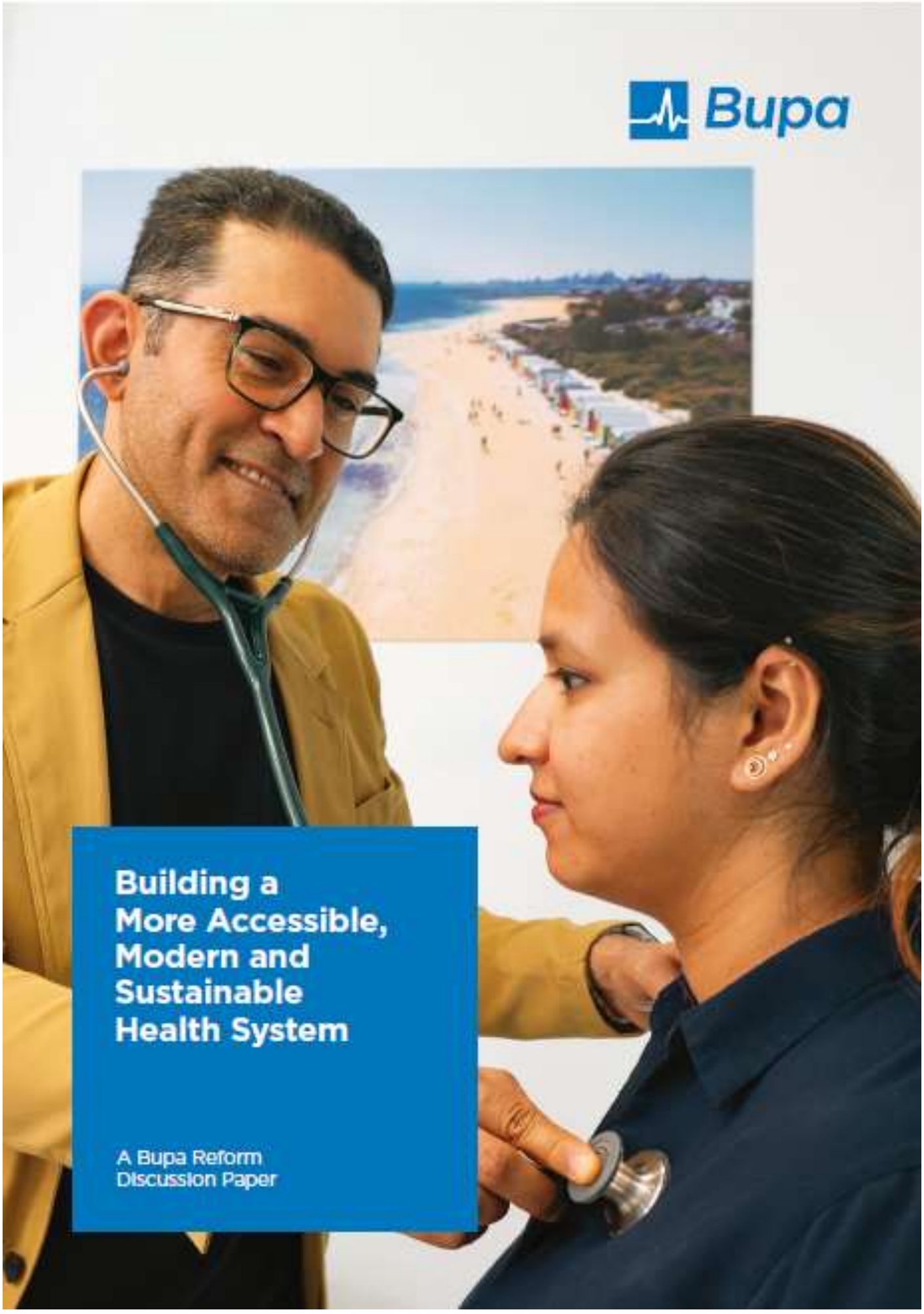
Bupa



Building a More Accessible, Modern and Sustainable Health System

A Bupa Reform Discussion Paper

About Bupa

Bupa is an international healthcare group which has been committed to a purpose of helping people live longer, healthier, happier lives and making a better world for more than 75 years.

Bupa Australia supports customers through a broad range of health and care services including health insurance, aged care, dental, medical, optical and hearing services.

Bupa Health Insurance has one of the largest hospital networks in Australia, providing high-value cover to 4.5 million members.

Bupa Health Services operates 32 medical centres (including four Urgent Care Clinics), 13 mental health clinics, over 170 dental clinics, and 49 optical and hearing stores. These health services are open to everyone, not just Bupa Health Insurance customers. We also partner with the Australian Government to deliver visa medical checks to migrants, and health services to Australian Defence Force (ADF) personnel and veterans.

Bupa Villages and Aged Care is one of Australia's largest aged care providers offering a wide range of residential aged care services. As a trusted care provider, we currently operate 57 residential aged care homes across four states, employing around 7,000 team members and caring for more than 5,500 residents.

About Mandala Partners

Mandala is an economics research and advisory firm. Mandala studies some of the most pressing public policy challenges facing businesses and governments, and specialises in combining analytics and policy expertise to generate fresh insights and perspectives. Mandala's clients span government, industry bodies, and businesses across sectors including health, social care, technology, financial services, energy, and the land sector.

Contents

Executive Summary

Australia's health system is facing growing pressure from an ageing population, rising chronic disease, increasing mental ill health, workforce shortages and escalating healthcare costs. While the system continues to deliver strong outcomes, maintaining the status quo will not be sufficient to meet future demand or consumer needs and expectations.

Bupa has developed this discussion paper to contribute to the national reform agenda and to provide recommendations on the areas that we believe would benefit from reform to help make a more accessible, affordable and sustainable health system for all Australians. The paper is offered as a starting point for collaboration and progression with governments, providers, consumers and industry stakeholders, recognising that no single organisation can deliver reform alone.

The paper argues for a shift from a health system focused on treating illness to one that invests more heavily in prevention, early intervention, coordinated care and innovative service delivery. It sets out four priorities:

1. Strengthen access to preventive and primary care

The paper recommends reforms to strengthen primary care as the foundation of the health system, recognising that prevention and early intervention remain underfunded despite growing rates of chronic disease and avoidable hospitalisation. Key reforms include expanding multidisciplinary team-based care, introducing more flexible and blended funding models, strengthening workforce capacity, and supporting better coordination of care. These reforms would enable primary care providers to focus on prevention, long-term condition management and improved patient outcomes rather than episodic treatment alone.

2. Scale innovative models of care

Australia's funding and regulatory frameworks have not kept pace with modern models of care that can safely deliver services closer to home. The paper proposes reforms to support Hospital in the Home in the private sector, virtual care, community-based mental health services and insurer-funded prevention programs. These reforms would enable more care to be delivered outside traditional hospital settings, improve consumer choice and experience, reduce avoidable hospital admissions, and make better use of limited workforce capacity.

3. Restore specialist care access and affordability

The paper proposes reforms to improve fee transparency and consumer protections, modernise referral arrangements and improve access to specialist services. These reforms are complemented by recommendations to strengthen specialist workforce planning, expand clinical training pathways, and improve collaboration between GPs and specialists through shared-care models and national secondary consultation services. Together, these measures would improve affordability, reduce unnecessary delays and ensure specialist expertise is used more effectively.

4. Strengthen long-term sustainability

To ensure Australia maintains strong and sustainable health system, the paper recommends reforms to increase private health insurance participation, modernise product design, improve transparency across the private hospital sector, complete Prescribed List reforms and strengthen the effectiveness of Risk Equalisation arrangements. These reforms seek to support affordability, encourage participation among younger Australians, improve system efficiency and strengthen the sustainability of Community Rating.

The paper proposes a five-year reform roadmap, combining immediate actions with longer-term structural reforms. Bupa believes private health insurers, governments, providers and consumers all have a role to play in building a more accessible and modern health system. These recommendations aim to create a more preventive, consumer-centred and sustainable health system that delivers better outcomes for Australians while preserving the strengths of both the public and private sectors.

Introduction: The case for reform

Australia's health system has delivered strong outcomes for decades, but pressures around access, affordability and sustainability are having a significant impact. Workforce shortages, rising out-of-pocket (**OOP**) costs, growing demand for chronic disease management and inequitable access to care are making timely, affordable care harder to obtain. There is an opportunity for Australia to adopt a more modern healthcare system that can better meet the needs of Australians. Importantly, Bupa believes reform should support care that is:

- More relevant to people's needs and preferences;
- More accessible across different settings;
- More affordable for consumers; and
- Better enabled by digital tools and data.

A more digitally connected health system will also be better placed to support new models of care and adapt to the changing way health services are delivered.

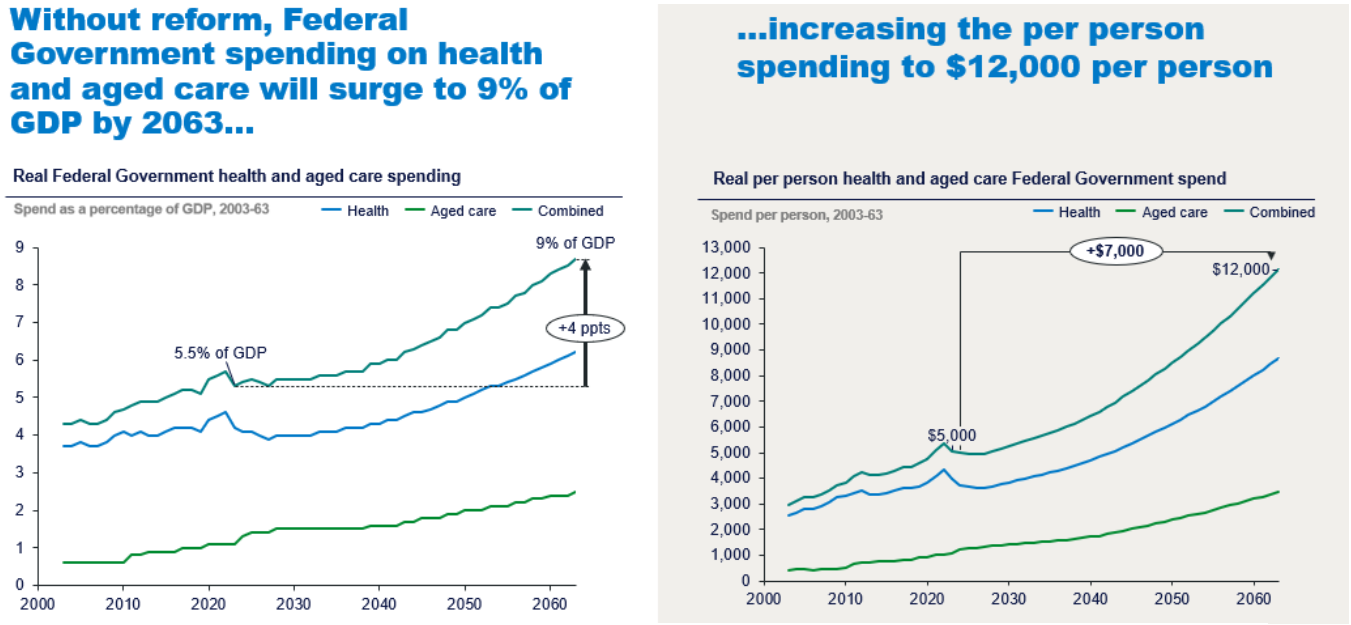
Current system

Australia's health system is based on a mixed funding model, combining public and private sources. This is both a historical strength and a strategic opportunity. In 2023-24, the Australian Government contributed $106.2 billion (around 4 per cent of Australia's annual GDP) to health expenditure, including funding for Medicare, preventive health programs, health protection initiatives and mental health services.[1]

Alongside government funding, more than half of Australians have some form of private health insurance (**PHI**), one of the highest levels in the developed world.[2] PHI paid nearly $27.4 billion in healthcare benefits over the 12 months to March 2026, with the vast majority directed to hospital treatment and a further $7 billion supporting dental and allied health services through extras cover.[3]

Amid rapidly rising costs and with Australia facing significant fiscal challenges, including a structural deficit, governments cannot, and should not, meet health reform costs alone. Private sector participation is both essential and beneficial to complement and support services offered by the public health sector. 2026 modelling by Mandala Partners indicates that, without significant reform, Australian Government spending on health and aged care will grow to 9 per cent of GDP by 2063, with per person expenditure rising from approximately $5,000 to $12,000.

[1] Australian Institute of Health and Welfare (AIHW), *Health Expenditure* (Web Page, 29 October 2025).
[2] Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Benefits Summary: March 2026* (Web Page, 11 June 2026).
[3] Ibid.



Analysis by Mandala Partners 2026 This data only includes Federal Government spending on health, not total Australian health spending. Source: Australian Government, *2023 Intergenerational Report: Australia's Future to 2063* (Report, The Treasury, 24 August 2023).

Converging pressures making meaningful reform urgent

The convergence of several systemic issues also makes the need for reform critical.

Issue 1: Ageing population

Australians over the age of 65 make up 18 per cent of the population today but will comprise 23 per cent of the population by 2050. This cohort already accounts for a disproportionate share of healthcare utilisation:

- 30 per cent of unreferred GP consultations
- 22 per cent of ED presentations
- 46 per cent of avoidable hospitalisations

Australia's ageing population is increasing demand for aged care and placing pressure on public hospitals, particularly in rural and regional areas. In New South Wales, the number of patients ready to leave hospital but unable to access an aged care placement increased from 300 in December 2023 to 776 in 2025.[4]

National demand for residential aged care is projected to more than double, from 198,302 people in 2024 to 409,677 by 2044, requiring around 10,600 additional places annually over the next 20 years, equivalent to a new average-sized aged care home opening every three days.[5] Without sufficient growth in aged care capacity, more older Australians will remain in hospital while awaiting care. As Australians continue to live longer, they are also experiencing increasing rates of chronic and complex disease which require ongoing care and support. Around six in ten Australians will live with at least one long-term health condition, many requiring ongoing specialist assessment and treatment.[6] [7]

Issue 2: The rise of chronic illness

The rise of chronic illness in Australia is also determining how we manage health care delivery into the future. In Australia,15.4 million people are living with one or more ongoing health challenges, requiring continuous, coordinated care rather than the episodic treatment the system was built around.[8] In Australia, chronic conditions account for around 84 per cent of the total burden of disease and 91 per cent of the non-

[4] New South Wales Government, *Productivity & Equality Commission Inquiry into Stranded Aged Care Patients* (Media Release, 25 June 2025).
[5] Department of Health, Disability and Ageing (Cth) (DoHDA), *Independent Review of Residential Aged Care Accommodation Pricing* (Final Report, April 2026) vi.
[6] AIHW, *Australian Burden of Disease Study 2023* (Report, 2023)
[7] AIHW, *Australia's Health 2024: Data Insights* (Report, 2024).
[8] Ibid.

fatal burden, highlighting the importance of funding arrangements that support earlier intervention and proactive management of long-term health conditions.[9]

The case for prevention is clear but difficult to measure. While Medicare's fee-for-service design funds individual episodes of care, it is poorly suited to prevention and coordination. As demand for health services continues to increase, investment alone will not be enough. We must look at preventive health models to help slow this rise.

Issue 3: The increasing cost and incidence of Mental Health

Australia's mental health system increasingly emphasises prevention, early intervention and community-based care, yet funding mechanisms remain largely geared towards treatment after illness has escalated. Private health insurers can contribute to treatment once a person's condition has deteriorated sufficiently to require hospital admission but have comparatively limited capacity to support interventions that could prevent deterioration in the first place.

Around one in five Australians experience a mental disorder each year, rising to almost two in five people aged 16-24.[10] Mental health expenditure increased from $12.7 billion in 2019-20 to $14.5 billion in 2023-24, including $9.1 billion for specialised mental health services and $3.8 billion for public hospital services.[11] Mental health conditions and substance use disorders combined are the second most burdensome disease group in Australia after cancer, accounting for 15 per cent of total disease burden in 2024.[12] The burden rate has increased 31 per cent between 2003 and 2024.[13] However, funding responsibilities remain fragmented across Commonwealth and state programs, limiting opportunities to deliver more integrated and preventive care.[14]

Issue 4: Demand is shifting away from traditional hospital care

Demand is increasingly shifting away from traditional hospital-based care, yet funding and regulatory settings have not kept pace. Same-day hospitalisations are growing faster than overnight admissions, particularly in private hospitals, highlighting the need for more flexible models of care.[15] In 2022-23, Australia recorded 158,900 Hospital in the Home (HITH) separations, but only 6,400 (4 per cent) occurred in private hospitals.[16] At the same time, providers are expanding virtual care, with St Vincent's Health Australia, one of Australia's largest health providers, aiming to deliver 50 per cent of health and aged care services at home or virtually by 2030, including an additional one million virtual patient interactions.[17]

Consumers increasingly expect healthcare to be convenient, connected, digital and personalised, wanting more control over their own health and greater flexibility and support to stay well and access care. Traditional models based around face-to-face, hospital-centric care are struggling to meet this expectation and the current funding and regulatory frameworks are struggling to keep up.

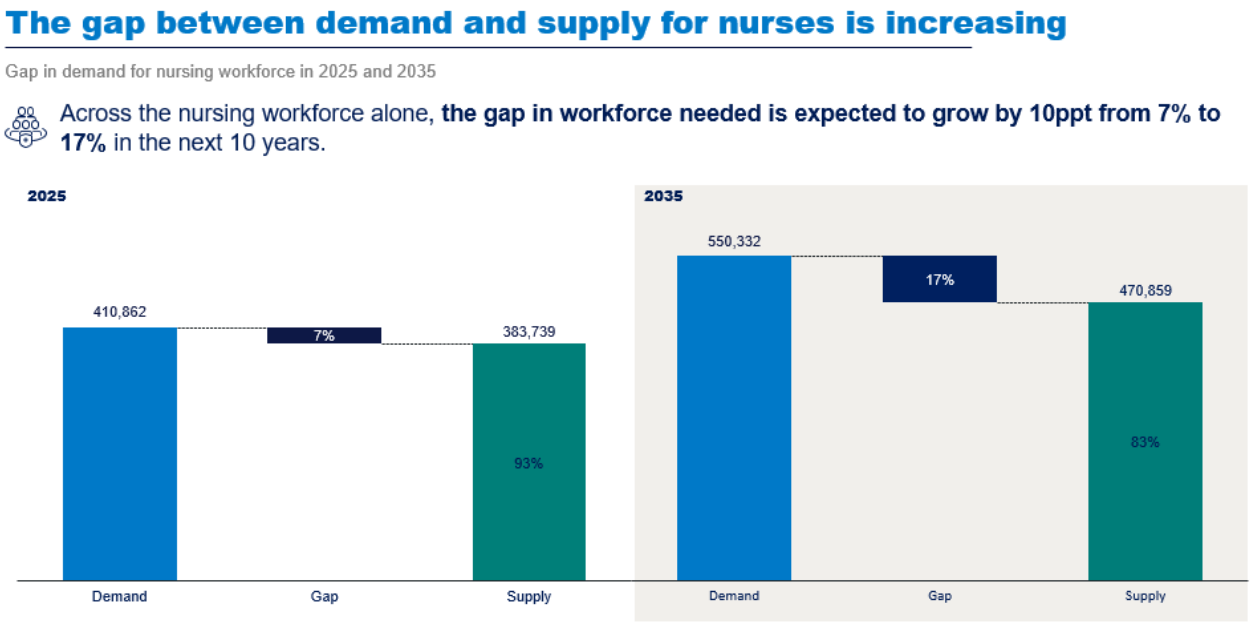
Issue 5: Workforce pressures

Workforce shortages are placing increasing pressure on Australia's health system. The Department of Health, Disability and Ageing (**the Department**) projected a General Practitioner (**GP**) shortfall of more than 800 in 2024, rising to more than 2,600 by 2028 and 8,600 by 2048.[18] At the same time, four in ten GPs are aged over 55, increasing retirement-related workforce pressures.

Specialist shortages are also expected to grow, reaching 6,981 full-time-equivalent specialists by 2033 and 12,812 by 2048.[19] Australia is increasingly reliant on internationally trained doctors, with annual overseas entrants now exceeding domestic medical graduates.[20] Modelling by Mandala Partners indicates that

[9] Ibid; AIHW, *The Ongoing Challenge of Chronic Conditions in Australia* (Web Page, 2 July 2024).
[10] AIHW, *Prevalence and Impact of Mental Illness* (Web Page, 24 June 2025).
[11] AIHW, *Expenditure on mental health related services* (Web Page, 8 July 2025).
[12] AIHW, *Mental illness burden of disease* (Web Page, 13 August 2026).
[13] Ibid.
[14] Productivity Commission, *Mental Health and Suicide Prevention Agreement Review* (Inquiry Report, October 2025) 37.
[15] AIHW, *Hospitalisations and Patient Days* (Web Page, 22 May 2026).
[16] Ibid.
[17] St Vincent's Health Australia, 'Half of St Vincent's Health and Aged Care to Be Provided at Home or Virtually by 2030' (Media Release, 25 November 2025)
[18] DoDHA, *GP Supply and Demand Study Compendium* (Report, August 2024) 8.
[19] DoDHA *Whole of Medical Workforce Supply and Demand Compendium Report* (Report, June 2026) 3.
[20] Ibid.

nursing shortages are also forecast to worsen, with the gap between demand and supply growing from 7 per cent in 2025 to 17 per cent by 2035, as demand rises to more than 550,000 nurses and supply meets only 83 per cent of that need. These workforce pressures are increasing costs and making it harder to access care, particularly in rural and regional communities.[21]



Analysis by Mandala Partners 2026 Source: Australian Government Department of Health and Aged Care, *Nursing Supply and Demand Study 2023–2035* (Report, 2024).

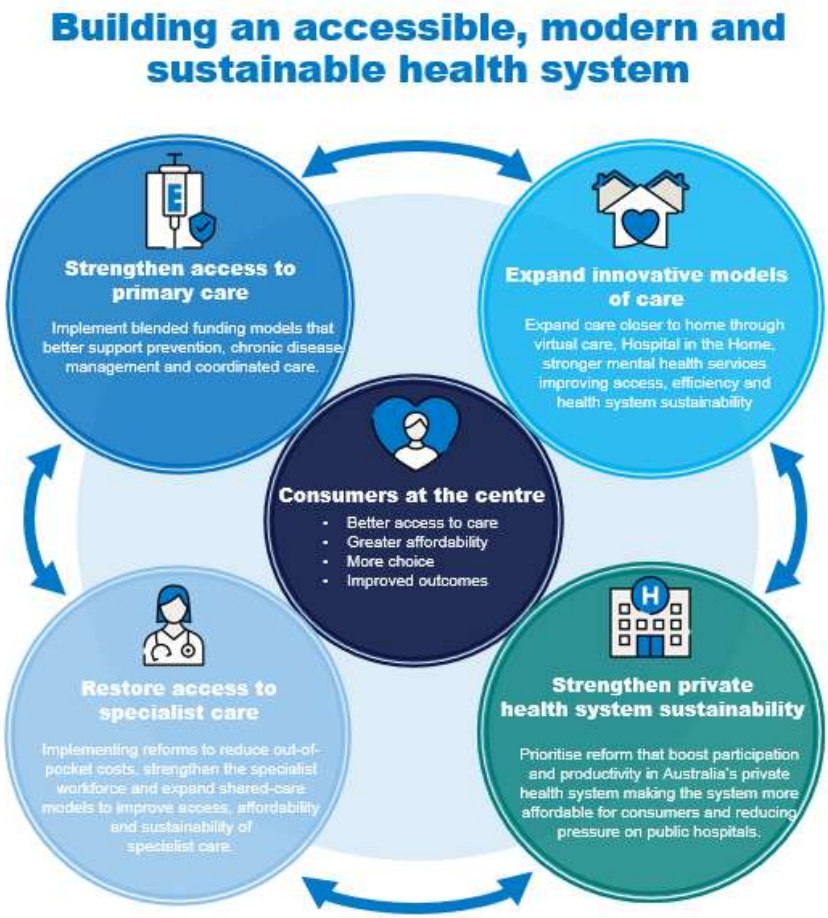
The case for reform

With the list of converging issues, and the growing appetite from consumers to look at how we can deliver care more effectively, Bupa wants to support health system reform with humility and in a genuine spirit of partnership. We want to play our part and work with governments and key sector stakeholders to drive reform and modernisation that improves the health and wellbeing of all Australians.

We know that earlier intervention, improved access to community-based care and more effective management of chronic and complex conditions, can reduce avoidable hospital admissions, improve workforce participation and reduce pressure on both the private and public hospital systems. Better alignment of financial incentives therefore has the potential to deliver broader productivity gains across the health system and economy, while improving consumer value and health outcomes.

Private Health Insurers are largely an untapped resource, that, if empowered by the right reforms, could help build a stronger prevention system focused on intervening before conditions develop. Insurers have unique attributes that can help strengthen and expand prevention in the health system. Improving health outcomes through better management of chronic disease and reduced hospitalisations is key, and reorienting our healthcare system towards prevention and integrated, person-centred care, delivered by a flexible, multidisciplinary workforce and enabled by technology is a large part of the solution to tackling chronic disease.

Health reform is complex and will take time, but targeted regulatory reform could help build momentum and begin addressing the pressures already facing the system. Customer-centred reform is key, and would deliver more personalised care, better access, stronger partnerships, and a healthcare system that evolves with people's needs.



Bupa's four connected system goals will help drive sensible, foundational reform across the sector and realise the vision of a more accessible, modern and sustainable health system:

1. Strengthening access to primary and preventive care by making it easier for people to access affordable, coordinated support earlier, before conditions become more complex and costly.
2. Accelerating innovative models of care by supporting safe and effective alternatives to traditional settings where they can deliver better experiences and outcomes.
3. Improving access and affordability in specialist care so consumers have greater visibility, choice and support when accessing specialist services.
4. Supporting long-term health system sustainability by ensuring Australia retains strong public and private health systems that support access, affordability and patient choice.

The chapters that follow set out the specific reforms Bupa believes are needed to achieve these goals.

Importantly, this paper is not intended to be a definitive blueprint for reform, nor does Bupa suggest that any one organisation has all the answers. The challenges facing Australia's health system are complex, interconnected and cannot be solved by any party acting alone. This paper is therefore offered in a spirit of partnership and collaboration. It represents Bupa's contribution to a broader conversation about how we can work together to improve health outcomes, strengthen sustainability and build a system that better meets the needs and expectations of Australians.

This paper is intended as a starting point, not an end point. We have focused on practical reforms that are customer-centred, evidence-informed and capable of supporting meaningful progress over time. Some proposals may be ready for implementation now, while others will require further consultation, testing, modelling and refinement. We expect these ideas will continue to evolve through engagement with governments, clinicians, consumers, researchers and industry stakeholders. Our objective is not to prescribe a single pathway forward, but to help identify shared priorities and contribute to a practical, achievable reform agenda that supports Australians and the long-term sustainability of the health system.

Chapter One: Strengthening Access to Affordable Preventive Primary Care

Introduction

Australia's primary care system is under growing pressure from rising chronic disease, workforce shortages, affordability barriers and growing demand for coordinated care. Australians spend almost 11 years in ill health, much of it associated with preventable or manageable conditions.[22] In 2023-24, there were approximately 788,000 potentially preventable hospitalisations, costing an estimated $7.7 billion or 8.5 per cent of total admitted patient expenditure.[23] When people cannot access timely primary care, chronic conditions can worsen, leading to poorer health outcomes and avoidable hospital use. Strengthening investment in preventive primary care is therefore both a health and economic imperative.

Affordability is an increasing barrier to care, particularly for people living with chronic conditions who require ongoing care and support. The proportion of Australians delaying or avoiding a GP visit due to cost more than doubled from 3.5 per cent in 2021–22 to 7.7 per cent in 2024–25.[24] Access challenges are particularly acute in regional, rural and remote Australia, where more than 18,000 people do not have access to a GP within an hour's drive of their home.[25]

Demand continues to grow, with 15 million Australians (61 per cent) living with at least one chronic condition and almost 10 million (38 per cent) experiencing multimorbidity.[26] Chronic conditions also account for more than half of Australia's disease expenditure, highlighting the importance of coordinated primary care that supports prevention, early intervention and effective ongoing management.[27] Consistent with the *National Preventive Health Strategy 2021-2030*, effective prevention requires coordinated action across governments, healthcare providers and communities, supported by a workforce enabled to operate to its full scope of practice.[28] Despite broad support for prevention, Australia's funding system remains focused on treatment with Medicare's fee-for-service model rewarding episodic care rather than continuity, multidisciplinary management, prevention and long-term health outcomes.

Australia spends 3.1 per cent annually on preventive healthcare despite more than one-third of Australia's disease burden being attributable to modifiable risk factors.[29] Without reform, prevention efforts will remain fragmented and insufficient to meet future health system demand. This chapter sets out the structural changes needed to strengthen primary care as the foundation of a more sustainable, equitable and prevention-focused health system.

Multidisciplinary teams in General Practice clinics

Case for reform

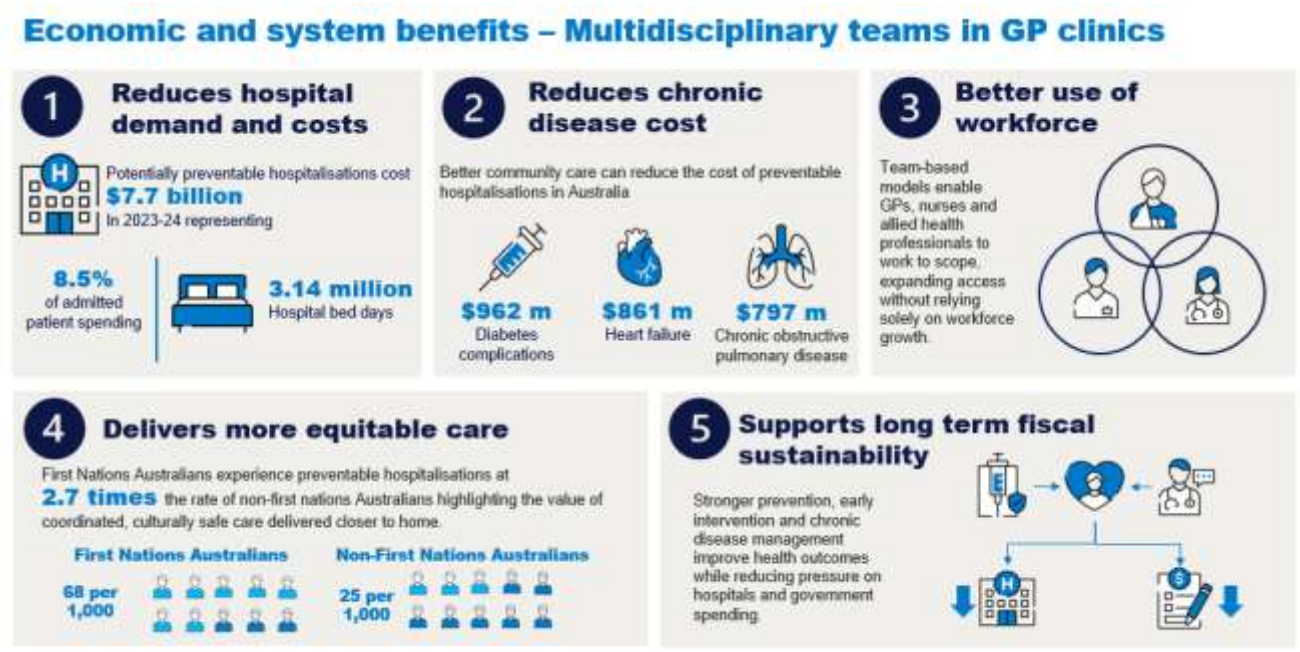
Australia's primary care system carries a large and growing chronic disease burden, with General Practice visits rising alongside an individual's number of conditions and management increasingly requiring coordinated teams beyond episodic, GP-only consultations.[30]

Australian and international evidence supports structured multidisciplinary care (GPs, nursing, allied health, pharmacists, care coordinators): a trial across 60 NSW and Victoria general practices found patients with

[22] Productivity Commission. *Shifting the Dial: 5-year Productivity Review – Supporting Paper No.6: Impacts of Health Recommendations* (Support Paper 6, August 2017).
[23] AIHW, *Cost of potentially preventable hospitalisations in Australia, 2014-15 to 2023-24* (Web Report, 26 November 2025).
[24] Australian Bureau of Statistics (ABS), *Patient Experiences 2024-25* (Web Page, 18 November 2025).
[25] National Rural Women's Coalition. Submission No 135 to Rural and Regional Affairs and Transport References Committee, *Rural, regional and remote Medicare access and funding* (2026); AIHW, *Rural and remote health* (Web Page, 20 November 2025).
[26] AIHW, *Chronic Conditions* (Web Page, 9 July 2026). Multimorbidity defines individuals experiencing more than one long-term health issue.
[27] AIHW. *Chronic Conditions*. (2024); Australian Government Department of Health, Disability and Ageing (DoHDA). *National Preventive Health Strategy 2021-2030.* (2021).
[28] Ibid.
[29] Australian Medical Association (AMA), *Health is the best investment: shifting from a sickcare system to a healthcare system* (Media Release, June 2023); Organisation for Economic Co-operation and Development (OECD), *Health at a Glance 2025: Australia* (2025)
[30] Above n 23.

Team Care Arrangements reported higher-quality chronic illness care, while international studies show reduced hospitalisation days for COPD and improved quality of life in chronic heart failure.[31] [32].[33]

The need for effective team-based models is reinforced by growing pressure on the GP workforce. Average full-time equivalent (FTE) work per GP fell from 0.79 in 2018 to 0.74 in 2023, despite GP headcount increasing by 2,533 over the same period.[34] On current projections, unmet demand is projected to rise from around 2,400 FTE in 2024 to 5,560 FTE by 2033, highlighting the need to better utilise the broader primary care workforce.[35]



Analysis by Mandala Partners 2026 Source: Australian Government Department of Health and Aged Care, *Nursing Supply and Demand Study 2023–2035* (Report, 2024).
Source: Australian Institute of Health and Welfare, Cost of Potentially Preventable Hospitalisations in Australia, 2014–15 to 2023–24 (Web Report, 26 November 2025)
Economic and system benefit – Multidisciplinary teams in GP clinics
Source: Australian Institute of Health and Welfare, Cost of Potentially Preventable Hospitalisations in Australia, 2014–15 to 2023–24 (Web Report, 26 November 2025)

The workforce challenge is not only the number of GPs but the limited team infrastructure supporting them. Australian general practice remains relatively GP-dependent, with fewer than three supporting clinicians embedded in primary care for every 10 GPs, compared with approximately 10 supporting clinicians per 10 GPs in England.[36] Expanding multidisciplinary teams would increase capacity by enabling GPs to focus on diagnosis, complex decision-making and continuity of care, while other professionals provide preventive care, education and follow-up in their scope of practice.

Current system challenges

Australia's workforce, implementation and funding settings make multidisciplinary care difficult to embed at scale. The specific fee-for-service barriers are addressed in the section on *Blended Funding Models*.

1. Existing incentives support workforce costs, but not necessarily team-based care

The Workforce Incentive Program – Practice Stream (**WIP – PS**) supports eligible general practices with the cost of engaging nurses, midwives, allied health professionals and Aboriginal and Torres Strait Islander

[31] DoHDA. *Review of General Practice Incentives: Expert Advisory Panel report to the Australian Government* (Final Report, September 2024).
[32] Mark F Harris et al, 'Multidisciplinary Team Care Arrangements in the management of patients with chronic disease in Australian general practice' (2011) 194(5) *Medical Journal of Australia* 236. *Team Care Arrangements were formal Medicare-funded agreements between GPs and other practitioners, replaced in July 2025 by GP Chronic Condition Management Plans.*
[33] Yanli Shi et al, 'Effects of multidisciplinary teamwork in non-hospital settings on healthcare and patients with chronic conditions: a systematic review and meta-analysis' (2025) 26(110) *BMC Primary Care* 1.
[34] DoHDA. *Supply and Demand Study: General Practitioners in Australia* (Final Report, August 2024).
[35] Australian Government Office of Impact Analysis (OIA), *Impact Analysis: Building the General Practice Workforce to Strengthen Medicare* (Final Report, February 2025).
[36] Peter Breadon and Danielle Romanes, 'A New Medicare: Strengthening General Practice' (Grattan Institute, December 2022).

health workers and practitioners. However, it is a workforce-cost subsidy and does not by itself ensure that professionals work as an integrated team.

In 2024, around 98 per cent of recipient practices engaged a nurse, but only 28 per cent employed an allied health professional.[37] GPs and other health professionals commonly identify insufficient funding, workforce availability, time to collaborate, supervision requirements and practice infrastructure as barriers to multidisciplinary care.[38,39] Thus, primary care reform must move beyond partial workforce support towards funding and governance settings that make team-based care sustainable in day-to-day practice.

2. Workforce supply is unevenly distributed, particularly outside major cities

Remote (MM6-7) regions have materially fewer GP FTE per 100,000 people, and small rural towns record the lowest FTE per 1,000 for GPs, nurses and allied health professionals - disparities persisting despite a 67 per cent rise in the allied health workforce over the past decade.[40] [41] [42] National models must therefore be flexible enough to work in thin markets, including through shared staff across practices, PHN-commissioned teams, virtual allied health support, visiting services, community health partnerships and formal partnerships with ACCHOs.

3. Evaluation gaps limit system learning and national scale-up

While multidisciplinary models show promise, the evidence is strongest amongst selected chronic disease measures with effects on clinical outcomes and hospital utilisation remaining variable and highly design-dependant.[43]

There is also a prevention gap given that current settings only enable targeted midlife health assessments and annual assessments from age 75 and do not provide systematic, risk-based reassessment during the intervening years, despite chronic disease and multimorbidity increasing before older age.[44]

Future reform should not simply fund “more team care” in general terms, but instead, it must identify the populations to be served, the functions being funded, the intended outcomes and the evaluation framework from the outset.

Reform priorities

With funding addressed in the *Blended Funding Models* section, these priorities focus on the settings needed to move from partial incentives and local pilots to a coherent national framework.

Priority 1: *Establish setting-neutral standards and accreditation for multidisciplinary primary care*

- Recognise accredited multidisciplinary care delivered through general practice, private primary care, community-controlled health services, hybrid models and telehealth-enabled services.
- Establish consistent requirements for quality and safety, clinical governance, referrals, transparent pricing, interoperability (e.g. with My Health Record), information sharing and integration with usual care, while allowing team composition and model of care to reflect local needs.

Priority 2: *Enable full-scope multidisciplinary teams through workforce and supervision settings*

- Introduce workforce incentive loadings for rural, regional and underserved communities to reflect higher delivery costs and workforce challenges.
- Strengthen the capacity of existing programs such as the *WIP – PS* for eligible practices to support a broader mix of nurses, midwives, allied health professionals and Aboriginal and Torres Strait Islander health workers and practitioners working to their full scope.

[37] Ibid.
[38] The Royal Australian College of General Practitioners (RACGP), *General Practice: Health of the Nation 2025* (Web Page, 2025)
[39] The Pharmaceutical Society of Australia (PSA) and RACGP, ‘Pharmacists and GPs united on the value of multidisciplinary care’ (Media Release, May 2025)
[40] Above n 34. **MM1 to MM7** refer to the Modified Monash Model remoteness classifications, which range from MM1 major city areas through to MM7 very remote areas.
[41] Colin H Cortie et al, ‘The Australian health workforce: disproportionate shortfalls in small rural towns’ (2024) 32(3) *Australian Journal of Rural Health* 538.
[42] Gregory Kolt, *Development of and support for the rural and remote allied health workforce in Australia* (Final Report, 22 March 2025).
[43] Shona Marie Bates et al, ‘Can multidisciplinary teams improve the quality of primary care? A scoping review’ (2025) 12(88) *eClinicalMedicine* 1.
[44] Explanatory Note, *Health Insurance Act 1973* (Cth) Note AN.0.36.

- Fund supervision and mentorship of multidisciplinary team members, including early-career clinicians and practitioners adopting new scopes of practice, and building team-based clinical governance over time.
- Apply safeguards for affordability, transparency, clinical governance, data-sharing, integration with usual care and evaluation. Models in Aboriginal and Torres Strait Islander communities should be community-led and developed with ACCHOs.

Blended Funding Models

Case for reform

General practice has shifted from episodic treatment towards more prevention and longer-term management of patients since Medicare began in 1984, yet funding remains heavily reliant on fee-for-service Medicare Benefits Schedule (MBS) payments – a model suited to discrete consultations rather than the proactive, team-based, longitudinal care now required.[45]

While fee-for-service payments suit discrete consultations for simple presentations, it poorly rewards prevention, follow-up, care coordination, medication management, multidisciplinary case discussion and monitoring. Given that practice revenue remains tied mainly to individual GP consultations, the model can also limit the use of nurses, pharmacists and allied health professionals even where they are well placed to provide components of care. These pressures have been compounded by MBS rebate growth lagging behind operating costs, with Medicare's share of GP fees declining from approximately 91 per cent to 84 per cent between 2022 and 2025.[46]

Blended funding should complement fee-for-service payments rather than replacing them, with comparable international systems using combinations of activity-based payments, capitation and practice-level funding to preserve access incentives while funding coordination and proactive management more predictably.[47]

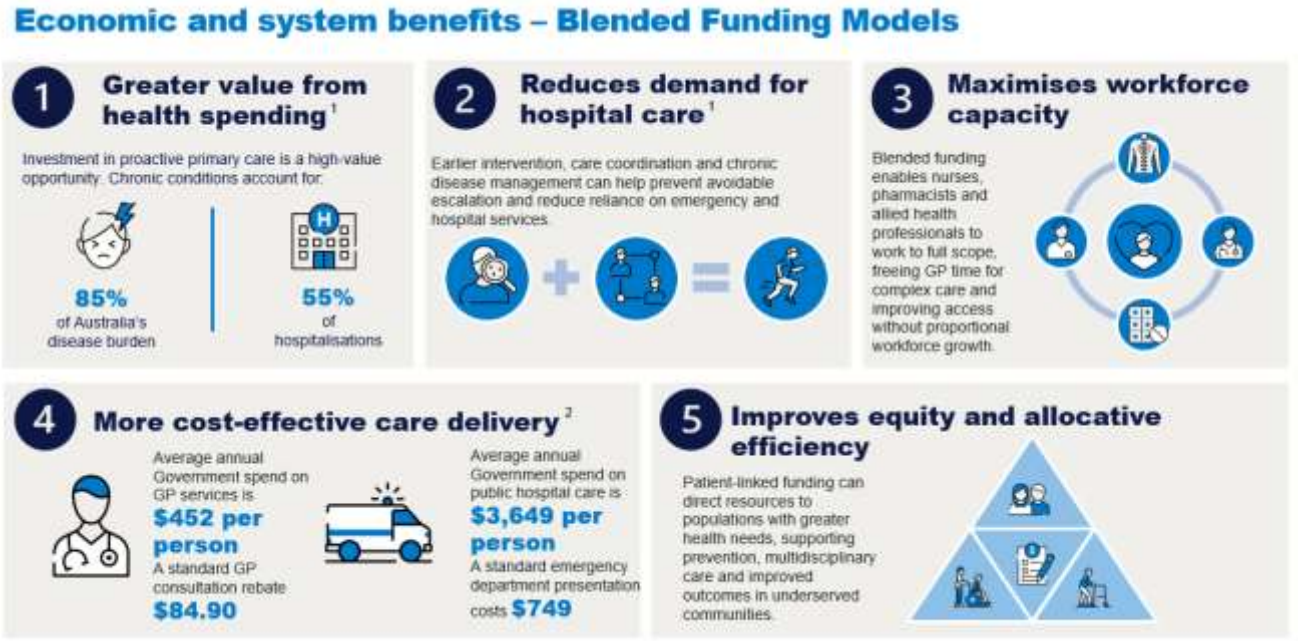
Successive Australian reviews, including the *Review of General Practice Incentives* and the *Scope of Practice Review*, have concluded a fee-for-service dominated model is no longer sufficient and recommended a progressive shift towards blended payment models.[48,49] A well-designed model would align incentives with patient need, strengthen prevention and continuity, and focus scarce GP capacity on diagnosis, complexity and clinical decision-making.

Blended funding can fund patient recall, follow-up, medication management and coordination, which are poorly supported under fee-for-service, also enabling nurses, pharmacists, allied health professionals, care coordinators and other clinicians to undertake appropriate components of ongoing care without each activity being dependent on a GP consultation.[50]

Chronic conditions account for most of Australia's disease burden and 55 per cent of hospitalisations, so funding proactive monitoring and earlier intervention maintains a tangible opportunity to identify deterioration before people require more intensive and costly acute care.[51] Government expenditure on GP services averaged approximately $452 per person in 2023–24, compared with public hospital expenditure of $3,649 per person.[52] For scale, average government expenditure on a non-admitted emergency department presentation was approximately $749, compared with an $84.90 Medicare rebate for a 20-to-39-minute GP consultation.[53] Although these are not directly equivalent services, this highlights the substantial cost difference between acute hospital care and primary care.

[45] DoHDA, *Strengthening Medicare Taskforce Report* (Final Report, December 2022).
[46] Peter Breadon and Molly Chapman, 'A better Medicare: How to reform GP funding' (Policy Brief, Grattan Institute, May 2026).
[47] Breadon, P. and Romanes, D. *A New Medicare: Strengthening General Practice*, Grattan Institute. (2022).
[48] DoHDA. *Review of General Practice Incentives: Expert Advisory Panel report to the Australian Government.* (2024).
[49] DoHDA, *Unleashing the Potential of our Health Workforce – Scope of Practice Review Final Report* (Final Report, October 2024).
[50] DoHDA. *Review of General Practice Incentives: Expert Advisory Panel report to the Australian Government.* (2024).
[51] AIHW. *Chronic Conditions*. (2024).
[52] AIHW, *General practice, allied health and other primary care services*. (Web Page, 26 March 2026); Independent Health and Aged Care Pricing Authority (IHACPA), *National Hospital Cost Data Collection Public Sector 2023-24* (Final Report, June 2026).
[53] Ibid.

Blended funding can also improve allocative efficiency by directing resources towards patients and communities with the greatest need, adjusting for age, multimorbidity, socioeconomic disadvantage, rurality



Source: 1. Australian Institute of Health and Welfare, *Chronic Conditions* (Web Article, 9 July 2026) 2. Australian Institute of Health and Welfare, *General Practice, Allied Health and Other Primary Care Services* (Web Article, 26 March 2026)

and disability.[54]

Current system challenges

1. Fee-for-service still determines the business model of general practice

General practice remains heavily reliant on individual billable consultations rather than predictable practice-level funding, thus rewarding activity over the functions required for coordinated, longitudinal care. Care coordination, patient follow-up, test-result review, multidisciplinary case discussion and care planning receive little or no direct funding. MBS consultation items largely remunerate direct patient contact and payments for longer consultations increase less than proportionally with time.[55]

Consequently, practices providing complex care receive lower returns per minute than those delivering shorter consultations, as the effective Medicare rebate declines from $2.93 per minute for 15 minutes to $2.43 per minute for 35 minutes and $2.27 per minute for 55 minutes.[56] Preventive items are also constrained by patient eligibility and claiming intervals rather than funding proactive risk stratification, recall, and outreach.[57]

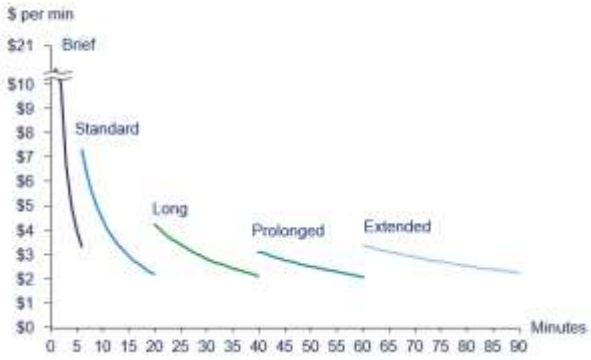
As shown in the case study below, two practices with comparable annual revenue of $1.9 million can produce materially different margins once patient complexity is considered. A practice serving more people with chronic disease operates at a lower margin, limiting its capacity to invest in longer consultations, prevention, multidisciplinary care and digital capability.[58] This pressure may be greater in lower-income communities, where practices have less capacity to recover inadequate rebates through patient gap fees.

[54] AIHW. *Chronic Conditions*. (2024).
[55] See generally *Health Insurance (General Medical Services Table) Regulations 2021*; DoHDA, *Medicare Benefits Schedule – Item 23* (2026).
[56] RACGP. *General Practice: Health of the Nation 2025.* (2025).
[57] DoHDA. *Medicare Benefits Schedule – Item 701* (2026); *Medicare Benefits Schedule – Item 699* (2026).Examples include **Health Assessment** items for people aged 40–49 years at high risk of type 2 diabetes (once every three years), people aged 45–49 years at risk of chronic disease (once only), and people aged 75 years and over (annually), as well as the **Heart Health Assessment**, generally available once every 12 months for eligible patients aged 30 years and over.
[58] Bupa modelling conducted by Mandala Partners (Mandala) (2026).

Case Study: How current FFS system rewards shorter consultations and financially disadvantages GPs who treat complex patients

Medicare rebate per minute, by consultation length

Shorter consultations earn more per minute than prolonged consultations, with the revenue per minute falling as duration increases within each category



Case studies of GP incentives, by patient type[1]

Serving vulnerable communities with longer appointment requirements is structurally less profitable under fee-for-service (FFS), Bulk-billing GPs who are dependent on high patient volume to break even may face financial losses on these consultations

Case	Low-needs patient	High-needs patient
Profile	• **29-year-old** patient with an upper respiratory infection	• **80-year-old** patient with hypertension, diabetes, cognitive decline
Consult time required	• **8** minutes	• **35** minutes
Revenue per minute	• **$5.50** per minute	• **$2.40** per minute
FFS incentive	• Book **7-8** patients per hour at this rate	• Not structurally set up to support this type of care
Outcome	• Clinics make a sustainable profit margin	• Lengthy consultations erode clinic margins, as revenue per minute falls

Note: 1. These case studies are illustrative examples that demonstrate how FFS funding can create misaligned outcomes

Source: *Australian Institute of Health and Welfare,* Medicare Bulk Billing and Out-of-Pocket Costs of GP Attendances Over Time *(Web Report, 13 December 2024); Australian Institute of Health and Welfare,* Rural and Remote Health *(Web Article, 20 November 2025); Australian Government, Department of Health, Disability and Ageing,* MBS Online: July 2026 Downloads *(Web Page, last updated 10 August 2026); Roz Glazebrook and Simone Harrison, 'Obstacles and Solutions to Maintenance of Advanced Procedural Skills for Rural and Remote Medical Practitioners in Australia' (2006) 6(4)* Rural and Remote Health *502; Mark F Harris and Joel Rhee, 'Achieving Continuity of Care in General Practice: The Impact of Patient Enrolment on Health Outcomes' (2022) 216(9)* Medical Journal of Australia *460–461*

These challenges are becoming more pronounced as consultations lengthen to an average of 19.7 minutes in line with presentations becoming more complex.[59] Furthermore, 68 per cent of GPs identify rising patient complexity as the profession's greatest challenge and 82 per cent report that existing MBS rebates and incentives are insufficient to support greater preventive care.[60]

The Review of General Practice Incentives recommended rebalancing funding so that around 60 per cent of practice income would continue to come from fee-for-service and around 40 per cent from flexible payments, ensuring that blended funding becomes a core component of practice income rather than a marginal incentive.[61]

2. Blended funding is only beginning to reach general practice

MyMedicare establishes Australia's first national voluntary patient-registration model and provides a foundation for funding to follow patients over time. However, blended funding remains at an early stage and continues to operate primarily as an additional payment stream within a system shaped by fee-for-service.[62]

Changes introduced from July 2025 simplified chronic condition management through a single GP Chronic Condition Management Plan and streamlined allied health arrangements, but these measures remain targeted to patient groups rather than providing a broader funding base across the registered population. Participation also remains limited relative to the total population with 2.6 million patients registered by March 2025, equivalent to around one in 10 Australians.[63]

[59] DoHDA. *MBS Online Medicare Benefits Schedule.* (2026)
[60] Ibid.
[61] Department of Health and Aged Care, *Review of General Practice Incentives – Expert Advisory Panel Report to the Australian Government* (Report, 8 October 2024).
[62] Michael Kidd et al, *Review of General Practice Incentives: International Evidence and Literature Review* (Final Report, UNSW and DoHDA, April 2024).
[63] Jialing Lin, *MyMedicare promises better health care. But only 1 in 10 patients has signed up* (Web Article, The University of New South Wales, 7 April 2025)

3. Patient registration is not yet a mature foundation for predictable funding

Effective blended funding requires a reliable mechanism for linking funding to genuine, ongoing patient-practice relationships given that current registration settings do not fully reflect care delivered across multiple practices, outreach services or temporary locations.

Senate inquiry evidence identified concerns that patients receiving linked care may be unable to register with multiple trusted providers.[64] Some patients were also reportedly unaware of existing registrations, creating administrative barriers when they sought care elsewhere.[65] As blended funding expands, registration settings will need to support patient mobility, shared care, evolving care relationships and different local models of service delivery.

4. The funding architecture for blended payments remains unresolved

The appropriate balance between fee-for-service and flexible funding remains unresolved. Fee-for-service retains important strengths, including incentives for timely access and responsiveness to demand, while fixed or capitated models can create risks of under-servicing.

Balance remains paramount as illustrative modelling indicates that a fully bulk-billing practice delegating 20 per cent of GP care to a multidisciplinary team would lose around $22,000 annually if flexible funding represented 25 per cent of revenue but gain around $15,000 if it represented 50 per cent.[66]

Blended funding must also account for variation in patient need and delivery costs across practices nationwide so that payments reflect the resources required to deliver comprehensive care.

5. Embedding reform at scale remains a challenge

Alternative payment models do not automatically change practice behaviour, with their impact depending on scale, predictability, implementation support and how effectively they are embedded in the broader funding environment.[67] *The Health Care Homes trial* (2017-2021) tested voluntary patient enrolment, bundled payments and coordinated care for people with chronic and complex conditions. While it improved access and some care processes, 53 per cent of practices withdrew from the trial, with no significant improvements in diabetes outcomes, hospital use or mortality.[68]

MyMedicare provides a national registration platform that was not available during earlier initiatives, but this development must be accompanied by robust funding, administrative arrangements and value propositions for practices, to produce effective outcomes.

Reform priorities

There is no single optimal split between fee-for-service and flexible funding, with the appropriate balance varying according to practice location, billing model, patient need and ownership structure.[69]

However, the flexible share must be high enough to cover the cost of multidisciplinary delivery relative to GP-delivered care. Across a range of assumptions, the break-even share sits close to half of total practice funding, at approximately 49 per cent for a practice with no existing profit and between roughly 43 and 55 per cent as profit and capacity to see additional patients vary.[70] As such, blended funding operating only as a marginal incentive layer is unlikely to support meaningful service redesign, also requiring a sufficiently scaled, needs-based and operationally practical model.

[64] Parliament of Australia (Senate Rural and Regional Affairs and Transport References Committee). *Proof Committee Hansard: Rural, regional and remote Medicare access and funding.* (2026); Queensland Aboriginal and Islander Health Council (QAIHC). *Submission: rural, regional and remote Medicare access and funding.* Parliament of Australia. (2026).
[65] Ibid.
[66] Peter Breadon and Carlos Jimenez, *The perfect blend: Getting flexible GP funding right.* (Policy Brief, Grattan Institute, July 2026)
[67] Lauren Richardson, Danielle Romanes and Peter Breadon, *Six lessons for Australia from decades of general practice reform*v (Web Article, Grattan Institute, January 2023)
[68] Duong T Tran et al, 'The Australian Health Care Homes trial: quality of care and patient outcomes: a propensity score-matched cohort study' (2024) 220(7) *Medical Journal of Australia* 372.
[69] Grattan Institute. *The perfect blend: Getting flexible GP funding right.* (2026).
[70] Ibid.

Priority 1: *Establish voluntary, needs-weighted blended funding for chronic and complex care*

- Build on MyMedicare by enabling practices to voluntarily participate in a blended funding model that combines fee-for-service payments for direct clinical care with flexible, patient-linked funding for chronic and complex care.
- Use needs-weighted funding to support prevention, chronic disease management, care coordination, multidisciplinary team-based care, follow-up, proactive recall, risk stratification, medication management, and data-driven quality improvement.
- Retain a fee-for-service component of sufficient weight to preserve incentives for direct GP consultations, maintain access to care, and limit practices' exposure to risk-adjustment errors, while shifting non-visit and coordination-based activities into flexible funding streams.
- Ensure blended funding is of sufficient scale to support genuine service redesign rather than operating as a marginal incentive layer.
- Require participating practices to align internal remuneration arrangements with the model, including sharing flexible funding with GPs, remunerating clinical oversight and coordination activities, and appropriately supporting multidisciplinary workforce costs and practice infrastructure. Funding arrangements should provide clear value for both practices and individual GPs to support adoption.
- Ensure the payment model does not financially disadvantage practices when care is appropriately delivered by nurses, pharmacists, allied health professionals, care coordinators, or Aboriginal and Torres Strait Islander health workers and practitioners.
- Use the GP Chronic Condition Management framework as the foundation for progressively expanding blended funding beyond discrete care planning items.
- Monitor implementation for unintended consequences, including under-servicing, reduced access to same-day care, patient selection, excessive administrative burden, and cost shifting to patients.

Example: the level of flexible funding determines whether switching pays *(Grattan Institute, 2026)*

This example is based on a fully bulk-billing practice with a single GP, earning $600,000 per year from Medicare and paying the GP $400,000 in wages. This practice adopts blended funding and delegates 20 per cent of the GP's care to a multidisciplinary team, with the GP using the freed-up time to see new patients.

Where flexible funding is set at 25 per cent, the practice loses approximately $22,000 per year. However, raising flexible funding at this same practice to 50 per cent increases profit by about $15,000 per year.

Priority 2: *Put equity and risk adjustment at the centre of payment design*

- Risk-adjust payments according to clinical complexity, multimorbidity, socioeconomic disadvantage, rurality and remoteness, First Nations health needs, disability, mental health needs, and aged care needs.
- Include additional loadings for practices serving populations with higher care needs or reduced capacity to recover costs through patient gap fees.
- Ensure rural and remote communities can use blended funding flexibly for locally viable models, including shared multidisciplinary teams, visiting allied health, telehealth-enabled care, partnerships with ACCHOs and PHN-commissioned services.
- Avoid blunt capitation by ensuring payments are risk-adjusted, regularly reviewed and supported by safeguards that reduce the risk of under-servicing high-need patients.[5]

- Establish an independent pricing and review mechanism to regularly update blended payment levels as patient need, workforce costs, and service delivery models evolve.

Priority 3: *Support flexible implementation through MyMedicare and local models of care*

- Strengthen MyMedicare as the platform for patient registration and blended funding through streamlined registration, stronger patient and provider participation, and a clearer value proposition for both patients and practices.
- Minimise administrative burden while supporting quality improvement, data sharing, and evaluation.
- Ensure funding follows genuine care relationships through flexible attribution arrangements that support shared care, outreach services, aged care, ACCHOs, mobile populations, and patients receiving care across multiple service settings.
- Allow practices flexibility to use blended funding for locally appropriate delivery models, including in-practice multidisciplinary teams, shared services, virtual care, hybrid care, and commissioned allied health services.

Chapter Two: Scale innovative models of care

Australia's health system is expected to deliver care through models that reflect advances in clinical practice, technology, and workforce capability. While many services have traditionally been delivered through hospital-based, clinic-based, and face-to-face models, new approaches are enabling care to be provided closer to home through community and digitally enabled settings.[71]

Hospital in the Home (**HITH**), virtual care, remote monitoring, community-based mental health services, and insurer-supported prevention each provide opportunities to intervene earlier, strengthen continuity of care and make more effective use of available clinical capacity.

Despite this progress, innovative models of care continue to rely on local funding agreements, pilot programs, individual provider capability or jurisdiction-specific arrangements rather than nationally consistent policy settings. Existing legislative, funding and regulatory frameworks often reflect where care is delivered rather than its clinical purpose or effectiveness. As a result, access can depend on where a person lives, the provider they attend, whether appropriate funding and contracting arrangements are in place, and whether existing rules are suitable.

Patients may experience unnecessary hospital admissions, repeated assessments, fragmented transitions between providers, avoidable travel or delays in receiving appropriate care. Clinicians are not always able to practise to their full scope of practice or use the most suitable methods and technologies to deliver best practice.

Addressing these challenges requires innovation to become a routine feature of healthcare delivery rather than an exception. Funding arrangements and regulatory frameworks can be reformed to deliver care models that better meet higher standards of quality, amenity, safety, accountability, and care continuity. The *Digital Health Blueprint 2023-2033* and the development of *National Safety and Quality Virtual Care Standards* provide important foundations for this transformation, but further reform is required to support consistent implementation across the health system.[72]

This chapter sets out reforms to modernise Australia's models of care by expanding HITH, embedding virtual care within routine healthcare delivery, strengthening out-of-hospital mental health services, enabling designated registered nurse prescribing and supporting PHI investment in prevention and early intervention. While each reform addresses a distinct policy challenge, together they support a common objective of enabling coordinated care to be delivered earlier, closer to home and via a broader range of clinical settings.

Collectively, these reforms would improve access and patient experience, strengthen workforce productivity, reduce avoidable pressure on hospitals and contribute to a more sustainable, connected and prevention-focused health system.

Hospital in the Home reform

Case for reform

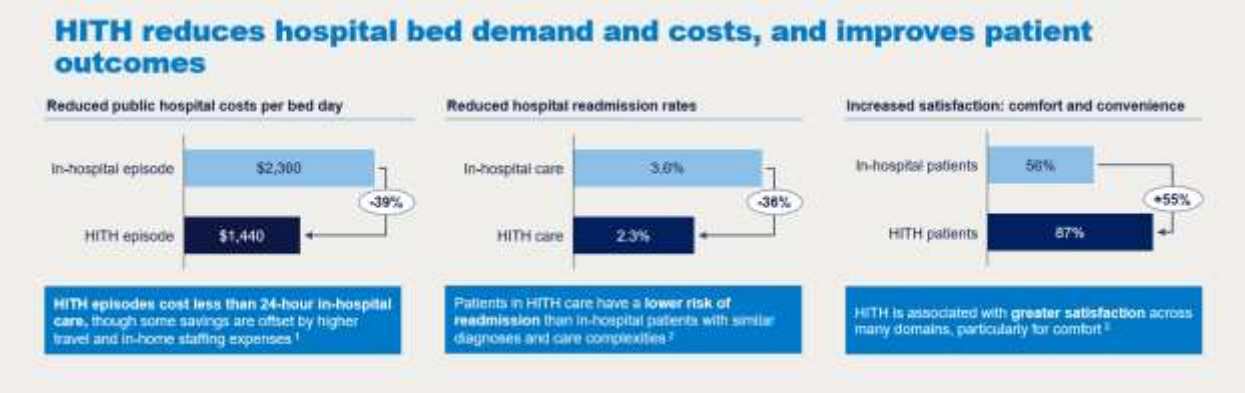
HITH enables admitted patients to receive hospital-level care at home instead of in a hospital bed, avoiding admission or supporting earlier discharge while maintaining inpatient-equivalent clinical governance, oversight and escalation pathways. As chronic and complex conditions grow alongside an ageing population, HITH offers a clinically proven way to meet rising acute care demand without expanding hospital capacity.

HITH is associated with lower mortality, fewer readmissions, lower costs and higher patient and carer satisfaction than inpatient care for appropriately selected patients.[73] Victoria's *Better at Home* initiative has saved more than 326,000 public hospital bed days since 2020 across 47 health services, with a further

[71] Gabriel Moore et al, *The effectiveness of 'virtual hospital' models of care: a Rapid Evidence Scan* (Final Report, Sax Institute, January 2020).
[72] DoHDA. *The Digital Health Blueprint and Action Plan 2023-2033* (2023); Australian Commission on Safety and Quality in Health Care, 'National standards to ensure safe, high-quality virtual care for all Australians' (Media Release, 19 June 2026).
[73] Michael Montalto, Patrick McElduff and Kristy Hardy, 'Home ward bound: features of hospital in the home use by major Australian hospitals, 2011–2017' (2020) 213(1) *Medical Journal of Australia* 22.

$130.3 million committed in the 2026–27 Budget.[74] [75] [76] Private hospitals deliver over 40 per cent of admissions and 67 per cent of elective surgery, yet only 4 per cent of Hospital in the Home (HITH) separations are delivered through the private sector.[77] [78] [79] Reforming funding and clinical settings would help make home-based acute care mainstream for privately insured patients.

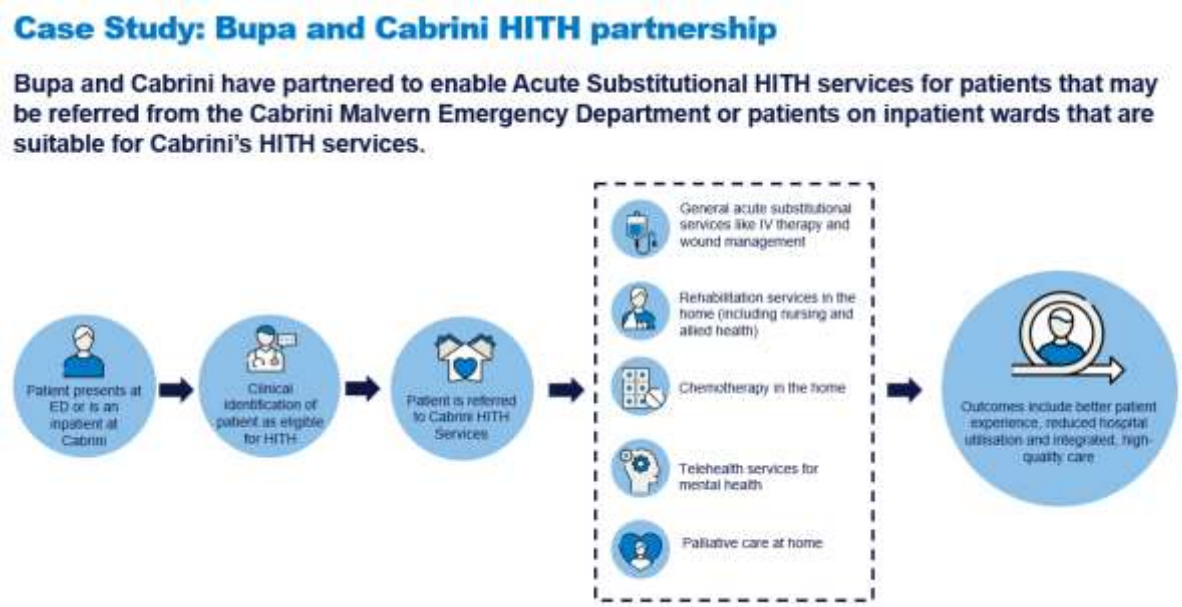
Expanding HITH frees hospital capacity for patients needing intensive monitoring or specialised infrastructure. Australian modelling shows savings of 39 per cent per episode versus inpatient care, consistent with a 2023 UK review finding savings in 13 of 15 economic evaluations.[80] [81]



Source: *1. AIHW (2026) Hospitals – Public hospitals and beds; IHACPA (2023) National Hospital Cost Data Collection – Public Sector Annual Report 2020-21 2. Montalto et al. (2020) Home ward bound: features of hospital in the home use by major Australian hospitals, 2011-2017. 3. Leff et al. (2006) Satisfaction with hospital at home care. Analysis by Mandala Partners 2026.*

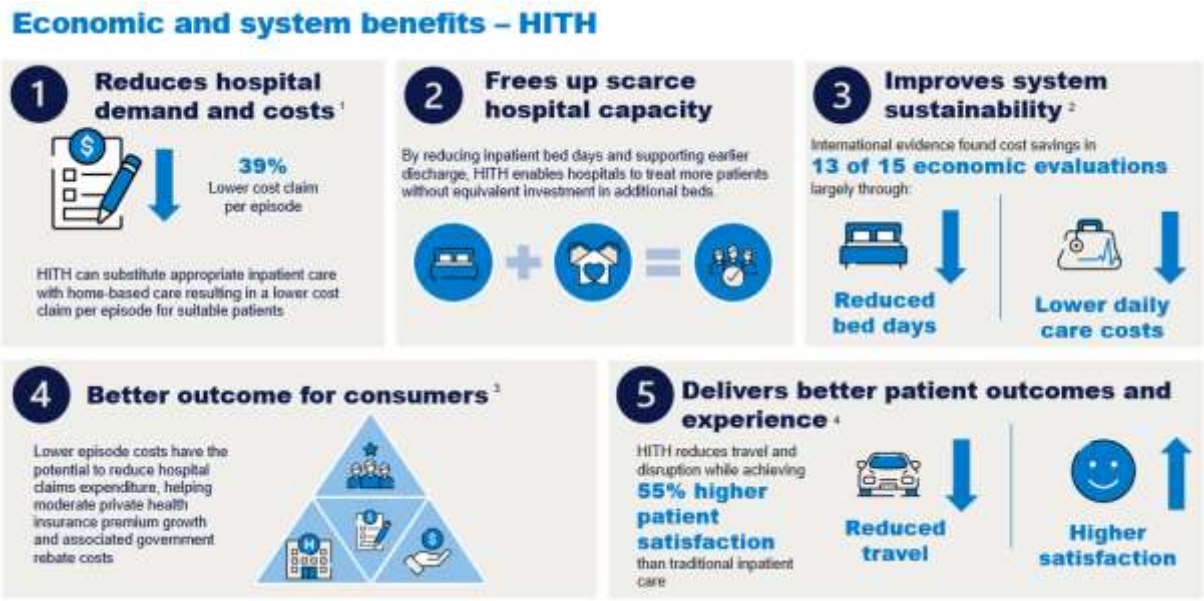
Modelling by Mandala Partners for Bupa shows that expanding HITH can lead to improved clinical outcomes such as lower hospital readmission rates, fewer hospital-acquired complications and lower mortality risk. Lower episode costs could moderate private hospital premium pressure, while patients report 55 per cent higher satisfaction, with particular benefit for regional and rural patients avoiding travel.

Bupa has been a strong advocate for private sector HITH reform over the last two years. In 2025, Catholic Health Australia (**CHA**) and Bupa undertook a co-design process with sector leads to identify the key elements needed to make HITH default benefits reform, a practical and sustainable solution.



[74] Ibid.
[75] Department of Health (Vic), *Better at Home initiative* (Web Page, 14 April 2025)
[76] Premier of Victoria, 'Labor is Delivering More Care, Closer to Home' (Media Release, 4 May 2026).
[77] AIHW, *Hospitals at a glance* (Web Page, 18 May 2026).
[78] AIHW, *Surgery and other interventions* (Web Page, 18 May 2026)
[79] AIHW, *Admitted patient care 2017-18, Data* (Web Page, 23 May 2019)
[80] Private Healthcare Australia (PHA), *There's no place like home: reforming out-of-hospital care* (White Paper, May 2023)
[81] New South Wales Health (Critical Intelligence Unit), *Evidence Brief: Hospital in the home* (18 June 2024).

Recommendations from this process have informed this paper. We have also worked hard to make HITH accessible for our members. Reforming HITH funding, regulation, and clinical settings would help make home-based acute care a mainstream option for privately insured patients, easing pressure on hospital capacity and supporting care in the most appropriate setting.



Source: 1 Private Healthcare Australia (PHA). *There's no place like home: reforming out-of-hospital care.* (2023). 2. New South Wales Health (Critical Intelligence Unit). *Evidence Brief: Hospital in the home*. (2024); 3. Bupa modelling conducted by Mandala Partners (Mandala). (20260 4. Leff et al. (2006) *Satisfaction with hospital at home care*.

Current system challenges

1. Disparity between public and private HITH access

In 2022–23, only 4 per cent of HITH separations (6,400 of 158,900) were delivered in the private sector.[82] Public hospitals can invest directly in HITH capacity and referral pathways, while private access instead depends on whether an individual hospital has invested in a program and negotiated funding with insurers.

2. Funding arrangements do not provide sufficient certainty

There is no nationally prescribed minimum hospital benefit for HITH, so access and payment depend on individual hospital-insurer contracts. This creates a circular problem where hospitals hesitate to invest in HITH teams and systems without predictable demand, while insurers and clinicians hesitate to refer without assured service availability. A minimum benefit would not replace contracting, but would establish baseline certainty for hospitals to invest, alongside alternative contracts and outcomes-based arrangements.

3. MBS settings restrict medical oversight and referral

MBS rules generally prevent telehealth items being claimed for admitted HITH patients, apart from limited psychiatry items, discouraging specialists from referring patients where ongoing review would otherwise require in-person attendance. Dedicated telehealth items for admitted HITH patients would support clinical continuity, autonomy and timely escalation.

4. Service definitions and reporting are inconsistent

HITH programs vary significantly in intensity, workforce and oversight, making it difficult to distinguish genuine hospital substitution from lower-intensity outpatient or virtual care.[83] Minimum service definitions and consistent data collection would allow HITH to be compared with conventional inpatient care.

[82] Australian Institute of Health and Welfare (AIHW), *Admitted patient care – Types of care provided* (Web page, August 2026)

[83] Man Qing Leong, Cher Wee Lim and Yi Feng Lai, 'Comparison of Hospital-at-Home models: a systematic review of reviews' (2021) 11(1) *BMJ Open* 1.

Reform priorities

Reform should establish HITH as a clinically governed hospital-substitution model rather than a lower-cost alternative that transfers responsibilities to patients, carers or community providers. Effective implementation requires nationally consistent quality and funding arrangements that remove barriers to private sector adoption.

Priority 1: *Reform MBS settings to support virtual medical oversight of HITH*

- Introduce dedicated MBS telehealth items for admitted HITH patients to support referral, specialist review, treatment adjustment, escalation and discharge planning.
- Monitor utilisation to ensure the items support comprehensive HITH services rather than fragmented or stand-alone virtual consultations.

Priority 2: *Introduce a minimum benefit for an initial tranche of established HITH services*

- Consider appropriate loadings for rural and remote delivery, culturally safe care, complex patients, and services requiring significant travel or specialist inputs.
- Introduce minimum benefits for an initial group of established HITH services with clear substitution potential, including IV antibiotics and infusion therapy, infection management, complex wound care, post-operative/post-acute care, and palliative care.
- Require genuine hospital substitution rather than routine outpatient, primary care, community nursing or virtual care, and preserve hospitals' and insurers' ability to negotiate alternative contracts, bundled payments and outcomes-based arrangements above the minimum benefit.
- Establish an independent mechanism to periodically review benefit levels as workforce costs, technology and models of care evolve.
- Review the initial tranche following implementation before extending minimum benefits to additional HITH services.

Priority 3: *Establish nationally consistent safety, quality, governance and service standards for HITH*

- Require HITH services to meet same governance and accreditation standards equivalent to admitted hospital care.
- Ensure informed patient consent, with no financial or clinical disadvantage for declining HITH.
- Allow flexibility in service delivery across metropolitan, regional, rural and remote settings.
- Avoid a single uniform benefit given HITH cost and intensity vary materially; benefits should reflect the full cost of care, including medical and nursing input, medicines, diagnostics, transport, digital monitoring, coordination and after-hours support.
- Consider loadings for rural and remote delivery, culturally safe care and complex patients, with sufficient certainty to support investment without incentivising lower-intensity services in place of clinically necessary inpatient care.

Error! Reference source not found.Out-of-hospital mental health care

Case for reform

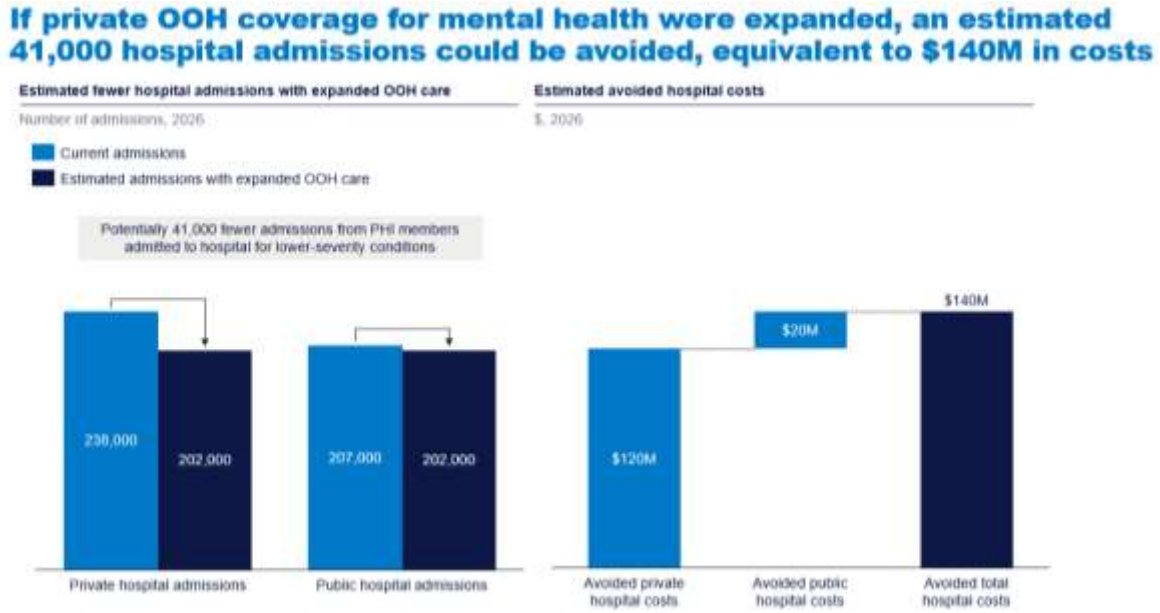
Mental ill health is one of the most substantial and persistent pressures on Australia's health system, workforce and economy. Around one in five Australians aged 16–85 experience a mental disorder each year, rising to almost two in five aged 16–24.[84] Government expenditure exceeds $14 billion annually (around 7 per cent of total health spending), yet the constraint lies less in funding quantum than its concentration in costly, reactive acute care rather than prevention.[85] Community-based, multidisciplinary

[84] AIHW. *Prevalence and impact of mental illness.* (2025).
[85] AIHW. *Expenditure on mental health-related services.* (2026).

and digitally enabled models of care can improve outcomes and reduce reliance on hospital-based services.[86]

The annual cost of mental ill health to the economy is estimated at $200-220 billion through lost productivity, reduced workforce participation and diminished quality of life.[87] Rebalancing towards prevention and out-of-hospital care would improve system efficiency and increase the return on existing investment. A South Australian evaluation of community-based psychosocial support found reductions in mental health hospitalisations of around 39 per cent and bed days of around 16 per cent.[88] Benefits are likely most pronounced for young people, given many conditions first emerge in adolescence, and would improve the return on the existing $14 billion yearly investment by directing more of it towards care that maintains wellbeing rather than treating deterioration.[89]

If PHI were expanded to cover out-of-hospital mental health care – for example, community care, residential, and stepped care – up to 41,000 hospital admissions could be avoided each year, by making lower-cost care options more accessible, preventing crisis escalations before they require admission. This is based on 15 per cent of the eligible cohort (PHI members admitted for lower-severity conditions manageable in the community) shifting to community-based care instead. Providing this cohort with access to more affordable care options would save the system $140 million.

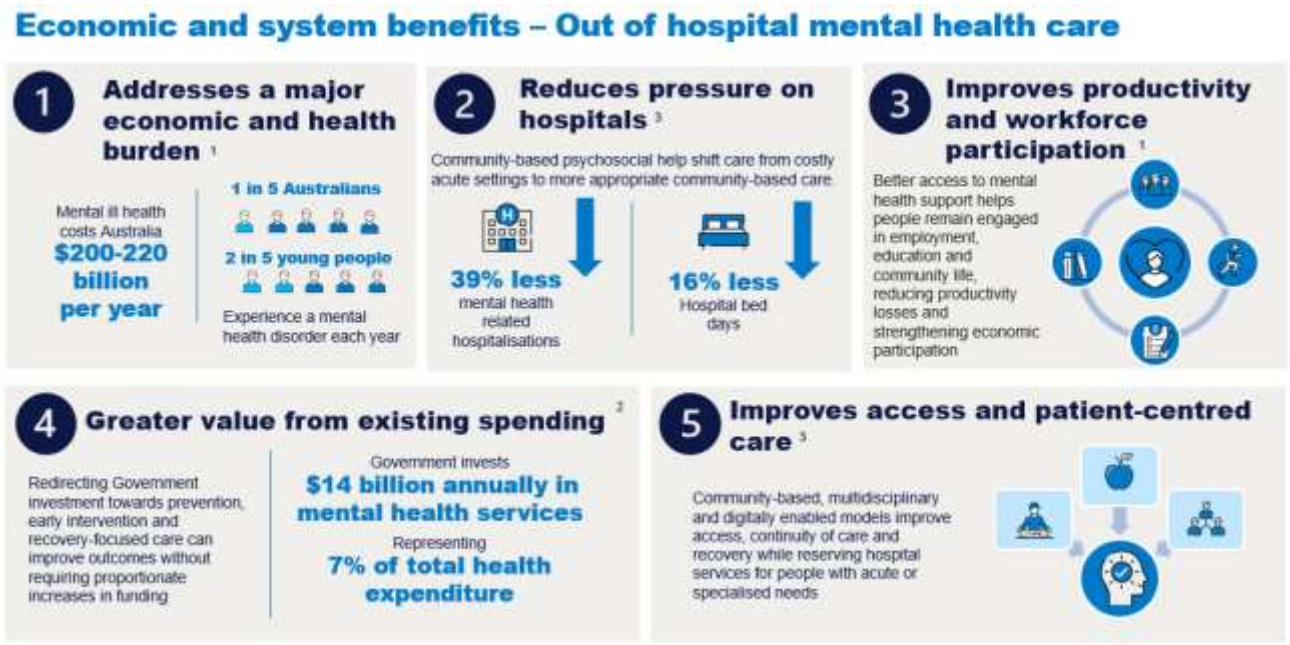


Excludes hospitalisations for intentional self-harm, manic episode, eating disorders, and unspecified mental health hospitalisations. Full assumptions and methodology available in Appendix B.Source: AIHW (2025) Mental health - data tables; DHDA (2026) Hospital Casemix Protocol, Annual report; IHACPA (2025) NHCDC Public Sector Appendix Tables; AIHW (2026) Expenditure on mental health-related services; Mandala analysis.

Bupa Mindplace

Over the last two years, Bupa has significantly increased its investment to enable a whole-of-person approach to mental health. We are moving beyond episodic psychology counselling to offer integrated, holistic programs of care. We are expanding our national Mindplace network from 13 clinics currently across NSW, Victoria and Queensland, providing integrated mental, physical and allied health services that are accessible to all Australians. The Mindplace model is built on access, inclusion and collaboration, offering personalised, whole-of-person care that combines multiple disciplines and supports long-term engagement and better health outcomes. Through Mindplace we aim to make mental healthcare more accessible, reduce barriers to care, and help more Australians access the support they need when they need it.

[86] Sebastian Rosenberg and Carol Harvey, 'Mental Health in Australia and the Challenge of Community Mental Health Reform' (2021) 2(1) *Consortium Psychiatricum* 40; World Health Organization, *Comprehensive Mental Health Action Plan 2013-2030* (2021).
[87] Productivity Commission, *Mental Health, Inquiry Report No. 95* (Inquiry Report, 16 November 2020).
[88] David McGrath, *Unmet Needs Report for Psychosocial Support Services in SA* (Final Report, Office of the Chief Psychiatrist South Australia, 25 July 2023).
[89] AIHW. *Expenditure on mental health-related services.* (2026).



Source: 1. AIHW, Prevalence and Impact of Mental Illness (2025). 2. AIHW, Expenditure on Mental Health-Related Services (2026). 3. David McGrath Consulting, Unmet Needs Report for Psychosocial Support Services in SA (2023); World Health Organization, World Mental Health Report (2022).

Current system challenges

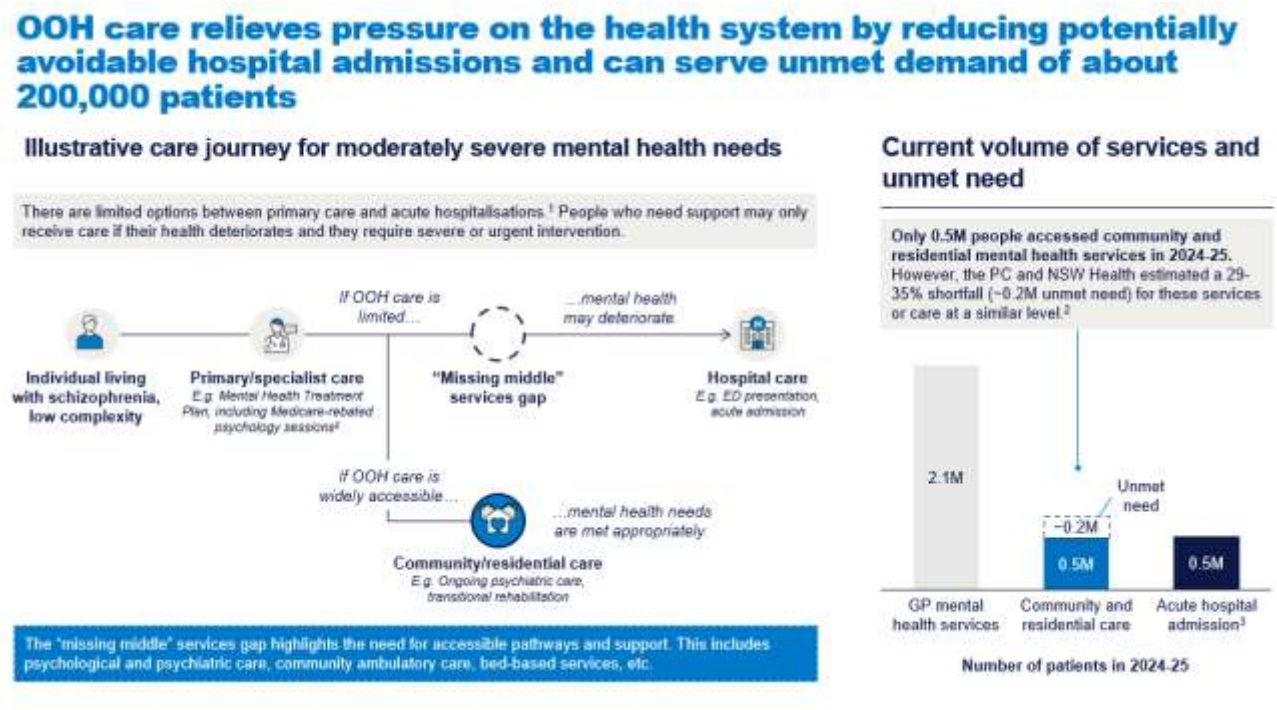
1. Acute care has become the system's pressure valve

Emergency departments and inpatient services increasingly function as the default access point once mental health needs escalate beyond what community care can manage. In 2024–25, public EDs recorded more than 300,000 mental health-related presentations, with substantially longer stays than for presentations overall.[90] Around 14 per cent of acute admitted mental health separations are followed by readmission within 28 days, a rate unchanged over the past decade, reflecting persistent gaps in post-discharge community care.[91]

2. Fragmentation continues to impede continuity of care

Responsibility for funding, commissioning and delivery is split across the Commonwealth, states and territories, with separate programs for primary care, specialist services, psychosocial support and hospital care. Consumers with needs too complex for low-intensity services but below the threshold for specialist public care, the 'missing middle', face particularly inconsistent pathways.[92] The Productivity Commission's review of the *National Mental Health and Suicide Prevention Agreement* found existing arrangements ineffective and called for new policy architecture.[93] Each transition between providers is a point at which a person may disengage from care altogether.

[90] AIHW, *Mental health services provided in emergency departments – National data* (Web Page, 13 August 2026)
[91] AIHW, *Admitted patient indicators* (Web Page, 13 August 2026).
[92] Productivity Commission. *Mental Health and Suicide Prevention Agreement Review.* (2025).
[93] Ibid.



1Note: 1. The PC (2020) describes the "missing middle" as services required by people who are often too unwell for primary care, but not acute enough for hospital admission. 2. The NSW Ministry of Health (2023) estimates a 29% shortfall, while PC (2020) estimates a 29% shortfall, while PC (2020) estimates a 35% shortfall. 3. Hospital admissions include readmissions for the same individual. Source: AIHW (2026) Medicare mental health services; AIHW (2026) Community-based services; AIHW (2025) Admitted patient mental health-related care; DHDA (2026) Better Access Initiative; Mandala analysis.

3. Access to care is constrained by affordability and workforce shortages

Rising demand has outpaced workforce capacity across primary care, specialist services and hospitals, while OOP costs have grown.[94] In 2024–25, almost one in five people needing mental health support delayed or went without care due to cost, rising to around one in four for psychology and psychiatry. [95] [96] The *National Mental Health Workforce Strategy* identifies persistent shortages and uneven distribution as key sustainability risks.[97] The combined effect reduces opportunities for early intervention and increases demand for avoidable specialist, emergency and inpatient care.

4. Funding arrangements reinforce treatment after deterioration rather than prevention

Policy has shifted towards prevention and community-based care, but funding has not kept pace. Responsibilities remain dispersed across Commonwealth and state programs with separate mechanisms for primary care, specialist services, hospitals and psychosocial supports.[98] PHI regulation reflects a similarly hospital-centric model, where insurers can fund hospital-based mental health care but have limited legislative authority to fund preventive, community-based and digitally enabled care outside hospital settings and limited ability to co-fund services from a broader range of medical specialists.[99] [100] This constrains insurers' ability to complement publicly funded services through earlier intervention and coordinated, multidisciplinary care.

5. Accountability remains focused on activity rather than outcomes

Australia collects extensive data on service activity, including ED presentations, admissions, Medicare services and prescriptions, but comparatively little on whether the system delivers timely access, continuity, recovery and better consumer experience.[101]

[94] AIHW, *Mental health* (Web Page, 13 August 2026).
[95] ABS. *Patient Experiences: 2024-2025.* (2025).
[96] Ibid.
[97] DoHDA. *National Mental Health Workforce Strategy 2022-2032.* (2023).
[98] Productivity Commission. *Mental Health and Suicide Prevention Agreement Review.* (2025)
[99] Australian Government, *Private Health Insurance Act 2007* (Cth).
[100] Ibid.
[101] AIHW. *Mental health.* (2026).

Reform priorities

Reform is already moving out of hospital, with *Medicare Mental Health Centres*, the *Medicare Mental Health Check In* and *Youth Specialist Care Centres*, alongside expanded PHI funding for home and community-based care.[102] [103] The priorities below focus on the regulatory, funding and risk-sharing settings needed to move from partial, hospital-anchored coverage to a coherent national framework.

Priority 1: *Enable private health insurers to fund preventive and community-based mental health care*

- Amend the Private Health Insurance Act 2007 and associated rules to enable private health insurers to fund a broader range of evidence-based early intervention, prevention, treatment and recovery services delivered outside hospital settings.
- Align benefit design with quality and recovery outcomes rather than admission or service volume, ensuring private funding complements Medicare and public services by supporting earlier access and continuity.

Priority 2: *Reorient funding towards value, outcomes and evidence*

- Establish nationally consistent outcome and experience measures covering recovery, continuity and avoidable hospital use, embedded in the successor to the National Mental Health and Suicide Prevention Agreement, and shift funding towards value-based outcomes with review of low-value services.[104]
- Support evidence generation through mechanisms such as a Mental Health Clinical Trials Network, with public reporting against outcomes so effective models can scale and ineffective ones be discontinued.

Priority 3: *Close the gap for the missing middle and strengthen care at transitions*

- Fund coordinated, moderate-intensity care for the 'missing middle', and embed step-up early intervention and step-down post-discharge follow-up as funded components of the care pathway, tracked against the 28-day readmission rate.[105]
- Assign explicit responsibility for care coordination at each interface between primary care, specialist services, hospitals and psychosocial supports.

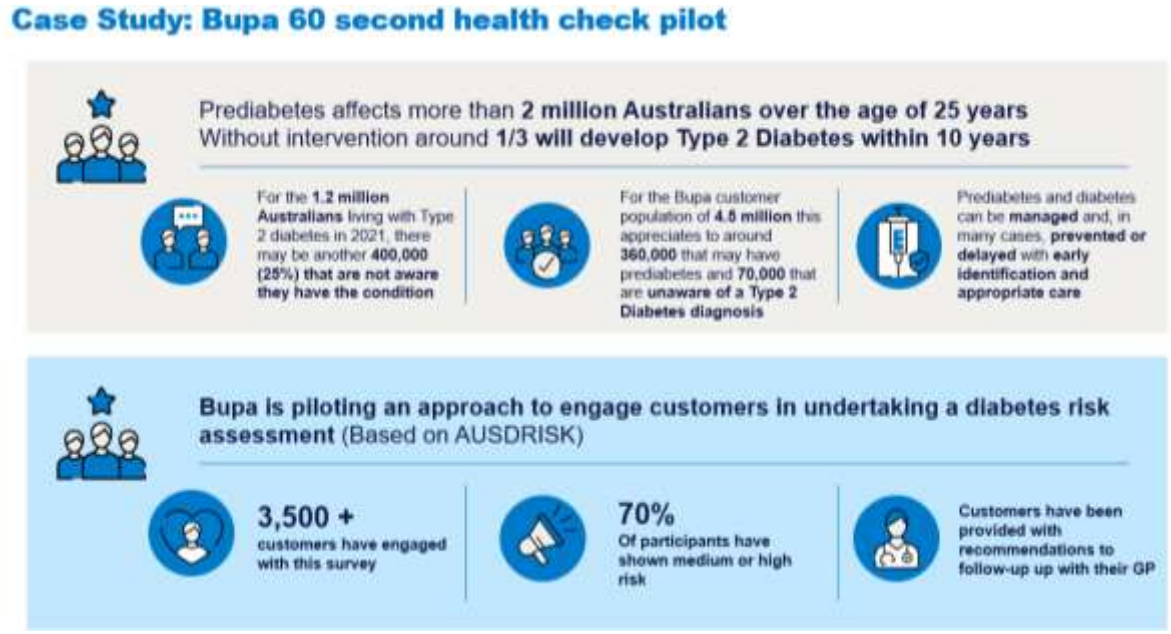
PHI investment in prevention

Case for reform

Preventable chronic conditions account for a substantial share of Australia's disease burden, yet the system remains oriented towards treating illness after it develops. 36 per cent of disease burden in 2024 was attributable to modifiable risk factors, and chronic conditions accounted for 84 per cent of total disease burden.[106] [107] The *National Preventive Health Strategy 2021-2030* targets government investment in prevention reaching 5 per cent of health expenditure by 2030, but Australia currently allocates around 3.1 per cent, against 6 to 7 per cent in Canada and the United Kingdom.[108] [109] The *Strategy* identifies private health insurers as prevention partners, and insurer-funded programs, including risk assessment, coaching and behavioural incentives, can deliver measurable, sustained health benefits.[110] [111]

[102] Prime Minister of Australia, 'Record funding for public hospitals and disability reform' (Media Release, 30 January 2026).
[103] Commonwealth Ombudsman, *Private health insurance changes* (Web Page, 2021) https://www.privatehealth.gov.au/health_insurance/phichanges/index.htm. The measure expands options for insurers to fund non-MBS mental health services under general treatment and hospital treatment policies.
[104] Productivity Commission. *Mental Health and Suicide Prevention Agreement Review.* (2025).
[105] AIHW. *Admitted patient indicators.* (2026).
[106] AIHW, *Australian Burden of Disease Study 2024* (Web Page, 12 December 2024).
[107] AIHW. *Chronic Conditions.* (2026).
[108] DoHDA. *National Preventive Health Strategy 2021-2030.* (2021).
[109] OE OECD. *Health at a Glance 2025: OECD Indicators.* OECD Publishing. (2025).
[110] DoHDA. *National Preventive Health Strategy 2021-2030.* (2021).
[111] Dona, S.W.A., et al. *Impacts of chronic disease prevention programs implemented by private health insurers: a systematic review.* BMC Health Services Research. (2021).

Prevention delivers a median return on investment of $14.30 for every $1 spent, though outcomes vary by intervention and population.[112] Modelling suggests non-communicable disease elimination could lower health expenditure by around 40 per cent and lift GDP by nearly 4 per cent. More realistically, closing the gap to best-performing countries on major risk factors could lower expenditure by 6.2 per cent and lift GDP by 1.3 per cent over 2026-2050.[113] [114] Victoria's SunSmart program illustrates the long-term value of sustained prevention, estimated to have prevented more than 43,000 skin cancers between 1988 and 2011.[115] Private health insurers are well placed to contribute earlier, through risk assessment, coaching and chronic disease management, with some programs already associated with reduced hospital admissions and costs.[116]



Source: 1. ADEA, ADS, DA et al A Position Statement on Screening and Management of Prediabetes in Adults in Primary Care in Australia (2020) 2. AIHW Type 2 Diabetes Facts (2026) 3. Australian Department of Health Australian National Diabetes Strategy 2016 – 2020

Current system challenges

1. Health expenditure remains concentrated after illness develops

Chronic conditions accounted for approximately $98.5 billion in health expenditure in 2023–24, almost 55 per cent of allocable spending, and preventable illness drives $7.7 billion in potentially preventable hospitalisations (8.5 per cent of admitted patient expenditure), with diabetes, cardiac failure and COPD among the most costly.[117] [118] [119]

2. PHI regulation limits earlier and integrated intervention

Insurers can fund eligible general treatment and certain chronic disease management programs, but are generally unable to fund out-of-hospital medical services for which Medicare benefits are payable, limiting their ability to commission coordinated preventive pathways spanning risk identification through to ongoing management.[120]

[112] Masters, R., et al. *Return on investment of public health interventions: a systematic review.* Journal of Epidemiology and Community Health. (2017).
[113] OECD. *The Health and Economic Benefits of Tackling Non-Communicable Diseases.* OECD Health Policy Studies. (2026).
[114] Ibid.
[115] Shih, S.T.F., et al. *Skin cancer has a large impact on our public hospitals but prevention programs continue to demonstrate strong economic credentials.* Australian and New Zealand Journal of Public Health. *(2017).*
[116] Dona, S.W.A., et al. *Impacts of chronic disease prevention programs implemented by private health insurers: a systematic review.* BMC Health Services Research. (2021).
[117] AIHW. *Chronic Conditions.* (2026).
[118] AIHW. *Cost of potentially preventable hospitalisations in Australia, 2014–15 to 2023–24.* (2025).
[119] Ibid.
[120] Dona, S.W.A., et al. *Impacts of chronic disease prevention programs implemented by private health insurers: a systematic review.* BMC Health Services Research. (2021).

3. Existing incentives weaken long-term investment in prevention

Preventive benefits often emerge over long timeframes and may not be captured by the insurer that made the investment.[121] Community rating, member movement between insurers and risk equalisation further reduce the incentive to invest in keeping members well, since programs may not remain viable after risk equalisation, reinforcing a focus on treating discrete episodes over sustained health maintenance.[122]

4. Fragmented data and care pathways constrain implementation

Insurers typically have far more complete information on hospital claims than on members' primary care, diagnostic and pharmaceutical histories, so prevention programs are often directed at people who already have a diagnosis rather than those at earlier risk.[123] Insurer programs also face practical challenges identifying participants, coordinating with providers and evaluating outcomes, compounded by fragmented information and accountability across primary care, insurance, allied health, pharmacy and hospitals.[124]

Collectively, these challenges contribute to a health system where preventable illness can progress before intervention occurs. While private health insurers play an important role in supporting members once treatment is required, current regulatory, funding and information settings limit their ability to contribute more consistently to prevention and early intervention.

Reform priorities

A sustainable system requires settings that support intervention before illness progresses, enabling private health insurers to play a greater role in evidence-based prevention, early intervention and coordinated care that complements Medicare and public health initiatives.

Priority 1: *Shift funding towards preventive care*

- Build on the National Preventive Health Strategy and establish a National Prevention Partnership Framework that formally recognises private health insurers as prevention partners and enables collaborative prevention and early intervention initiatives across government, primary care, hospitals and insurers. The framework should support shared national prevention priorities, coordinated delivery models, consistent outcome measurement and robust evaluation to improve population health and reduce avoidable demand on the health system.
- Amend the *Private Health Insurance Act 2007* and associated rules to permit insurers to fund preventive health programs, early intervention and non-admitted care as substantive benefits, covering risk assessment, screening, health coaching, digital interventions, care coordination and chronic disease management, with eligibility determined by clinical effectiveness and value rather than whether care is delivered in an admitted hospital setting.

Priority 2: *Early intervention for chronic disease*

- Enable insurers to fund clinically appropriate interventions for members at elevated risk of chronic disease before the threshold of immediate medical necessity, with eligibility based on identifiable risk, clinical evidence and value for money.

Priority 3: *Support integrated care models*

- Enable insurers to support coordinated care across the full health continuum, from prevention and early detection through to treatment and ongoing management, facilitating referral pathways and information exchange between insurers, GPs, specialists, allied health, pharmacists and hospitals.

[121] Productivity Commission. *Inquiry report: Delivering quality care more efficiently.* (2025).
[122] Finity Consulting (funded by DoHDA). *Risk Equalisation: Final Report.* (2022).
[123] Khoo, J., Hasan, H. and Eagar, K. *Emerging role of the Australian private health insurance sector in providing chronic disease management programs: current activities, challenges and constraints.* Australian Health Review. (2019).
[124] Dona, S.W.A., et al. *Impacts of chronic disease prevention programs implemented by private health insurers: a systematic review.* BMC Health Services Research. (2021).

Chapter Three: Restore Specialist Care Access and Affordability

Specialist care is the critical link between primary care and hospital treatment, providing the expertise needed to diagnose and manage complex conditions and perform procedures. Yet Australia's capacity to deliver this care equitably is being constrained by three related pressures: unaffordable and unpredictable costs, an undersized and maldistributed workforce and inefficient use of specialist expertise. Among Australians who needed specialist care in 2024–25, 18.3 per cent delayed or did not see a specialist, while 8.6 per cent identified cost as a reason for delaying or foregoing care.[125]

Cost is the most immediate pressure, driven by uncertainty about the total and component costs of care (e.g. consultations, diagnostics, medications, procedures, assisting practitioners, devices), often without understanding their likely financial liability before treatment begins. Median in-hospital private specialist gap fees increased from $222 in 2022 to $270 in 2024, with variation between procedures, providers and jurisdictions.[126] A significant contribution to these rising costs has been insufficient indexation of MBS rebates compared with the costs of providing care.

The specialist workforce needed is not keeping pace with community need or reaching the areas that need it most, driving cost and access issues. Despite growth in the domestic specialist workforce, training bottlenecks, fragmented workforce planning and limited accredited positions continue to constrain progression into specialist practice. By 2033, Australia will have an estimated undersupply of 6,981 full-time-equivalent specialists, increasing to 12,812 by 2048.[127] These pressures are particularly acute in regional, rural and remote Australia, that can experience longer waits and travel demands.

Existing specialist capacity is also not always used efficiently. Many stable patients remain under specialist care when appropriate shared-care arrangements with GPs could provide equivalent management. At the same time, limited access to specialist advice for GPs often results in unnecessary specialist referrals. Expanding shared-care and secondary consultation models would improve access to specialist expertise while ensuring timely specialist assessment for patients with more complex needs.

Restoring accessible and affordable specialist care therefore requires a coordinated response across affordability, workforce supply and service delivery. This chapter sets out reforms focused on reducing unexpected OOP costs, strengthening the specialist workforce pipeline and embedding shared care and secondary consultation within routine healthcare, to support a specialist care system that remains accessible, affordable and sustainable as community need grows.

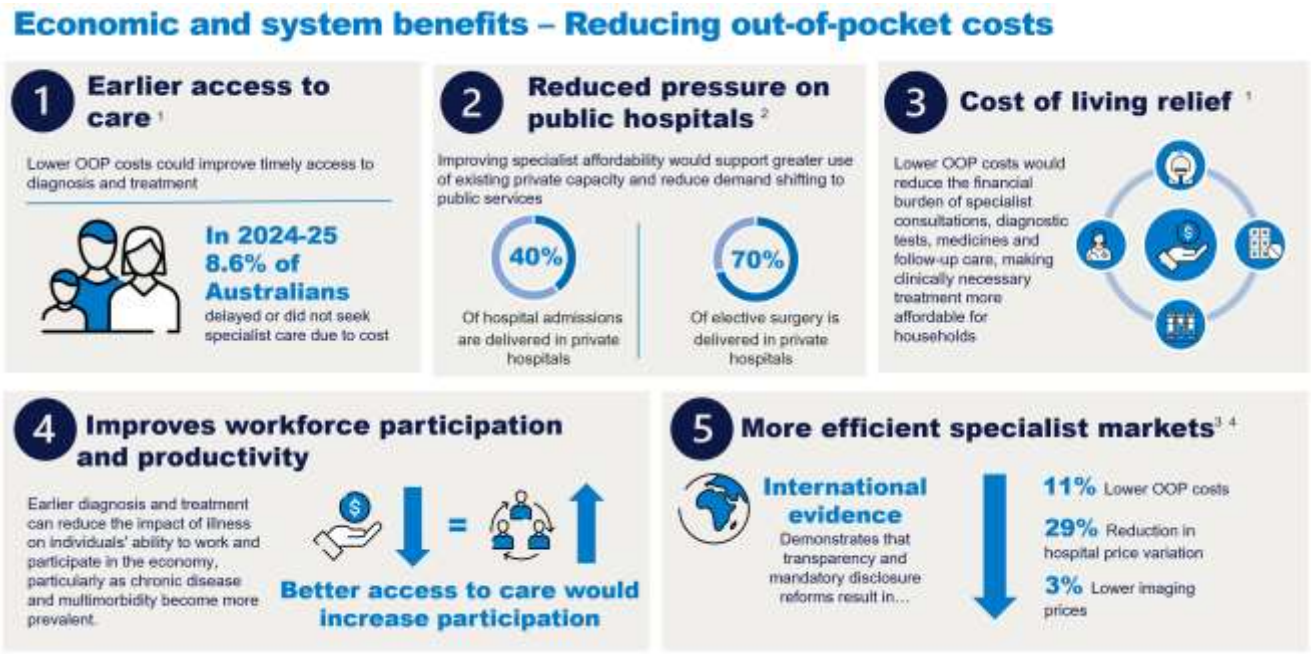
The total cost of out-of-pocket fees

Case for reform

Rising OOP costs are undermining Australia's private health system, creating financial barriers to treatment and shifting demand to publicly funded services. A 2024 CommBank consumer survey found that 71 per cent of surveyed respondents had delayed or cancelled a GP or specialist appointment due to cost.[128] While 92 per cent of specialist hospital episodes were billed under no-gap or known-gap arrangements in FY23, the remaining 8 per cent of episodes accounted for 61 per cent ($0.7 billion) of the $1.1 billion in total OOP costs.[129,130] Bupa welcomes the Government's proposed reforms on fee transparency through the Medical Costs Finder, but transparency alone will not fix affordability: patients need visibility of expected costs to enable better health planning and protection from unreasonable billing, and access without unnecessary financial barriers.

[125] ABS. *Patient Experiences 2024-25 Financial Year.* (2025).
[126] Mandala Partners, *Restoring affordable access to specialist care in Australia* (Final Report, PHA, February 2026).
[127] DoHDA. *Whole of Medical Workforce Supply and Demand Compendium Report.* Australian Government. (2026).
[128] Commonwealth Bank, *CommBank Patient Experience Insights 2024: Patient Perspectives* (Final Report, May 2024).
[129] Private Healthcare Australia, *Reducing out-of-pocket costs for Australian healthcare consumers* (Final Report, March 2025).
[130] Ibid.

Reducing OOP costs would improve access, efficiency and household resilience. Affordable access supports earlier diagnosis and keeps demand within the private health system, which delivers over 40 per cent of admissions and around 70 per cent of elective surgery.[131] [,132] Transparency also strengthens markets: New Hampshire's price website cut listed imaging prices by around 3 per cent and OOP costs by 11 per cent after five years, and Dutch disclosure reduced price variation by 29 per cent between 2016 and 2022 without prices rising above inflation.[133] [,134] Expanding the Medical Costs Finder would extend these gains.[135]



Source: 1. Australian Bureau of Statistics, *Patient Experiences* (Catalogue No 4839.0, 2024-25 Financial Year, 2025) 2. Department of Health and Aged Care, *Private Hospital Sector Financial Health Check: Summary* (Australian Government, 2024). 3. H Araich et al, 'Healthcare Price Transparency in North America and Europe' (2023) 96(1149) *British Journal of Radiology*. 4. Fleur Franken et al, 'Price Transparency in the Dutch Market-Based Health Care System: Did Price Dispersion for Similar Hospital Services Reduce over Time?' (2025) *European Journal of Health Economics*.

Current system challenges

1. Rising OOP costs are affecting timely access to specialist care

Rising medical fees and cost uncertainty are making specialist care less accessible. Among patients admitted to private hospitals, 60 per cent report an OOP cost and 70 per cent of those pay more than $500;[136] 37 per cent reported psychological distress and one in five skipped care because of expense.

2. Limited fee transparency constrains informed patient choice

Patients have limited visibility of specialist fees and likely costs before treatment; the Medical Cost Finder helps but its usefulness depends on data availability, and under the voluntary scheme, uptake was low. Where supply is limited, patients have little ability to compare providers, letting higher fees become the default.

3. Referral rules disrupt continuity of specialist care

Referral arrangements create administrative interruptions for chronic or complex patients: GP referrals default to 12 months and specialist referrals to three, both from first attendance rather than issue date, and cover only a single course of treatment.[137] [,138] If a referral expires mid-treatment, patients must return to the

[131] DoHDA. *Private Hospital Sector Financial Health Check – Summary* (Report, October 2024).
[132] Ben Keneally, Stephen Hosie and Max McArthur, *Delayed Recovery: Why Times Are Tough for Australia's Private Hospitals and What They Can Do About It* (Report, Boston Consulting Group, March 2024).
[133] Harman Araich et al, 'Healthcare price transparency in North America and Europe' (2023) 3(96) *British Journal of Radiology* 1151.
[134] Frédérique Franken et al, 'Price transparency in the Dutch market-based health care system: did price dispersion for similar hospital services reduce over time?' (2025) 26(7) *The European Journal of Health Economics* 1137.
[135] David Bernstein and Jonathan Crowe, 'Price Transparency in United States' Health Care: A Narrative Policy Review of the Current State and Way Forward' (2024) 26(61) *Inquiry* 1.
[136] Patients Australia and La Trobe University, *Patient View Report 2025* (Final Report, March 2025).
[137] DoHDA. *Consultation Paper – Modernising Referral Pathways* (Consultation Paper, February 2026).
[138] Ibid.

referrer for a new one, interrupting management. GPs can specify a different period or indefinite where a patient condition needs continued care.

((Private Healthcare Australia, Private health reform options, *2025).AIHW,* Australia's Mothers and Babies, *1994; AIHW,* Admitted patient care 2024–25: Types of care provided, *2025).*

4. Existing arrangements do not consistently protect consumers from rising costs

Insurer gap schemes can reduce or eliminate OOP costs where the specialist agrees to participate, accepting the combined Medicare and insurer benefit as full payment (no-gap) or a limited contribution (known-gap). Participation is voluntary and decided per episode, so non-participation leaves patients with less certainty and higher costs.

Reform priorities

These reforms aim to reduce unexpected medical costs, support informed choice and encourage effective competition, while preserving clinical autonomy and specialists' ability to set their own fees.

Priority 1: *Improve specialist fee transparency and market information*

- Expand the Medical Costs Finder to include typical fees, Medicare benefits, gap-scheme participation requiring specialists to publish indicative fees and an ability to correct information between updates. Contextual information should also be considered for inclusion (such as case complexity) and additional typical related costs such material diagnostic

Priority 2: *Ensure MBS rebates are adequately indexed*

- Index MBS rebates in line with appropriate inflationary indexes, such as the health inflation index

Priority 3: *Modernise referral arrangements to improve continuity of care and patient choice*

- Educate consumers that referrals to a named specialist is not required and can be addressed to the relevant specialty so they can choose their own specialist
- Review referral default validity periods to better support chronic conditions, and develop nationally consistent guidance on referral governance and continuity of care.

Priority 4: *Strengthen consumer protections through a national no-surprise billing framework*

- Introduce a national no-surprise billing framework prohibiting split billing, with each practitioner's full charge recorded in a single bill, alongside standardised financial consent so patients get clear, itemised costs before treatment.
- Require patients be informed of any material cost changes before treatment proceeds, except where urgency makes disclosure impracticable

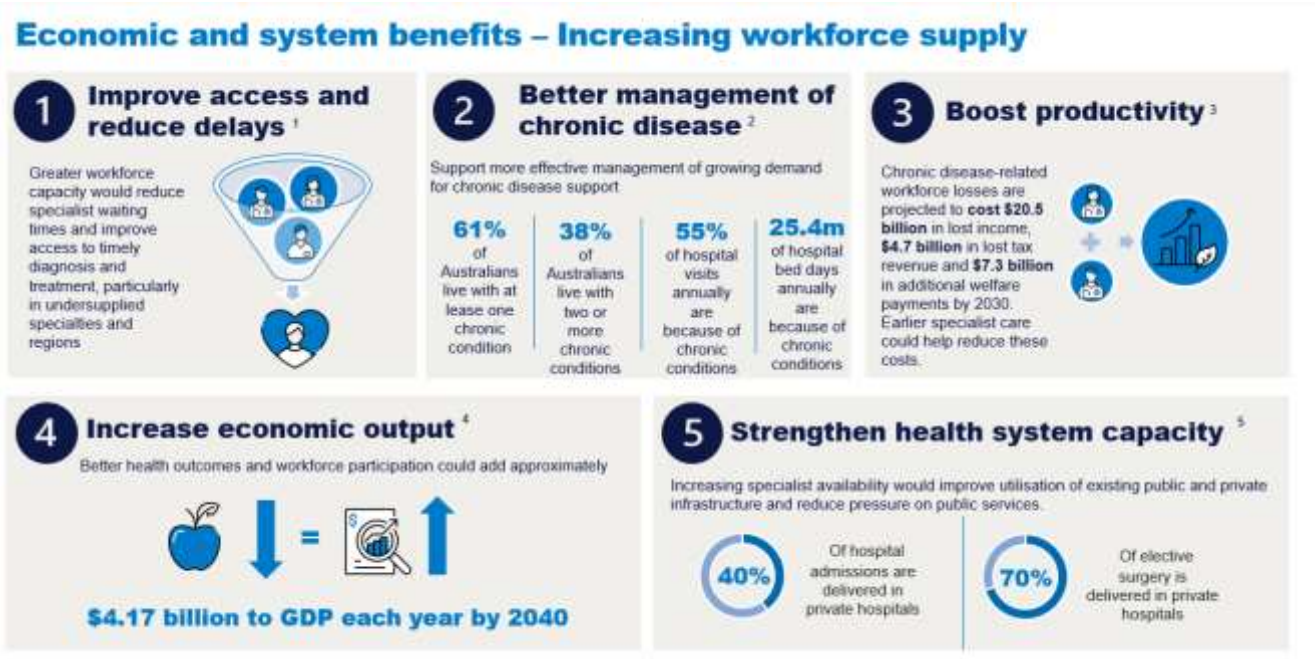
Increasing workforce supply to reduce the pressure on costs

Case for reform

National modelling projects a shortfall of 6,981 full-time-equivalent specialists by 2033 and 12,812 by 2048.[139] The medical workforce more than doubled between 2003 and 2023 shortages persist across disciplines, and international medical graduates (34 per cent in 2023), are projected to account for 42 per cent of workforce growth to 2048.[140,141] Availability in 2025 ranged from 1.3 practitioners per 1,000 people in major cities to 0.7 in inner regional, 0.5 in remote and 0.1 in very remote Australia. One additional practitioner per 1,000 residents could reduce median medical gap payments by 1.02 per cent, showing workforce supply is a genuine, if partial, lever on affordability.[142]

If properly directed towards undersupplied specialties and communities, greater specialist capacity would improve timely access, continuity of care and use of existing infrastructure. 61 per cent of Australians live with at least one chronic condition, which drove 55 per cent of hospitalisations in 2023-24.[143] Reduced workforce participation from chronic conditions among 45-64 year olds is projected to cost $20.5 billion in lost personal income and $4.7 billion in lost tax revenue by 2030, while improved health and carer participation could add $4.17 billion to GDP by 2040.[144,145] Regional and remote workforce growth would reduce travel and reliance on visiting services,[146,147] and better use of private capacity, which delivered 67 per cent of planned surgery in 2024-25, would ease pressure on public outpatient and elective surgery services.[148] A centralised workforce planning authority could directly address these supply bottlenecks and regional imbalances.[149]

[139] DoHDA. *National Medical Workforce Strategy 2021 – 2031* (2022).
[140] DoHDA. *Whole of Medical Workforce Supply and Demand Study* (2026).
[141] Ibid.
[142] Mandala Partners (for PHA). *Reducing out-of-pocket costs for Australian healthcare consumers.* (2025).
[143] DoHDA. *Whole of Medical Workforce Supply and Demand Compendium Report.* Australian Government. (2026).
[144] Deborah Schofield et al, 'Economic costs of chronic disease through lost productive life years (PLYs) among Australians aged 45–64 years from 2015 to 2030: results from a microsimulation model' (2016) 6(9) *BMJ Open* 1.
[145] Productivity Commission. *Shifting the Dial 5-year Productivity Review: Supporting Paper No. 6 – Impacts of Health Recommendations.* Australian Government. (2017).
[146] RACP, *Regional, Rural and Remote Physician Strategy* (June 2023).
[147] AIHW. *Rural and remote health.* (2025).
[148] Australian Private Hospitals Association (APHA), *Private Hospital Facts* (Web Page, 2026).
[149] AIHW. *Rural and remote health.* (2025).



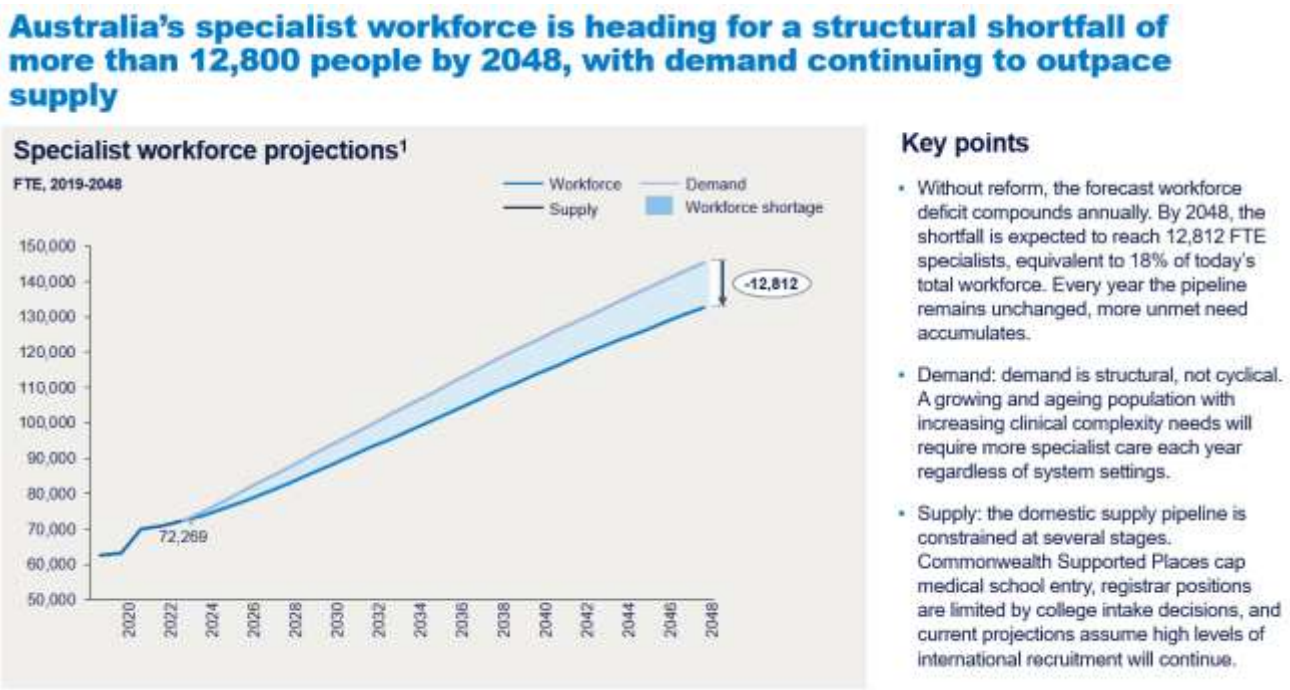
Source: 1. Department of Health and Aged Care, *National Medical Workforce Strategy 2021-203*1 (Australian Government, 2021). 2. Australian Institute of Health and Welfare, *Australia's Health: Chronic Conditions* (Web Report, 2026). 3. Deborah Schofield et al, 'Economic Costs of Chronic Disease through Lost Productive Life Years among Australians Aged 45-64 Years from 2015 to 2030: Results from a Microsimulation Model' (2016) 6(3) *BMJ Open*.4. Productivity Commission, *Shifting the Dial: 5 Year Productivity Review, Supporting Paper No 6 – Impacts of Health Recommendations* (Supporting Paper, Australian Government, 2017).5. Department of Health and Aged Care, *Private Hospital Sector Financial Health Check: Summary* (Australian Government, 2024); Australian Private Hospitals Association, Private Hospital Facts (2026).

Current system challenges

1. Specialist training capacity is not keeping pace with workforce demand

National modelling projects a shortfall of 6,981 full-time-equivalent specialists by 2033, rising to 12,812 by 2048 under current settings. Geographic maldistribution compounds the shortage problem: specialist availability in 2025 was 1.3 per 1,000 people in major cities against just 0.1 in very remote Australia.[150] Public elective surgery waiting times illustrate the resulting pressure, with median waits rising over the past decade for ENT, ophthalmology and orthopaedic surgery.[151] The complete pathway to specialist qualification typically takes 12 to 16 years and depends on teaching resources, clinical placements and accredited training environments, so growing medical student numbers alone will not resolve specialist shortages without matching investment across the full pipeline.[152] ,[153]

[150] DoHDA, *Health Workforce Dataset* (Web Page, 2026); ABS, *Estimates of resident population: Local Government Areas (a) – Australia* (Web Page, 31 March 2026); Mandala analysis 2026.
[151] AIHW, *Elective surgery: Waiting times by surgical specialty* (Web Page, 25 November 2025; Mandala analysis.
[152] DoHDA. *National Medical Workforce Strategy 2021 – 2031.* Australian Government. (2021).
[153] Ibid.



Source: Department of Health, Disability and Ageing (2026) Whole of Medical Workforce Supply and Demand Study; Mandala analysis.

2. Specialist training pathways contain structural bottlenecks

Competition for vocational training substantially exceeds available positions in many specialties; only 34 per cent of surgical applicants succeeded in obtaining a training position in 2024. [154,155] This mismatch has produced a substantial cohort of doctors in unaccredited registrar roles, performing specialist-level duties without the structured education, supervision or defined progression of accredited training, extending the pathway to independent practice.[156,157] The principal constraint is progression from prevocational employment into accredited registrar and specialist training: the surplus of prevocational doctors is projected to rise from 8.7 per cent in 2025 to around 28 per cent by 2033, while the transition rate to registrar training falls from 36 per cent in 2024 to 15 per cent by 2048.[158]

3. Workforce planning responsibilities are fragmented across the health system

Governance of the specialist workforce is spread across governments, health services, universities, colleges, regulators and accreditation bodies, with no single body controlling the levers needed to align student numbers, training positions, specialist supply and geographic distribution with community need.[159] Decisions on university intake, hospital staffing, training-site accreditation and workforce distribution are made through separate processes with different objectives and timeframes, making it difficult to respond to emerging shortages before they affect access.[160]

4. Specialist workforce distribution remains uneven across Australia

Remote areas have around seven times fewer specialists than major cities despite higher disease burden. [161] The share of people citing absence of a nearby specialist as a barrier to care rises from 6 per cent in major cities to 58 per cent in remote areas.[162] In 2025, regional ophthalmology and orthopaedic waits were around 30-50 days longer than in major cities, and difficulty attracting and retaining regional specialists

[154] Daniel Thompson et al, 'Additional qualifications of trainees in specialist training programs in Australia' (2019) 19(1) *BMC Medical Education* 247.
[155] Caroline Dowling et al, 'Unaccredited Specialty Surgery "Training": The Impact of the Years Prior to SET Entry' (2026) 96(4) *ANZ Journal of Surgery* 717.
[156] Jerome Martin Laurence, 'Unaccredited medical training in Australia: from hidden problems to practical workforce solutions' (2026) 56(6) *Internal Medicine Journal* 1091.
[157] Laurence, J.M. *Unaccredited medical training in Australia: from hidden problems to practical workforce solutions*. Royal Australasian College of Physicians (RACP) Internal Medicine Journal. (2026).
[158] DoHDA. *Whole of Medical Workforce Supply and Demand Compendium Report.* Australian Government. (2026).
[159] DoHDA. *National Medical Workforce Strategy 2021 – 2031.* Australian Government. (2021).
[160] DoHDA. *Whole of Medical Workforce Supply and Demand Compendium Report.* Australian Government. (2026).
[161] RACP. *Regional, Rural and Remote Physician Strategy.* (2023).
[162] Ibid.

increases reliance on visiting clinicians, outreach and patient travel, disparities likely to widen without stronger regional training and retention pathways.[163]

Source: Department of Health, Disability and Ageing (2026) Health Workforce Dataset; ABS (2026) Estimates of resident population, Local Government Areas (a), Australia; Mandala analysis Note: 1. Weighted average number of days waiting for elective surgery by specialty and number of surgeries. Data for medium and large hospitals.

Source: Department of Health, Disability and Ageing (2026) Health Workforce Dataset; ABS (2026) Estimates of resident population, Local Government Areas (a), Australia; Mandala analysis.

5. Australia remains increasingly reliant on internationally trained doctors

International medical graduates now exceed the number of domestic graduates entering the workforce each year, reflecting Australia's reliance on international recruitment.[164] Assessment, supervised practice and registration requirements for internationally trained doctors are important for patient safety, but delays within these pathways can restrict timely entry into areas of need. Long-term dependence on overseas-trained clinicians leaves Australia exposed to global competition for health professionals and migration disruptions, underlining the need to strengthen domestic training, distribution and retention alongside international recruitment.[165]

[163] DoHDA. *Health Workforce Dataset.* (2026); ABS. *Estimates of resident population: Local Government Areas (a) – Australia.* (2026); Mandala analysis. *Note: Weighted average number of days waiting for elective surgery by specialist surgeon and number of surgeries. Data for medium and large hospitals;* AIHW. *Rural and remote health.* (2025).
[164] DoHDA. *Whole of Medical Workforce Supply and Demand Study.* Australian Government. (2026).
[165] AIHW, *Health workforce* (Web Page, 9 July 2026)

Source: Mandala analysis

Reform priorities

Given that specialist supply is shaped by decisions across university funding, hospital employment, vocational training, accreditation, migration and healthcare financing, reform should establish a nationally coordinated framework that aligns the levers held by governments, health services, training organisations and regulators.

Priority 1: *Streamline pathways for internationally trained specialists*

- Expand the Expedited Specialist pathway to additional shortage specialties aligned with national workforce modelling.
- Improve coordination between stakeholders so internationally trained specialists can access employment in areas of need, maintaining international recruitment as a complement to, not a substitute for, domestic training capacity.

Priority 2: *Establish a national specialist workforce planning authority to advise governments on the required size, specialty mix and geographic distribution of Australia's specialist workforce*

- Establish a national specialist workforce planning authority, with representation from the Commonwealth, states and territories, public and private health services, universities, training organisations, regulators and underserved communities, to set and oversee delivery of nationally agreed specialty-level training targets based on projected need while colleges retain responsibility for curricula and clinical standards.
- Develop a nationally consistent workforce planning framework and dataset (including public transparency) spanning medical school places through post-qualification employment, specialty trainees, fellows & supervisors, linked to demand and access indicators such as waiting times

Priority 3: *Expand and better target the domestic specialist training pipeline*

- Establish a nationally coordinated pool of funded specialist training positions, sized and distributed by workforce modelling and agreed specialty targets, with Commonwealth and jurisdictional funding also linked to delivery in undersupplied specialties and locations.

Improving GP-Specialist collaboration

Case for reform

As our population ages and demand for timely and affordable access to non-GP specialists increases, GPs remain central to continuous, whole-person care.[166] This opens up two complementary changes: sharing more of the patients care across GP's and specialists and having access to a secondary consultation service to resolve discrete clinical questions without automatically requiring referral. Secondary consultation and shared care would expand effective access to specialist expertise without converting every clinical question into a patient-facing appointment and concentrating specialist time on complex assessment and procedural care.[167]

A nationally available system delivering an estimated 140,500 secondary consultations a year could avoid around 68,000 specialist referrals and reduce patient OOP costs by about $4 million annually.[168] [169] Since specialist OOP fees are $77 higher than GP fees and Medicare contributions $44 higher, shifting appropriate care to general practice would lower costs for both patients and government.

Queensland's Mater eConsultant service illustrates the model in practice: since October 2025 it has supported more than 250 regional and rural GPs, with over 1,000 patients receiving earlier advice and almost 92 per cent avoiding a face-to-face specialist appointment, with responses averaging 2.1 business days.[170] [171] Under an illustrative scenario, redirecting 5.3 per cent of specialist consultations involving primary-care activity to general practice could deliver an estimated annual saving of $161 million: $99 million for patients and $62 million for government.[172] The approach reduces avoidable referrals and travel, and directs face-to-face specialist appointments towards patients with the greatest clinical need.[173]

GPs currently lack a formal, accessible pathway to seek specialist advice, often defaulting to a specialist referral or relying on informal collegial networks, since existing funding provides limited support for direct communication outside a formal consultation.[174]

[166] Peter Breadon et al, *Special treatment: Improving Australians' access to specialist care* (Final Report, Grattan Institute, June 2025).
[167] RACGP, *Shared Care Model between GP and non-GP specialists for complex chronic conditions* (Position Statement, February 2023).
[168] Peter Breadon et al, *Special treatment: Improving Australians' access to specialist care* (Final Report, Grattan Institute, June 2025
[169] AIHW. *Rural and remote health.* (2025).
[170] Minister for Health and Ambulance Services (QLD), 'Faster specialist care for regional Queenslanders' (Media Release, 22 July 2026).
[171] Jennifer Job et al, 'Feasibility of an asynchronous general practitioner–to–general physician eConsultant outpatient substitution program: A Queensland pilot study' (2021) 50(11) *Australian Journal of General Practice* 1.
[172] Roy, S. *30+ Patient Referral Statistics: Why Your System Is Bleeding Money.* Dialog Health. (2026); Hashim, M.J. *Provision of primary care by specialist physicians: a systematic review.* Family Medicine and Community Health. (2020); Smith, H.E., et al. *What proportion of adult allergy referrals to secondary care could be dealt with in primary care by a GP with special interest?* Clinical and Translational Allergy. (2016). *Note: 5.3% represents the lower end estimate of the specialist consultations classified as primary care in Hashim.*
[173] Ibid.
[174] RACGP. *Position Statement: Shared Care Model between GP and non-GP specialists for complex chronic conditions.* (2023).

Source: 1. Peter Breadon et al, Special Treatment: Improving Australians' Access to Specialist Care (Grattan Institute, 2025) 2. Tim Nicholls, Faster Specialist Care for Regional Queenslanders (Media Release, Queensland Government, 2026) 3. Jennifer Job et al, 'Feasibility of an Asynchronous General Practitioner-to-General Physician eConsultant Outpatient Substitution Program: A Queensland Pilot Study' (2021) 50(7) Australian Journal of General Practice. 4. S Roy, 30+ Patient Referral Statistics: Why Your System Is Bleeding Money (Dialog Health, 2026); Mohamed J Hashim, 'Provision of Primary Care by Specialist Physicians: A Systematic Review' (2020) 8(2) Family Medicine and Community Health. 5. Royal Australian College of General Practitioners, Position Statement: Shared Care Model between GP and Non-GP Specialists for Complex Chronic Conditions (2023).

Current system challenges

1. Australia's care model does not consistently support specialists to work at the top of their scope of practice

Shared care arrangements can enable activities such as routine monitoring, management of comorbidities to be undertaken by GPs within agreed parameters, while diagnosis, complex treatment changes and complications remain with the specialist. The share of specialist visits involving primary-care activity varies from 2.6 to 65 per cent across specialties and settings, showing opportunities vary materially by patient complexity and specialty.[175] Shared care already operates in antenatal, cancer and diabetes care but is not consistently embedded elsewhere, constrained by poor communication and unclear responsibilities.[176] Any expansion must account for general practice capacity, with GPs able to decline or return care that falls outside their competence or capacity.[177]

2. GPs have limited access to timely specialist advice

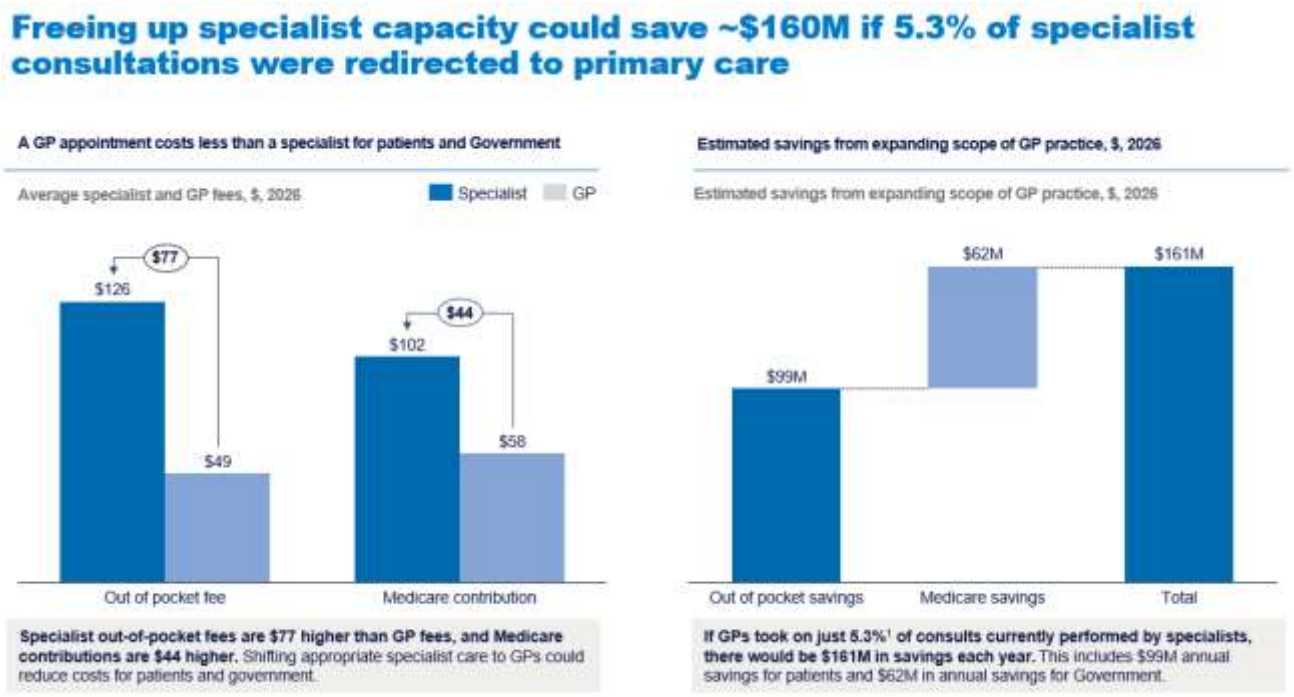
GPs frequently need specialist input on a discrete question but the MBS provides no dedicated mechanism for brief specialist advice outside a formal consultation, and case-conferencing items are ill-suited to routine secondary consultation.[178].[179] This drives avoidable referrals and inconsistent access to advice across jurisdictions and specialties.

3. Funding, referral and information-sharing arrangements do not adequately support collaborative care

Funding and referral arrangements support discrete episodes of care more readily than continuing collaboration: existing case-conferencing mechanisms are poorly suited to routine asynchronous GP-specialist communication, and the lack of dedicated remuneration for Requests for Advice discourages

[175] Hashim, M.J. *Provision of primary care by specialist physicians: a systematic review.* Family Medicine and Community Health. (2020).
[176] RACGP. *Position Statement: Shared Care Model between GP and non-GP specialists for complex chronic conditions.* (2023).
[177] Ibid.
[178] Breadon, P., et al. *Special treatment: Improving Australians' access to specialist care.* Grattan Institute. (2025).
[179] Council of Presidents of Medical Colleges (CPMC), Submission 98 to Senate Rural and Regional Affairs and Transport References Committee, *Rural, regional and remote Medicare access and funding* (2026).

participation and limits scalability.[180] My Health Record's sharing-by-default requirements apply only to specified pathology and imaging reports, so other clinical information often remains unavailable, and it functions as a repository rather than a direct communication channel for discussing management or seeking timely advice.[181] ,[182]



Estimated total savings 5.3% represents the lower end estimate of the specialist consultations classified as primary care in Hashim (2020).

Source: Dialog Health (2026) 30+ Patient Referral Statistics: Why Your System Is Bleeding Money; Frew et al. (2016) What proportion of adult allergy referrals to secondary care could be dealt with in primary care by a GP with special interest?; Mandala analysis.

Reform priorities

Embedding collaboration as a routine feature of specialist care requires a coordinated framework that supports timely clinical advice, clearly allocates responsibility and funds the work of both GPs and non-GP specialists, while preserving direct referral and rapid specialist review for patients who need diagnosis, complex management or procedural intervention.

Priority 1: *Establish a national secondary consultation service*

- Create a national service through which GPs can seek patient-specific advice from participating public and private specialists without first converting the request into a formal referral, covering diagnostic clarification, interpretation of investigations, treatment and medicines management and whether direct referral is required.
- Require each response to set out recommended action, monitoring and escalation triggers and confirm the GP retains responsibility unless care is formally transferred, under coordinated Commonwealth and jurisdictional funding remunerating both the GP and specialist.

[180] Breadon, P., et al. *Special treatment: Improving Australians' access to specialist care.* Grattan Institute. (2025).
[181] DoHDA. *Frequently Asked Questions – Modernising My Health Record (Sharing by Default) Act 2025* (Web Page, February 2025)
[182] David Homewood et al, 'Updates in digital shared care: Launching into the 21st century' (2024) 53(11) *Australian Journal of General Practice* 1.

- Apply national standards for clinical governance, consent, privacy and response timeframes, and integrate the service with clinical software so relevant histories and results accompany each request and advice is recorded in the patient's file.

Case study: Maintaining specialist oversight through GP specialist secondary consultations

GP specialist secondary consultation process

Consultation step	1 GP identifies a suitable case	2 GP submits a structured Request for Advice	3 A specialist reviews the RFA and responds	4 GP actions advice with patient
	A GP sees a patient who would normally need a specialist referral, but they have a specific question rather than needing a full specialist review.	A secure messaging platform with a software template is used, with patient information populated and a clear clinical question specified.	A specialist reviews in their own time, usually attached to a hospital-led specialist hub that rosters specialists to the secondary consultation service.	Advice is documented in the patient record, and the GP manages ongoing care. The patient retains the option of a standard specialist referral at any point.
Case study	**GPs across Queensland identify patients needing specialist input** across more than ten specialties which are covered by Mater's eConsultant service. Cases typically involve the diagnosis, management, and monitoring of chronic conditions.	**GP submits a Request for Advice** through the Consultmed platform, integrated with major GP systems such as "Best Practice" and "Medical Director". Information is transferred in a secure, cloud-based environment to protect patient confidentiality.	**Specialist attached to the Mater Hospitals hub responds** with a median turnaround of 1.7 days, funded at the specialist's current sessional rate.	**GP manages the patient's care directly in 82% of cases** on the specialist's advice, avoiding the need for a face-to-face outpatient referral. **The mean turnaround time for patients** to discuss the eConsultant advice with their GP was 12 days, well within recommended waiting list timeframes.

Specialist secondary consultation pathway based on the Queensland eConsultant model. [183]

Priority 2: *Create shared-care pathways that are consistent and implementable across Australia*

- Co-design a national framework and specialty-specific protocols defining activities, monitoring thresholds and responsibility for treatment changes and specialist reassessment, expanding shared-care pathways for relevant conditions with clear re-entry when a patient's condition changes.
- Require structured information exchange at key clinical points, allow GPs to decline or return care outside their competence or capacity, and support shared care with appropriate funding and multidisciplinary capacity, monitoring volume to prevent unsustainable pressure on general practice.

Priority 3: *Align funding, digital infrastructure and accountability with collaborative care*

- Reform Medicare arrangements to support asynchronous specialist advice, case conferencing and joint care planning outside conventional attendances, and implement nationally consistent interoperability standards so referrals, care plans and results move securely between systems, strengthening My Health Record's clinical utility without replacing direct clinician communication.
- Establish national measures covering response times, referrals, costs, continuity and outcomes, alongside unintended effects such as GP workload and delayed escalation, and use implementation evidence to refine and scale models that demonstrate safety and value.

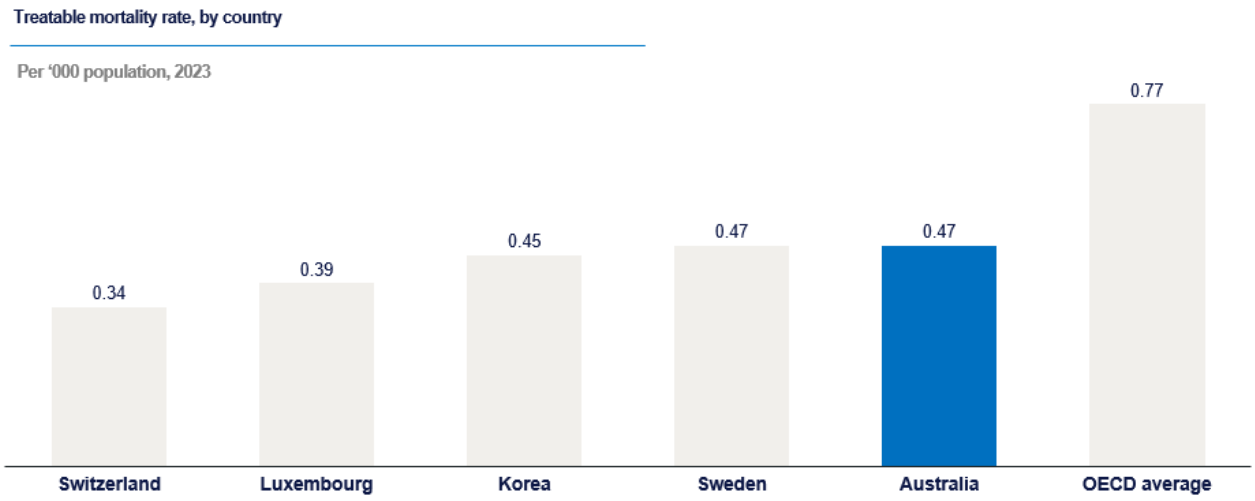
[183] Consultmed. *Queensland eConsultant Service.* (2025); Job, J., et al. *Implementing a general practitioner-to-general physician eConsult service (eConsultant) in Australia.* BMC Health Services Research. (2022).; Job, J. *eConsultant implementation and evaluation.* Clinical Excellence Queensland (Queensland Health). (2022).

Chapter Four: Achieve financial sustainability across the health and care sectors

Australia's health sector performance compares favourably against the OECD average across several indicators, including perceived health status, mortality, and health insurance coverage[184]. However, this system is facing mounting pressure, leading to higher prices which hinders access. [185]

Treatable mortality rate by country

Australia has the fifth lowest treatable mortality rate in the OECD.
This reflects Australia's high-quality healthcare system, which plays an important role in lowering treatable mortality.



Source: ABS (2026) *Patient experiences*; AIHW (2026) *Emergency department care;* AIHW (2024) *Medicare bulk billing and out-of-pocket costs of GP attendances over time;* AIHW (2024) *Use of emergency departments for lower urgency care 2020–21 and 2021–22;* Australian Government (2024) *Current GP Workforce and Projections;* OECD (2026) *Avoidable mortality;* RACGP (2026) *How does burnout impact GPs globally*; Toledo (2024) *Reducing Population Mortality through Primary Care Physicians;* Mandala analysis.

Australians are living longer but experiencing increasing rates of chronic and complex disease which require ongoing care and support. National projections indicate that the proportion of Australians aged 65 years and over will rise significantly over coming decades, while fertility rates remain below replacement levels and the working-age population grows more slowly[186]. A smaller proportion of taxpayers will consequently be supporting a larger proportion of older Australians with greater health and aged care needs.

At the same time, health care expenditure is projected to account for 16.4 per cent of all Commonwealth spending in 2026-27 according to the Federal Budget.[187] The balance between public and private funding is becoming unstable, with weaker PHI participation among causing a shift in demand on to the public health system, which is already facing significant stress.

While advances in clinical care and digital health mean more services can be delivered outside traditional hospital settings, funding and regulatory arrangements have not kept pace with these opportunities. There is also a disconnect between healthcare funding models and value, with our established fee-for-service models incentivising volume optimisation. This can inadvertently result in cases where funding is not aligned with patient outcomes, the need for care coordination across different healthcare settings, and the requisite investment in preventive care.[188]

Against this backdrop, strengthening the long-term financial sustainability of Australia's mixed public-private healthcare system should be a central policy objective. A strong private sector can help absorb increasing

[184] AIHW. *International comparisons of health data.* (2026).
[185] OECD, *Avoidable mortality* (Web Page, 9 July 2026)
[186] The Treasury, *2023 Intergenerational Report: Australia's Future to 2063* (Report, 24 August 2023).
[187] Australian Government, *Budget Paper No 1: Budget Strategy and Outlook 2026–27* (Budget Paper, 12 May 2026)
[188] Productivity Commission. *Inquiry report: Delivering quality care more efficiently.* (2025).

demand, provide consumers with greater choice and control over their health, reduce pressure on the public health systems and broaden the funding base for healthcare. This chapter sets out system-wide reforms to increase participation in PHI, improve productivity in the private healthcare sector, support more productive and prevention-focused models of care and expand residential aged care capacity to meet the needs of an ageing population.

Growing participation

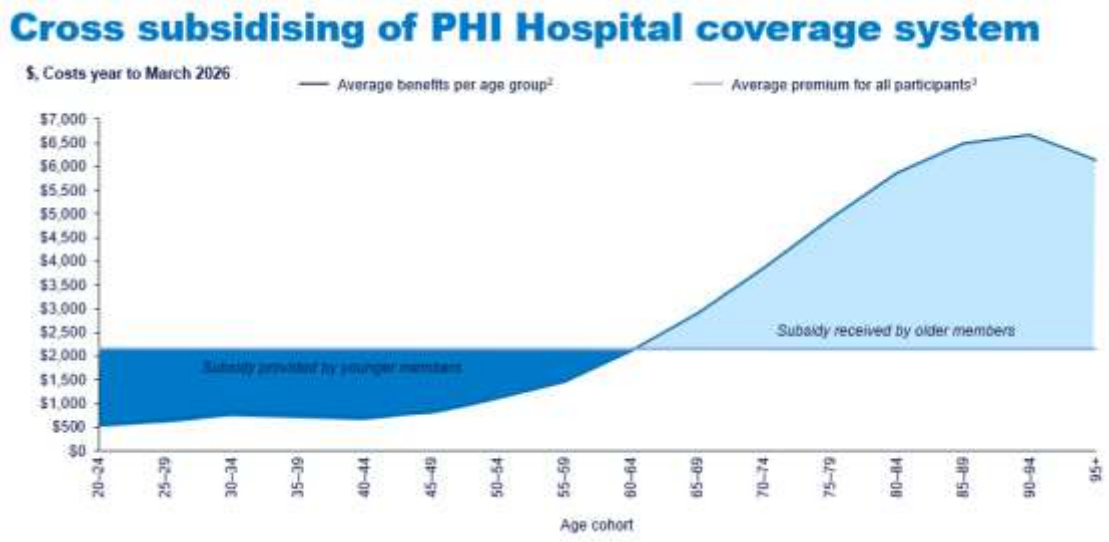
Case for reform

Australia's mixed public-private health system has delivered outstanding outcomes, combining universal access through Medicare with a private system that adds capacity, choice, and funding for less acute needs.[189]

But policy settings underpinning PHI were largely established in the 1990s and have not kept pace with demographic and economic change. A sustainable private system depends on strong participation, particularly among younger and working-age Australians, since participation spreads risk and eases pressure on the public system. Growth has softened among younger, price-sensitive cohorts. Participation concentrates among older Australians with higher utilisation, creating affordability and sustainability pressures.

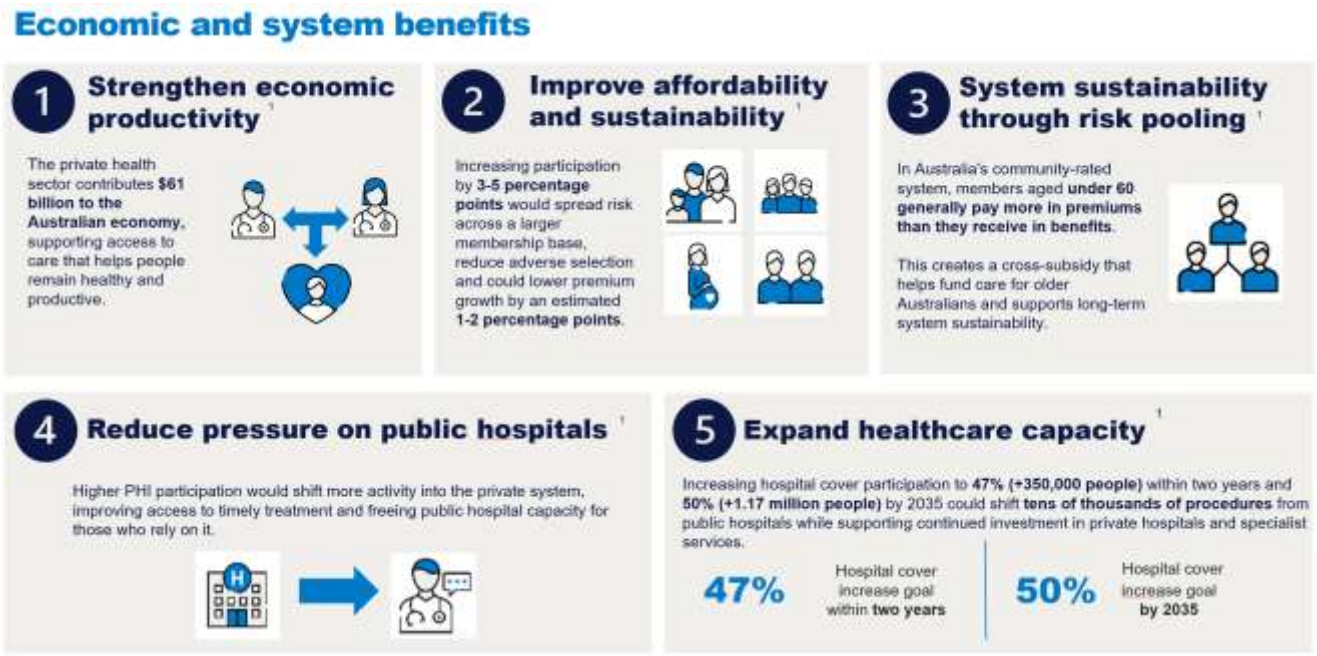
Since December 2020, PHI membership (for hospital cover) rose from 11.3 million people, 44.2 per cent of the population, to 12.8 million, 45.8 per cent, but this growth masks structural pressure. Reform should broaden participation in a way that strengthens the whole system rather than shifting costs from government to private patients, since transferring costs without attracting younger, healthier members would raise premiums and further weaken participation.

Higher participation delivers real value when incentives are well designed. The sector contributes $61 billion to the economy and supports access to care that keeps people healthy and productive.[190] Spreading fixed costs across a larger and younger membership base reduces adverse selection and moderates premium growth, since members under 60 typically pay premiums exceeding their claims, pre-paying for care they will need later. A larger insured population could also ease pressure on public hospitals. This cross-subsidy is a critical foundation of the health system in Australia.



[189] Finity Consulting Pty Limited, *Review of MLS, PHI Rebate and LHC* (Report prepared for the Department of Health and Aged Care, 2023).
[190] Furnival, A. and McGovern, C. *A sustainable private health sector: an economic study.* Evaluate. (2022).

Bupa believes Australia should aim to lift participation to 47 per cent within two years, an additional 350,000 people, and to 50 per cent by 2035, an additional 1.17 million. A 3 to 5 percentage point increase will spread fixed costs, and could reduce premium growth by 1 to 2 percentage points, and shift tens of thousands of procedures from public hospitals.



Source: Amanda Furnival and Chris McGovern, *A Sustainable Private Health Sector: An Economic Study* (Evaluate Consulting, 2022).

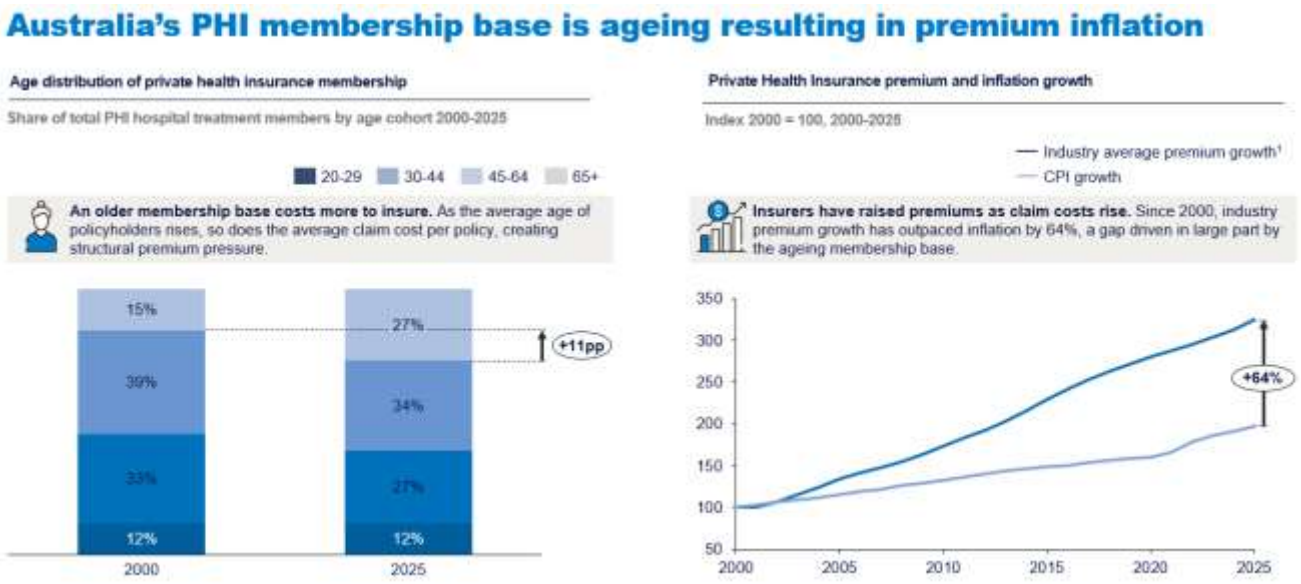
Current system challenges

Australia's PHI incentive framework combines the *Private Health Insurance Rebate*, *Lifetime Health Cover loading* and *Medicare Levy Surcharge* to encourage participation, support affordability and maintain a balanced risk pool, but demographic and economic change has reduced the effectiveness of these settings.

1. PHI participation is increasingly concentrated among older Australians

Participation in private hospital cover has stayed near 45.8 per cent of the population, but this masks a growing imbalance.[191] Working-age Australians aged 20 to 59 participate less than older cohorts, concentrating the risk pool among higher-utilisation members. Younger Australians face cost-of-living pressures and see limited value in cover they may not use. From 2000 to 2025, the share of policyholders aged over 65 rose from 15 to 27 per cent, adding between 2 to 3 per cent to premiums per annum, contributing to premium increases which are 64 per cent above inflation.

[191] APRA, *Quarterly Private Health Insurance Membership and Benefits Summary – March 2026* (Statistical Publication, 29 May 2026) as of 31 March 2026, 12,790,111 people, or 45.8% of the population, were covered by hospital treatment cover.



2. The PHI Rebate is providing less effective affordability support

The *Rebate* is meant to reduce premiums and encourage healthier members to join, but it has eroded over time, falling from 30 per cent to 24 per cent for under-65s.[192] This matters most for younger and lower-income Australians, whose participation is most price sensitive.

3. The Medicare Levy Surcharge is not consistently encouraging participation

The *Medicare Levy Surcharge* is meant to push higher-income Australians toward private cover, but the number paying it rose from around 200,000 in 2017 to approximately 885,000 in 2023-24.[193] More taxpayers are choosing to pay the MLS rather than take out cover.

4. The impact of the Lifetime Health Care (LHC) loading has been diminished

Lifetime Health Cover loading is meant to encourage early cover, applying a 2 per cent premium loading for each year cover is delayed after age 30, up to 70 per cent. Policy changes in 2007 let the loading be removed after ten continuous years rather than over a lifetime, allowing people to opt out and rejoin later at lower cost, contributing to more Australians choosing to pay the MLS instead.

5. Limited understanding of Community Rating weakens the perceived value of PHI

Community Rating prevents premiums being set by health status or expected use of care, letting people with existing conditions access cover without risk-based premiums. Understanding remains limited, particularly among younger, healthier members who may see this cross-subsidy as unfair rather than a shared safety net, weakening trust and willingness to participate.

Reform priorities

Australia's private health insurance incentive framework should be recalibrated to improve participation, particularly among younger and lower to middle-income earners. The Australian Government's 2023 consultation on PHI incentives provides a pathway for implementation. Bupa strongly encourages the sector to move from consultation to implementation, working with industry to effectively recalibrate consumer incentives and better support participation.

[192] Private Health Insurance (Incentives) Rules 2025 (Cth) sch 1; Department of Health and Aged Care (Cth), *Private Health Insurance Rebate Tiers and Rebate Percentages 2025–26* (Web Page)

[193] Australian Taxation Office, *Taxation Statistics 2023–24* (Statistical Publication, 17 June 2026).

Priority 1: *Strengthen participation in PHI through a package of reforms focusing on affordability, uptake and retention incentives.*

- Increase the Private Health Insurance Rebate from 24.1 per cent to 30 per cent for lower-income Australians to improve affordability and encourage participation among price-sensitive cohorts.
- Increase the Medicare Levy Surcharge to 1.5 per cent, rising to between 2-3 per cent for higher-income earners, to encourage take-up among working-age Australians.
- Review Lifetime Health Cover and restore the loading to be applied over the lifetime of a person's policy and consider amending the current 2 per cent annual loading rate.

Priority 2: *Strengthen consumer confidence through a public education campaign to explain the Community Rating principle.*

- Develop a joint government and industry education campaign explaining how Community Rating supports fairness, affordability and PHI as a shared social safety net.

Product tier reform

Case for reform

The 2019 PHI Reforms required insurers to sort hospital cover into four standardised tiers, Gold, Silver, Bronze and Basic, while 'Plus' products add benefits above the baseline. The reforms improved comparability, but their impact has been mixed. Concentrating high-cost services such as maternity and psychiatric care in Gold on an unrestricted basis has changed consumer behaviour, weakening the risk pooling that keeps top-level cover affordable, and reduced insurers' ability to design products around life stages. Product development is now driven by tier compliance and price competition rather than health needs.

A sustainable PHI system depends on participation across all age groups, with Community Rating sharing costs between healthy and less healthy members.[194] This pooling has eroded as consumers increasingly buy cover only when they expect to use specific services, before downgrading after using their cover.

Gold's benefit structure is currently skewed towards services younger policyholders rarely use, such as cataracts or joint replacements, pushing members toward lower tiers.

Well-designed reform can improve affordability, strengthen risk pooling and give insurers flexibility to design products aligned to life stages, making PHI more relevant to younger Australians.

Gold benefits misaligned with younger members' needs

Hospital treatment products by coverage tier

Gold premiums fund high-cost procedures concentrated in older age groups – cataracts and joint replacements – that younger members are unlikely to need in the near term. Paying for benefits they will not use makes lower tiers more attractive, further thinning the gold pool over time. Certain categories of care, including maternity services, tend to follow a more predictable utilisation pattern than chronic or acute conditions.

Hospital treatment by clinical category (non-exhaustive)	Coverage[1]				Typical costs of procedures[2]	
	Basic	Bronze	Silver	Gold	Out-of-pocket fee	Cost to insurer
Cataracts	✗	✗	✗	✓	$480	$860
Joint replacements – knee replacement[3]	✗	✗	✗	✓	$1,000	$1,800
Pregnancy and birth – uncomplicated delivery only[4]	✗	✗	✗	✓	$420	$1,800
Assisted reproductive services – egg retrieval[5]	✗	✗	✗	✓	$220	$350
Weight loss surgery – gastric bypass[6]	✗	✗	✗	✓	$630	$1,200
Sleep studies	✗	✗	✗	✓	$20	$270

[194] Finity Consulting (funded by DoHDA) *Review of MLS, PHI Rebate and LHC.* (2023).

Strengthening risk pooling would broaden the insured population, reduce concentration of high-cost claims and support stable premiums, while keeping maternity and mental health care accessible to private patients rather than being increasingly reliant on public services. It would also ease pressure on public hospitals and support the sustainability of Australia's mixed health system.

'Plus' products already give insurers a mechanism for life-stage design without forcing every member into full Gold cover, though this remains constrained under current settings.

Government should create more flexibility within the tier framework so funds can offer products tailored to different cohorts, such as young singles, families planning pregnancy, and people managing chronic conditions.

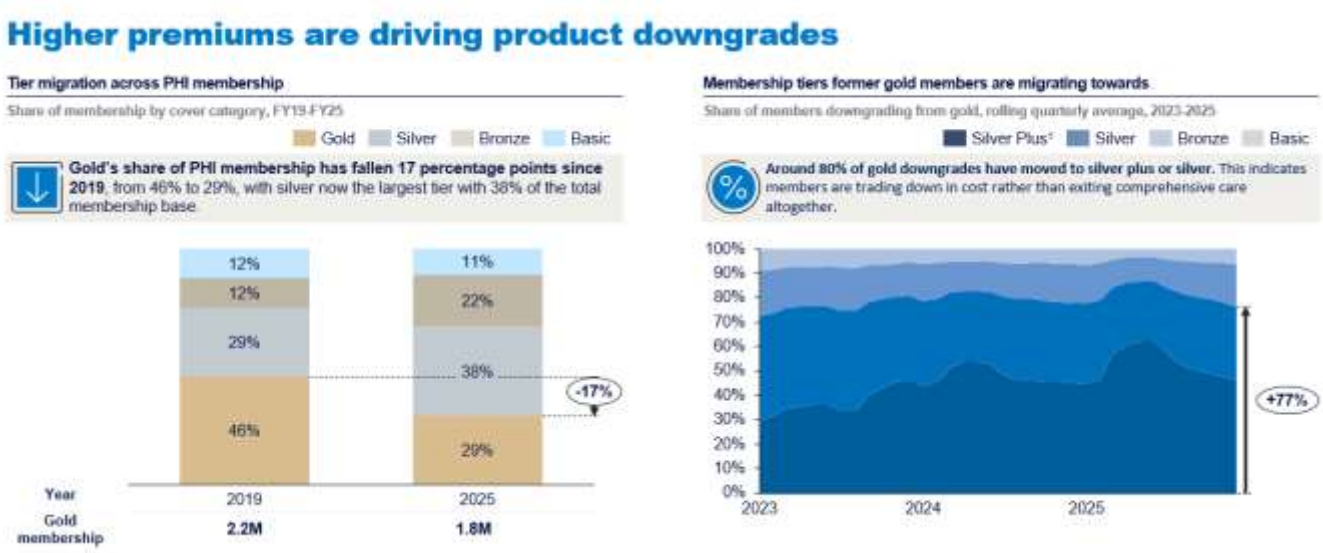
Current system challenges

The current product tier framework has created structural issues that push up premium prices, limit product design flexibility and degrade system sustainability, with the biggest impact on Gold products.

1. The market for Gold products has contracted sharply since the reforms.

Many insurers have withdrawn Gold products from sale, stopped marketing them, or raised premiums and excess levels. Between 2021 and 2026 the number of actively sold Gold hospital products fell substantially, with only two traditionally packaged products remaining across major insurers.[195] Gold's share of PHI membership has fallen 17 percentage points since 2019, from 46 to 29 per cent, with Silver now the largest tier at 38 per cent. Bupa is concerned this will worsen following the Government's proposed changes to the Rebate for people over 65.

[195] Analysis of health insurers available products on 12 May 2026 showed that out of the 19 open member Private Health Insurers 10 advertise gold products for sale on their websites. NIB does have a gold hospital product available, but it is off books and not available for comparison. Australian Unity and Mildura District Hospital Fund both require a daily co-payment for Gold of $100 and $80 respectfully. There are currently 42 Silver + Products on sale (HCF has 4 different Silver + Products). 8 of these have Pregnancy and Birth cover and 1 covers Hospital Psychiatric Services. Some Gold products are also only available when packaged with extras.



2. Risk within the pool has also become increasingly concentrated in Gold.

Clinical categories only available in Gold cover, particularly maternity and psychiatric services, attract members with higher expected utilisation, and many buy Gold only when they anticipate needing those services before downgrading afterwards. Mental health waiting period waivers compound this, letting members upgrade to Gold within two months before claiming. This has reduced cross-subsidisation and driven premium increases. Bupa's own data shows claims rates among newer Gold customers are 25 to 30 per cent higher than long-tenured customers.

3. Concentrating maternity and psychiatric care within Gold also creates structural inequity.

Consumers needing those services, predominantly women during childbearing years or people managing a mental health condition, must buy significantly more expensive products than consumers accessing equivalent high-cost services available in lower tiers, undermining affordability and the perceived value of PHI. Without reform, PHI risks a negative risk pool spiral in which healthier members leave higher cover as premiums rise, concentrating risk further and threatening the long-term availability of maternity and mental health services within the private system.

Reform priorities

Addressing the challenges created by the current product tier framework will require a combination of targeted reforms. We propose several policy reform options that could be pursued to improve affordability, strengthen risk pooling, and increase product flexibility to ensure PHI remains relevant to the needs of contemporary consumers.

Importantly, this should also include a comprehensive review of the 2019 PHI reforms, which have not been evaluated on their real-world impact, to ensure further reforms are designed effectively.

Priority 1: *Conduct a consultative process for Product Tier design*

- That a consultative process should be undertaken to examine the 2019 reforms to ensure they delivered on their objectives, assess their impact on premiums and risk pool sustainability and identify unintended consequences for affordability and consumer behaviour, including accelerated downgrades.

Priority 2: *Strengthen consumer confidence*

- Protect consumer choice by maintaining product design flexibility through current product tiers and “plus” optionality on product tiers.

Priority 3: *Strengthen risk pooling and reduce complexity*

- Simplify products by standardising quasi risk-rating settings, including discounting practices, dependent-age definitions, waivers, excess and co-payment practices.
- Strengthen risk mitigation measures for uninsurable risks to improve fairness.
- Review mental health waiting period waivers that let members upgrade to Gold within two months before claiming, and introduce longer standard waiting periods for high-cost categories such as psychiatric and pregnancy care to stabilise the risk pool.
- Consider co-payments and annual caps on psychiatric claims, and post-claim loadings similar to Lifetime Health Cover for members who claim without prior coverage.

Data Transparency

Case for reform

Private hospitals are a critical part of Australia's health system. As at July 2024, Australia had 647 private hospitals operating more than 36,000 beds and accounting for over 40 per cent of all hospital admissions.[196] In 2024-25, insurers paid approximately $19 billion in hospital treatment benefits for around 5 million episodes, and more than 12.7 million Australians held hospital cover as of March 2026.[197]

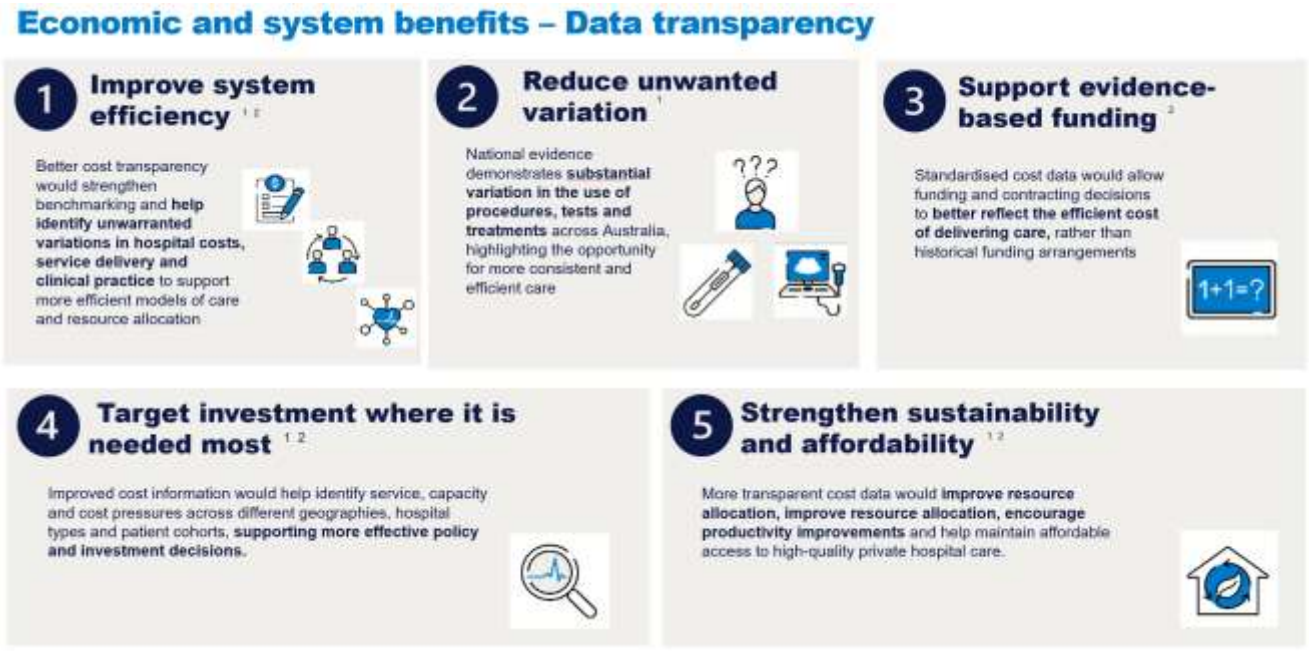
Given this scale, funding decisions should be underpinned by robust, transparent data. The *Private Hospital Sector Financial Health Check* found this data remains incomplete. Financial data was voluntarily provided by only 243 of Australia's 647 private hospitals, representing 58 per cent of separations and 63 per cent of sector revenue, with no episode-level cost data for day hospitals.[198]

Comprehensive, standardised cost data would give governments, insurers and providers a common evidence base for policy, pricing and investment.

Mandatory reporting introduced across aged care in 2022 has already strengthened the evidence available for funding and oversight decisions.[199] A comparable approach should now apply to private hospitals, which currently lack the nationally consistent framework public hospitals already have through the National Hospital Cost Data Collection.[200]

A comprehensive framework would also improve efficiency and productivity, strengthen benchmarking and help identify unwarranted variation in costs and clinical practice, distinguishing differences driven by patient complexity from those that may be avoidable.[201] Research undertaken by Mandala Partners shows how standardised, transparent cost data allows funding to reflect the efficient cost of care rather than historical budgets.

[196] DoHDA. *Private Hospital Sector Financial Health Check – Summary.* (2024).
[197] DoHDA. *Private Health Sector Reform – Consultation Paper 1.* (2026); APRA. *Annual private health insurance statistics.* (2025); *Quarterly private health insurance membership and benefits summary – March 2026.* (2026).
[198] DoHDA. *Private Hospital Sector Financial Health Check – Summary.* (2024).
[199] DoHDA. *Quarterly Financial Report* (29 June 2026). Department of Health, Disability and Ageing, *Quarterly Financial Report* (Reporting Framework, 29 June 2026).
[200] IHACPA. *National Hospital Cost Data Collection.* (2026).
[201] Australian Commission on Safety and Quality in Health Care, *Australian Atlas of Healthcare Variation Series* (Web Resource, 13 March 2026).



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Current system challenges

1. Private hospitals operate with less financial transparency than comparable parts of the health system

Private hospitals are subject to less standardised financial and activity reporting than other major parts of the health system. Private health insurers submit standardised quarterly financial and prudential data to APRA,[202] and public hospitals are funded through activity-based arrangements underpinned by the National Efficient Price, set annually by IHACPA using detailed cost data.[203] Aged care providers similarly submit mandatory financial reports that inform IHACPA's pricing advice.[204] Private hospitals do not have a comprehensive, mandatory and nationally consistent framework that provides complete hospital-level cost, financial and activity data across the sector leaving governments, insurers and providers without a consistent evidence base to assess performance, monitor sustainability or inform funding decisions.

2. Limited cost transparency undermines efficient pricing, competition and productivity

Private hospitals are funded through a complex mix of insurance benefits, Commonwealth subsidies, patient co-payments and State and Territory arrangements, making it hard to determine efficient cost without comprehensive data. The Financial Health Check found profitability declining as costs outpaced revenue, with average earnings margins falling from 8.7 per cent in 2018-19 to 4.4 per cent in 2022-23.[205] But incomplete participation and the absence of episode-level data for day hospitals limited the review. Only one in two in-scope overnight private hospitals voluntarily took part in the most recent National Hospital Cost Data Collection, and 25 per cent of activity went unreported. Without robust data, governments cannot identify unwarranted cost variation or target funding effectively, weakening competitive incentives and adding pressure on premiums.

3. Data gaps constrain long-term capacity planning and investment

The absence of comprehensive private hospital data also limits long-term capacity planning and investment. Reliable information on capacity, utilisation and financial performance is essential for forecasting demand

[202] APRA. *Quarterly private health insurance membership and benefits summary – March 2026.* (2026).
[203] Independent Health and Aged Care Pricing Authority, *National Efficient Price Determination 2026–27* (Determination, March 2026).
[204] DoHDA, *Financial Report on the Australian Aged Care Sector 2024–25* (Report, 26 June 2026); IHACPA, *Aged Care Pricing Policy* (Policy, Version 1.0, July 2025)
[205] DoHDA. *Private Hospital Sector Financial Health Check – Summary.* (2024).

and allocating capital efficiently. The discontinuation of nationally consistent reporting on private hospital bed capacity has reduced visibility of service availability, potentially contributing to maldistribution of beds and poorer investment decisions. The *Private Hospital Financial Health Check* also found declining capital replacement rates, suggesting rising asset deterioration risk. Reinstating consistent reporting on licensed beds would strengthen planning and help governments anticipate future capacity constraints.

Reform priorities

The Australian Government should look to a reform program to establish a comprehensive, standardised and transparent private hospital cost data framework. Improving financial transparency is a critical first step towards broader system reform, providing the evidence base required to guide future funding, pricing and policy settings.

***Priority 1:** Establish a mandatory national private hospital cost data framework*

- Introduce a mandatory, nationally consistent cost data framework covering all private and day hospitals, requiring participation from all providers to ensure complete, representative data.

***Priority 2:** Expand the scope and consistency of data collection*

- Collect standardised financial, activity, cost and clinical quality data, including workforce, capital investment and capacity, aligned where possible with existing public hospital and aged care frameworks and designed in consultation with the sector.

***Priority 3:** Improve transparency and access to sector information*

- Publish annual provider-level and sector-wide information to support transparency and benchmarking, balancing this with commercial confidentiality and privacy obligations, and establish clear governance for data access, validation and use.

***Priority 4:** Strengthen health system planning and market stewardship*

- Reinstate nationally consistent reporting of private hospital capacity, including licensed beds, to support infrastructure, workforce and service planning and better integration of public and private capacity.

***Priority 5:** Sequence transparency ahead of broader pricing reform*

- Establish comprehensive cost transparency before introducing any new private hospital pricing framework, ensuring future pricing reform is informed by robust data and objective assessment of efficient service delivery, building on the work of the Private Health CEO Forum.

Prescribed List reform

Case for reform

The Prescribed List sets the minimum benefit an insurer must pay for a medical device or human tissue product used in a privately insured hospital episode.[206] It is one of the largest regulated components of private health expenditure.[207] In 2020-21, more than 3.3 million prostheses were supplied at a cost of approximately $2.2 billion, around 14 per cent of annual PHI hospital benefits.[208] Annual benefits for these products are now around $2.4 billion.[209]

Benefits have historically been well above prices paid for equivalent devices elsewhere. In 2019-20, benefits for some devices were up to 145 per cent higher than Australian public hospital prices,[210] and international comparisons found Prescribed List benefits averaged 21.2 per cent higher than NHS prices in the United

[206] Nous Group, *Baseline Evaluation of the Prostheses List Reforms* (Report prepared for the Department of Health and Aged Care, 29 April 2024).
[207] Ibid.
[208] Parliament of Australia (House of Representatives). *Private Health Insurance Legislation Amendment (Medical Device and Human Tissue Product List and Cost Recovery) Bill 2022 – Explanatory Memorandum. (2022).*
[209] APRA. *Quarterly private health insurance membership and benefits summary – March 2026.* (2026).

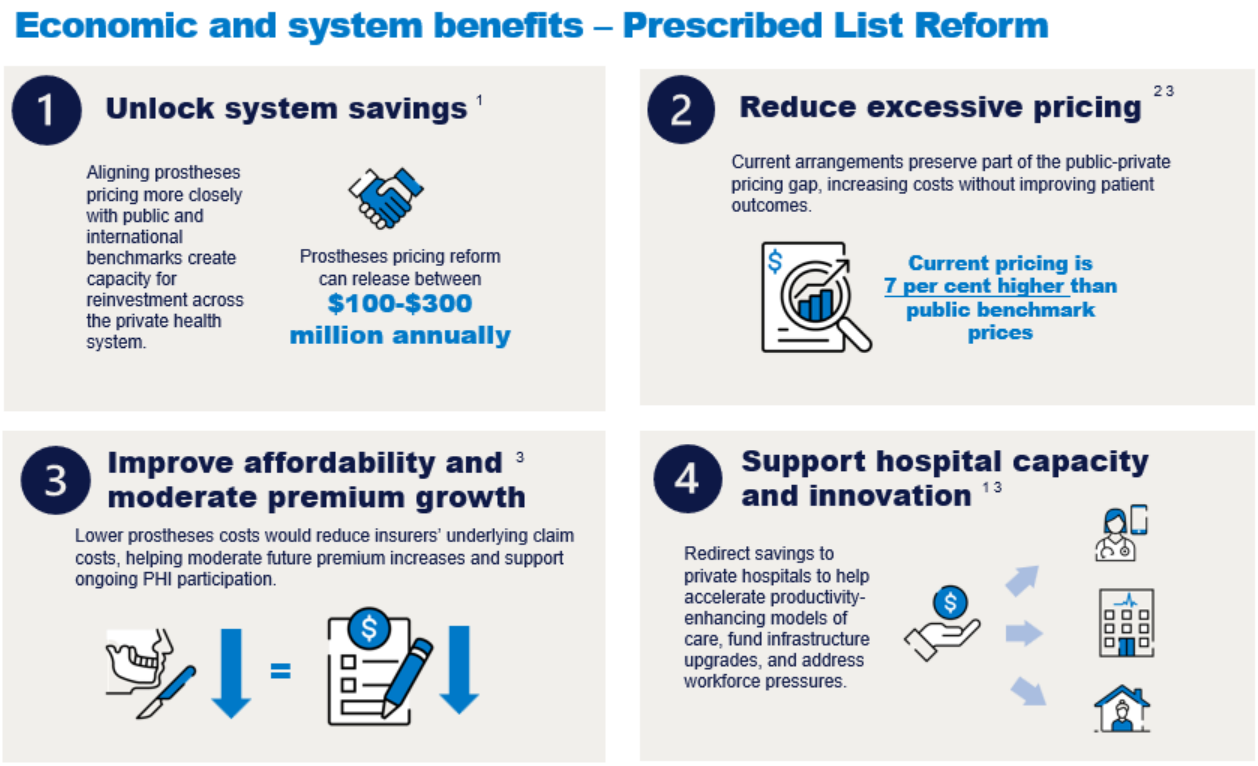
[210] Nous Group, *Baseline Evaluation of the Prostheses List Reforms* (Report prepared for the Department of Health and Aged Care, 29 April 2024) 26.

Kingdom, 36.7 per cent higher than Pharmac prices in New Zealand, and 38.4 per cent higher than prices in South Africa.[211]

The Government addressed this through a *Memorandum of Understanding with the Medical Technology Association of Australia*, staging reductions where benefits exceeded 107 per cent of the IHACPA weighted average public benchmark price.[212] Benefits were cut by 40 per cent of the gap from mid-2022, 20 per cent from mid-2023, and a final 20 per cent from mid-2024, subject to a 7 per cent floor, reducing the public-private gap by up to 80 per cent. [213] [214]

Together, the adjustment factor and pricing floor mean privately insured Australians continue to fund higher device prices than the public system.[215] Further reform could release between $100 million and $300 million annually by aligning pricing more closely with benchmarks, a material opportunity against annual insurer expenditure of around $2.4 to $2.5 billion.[216]

Redirecting the residual 7 per cent margin to private hospitals rather than device pricing would fund workforce, infrastructure and productivity improvements.[217] Removing the retained adjustment factor would separately reduce insurer costs and create room for premium restraint.[218] These gains can be achieved while preserving the List's core protections. OOP costs for listed devices occur in fewer than one per cent of privately insured episodes, and aligning benefits with benchmarks need not compromise clinician choice or access to innovative technology. [219] [220]



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[211] Ibid.
[212] DoHDA, *Reducing the Public and Private Sector Price Gap for Some Prescribed List Devices and Products* (Web Page, 23 January 2026).
[213] Department of Health and Medical Technology Association of Australia, *Memorandum of Understanding for the Policy Parameters of the Prostheses List Reforms* (Memorandum of Understanding, 18 March 2022)
[214] DoHDA, *Reforms of the Prescribed List of Medical Devices and Human Tissue Products (2021–2025): A Summary of the Reform Objectives and Achievements* (October 2025).
[215] D oHDA and Medical Technology Association of Australia (MTAA). *Memorandum of Understanding for the policy parameters of the Prostheses List Reforms (MoU).* (2022).
[216] APRA, *Annual Private Health Insurance Statistics* (Statistical Publication, 12 December 2025)
[217] DoHDA. *Reducing the public and private sector price gap for some Prescribed List devices and products.* (2022).
[218] Nous Group. *Baseline Evaluation of the Prostheses List Reforms.* (2024).
[219] Ibid.
[220] Ibid.

Current system challenges

1. Prescribed List benefits remain above public and international benchmarks

Despite reductions delivered between 2022 and 2024, Prescribed List benefits remain above public and, for some categories, international benchmarks. This is a structural outcome. The MoU intentionally retained a 20 per cent private adjustment factor after reductions of up to 80 per cent of the original gap, subject to a 7 per cent floor.[221] For higher-value devices, where the original gap was greatest, this retained margin remains a material premium. The median gap between listed benefits and public benchmark prices started around 25 per cent for Part A and D items,[222] falling to 9 per cent by the November 2023 update.[223] Benefits are now better aligned with some international markets, but gaps remain against New Zealand and France.[224]

2. Current pricing incentives do not consistently reward clinical value

The Prescribed List's structure, under which benefit groups are set by product characteristics and claimed clinical benefit, has grown increasingly complex. Between 1997 and 2021 the number of listed items grew roughly tenfold, to more than 11,600 billing codes and 1,700 unique groupings.[225] Reviews have found this structure can encourage sponsors to target higher-benefit groups or list products with incremental differences that attract higher benefits without clear evidence of improved outcomes.[226] Higher device costs flow through to higher hospital charges, increased insurer payments and upward pressure on premiums, and because prices negotiated between hospitals and suppliers remain opaque, procurement efficiencies are not necessarily passed on to consumers.[227]

3. Elements of the reform program remain incomplete

General use items, such as sponges, patches, staples, sealants and surgical glues, continue to be funded through the Prescribed List even though they are low-cost, high-usage inputs rather than discrete implantable devices. Tightening listing criteria and moving these items to case-based or bundled funding would better align them with contemporary hospital payment practice.[228] Their removal, originally scheduled for mid-2023 alongside bundling arrangements, was deferred after stakeholders raised implementation difficulties, and the Government has since confirmed general use items will remain listed under Part D, leaving this inefficiency unresolved.[229] [230]

Reform priorities

The Australian Government has already made substantial progress in reducing the historical disparity between public and private medical device pricing. The next phase of reform should focus on completing this work through a staged implementation program over the next two years.

Priority 1: *Establish a transparent and sustainable pricing framework*

- Establish an ongoing benchmark pricing framework comparing Prescribed List benefits with the Australian public system and comparable international markets, publishing comparisons to improve transparency and reviewing benefits against benchmarks on a regular cycle rather than periodic negotiated settlements.

Priority 2: *Complete alignment with public benchmark pricing*

- Remove the remaining 20 per cent private adjustment factor retained under the MoU, and convert the 7 per cent pricing floor into a ceiling by capping Prescribed List benefits at no more than 107 per

[221] DoHDA. *Reforms of the Prescribed List of Medical Devices and Human Tissue Products – Summary of Objectives and Achievements.* (2025).
[222] Nous Group. *Interim Evaluation #1 of the Prescribed List Reforms.* (2024).
[223] Ibid.
[224] Ibid.
[225] Parliament of Australia (House of Representatives). *Private Health Insurance Legislation Amendment (Medical Device and Human Tissue Product List and Cost Recovery) Bill 2022 – Explanatory Memorandum. (2022).*
[226] Ernst & Young (EY). *Review of the General Miscellaneous Category of the Prostheses List.* (2020); Nous Group. *Baseline Evaluation of the Prostheses List Reforms.* (2024).
[227] Nous Group. *Baseline Evaluation of the Prostheses List Reforms.* (2024).
[228] DoHDA. *PHI 21/22 Prostheses List Reform – Schedule of Prostheses List Price Reductions.* (2022).
[229] Ibid
[230] DoHDA. *General Use Items on the Prescribed List* (Web Page, 23 January 2026).

cent of the IHACPA weighted average public benchmark price, implemented through a staged transition consistent with 2022-2024.

***Priority 3:** Redirect value to support private hospital sustainability*

- Redirect the residual 7 per cent margin above the public benchmark price to private hospitals rather than embedding it in device pricing, and enable hospitals to negotiate directly with suppliers so procurement efficiencies are realised and shared across the system, supporting investment in workforce, infrastructure and productivity.

***Priority 4:** Reinvest savings to strengthen the private health system*

- Direct insurer savings towards moderating future premiums, maintain the absence of OOP costs for listed devices while preserving clinician choice and timely access to innovation, and complete reforms to general use items to remove this acknowledged inefficiency.

Risk Equalisation reform

Case for reform

Risk Equalisation is fundamental to Australia's community-rated PHI system. Risk Equalisation redistributes claims costs across insurers to help fund higher-risk membership profiles, supporting Community Rating and affordable access for all Australians.[231]

APRA administers this through two mechanisms. An age-based pool shares 15 to 82 per cent of eligible costs for members 55 and over, and a high-cost claims pool shares 82 per cent of costs above $50,000 a year. [232] [233]

The scale of Risk Equalisation has grown substantially over time. In 2024–25, the Risk Equalisation pool (gross deficit) were approximately $9.3 billion, compared with approximately $8.66 billion in 2023–24.[234] These pressures reflect softening participation among younger Australians amid demographic and cost-of-living change,[235] placing greater pressure on premiums as membership shifts toward older, higher-claiming members, particularly in lower-tier products.[236]

A 2021 actuarial study found limitations in the current model and examined a hybrid approach combining retrospective sharing with prospective risk adjustment.[237] The principal benefit of reform is stronger incentives for insurers to invest in prevention and efficient care, lowering claims inflation and supporting higher-value models such as chronic disease management, hospital avoidance, HITH and virtual care.[238]

Better aligning Risk Equalisation with contemporary needs would reduce anti-selection and encourage continued participation by younger Australians, essential to sustaining Community Rating. Expanding it alone would redistribute costs between insurers without improving efficiency. The greatest gains will come from reforms that strengthen incentives for prevention while maintaining pool neutrality.

[231] Finity Consulting. *Risk Equalisation: Final Report.* (2022).
[232] Ibid.
[233] Ibid.
[234] APRA, *Private Health Insurance Risk Equalisation Statistics* (Statistical Publication, 31 March 2026).
[235] APRA, *Private Health Insurance Annual Coverage Survey 2025* (Statistical Publication, 2026).
[236] Finity Consulting. *Risk Equalisation: Final Report.* (2022)
[237] Ibid.
[238] APRA. *Private health insurance risk equalisation statistics.* (2026).

Source 1, 2: Finity Consulting, Risk Equalisation: Final Report (2022). *2. APRA,* Private health insurance risk equalisation statistics. *(2026).*

Current system challenges

1. The retrospective model weakens incentives to invest in better care

Risk Equalisation arrangements equalise costs after they are incurred. An insurer that invests in prevention or hospital avoidance bears the upfront cost, while only part of any savings is redistributed through the pool, weakening incentives to invest in outcomes that reduce avoidable utilisation. This challenge grows as the pooled share of claims increases, since insurers retain less benefit from investments that improve care and control costs.[239]

2. Risk sharing is concentrated on age and does not fully reflect contemporary patterns of healthcare need

Risk sharing operates mainly through the age-based pool, from age 55, and the high-cost claims pool, above a $50,000 threshold.[240] Pregnancy, weight-loss surgery and psychiatric treatment fall outside both, typically accessed by members younger than 55 and rarely reaching the $50,000 high claims threshold, so insurers retain more of this risk.[241]

3. Expansion of the current risk equalisation does not address the root cause of underlying claims inflation, nor does it create claims savings or additional funding for hospitals.

Risk Equalisation redistributes existing costs between insurers rather than creating new funding, so expanding it changes how costs are shared rather than reducing the cost of care. Adding categories without recalibrating existing settings could shift contributions between products, pressuring members whose products draw less on the expanded categories. This does not address the drivers of claims growth, and without broader efficiency improvements, wider pooling may simply spread costs without improving performance.

[239] Finity Consulting. *Risk Equalisation: Final Report.* (2022).
[240] Ibid.
[241] Gold Product Workstream Working Group, 'Time to Rethink Risk Equalisation to Save Gold Hospital', *Actuaries Institute* (Article, 3 December 2025) https://www.actuaries.asn.au/research-analysis/time-to-rethink-risk-equalisation-to-save-gold-hospital. Gold Product Workstream Working Group (Actuaries Institute), *Time to Rethink Risk Equalisation to Save Gold Hospital* (Actuaries Institute, 2025)

4. Current risk equalisation has not kept up with product developments and may not be fit for purpose to support product tiers.

Risk equalisation should support the product tiers' goals of consumer choice, innovation and participation by younger, healthier consumers, but current settings were designed in the early 2000s, before many subsequent policy and product changes, including:

- The proliferation of restrictions and exclusion products, leading to the standardisation of product tiers in 2019, and the concentration of maternity cover into Gold cover under that reform.
- Since April 2018, members with restricted psychiatric cover can upgrade to higher benefits without a further two-month wait, subject to a once-in-a-lifetime exemption, concentrating psychiatric claims in Gold. In 2024-25, approximately $81 million in psychiatric care was paid to members joining within the exemption period, up from $44 million in the scheme's first year.[242] [243] [244]
- The rise in the maximum hospital excess from $500 to $750, the limiting of Lifetime Health Cover to 10 years, and the industry's changing age profile.

Future reform therefore needs a review and maintenance process to keep risk equalisation relevant as the system evolves.

5. Risk equalisation requires complex and costly administration as such reforms require meaningful and efficient outcomes

Risk Equalisation's administration involves significant data and reporting, so changes must deliver meaningful, efficient outcomes, with a key goal being incremental improvement in PHI participation.

Given the cost and disruption of implementing changes, reforms should minimise disruption and be “measured twice, cut once”, rather than pursued through amendments that cause reform fatigue and erode consumer confidence. Reforms should therefore avoid guardrails that end up negating their own intent.

6. Risk equalisation by itself cannot fully support community rating

The current retrospective system cannot alone fully support Community Rating. It equalises paid claims but does not address anti-selection or OOP costs, nor proactively reduce inefficiencies.

Other adjustments, such as changes to the Medicare Levy Surcharge and PHI Rebate, are needed alongside Risk Equalisation for a sustainable pool.

Reform priorities

Risk Equalisation reform should be implemented through a transition program with clear guard rails to avoid adverse impacts on customers, preserving the objectives of community rating and strengthening incentives for prevention, innovation and sustainable participation in PHI.

Priority 1: *Support reform with transparent modelling and a staged transition*

- Publish a clear statement of reform objectives and pathway, release sufficient modelling for insurers to assess impacts, validate and back-test the model before implementation, and stage the transition around the annual premium round.

Priority 2: *Transition to a prospective Risk Equalisation framework*

- Deliver a framework combining prospective adjustment with retrospective sharing while preserving Community Rating, aligning incentives so insurers retain value from investment in prevention, and promoting fair cost sharing and competition.

[242] DoHDA. *Private health insurance reforms: Supporting mental health* (April 2018). Department of Health, *Private Health Insurance Reforms: Supporting Mental Health* (Fact Sheet, Australian Government, 2018)
[243] Gold Product Workstream Working Group, ‘The Psychiatric Waiver: Balancing Access and Sustainability in Gold Hospital Products’, *Actuaries Institute* (Article, 14 December 2025) https://www.actuaries.asn.au/research-analysis/the-psychiatric-waiver-balancing-access-and-sustainability-in-gold-hospital-products. Gold Product Workstream Working Group (Actuaries Institute), *The Psychiatric Waiver: Balancing Access and Sustainability in Gold Hospital Products* (Actuaries Institute, 2025)
[244] Ibid.

Priority 3: *Maintain a simple, transparent and efficient Risk Equalisation system*

- Support IHACPA and APRA to administer the prospective system, minimising reporting burden and keeping the framework transparent and straightforward, while avoiding unnecessary complexity within clinical categories.

Chapter Five: Recommendations and conclusion

We know that maintaining the status quo will not meet Australia's current and future health needs. Rapidly rising costs, an ageing population, increasing rates of chronic disease, and changing consumer expectations mean our health system must evolved to remain sustainable, accessible and affordable. Australians increasingly want healthcare that is more personalised, connected and focused on helping them stay well, not just treating illness when it occurs

There is broad agreement that the health system needs reform and modernisation are essential to achieve this shift, with prevention, early intervention and innovation at its core. As we work towards a more person-centred and sustainable health system, we believe our reform priorities are an important first step in supporting better health outcomes for Australians while strengthening the long-term sustainability of the system.

Where to from here? A roadmap of reform

Bupa recognises that no single reform, organisation or sector can address Australia's healthcare challenges in isolation. We also recognise that governments cannot, and should not, be expected to shoulder the challenge of health system reform alone. Achieving meaningful and lasting change will require shared responsibility and genuine collaboration between governments, clinicians, insurers, providers, consumers and the broader health sector to ensure reforms are implemented effectively and deliver better health outcomes for Australians.

We welcome the steps the Government has already taken to lay the foundations for reform in several of these key areas. Our recommendations are intended to complement and strengthen existing reform efforts. Building on this momentum, we have outlined a practical pathway for implementing our recommendations, showing how they can work together to support a more sustainable, accessible and person-centred health system.

Government has already laid the foundations for reform

Governments have already established important foundations for future reforms particularly through initiatives that improve affordability, expand access to care, strengthen data transparency, and support new funding models for multidisciplinary care.

1. **Medical Costs Finder and fee transparency**

The Government's proposal to mandate specialist fee transparency through the Medical Costs Finder tool represents an important step in helping patients make more informed decisions about the specialist care they receive. By improving visibility of likely OOP costs before treatment, the Medical Costs Finder tool supports greater patient transparency and choice. However, as healthcare costs continue to rise, further reforms are needed to strengthen affordability, transparency, and access.

2. **MyMedicare and introduction of other blended funding models**

Australia has established the foundations for blended funding through MyMedicare, the introduction of new chronic condition management arrangements, and emerging patient-linked payments. Reforms that came into effect from July 2025 have also simplified access and strengthened continuity of care through the introduction of a single GP Chronic Condition Management Plan and streamlined allied health referral requirements. These changes have laid the groundwork for longer-term reform towards a blended funding model that is sufficiently scaled, needs-based and practical for general practice to implement.

3. **Significant investment in mental health**

Australian governments already make substantial investment in mental health, with expenditure on mental health-related services exceeding $14 billion in 2023-24 or representing around 7 per cent of total government health expenditure. Sustained investment is essential to addressing mental ill health, which remains a significant and persistent pressures on Australia's health system, workforce and economy.

Reform is already moving towards care delivered outside hospital, including through expanded *Medicare Mental Health Centres*, the introduction of *Medicare Mental Health Check InYouth Specialist Care Centres* alongside greater innovative models of care such as Hospital in the Home and virtual care, will be important to supporting the next phase of reform.

Given that specialist supply is shaped by decisions across university funding, hospital employment, vocational training, accreditation, migration and healthcare financing, reform should establish a nationally coordinated framework that aligns the levers held by governments, health services, training organisations and regulators.

Roadmap of reform
A staged pathway to a more accessible, modern and sustainable health system

Timeframe	Reform focus	Why it matters	Priority actions
Short term 12-month horizon	**Multidisciplinary primary care**	Embed broader team-based care in routine practice and improve access in underserved communities.	• Introduce rural, regional and underserved workforce loadings. • Strengthen WIP–PS for broader multidisciplinary teams. • Fund supervision, mentorship and team-based governance.
	PHI participation	Improve affordability support and strengthen the risk pool by encouraging younger participation.	• Increase the PHI Rebate for lower-income Australians. • Increase the Medicare Levy Surcharge to strengthen uptake incentives. • Review Lifetime Health Cover and educate consumers on Community Rating.
	Hospital in the Home	Scale clinically governed home-based acute care and remove key barriers to private sector adoption.	• Enable MBS virtual medical oversight for admitted HITH patients. • Introduce a minimum benefit for established HITH services. • Develop nationally consistent safety, quality and governance standards.
Medium term 3-year horizon	**Private sector sustainability**	Improve value and strengthen risk pooling across the mixed public-private system.	• Progress product tier reform. • Support Risk Equalisation reform with transparent modelling. • Reform the Prescribed List and benchmark pricing. • Private hospital data reporting.

	Specialist access and affordability	Reduce cost barriers, address workforce shortages and improve use of specialist expertise.	• Improve fee transparency, MBS indexation, referral settings and consumer protections. • Establish a national specialist workforce planning authority. • Expand targeted domestic specialist training pathways. • Scale secondary consultation and shared-care pathways.
	Innovative models of care	Move care earlier, closer to home and through more flexible clinical settings.	• Enable PHI funding for preventive and community-based mental health care. • Close the missing middle gap and strengthen transitions.
	Prevention and early intervention	Shift the system from treating illness after it occurs to intervening before conditions progress.	• Enable insurers to fund prevention, early intervention and non-admitted care. • Enable support for members at elevated chronic disease risk. • Support integrated care across prevention, treatment and ongoing management.
Long term 5-year horizon	**Scale reform**	Move proven reforms from pilots and marginal incentives into sustainable system architecture.	• Scale blended funding. • Transition to prospective Risk Equalisation while preserving Community Rating.

Enablers: Review mechanisms, evidence gathering, and monitoring related to implemented reforms

To ensure that the implemented reforms are working effectively, it is integral that governance tools are baked into the design of policy that allow for adjustments to be made based on relevant feedback and evidence gathered. This should include:

- Active and ongoing monitoring of impacts of policy by responsible agencies and bodies.
- Regular dataset creation and evidence gathering relating to policy implementation to assess effectiveness.
- Review mechanisms that allow for policy settings to be changed where they are deemed to not be effective.

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