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POSITION STATEMENT

Key principles for private maternity funding

2025

This document outlines the AMA position on key principles that should govern private maternity funding arrangements.

1. The level of funding to support private maternity must support a viable and sustainable service, recognising the importance of maintaining a balanced system of private versus public delivery of services.

2. Policy settings and government funding should provide appropriate incentives and support for patients to access private maternity services led by the doctor of their choice, recognising that maternity care has traditionally been seen as an important part of attracting consumers into and maintaining the value proposition of private health insurance.

3. The Australian Government must review private health insurance product tiers and risk equalisation settings to ensure there are private health insurance policy products that include cover for maternity services that are affordable and accessible when needed.

4. The quality and safety of patient maternity care must be the paramount consideration in the development of private maternity funding models. Funding models must be designed to ensure they fully support high-quality, safe care and do not indirectly compromise that safety and quality through underfunding or conditions attached to receipt of that funding.

5. To ensure that accurate, up-to-date information on the quality and safety of different models of maternity care is available to both policymakers and the public, the Australian Government should urgently fund standardised national data collection and independent analysis of maternity care model outcomes through a public national maternity clinical quality registry that includes a consumer search function.

6. Private health insurance contracts with clinicians for maternity care must not interfere with the clinical autonomy of doctors and other health practitioners involved in the patient's care at any point in their pregnancy, or direct when and where the patient should receive treatment.

7. Patient choice is the foundation of the private health system. Within accepted safety parameters, any patient whose private health insurance covers maternity care must be supported to choose the clinician they want to lead their maternity care and the setting/facility in which they want to give birth.

8. Funding models and private insurance products should recognise the frequent after-hours and emergency presentations involved in obstetric care.

9. Medicare Benefits Schedule (MBS) and private health insurance rebates for medical item numbers relevant to maternity care (including those for general practitioners, obstetricians, anaesthetists, gynaecologists, paediatricians, pathologists, physicians, and psychiatrists) must be corrected to remove gender bias.[i]

10. Correction of gender bias requires increasing rebates for some MBS items, such as the currently inadequate rebates for antenatal consultations and maternity-related diagnostic imaging. In other cases, it requires establishing MBS items and insurer rebates for services that are currently unfunded, such as paediatrician-specific MBS items for private neonate hospital attendances. The inadequacy — or complete absence — of such rebates is threatening the quality, safety, and viability of the private model of maternity care by reducing the viability of private specialist maternity-related practice and increasing out-of-pocket costs for patients.

11. MBS and insurer rebates for private specialist maternity care should also be increased to address the funding shortfall caused by the Medicare indexation freeze (2013–2019) and appropriately indexed each year to the increasing costs of maternity care provision.

12. Privately insured patients requiring maternity care who do not have local access to private maternity units must retain the option to use their private health insurance and choose their doctors in their local public hospitals.

13. Clinicians must be supported to provide birthing services in the hospital/facility/setting the patient prefers, even if the patient's private health insurer does not have a contract with that hospital/facility, without it affecting the medical benefits the private health insurer pays to the patient for the services provided by their clinical care team.

14. The AMA rejects 'bundled' models of private maternity funding as proposed by Private Healthcare Australia that would require a 'lead clinician' (obstetrician, general practitioner, or midwife) to negotiate a single price in advance with all other health practitioners who may need to be involved in the care of the patient and newborn child.

15. Such models are impractical and administratively unworkable and would greatly increase the medico-legal risk of the 'lead clinician'. They may also increase risks to patient safety and reduce continuity of care, not least because the care the patient and newborn child may need cannot be accurately predicted early in the pregnancy, or because clinicians who agreed to the bundled price may be unavailable at the time of the birth.

16. Health funds that choose to introduce bundled funding[ii] for private maternity care must not coerce clinicians in private practice to agree to those bundles by refusing to pay those clinicians the medical benefits they would usually pay for the services those clinicians provide in hospital.

See also:

AMA Women's health position statement 2025

[i] For example, see the AMA submission to the reviews of diagnostic breast imaging services and diagnostic imaging ultrasound services (2024) and the AMA submission on pelvic ultrasound for suspected complex gynaecological conditions (2025).

[ii] In this context, the term 'bundled funding' means the same thing as bundled price.