractiveness of PHI by various funds. [231]

Impact on public sector

Implications of this decline in PHI coverage include a greater tendency for people in need of hospital care to use the public hospital system and a relatively smaller pool of funds available for treatment of patients in private hospitals.[232]

The decline in PHI coverage led to concerns about strain and financial burden on the public sector. Safety and quality issues were regularly raised both in the media and more generally.

There was significant concern regarding the impact of falling PHI coverage on the sustainability of public hospitals with then Minister for Health and Ageing, the Hon Dr. Michael Wooldridge, stating in a submission to a Senate Inquiry that: '*...the health of the publicly funded health sector depends upon a vital private sector. Having some six million Australians with PHI directly pays for around one-third of the costs of hospital care in Australia. If there were no private sector, the extra costs borne by the taxpayer would simply be unsustainable*.'

Text Box 13: Economic rationale for PHI

Economic rationale for PHI

Government funding for hospital services is limited, mostly by a combination of the population's tolerance for taxation; and, the expectation that tax income will be spent on a mix of services, not just healthcare. The consequence of this is a requirement for rationing in-hospital care, which is done via waiting lists. The fact that care in public hospitals does not attract a user charge may lengthen the waiting lists, to the extent to which it induces moral hazard by consumers or health care providers. There are welfare losses from waiting lists and substantial costs associated with maintaining the quality of life of those in the queue.

Conversely, PHI allows insured persons the choice of opting out of the waiting list and being treated more expeditiously, in a private hospital. At the same time, they receive some other benefits, including doctor selection. There is a mix of public and private benefits here. The private benefits are captured in the insured patient's experience: having rapid treatment; peace of mind from having selected a service provider; potentially avoiding comorbidities or longer recovery associated with treatment delays. This may be paid for by a mixture of PHI and out-of-pocket copayments.

There are also public benefits associated with this activity. Some of these are related to the private experience: patients receiving timely interventions will have less time out from workforce participation; and earlier intervention may save costs in the future. However, the broad public benefit is a reduction in the length of the public waiting list. This is measured as a welfare gain, associated with shorter waiting times. Again, some of this is a private benefit (individual patients in

[230] Stephen Duckett and Kristina Nemet, *The History and Purposes of Private Health Insurance*, Grattan Institute Reports (Grattan Institute, 2019).

[231] Industry Commission, *Private Health Insurance* (1997), https://www.pc.gov.au/__data/assets/pdf_file/0006/156678/57privatehealth.pdf.

[232] Australian Bureau of Statistics, *Health Expenditure: Private Health Insurance: Who Has It?*

the public space being treated more quickly) and some of it is shared (reduction in interruptions to workforce participation and reduction in non-hospital health costs). This combination of private and public benefits from PHI is why there is merit in some public participation in PHI funding, to increase the rate of insurance across the population.

Rebate rates

The rebate rate is the percentage of the PHI fee that the government has agreed to pay as a subsidiary to policy holders. Since 2014, rebate rates are adjusted annually on April 1st, based on the rebate adjustment factor (RAF), which is calculated by DoHDA.[233] The calculation, shown below, is the ratio of general inflation over premium inflation.[234]

$$Rebate\ Adjustment\ Factor = \frac{General\ Inflation\ (Consumer\ Price\ Index)}{Premium\ Inflation\ (Weighted\ Average\ Increase\ in\ Premiums)}$$

To calculate the new rebate rates for a year (encompassing April through to March), the rebate rates from the preceding year are multiplied by the RAF for the new year. Due to the indexing of rebate rates occurring on April 1st, a financial year contains two distinct rebate rate periods: July 1st to March 31st (using the old rates) and April 1st to June 30th (using the newly indexed rates). For more detail on the calculation of the RAF.

The intent of the RAF is to limit the liability of the PHI rebate to the Commonwealth in the case of rising premiums. If premiums rise faster than general inflation, the effect of the RAF is to decrease rebate rates. The formula is such that the scale of the PHI rebate in real terms will not increase due to premiums rising. However, the scale of the rebate can still vary based on the number of policy holders and the makeup of policies held.

Additionally, there is a clause that if premium inflation is lower than general inflation, the RAF is taken to be 1. As such, rebate rates cannot increase, they can only decrease. Before the introduction of the RAF, the rebate rates for policy holders in the lowest income tier were:

- 30 per cent for policy holders under 65 years old
- 35 per cent for policy holders aged 65 to 69
- 40 per cent for policy holders aged 70 and over.

Each step up to Tier 1 and Tier 2 attracted a reduction of 10 per cent of the rebate rate, with policy holders in Tier 3 not eligible for any rebate. As a consequence of applying the RAF, rebate rates have steadily decreased since the RAF's introduction in 2014. Table 10 presents the current PHI rebate rates in comparison with the initial rebate rates prior to the introduction of the RAF.

Figure 80The graph below presents the cumulative change in rebates over this period, which shows a reduction of 19.04 per cent.

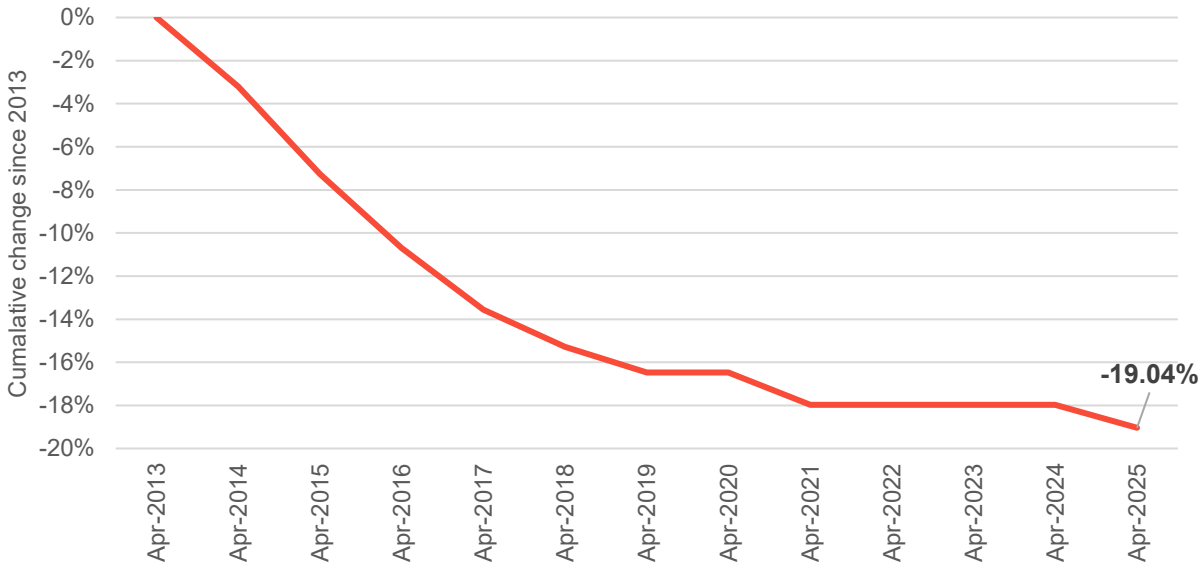
[233] Private Health Insurance Legislation Amendment Act 2014.

[234] Private Health Insurance (Incentives) Rules 2012 (No. 2).

Table 10: PHI rebate rates, 2012–13 and 2024–25 [235]

	Rebate Rate – Prior to Introduction of RAF (1 July 2012 – 31 March 2014) Age of oldest person covered			**Rebate Rate** – *Current* **(1 April 2025 – 30 June 2025)** Age of oldest person covered		
	<65	65–69	70+	<65	65–69	70+
Base Tier	30%	35%	40%	24.288%	28.337%	32.385%
Tier 1	20%	25%	30%	16.192%	20.240%	24.288%
Tier 2	10%	15%	20%	8.095%	12.143%	16.192%
Tier 3	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible

Figure 80: Cumulative percentage change in rebate rates since 2013 [236] [237] [238]



[235] Australian Taxation Office, *Income Thresholds and Rates for the Private Health Insurance Rebate*.

[236] Ibid.

[237] Department of Health, Disability and Ageing, *Average Annual Price Changes in Private Health Insurance Premiums*.

[238] Australian Bureau of Statistics, *Consumer Price Index, Australia*.

Text Box 14: Rebate indexation

Rebate Indexation

Both the income thresholds and the rebate rates for the PHI rebate are indexed annually. However, each of the components of the PHI rebate assessment is indexed using different calculations, using different rates, on different dates. Below we seek to explain the differences and the impact on PHI rebates over time.

Each year general inflation (price level increase) in the economy would push more people into higher tiers of assessment under the PHI rebate thresholds, which reduces the subsidy paid and, therefore, increases the real cost for each policy holder. Since the introduction of means testing in 2012,[239] the Commonwealth Government increases the threshold values each year to reduce the impact of inflation.

Income thresholds for the PHI rebate are calculated and adjusted annually at the beginning of each financial year by the Australian Tax Office. The thresholds are indexed to Average Weekly Ordinary Time Earnings. [240]

However, indexation was paused between 2014–25 and 2022–23.[241] The graph and table below show the change of income thresholds over this period, against the calculated income thresholds had indexation not been paused. The indexation pause has meant that the current income thresholds are approximately[242] 22 per cent to 24 per cent lower than they would be if indexation had been continuously applied, effectively pushing more policy holders into higher rebate tiers and increasing their out-of-pocket costs.

[239] Fairer Private Health Insurance Incentives Act 2012, Cth (2012).

[240] Ibid.

[241] Private Health Insurance Amendment (Income Thresholds) Bill 2021, House of Representatives 46, Cth (2021). https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fbillhome%2Fr6705%22.

[242] There are slight differences for each tier in the percentage difference between actual income thresholds and the income thresholds if indexation had not been paused. This is the result of:

- Different base years were implemented for the indexation of the Tier 1 threshold than the Tier 2 and Tier 3 thresholds. Since the reintroduction of indexation, all three tiers now use a consistent base year (2021).
- Rounding down to the nearest thousand.

Rebate Indexation

Figure 81: PHI income thresholds: 2012–13, 2024–25 and 2024–25 if indexation was not paused [243] [244]

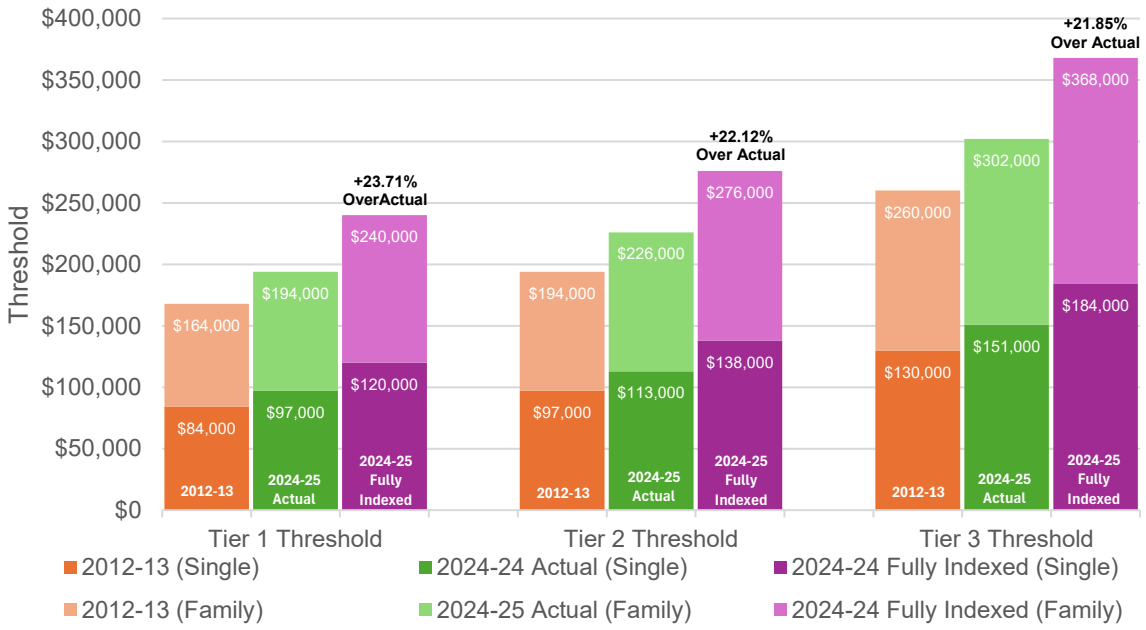


Table 11: PHI income thresholds: 2012–13, 2024–25 and 2024–25 if indexation was not paused [245] [246]

	Income Threshold (2012–13) Original Family Status		**(2024–25) Actual** Family Status		**Without Indexation Pause** Family Status	
	Single	Family	Single	Family	Single	Family
Base Tier	$84,000 or less	$168,000 or less	$97,000 or less	$194,000 or less	$120,000 or less	$240,000 or less
Tier 1	$84,001 – $97,000	$168,001 – $194,000	$97,001 – $113,000	$194,001 – $226,000	$120,001 – $138,000	$240,001 – $276,000
Tier 2	$97,001 – $130,000	$194,001 – $260,000	$113,001 – $151,000	$226,001 – $302,000	$138,001 – $184,000	$276,001 – $368,000
Tier 3	$130,001 or more	$260,001 or more	$151,001 or more	$302,001 or more	$184,001 or more	$368,001 or more

[243] Australian Taxation Office, *Income Thresholds and Rates for the Private Health Insurance Rebate*.

[244] Australian Bureau of Statistics, *Average Weekly Earnings, Australia* (2025), https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia.

Income for Surcharge Purposes

Income for surcharge purposes is established in section 995-1 of the *Income Tax Assessment Act 1997*:[247]

income for surcharge purposes, for a person and an income year, means the sum of the following:

(a) the person's taxable income for the income year (disregarding the person's *assessable first home super saver (FHSS) released amount for the income year and subsection 271-105(1) in Schedule 2F to the *Income Tax Assessment Act 1936*);

(b) the person's *reportable fringe benefits total (if any) for the income year;

(c) the person's *reportable superannuation contributions for the income year;

(d) the person's *total net investment loss for the income year;

less the amount mentioned in subsection 301-20(3) for the person for the income year if the person is entitled to a tax offset under subsection 301-20(2) for the income year.

Assessable FHSS released amount refers to the amount included in a person's assessable income under the First Home Super Saver Scheme established in the *Income Tax Assessment Act 1997* and *Taxation Administration Act 1953*.[248] [249]

Subsection 271 105(1) in *Schedule 2F to the Income Tax Assessment Act 1936* refers to reduction in assessable income on amounts on which the family trust distribution tax has been paid. [250]

Subsection 301-20(3) refers to the amount included in an in a person's assessable income from superannuation lump sum payments that does not exceed their *low rate cap*, for individuals under 60 who have reached their *preservation age*.[251]

The ATO provides an explanation on the calculation of *income for surcharge purposes* that outlines the above contributing components, reproduced in Text Box 15 below. Since 1 July 2024, the reduction relating to superannuation lump payments for individuals under 60 and who have reached their preservation age has no practical effect, as from that date onwards all individuals who have reached their preservation age are at least 60 years old.[252]

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[245] Australian Taxation Office, *Income Thresholds and Rates for the Private Health Insurance Rebate*.

[246] Australian Bureau of Statistics, *Average Weekly Earnings, Australia*.

[247] Income Tax Assessment Act 1997, Cth (2025).

[248] Ibid.

[249] Taxation Administration Act 1953, Cth (2025).

[250] Income Tax Assessment Act 1997.

[251] Ibid.

[252] Superannuation Industry (Supervision) Regulations, Cth (2025).

Text Box 15: ATO explainer – Calculating income for surcharge purposes

ATO explainer – Calculating income for surcharge purposes[253]

Your income for Medicare levy surcharge purposes is the sum of the following items for you (and your spouse, if you have one):

- Taxable income
    - include the net amount on which family trust distribution tax has been paid.
    - do not include any assessable FHSS released amount for the income year under the FHSS scheme.
- Reportable fringe benefits.
- Total net investment losses – the sum of:
    - net financial investment losses.
    - net rental property losses.
- Reportable super contributions – the sum of:
    - reportable employer super contributions.
    - deductible personal super contributions.

If you have a spouse, their share of the net income of a trust on which the trustee must pay tax (under section 98 of the *Income Tax Assessment Act 1936*) and which has not been included in their taxable income.

If you had exempt foreign employment income, add it to your taxable income if your taxable income is $1 or more. If you meet both of the following conditions, you can reduce your income for MLS purposes by any taxed element of the super lump sum, other than a death benefit, that does not exceed your (or your spouse's) low rate cap:

- you (or your spouse) are aged from your (or their) preservation age to under 60 years old.
- you (or your spouse) received a super lump sum.

[253] Australian Taxation Office, *Medicare Levy Surcharge Income, Thresholds and Rates* (2024), https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge/medicare-levy-surcharge-income-thresholds-and-rates.

Rebate Adjustment Factor

The rebate adjustment factor is established in section 5A of the *Private Health Insurance (Incentives) Rules 2012 (No. 2)*:[254]

RAF

For the purposes of paragraph 22-15(5E) of the Act the RAF is determined according to the following formula:

a) For the adjustment year commencing on 1 April 2020:

RAF = 1

b) For all other adjustment years:

RAF = CPI factor for the relevant adjustment year

1 + Average premium increase for the relevant adjustment year

Where:

RAF = rebate adjustment factor expressed as a factor to 3 decimal places (rounding up where the fourth decimal place is 5 or more).

CPI factor for the relevant adjustment year is the number worked out by dividing the CPI index number for the December quarter immediately preceding that year by the CPI index number for the December quarter preceding the first mentioned December quarter expressed as a factor to 4 decimal places (rounding up where the fifth decimal place is 5 or more).

CPI index number for a quarter is the All Groups Consumer Price Index number, being the weighted average of the 8 capital cities, published by the Australian Statistician in respect of that quarter.

Average premium increase for the relevant adjustment year means the figure published by the Department of Health during the course of an adjustment year that represents the industry average premium increase (including rate protection and the age-based discount factor) being the average change in premiums for each product subgroup offered by every private health insurer, weighted according to the number of people covered under complying health insurance policies in each product subgroup, expressed as a factor to 4 decimal places (rounding up where the fifth decimal place is 5 or more).

The adjustment factor for an adjustment year is to be determined in accordance with the PHI (Incentives) Rules and section 22-15(5E) of the *Private Health Insurance Act 2007*.[255] However, if the factor so determined for an adjustment year is more than 1, the adjustment factor for that year is instead taken to be 1.

[254] Private Health Insurance (Incentives) Rules 2012 (No. 2).

[255] Private Health Insurance Act 2007, Cth (2025).

Appendix 5. Model design

The modelling in this report undertakes an impact and offset analysis of the PHI rebate. The analysis seeks to estimate how changes to PHI rebate rates influence: PHI coverage, migration within PHI tiers and demand on public hospital services. Increases or reductions to expenditure on the rebate can then be compared to the offset burden on the public hospital system.

Not all individuals who receive the rebate are solely incentivised by that part of the whole PHI offering or government incentives. A segment of the population would likely maintain PHI even in the absence of the rebate, driven by factors such as personal preference for private care, desire for choice, or higher-income levels. Previous analyses of the PHI market have often relied on estimating price elasticity—a measure of how demand changes when price changes. However, understanding the true impact of rebate adjustments through measure of price elasticity is problematic for three key reasons:

- **It ignores shifts between levels of cover.** Estimating shifts in overall levels of coverage through measures of price elasticity fails to capture the complex reality of the PHI market. As discussed throughout this report, consumers are not just incentivised to take out or drop out of PHI but are also incentivised to shift between different levels of cover.
- **Not all price changes are equal.** In a competitive insurance market, a premium increase is often linked to the underlying cost and expected benefit of the product; it may reflect rising healthcare costs or a higher-risk membership pool. In contrast, the PHI rebate is an artificial price adjustment. It is a government subsidy that lowers the cost to the consumer without changing the intrinsic value or cost of the insurance product itself.
- **It is inherently difficult to measure accurately.** A reliable measure of price elasticity requires isolating the effect of a price change from all other factors that influence a consumer's decision. In the context of PHI, this is particularly challenging because demand is driven by a complex mix of variables. For example, a person's decision to buy or upgrade a policy is influenced by their age, health status, their income level, changes in public hospital waiting times, media reports on health system pressures, or the perceived quality of care. Because these factors are constantly changing, it is difficult to attribute a change in demand solely to a change in price, making traditional elasticity measures unreliable for precise policy modelling.

The modelling presented in this report is built to overcome these limitations. Instead of using a measure of general price elasticity, it simulates the decision-making process of consumers based on their perceived value of a product versus its effective cost, providing a more accurate picture of how a purely financial instrument such as the rebate influences behaviour.

Specifically, the analysis focuses on the expenditure and impacts related to the hospital component of PHI, as the hospital component has a direct and quantifiable offset in terms of reduced demand on the public hospital system. While the general treatment component of PHI also provides benefits to consumers and the broader health system, a direct offset analysis to government medical expenditure within the public system is not possible. This is because general treatment covers ancillary services that a not typically covered by Medicare. We do note that subsidising general treatment provides benefits in the form health gains to the population and support for the ancillary healthcare sector. Furthermore, general treatment policies encourage the uptake of hospital insurance. Effectively all policy holders who elect to hold hospital cover elect to take out a combined hospital and general treatment policy.[256] [257]

[256] 0.1 per cent of policy holders with hospital cover hold hospital cover only.

[257] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Coverage*.

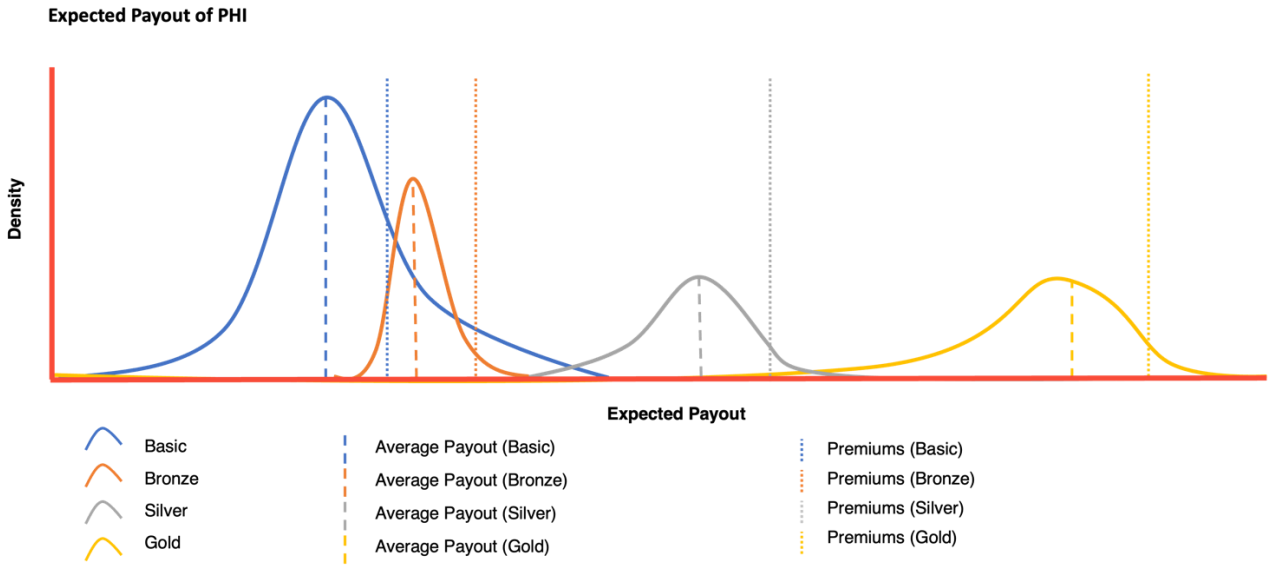
To accurately forecast the impacts of policy changes, our model begins by representing the Australian PHI market, which is composed of different product tiers: Basic, Bronze, Silver and Gold and their various 'Plus' variants.[258] We assume that in a competitive market, each of these products is distinct and caters to a different type of consumer.

The key assumptions are:

- **Insurance payouts follow a bell curve.** For any given insurance tier, the claims paid out to policyholders will cluster around an average value. This clustering accounts for both adverse and advantageous selection. This average payout is naturally lower than the premium paid, as the difference covers administration costs and insurer profits.
- **Differentiated products attract differentiated risk pools.** This natural sorting of consumers is why the payout distributions for each tier have very little overlap.

Figure 82 presents a simple visual representation of expected payouts of differentiated insurance products in a competitive market.

Figure 82. Illustrative Visual Representation of Differentiated Product Tier Payouts



How Consumers Choose Their Insurance

A central concept in our model is that people buy health insurance based on its perceived value and not just an expected financial payout. In the context of the Australian dual system with free Medicare as an alternative, this perceived value is influenced by many factors such as reduced risk expectations of extended waiting lists, access to private rooms, the flexibility to schedule procedures, the ability to choose preferred doctors, peace of mind and exemption from the Medicare levy surcharge. Crucially, different individuals will hold different risk tolerances, impacting their perceived value of PHI.

We model skewed normal distributions for the perceived value of a given insurance product to individuals, given the following constraints:

- **Individuals elect to hold a policy if the perceived value is greater than the effective cost.** All policy holders of a given insurance product elect to hold that product because they perceive the value of that product is greater than the effective cost to the induvial of the premiums. We further assume that all individuals in a higher level of cover would also perceive the value of lower levels

[258] Insurance products are further differentiated by additional features, such as the level of excess and gap arrangements.

of cover as being greater than the effective cost of the premiums. The area of the distribution to the right of the effective price (premiums minus rebate) is therefore equal to the fraction of individuals who hold that policy or higher tiers of policy.

- **Insurance products are differentiated.** The distribution approaches zero at the halfway point between the premium of the policy tier and the premium of the next policy tier.
- **Perceived value distributions are centred around premiums in market equilibrium.** The mode of the distribution is equal to the premium.

That is, the density curves of the skewed normal distribution for each insurance product are determined by the following constraints:

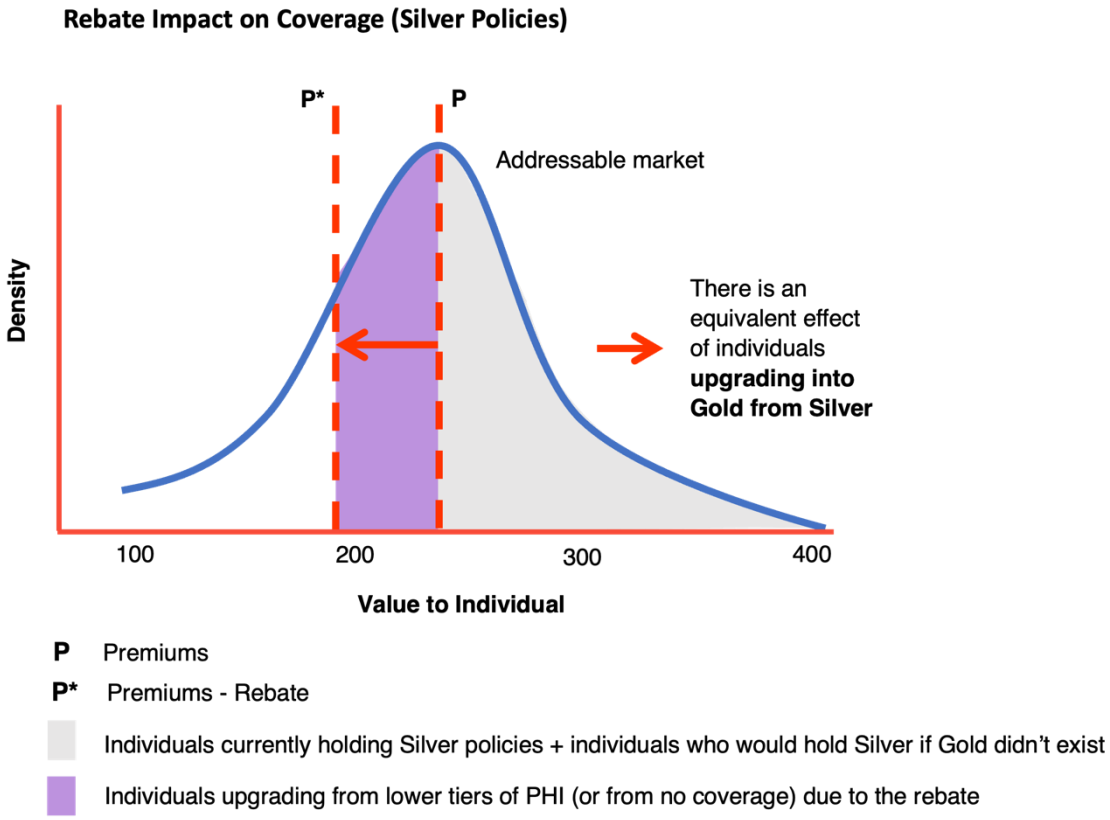
$$Constraint_1 : Probability(V \geq P^*) = PolicyHolders_{frac} + {PolicyHolders_{frac}}^{++}$$
$$Constraint_2 : Probability\big(V \leq (P + P^+)\big) \to 0$$
$$Constraint_3 : Mode\big(f(V)\big) = P$$

Where:

$$V := The\ expected\ value\ to\ an\ individual\ of\ holding\ the\ insurance\ product$$
$$P := The\ premiums\ of\ the\ insurance\ product$$
$$P^* := The\ effective\ price, given\ by\ (P - rebate)$$
$$P^+ := The\ premiums\ of\ the\ insurance\ product\ one\ tier\ higher$$
$${PolicyHolders_{frac}} := The\ fraction\ of\ individuals\ holding\ the\ insurance\ product$$
$${PolicyHolders_{frac}}^{++} := The\ fraction\ of\ individuals\ holding\ insurance\ products\ of\ higher\ tiers$$

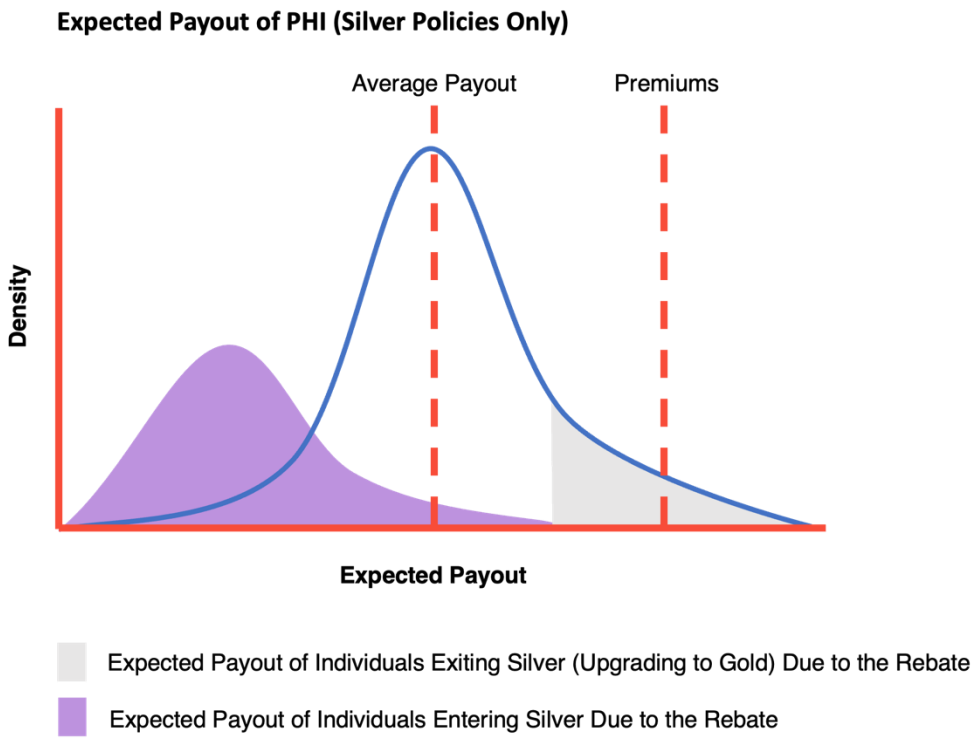
Figure 83 illustrates the impact of the rebate on policy holders on a given product tier. Increasing the rebate shifts P* to the left, increasing the number of individuals who elect to hold that insurance product. Conversely, decreasing the rebate shifts P* to the right, decreasing the number of individuals who elect to hold the insurance product. As demonstrated in Figure 83, there are marginal returns to the impact of the rebate. Greater increases to the rebate encourage marginally fewer individuals hold an insurance product.

Figure 83. Illustrative Representation of the Impact of the PHI Rebate on Silver Tier Policy Holders



Second Order Effects

There is a second order effect of adjustments to rebate policy. Individuals who exit each tier of private health due to a reduction in the rebate have a lower risk profile than individuals who remain. Similarly, individuals who are entering each tier from a higher tier due to a reduction in the rebate have a higher-risk profile than those currently with policies in that tier. A reduction in the rebate will therefore lead to a higher-risk profile makeup in each tier, resulting in a spiral of rising premiums and further individuals to reduce or drop coverage until a new equilibrium is reached. Additionally, higher premiums would mean a higher rebate expenditure per individual for a given rebate rate, offsetting the reduction in rebate expenditure from reducing the rebate rate. This second order effect is not modelled in this report and as such the impact of rebate policy adjustments presented likely represents a conservative estimate.



Key model inputs

- The current proportion of policy holders in each of the four product tiers of PHI was estimated from the most recent available DoHDA PHI reform data,[259] and APRA data[260] showing a further decline in the proportion of policy holders holding non-exclusionary[261] policies.
- The proportion of policy holders in each of the four income threshold tiers was derived from the most recent available ATO taxation statistics.[262]
- Premiums for different tiers of PHI are estimated from the PrivateHealth.gov.au dataset and APRA insurer performance data.[263] [264]
- Long-run inflation is assumed to be 2.5 per cent per annum.
- Notional capital cost adjustment is assumed to be 6 per cent.

[259] Department of Health and Aged Care, *Private Health Insurance Reform Data Quarterly Trends Reports*.

[260] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Benefits*.

[261] Non-exclusionary policies correspond to Gold Tier policies under the product tier reforms.

[262] Australian Taxation Office, *Taxation Statistics 2022–23* (2025), https://www.ato.gov.au/about-ato/research-and-statistics/in-detail/taxation-statistics/taxation-statistics-2022-23.

[263] Private Health Insurance Ombudsman, *PrivateHealth.Gov.Au Dataset* (2025), https://data.gov.au/data/dataset/private-health-insurance.

[264] Australian Prudential Regulation Authority, *Annual Private Health Insurance Statistics*.

Appendix 6. Modelling PHI rebate policy impacts

A key component of assessing the value of the PHI rebate lies in robust modelling of possible policy scenarios. We develop four scenarios to evaluate the implications of changes to the rebate on public hospital capacity, government health expenditure and the long-term viability of the private health system.

The four selected scenarios, to be considered over a 10-year projection period, are:

- Base Case – No change to the PHI Rebate.
- Scenario 1 – Complete removal of the PHI, staggered over a 5-year period.
- Scenario 2 – Partial removal of the PHI (e.g., to fund a public dental scheme).
- Scenario 3 – Freezing PHI rebate rates at their current levels.
- Scenario 4 – Return PHI rates to their levels before the introduction of the RAF.

Under Scenarios 1 and 2, to model the effects of withdrawal of the PHI rebate, we will consider:

- changes in the proportion and numbers of insured individuals (with PHI and hospital cover) and analysis of whether any demographic groups (by age or income) will be more affected.
- the shift from private to public hospital services and the impact on each sector in terms of health service utilisation, costs and wait times (including staffing effects and costs of dealing with high demand).
- equity and distributional effects (e.g., whether changes differentially impact rural/ regional vs metro areas, which population groups will be most impacted by the PHI rebate changes and how this will impact public hospital wait lists and access to care); and
- the net effect on public sector expenditure for Commonwealth And State/Territory Governments.

Each scenario demonstrates that maintaining or strengthening the rebate is critical to preserving the efficiency and sustainability of Australia's health system, while changes that reduce or remove it carry significant risks for patients, providers and governments.

Base Case – No change to the PHI Rebate

The base case models the status quo, that is, the outcomes if the government does not make any changes to the current PHI rebate system. Importantly, even under the base case, rebate rates will decline over time due to the design of the RAF.

Over the 10-year period from 2026–27 to 2035–36, modelling estimates the RAF will result in over one million individuals downgrading or dropping out of PHI, resulting in approximately 1.3 million fewer episodes of care being treated in the private healthcare system. This reduced private coverage equates to an estimated $6.7 billion in lost medical expenditure that would otherwise occur under private healthcare. This $6.7 billion in reduced private medical expenditure is a cost that would be borne by the public system in either an increase in funding of the public hospital system, or increased waiting times, fewer individual receiving care within clinical recommended timeframes and worse health outcomes in the public system.

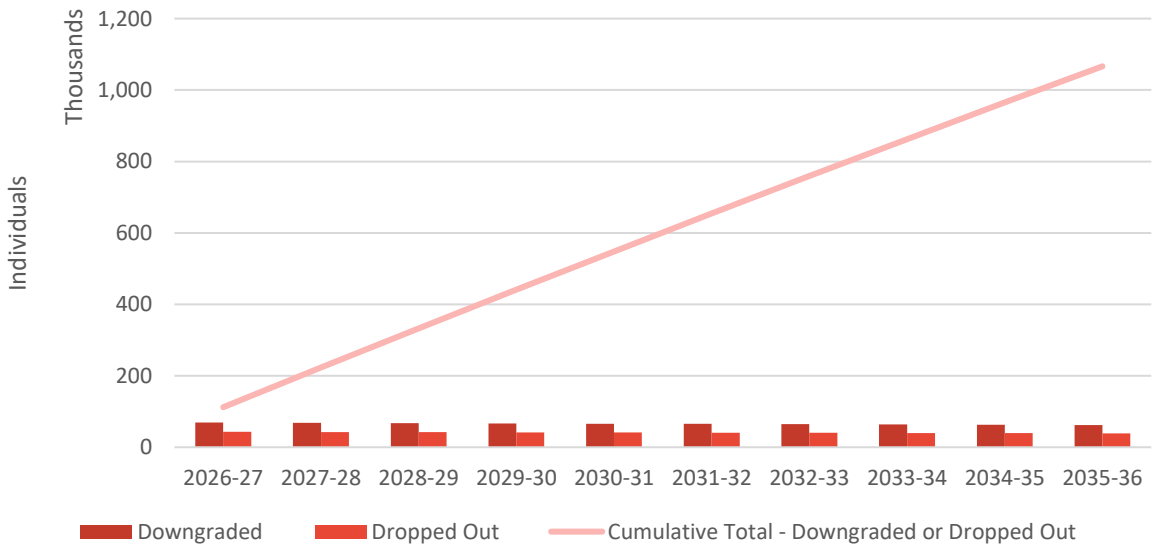
Key Model Outputs – Base Case

Base Case Expected Impact on PHI Coverage

Table 12. Base case results of individuals downgrading and dropping out of PHI coverage due to the RAF[265]

Year	Downgraded	Dropped Out	Downgraded or Dropped Out	Cumulative Total – Downgraded or Dropped Out
2026–27	69,000	43,000	112,000	112,000
2027–28	68,000	42,000	111,000	223,000
2028–29	68,000	42,000	110,000	333,000
2029–30	67,000	42,000	108,000	441,000
2030–31	66,000	41,000	107,000	548,000
2031–32	65,000	41,000	106,000	654,000
2032–33	64,000	40,000	105,000	759,000
2033–34	64,000	40,000	104,000	863,000
2034–35	63,000	40,000	102,000	965,000
2035–36	62,000	39,000	101,000	1,066,000
Total	**656,000**	**410,000**	**1,066,000**	

Figure 84. Base case of individuals downgrading and dropping out of PHI coverage due to the RAF [266]



[265] DeltaPearl Partners Modelling, see Appendix 5.

[266] DeltaPearl Partners Modelling, see Appendix 5.

Base Case Expected Impact on Medical Services

Table 13. Reduction in medical services within the private hospital sector, under the base case[267]

Year	Reduction in Episodes Treated	Reduction in Benefits Paid	Reduction in Individual Contributions	Total Lost Private Medical Expenditure
2026–27	24,000	$95,797,000	$12,308,000	$108,105,000
2027–28	47,000	$195,320,000	$25,095,000	$220,415,000
2028–29	70,000	$298,677,000	$38,374,000	$337,051,000
2029–30	93,000	$405,978,000	$52,160,000	$458,138,000
2030–31	116,000	$517,336,000	$66,467,000	$583,803,000
2031–32	138,000	$632,866,000	$81,310,000	$714,177,000
2032–33	161,000	$752,689,000	$96,705,000	$849,394,000
2033–34	183,000	$876,925,000	$112,667,000	$989,592,000
2034–35	204,000	$1,005,701,000	$129,212,000	$1,134,913,000
2035–36	226,000	$1,139,145,000	$146,357,000	$1,285,502,000
Total	**1,262,000**	**$5,920,434,000**	**$760,655,000**	**$6,681,090,000**

Scenario 1 – Complete removal of the PHI rebate, staggered over a five-year period

The complete phase-out of the PHI rebate, as modelled in this scenario, would fundamentally alter the architecture of Australia's mixed health system, leading to immediate and far-reaching effects. Essentially, eliminating the rebate would shift a significant number of patients into the public system, increasing costs and worsening waiting times, thereby reducing overall system efficiency. Modelling suggests individuals would respond quickly by moving to lower coverage tiers or dropping PHI altogether.

The rebate withdrawal is modelled as occurring over a five-year period, starting in 2026–27. Rebate rates are reduced by twenty per cent of their current levels each year, reaching zero in the fifth year, 2030–31 and remaining at zero thereafter.

Over the 10-year period from 2026-27 to 2035-36, modelling estimates the removal of the PHI rebate will result in over 8 million individuals downgrading or dropping out of private health insurance, resulting in approximately 14.3 million fewer episodes of care being treated in the private healthcare system. The Scenario 1 projected reduced private coverage equates to an estimated $74.3 billion in lost medical expenditure that would otherwise occur under private healthcare. The Commonwealth Government is projected to save $43.6 billion on the hospital component of the rebate expenditure relative to the base case over this period, however, this saving represents poor value.[268]

[267] DeltaPearl Partners Modelling, see Appendix 5.

[268] The Commonwealth Government would save a further $22.4 billion on the general treatment component of the rebate over this period. As noted in Appendix 5 the returns on the general treatment component of the rebate are not included in the presented modelling as general treatment coverage does not directly lead to increased medical services and the subsidisation of general treatment is a separate funding decision. We note that subsidising general treatment provides benefits in the form of incentivising private health insurance uptake, health gains to the population, and support for the ancillary healthcare sector.

The $74.3 billion in reduced private medical expenditure is a cost that would be borne by the public system in either an increase in funding of the public hospital system, or increased waiting times, fewer individual receiving care within clinical recommended timeframes and worse health outcomes in the public system.

In the long run, the Commonwealth Government is projected to save approximately $4.4 billion annually (in real terms)[269] on the hospital component of the rebate, at a cost of approximately $7.9 billion in reduced medical expenditure within the private sector and 1.7 million fewer episodes of care treated under private healthcare annually.[270] To avoid a resultant increase in waiting times and reduced outcomes in the public system, the Commonwealth Government would need to redirect the entire savings of the rebate into the public system and find an additional $3.5 billion annually. If the burden of this increased public system expenditure were shared between the Commonwealth Government and State/Territory Governments under the current 45 per cent / 55 per cent agreement, the net fiscal outcome for the Commonwealth Government would be an annual saving of $845 million, while State/Territory Governments would face an annual cost of $4.345 billion.

Individuals most likely to reduce or drop PHI due to the rebate's removal tend to be those who perceive less value in maintaining coverage, particularly younger and healthier groups. This selective exodus from private healthcare would trigger a ‘death spiral’: increased risk pools for remaining policyholders, leading to a cycle of premium increases and further reductions in PHI participation.[271] Consequently, the shift in treatment from the private to the public system and the associated costs, would likely be even greater than presented in the modelling estimates.

The projected reduction of 14.3 million episodes of care and $74.3 billion in associated medical expenditure between 2026–27 and 2035–36 would represent a significant financial loss to the private healthcare sector. This financial pressure could potentially trigger reductions in capacity, closures of private hospitals and specialist practices and job losses across the health and allied services industries. Hospitals specialising in clinical categories exclusively covered under higher levels of PHI policies would be especially vulnerable, particularly maternity and psychiatric care, which are only required to be covered under Gold tier policies. The private maternity and psychiatric sectors are already struggling and the removal of the rebate would significantly increase this strain. The equity and distributional impacts of these closures are difficult to quantify, but industry reports consistently highlight that the burden would be most acutely felt in regional communities. In these areas, private facilities are often marginal, and the closure of a single private hospital could mean the complete absence of private healthcare options, forcing patients into an already-strained public system. While a comprehensive viability model for private healthcare is beyond the scope of this analysis, the expected diminished value of PHI would further accelerate the death spiral, intensifying these impacts further.

[269] Real terms in 2026–27 dollars.

[270] The amount of reduced medical expenditure and reduced episodes of care would gradually decline over time, and the amount of rebate saving would gradually increase, as rebate rates would otherwise decline slowly under the status quo due to the rebate adjustment factor.

[271] This spiral of increasing premiums and reduced private health insurance is elaborated on in Appendix 5.

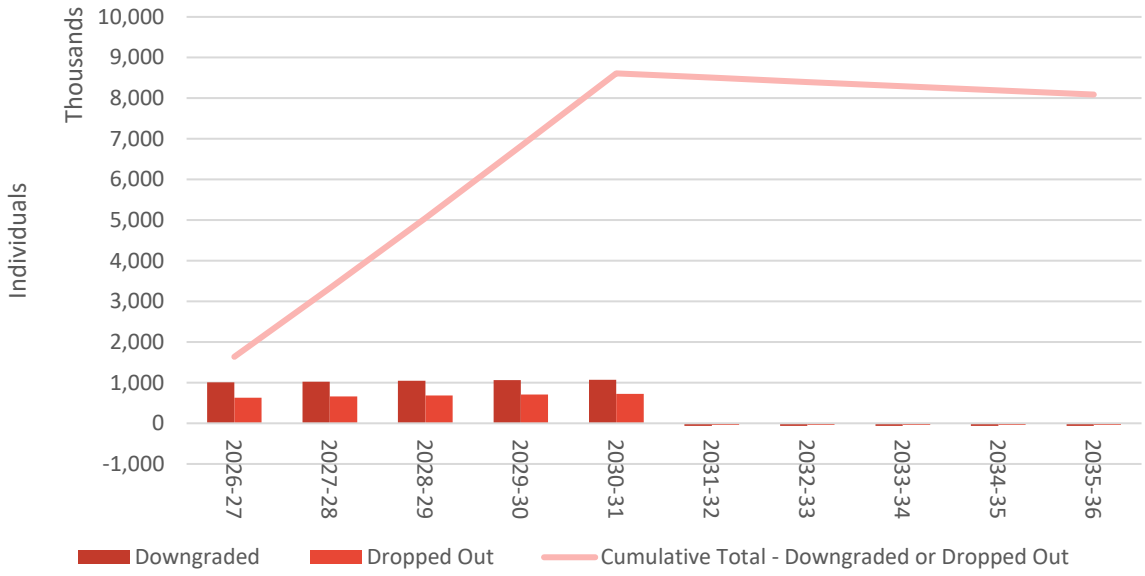
Key Model Outputs – Scenario 1

Scenario 1 Expected Impact on PHI Coverage

Table 14. Individuals downgrading and dropping out of phi coverage, relative to the base case[272]

Year	Downgraded	Dropped Out	Downgraded or Dropped Out	Cumulative Total – Downgraded or Dropped Out
2026–27	1,005,000	631,000	1,636,000	1,636,000
2027–28	1,026,000	660,000	1,686,000	3,322,000
2028–29	1,044,000	685,000	1,729,000	5,051,000
2029–30	1,060,000	706,000	1,766,000	6,818,000
2030–31	1,071,000	722,000	1,793,000	8,610,000
2031–32	−65,000	−41,000	−106,000	8,504,000
2032–33	−64,000	−40,000	−105,000	8,400,000
2033–34	−64,000	−40,000	−104,000	8,296,000
2034–35	−63,000	−40,000	−102,000	8,194,000
2035–36	−62,000	−39,000	−101,000	8,092,000
Total	**4,888,000**	**3,204,000**	**8,092,000**	

Figure 85. Individuals downgrading and dropping PHI coverage, relative to the base case, thousands[273]



[272] DeltaPearl Partners Modelling, see Appendix 5.

[273] DeltaPearl Partners Modelling, see Appendix 5.

Scenario 1 Expected Impact on Medical Services and Rebate Expenditure

Table 15. Reduction in medical services within the private hospital sector and government rebate expenditure, relative to base case [274]

Year	Reduction in Episodes Treated	Reduction in Benefits Paid	Reduction in Individual Contributions	Total Lost Private Medical Expenditure	Reduction in Rebate Expenditure[275]
2026–27	347,000	$1,400,858,000	$179,981,000	$1,580,839,000	$1,163,462,000
2027–28	705,000	$2,919,730,000	$375,125,000	$3,294,856,000	$2,284,582,000
2028–29	1,074,000	$4,557,184,000	$585,504,000	$5,142,688,000	$3,353,154,000
2029–30	1,451,000	$6,312,523,000	$811,029,000	$7,123,552,000	$4,358,861,000
2030–31	1,834,000	$8,180,755,000	$1,051,059,000	$9,231,814,000	$5,291,479,000
2031–32	1,812,000	$8,282,677,000	$1,064,154,000	$9,346,831,000	$5,336,801,000
2032–33	1,790,000	$8,385,743,000	$1,077,395,000	$9,463,139,000	$5,382,649,000
2033–34	1,768,000	$8,489,968,000	$1,090,786,000	$9,580,754,000	$5,429,027,000
2034–35	1,746,000	$8,595,364,000	$1,104,327,000	$9,699,692,000	$5,475,943,000
2035–36	1,725,000	$8,701,947,000	$1,118,021,000	$9,819,968,000	$5,523,404,000
Total	**14,252,000**	**$65,826,749,000**	**$8,457,381,000**	**$74,284,133,000**	**$43,599,362,000**

Scenario 2 – Partial removal of the PHI (e.g. to fund dental)

This scenario considers a partial remove of the PHI rebate, with the funds allocated to other purposes, such as the often-proposed extension of Medicare to cover adult dental services.

Although Scenario 2 may seem politically appealing on face value, it is important to note that the Parliamentary Budget Office estimates the cost of universal dental coverage at around $14 billion annually, far exceeding the current PHI rebate expenditure. Therefore, even the complete redirection of the rebate would fail to fully fund a national dental program, and it would impose large-scale systemic disruption as covered in Scenario 1.

Text Box 16: Parliamentary Budget Office estimate of dental

PBO estimate of dental[276]

The Parliamentary Budget Office estimates funding required for universal dental coverage at $14 billion per year, which significantly dwarfs the current PHI rebate.

Scenario 2 assumes a 25 per cent partial funding of the proposed introduction of dental under Medicare, achieved via a 50 per cent reduction in the current levels of the PHI rebate rates and redirecting the direct $3.5 billion long-run annual savings in rebate expenditure. The rebate withdrawal

[274] DeltaPearl Partners Modelling, see Appendix 5.

[275] Hospital Component

[276] Parliamentary Budget Office (PBO). (2023). Policy costing—Dental coverage expansion. Retrieved from https://www.pbo.gov.au

is modelled as occurring over a five-year period, starting in 2026–27. Rebate rates are reduced by ten per cent of their current levels each year, reaching half the current levels in the fifth year, 2030–31, and subject to the RAF thereafter.

Although less drastic than full removal (Scenario 1), even partial rebate reductions would produce similar dynamics, albeit at a slower rate. Downgrading and PHI drop-out would still accelerate, shifting a significant number of patients into the public system, increasing costs and worsening waiting times, thereby reducing overall system efficiency as in Scenario 1.

Over the 10-year period from 2026–27 to 2035–36, modelling estimates the reduction of the PHI rebate will result in approximately 3.7 million individuals downgrading or dropping out of private health insurance, resulting in approximately 6.5 million fewer episodes of care being treated in the private healthcare system. This reduced private coverage equates to an estimated $33.7 billion in lost medical expenditure that would otherwise occur under private healthcare. While the Commonwealth Government is projected to save $22.6 billion on the hospital component of the rebate expenditure relative to the base case over this period, this saving again represents poor value relative to the 33.7 billion in reduced private medical expenditure which would then be borne by the public system.[277]

In the long run, the Commonwealth Government is projected to save approximately $2.3 billion[278] annually (in real terms)[279] on the hospital component of the rebate, at a cost of approximately $3.6 billion in reduced medical expenditure within the private sector and 780 thousand fewer episodes of care treated under private healthcare annually.[280] To avoid a resultant increase in waiting times and reduced outcomes in the public system, the Commonwealth Government would need to redirect the entire savings of the rebate into the public system, and find an additional $1.3 billion annually. If the burden of this increased public system expenditure were shared between the Commonwealth Government and State and Territory Governments under the current 45 per cent / 55 per cent agreement, the net fiscal outcome of the rebate reduction for the Commonwealth Government would be an annual saving of $680 million, while State and Territory Governments would face an annual cost of $1.98 billion.

Reallocating the rebate without fully accounting for the hidden fiscal offset it provides would likely be counterproductive from both a budgetary and service delivery perspective. This is because the rebate indirectly reduces the financial burden on the public healthcare system. If the Commonwealth Government were to redirect the $3.5 billion in savings annually from reducing the rebate (comprising $2.3 billion saved on the hospital component and $1.2 billion saved on the general treatment component) to fund 25 per cent of dental services under Medicare, both Commonwealth and State/Territory Governments would face increased costs. Specifically, to maintain the existing level of care in the public system, the Commonwealth Government would need to find an additional $1.62 billion, and State and Territory Governments would collectively need an extra $1.98 billion.

[277] The Commonwealth Government would save a further $12.2 billion on the general treatment component of the rebate over this period. As noted in Appendix 5, the returns on the general treatment component of the rebate are not included in the presented modelling as general treatment coverage does not directly lead to increased medical services and the subsidisation of general treatment is a separate funding decision. We note that subsidising general treatment provides benefits in the form of incentivising private health insurance uptake, health gains to the population, and support for the ancillary healthcare sector.

[278] The Commonwealth Government would save a further $1.2 billion annual on the general treatment component of rebate expenditure, allowing for a 25 per cent funding of the projected costings of the inclusion of dental in Medicare.

[279] Real terms in 2026-27 dollars.

[280] The amount of reduced medical expenditure and reduced episodes of care would gradually decline over time, and the amount of rebate saving would gradually increase, as rebate rates would otherwise decline slowly under the status quo due to the rebate adjustment factor.

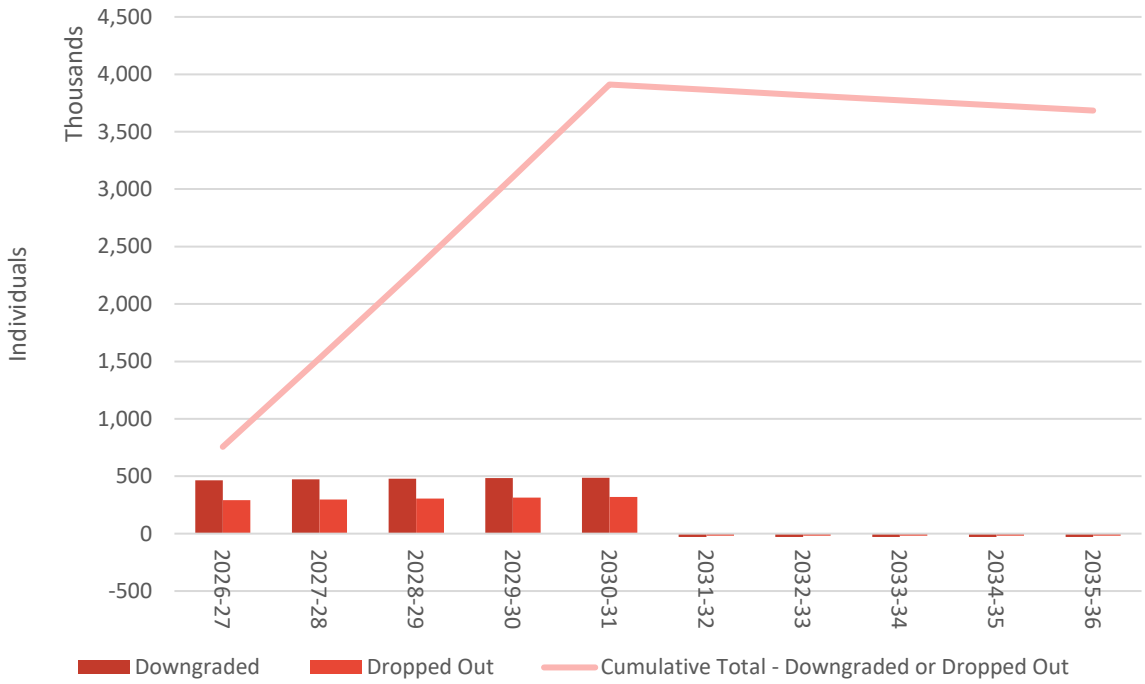
Key Model Outputs – Scenario 2

Scenario 2 Expected Impact on PHI Coverage

Table 16. Individuals downgrading and dropping PHI coverage, relative to the base case[281]

Year	Downgraded	Dropped Out	Downgraded or Dropped Out	Cumulative Total – Downgraded or Dropped Out
2026–27	465,000	290,000	756,000	756,000
2027–28	471,000	298,000	770,000	1,525,000
2028–29	477,000	306,000	783,000	2,308,000
2029–30	483,000	313,000	795,000	3,104,000
2030–31	488,000	319,000	807,000	3,911,000
2031–32	−29,000	−17,000	−46,000	3,865,000
2032–33	−29,000	−17,000	−46,000	3,819,000
2033–34	−28,000	−17,000	−45,000	3,774,000
2034–35	−28,000	−17,000	−45,000	3,729,000
2035–36	−28,000	−17,000	−44,000	3,685,000
Total	**2,242,000**	**1,441,000**	**3,685,000**	

Figure 86. Individuals downgrading and dropping PHI coverage, relative to the base case, thousands[282]



[281] DeltaPearl Partners Modelling, see Appendix 5.

[282] DeltaPearl Partners Modelling, see Appendix 5.

Scenario 2 Expected Impact on Medical Services and Rebate Expenditure

Table 17. Reduction in medical services within the private hospital sector and government rebate expenditure, relative to base case [283]

Year	Reduction in Episodes Treated	Reduction in Benefits Paid	Reduction in Individual Contributions	Total Lost Private Medical Expenditure	Reduction in Rebate Expenditure[284]
2026–27	160,000	$646,502,000	$83,062,000	$729,564,000	$551,859,000
2027–28	323,000	$1,338,751,000	$172,002,000	$1,510,753,000	$1,107,957,000
2028–29	490,000	$2,078,323,000	$267,022,000	$2,345,345,000	$1,666,890,000
2029–30	659,000	$2,866,772,000	$368,321,000	$3,235,093,000	$2,227,169,000
2030–31	831,000	$3,705,624,000	$476,096,000	$4,181,720,000	$2,787,221,000
2031–32	821,000	$3,753,900,000	$482,299,000	$4,236,199,000	$2,808,261,000
2032–33	812,000	$3,802,704,000	$488,569,000	$4,291,274,000	$2,829,537,000
2033–34	802,000	$3,852,043,000	$494,908,000	$4,346,951,000	$2,851,055,000
2034–35	793,000	$3,901,923,000	$501,317,000	$4,403,239,000	$2,872,815,000
2035–36	783,000	$3,952,350,000	$507,796,000	$4,460,145,000	$2,894,823,000
Total	**6,474,000**	**$29,898,892,000**	**$3,841,392,000**	**$33,740,283,000**	**$22,597,587,000**

Scenario 3 – Freezing PHI rebate rates at their current levels

Freezing rebate rates, as modelling in this scenario, would preserve the current benefits of the PHI rebate and public–private dual system and avoid further cost creep for consumers, which is important for maintaining demand for private health insurance. Essentially, this scenario is a corollary to the base case, as it maintains the status quo but reverses the declining trend in rebate value by freezing the RAF.

Relative to the base case, this scenario is expected to slow the growth of out-of-pocket costs to policy holders, improve insurance retention and encourage a modest shift back toward higher tiers of coverage. Improved participation in PHI would reduce pressures on the public system and preserve the fiscal offset benefits of private sector engagement.

Over the 10-year period from 2026–27 to 2035–36, modelling estimates that freezing rebate rates will result in over one million individuals upgrading or retaining PHI relative to the base case, resulting in approximately 1.3 million additional episodes of care being treated in the private healthcare system. This increased private coverage equates to an estimated $6.7 billion in additional medical expenditure occurring under private healthcare. The Commonwealth Government is projected to spend an additional $5.1 billion on the hospital component of the rebate expenditure over this period.[285] This additional spending on the rebate represents good value relative to the $6.7 billion in additional private medical expenditure, which would otherwise be borne by the public system.

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[283] DeltaPearl Partners Modelling, see Appendix 5.

[284] Hospital Component

[285] The Commonwealth Government would save a further $2.7 billion on the general treatment component of the rebate over this period. As noted in Appendix 9, the returns on the general treatment component of the rebate are not included in the presented modelling as general treatment coverage does not directly lead to increased medical services and the subsidisation of general treatment is a separate funding decision. We note that subsidising general treatment provides benefits in the form of incentivising private health insurance uptake, health gains to the population, and support for the ancillary healthcare sector.

In the long run, the Commonwealth Government is projected to spend approximately $800 million annually (in real terms)[286] on the hospital component of the rebate, offset by $1 billion in increased medical expenditure within the private sector and 230 thousand more episodes of care treated under private healthcare annually.[287] The government is therefore able to save a net spending of $200 million annually after accounting for the increased cost of the rebate. If the savings of this decreased public system expenditure were shared between the Commonwealth Government and State and Territory Governments under the current 45 per cent / 55 per cent agreement, the net fiscal outcome for the Commonwealth Government would be an annual cost of $350 million, while State and Territory Governments would save $550 million.

Key Model Outputs – Scenario 3

Scenario 3 Expected Impact on PHI Coverage

Table 18. Individuals upgrading and entering PHI coverage, relative to the base case[288]

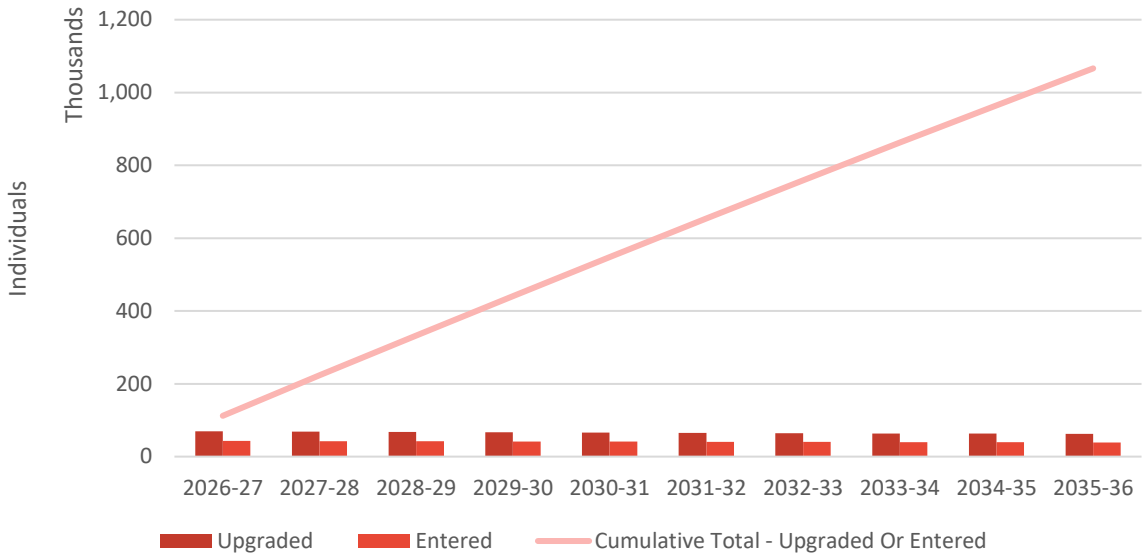
Year	Upgraded	Entered	Upgraded Or Entered	Cumulative Total – Upgraded Or Entered
2026–27	69,000	43,000	112,000	112,000
2027–28	68,000	42,000	111,000	223,000
2028–29	68,000	42,000	110,000	333,000
2029–30	67,000	42,000	108,000	441,000
2030–31	66,000	41,000	107,000	548,000
2031–32	65,000	41,000	106,000	654,000
2032–33	64,000	40,000	105,000	759,000
2033–34	64,000	40,000	104,000	863,000
2034–35	63,000	40,000	102,000	965,000
2035–36	62,000	39,000	101,000	1,066,000
Total	**656,000**	**410,000**	**1,066,000**	

[286] Real terms in 2026-27 dollars.

[287] The amount of reduced medical expenditure and reduced episodes of care would gradually decline over time, and the amount of rebate saving would gradually increase, as rebate rates would otherwise decline slowly under the status quo due to the rebate adjustment factor.

[288] DeltaPearl Partners Modelling, see Appendix 5.

Figure 87. Individuals upgrading and entering PHI coverage, relative to the base case[289]



Scenario 3 Expected Impact on Medical Services and Rebate Expenditure

Table 19. Increase in medical services within the private hospital sector and government rebate expenditure, relative to base case [290]

Year	Increase in Episodes Treated	Increase in Benefits Paid	Increase in Individual Contributions	Total Gained Private Medical Expenditure	Increase in Rebate Expenditure[291]
2026–27	24,000	$95,797,000	$12,308,000	$108,105,000	$84,013,000
2027–28	47,000	$195,320,000	$25,095,000	$220,415,000	$170,704,000
2028–29	70,000	$298,677,000	$38,374,000	$337,051,000	$260,147,000
2029–30	93,000	$405,978,000	$52,160,000	$458,138,000	$352,416,000
2030–31	116,000	$517,336,000	$66,467,000	$583,803,000	$447,589,000
2031–32	138,000	$632,866,000	$81,310,000	$714,177,000	$545,742,000
2032–33	161,000	$752,689,000	$96,705,000	$849,394,000	$646,959,000
2033–34	183,000	$876,925,000	$112,667,000	$989,592,000	$751,321,000
2034–35	204,000	$1,005,701,000	$129,212,000	$1,134,913,000	$858,913,000
2035–36	226,000	$1,139,145,000	$146,357,000	$1,285,502,000	$969,824,000
Total	**1,262,000**	**$5,920,434,000**	**$760,655,000**	**$6,681,090,000**	**$5,087,628,000**

[289] DeltaPearl Partners Modelling, see Appendix 5.

[290] DeltaPearl Partners Modelling, see Appendix 5.

[291] Hospital Component

Scenario 4 – Reinstating PHI rates their levels before the introduction of the RAF

Scenario 4 considers restoring rebate rates to their levels prior to the introduction of the RAF. For example, the rebate for individuals under 65 years old in the base tier would return to 30 per cent from the current 24.288 per cent. Scenario 4 is the corollary to Scenario 2, which considered the reduction of rebate rates. Compared to Scenarios 1 and 2, this scenario represents a cost to government but downstream savings due to reduced demand for public services.

Reinstating rebate rebates to their original levels would increase the financial attractiveness of PHI and substantially boost membership in higher tiers of cover. The impact of the increased rate is lowering the effective premiums paid by the community and would lead to a reduced burden on the public health system. The size of the effects will be greater than those under Scenario 3 as the magnitude of the change is greater. Due to marginal returns on the government's PHI rebate, the effect per dollar spent will be smaller than reductions in the PHI, but the overall effects will still be positive. Although the marginal effect per dollar spent may diminish as rebates increase, the net fiscal impact remains positive, especially when accounting for capital infrastructure avoided, elective surgery delays mitigated and improved population health outcomes from more timely care.

Scenario 2 assumes rebates will be increased gradually over a five-year period, starting in 2026–27, reaching their original levels (pre-RAF) in the fifth year, 2030–31. There after rebate rates are assumed to remain at these original pre-RAF levels.

Over the 10-year period from 2026–27 to 2035–36, modelling estimates that reinstating rebate rates will result in over three million individuals upgrading or retaining PHI relative to the base case, resulting in approximately 4.6 million additional episodes of care being treated in the private healthcare system. This increased private coverage equates to an estimated $24.2 billion in additional medical expenditure occurring under private healthcare. The Commonwealth Government is projected to spend an additional $19.6 billion on the hospital component of the rebate expenditure over this period.[292] This additional spending on the rebate represents good value relative to the $24.2 billion in additional private medical expenditure, which would otherwise be borne by the public system.

In the long run, the Commonwealth Government is projected to spend approximately $2.4 billion annually (in real terms)[293] on the hospital component of the rebate, offset by $2.9 billion in increased medical expenditure within the private sector and 650 thousand more episodes of care treated under private healthcare annually.[294] The government is therefore able to save a net spending of $500 million annually after accounting for the increased cost of the rebate. If the savings of this decreased public system expenditure were shared between the Commonwealth Government and State and Territory Governments under the current 45 per cent / 55 per cent agreement, the net fiscal outcome for the Commonwealth Government would be an annual cost of $1.1 billion, while State and Territory Governments would save $1.6 billion.

[292] The Commonwealth Government would save a further $22.4 billion on the general treatment component of the rebate over this period. As noted in Appendix 9, the returns on the general treatment component of the rebate are not included in the presented modelling as general treatment coverage does not directly lead to increased medical services and the subsidisation of general treatment is a separate funding decision. We note that subsidising general treatment provides benefits in the form of incentivising private health insurance uptake, health gains to the population, and support for the ancillary healthcare sector.

[293] Real terms in 2026-27 dollars.

[294] The amount of increased medical expenditure and increased episodes of care would gradually increase over time, and the amount of rebate saving would gradually increase, as rebate rates would otherwise decline slowly under the status quo due to the rebate adjustment factor.

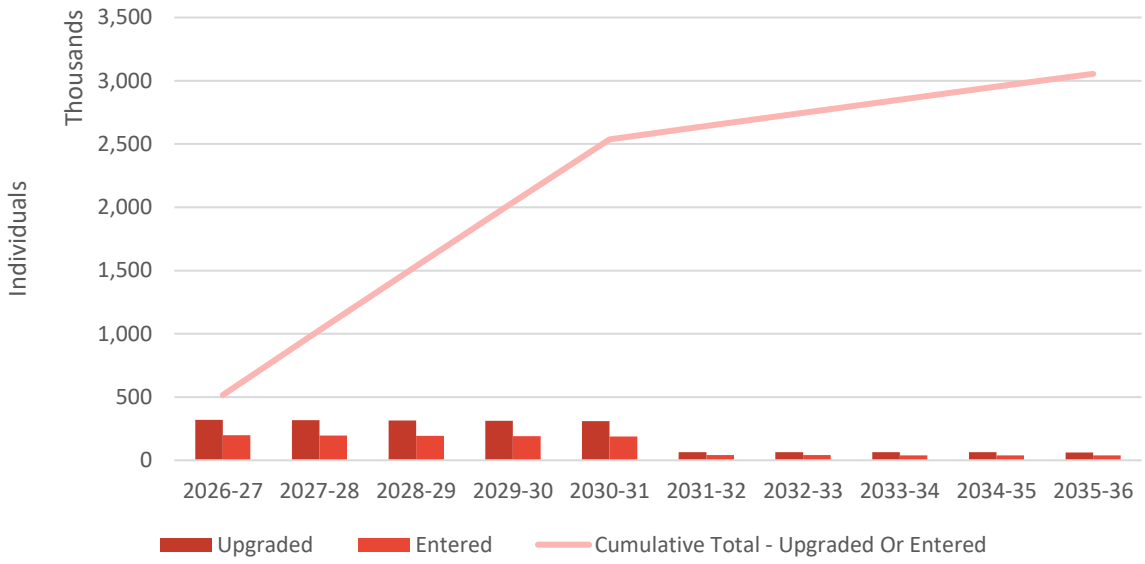
Key Model Outputs – Scenario 4

Scenario 4 Expected Impact on PHI Coverage

Table 20. Individuals upgrading and entering PHI coverage, relative to the base case[295]

Year	Upgraded	Entered	Upgraded Or Entered	Cumulative Total – Upgraded Or Entered
2026–27	319,000	197,000	516,000	516,000
2027–28	317,000	195,000	512,000	1,027,000
2028–29	315,000	193,000	507,000	1,535,000
2029–30	313,000	190,000	503,000	2,038,000
2030–31	311,000	188,000	499,000	2,536,000
2031–32	65,000	41,000	106,000	2,642,000
2032–33	64,000	40,000	105,000	2,747,000
2033–34	64,000	40,000	104,000	2,851,000
2034–35	63,000	40,000	102,000	2,953,000
2035–36	62,000	39,000	101,000	3,055,000
Total	**1,893,000**	**1,163,000**	**3,055,000**	

Figure 88. Individuals upgrading and entering PHI coverage, relative to the base case[296]



[295] DeltaPearl Partners Modelling, see Appendix 5.

[296] DeltaPearl Partners Modelling, see Appendix 5.

Scenario 4 Expected Impact on Medical Services and Rebate Expenditure

Table 21. Increase in medical services within the private hospital sector and government rebate expenditure, relative to base case [297]

Year	Increase in Episodes Treated	Increase in Benefits Paid	Increase in Individual Contributions	Total Gained Private Medical Expenditure	Increase in Rebate Expenditure[298]
2026–27	109,000	$440,611,000	$56,609,000	$497,220,000	$391,305,000
2027–28	217,000	$899,271,000	$115,538,000	$1,014,808,000	$805,937,000
2028–29	324,000	$1,376,459,000	$176,847,000	$1,553,306,000	$1,244,864,000
2029–30	430,000	$1,872,667,000	$240,599,000	$2,113,266,000	$1,709,090,000
2030–31	536,000	$2,388,394,000	$306,860,000	$2,695,254,000	$2,199,649,000
2031–32	558,000	$2,550,701,000	$327,713,000	$2,878,414,000	$2,341,605,000
2032–33	580,000	$2,718,469,000	$349,267,000	$3,067,737,000	$2,487,718,000
2033–34	602,000	$2,891,850,000	$371,543,000	$3,263,393,000	$2,638,099,000
2034–35	624,000	$3,070,999,000	$394,560,000	$3,465,559,000	$2,792,861,000
2035–36	645,000	$3,256,076,000	$418,339,000	$3,674,414,000	$2,952,120,000
Total	**4,625,000**	**$21,465,497,000**	**$2,757,875,000**	**$24,223,371,000**	**$19,563,248,000**

[297] DeltaPearl Partners Modelling, see Appendix 5.

[298] Hospital Component.

Appendix 7. The efficiency of the PHI rebate

In this section, we consider the relative efficiency of the Commonwealth Government's two modes of expenditure on hospital care, namely expenditure through the grants to the states and territories (for care in public hospitals) and expenditure through the PHI rebate (for care in private hospitals).[299]

Text Box 17: Allocative efficiency

Allocative efficiency

Health system efficiency is a priority for policy makers in the face of mounting health system expenditures and ageing populations. Achieving efficiency involves good use of available resources and elimination of wastage. Given the scarcity of healthcare resources, it is imperative that health systems use their resources efficiently to optimise the achievement of stated health system goals and promote financial sustainability in the long term.[300]

Efficiency refers to the extent to which system objectives are met given the resources invested in the system. Allocative efficiency is achieved when resources are allocated such that outputs are maximised for a given level of input cost, or input costs are minimised for a given level of outputs.[301]

As the Productivity Commission noted, 'improved efficiency does not mean reducing government expenditure for its own sake. Rather, it means improving the quality of health services, expanding access or reducing costs, for a given level of funding.'[302]

The total per-separation economic cost for public hospital care is the direct cost borne by the Commonwealth and the State/Territory Governments under the current activity-based funding arrangements and the deadweight cost imposed on the economy by the taxation that supports that expenditure.

It is equal to:

$$AP_{Sep}^{N}(1+M)$$

where AP_{Sep}^{N} is the average cost in the public hospital system for a particular type of separation and M is the marginal excess burden of taxation (MEBT), which is the primary deadweight loss associated with public revenue raising, and is expressed as an incremental fraction per dollar of taxation. Throughout this section, we use $\boldsymbol{N}$ (national) to denote public (uninsured) health care, and $\boldsymbol{P}$ to denote health care that is covered at least in part by private insurance.

[299] The analysis in this chapter follows that presented in: David Cullen et al., *The Relative Efficiency of The Private Health Insurance Rebate v. Direct Public Health Expenditure* (Evaluate, 2017), https://www.evaluate.net.au/reports-feed/the-relative-efficiency-of-the-private-health-insurance-rebate-v-direct-public-health-expenditure.

[300] Rahab Mbau et al., "Analysing the Efficiency of Health Systems: A Systematic Review of the Literature," *Applied Health Economics and Health Policy* 21, no. 2 (2023): 205–24, https://doi.org/10.1007/s40258-022-00785-2.

[301] Ibid.

[302] Productivity Commission, *Public and Private Hospitals, Research Report* (2009), 1, https://www.pc.gov.au/inquiries/completed/hospitals/report/hospitals-report.pdf.

We focus on the average price ($\boldsymbol{AP}$) rather than marginal price as there are obvious supply constraints (indicated by wait lists for example), so the marginal price would be expected to be higher. This is also consistent with the prevailing activity-based funding approach to public hospital transfers. Ideally, we would determine a weighted average of A_{Sep}^{N} taking into account events priced by the National Efficient Price and the National Efficient Cost, which are set by the IHACPA. The former is for large hospitals and the latter for small or regional centres. It may also include purchases by the Department of Veterans' Affairs and other agencies. This may include some purchases from private hospitals.

The total direct cost of a PHI-funded episode of care is simply:

$$AP_{Sep}^{P}$$

For the purposes of the analysis, we assume that there is no practical difference between the direct prices AP_{Sep}^{P} and AP_{Sep}^{P}. That is, we assume that

$AP_{Sep}^{P} = AP_{Sep}^{N}$.

This assumption is supported by the comprehensive study of public and private hospitals undertaken by the Productivity Commission in 2009, which found that, despite substantial variance between states, the average costs for a case mix-adjusted separation public and private hospitals was about 3.0 per cent.[303] The mean technical efficiency score of Australian hospitals was found to be 89.9 per cent with the mean technical efficiency score of Australian public hospitals equal to 89.1 per cent and the mean technical efficiency score of Australian private hospitals equal to 92.0 per cent. Within the private hospital sector, the mean technical efficiency score of not-for-profit hospitals was 87.9 per cent and the mean technical efficiency score of for-profit hospitals was 93.3 per cent.[304]

The total economic cost of the public contribution to a single PHI-funded separation is given by:

$$Ae_{Sep}^{P}(1+M)$$

where Ae_{Sep}^{P} is the average cost of the rebate per separation in dollars, given by the total annual expenditure on the PHI rebate divided by the number of separations covered at least in part by PHI.

The total economic cost of a separation from a public hospital is given by the following formula, which includes expenditure by the Commonwealth Government through states and territories, direct expenditure by the states and territories, and the deadweight losses associated with the taxes imposed by all levels of government to support that expenditure:

$$\frac{AP_{Sep}^{N}}{1-D_N}(1+M)$$

where D_N is the administrative cost per episode of public hospital care (expressed as a percentage of the total cost per episode).

The total economic cost of a separation from a private hospital is equal to:

$$\frac{AP_{Sep}^{P}}{1-D_P}+\frac{AP_{Sep}^{P}}{1-D_P}\,A\varphi_{Sep}^{P}(1+M)$$

where D_P is the administrative cost per episode of private hospital care (expressed as a percentage of the total cost per episode) and $A\varphi_{Sep}^{P}$ is the average public share of the PHI component per separation expressed as a percentage. It is equivalent to the average rate of the rebate as a percentage of PHI premiums (for products including hospital cover). The first term represents the direct cost of the private hospital episode, and the second term represents the deadweight loss associated with the PHI rebate.

The relative economic efficiency of the two approaches to funding hospital care is given by the ratio:

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[303] Ibid., 102.

[304] Ibid., 93.

$$\frac{\frac{AP_{Sep}^{N}}{1-D_N}(1+M)}{\frac{AP_{Sep}^{P}}{1-D_P}+\frac{AP_{Sep}^{P}}{1-D_P}A\varphi_{Sep}^{P}(1+M)}$$

We note that this ratio is greater than 1 if and only if:

$$\frac{D_P-D_N}{1-D_N}\times AP_{Sep}^{N}\times(1+M)<\left(1-A\varphi_{Sep}^{P}\right)\times AP_{Sep}^{N}\times M$$

The left-hand side of the equation is the economic cost of using the funds currently spent on the administration of PHI (in excess of the costs of social insurance). The right-hand side is the tax payable on the out-of-pockets costs of the hospital care.

Put another way, the PHI rebate is economically efficient if the share of PHI costs for which it pays is less than:

$$\frac{D_P-D_N}{1-D_N}\times\frac{(1+M)}{M}$$

The examination here is whether the higher administrative costs of payment via PHI are outweighed by the opportunity cost to the economy from the deadweight loss of Commonwealth revenue raising.

If we assume: a MEBT of 33 per cent;[305] an administration cost loading for private health insurers of 11.5 per cent;[306] and an administration cost loading for the public health system of 2.9 per cent[307] then we find that the PHI rebate is economically efficient if it is set at less than 62 per cent.

This efficiency is driven by the fact that the insured's co-contribution to PHI costs (i.e. the share of those costs not covered by the rebate) does not incur the MEBT; obviously, if the rebate increased, that statement would be less true. If the rebate were reduced to zero, the (1+M) term would drop out of the PHI component entirely (although PHI, which competes with a service provided at no direct charge to consumers, might not be viable were that to occur).

Effectively, the key point here is that because it allows consumers to avoid waiting times, PHI provides a higher quality service. As a result, consumers are willing to make some contribution from their own pockets to obtain that service, and associated benefits such as hospital and doctor selection. This contribution allows governments to spend less, avoiding some of the cost of taxation. However, there are some consumers who are at the margin between the higher waiting time public system and the higher consumer charge in the private system and who would switch to the public system when the rebate is cut. As a result, neither a rebate set at zero nor one set at 100 per cent will be efficient, with the optimal point depending on the elasticities of demand.

Cullen et al. (2017) expanded on this analysis to examine the relative welfare gains from public sector expenditure between two initial options:[308]

- Marginal increases in direct expenditure on public hospital services, and
- Marginal increases in indirect expenditure on private hospital services via contributions to PHI.

In the Australian context, this is a choice between increased funding for hospitals from the Commonwealth via State/Territory Governments and the PHI subsidy.

[305] Chris Murphy, *Efficiency of the Tax System: A Marginal Excess Burden Analysis*, Working Paper 4/2016 (Australian National University - Tax and Transfer Policy Institute, 2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2791264.

[306] Australian Prudential Regulation Authority, *Annual Private Health Insurance Statistics*.

[307] Australian Institute of Health and Welfare, *Health Expenditure Australia 2022–23*.

[308] Cullen et al., *The Relative Efficiency of The Private Health Insurance Rebate v. Direct Public Health Expenditure*.

They measured welfare gains as a reduction in the opportunity cost of waiting for care: bypassing queues is the principal role of payments made by PHI; and the shift in demand to insured care reduces the waiting time of public patients.

The results of their analysis showed that there is a greater welfare gain from the PHI rebate than from marginal investment in public care. In other words, holding everything else constant, redirecting a dollar of public expenditure from the PHI rebate to public hospitals would reduce efficiency. This result seems reasonably robust to changes in the modelling parameters used in the analysis.

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