AMA

2026–2027 Pre-Budget Submission

Pillar 3
Private healthcare

Chapter 3: Private health

Problem statement

The private health system in Australia provides an important complement to the public system, offering patients a wide range of services and greater choice in their care. Private hospitals account for about two in five hospitalisations and seven in ten planned surgeries in Australia.[i] Retaining a strong private hospital sector reduces demand on the public health system, enables patients to have more control over their healthcare, and encourages innovation and quality improvement in healthcare services.

Private hospitals are largely funded by private health insurance (81.7 per cent[ii]), and a healthy fiscal balance between the two supports a sustainable private system. However, this balance has not always been achieved. In the lead-up to the COVID-19 pandemic, private health insurers came under increasing pressure as participation rates declined, the insured population aged, and members were more likely to use their cover — continuously increasing insurer's outlays.

During the pandemic, participation rates rose (more Australians taking out private health insurance) while outlays decreased (less benefits paid out by insurers) due to the impact of lockdowns and workforce shortages, which lowered activity and claims. This strengthened the fiscal position of private health insurers, resulting in several years of record reported profits. Yet for private hospitals, this same low activity combined with rapidly rising costs (including wages, utilities, and consumables) and low indexation in existing contracts caused significant financial strain, leading to the closure of services, beds, and even entire hospitals. These closures make the case for the necessity of clinical leadership and should underline their requirements to act in the best interests of the community they serve.

Notwithstanding the recent increase in insurance uptake, people aged 60 years and over are set to become the largest insured population in the foreseeable future, while many younger and healthier Australians are increasingly opting for reduced cover. As the insured population ages, they are more likely to draw on their insurance to access care, and with fewer younger, healthier people in the system, pressure on insurance premiums will rise.

Consumers are paying more for their private health insurance products through higher premiums but are receiving less back from insurers when claiming for their care.

The Private Health CEO Forum, established following the completion of the Private Hospitals Viability Health Check in mid-2024, was welcomed by the AMA as a positive step and has been tasked with finding solutions to ensure private hospital viability.

Policy proposals

Fund hospital-in-the-home

This section draws on the AMA position statement Principles for private health insurance to cover out-of-hospital care from December 2024.

The AMA supports a wider range of hospital-in-the-home programs available to patients. However, the absence of clear rules governing the provision of private out-of-hospital care in Australia limits patient access to innovative models of care, such as home rehabilitation or hospital-in-the-home.

The AMA notes several private health insurers have developed their own models. However, these programs are designed to funnel patients into in-house services. Instead of expanding access to alternative models of care, they effectively control which services are available to patients and what those services can charge — through vertical integration and manage care.

There are many procedures for which clinically suitable patients should be able to access out-of-hospital care, such as rehabilitation following hip and knee replacements. Access should not be restricted to certain patients in specific areas who hold particular private health insurance policies.

To improve access to hospital-in-the-home services for privately insured patients, the AMA proposes the government work with stakeholders to develop and mandate a minimum payable benefit for out-of-hospital models of care in the private health system. This should be underpinned by legislative arrangements that enshrine patient safety, protect patient choice, and maintain clinical autonomy.

Risks and implementation

It is crucial to establish regulations, rules, and standards to ensure genuine contestability of services and equitable access to out-of-home models of care in the private health system. We envision a private health system in which, regardless of where they live in Australia, all patients with appropriate private health insurance cover can choose the best care option for themselves under the clinical guidance of their medical practitioner, funded by their private health insurer.

In our position statement Principles for private health insurance to cover out-of-hospital care, we set out principles that should define private out-of-hospital care. These include:

1. Protection of patient choice and clinical autonomy.
2. Quality and safety standards.
3. Effective management of patient deterioration and re-escalation of care.
4. A clear and equitable funding mechanism.

Risks of not taking action

The AMA supports greater provision of out-of-hospital care and services within the private health system. A considerable amount of evidence, much of which is cited in the AMA report Out-of-hospital models of care in the private health system,[iii] suggests well-designed out-of-hospital models of care, when applied in clinically appropriate cases, can offer substantial benefits for patients, hospitals, and the health system.

For patients, these benefits may include improved health outcomes — for example, through a reduced risk of hospital-acquired infections. The ability to recover in the comfort of home, better manage caring responsibilities, and, where appropriate, continue working from home can all help reduce stress and anxiety during treatment and recovery.

Furthermore, patients who do not need to travel back and forth to hospital for treatment may benefit from reduced time commitments, less discomfort, and lower travel costs — particularly those living in regional and rural areas who may be a significant distance from the nearest hospital. With respect to benefits for hospitals and the wider health system, out-of-hospital care also provides an efficient way for hospitals to manage bed flow, thereby reducing pressure and potential wait times for patients.

In some cases, it is cheaper to deliver care in the home, as overheads are far greater when a patient is admitted overnight. Improvements in the private system will help relieve pressure on public hospitals, reduce pressure on private health insurance premiums, and offer better value for taxpayers. However, it is critical out-of-hospital care in the private system is equitable and clinically led, rather than the current model, which is largely insurer-led and only available to patients with specific private health cover policies in certain areas of Australia.

Timeframe and costing

Under this proposal, hospital-in-the-home services would be funded through a patient's private health insurance and private health insurers have generally described this as likely to result in significant cost

savings. The development of a robust framework and funding model would be led by the Department of Health, Disability and Ageing, using existing resources.

This concept is something the department has previously identified as a reform that could potentially be delivered in the short term.

Establish a Private Health System Authority

This section draws on the AMA research report A whole of system approach to reforming private healthcare, with some of the modelling adapted and extended to provide for estimates for the period between 2026–27 and 2029–30.

Regulatory arrangements were designed at a time when private health insurance was in a strong position, with high membership, when most private health insurers operated on a not-for-profit basis, and when private hospitals had larger profit margins. These arrangements remain effective in protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare. However, they offer limited flexibility for government policy to keep pace with a changing population, market imbalances in negotiated contracts, and economic shocks.

The AMA continues to call for the establishment of an independent and well-resourced Private Health System Authority to address gaps in the regulatory environment and to independently oversee the private healthcare system.

This independent umpire would have the capacity, objectivity, and expertise to ensure the system evolves in line with government policy, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors. It would also provide a platform for all the stakeholders in the sector to come together and agree on the necessary once-in-a-generation reforms required to ensure the future viability of private healthcare in Australia.

Risks and implementation

An independent authority would consolidate regulatory functions previously carried out by other parts of government and agencies, enabling them to operate in a more cohesive and effective way. This would include relieving the department of its conflicted role as both regulator and policy maker.

It would also incorporate new functions and skills to address gaps in the regulatory environment, while supporting the regulatory and advisory functions performed by other agencies. Cost transfers for existing functions carried out by other agencies, as well as additional costs, would be required. Sufficient transition time and resources should be allocated to ensure this is done effectively; however, overall costs are not anticipated to be high.

Risks of not taking action

The current private health regulation and legislative framework is complex and limits innovation and reform. Additionally, the mechanisms in place to ensure the private health system evolves in a lasting way, as government policy intends, are limited and ad hoc. There are also few whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors are considered and balanced.

The private health system is already lagging in terms of reform, particularly in relation to out-of-hospital models of care, as outlined above. This will continue if the regulatory and legislative frameworks remain unfit for purpose. Furthermore, gaps in regulation affect patients through unexpected out-of-pocket costs, restricted choice, and added complexity.

Timeframe and costing

The direct cost of establishing an independent authority, which does not exist, is difficult to estimate; however, an indicative estimate can be made using similar agencies as a proxy.

At present, the Australian Prudential Regulation Authority (APRA) provides prudential regulation of private health insurers. APRA reported its total operating expenditure for the 12 months to 30 June 2025 was $229 million[iv] (the most recent data available). In 2023–24, APRA also collected $240.7 million in levies to recover

costs,[v] $10 million of which was directly attributed to revenue levied against private health insurers.[vi] In 2024–25, APRA regulated a total of 30 insurers.[vii]

This role, currently performed by APRA, represents only one of an expanded set of roles envisioned for the proposed authority. Therefore, additional funds would be required to fulfil these extra functions. The total annual cost of the proposed authority is estimated in the table below, which includes the $10 million[viii] cost reallocated from APRAs responsibilities.

An additional $11 million is estimated to be required to establish the new authority and consult with stakeholders regarding its ongoing roles and responsibilities. If cost recovery were undertaken, this $11 million would be the only net cost to government between 2026–27 and 2029–30.

Table 1: Cost of a Private Health System Authority

	2026–27	2027–28	2028–29	2029–30	Total
Establishment cost ($m)	$11.0				$11.0
Ongoing cost ($m)	$33.3	$34.8	$36.5	$38.3	$142.8
Total cost to government ($m)	**$44.3**	**$34.8**	**$36.5**	**$38.3**	**$153.8**

Mandate a minimum payout

This section draws on the AMA report The repeat prescription for private health insurance, with some of the modelling adapted and extended to provide estimates for the period between 2026–27 and 2029–30.

Private health insurers have been generating significant profits since the COVID pandemic, returning some of these to consumers who were unable to access care using their insurance due to lockdowns and restrictions on planned surgery, while still reporting substantial profits. In the 12 months to 30 June 2025, private health insurers reported an after-tax profit of $2.1 billion,[ix] up from $1.8 billion the previous year.[x] A significant share of this profit was the result of higher investment returns, which rose materially in line with higher market interest rates.

Despite rising premiums and increasing memberships, these gains did not flow through to private hospitals. Private hospitals were severely impacted by fixed costs during the pandemic and the slow return of activity, further exacerbated by rapidly increasing costs and supply disruptions. Compounding these issues, many contracts between private hospitals and private health insurers last two to three years and did not anticipate the post-pandemic inflation that eventuated. As a result, several private health insurers posted near-record profits, while hospitals claimed underfunding, with insurers paying a smaller share of their total premium revenue to them.

Private health insurers generally aim to set premium levels to cover the expected benefit costs (the amount paid for members' medical treatment), as well as their own management expenses. Management expenses represent the portion of premiums per policy used to operate the business of the insurer. All private health insurers incur management expenses, and depending on their size, market share, and whether they are for-profit or not-for-profit, they can include varying marketing costs, salaries, overheads, incidental expenditure (such as cyber security upgrades to systems), and profit margins that must be built into these expenses.

The benefit payout ratio is the proportion of benefits paid out for patient care compared to the premium revenue generated over a given period. When management expenses account for a higher share of payments, a smaller proportion of premiums is directed toward treatment.

There is no government policy directing or indicating what the payout ratio should be. However, the Minister for Health, Mark Butler, asked private health insurers in March 2025 to outline steps to increase their payout rate,[xi] which has dropped in recent years to 84 per cent in 2024–25, even as their profits have increased. The impact of this directive remains unclear

The AMA agrees to improve the value proposition of private health insurance, there should be a mandated minimum return amount (e.g., 90 per cent) to the health consumer for every premium dollar paid. A standardised return higher than the current private health insurance industry average is needed.

Risks and implementation

The federal government increasingly plays a role in promoting private health insurance, particularly given its involvement in recent reforms and its contributions to supporting access (such as the private health insurance rebate).

As the department is both the policymaker and regulator, there is a risk that this conflict of interest may affect reforms (such as a minimum payout) if issues arise during implementation. Establishing an independent Private Health System Authority could help mitigate this risk. Furthermore, some private health insurers may resist a mandated minimum payout, as it could affect their viability. A Private Health System Authority would be well placed to determine an appropriate minimum payout while also ensuring private health insurers remain solvent.

Risks of not taking action

Negative media coverage about the lack of value in private health insurance, coupled with a focus on the profit margins of for-profit providers, erodes the perceived value of private health insurance in the eyes of the public. In addition, many private hospitals are struggling to remain viable. This issue needs to be urgently addressed, particularly if the federal government is called upon to invest additional taxpayer funds in the private health system, or if a significant number of private patients are forced to turn to the public sector because private services are no longer available. Australians therefore need assurances their investment in private health insurance will be returned in the form of appropriate coverage for services when it is needed.

Since the AMA first called for this reform, the payout ratio has dropped a further 2 per cent of the base hospital premium paid as hospital benefits. The latest APRA Quarterly private health insurance performance statistics show hospital treatment benefits of $19.4 billion, compared with premium revenue of $23 billion across the past four quarters, meaning the payout ratio is now 84 per cent. In addition, funds can now generate much higher investment income from premiums than the recent past, further enhancing their profitability.

Timeframe and costing

The direct cost to government of increasing the minimum payout ratio is zero. However, there would be indirect costs — the two main components being: (1) additional private health insurance policies leading to higher government outlays for the private health insurance rebate, and (2) lower rebate outlays from a reduction in the base premium. Some of these indirect costs may be offset by fewer patients attending public hospitals.

A behavioural shift towards more private health insurance policies would mainly occur among those not subject to tax penalties or incentives — that is, individuals earning $97,000 or less — as well as among those less likely to claim, given people with high expected claims are likely to already hold a policy.

With more people taking out private health insurance policies, there would be ‘second-round effects’ of lower premiums, further boosting uptake, including among those earning more than $97,000. These second-round effects are not estimated or included in the costs.

The policy itself would not encourage as many people over the age of 65, or those subject to Medicare Levy Surcharge, to take out private health insurance, as these groups already receive a larger benefit on average (through greater use) or a much stronger price incentive under existing policies. The policy is projected to result in net savings for the government of $219 million over the four years from 2026–27 to 2029–30.

Table 2: Impact of implementing a 90 per cent minimum payout ratio

	2026–27	2027–28	2028–29	2029–30	Total
Direct change in premium (%)	-6.39%	-6.39%	-6.39%	-6.39%	
Additional private health insurance policies	276,100	274,370	272,450	272,500	
Additional rebate for additional policies ($m)	$167	$169	$172	$175	$684
Reduction in rebate from lower premiums ($m)	$226	$226	$226	$226	$903
Total cost to government ($m)	**-$58**	**-$56**	**-$54**	**-$50**	**-$219**

Note: totals may not sum exactly due to rounding

Increase the Medicare Levy Surcharge

This section draws on the AMA report The repeat prescription for private health insurance, with some reworking of the modelling adapted and extended to provide estimates between 2026–27 and 2029–30.

Originally introduced in July 1997 for income earners over $50,000, the 1 per cent Medicare Levy Surcharge (MLS) was designed to encourage those who could afford it to take up private health insurance. The key policy principle behind the MLS was that higher-income earners who did not have private health insurance were penalised with a higher surcharge.

At the time, an income of $50,000 was the threshold for the highest income bracket of taxation, with a marginal rate of 47 per cent. The comparable threshold is now $190,000 where marginal tax is paid at 47 per cent (a 45 per cent marginal tax rate plus a 2 per cent Medicare levy).[xii] The additional MLS is now levied at the rates of 1 per cent, 1.25 per cent, or 1.5 per cent, depending on taxable income.[xiii]

The policy intent behind the MLS has been eroded by the federal government, which froze and applied low indexation to the high-income bracket threshold over several years. This was only recently unfrozen in 2023–24. Until recently, growth in premiums outstripped low wage growth, compounding the impact. For some cohorts, this has led to the perverse outcome of the MLS being applied to people at lower income levels than originally intended. However, the amount levied is less than the rate likely to be paid for a reasonable private health insurance product, due to increased premiums.

The AMA is calling for the MLS settings to be reconsidered, to ensure they best deliver on the original policy intent.

Risks and implementation

In implementing changes to the MLS, the federal government must consider which other policy levers (specifically lifetime health cover (LHC) and the private health insurance premium rebate) may also need adjustment to ensure changes to the MLS have the desired impact. For example, if the proposed changes are applied to the MLS without corresponding incentives for LHC, the effect will be to raise more revenue but reduce the number of additional private health insurance policies.

Any changes to policy levers must be carefully calibrated, as the settings for each lever have a powerful impact on the equity, efficiency, and effectiveness of the others. They also strongly influence the viability of other foundational policy settings, including community rating, the mixed public/private system, and the clinical autonomy of medical practitioners. It is critical changes improve the value proposition of private health insurance for patients.

To achieve this, the policy levers must be reviewed regularly, and an evidence-base generated to support decision-making. As outlined in the AMA's discussion paper A whole of system approach to reforming private healthcare, this is one of the key roles suggested for the Private Health System Authority.

Risks of not taking action

For Australians to take out private hospital insurance and maintain coverage throughout their lives, they must perceive value in the product they are purchasing. Private health insurance products must not only deliver value to consumers for the amount they pay but also be easy for them to understand. If changes to the MLS are not made, there is a risk the effectiveness of the MLS will decline.

Timeframe and costing

For the purpose of this costing, the AMA has demonstrated the impact of increasing the MLS to 2 per cent for those earning $118,001 or more. The total cost to government across the forward estimates is estimated at $1.5 billion. The primary source of this cost to government is the reduction in the MLS collected. This would also represent a saving to households. This policy cost estimate does not include any increase in the private health insurance rebate rate.

Many more households are now falling into these higher tiers as a result of the prolonged freeze in the thresholds. So far, there has been only a tepid response to the MLS disincentive in recent years, following a jump in nominal incomes post-COVID. The MLS is now a significant tax revenue driver, expected to collect more than $1 billion in revenue per year under the current policy settings.

Table 3: Impact of increasing Medicare Levy Surcharge to 2 per cent for people currently earning $118,001 or greater

	2026–27	2027–28	2028–29	2029–30	Total
Additional private health insurance policies	294,770	309,310	325,410	341,720	
Rebate for additional private health insurance policies ($m)	$62	$67	$73	$79	$202
Reduction in Medicare Levy Surcharge revenue ($m)	$452	$498	$547	$628	$1,497
Reduction in average premium (%)	1.4%	1.5%	1.6%	1.7%	
Save (Clawback of rebate) from lower premium ($m)	$60.2	$65.1	$70.4	$76.1	$196
Total cost to government ($m)	**$454**	**$500**	**$550**	**$631**	**$1,503**

Note: Totals may not sum exactly due to rounding.

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