AMA

Private Health Insurance Report Card 2025

Contents

Acronyms

ABS	Australian Bureau of Statistics
AMA	Australian Medical Association
APRA	Australian Prudential Regulation Authority
DHDA	Australian Department of Health, Disability and Ageing
GP	General practitioner
HPPA	Hospital provider/purchaser agreement
IHACPA	Independent Health and Aged Care Pricing Authority
MBS	Medicare Benefits Schedule
PHIO	Private Health Insurance Ombudsman

President's message

Australia has a unique balance of public and private healthcare options. These parts of the healthcare sector complement each other, helping to deliver world-leading healthcare outcomes. The private sector provides a wide range of services, including two out of every five hospital admissions and more than two in three planned surgeries. These are services that would otherwise need to be delivered in our public hospitals.

Since 2020, more Australians have been purchasing private health insurance, and today more Australians hold hospital treatment cover than ever before. But a closer look tells a different story: fewer policies now offer top-level coverage, exclusions are at record levels, and the overall value of private health insurance is eroding.

At the same time, private hospitals are grappling with significant post-pandemic cost inflation. Despite inflation coming down from the huge spikes we saw post-pandemic, many hospitals are warning their existing contracts with insurers no longer cover the cost of care. This combination of rising costs, shrinking coverage, and mounting financial pressure is placing the entire private health system under strain — and now there is an urgent need for reform to protect patient access and choice, and to ensure the sustainability of our entire health system.

The AMA's 2025 Private Health Insurance Report Card reveals a system increasingly failing to deliver value for money. Premiums have risen sharply, outpacing inflation, wage growth, and Medicare indexation — while coverage has narrowed. Sixty-eight per cent of hospital policies now contain exclusions, meaning many Australians are paying more, but are covered for less. At the same time, a smaller share of premiums goes towards covering the cost of care for policyholders: in the last financial year, only 84 per cent of premium revenue was paid out as benefits reimbursing care.

The tiered product system introduced in 2020 — basic, bronze, silver, and gold — was designed to simplify choices but has instead created confusion and contributed to underinsurance. Since the start of the COVID-19 pandemic, the number of Australians with gold-tier health cover has fallen by 360,000 to just 743,000, despite overall growth in health policy coverage. Many Australians have shifted to silver or bronze policies, which often exclude critical services. Meanwhile, those seeking to purchase insurance for the first time are being priced out of the market for gold-tier policies, which have become prohibitively expensive.

Gold-tier policies, which provide the most comprehensive coverage, are particularly susceptible to phoenixing — a term used when insurers close an existing policy and replace it with a nearly identical one at a higher price — a practice that has become increasingly common. This tactic bypasses the regulated premium-increase approval process, allowing insurers to raise costs without ministerial oversight and leaving consumers, especially those seeking top-tier hospital cover, paying more. The AMA hopes the recent consultation by the Department of Health, Disability and Ageing on this practice will close the phoenixing loophole.

Specialist fees and out-of-pocket costs remain a major challenge for patients seeking affordable care. Rising costs are driven by unavoidable overheads such as staff wages, insurance, utilities, leasing, IT systems, and medical equipment — all of which have increased by multiples of the Medicare rebate indexation. This problem is compounded by the Medicare freeze and rebates never catching up to where they should have been, resulting in a widening gap between treatment costs and what Medicare covers — a gap that now spans the entire health system and affects patients nationwide. What was once a manageable gap has now become a gulf.

Additionally, decades of inadequate funding across the health system, particularly in public hospitals, have created knock-on effects that undermine access and affordability. Private healthcare remains a vital part of our system, but it was never intended to be the only option. It exists to provide choice — not to compensate for a public system that cannot cope.

Doctors and patients must work together to hold government accountable. Underfunding has weakened the public system for decades, and now private practitioners are being blamed for the resulting lack of access. Medicare is cherished by both patients and doctors, but it needs a substantial funding boost across the board if it is to remain fit for purpose.

The AMA advocates for transparency and informed financial consent. We support tools like the Medical Costs Finder website and have developed a comprehensive guide to informed financial consent for our members, the profession, and patients — because clarity matters. But we also want this website to include private health insurer rebates — allowing for a fuller picture for the patient.

Private health insurer profits and management expenses have also come under scrutiny. In 2024–25, insurers retained nearly 16 per cent of hospital premiums as gross margin — amounting to $3.6 billion. Management expenses remain high at 10.9 per cent in 2024–25. This is lower than last year (11.5 per cent) but still higher than it was in the last pre-pandemic year of 2018–19, when it was 9.1 per cent.

It is time for structural reform. The AMA continues to call for the establishment of an independent Private Health System Authority to oversee the sector. We also urge the government to mandate a minimum percentage of premiums that must be returned to consumers as treatment benefits. Australians deserve a transparent, affordable private health insurance system that delivers real value.

The AMA's report card is designed to support consumers in navigating the complexities of private health insurance. It helps Australians understand what they are paying for, compare benefits across insurers, and make informed decisions about their healthcare. I urge all Australians who hold private health insurance to take the time to carefully review their policies. This report contains explainers as well as resources that may assist you in making the right choices for you and your family.[1] If you have questions or concerns about your coverage, your first step should be to contact your private health insurer directly. It is essential to ask for written confirmation of any advice or information they provide — this not only ensures clarity but also gives you something to refer to back if needed. For any planned hospital admission, the AMA strongly recommends securing written confirmation of your benefit entitlements well in advance, helping to avoid unexpected costs and giving you greater confidence in your care arrangements.

With greater transparency and accountability, we can build a system that better serves patients, practitioners, and the future of Australian healthcare.

Dr Danielle McMullen
President, Australian Medical Association
December 2025

[1] Consumers should note information provided in this document is not tailored for individual circumstances and is not intended as a substitute for professional advice. As with any insurance policy, consumers should consider carefully which private health insurance product is right for them and seek professional advice where necessary.

Private health insurance in Australia

What is private health insurance?

In Australia, federal, state, and territory governments fund public hospitals, which provide admitted services to public patients, paid for by government revenues.

Australians can choose to purchase private health insurance to cover their healthcare needs (either in full or in part) and are encouraged to do so through various government incentives.

Private health insurance provides consumers with choice of hospital, choice of doctor, and continuity of care. It can also pay for healthcare costs Medicare does not cover, such as physiotherapy, optical, and other extras.

Choosing the right private health insurance policy can be difficult; there are 30 private health insurers in Australia, each offering a range of products for individuals, couples, or families. What is covered — and how much — depends on the policy purchased.

To avoid surprises when settling medical bills, it is important to understand which parts of medical fees are covered by each of the three key funders — Medicare, private health insurers, and the patient.

There are four commonly misunderstood aspects of private health insurance for hospital treatment:

- Private health insurers do not cover the costs of consultations or treatment provided by a doctor[2] outside of hospital as a non-admitted patient.
- Not all private health insurance policies cover every medical treatment.
- Insurers can change what is covered by a purchased policy, but they must inform the policyholder of any changes.
- Patients may still face out-of-pocket costs even when their policy covers the medical treatment they need.

How private healthcare is funded

There are three key funders of private healthcare in Australia:

- the Australian Government, through the Medicare Benefits Schedule (MBS)
- private health insurers (funded by consumers' premiums and government subsidies)
- the patient (through out-of-pocket costs).

Funding from government, as well as premiums, is regulated, with legislation determining both the MBS and how much premiums are allowed to increase by year on year.[3] Patient out-of-pocket costs are sometimes constrained through contracting[4] but not regulated.

Private health insurance settings

Premiums

A premium is the amount consumers pay for their insurance coverage. Premiums are an income source for insurers, which helps pay for their business costs, including (benefit) payments for hospital admissions. The private health insurer premium is paid by:

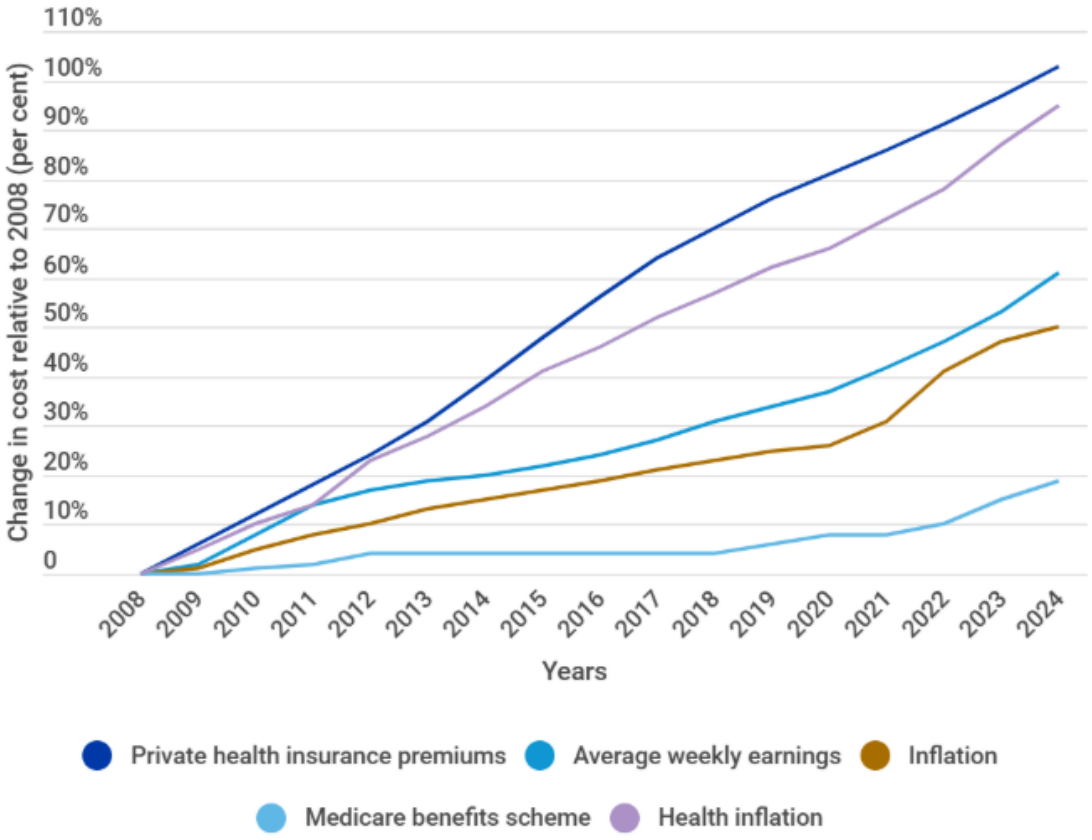
- a component from consumers (the purchaser and beneficiary of a policy)
- a rebate from the Australian Government, calculated as a proportion of the premium based on the consumer's income.

[2] General practitioner or a non-general practitioner specialist.
[3] See phoenixing of policies below on how private health insurers try to get around this regulation.
[4] See contracting, and the section on gaps below.

Once a premium is received from a consumer, the insurer is liable for providing coverage for claims according to the terms and conditions of the insurance policy.

Once a year, private health insurers can apply to the Minister for Health for approval to increase the premiums for their policy products. This process is called the premium round. It usually begins in August, with insurers submitting bids for the premium increases they seek for the following year, supported by documentation justifying the requested increases.

Figure 1: Rate increase in private health insurance premiums, inflation, health inflation, MBS indexation and average weekly earnings, 2008 to 2024[i]



Sources: Department of Health, Disability and Ageing (DHDA), Australian Bureau of Statistics (ABS), and the AMA.

If the minister is satisfied with these bids, premium increases are typically announced early in the following year. However, if the minister considers the requested price increases for any health insurance policy product to be unjustified, they are empowered to reject the bid and require the insurer to resubmit a lower increase. Once the minister is satisfied, the approved premium increase takes effect on 1 April.

Despite this ministerial oversight, private health insurance premiums have been increasing at a much faster rate than inflation (measured by the consumer price index, or CPI), average weekly earnings, MBS indexation, and health inflation.[5] This is illustrated in Figure 1, where the dark blue line outpaces all other lines between 2008 and 2024.

[5] A sub-component of inflation (CPI), which measures increases in a range of health-related costs.

Cover

Private health insurance cover is what a private health insurer will or will not pay for under a specific product. All consumers must receive a product disclosure statement at the time of purchase of a product. However, these product disclosure statements can be complex, long, and difficult to read and understand.

Doctors working in the private health system sometimes see patients who believe they are covered for treatment under their private health insurance policy, only to discover they are not. This can be highly distressing for patients at a vulnerable time, when they require care.

Patients sometimes understandably assume — based on the significant premiums they pay — that they must be covered for everything. However, the term cover does not always mean fully insured for all costs associated with a particular treatment or medical service. When a patient is treated as a private patient, either in a public or private hospital, each of the doctors involved in their care can charge a fee for their services. In addition, the hospital will also charge a fee for accommodation and any other services it provides.

For services delivered to privately insured patients admitted to hospital, private health insurance covers:

- the accommodation and theatre cost at a private hospital
- some, or all, of the medical technology accessed during the in-hospital stay
- some, or all, of the cost difference between a doctor's fee and 75 per cent of the MBS fee (the MBS rebate) paid by the Australian Government.

There may be an excess or a co-payment at the time of hospitalisation, and this amount will depend on the choices made by the patient when purchasing the insurance policy.

Comparing cover

Private health insurance customers are encouraged to shop around for the cover that best suits their circumstances. To facilitate this, the Office of the Commonwealth Ombudsman launched a new version of its PrivateHealth.gov.au website in 2019. Private health insurers are required to keep information on the website up to date, and it serves as an independent source of consumer information about private health insurance. The site allows users to search the features and premium costs of every policy available in Australia.

The website also includes a premium estimator, enabling users to compare policies either by base premiums or by estimated premium that take their rebate and/or Lifetime Health Cover[6] loading into account.

Tiers of hospital cover

In 2020, the government mandated private health insurers classify and market their hospital policy products as either basic, bronze-, silver-, or gold-tier policies, depending on the clinical categories of treatment covered.

The treatments or medical services a patient is covered for depend on what tier of hospital cover they have purchased. To be classified as a basic, bronze, silver, or gold policy, private hospital insurance policies must, at a minimum, include certain clinical categories of hospital treatment set by the government, which are listed on the PrivateHealth.gov.au website. For example, basic or bronze tier hospital insurance products with relatively low premium costs include coverage for very few clinical categories of treatment. In other words, basic or bronze-tier policies exclude or restrict cover for many types of treatment.

Silver-tier policy products, which are more expensive, restrict or exclude cover for a smaller number of clinical treatment categories. Gold-tier policy products, which are the most expensive, cover the widest range of clinical treatments and prostheses/devices. If a policy meets the minimum requirements of a tier, but also includes additional coverage, then it can be classified as a plus policy — for example, bronze plus

[6] Lifetime Health Cover is a loading added to your hospital premium if you didn't have private hospital cover from the year you turn 31.

or silver plus. Given this, when choosing a private hospital insurance policy product, it is critical consumers consider not only the upfront premium cost but also whether the policy covers the types of clinical treatment they are likely to need in future.

See the section below on "Trends in private health insurance" for information on the uptake of the various tiers of hospital cover.

Phoenixing of policies

In December 2024, the Commonwealth Ombudsman released a report into the loophole private health insurers had been using to circumvent the restrictions on increasing premiums beyond what was allowable by the minister. This loophole was dubbed product phoenixing, referring to the practice of private health insurers closing or discontinuing a policy and then launches a new, almost identical policy at a higher cost. The minister at the time noted:

> *"This means new customers taking out gold tier policies are paying hundreds of dollars more than existing customers each year, and hundreds more in excess fees if they ever need to go to hospital."*[ii]

The Commonwealth Ombudsman report found these practices "may be circumventing premium approval processes, but they are also restricting consumer choice"[iii] by ensuring that when customers shop around for a better deal or a cheaper policy, they are unlikely to find one.

See the section below on "Trends in private health insurance" for recent developments regarding phoenixing.

Private health information statement

Since 1 April 2020, private health insurers have been required to send their members an annual statement in the form of a private health information statement, summarising what their policy does and does not cover, and to issue it again each time the policy changes. A private health information statement for each policy product an insurer offers is also available on the PrivateHealth.gov.au website and the insurer's own website.

A private health information statement provides a summary of the key product features. It allows consumers to see whether their broad needs are covered and where products differ in both price and features. However, to obtain the full details of an insurance policy, consumers should still contact the insurer and carefully read any associated terms and conditions or fund rules documents, as these usually contain important about the circumstances in which the insurer will pay benefits.

Excesses and co-payments

Most private health insurers offer the option of nominating an excess or co-payment on a hospital policy in return for reduced premiums. If you nominate a high excess or co-payment, you may pay a lower premium than someone with no excess.

The excess is an amount a patient will pay for hospital-related costs and is separate from any gap payment made for a doctor's treatment or services. Most policies now include an excess or co-payment, meaning patients will pay more out of pocket at the time they access care. The amount a private health insurer can offer as an excess is regulated by the government.

An excess is a lump sum the consumer agrees to pay towards their hospital admission before the private health insurer will pay benefits.

Private health insurer contracts

Due to an ageing population with increasing comorbidities and healthcare needs, private health insurers continue to look for ways to reduce their costs. Some insurers are focusing on improving the health of their customers by promoting preventive health strategies, thereby potentially reducing the need for hospital treatments. Others are looking at providing healthcare more flexibly by offering some services through hospital-in-the-home programs and other out-of-hospital medical and allied health services. These programs allow patients to remain at home during all, or part, of their treatment.

With the largest for-profit private health insurers each holding a significant market share, these companies are also making increased use of selective contracting with both hospitals and doctors. Such contracting arrangements, designed to drive down costs, also enable insurers to influence or control the healthcare pathways and providers available to policyholders seeking to reduce their out-of-pocket expenses.

Paying for medical care

MBS and the private sector

The MBS is a listing of the Medicare services subsidised by the Australian Government. This means the Australian Government will pay a set amount of money (called a Medicare rebate) for those medical services listed. Each service has a number (known as an MBS item) attached to identify the service provided and the fee payable for that service.

Generally, Medicare pays a percentage of the MBS fee depending on the service provided:

- 100 per cent for consultations provided by a general practitioner
- 85 per cent for all other services provided by a medical practitioner in the community
- 75 per cent for all services provided by a medical practitioner during an episode of hospital treatment when the patient is admitted as a private patient.

The MBS is not designed to cover the full cost of services provided privately.

Out-of-pocket costs

Consumers are often concerned they may face out-of-pocket costs for doctors' fees for their treatment — even when they have the highest level of private health insurance coverage.

Doctors who treat patients will generally send them a bill for their services.[7] Doctors are free to set their fees at a level they believe is fair and reasonable. These fees take into account the costs of running a practice, including professional indemnity and other insurances, wages, rent, consumables, and equipment.

If a patient with private health insurance is admitted to hospital (either public or private) and chooses to be treated as a private patient, Medicare will pay 75 per cent of the MBS fee for each service provided by a hospital doctor.

> *An out-of-pocket cost is the difference between the fees charged by the doctor and the combined MBS benefit plus the private health insurance benefit.*

By law, private health insurers must top up the Medicare payment by at least 25 per cent of the relevant MBS fee. Insurers may pay a higher level of benefit in specific circumstances, depending on the contracting arrangements they have with the treating doctor and the insurance product the patient holds. These circumstances are explained under the heading "No gap and known gap" below.

[7] That is, unless the doctor has a no-gap agreement with the patient's insurer, in which case the patient is sent a copy of the payments made by the private health insurer.

Sometimes, a remaining gap exists after the private health insurer pays their agreed amount. This remaining gap then falls to the patient to pay and is known as an out-of-pocket cost, as the patient must make up the difference from their own pocket.

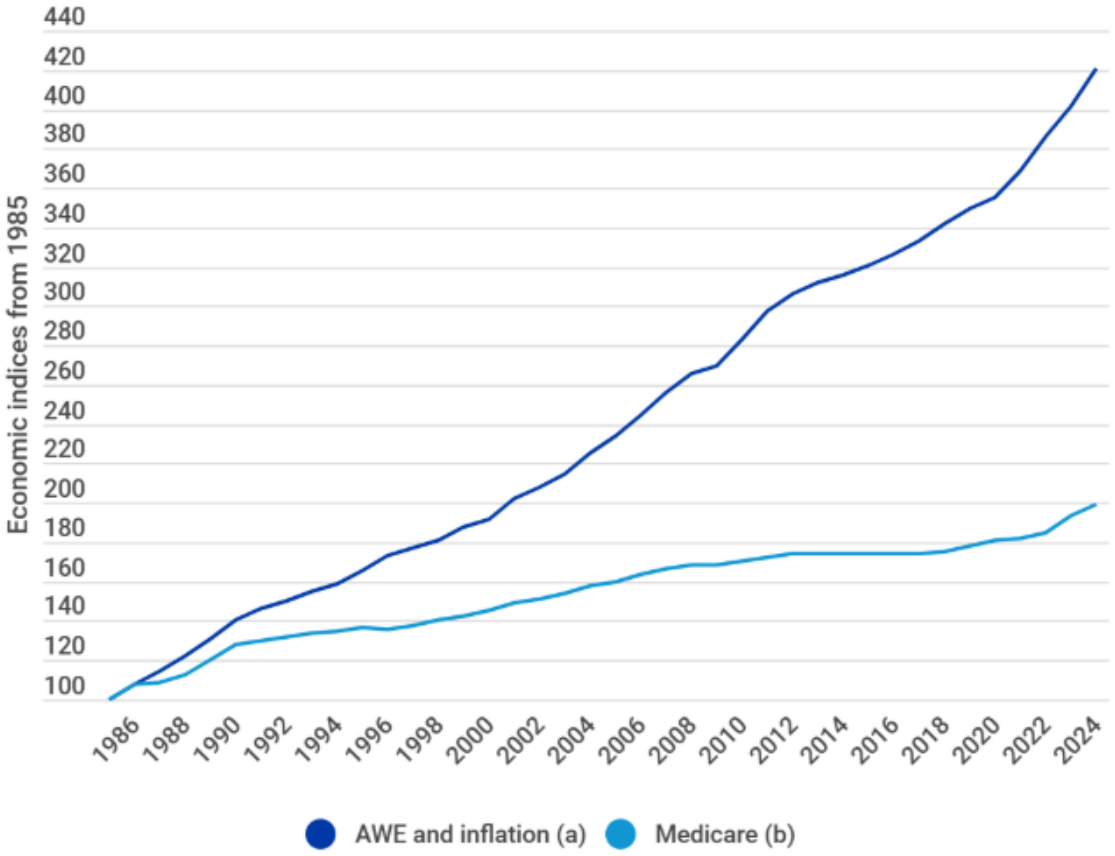
Inadequate Medicare indexation

As noted, the MBS was not designed to reimburse the full cost of medical services. The gap between the MBS rebate and the doctor's fee, along with any hospital fees, must be paid by someone. This can be private health insurers, other funders, or the patient. Furthermore, MBS items have not been appropriately indexed (increased to reflect healthcare provider costs for doctors) for many years.

Under an indexing process in place from 1996 until November 2023, MBS rebates were raised according to the Australian Government's Wage Cost Index, a combination of indices relating to wage levels and inflation. This indexation has been considerably lower than inflation, let alone the rising costs of providing medical care. For example, in the five years from 2016–20, inflation rose 7.8 per cent, while health inflation alone rose 16.8 per cent. Over the same period, the MBS increased by only 3.7 per cent.[iv]

In 2013, the Australian Government froze MBS rebates, meaning they remained stagnant for more than five years despite inflation and the rising costs of delivering healthcare. The freeze was lifted (though not for all items) in 2019. The impact of inadequate indexation, followed by the freeze, was compounded by the fact most private health insurers' rebates track more closely with increases to MBS rebates than with increases in the premiums they charge consumers.

Figure 2: The increasing gap between Medicare indexing, and average weekly earnings and inflation, 1985 to 2024[v]



(a) Index comprising of average weekly earnings (AWE) and inflation (70:30) reflecting the average cost structures in medical practices.
(b) Index of Medicare fees as determined by the Australian Government.

Sources: Australian Bureau of Statistics (ABS), MBS Online, and the AMA Fees List.

Medical fees cover income, staff wages, medical indemnity insurance, and practice costs (including rent, medical supplies, telecommunications, and equipment). All these costs have risen year-on-year, even when MBS rebates have not. This has contributed to a growing gap between MBS rebates and the actual costs of providing healthcare in Australia.

This is illustrated in Figure 2, which compares increases over time in:

(a) a composite index of average weekly earnings (70 per cent) and inflation (CPI) (30 per cent), reflecting the average cost structures of medical practices
(b) indexation of MBS rebates as determined by the Australian Government.

Changes to Medicare indexation from 1 November 2023

Following a strong and consistent AMA campaign highlighting inadequate Medicare indexation and the impact of the Medicare freeze on patients and doctors alike, the Australian Government announced welcome changes to the Medicare indexation formula in its 2023–24 Budget.[vi]

In addition to a one-off top-up to Medicare rebates of 0.5 per cent in November 2023, the government announced changes to the formula for Medicare indexation that will place greater weight on labour costs, a key component of medical practice expenses. From 1 July 2025, a 2.4 per cent indexation factor was applied to most general medical, diagnostic imaging, and pathology items. Arguably, while this increase is significantly higher than recent adjustments, it still does not keep pace with rising costs.

The 2025 National Efficient Price determination from the Independent Health and Aged Care Pricing Authority (IHACPA) noted health costs are rising by 5.6 per cent going forward. The IHACPA retrospectively adjusted the 2021–22 and 2022–23 financial years based on actual cost data for public hospitals.[vii] While these two data series are not directly comparable — since one covers the entire hospital stay and the other medical expenses — the National Efficient Price determination provides relevant evidence of cost escalation.

No gap and known gap arrangements

Consumers should check whether a private health insurer pays more than the minimum 25 per cent of the MBS fee required by law. This should be clearly and explicitly explained in every policyholder's health insurance brochure.

Private health insurers and doctors can enter into contracts that establish either a 'no gap' or a 'known gap' arrangement when a doctor treats a patient insured with that private health insurer.

No gap arrangements

Most private health insurers offer 'no gap' arrangements. In these cases, the doctor agrees with the insurer to charge the same amount the insurer agrees to pay for the medical service. Patients do not incur an out-of-pocket cost for these services, and the agreed no gap fee is generally higher than the MBS rebate.

Table 1: Proportion of private health insurance services with a gap, a known gap or no gap, 2018–19 to 2024–25[viii]

Financial year	Proportion of services with no gap (%)	Proportion of services with known gap (%)	Proportion of services without gap arrangement in place (%)
2018–19	87.4	7.7	4.9
2019–20	89.9	7.5	2.6
2020–21	89.3	7.8	2.9
2021–22	88.8	8.5	2.6
2022–23	88.3	8.9	2.8
2023–24	87.7	9.3	2.9
2024–25	87.1	10.0	2.9

Source: Australian Prudential Regulation Authority (APRA).

In the 2024–25 financial year, 87.1 per cent of medical services provided to privately insured patients in hospitals were delivered by doctors at no gap rates. This represents a decline of 0.6 percentage points from last year and 2.8 percentage points compared to five years ago (see Table 1). The decline also reflects the choice of some doctors not to accept the no gap arrangements offered by certain insurers, as they consider the amounts paid under those arrangements too low to cover the costs of providing the relevant medical service.

Known gap arrangement

Many, but not all, private health insurers pay a benefit that includes a 'known gap'. This means the insurer will pay a higher benefit (above the minimum required by law) towards the doctor's fee if:

- the doctor has an agreement with the insurer
- the doctor's fee does not result in a patient out-of-pocket cost greater than the known gap amount.

In the 2024–25 financial year, 10 per cent of medical services provided to privately insured patients in hospitals were provided at insurers' known gap rates (see Table 1).

No arrangement

It is up to the doctor to decide, on a case-by-case basis, whether to use a private health insurer's gap cover arrangement (no gap or known gap). When there is no arrangement in place between a doctor and a private health insurer, or when the doctor charges more than the known gap, the difference between the MBS rebate and the doctor's fee must be paid by the patient's out-of-pocket costs, which can increase significantly in these instances. This is because, in such situations, the private health insurer will only pay the minimum benefit amount required — 25 per cent of the MBS fee. Lower benefits paid by the insurer usually mean higher out-of-pocket costs. This can be confusing for patients, especially if not communicated early. It also means any increase in the doctor's fee above the no gap or known gap rates (depending on the insurer), no matter how small, results in a significant drop in payment from the insurer and a much greater increase in the patient's out-of-pocket costs.

Using a knee replacement (MBS 49518) as an example, Table 2 demonstrates three billing and payment scenarios:

1. A no gap medical benefit of $2,529.55, where the patient pays nothing.
2. A known gap medical benefit of $2,392.90, where the patient pays $500 (the maximum gap).
3. A no arrangement scenario, where the patient pays nearly $1,700.

Table 2: Private health insurer billing scenarios and out-of-pocket costs for a knee replacement, 2025[ix]

Situation	Doctor's fee	MBS Benefit	Insurance medical benefit	Out-of-pocket costs
Doctor accepts insurers no gap medical benefit amount	$2,529.55	$1,153.05	$1,376.50	$0.00
Doctor accepts insurers known gap arrangement	$2,892.90	$1,153.05	$1,239.85	$500.00
Doctor does not accept fee cap under insurer's no gap or known gap scheme	$2,900.00	$1,153.05	$384.34	$1,362.61

Note: MBS 49518 Fee: $1,537.35, 75 per cent = $1,153.05.

Sources: MBS online, Bupa.

Hospital provider/purchaser agreements

The private health insurance benefits paid for hospital and medical services depend not only on the product type and tier of cover purchased, or the fees charged by the treating doctor, but also on whether

the private health insurer has an agreement in place with the hospital where treatment occurs. These agreements are called hospital provider/purchaser agreements (HPPAs).

Most HPPAs do not allow the private hospital to charge privately insured patients out-of-pocket fee for accommodation and care. Therefore, if a private health insurer has a current, negotiated contract with a private hospital, there will be no hospital out-of-pocket costs for patients insured by that provider, as long as the procedure they are admitted for is covered by their policy.

All major private health insurers have agreements with a significant number of private hospitals, but patients are advised to check before deciding where to be treated.

This is particularly important for patients who:

- have a specific hospital in mind before treatment
- live in a rural area where the nearest private hospital with a current agreement may be some distance away
- want to ensure they can choose their doctor and that the doctor can access the relevant insurers' gap arrangements at that hospital.

As with medical treatment, all patients are entitled to — and should always request — an estimate of treatment costs in advance, whether in private or public hospitals.

To find out which private hospitals near you have agreements with your health insurance fund, contact your insurer or use the tool provided on the PrivateHealth.gov.au website

Out of contract

If a private health insurer and a private hospital do not have a current agreement, they will not have an arrangement in place for reimbursing the cost of care for patients admitted to that private hospital. This situation may arise if:

- an existing agreement expires or is cancelled before the parties reach a new agreement
- a new hospital opens and has not had the opportunity to negotiate with private health insurers
- private health insurers choose not to contract with smaller (day) hospitals.

The Australian Government has recognised patients may be at risk of having to pay the full cost of their care in an out-of-contract scenario and has established a default price, known as the second-tier default benefit. Private health insurers must pay second-tier default benefits for private hospital treatment if they do not have an agreement with the hospital and the hospital is eligible for second-tier default benefits.

The second-tier default benefit for hospital treatment is at least 85 per cent of the average charge for the equivalent treatment, based on that private health insurer's negotiated agreements with comparable private hospitals. Comparable private hospitals are those located in the same state and within the same second-tier hospital category. Each private health insurer must calculate second-tier default benefit rates for each category in every state and territory.

If a person discovers their private health insurer does not have a current contract with the hospital where they wish to be treated, they may choose to switch to a different hospital or a different insurer.

Consumers should check the details relevant to their own and their family's situation. The PrivateHealth.gov.au website provides information on what to consider when changing private health insurers

A privately insured person may transfer to an insurer and policy product offering the same or lower benefits than the plan they currently hold. This process should be relatively straightforward, and the consumer should retain continuity for any waiting periods already served.

Informed financial consent

Navigating the health system is difficult for most people, but even harder when they are sick or disadvantaged. Medical practitioners understand how important it is to ensure patients are aware of their treatment options and to support them in understanding the fees and costs associated with their care.

A general practitioner who has an ongoing relationship with a patient is best placed to provide referrals for appropriate specialist care. Doctors should be prepared to outline their estimated costs when contacted by patients, particularly for standard treatments or initial consultations.

The AMA has worked with key medical organisations to create and update a comprehensive resource that supports collaboration between doctors and their patients to ensure fully informed financial consent.

The AMA Guide to Informed Financial Consent 2024 — which assists patients in understanding their healthcare and its costs — supports patients to be more engaged in conversations with their doctors, their private health insurer, and their choice of hospital. It helps create a dialogue that improves transparency about treatment options, charges, and expected out-of-pocket costs.

The guide is designed to empower patients with important information, helping them understand medical costs and giving them confidence to discuss and question fees with their doctors. It includes:

- an Informed Financial Consent Form for doctors and patients to use together
- information on fees, billing practices, and medical gaps
- questions for patients to ask their doctors about costs.

Publishing doctors' fees

Over the past few years, the publication of doctors' fees has been an area of ongoing media and public scrutiny. On 30 December 2019, the then Minister for Health, Greg Hunt, launched the Medical Costs Finder website to help Australians understand the cost of common medical procedures provided by specialist medical professionals.[x]

This tool can be used to:

- see how much people have paid out-of-pocket for a medical service over the past year
- compare estimated costs estimated by a specialist and other health providers for a service with the typical costs for the same service.

The website provides general information on typical costs for common services offered by general practitioners and non-general practitioner specialists, both in and out of hospital, with more than 1,000 specialist treatments listed. The Department of Health, Disability and Ageing has been working to enhance the website so individual medical specialists can more easily add indicative fee estimates for common procedures, along with details of their arrangements with different private health insurers. While this website can help the public better understand typical costs, it does not provide specific information about the medical fees that will be charged for a procedure. These fees will vary depending on the patient's age, risk factors, and any complicating issues. It is therefore important to note any indicative fees published on the site by medical practitioners are not a substitute for a quote specific to your individual circumstances.

Consumers should note that while a patient's out-of-pocket costs arise from the doctor's fee and the benefit paid by the fund, benefit rates are not uniform across insurers, procedures, states and territories, or hospital settings. To ensure patients can access the wide number of no gap or known gap schemes offered by insurers (and reduce their out-of-pocket costs), medical practitioners must maintain multiple fee schedules — sometimes up to 17 different rates — for the same procedure. This to comply with the different rebates paid by private health insurers to meet their no gap or known gap requirements for that one procedure.

Doctors are free to decide whether to participate in a particular fund's gap cover arrangements. Several factors can affect that choice, including whether the fund holds a substantial share of the health insurance market in a particular state, the amounts paid under the gap arrangements compared with the doctor's

chosen fee, and the specific details of the insurer's gap cover arrangements, such as any administrative arrangements.

Consumers should also be aware the government's Medical Costs Finder website does not provide any information on how long they are likely to wait for planned surgery or an outpatient clinic appointment at a local public hospital — important information when weighing their options. The AMA's Public Hospital Report Card 2025 offers data on average waiting times for planned surgery in each state and territory, which may be helpful.

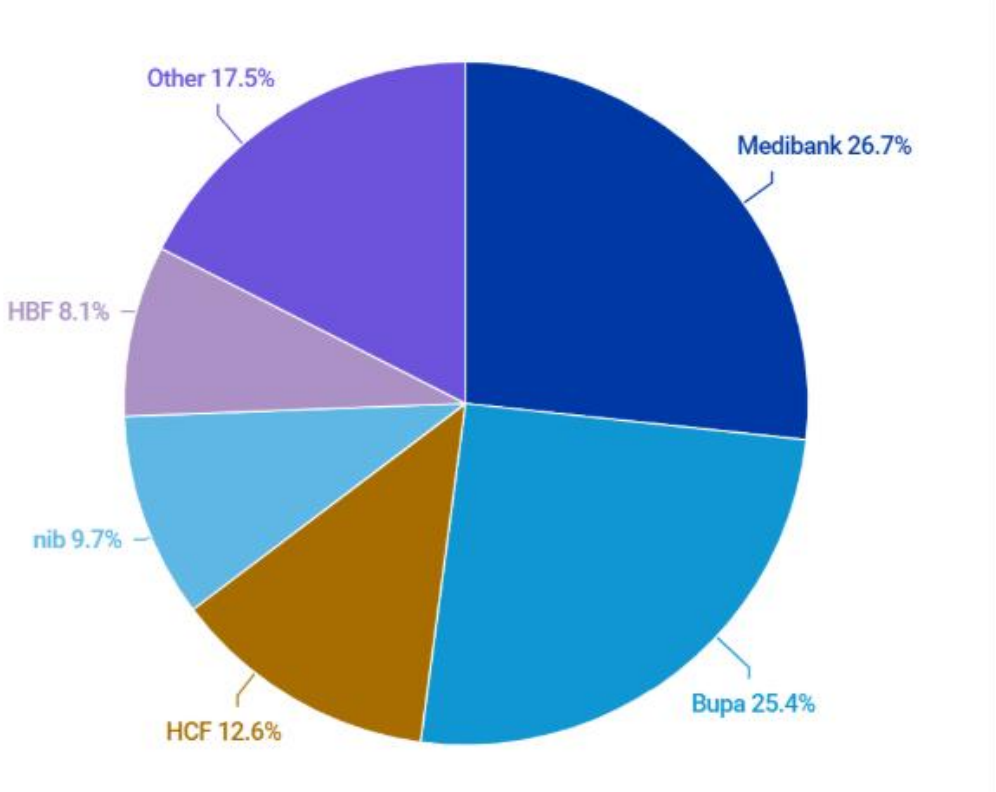
The AMA is strongly committed to promoting information sharing between doctors and patients to establish agreed treatment plans and ensure patients understand the associated costs. Given the limitations of the government website, the most effective way to gain a clear understanding of likely out-of-pocket expenses is to discuss the procedure directly with the medical practitioner and to ask relevant questions, so that financial consent to a procedure (or a decision to explore other options) is fully informed.

To that end, the AMA strongly recommends patients refer to its Informed Financial Consent Guide 2024 to fully understand the financial issues relevant to their individual circumstances.

What your premiums give back

As shown in Figure 3, by the June quarter of 2025, the five largest health insurers had increased their combined market share to 82.5 per cent, up 0.4 percentage points on the June 2024 quarter.[xi] This market share gives the large insurers significant power when negotiating contracts with private hospitals and medical practitioners.

Figure 3: Insurer market share, June 2025[xii]



Source: Private Health Insurance Ombudsman (PHIO).

Benefits for hospital treatment paid by health insurers

There are two key measures of benefits insurers pay for medical treatment in hospital:

- the percentage of hospital-related charges covered (this includes accommodation at the hospital, provision of nursing care, and the cost of any prostheses)
- the percentage of medical service charges covered (doctor's fees for service).

Private health insurers aim to set policy premium levels to cover the expected costs of benefits plus the insurer's management costs. For-profit insurers also factor in their desired profit margins. However, the benefit an insurer agrees to pay varies by insurer, policy, procedure, and whether the treatment is planned or required due to an accident or other emergency. The PrivateHealth.gov.au website provides information for consumers on how insurers deal with unplanned treatment and complications, and the AMA recommends consumers consult it.

When there is a difference between the doctor's fee and the insurance benefit, out-of-pocket costs can arise. It is a common misunderstanding that the doctor's fee is the sole reason for an out-of-pocket cost, but as shown in Figure 4, different private health insurers can pay significantly different medical benefit amounts for the same procedure. Figure 4 illustrates the different medical benefit amounts paid by insurers for a selected range of common procedures. Red indicates the lower level of benefits paid, while green shows which insurers pay a higher level of benefits. The scale is relative to the benefits paid for the same procedure by the insurers listed in Figure 4; however, it is important to note the table does not represent benefits paid across the entire industry.

There is significant variation in the amounts private health insurers will pay for the same procedure. For example, for MBS Item 16519 (uncomplicated delivery of a baby), there is a 29 per cent variation ($522 difference) between the benefits paid by the insurer that pays the most, and the one that pays the least. These differences contribute to varying out-of-pocket costs for patients and highlight the importance of looking beyond the premium charged for different policy products to ensure value for money.

It is also important to note these payments relate to the relevant MBS item and insurer description. For any specific procedure or service, such as a knee replacement or other surgery, additional MBS items may need to be billed by other doctors or health practitioners who provide necessary related services (for example, anaesthesia, pathology, or diagnostic imagery).

Figure 4: Benefits paid for select admitted medical services by different private health insurers, 1 November 2025[xiii]

MBS Item	MBS Description	MBS Fee	BUPA	HCF	Medibank	NIB	AHSA (NSW)	HBF AHSA (WA)	Variation, lowest to highest
326	Attendance by a consultant physician at hospital	$ 217.50	$ 248.85	$ 261.00	$ 263.20	$ 253.50	$ 244.90	$ 230.10	$ 33.10
12203	Overnight investigation for sleep apnoea	$ 685.95	$ 816.85	$ 816.30	$ 829.85	$ 831.75	$ 793.00	$ 740.80	$ 90.95
13950	Cytotoxic chemotherapy	$ 126.00	$ 152.40	$ 160.00	$ 148.70	$ 143.25	$ 138.50	$ 138.70	$ 21.50
16519	Uncomplicated delivery (of baby)	$ 809.55	$ 2,266.70	$ 2,331.50	$ 2,201.30	$ 1,809.30	$ 2,013.60	$ 2,132.40	$ 522.20
16522	Complicated delivery (of baby)	$ 1,900.70	$ 2,721.80	$ 2,718.00	$ 2,699.15	$ 2,682.45	$ 2,531.70	$ 2,439.40	$ 282.40
18216	Epidural anaesthesia during labour	$ 221.55	$ 359.00	$ 358.90	$ 348.80	$ 345.15	$ 346.10	$ 327.00	$ 32.00
30445	Cholecystectomy	$ 970.70	$ 1,385.60	$ 1,378.40	$ 1,381.70	$ 1,164.80	$ 1,343.50	$ 1,167.80	$ 220.80
30648	Femoral or inguinal hernia	$ 541.95	$ 780.90	$ 769.55	$ 780.40	$ 769.55	$ 750.10	$ 652.00	$ 128.90
30720	Appendicectomy	$ 519.65	$ 745.55	$ 737.90	$ 753.50	$ 737.90	$ 719.20	$ 625.10	$ 128.40
31512	Breast, malignant tumour, removal	$ 758.45	$ 1,112.10	$ 1,077.00	$ 1,036.15	$ 1,077.00	$ 1,049.70	$ 912.40	$ 199.70
32139	Haemorrhoidectomy	$ 428.95	$ 609.05	$ 587.65	$ 610.50	$ 587.65	$ 566.20	$ 505.70	$ 104.80
32222	Colonoscopy	$ 390.05	$ 541.20	$ 534.35	$ 518.75	$ 504.75	$ 514.90	$ 459.90	$ 81.30
32500	Varicose veins	$ 128.10	$ 197.80	$ 187.05	$ 200.30	$ 187.05	$ 186.80	$ 154.90	$ 45.40
35657	Vaginal hysterectomy	$ 787.15	$ 1,292.45	$ 1,275.20	$ 1,289.20	$ 1,289.20	$ 1,270.90	$ 1,186.20	$ 106.25
37623	Vasectomy	$ 268.20	$ 412.85	$ 407.65	$ 434.50	$ 417.00	$ 416.90	$ 324.20	$ 110.30
38316	Cardiac percutaneous coronary intervention	$ 1,848.75	$ 2,717.60	$ 2,606.75	$ 2,717.65	$ 2,493.20	$ 2,514.30	$ 2,362.70	$ 354.95
38502	Coronary artery bypass	$ 2,748.45	$ 4,165.45	$ 4,150.15	$ 4,162.45	$ 3,860.70	$ 4,330.40	$ 4,004.50	$ 469.70
39331	Carpal tunnel release	$ 322.85	$ 554.65	$ 529.45	$ 540.90	$ 489.40	$ 516.90	$ 462.00	$ 92.65
39710	Craniotomy	$ 2,827.05	$ 4,641.85	$ 4,636.35	$ 4,514.50	$ 4,514.50	$ 4,526.00	$ 4,045.50	$ 596.35
41789	Tonsils or tonsils and adenoids	$ 344.95	$ 635.00	$ 634.70	$ 569.35	$ 604.00	$ 605.40	$ 537.10	$ 97.90
42702	Cataract surgery	$ 887.30	$ 1,421.60	$ 1,375.30	$ 1,381.05	$ 1,342.20	$ 1,394.00	$ 1,206.10	$ 215.50
46340	Synovectomy of wrist	$ 462.30	$ 721.55	$ 716.55	$ 776.65	$ 731.00	$ 731.00	$ 607.50	$ 169.15
49518	Knee replacement	$ 1,537.35	$ 2,529.55	$ 2,429.00	$ 2,446.20	$ 2,361.50	$ 2,443.40	$ 2,172.30	$ 357.25

Notes: Private health insurer rates listed include the applicable MBS benefit.
HBF uses one schedule for WA providers, and the AHSA AGC schedules for doctors providing services through HBF in other states.
Sources: MBS Online, Bupa, HCF, Medibank, nib, AHSA.

State-based differences in insurer gap schemes

The value of some private health insurers' gap schemes and benefits schedules can differ between states and territories, and these differences are not apparent in the national figures provided for some insurers in Figure 4. For example, in their 1 November 2025 schedules, the Australian Health Service Alliance benefit for cataract surgery (MBS 42702) in New South Wales is $1,394. However, if the procedure occurs in South Australia, the benefit is only $1,228[xiv] — a difference of $166.

In addition to varying the benefit paid, different insurers operating in the same state or territory may cover a higher or lower percentage of medical and hospital services at no gap. This indicates that the insurer with a greater percentage of no gap services has a more effective rebate scheme in that state, and consumers who hold hospital insurance policies with that insurer are less likely to face out-of-pocket costs after their medical service.

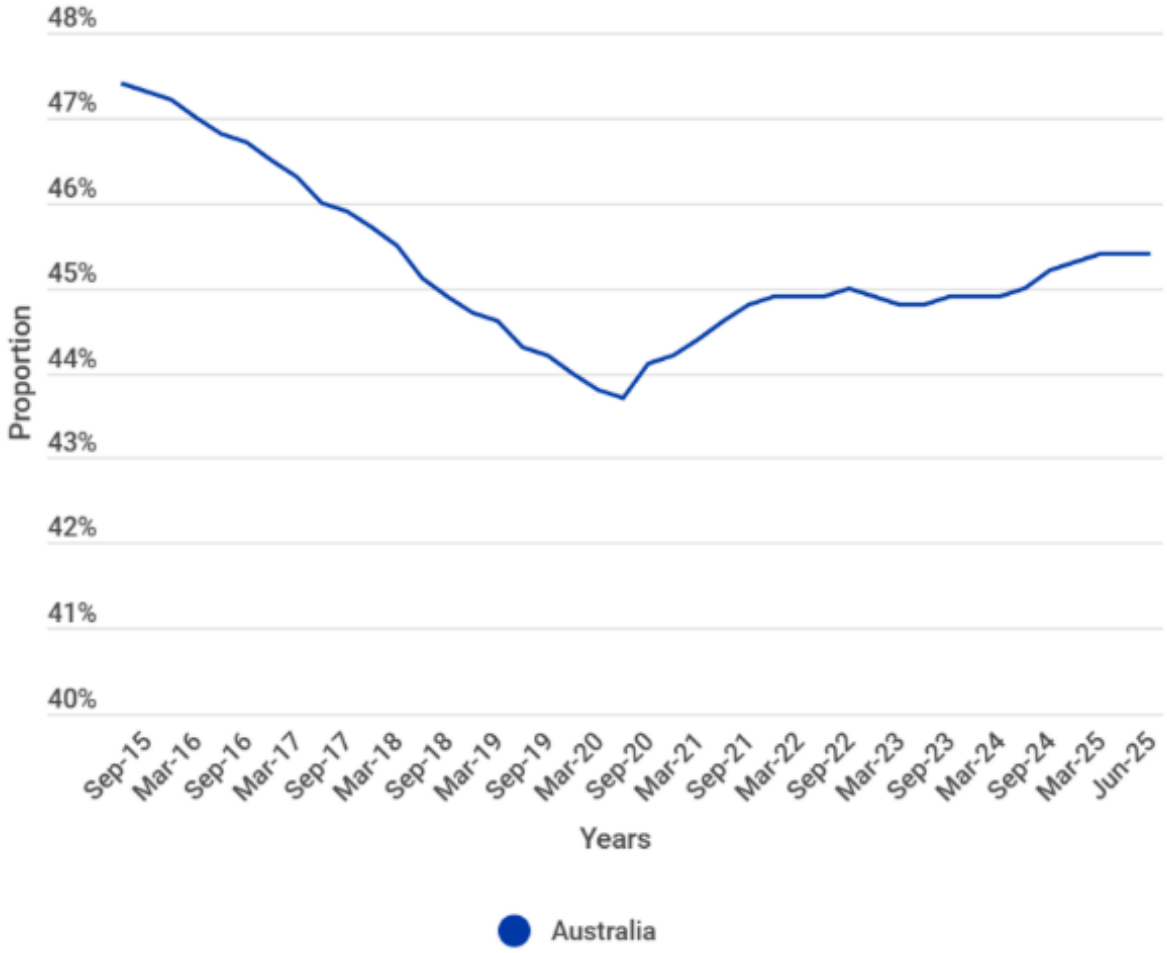
Overall, the best private health insurer for consumers may depend on where they live, so it is important to compare benefits and gap schemes of different insurers operating in each state or territory before selecting a private health insurance policy.

Trends in private health insurance

Private health insurance performance

At the end of June 2025, 45.4 per cent of Australians had private hospital treatment insurance,[xv] representing an increase of 0.4 percentage points from the June 2024 figure of 45.0 per cent, but a drop of 1.9 percentage points from the June 2015 figure of 47.4 per cent (Figure 5).[xvi]

Figure 5: Proportion of population with private health insurance hospital treatment cover, June 2015–June 2025xvii



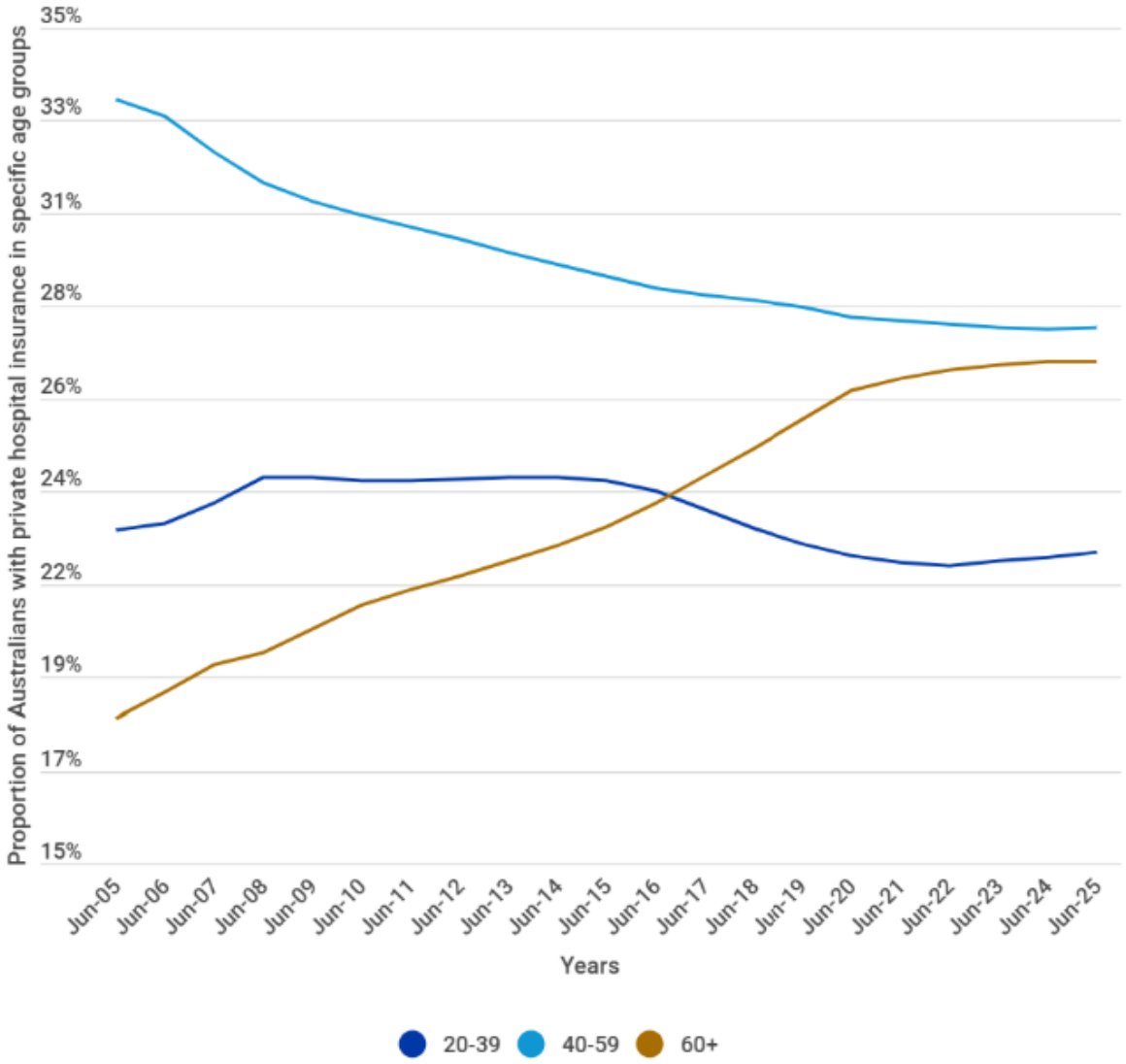
Source: APRA

Although Figure 5 illustrates a decline in the proportion of the Australian population with private hospital insurance between 2015 and mid-2020, not all age cohorts reduced their private health insurance coverage at the same rate. For example, between June 2019 to June 2020, the number of people aged over 65 with hospital treatment policies increased by 71,496 or 0.71 per cent.

An increase in the proportion of people with hospital insurance from more senior age groups has consequences for policy premiums, because insurers pay significantly more in benefits to these age groups than they do for younger cohorts of insured people. To cover those additional costs and keep insurance affordable for seniors (most particularly retirees, many of whom may rely on the pension or have lower incomes than working-age people), private health insurers spread the costs by raising premiums for all age groups.

As shown in Figure 6, the rate of increase in the over 60 age group taking out private hospital insurance has slowed considerably in recent years, as has the decline in the proportion of those in the 40–59 age group. The age group that recorded the largest increase in private hospital insurance membership between the June quarter of 2024 and June 2025 was people aged 40–44, with an increase of 4 per cent, or 37,000 members. By contrast, the 60–64 age group decreased by 400 over the same period.[xviii] Nevertheless, given an ageing population, it is likely the 60-plus age group will become the largest hospital-insured cohort in the foreseeable future.

Figure 6: Demographics of the private hospital insured population, June 2005–June 2025[xix]



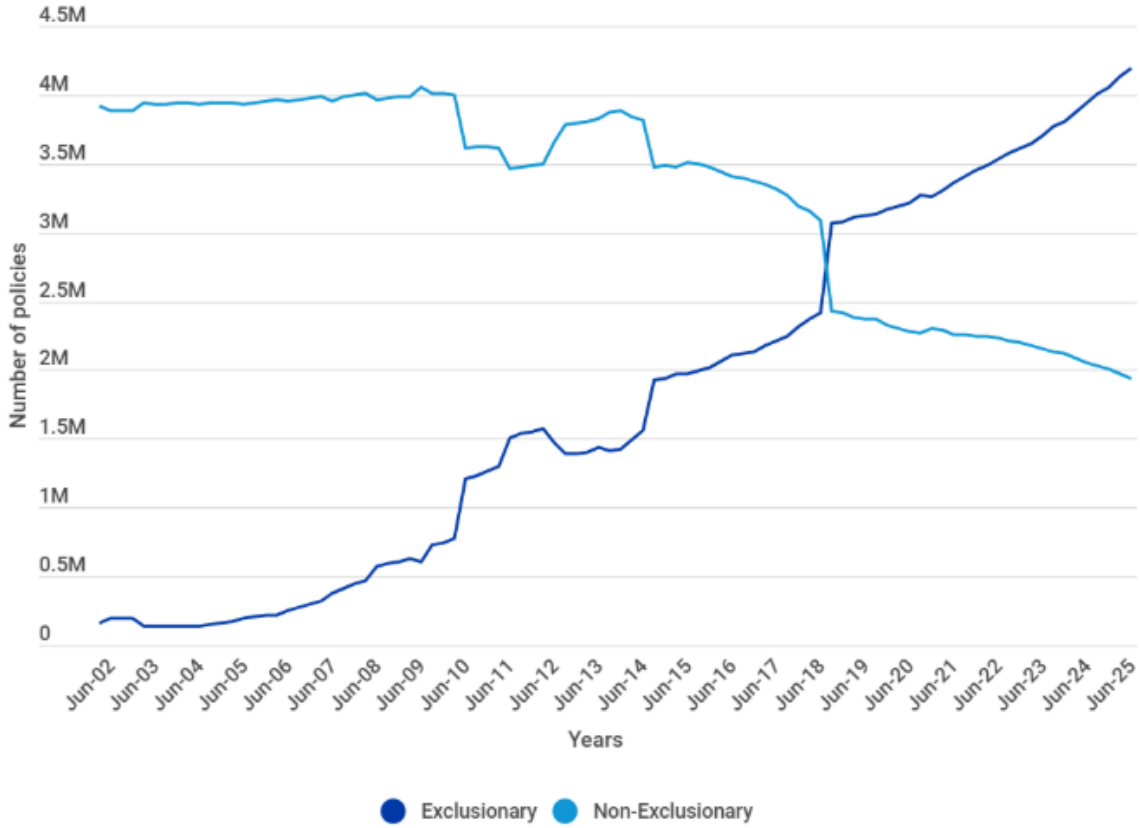
Source: APRA.

Change in exclusions

Another useful measure for consumers in assessing the value of private health insurance is whether their policy contains exclusions. Only 15 years ago, few hospital policies contained exclusions, but by 2018 most hospital insurance policies had shifted to include them.

As shown in Figure 7, the trend towards an increasing proportion of hospital insurance policies with exclusions has continued its steady rise, with 68.4 per cent of private hospital treatment policies no longer covering all types of care (Figure 7).[xx]

Figure 7: Change in private health insurance hospital treatment exclusionary and non-exclusionary policies, June 2003–June 2025[xxi]



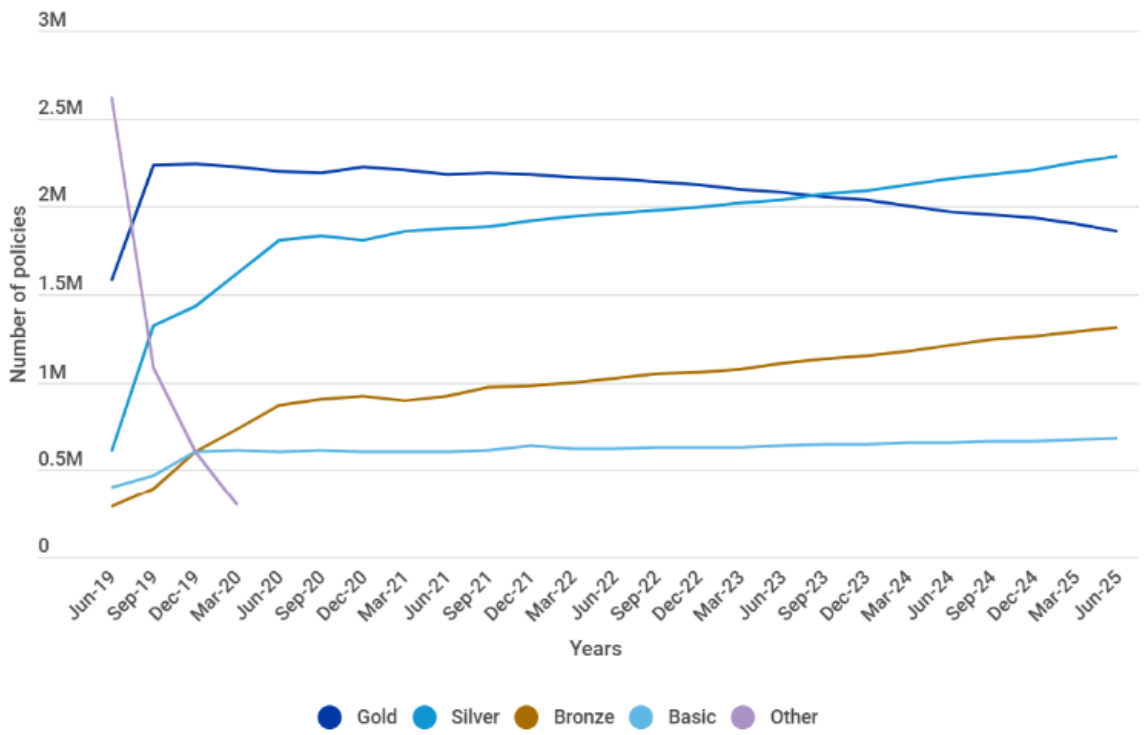
Source: APRA.

Trends in hospital cover tiers

The trends shown in Figures 7 and 8 reflect changes in the tiers of hospital cover consumers are willing and able to pay for. The policy premiums some private health insurers charge for gold-tier policies — the only tier of policy products that provides no-wait hospital maternity and psychiatric care — have become so expensive most Australians holding private health insurance have dropped them in favour of less expensive silver or bronze policies.

Australian government data shows that, in the face of increased premiums competing with other cost-of-living pressures, the number of gold-tier policies held by Australians with hospital cover is falling sharply. In June 2025, 360,000 fewer gold-tier policies (covering 743,000 Australians) were held compared with the start of the pandemic (March 2020 quarter). This occurred despite a total increase of 640,000 policies (covering 1.3 million people) over the same period. Figure 8 illustrates this trend: since the September 2023 quarter, there have been more silver than gold-tier policies held in Australia.[xxii]

Figure 8: Change in gold, silver, bronze and basic policies post implementation of government reform, June 2019–June 2025[xxiii]



Source: Australian Department of Health, Disability and Ageing (DHDA).

Phoenixing

In February 2024, CHOICE magazine claimed some insurers were exploiting loopholes in private health insurance regulations to increase the price of their gold tier policy products by closing existing products to new policy holders and opening near-identical policies at a much higher price, thereby circumventing the ministerial approval process for price increases.[xxiv]

In December 2024, the Private Health Insurance Ombudsman released a statement on the fairness of insurer practices with respect to the pricing of gold tier hospital policy products.[xxv] The ombudsman largely substantiated CHOICE's claims and found some private health insurers had continued such practices even after CHOICE called them out in early 2024.

The ombudsman argued that although phoenixing is not strictly against the law, it is unfair to consumers and discourages them from changing private health insurers or policy products for fear of having to pay a higher price for a similar product if they do so. For this reason, the ombudsman raised concerns about the practice of phoenixing with the Health Minister, Mark Butler, and the Department of Health and Aged Care in August 2024. The minister publicly condemned the practice as 'price-gouging', saying it was contrary to the spirit and intention of the law, which requires the pricing of health insurance products be subject to ministerial approval. He added that his advice was that these practices are widespread.[xxvi]

In October 2025, the Department of Health, Disability and Ageing called for public submissions on the practice. The AMA provided a submission to the consultation.

Private health insurer management expenses and profits

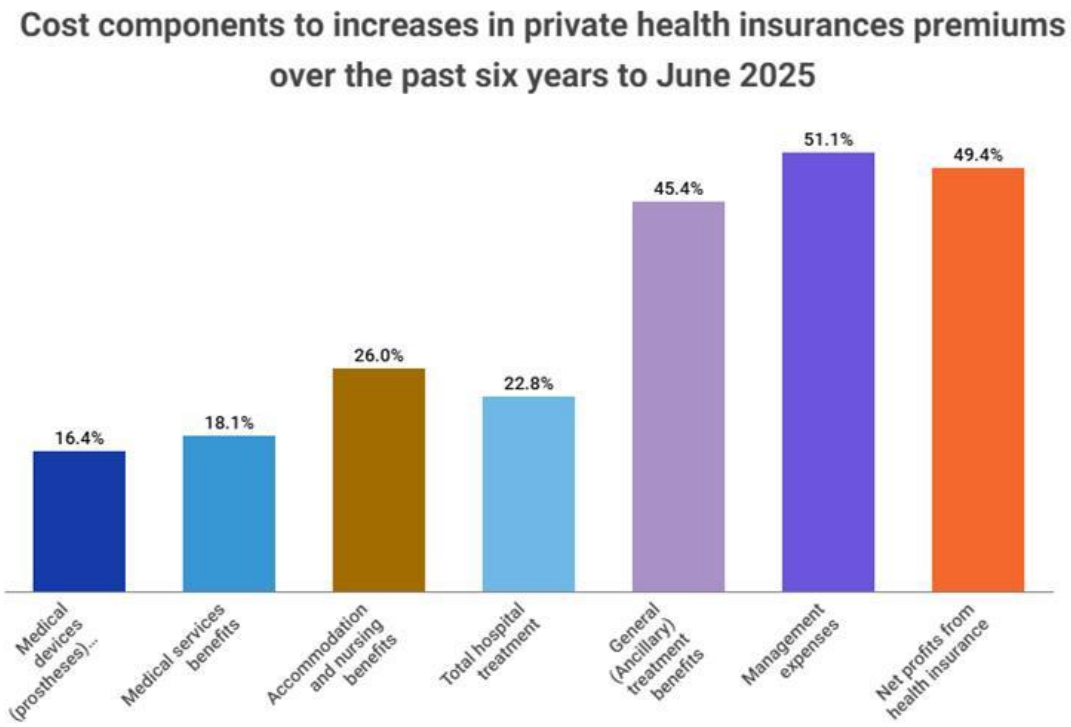
Private health insurers aim to set premium levels to cover the expected (forecast) costs of benefits (that is, payments made on behalf of insured members for admitted hospital costs, including doctors' fees), as well as the insurer's management costs. Regardless of whether a private health insurer is for-profit or not-for-profit, they share several common expenses.

For any episode of hospital treatment funded by a private health insurer, they cover (in full or in part):

- hospital expenses: the amount paid to the private hospital
- medical expenses: the amount paid to doctors
- prostheses: the amount paid to buy item such as hip and knee joints or cardiac stents
- management costs: the proportion of policy premiums that are used to manage the business of the fund.

All private health insurers incur management expenses. Depending on their position in the market and their non-profit or for-profit status, they may also face varying marketing costs, staff salaries, overheads such as rent and claims-handling expenses, and profit margins that must be built into these expenses. It is also important to note all insurers, including not-for-profits, must retain some profit to remain viable, under APRA's capital requirement rules.

Figure 9: How private health insurers spend the premiums they collect[xxvii]



Note: The financial year ending June 2019 has been used as the base year, as the most recent pre-pandemic annual period. Re the 'net insurance profit' column, only net investment income attributed to private health insurance has been included, and tax paid is excluded, along with other revenue from health-related business and net investment income from other health-related business.

Source: APRA.

However, as demonstrated in Figure 9, the key drivers to increases in private health insurance premiums over the past six years have been management expenses (51 per cent) and net insurance profits (50 per cent). These have risen more than benefits paid out for medical treatment in hospital (18 per cent) and out-of-hospital treatment such as dentistry or physiotherapy (45 per cent).

Private health insurer profits

In the 2025 financial year, the gross margin[8] Australian private health insurers made from hospital insurance premiums alone amounted to $3.62 billion. This reflects a gross margin of 15.8 per cent of hospital premiums paid by consumers, meaning about 16 per cent of premiums were not returned to consumers in the form of benefits for treatment. Although this represents a significant improvement for consumer value-for-money compared with the 2023 financial year (a $3.69 billion, or 18.4 per cent gross margin for hospital treatment insurance, which was the

[8] Calculated as the total dollar amount of hospital insurance policy premiums received by the whole Australian health insurance industry in 2024–25, minus the total amount of hospital treatment benefits they paid out during the year. Management expenses and profit are taken from this gross margin.

highest benchmark in recent years), it remains significantly worse than gross hospital insurance margins for the 2019 financial year, which were about 12 per cent.

The AMA continues to call for insurers to be required to return at least 90 per cent of private health insurance premiums to consumers in the form of benefits for treatment. However, by our calculation, this was only 84.2 per cent for 2024–25.[9]

While the government's calculation for the payout ratio is slightly different, the minister is also dissatisfied with the current figure. In September 2025, the minister issued his statement of expectations for the 2026 private health insurance premium round, noting:

> *"However, the information from private health insurers to the department earlier this year that indicated the industry hospital benefits ratio would approach around 87% for 2024-25 has not materialised. Rather, the hospital benefits ratio for 2024-25 is unchanged from the previous financial year, at 85.5%."*[xxviii]

Health benefits funds are defined under the Private Health Insurance Act 2007 as funds that operate a health insurance business, or both a health insurance business and health-related businesses (which may include businesses that provide goods or services to manage or prevent injuries, diseases or conditions, and/or provide insurance to people living in Australia who are ineligible for Medicare, among other things). Profit at a health benefits fund level therefore includes profits from health insurance and any eligible health-related businesses operated by the private health insurer.

Overall, in the 2025 financial year, health benefit funds made $2.132 billion in after-tax profits from continuing operations, including a substantial $1,084 million contribution from investment profits.[xxix]

Management expenses

While private health insurers' benefit payouts for hospital medical services have increased by 18 per cent over the past six years, the amount they spend on management expenses has increased by 51 per cent over the same period (Figure 9).

The amount paid by insurers for management expenses can vary considerably, with some insurers paying more than 15 per cent of their contribution income. However, the industry average for management expenses has grown over many years. For example, in the 2024–25 financial year, the industry average was 10.9 per cent. This is lower than the previous year (11.5 per cent) but still higher than in 2019–18, when it was 9.1 per cent.[xxx]

Private health insurers with relatively high management expenses pay out a smaller proportion of premiums on members' claims for admitted hospital treatments than insurers with lower management expenses. Naturally, such calculations are complex, but it is likely that a greater proportion of premiums being directed towards benefits is one indicator of value and return on investment.

Complaints made about private health insurers

The Private Health Insurance Ombudsman, which is part of the Commonwealth Ombudsman's office, provides private health insurance members with an independent service for complaints and enquiries. The ombudsman reports on complaints about private health insurers and how they are resolved, particularly through its quarterly and annual publications.

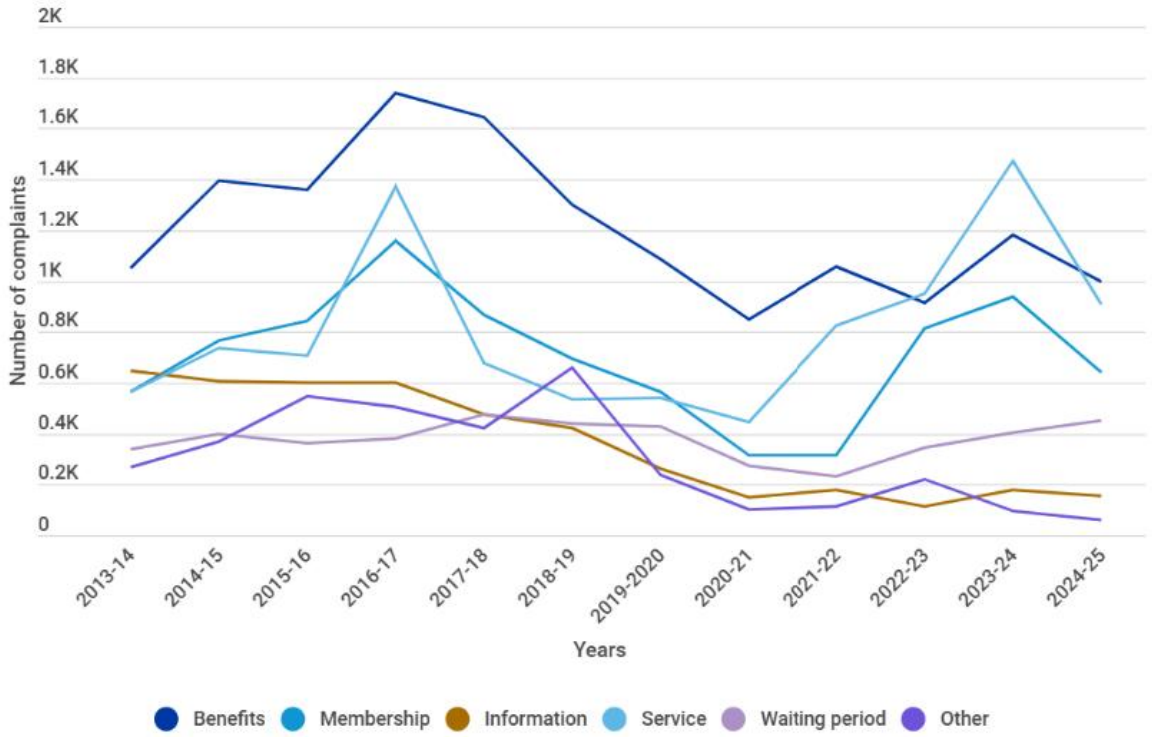
Complaint statistics published by the ombudsman suggest that, despite fluctuations in total numbers, the greatest problems consumers experience continue to arise from a small number of recurring issues. In recent years, the highest number of complaints have centred on benefits (non-payment or delayed payment, gap payments), membership issues, service-related issues, waiting periods, and information provided that does not meet consumer needs. Figure 10 shows selected categories of complaints in relation to private health insurers.

During 2024–25, the ombudsman handled 3,427 complaints about private health insurers, hospitals, practitioners, and brokers[xxxi] — a decrease of 19.1 per cent on the previous financial year (4,236 complaints[xxxii]). The previous year

[9] Total hospital revenue for the 2024–25 year was $23.013 billion, whereas hospital claims were $19.388 billion, giving a gross payout rate of 84.2 per cent.

was a high-water mark, particularly for complaints related to services, largely attributable to the large volume of complaints received in relation to Defence Health following a major computer system upgrade.

Figure 10: Complaints made to the Private Health Insurance Ombudsman, by private health insurance issue, 2013–14 to 2024–25[xxxiii]



Source: PHIO.

In response, the ombudsman published an issues paper for private health insurers on best practice when undertaking a major system upgrade, so disruptions and delays for policy holders can be avoided as far as possible.[xxxiv] The ombudsman suggested private health insurers must do better at anticipating and planning for unexpected events, establishing centralised complaint handling processes, employing sufficient well-trained and experienced staff to manage customer service problems, providing advance notice of the system change to customers, and monitoring the impacts of those changes.[xxxv]

In February 2024, the ombudsman published another issues paper, titled Can private health insurers decide that a patient does not need treatment in hospital?, which contained best practice guidance for private health insurers on this issue.[xxxvi]

The AMA recommends consumers with queries about their private health insurance speak to their private health insurer in the first instance. Like the ombudsman, the AMA suggests consumers always ask private health insurers to confirm their advice in writing. This way, consumers and patients can double check their understanding with the ombudsman if unsure about benefit eligibility or entitlements under their policy. For a planned admission, consumers should always obtain written confirmation of benefit entitlements from their insurer well before admission to hospital.

If a consumer requires further assistance or wishes to lodge a complaint about a private health insurer, they can contact the ombudsman directly on 1300 362 072 or use the private health insurance complaint form available on the ombudsman's website.

More information about private health insurers and their products

AMA resources

The AMA has several public position statements and resources relevant to medical fees:

- Setting medical fees and billing practices position statement 2024
- Informed Financial Consent position statement 2024
- AMA Guide to Informed Financial Consent 2024 — assisting patients to understand their health care and its costs
- AMA guide for patients on how the healthcare system funds medical care

Federal government information

The federal government's PrivateHealth.gov.au website provides:

- detailed information about how private health insurance works
- a tool for comparing the features of policies
- the Private Health Information Statements for every policy.

Medical Cost Finder

The federal government has developed an online tool — the Medical Costs Finder — which covers the costs of common services in and out of hospital that patients want to know more about. The tool's results are based on the most recent publicly available government data about what people have paid for medical services.

Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman protects the interests of people covered by private health insurance. It carries out this role in several ways, including an independent complaint handling service. If a consumer requires further assistance, or wishes to lodge a complaint about a private health insurer, they can contact the ombudsman directly on 1300 362 072 or through their website.

MBS Online

Consumers can search the MBS for all the latest fees and information at MBS Online, which contains a listing of the Medicare services subsidised by the federal government.

References

[i] ABS (2025). Average Weekly Earnings, Australia. May 2025. Retrieved 30/10/2025 from: https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia

ABS (2025). Consumer Price Index, Australia. September Quarter 2025. Retrieved 30/10/2025 from: https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release

AMA (2025). AMA Fees List: AMA Gaps poster 2025. Retrieved 30/10/2025 from: https://feeslist.ama.com.au/resources-ama-gaps-poster

DHDA (2025). Average annual price changes in private health insurance premiums. Retrieved 30/10/2025 from: https://www.health.gov.au/resources/publications/average-annual-price-changes-in-private-health-insurance-premiums

[ii] Minister Butler (9 Dec 2024). Commonwealth Ombudsman Report into "loopholes" making private health insurance more expensive. Retrieved 16/11/2025 from: https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/commonwealth-ombudsman-report-into-loopholes-making-private-health-insurance-more-expensive

[iii] PHIO (Mar 2025). State of the Health Funds Report 2023–24. Retrieved 16/11/2025 from: https://www.ombudsman.gov.au/_media/publication-documents/reports/state-of-the-health-funds-reports/State-of-the-Health-Funds-Report-2023-24.pdf

[iv] ABS (2025). Consumer Price Index, Australia. September Quarter 2025. Retrieved 30/10/2025 from: https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release.

DHDA (2025). MBS Online: MBS indexation. Retrieved 30/10/2025 from: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads

[v] AMA (2025). AMA Fees List: AMA Gaps poster 2025. Retrieved 30/10/2025 from: https://feeslist.ama.com.au/resources-ama-gaps-poster

[vi] AMA (11 May 2023). We asked for a health budget and they delivered. Retrieved 16/11/2025 from: https://www.ama.com.au/ama-rounds/12-may-2023/articles/we-asked-health-budget-and-they-delivered

[vii] IHACPA (Mar 2025). National Efficient Price Determination 2025–26: For Australian public hospital services. Retrieved 15/11/2025 from https://www.ihacpa.gov.au/sites/default/files/2025-03/national_efficient_price_determination_2025-26.pdf

[viii] APRA (13 Dec 2024). Annual private health insurance statistics 2023–2024. Retrieved 28/10/2025 from: https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

APRA (29 Aug 2025). Quarterly private health insurance statistics: Quarterly private health insurance medical gap June 2025. Retrieved 28/10/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Medical%20Gap%20June%202025.xlsx

[ix] Bupa (1 Nov 2025). Bupa medical gap scheme schedule – 1 November 2025. Retrieved 11/11/2025 from: https://www.bupa.com.au/for-providers/medical/bupa-australia-medical-gap-scheme-schedule

DHDA (28 Oct 2025). MBS Online. Retrieved 11/11/2025 from: https://www.mbsonline.gov.au/

[x] Minister Hunt (30 Dec 2019). New website to improve consumer understanding of medical costs. Retrieved 16/11/2025 from: https://www.greghunt.com.au/new-website-to-improve-consumer-understanding-of-medical-costs/

[xi] PHIO (2025). Quarterly update, Q4 2024–25, page 4. Retrieved 28/10/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_fil

e/0013/322123/PHIO-Quarterly-Update-Q4-2024-25.pdf

[xii] PHIO (2025). Quarterly update, Q4 2024–25, page 4. Retrieved 28/10/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0013/322123/PHIO-Quarterly-Update-Q4-2024-25.pdf

[xiii] AHSA (1 Nov 2025). Access Gap Cover Fee Schedules - 1 Nov 2025 Update: NSW fee schedules. Retrieved 11/11/2025 from: https://doctors.ahsa.com.au/hc/en-au/articles/28163123992729

AHSA (1 Nov 2025). Access Gap Cover Fee Schedules - 1 Nov 2025 Update: WA fee schedules. Retrieved 11/11/2025 from: https://doctors.ahsa.com.au/hc/en-au/articles/28163387234969

Bupa (1 Nov 2025). Bupa Australia Medical Gap Scheme Schedule. Retrieved 11/11/2025 from: https://www.bupa.com.au/-/media/dotcom/files/for-provider/bupa-national-medical-no-gap-and-known-gap-scheme-schedule-1st-november-2025.xls

DHDA (28 Oct 2025). MBS Book last updated 31 October 2025, Word version. Retrieved 11/11/2025 from: https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/650f3eec0dfb990fca25692100069854/928fae91a23256aaca258d0d0007eede/$FILE/MBS%20Book%201%20November%202025.DOCX

HCF (1 Nov 2025). HCF Medicover no and known gap rates. Effective 1 November 2025. Retrieved 11/11/2025 from: https://www.hcf.com.au/pdf/provider-portals/HCF_Medicover_Schedule_of_Benefits.pdf

Medibank (1 Nov 2025). Medibank GapCover scheme: Current GapCover rates. Retrieved 11/11/2025 from: https://www.medibank.com.au/content/dam/retail/providers/gap-cover/GapCover_Rates_1_November_2025.xls

nib (1 Nov 2025). nib MediGap Scheme: Schedule of benefits November 2025. Retrieved 11/11/2025 from: https://www.nib.com.au/docs/medigap-schedule-of-benefits-november-2025

[xiv] AHSA (1 Nov 2025). Access Gap Cover Fee Schedules - 1 Nov 2025 Update: NSW fee schedules. Retrieved 11/11/2025 from: https://doctors.ahsa.com.au/hc/en-au/articles/28163123992729

AHSA (1 Nov 2025). Access Gap Cover Fee Schedules - 1 Nov 2025 Update: SA fee schedules. Retrieved 15/11/2025 from: https://doctors.ahsa.com.au/hc/en-au/articles/31566840150809

[xv] APRA (29 Aug 2025). Quarterly private health insurance membership and benefits summary - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/quarterly-private-health-insurance-membership-and-benefits-summary-june-2025

[xvi] APRA (29 Aug 2025). Quarterly private health insurance membership trends - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202025.xlsx

[xvii] APRA (29 Aug 2025). Quarterly private health insurance membership trends - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202025.xlsx

[xviii] APRA (29 Aug 2025). Quarterly private health insurance membership trends - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202025.xlsx

[xix] APRA (29 Aug 2025). Quarterly private health insurance membership trends - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202025.xlsx

[xx] APRA (29 Aug 2025). Quarterly private health insurance membership trends - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202025.xlsx

[xxi] APRA (29 Aug 2025). Quarterly private health insurance membership trends - June 2025. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202025.xlsx

[xxii] DHDA (2025). Private health insurance reform data quarterly trends report – June 2025. Retrieved 10/11/2025 from: https://www.health.gov.au/resources/publications/private-health-insurance-reform-data-quarterly-trends-report?language=en

[xxiii] DHDA (2025). Private health insurance reform data quarterly trends report – June 2025. Retrieved 10/11/2025 from: https://www.health.gov.au/resources/publications/private-health-insurance-reform-data-quarterly-trends-report?language=en

[xxiv] CHOICE (2024). Health insurers are increasing their top-level policy prices by over 30%. Retrieved 16/11/2025 from: https://www.choice.com.au/about-us/media/media-releases/2024/feb/gold-cover-sneaky-tactics

[xxv] PHIO (2024). Public statement: Are health insurers using loopholes to increase premiums? Review of Choice Magazine's analysis about health insurers. Retrieved 16/11/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0026/314828/Public-statement-health-insurers-using-loopholes-to-increase-premiums-December-2024.pdf

[xxvi] Minister Butler (9 Dec 2024). Commonwealth Ombudsman Report into "loopholes" making private health insurance more expensive. Retrieved 16/11/2025 from: https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/commonwealth-ombudsman-report-into-loopholes-making-private-health-insurance-more-expensive

[xxvii] APRA (5 Nov 2019) Operations of Private Health Insurers Annual Report 2018–19. Retrieved 18/11/2025 from: PHI_operations_June2019.xlsx
APRA (29 Aug 2025). Quarterly private health insurance membership and benefits. Retrieved 15/11/2025 from: https://www.apra.gov.au/sites/default/files/2025-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Benefits%20June%202025.xlsx

APRA (29 Aug 2025). Quarterly private health insurance performance statistics – June 2025. Power BI version, page 6. Retrieved 15/11/2025 from: https://app.powerbi.com/view?r=eyJrIjoiZDE1YjVhNjktODViMC00MmYyLWE1N2EtZDA5YTUyMDQ2NWU4IiwidCI6ImMwNWUzZmZkLWI0OTEtNDQzMS05ODA5LWU2MWQ0ZGM3ODgxNiJ9

[xxviii] Minister Butler (19 Sep 2025). Statement of expectations for the 2026 private health insurance premium round. Retrieved 18/11/2025 from: www.health.gov.au/sites/default/files/2025-09/phi-75-25-attachments-2026-private-health-insurance-premium-round-statement-of-expectations.pdf

[xxix] APRA (29 Aug 2025). Quarterly private health insurance performance statistics – June 2025. Power BI version, page 6. Retrieved 15/11/2025 from: https://app.powerbi.com/view?r=eyJrIjoiZDE1YjVhNjktODViMC00MmYyLWE1N2EtZDA5YTUyMDQ2NWU4IiwidCI6ImMwNWUzZmZkLWI0OTEtNDQzMS05ODA5LWU2MWQ0ZGM3ODgxNiJ9

[xxx] APRA (29 Aug 2025). Quarterly private health insurance performance statistics – June 2025. Power BI version, page 6. Retrieved 15/11/2025 from: https://app.powerbi.com/view?r=eyJrIjoiZDE1YjVhNjktODViMC00MmYyLWE1N2EtZDA5YTUyMDQ2NWU4IiwidCI6ImMwNWUzZmZkLWI0OTEtNDQzMS05ODA5LWU2MWQ0ZGM3ODgxNiJ9

[xxxi] PHIO (June 2025). Quarterly update: 1 April to 30 June 2025. Retrieved 26/11/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0031/319549/PHIO-Quarterly-Update-Q3-2024-25.pdf

[xxxii] PHIO (June 2024). Quarterly update: 1 April to 30 June 2024. Retrieved 26/11/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0019/305263/PHIO-Quarterly-Update-Q3-Q4-2023-24.pdf

[xxxiii] PHIO (Mar 2025). State of the Health Funds Report 2023–24. Retrieved 16/11/2025 from: https://www.ombudsman.gov.au/_media/publication-documents/reports/state-of-the-health-funds-reports/State-of-the-Health-Funds-Report-2023-24.pdf

PHIO (June 2025). Quarterly update: 1 April to 30 June 2025. Retrieved 26/11/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0031/319549/PHIO-Quarterly-Update-Q3-2024-25.pdf

[xxxiv] PHIO (Oct 2025). PHIO issues paper: Lessons learned following a major system transformation. Retrieved 16/11/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0034/287098/Private-Health-Insurance-Ombudsman-issues-paper-Lessons-learned-following-a-major-system-transformation.pdf

[xxxv] PHIO (Mar 2025). State of the Health Funds Report 2023–24. Retrieved 16/11/2025 from: https://www.ombudsman.gov.au/_media/publication-documents/reports/state-of-the-health-funds-reports/State-of-the-Health-Funds-Report-2023-24.pdf

[xxxvi] PHIO (Feb 2024). Issues paper: Can private health insurers decide that a patient does not need treatment in hospital? Retrieved 16/11/2025 from: https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/302884/Issues-paper-on-Type-C-certification.pdf