Private Health Sector Reform - Consultation Paper 1

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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.

Introduction

Bupa welcomes the opportunity to respond to the *Private Health Sector Reform – Consultation Paper 1* issued by the Department of Health, Disability and Ageing (**the Department**) on 2 July 2026. We support the Government's objectives of improving access, affordability and sustainability across the private health system and recognise that the consultation package contains several practical reforms that have the potential to deliver meaningful benefits for consumers. Overall, we welcome several of the proposed reforms relating to mental health, maternity care and Hospital in the Home (**HITH**) where they have the potential to improve patient access, consumer choice and system efficiency. We are a strong advocate for reforms that support care outside traditional hospital settings, promote multidisciplinary and integrated models of care, and address workforce constraints. This has the potential to deliver better outcomes for consumers and better value across our private health system.

However, we have strong reservations about proposals that reduce consumer choice, limit product flexibility, increase costs for policyholders or create unintended market distortions. In relation to risk equalisation, we consider that the proposed reforms require further independent analysis, transparent financial modelling and broader consideration as part of a comprehensive PHI reform agenda. Any future reforms should be guided by clear consumer-focused principles, supported by robust consultation processes and implemented through appropriate transition arrangements to ensure any changes deliver sustainable benefits for consumers, insurers and the broader health sector.

While the proposed reforms are an important step forward, they should be accompanied by a broader long-term strategy for the future of private healthcare and private health insurance (**PHI**) in Australia. This consultation process presents an opportunity not only to address immediate challenges, but also to establish a clearer vision for the role private healthcare will play in meeting Australia's future health needs.

The need for reform

Australia’s private health system faces several structural challenges that require coordinated action across government, insurers, providers and consumers.

While participation in hospital cover remains relatively stable at around 46 per cent of Australians, membership is becoming increasingly concentrated among older age groups. Working-age Australians face growing barriers to participation, including cost-of-living pressures, rising premiums, out-of-pocket (**OOP**) costs and perceptions that private health insurance does not always provide sufficient value.

These pressures are contributing to policy downgrades, increasing adverse selection and placing upward pressure on premiums. Without action to improve affordability, participation and value, the risk pool will continue to age, creating further sustainability challenges for both private health insurance and private hospitals, while increasing pressure on the public health system.

Principles for reform

Bupa's support for the Government’s reform initiatives is guided by three core principles:

1. Better value and outcomes for members

Reforms should deliver meaningful improvements in affordability, access, health outcomes and customer experience. Success should be measured through tangible outcomes that are data-led and benefit the broader membership base.

2. Long-term sustainability

Reforms should strengthen the sustainability of private healthcare and private hospitals over the medium to long term and support a viable, competitive system that continues to deliver value for consumers.

3. Competition, transparency and efficient regulation

Policy settings should encourage transparency, competition and innovation while reducing unnecessary regulatory complexity and supporting efficient market outcomes.

Bupa supports practical reforms that improve access to safe, high-quality and contemporary models of care, increase participation in private health insurance, enhance affordability and deliver better value for members, and strengthen the long-term sustainability of the private health system.

At the same time, reforms must be carefully designed and implemented to avoid unintended consequences for consumers and the broader health system. This includes ensuring adequate implementation timeframes, robust evidence-based design, and appropriate assessment of system-wide impacts.

Collaboration and implementation

Successful reform will require ongoing collaboration that prioritises customer-centred care across all parts of the sector. Bupa sees significant value in continued engagement between government, insurers, providers and consumer representatives as reforms are developed and implemented. Effective reform is more likely when informed by operational experience, evidence and consumer insights.

We support mechanisms that strengthen sector engagement, including more regular workshops, implementation forums and a broader government-led advisory structure with a focus on reform delivery. Collaborative approaches can help identify emerging issues early, improve policy design and build sector-wide support for reforms that deliver lasting benefits for consumers.

Recommendations

Prioritising contemporary models of care	
1.1 Mental Health Care	
Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals	**Support in full:** The Government should apply targeted exemptions to the Medicare moratorium to enable overseas-trained psychiatrists to deliver admitted patient care in private hospitals not located in a District of Workforce Shortage. Any lifting of the current Medicare moratorium should come with appropriate credentialling, peer review, multidisciplinary support and quality assurance arrangements to ensure safe patient care.
Initiative 2: Increased access to contemporary models of mental health care	**Support in principle:** The Government should 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.
Initiative 3: Private health sector to reconvene the Private Mental Health Alliance	**Support in full:** The Government should re-establish the Private Mental Health Alliance with a clear mandate, strong governance and broad stakeholder representation to drive coordinated reform, address systemic challenges, and improve the sustainability, quality and accessibility of private mental health care. Prior lessons from the Private Mental Health Alliance operation should be reviewed to ensure its long-term effectiveness and accountability.
Initiative 4: Review of risk equalisation arrangements	**Do not support:** See section 2.3
1.2 Maternity Care	
Initiative 1: Sector Education	**Support in principle:** The Government should establish a cross-sector working group to co-design, trial and evaluate innovative maternity care models, with representation from clinicians, providers, insurers and consumers. This would help identify, scale and embed successful shared-care approaches by addressing implementation barriers and fostering greater collaboration across the private maternity sector.
Initiative 2: Increased access and choice to different models of maternity care	**Support in principle:** The Government should amend the *Private Health Insurance Act 2007* and *Health Insurance Act 1973* to establish an eligible product in the Hospital Cover schedule which supports a bundled payment for maternity care. This payment should be inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a General Practitioner shared care model.
Initiative 4: Review of product tier structure	**Do not support:** See section 2.2
Initiative 5: Review of risk equalisation arrangements	**Do not support:** See section 2.3

Initiative 6: Review of Medicare Benefits Schedule items for paediatricians	**Support in full:** The Government should amend Medicare Benefits Schedule items for paediatricians so that attendance by a paediatrician provides Medicare Benefits Schedule benefits at a level that would not require an out-of-pocket cost for new families.
1.3 Hospital in the Home	
Initiative 1: Apply a minimum hospital benefit for Hospital in the Home of $360 per day for an initial tranche of 3 treatment services	**Support in principle:** The Government should introduce a minimum benefit for Hospital in the Home that accounts for the varying clinical complexity and resource needs across Hospital in the Home services. This would mean the introduction of a base benefit for Hospital in the Home services with additional supplements for services requiring higher costs or distinct care types. Benefit eligibility should be contingent on demonstrable alignment with nationally consistent hospital safety and quality frameworks.
Initiative 2: Introduction of a telehealth item for Hospital in the Home services	**Support in full:** The Government should introduce specific Medicare Benefits Schedule telehealth items for admitted Hospital in the Home patients to incentivise referrals and support continuity of care and help meet both patient demand and system pressures.
1.4 Type C certification requirements exemption criteria	
Initiative 1: Implement two 'exemption criteria' for the certification requirements for Medicare Benefits Schedule items classified as Type C procedures	**Support in part:** The Government should retain the existing Type C certification framework, while implementing the proposed exemptions for patients ≥ 75 years where procedures performed under general, regional or intravenous sedation, subject to further clarification of the regional anaesthesia exemption. The Government should reclassify Medicare Benefits Schedule item 14245 from a Type C to a Type B procedure.
Delivering better value for consumers	
2.1 Improving access to regional private hospitals	
Initiative 1: Increase the second-tier benefits from 85% to 100% for established regional private hospitals	**Do not support:** The Government should review the current second-tier default benefit arrangements. Any reforms to second-tier default benefits should be carefully targeted, evidence-based and focused on addressing genuine market failure. Where additional support is warranted, it should be linked to demonstrated access, sustainability or community need rather than applied universally across a broad category of providers.
2.2 Private Health Insurance product simplification	
Initiative 1: Simplifying PHI product structure	**Do not support:** The Government should retain Basic and 'Plus' products, strengthen product disclosure and terminology, and pursue greater consistency in areas such as ambulance coverage. Any simplification of private health insurance products should focus on improving transparency, comparability and consumer understanding, while preserving consumer choice, affordability and the integrity of risk pooling arrangements.
Initiative 2: Standardising the age threshold and associated eligibility for dependants	**Support in principle:** The Government should introduce greater consistency in dependant eligibility arrangements across insurers, including a standardised age threshold and a minimum requirement for all insurers to cover dependants with a disability

	beyond age 31. These reforms would improve transparency, portability and equity for consumers while preserving sufficient flexibility for insurers to design products that meet the needs of their membership base.
Initiative 3: Excess and co-payment standardisation	**Do not support:** The Government should not implement reforms that mandate standardised excess levels, materially limit insurers' ability to use excesses and co-payments as legitimate product design features or implement an outright ban on excess waivers.
Initiative 4: Ensuring consistency across premium structures	**Do not support:** The Government should not introduce additional restrictions on the management of closed and new products beyond those proposed through the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026*.
2.3 Risk equalisation	
Initiative 1: Introduction of new Risk Equalisation pool arrangements for maternity and mental health care	**Do not support:** The Government should not introduce new Risk Equalisation pool arrangements for maternity and mental health care but should pursue a holistic reform pathway for risk equalisation, with a transition to prospective risk equalisation as the preferred long-term approach. This would better align pricing, risk and insurer behaviour, support more efficient hospital contracting and product design, and improve productivity across the PHI sector.
Initiative 2: Recalibration of existing mechanisms for younger age cohorts covered by Gold tier	**Do not support:** The Government should not recalibrate existing mechanisms for younger age cohorts covered by Gold tier.
Proposed options for risk equalisation reform	**Do not support:** The Government should commence independent modelling of the proposed Risk Equalisation reforms over the next 12 months, with a view to implementing evidence-based changes that improve consumer value, support innovation and strengthen the long-term sustainability of the private health insurance system. This modelling should form part of a broader Risk Equalisation agenda through a transparent consultation process with insurer access to modelling and implementation analysis. Reforms should include appropriate transition arrangements, review points and safeguards to monitor outcomes and address unintended consequences.

1. Prioritising contemporary models of care

1.1 Mental Health Care

Introduction

Contemporary models of mental health care prioritise prevention, early intervention, community-based treatment and recovery-oriented support, enabling people to access the right care, in the right setting, at the right time. These models can improve continuity of care, prevent deterioration, reduce avoidable hospital admissions and relieve pressure on acute services. However, their delivery is constrained by significant workforce shortages, with Australia's current psychiatry workforce estimated to meet only 56 per cent of national demand.[1] There are also indications that fewer psychiatrists are admitting patients to private hospitals, opting instead for clinic-based practice.[2] This is partly driven by the expansion of Medicare Benefits Schedule (**MBS**) funded telehealth consultations, which has increased the attractiveness and viability of outpatient care.[3]

Australia's mental health policy settings have increasingly shifted towards earlier intervention and care delivered in the community. Funding and regulatory arrangements have not evolved at the same pace, with private health insurance regulation continuing to focus primarily on admitted hospital treatment. Responsibilities also remain dispersed across governments, programs and service systems, limiting the delivery of coordinated care across the consumer journey.[4] As a result, private health insurers (**insurers**) can support mental health care once a person requires hospital admission but have limited capacity to fund many evidence-based preventive, community-based, multidisciplinary and digitally enabled services.

Without reform, this misalignment will continue to constrain access to necessary models of privately provided mental health care resulting in delayed access, fragmented care pathways and limited access to services that could prevent mental health conditions from deteriorating. Bupa considers that workforce shortages, hospital-centric funding arrangements and insufficient measures to address anti-selection also affect the availability and long-term sustainability of private mental health cover. Changes to individual MBS items or risk equalisation arrangements alone will not address these underlying challenges.

Bupa supports the intent of the proposed reforms and welcomes the focus on improving access to private mental health care. Well-designed reform should increase psychiatric workforce capacity, enable insurers to fund evidence-based out-of-hospital care and strengthen collaboration across the private mental health sector. This should include targeted exemptions for appropriately qualified overseas-trained psychiatrists, amendments to private health insurance legislation, a purpose-driven Private Mental Health Alliance and a holistic, evidence-led approach to risk equalisation. Together, these reforms have the potential to improve patient outcomes and access, reduce avoidable hospitalisation and support the sustainability and productivity of Australia's private health system.

Initiative 1 - Allowing overseas-trained psychiatrists to practice in private hospitals

Bupa recognises the significant and ongoing shortage of psychiatrists across Australia and the potential for this reform to improve access to mental health services. We believe that applying targeted exemptions to the Medicare moratorium to enable overseas trained psychiatrists to deliver admitted

[1] Royal Australian and New Zealand College of Psychiatrists, *Advocacy and Collaboration to Improve Access and Equity: Working Better for Medicare Review* (Submission to the Department of Health and Aged Care, February 2024), 2.
[2] Robert Duong, Jemima Whyte and Michael Smith, 'The Mental Health Crisis Gripping Australia's Private Hospitals', *Australian Financial Review* (online, 25 October 2024)
[3] Department of Health and Aged Care, *Private Hospital Sector Financial Health Check: Summary* (Report, October 2024)
[4] Australian Government Productivity Commission, *Mental Health and Suicide Prevention Agreement Review: Final Report.* (2025)

patient care in private hospitals not located in a District of Workforce Shortage (**DWS**) would make it easier for our members to access psychiatric care closer to home. As noted by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australia will not meet current and further mental health needs without a substantial increase to number of practicing psychiatrists with the current workforce only meeting 56 per cent of total demand.[5] This reform could increase access to and the viability of mental health services by:

- Reducing waiting times for psychiatric treatment and assessment through increased workforce capacity.
- Increasing the availability of private inpatient and outpatient psychiatric services.
- Improving access to psychiatry subspecialties such as Child and Adolescent Psychiatry.
- Providing greater access to care for patients with lower-acuity conditions such as anxiety disorders, affective disorders and substance use disorders.

The RANZCP has reported that the current Medicare moratorium has resulted in increased job dissatisfaction and burnout amongst psychiatrists. This is felt both by the International Medical Graduates (IMGs) who are required to practice in DWS areas as well as locally trained psychiatrists who are shouldering the burden of practice in non DWS areas.[6] We support the guardrails outlined by the department for an exemption cap of 2 psychiatrists to each private hospital in a non-DWS area. This will prevent an exodus of overseas trained psychiatrists away from DWS areas. It would be prudent to ensure this mechanism is reviewed as part of the proposed post implementation review.

Finally, in addition to the guardrails put forward by the Department, any lifting of the current Medicare moratorium should come with appropriate credentialling, peer review, multidisciplinary support and quality assurance arrangements to ensure safe patient care.

Recommendation 1: Government should apply targeted exemptions to the Medicare moratorium to enable overseas trained psychiatrists to deliver admitted patient care in private hospitals not located in a DWS. Any lifting of the current Medicare moratorium should come with appropriate credentialling, peer review, multidisciplinary support and quality assurance arrangements to ensure safe patient care.

Initiative 2: Increased access to contemporary models of privately provided mental health care

We support the intent of the proposed reform and recognise the important role it can play in improving access to mental health services. However, achieving meaningful and lasting improvements in patient outcomes will require a broader approach than changes to Medicare Benefits Schedule (MBS) items alone. Contemporary models of privately provided mental health care increasingly emphasise early intervention, prevention, community-based treatment, and recovery-oriented support delivered outside of hospital settings. To fully realise the objectives of the reform, policy settings should also enable insurers to fund a wider range of evidence-based out-of-hospital psychiatric prevention, treatment, and recovery services. Expanding the capacity of insurers to support these models of care would help

[5] Royal Australian and New Zealand College of Psychiatrists, *Advocacy and Collaboration to Improve Access and Equity: Working Better for Medicare Review* (Submission to the Department of Health and Aged Care, February 2024), 2.
[6] Ibid 3.

address service gaps, promote continuity of care, reduce avoidable hospital admissions, and ensure consumers can access the right care, in the right setting, at the right time.

Australia's approach to mental health policy has increasingly shifted towards prevention, early intervention, and recovery-oriented care delivered in community settings. Funding arrangements, however, have not evolved at the same pace. Responsibilities remain dispersed across Commonwealth and state programs, with separate funding mechanisms for primary care, specialist services, hospitals, and psychosocial supports, limiting opportunities to deliver integrated care across the consumer journey.[7]

Private health insurance regulation reflects a similarly hospital-centric model of care. Existing legislative settings under the *Private Health Insurance Act 2007* (**PHI Act**) were designed primarily to support admitted hospital treatment and rehabilitation services.[8] While private health insurers can contribute to the cost of hospital-based mental health care once admission is required they have limited legislative authority to fund many evidence-based preventive, community-based and digitally enabled mental health services delivered outside hospital settings where MBS item numbers are attached, except in very limited cases which are exempt as a result of Rule 10 of the *Private Health Insurance (Health Insurance Business) Rules 2018*.[9]

Successive reviews have emphasised the importance of intervening earlier, supporting people in the community and reducing avoidable hospitalisation and readmission, yet current funding arrangements limit the capacity of private health insurers to complement publicly funded services through earlier intervention, coordinated care, and relapse prevention.[10] A structural misalignment has therefore emerged between the policy objectives of Australia's mental health system and the funding mechanisms available to support it. 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. This not only constrains innovation in service delivery but also limits opportunities to reduce pressure on public hospitals, improve continuity of care and deliver better value across the health system.

Bupa believes that the Government should amend the *PHI Act* and associated rules so that insurers may fund early intervention, prevention and community-based mental health care as a substantive benefit, rather than only as an adjunct to admitted hospital treatment.[11]

- Complete the expansion of home and community-based mental health services flagged under the second wave of private health insurance reforms, including options for insurers to fund services outside the Medicare Benefits Schedule under both general treatment and hospital treatment policies.
- Expand the range of evidence based out of hospital mental health services that can be supported through private health insurance, including multidisciplinary care, digital virtual and in person interventions and stepped care models delivered in partnership with local providers.
- Align benefit design with quality outcomes rather than fee for service or admission-based payment, so that the incentive to intervene early is not offset by the incentive to admit.

[7] Productivity Commission, *Mental Health and Suicide Prevention Agreement Review* (Inquiry Report No 108, Commonwealth of Australia, 2025).
[8] *Private Health Insurance Act 2007 ss 69.1, 69.10*
[9] *Private Health Insurance (Health Insurance Business) Rules 2018, r 10.*
[10] Ibid n 8.
[11] Ibid.

- Ensure these arrangements complement, rather than duplicate, Medicare and publicly funded services by directing private investment towards earlier access, continuity of care and reduced reliance on acute settings.

Recommendation 2: To maximise consumer access to contemporary models of mental health care, the Government should 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.

Initiative 3 - Reconvening the Private Mental Health Alliance (PMHA)

Bupa supports collaboration across the private mental health sector where there is a clearly defined purpose, transparent governance arrangements and a commitment from members to work toward shared outcomes. Given the complexity of Australia's mental health system, there is significant value in creating a forum that brings together funders, providers, clinicians, consumers and policymakers to identify systemic issues and develop coordinated solutions.

The Private Mental Health Alliance (**PMHA**) was previously disbanded in 2016 due to challenges in achieving alignment across stakeholders. Prior to any reconvening of the Alliance, it will be important to understand the factors that contributed to its dissolution, including governance arrangements, stakeholder expectations, decision-making processes, competing priorities and the extent to which members shared a common vision and objectives. A review of previous lessons learned would help ensure that any future Alliance is established on a more sustainable footing and is positioned to deliver meaningful outcomes. Any reconvened PMHA should have a clear mandate, measurable objectives and a focus on practical improvements that benefit patients and support the long-term sustainability of the private mental health system. To be effective, the PMHA should include representation from across the private mental health ecosystem, ensuring balanced participation from providers, insurers, clinicians and consumers.

Bupa considers that a reconvened PMHA should focus on strategic issues affecting the performance, sustainability and quality of Australia's private mental health system. The Alliance should avoid becoming solely a discussion forum and instead be tasked with identifying priorities, driving reform and monitoring progress against agreed objectives. Key focus areas of a reconvened PMHA should include:

- Understanding key challenges in the current system
- Monitoring and advocating for validated innovative models of care
- Identifying opportunities to improve system productivity, innovation and efficiency
- Examining workforce challenges and sustainability
- Improving service access and equity
- Improving data transparency and evaluation.

To be effective, the PMHA should include representation from across the private mental health ecosystem, ensuring balanced participation from providers, insurers, clinicians and consumers.

Recommendation 3: Government should re-establish the Private Mental Health Alliance with a clear mandate, strong governance and broad stakeholder representation to drive coordinated reform, address systemic challenges, and improve the sustainability, quality and accessibility of private mental health care. Prior lessons from the Private Mental Health Alliance operation should be reviewed to ensure its long-term effectiveness and accountability.

Initiative 4 - Review of risk equalisation arrangements

See below ***Section 2.3.***

1.2 Maternity Care

Introduction

Private maternity care is experiencing sustained affordability and viability pressures, with the average cost of private obstetrician-led care exceeding $12,000, the proportion of births occurring in private hospitals declining and 10 private maternity services closing between July 2017 and May 2025.[12] Private hospital maternity units are expensive to run, and as more of these private units close, there will be a subsequent shift of obstetricians to public hospital settings due to lack of private servicing options. Bupa supports the objective of improving access, affordability and choice in private maternity care. However, reform must address the underlying costs, funding arrangements and coordination barriers affecting service delivery, while avoiding changes that could increase premiums, encourage anti-selection or further undermine the viability of maternity-inclusive products.

Although sector education and information sharing may increase awareness of innovative maternity care models, Bupa does not consider that limited understanding of the existing regulatory framework is the principal barrier to their broader adoption. Collaborative models already operating in the private sector, including *Hatch Private Maternity* in Brisbane and the *Embrace Program* in Melbourne, illustrate how obstetricians and midwives can provide coordinated and personalised care within the current private maternity system.

Increasing access to alternative models of maternity care will also require changes to funding arrangements so that private health insurers can support integrated services delivered across primary, out-of-hospital and hospital settings. The recommendation of the *Unleashing the Potential of our Health Workforce – Scope of Practice Review* to introduce a private sector bundled maternity payment provides an appropriate basis for further reform, as it would support midwifery continuity of care, traditional midwife and medically-led care and GP shared-care models across the maternity journey.[13] Subject to appropriate clinical, quality and risk safeguards, amendments to private health insurance legislation to enable such payments would provide greater certainty for providers and insurers seeking to invest in innovative care than reliance on time-limited pilot arrangements.

Changes to waiting periods, product tiers and risk equalisation should be considered within a broader assessment of the underlying cost and sustainability of private maternity care, rather than as stand-

[12] Australian Government Department of Health, Disability and Ageing, *Private Health Sector Reform – Consultation Paper 1*, (2026).
[13] Cormack, M. *Unleashing the Potential of our Health Workforce – Scope of Practice Review: Final Report*, DoHDA (2024).

alone mechanisms for redistributing costs between insurers or policyholders. Bupa does not support reducing the existing 12-month waiting period for pregnancy and birth, as doing so would increase anti-selection risk and place further pressure on the affordability and viability of maternity-inclusive products without addressing significant consumer costs such as specialist fees and diagnostic services. Bupa also supports reviewing paediatric MBS items to reduce unexpected out-of-pocket expenses for new families, alongside a more holistic reform program that improves the funding and delivery of collaborative maternity care while preserving the long-term sustainability and value of private health insurance.

Initiative 1 - Sector education

Bupa agrees that sector wide education and collaboration can play a role in raising awareness of innovative maternity care models and improving understanding of the regulatory settings that support them. Bringing together stakeholders from across the private health sector can help to build a shared understanding of innovative approaches to care, demonstrate examples of successful service delivery and identify opportunities for broader cross-sector collaboration.

We believe that sector education alone will not address the key barriers to the adoption of innovative models of maternity care. The Department's proposal for workshops and information sharing activities is positive but it is not clear what the specific outcomes of these initiatives would be, nor how they would translate into sustained systemic change.

We do not agree with the premise that the shortage of innovative models of maternity care within the private sector is driven by a lack of understanding of regulatory barriers or enablers. There are several examples of successful shared maternity care models operating across the private health sector including in private hospitals and private obstetric groups. The *Hatch Private Maternity* program at the Mater Mothers' Private Hospital in Brisbane, *Kindred* in Brisbane and the *Embrace* Program at St Vincent's private maternity in Melbourne both demonstrate innovative maternity programs that deliver excellent value for patients while ensuring that mothers and their babies receive collaborative, personalised care. These models demonstrate that innovation is possible within the current regulatory environment.

We believe the more significant challenge is the limited coordination and engagement across the sector to identify, evaluate and scale successful models of care. While education can increase awareness of existing approaches it will not create the partnerships, incentives or implementation frameworks required to support the broader adoption of innovative models of maternity care in the private health sector. There is a need for a practical mechanism that brings stakeholders together to collaboratively design, test and evaluate new approaches to maternity care delivery.

To support meaningful reform, we recommend that Government establish a cross-sector working group tasked with co-designing and trialling innovative maternity models within the private health sector. This working group should include representation from key stakeholders including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**), Australian College of Midwives, private hospitals, private obstetric providers, private health insurers and consumer representatives. Bringing together these voices would help the sector to identify opportunities and challenges in innovative maternity care models and build consensus around the implementation of these models in the private health system.

Terms of reference for this working group could include:

- Mapping existing shared care and collaborative maternity care models currently operating within Australian private hospitals and private obstetric & midwifery practices.

- Identifying examples of best practice and assessing factors that support successful implementation
- Identifying workforce and operational barriers to the implementation of shared care models
- Evaluation of shared-care pilot programs within private hospital settings.
- Developing recommendations to support the broader adoption of evidence based shared maternity care models in the private health sector.

Recommendation 4: Government should establish a cross-sector working group to co-design, trial and evaluate innovative maternity care models, with representation from clinicians, providers, insurers and consumers. This would help identify, scale and embed successful shared-care approaches by addressing implementation barriers and fostering greater collaboration across the private maternity sector.

Initiative 2 - Increased access and choice to different models of private maternity care

Bupa believes that private health insurers have a central role to play in the development of innovative models of care within the private maternity sector. For example, Bupa has partnered with *Hatch Private Maternity* in Brisbane to enable eligible members to receive a no gap private maternity shared care experience. This means that eligible members had their antenatal and postnatal visits, pregnancy management fee and delivery fee covered by Bupa saving our members significant out of pocket fees. Partnerships like this support providers engaging in innovative models of care by connecting members with these providers. It also provides better value for consumers with a no-gap hospital birth experience, improving the value proposition for private health.

Regulatory barriers prevent private health insurance from covering out of hospital expenses for innovative models of maternity care meaning that there is less financial security for providers to incentivise investment. Currently, programs such as *Hatch* no-gap obstetric care, are only made possible through pilot programs under the *Private Health Insurance Act (2007) (***PHI Act***)* and the *Private Health Insurance (Complying Product) Rules 2015*. This means that these programs are not subject to ongoing funding by insurers, limiting the development of new and innovative models of care. They are also not able to be built into product development, so are unable to be priced effectively. In 2024, the final report of the *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (**the Cormack Review**) led by Professor Mark Cormack recommended the introduction of a private sector version of the bundled payment for maternity care.[14] This would require Government to amend the PHI Act and *Health Insurance Act 1973* to establish an eligible product in the Hospital Cover schedule which supports a bundled payment for maternity care. The Cormack Review recommended that this payment be inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model.

The adoption of this recommendation would provide pregnant women with more continuous and connected care from the maternity care team involved in their journey across primary, acute, public

[14] Ibid, Recommendation 11.1.

and private settings. It would also enable investment in innovative models of care by clinician midwives and private hospitals.

Recommendation 5: Government should amend the *Private Health Insurance Act (2007)* and *Health Insurance Act 1973* to establish an eligible product in the Hospital Cover schedule which supports a bundled payment for maternity care. This payment should be inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model.

Initiative 3 - Shorter PHI waiting periods for privately provided pregnancy and birth

Bupa does not support a reduced waiting period for privately insured pregnancy and birth services. Pregnancy and birth services differ from many other forms of healthcare covered by private health insurance because they are more likely to be foreseeable and planned events. As such, maternity care presents unique challenges for insurance design, as it does not align with the traditional insurance principle of pooling risk to cover uncertain and unexpected events.

Waiting periods are an important risk management and risk equalisation mechanism within private health insurance. They help maintain fairness between members by ensuring individuals contribute to the insurance pool over an appropriate period before accessing high cost planned services. Portability rules under the PHI Act, enable policyholders to upgrade their level of cover, serve a 12-month waiting period until the date of delivery, access treatment and subsequently downgrade or cancel their cover once those services are no longer required.

Reducing the current 12-month waiting period for pregnancy and birth services would increase the opportunity for consumers to purchase or upgrade cover only when they anticipate needing maternity benefits, rather than maintaining ongoing participation in the insurance pool. This creates a significant anti-selection risk, whereby individuals with a high likelihood of claiming join the pool shortly before incurring substantial costs, while lower-risk members continue to subsidise those claims. The current arrangements support the long-term sustainability and affordability of private health insurance by reducing anti-selection and spreading costs across the membership base. A shorter waiting period for maternity services would materially weaken these protections.

Bupa does not believe that a reduction in waiting periods for pregnancy and birth services would address many of the key affordability concerns raised by consumers, including high out-of-pocket specialist costs, diagnostic services and other pregnancy-related items. While a shorter waiting period may improve the speed at which some consumers can access insured benefits, it would not necessarily reduce the overall cost of care experienced by members.

Reducing waiting periods risks increasing claims costs and placing upward pressure on premiums, particularly within Gold-tier products where maternity services are currently included. Higher utilisation of maternity benefits driven by shortened waiting periods would likely require insurers to recover increased costs through premium increases, potentially affecting affordability for existing members who may never use maternity services.

For these reasons, Bupa considers that maintaining existing maternity waiting periods remains an important safeguard for the sustainability, affordability and equity of the private health insurance system.

Recommendation 6: Government should maintain the current waiting periods for pregnancy and birth as an important safeguard for the sustainability, affordability and equity of the private health insurance system.

Initiative 4 - Review of product tier structure

See below **Section 2.2**

Initiative 5 - Review of risk equalisation arrangements

See below **Section 2.3**

Initiative 6 - Review of MBS items for paediatricians

Bupa supports the amendment of MBS items for paediatricians so that the attendance by a paediatrician provides MBS benefits at a level that would not require an out-of-pocket cost for new families. We find that our members can be shocked to receive a bill once they have returned home from hospital for their child's paediatric care when they had thought that their hospital medical expenses had been covered under their insurance policy. New parents are unlikely to opt-out of their baby being reviewed by a paediatrician.

Out-of-pocket fees are also not generally explained to new parents at the time of review by the paediatrician. This undermines the value proposition of private health insurance and leads consumers to question why they are paying high premiums for Gold hospital coverage when they are not having their in hospital medical expenses covered.

Recommendation 7: The Government should amend MBS items for paediatricians so that the attendance by a paediatrician provides MBS benefits at a level that would not require an out-of-pocket cost for new families.

1.3 Hospital in the Home

Introduction

Hospital in the Home (**HITH**) is a proven clinical model that results in better outcomes for referred patients, including lower 30-day mortality and readmission rates and higher patient and carer satisfaction. A 2025 study of a large national program found satisfaction rates above 80 per cent among both patients and providers. HITH also supports the long-term sustainability of the health system through substantial cost savings and holds particular value for rural and regional communities, allowing patients to remain close to home and helping to sustain small local health services.

These benefits are already being realised in the public hospital system with Government investment in HITH programs steadily increasing. The 2026-27 Victorian State Budget invested a further $174.8

million in Victoria's hospital in the home program – *Better at Home.*[15] The program is currently delivered by 47 health services across Victoria and has saved more than 362,000 hospital bed days since it was established in 2020.[16]

The private hospital sector substantially trails the public hospital sector in the delivery of HITH programs due to lack of investment and complexities in funding arrangements. In the 2022-23 financial year there were 158,900 HITH separations in Australia, only 6,400 (4 per cent) were delivered in the private hospital sector.[17] Unless there is reform, the disparity in HITH delivery between the public and private sectors will continue resulting in public patients receiving better and more consistent HITH care in the public hospital sector.

In May 2026, Bupa released a position paper on HITH reform which was developed through a co-design process with sector leads. We are pleased to see that the Department has adopted several of these recommendations as proposals for this consultation process. Overall, we believe that well-designed reform of the funding, regulatory and policy framework for HITH has the potential to lower the cost of care with reduced claims per admission episode, improve member satisfaction and retention and support private health system sustainability and innovation. This will result in economic benefits for Government, privately insured patients, and the private health system.

Introduction of a minimum benefit for Hospital in the Home

Currently, there is no minimum benefit for HITH services, meaning that a patient may not be covered for HITH if their insurer is not contracted with the hospital. This can lead to fragmented care and limits referrals to HITH services. The lack of a minimum benefit for HITH means that hospitals are less likely to invest in appropriate HITH services. This means there are missed opportunities in the private sector for innovation and investment in care delivery.

Bupa does not support the proposed minimum hospital benefit of $360 per day put forward by the Department. We believe that any default benefit should account for varying clinical complexity and resource needs across HITH services. This would mean the introduction of a base benefit for HITH services with additional supplements for services requiring higher costs or distinct care types. A HITH minimum benefit cannot take a one-size-fits-all approach. Careful design, appropriate pricing and robust oversight are critical to the introduction of any HITH minimum benefit. Without these safeguards, reforms could:

- Increase costs and place upward pressure on premiums.
- Result in minimum benefits that do not reflect the actual cost of delivering HITH services.
- Funding for HITH services that may not be clinically appropriate or safe for some patients, potentially compromising quality of care.

Proposed service categories

A single minimum benefit is unlikely to provide adequate funding across the full spectrum of HITH services and risks creating incentives that favour lower-cost models while undermining access to higher-acuity care delivered in the home. Minimum benefits should be linked to clearly defined service

[15] Victorian Government, *Budget Paper No 3: Service Delivery* (2026–27).
[16] Victorian Government, 'Better at Home Initiative' (Web Page, 19 May 2026)
[17] Above n 1.

requirements for each HITH category, ensuring that benefit levels reflect the resources required to safely deliver care that is genuinely substitutive for an inpatient admission.

Agreed minimum service expectations are essential to make sure HITH services are safe, reliable and provide meaningful benefit for patients. While not every element of care will be clinically necessary for every patient, services must have clear systems in place to provide these supports when they are needed. This ensures flexibility for individual patient needs without compromising safety, quality, or continuity of care.

1. Acute-inpatient level care substitution

For patients receiving acute care in their own home, services must meet a level of care equivalent to an in-hospital admission. Minimum service expectations should include:

- Daily face-to-face nursing assessment and care.
- Regular medical assessment and review, with frequency determined by clinical need.
- Access to face-to-face medical consultations where clinically indicated.
- Availability of 24/7 clinical escalation pathways.
- Access to hospital-level diagnostics, interventions and multidisciplinary care.

2. Home based palliative and end-of-life care

A separate minimum benefit should apply to palliative and end-of-life care delivered as a substitute for an acute inpatient admission. While this care may require high levels of nursing support and responsive clinical management, the resource profile differs from acute inpatient substitution with a focus on symptom management, care coordination and rapid response capability. Minimum service expectations should include:

- Daily face-to-face nursing care.
- Regular medical review based on clinical need.
- Access to 24/7 escalation pathways.
- Coordination with specialist palliative care services and community supports.
- Capacity to respond rapidly to changing patient needs to avoid hospital admission.

Structuring and setting appropriate benefits

Rather than prescribing a single minimum benefit amount across all HITH services, we recommend the Department establish benefits using a transparent cost-based methodology for each service category, incorporating the following cost components:

- Nursing and medical workforce costs.
- 24/7 clinical governance and escalation capability.
- Logistics associated with equipment and consumable delivery and retrieval.
- Allied health and multidisciplinary supports where required.
- Medical consumables and HITH-related pharmacy supply.

Additional complexity loadings should be available where services incur demonstrably higher costs, including:

- Travel and outreach costs, including geographic loadings.

- Culturally safe care models, including support for Aboriginal and Torres Strait Islander patients receiving care on Country.
- Allied health and other wrap-around supports that may be indicated to support acute-inpatient level care.

The following components should be excluded from benefit setting:

- Prostheses payable under the Prescribed List of Medical Devices and Human Tissue Products (PL)
- Pharmacy funded under health fund agreements.
- Capital infrastructure including IT.
- Radiology and hospital diagnostics.
- Equipment and consumables for palliative care, given variability in sourcing and pricing.

Bupa believes that this approach would ensure benefit levels appropriately reflect the complexity and cost profile of each HITH service type while maintaining consistency, transparency and flexibility across the sector.

Initial tranche of HITH treatment services

Bupa believes the Department's proposal to prioritise reform for the following initial tranche of priority conditions.

- Intravenous (IV) infusions
- Complex wound care
- Palliative care

These conditions represent well established forms of acute inpatient substitution that are already widely delivered across Australian public and private health systems. They are supported by a strong clinical evidence base, clear patient eligibility criteria, and mature models of care meaning patients can be confident that they are receiving true in hospital substitution.

Bupa supports the inclusion of IV chemotherapy as an eligible IV infusion in the initial tranche of HITH treatment services where considered appropriate by a Visiting Medical Officer (**VMO**), as is currently done under Chemo in the Home programs.

Introduction of Medicare Benefits Schedule telehealth items

Bupa strongly supports the introduction of Medicare Benefits Schedule (MBS) telehealth items for admitted HITH patients. The introduction of specific MBS telehealth items for admitted HITH patients to incentivise referrals and support continuity of care and help meet both patient demand and system pressures.

Current MBS telehealth settings restrict a VMO from referring a patient to a HITH program due to the lack of MBS telehealth items for admitted HITH patients. It is also a barrier to clinical governance requirements as the VMO cannot review their patient other than in person. Reforming MBS telehealth items would enable VMOs to be compensated for HITH consultations and ensure treating specialists can review patients in HITH settings.

Any new MBS telehealth items should be supported by strict record keeping requirements and should only be accessible to HITH referring specialists who are supporting the continuity of care for patients who are, in effect, an acute inpatient transferred from the typical inpatient hospital setting.

Ensuring patient safety and care quality

Bupa believes that to be eligible for default benefits, HITH services must meet the same foundational criteria, quality, governance and reporting requirements as admitted hospital settings. We want to ensure that our members receive safe care equivalent to that of inpatient settings.

We note that the Department has outlined that the intended definition of a HITH service is intended to align with the Australian Institute of Health and Welfare's Metadata Online Registry definition where 'Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.' As outlined in the proposed definition, a core component of HITH is that it provides equivalent care to hospital admission without compromising patient safety or quality of care. As such, benefit eligibility should be contingent on demonstrable alignment with nationally consistent hospital safety and quality frameworks including the NSQHS.

This would include:

- Accreditation to the National Safety and Quality Health Service (NSQHS) Standards
- Reporting against validated safety and quality indicators suitable for HITH, for example those outlined in the HITH Society Australasia Position Statement and Australian Council of Healthcare Standards (ACHS) clinical indicators for HITH.

Any services that are proposed to receive minimum benefits must demonstrate either:

- current accreditation to NSQHS Standards as part of a hospital-wide assessment; or
- the capacity to meet NSQHS Standards if not currently accredited, confirmed by assessment or audit within 12 months.

The Australian Commission on Safety and Quality in Health Care (**ACSQHC**) produces audit, monitoring and reporting tools. We recommend HITH-specific guidance and audit tools be developed in relation to the operation of HITH services to help services interpret the standards and demonstrate compliance. These could incorporate relevant Clinical Care Standards for specific service types and, in time, support accreditation of HITH services directly.

Recommendation 8: The Government should introduce a minimum benefit for HITH that accounts for the varying clinical complexity and resource needs across HITH services. This would mean the introduction of a base benefit for HITH services with additional supplements for services requiring higher costs or distinct care types. Benefit eligibility should be contingent on demonstrable alignment with nationally consistent hospital safety and quality frameworks.

Recommendation 9: The Government should introduce specific MBS telehealth items for admitted HITH patients to incentivise referrals and support continuity of care and help meet both patient demand and system pressures.

1.4 Type C certification requirements

Under the *Private Health Insurance (Benefit Requirements) Rules 2011*, benefits for accommodation associated with a Type C procedure are only payable where the treating medical practitioner certifies that hospital admission is clinically necessary for that patient.[18] The practitioner must confirm that admission is required because of the patient's medical condition or other special circumstances that make treatment outside a hospital setting inconsistent with accepted medical practice.

Bupa believes that the broad policy rationale for Type C certification remains sound. Type C procedures are generally procedures that can ordinarily be performed safely in a consulting room or community setting, such as minor skin lesion excisions and certain diagnostic procedures. On the most part, certification requirements act as an important safeguard by requiring both the treating practitioner and hospital provider to actively consider whether hospital admission is clinically necessary. At a macro level, Type C certification requirements:

- Discourage hospital admission for procedures that can be safely and appropriately performed in community-based settings.
- Reduce costs to the health system, including higher claims costs for health funds from overnight and day procedures resulting in increased private health insurance premiums for consumers.
- Ensure clinician accountability requiring justification as to why hospitalisation is necessary for a particular patient.

The Department has proposed to implement two ‘exemption criteria’ for the certification requirements for MBS items classified as Type C procedures, where:

- a patient is ≥ 75 years of age, and
- the procedure is conducted under general anaesthesia, regional anaesthesia or IV sedation.

Bupa believes that the exemption criteria proposed by the department is appropriate in theory, and would reduce the administrative burden on practitioners and hospitals. At the same time, we would like further clarity and information about the ‘regional anaesthesia’ exemption given the broad definition of this pain management method.

Bupa also supports the reclassification of MBS item 14245 from a Type C to a Type B procedure. MBS item 14245 covers the intravenous infusion of an immunomodulating agent lasting at least 2 hours. Given the lengthy infusion time, this is a more appropriate procedure for a hospital setting and reclassification would reduce the administrative burden for hospitals, practitioners and insurers.

Bupa does not support introducing any further exemption requirements for Type C certification requirement which would risk risks undermining the current policy framework. On balance, retaining the current Type C certification framework supports both clinical appropriateness and system

Recommendation 10: The Government should retain the existing Type C certification framework, while implementing the proposed exemptions for patients ≥ 75 years where procedures performed under general, regional or IV sedation, subject to further clarification of the regional anaesthesia exemption. The Government should reclassify MBS item 14245 from a Type C to a Type B procedure.

[18] Private Health Insurance (Benefit Requirements) Rules 2011 r 7, r 11.

productivity. It is incongruous to encourage investment in innovative models of care whilst removing barriers that promote care being delivered outside hospital settings. The existing certification requirement is a proportionate and effective mechanism for maintaining these protections and should be retained.

2. Delivering better value for consumers

2.1 Improving access to regional private hospitals

Second-tier default benefits are payable where a private health insurer does not have a contract with an eligible private hospital and the hospital is second-tier registered. [19] They are currently set at no less than 85 per cent of the average charge for equivalent treatment under an insurer's contracts with comparable hospitals in the same state or territory. Bupa believes that the current second-tier default benefit arrangements are no longer operating as originally intended and would benefit from significant reform.

While second-tier default benefits play an important role in ensuring access to care where contractual arrangements are not in place, the current framework can weaken incentives for hospitals and insurers to negotiate sustainable commercial agreements. In some cases, it may also allow providers to access funding arrangements without demonstrating the same value, quality, efficiency and consumer outcomes expected under contracted arrangements. We are concerned that the current settings do not consistently support the objectives of affordability, quality and value for consumers and may contribute to avoidable cost pressures within the system that ultimately flow through to premiums.

Bupa recognises the challenges facing some regional private hospitals and supports consideration of measures that improve access to care and provider sustainability where there is clear evidence of need. However, we do not support a broad increase in second-tier default benefits to 100 per cent for regional hospitals.

A blanket increase based on geographic location alone would not adequately recognise the significant differences in operating models, service profiles, utilisation levels and financial performance that exist across regional providers. Such an approach risks reducing incentives for hospitals to enter into value-based contractual arrangements and may result in higher funding levels without corresponding improvements in efficiency, quality or member outcomes.

Bupa considers that any reforms to second-tier default benefits should be carefully targeted, evidence-based and focused on addressing genuine market failure. Where additional support is warranted, it should be linked to demonstrated access, sustainability or community need rather than applied universally across a broad category of providers. This approach would better support the long-term sustainability of the private health system while minimising unnecessary pressure on consumer premiums and maintaining incentives for effective contracting.

It is also important to recognise that second-tier default benefits increase each year in alignment with growth in contracted private hospital rates. The existing framework therefore already provides hospitals with ongoing funding growth. A further increase to 100 per cent would effectively provide non-contracted hospitals with funding equivalent to contracted providers without requiring them to enter into contractual arrangements or demonstrate the value, quality and efficiency outcomes typically

[19] *Private Health Insurance (Benefit Requirements) Rules 2011*

negotiated through those agreements. This would undermine incentives for effective contracting and place additional upward pressure on premiums for members.

Recommendation 11: The Government should review the current second-tier default benefit arrangements. Any reforms to second-tier default benefits should be carefully targeted, evidence-based and focused on addressing genuine market failure. Where additional support is warranted, it should be linked to demonstrated access, sustainability or community need rather than applied

2.2 PHI product simplification

Introduction

Bupa supports the intent of reforms to improve consumer understanding and comparability of PHI hospital products. However, reforms should not undermine community rating, PHI affordability or risk pooling or lead to significant anti-selection. Experience since the introduction of the 2019 product tier reforms suggests that some simplification measures have had unintended consequences, particularly for Gold hospital products, which should be carefully considered before further structural changes are implemented.

The 2019 product tier reforms introduced a standardised hospital product tier framework comprising Gold, Silver, Bronze and Basic products, with minimum coverage requirements defined through clinical categories. While the reforms have improved transparency and made products easier for consumers to compare, they have also had the following unintended consequences:

- Reduction in Gold hospital market offerings, with some insurers closing products, limiting sales or increasing excess levels
- Increased concentration of claims in Gold clinical categories like pregnancy and psychiatric services
- Higher claims drawing rate of Gold hospital policyholders with less than 5 years tenure
- Increased anti-selection behaviour with consumers purchasing Gold products based on anticipated coverage requirements

Together, these trends have contributed to increasing pressure on Gold premiums and reduced affordability for consumers requiring Gold hospital cover.

Bupa is particularly concerned about the long-term sustainability of Gold products, given their importance in supporting access to maternity and mental health services. Any reforms to product structures must balance impacts on risk pooling, affordability and participation alongside those to make products simpler for consumers.

Initiative 1: Simplifying PHI product structure

Bupa supports simplifying PHI products through clearer communication, standardised terminology and greater transparency but would not support reforms that materially reduce consumer choice, product flexibility or affordability.

1. Removal of basic hospital product tier

Basic hospital products provide an important entry point to the PHI system for younger and lower income consumers. Basic hospital products also provide access to Mental Health Waiver exemptions, enabling consumers to access private inpatient psychiatric care immediately and bypass the standard

2-month waiting period. They support participation in the PHI system and assist consumers seeking to avoid Lifetime Health Cover (LHC) loading and Medicare Levy Surcharge (MLS) impacts. Critically, this supports Australia's broader health system by reducing pressure on public hospitals. On this basis, Bupa would not support the removal of the Basic hospital product tier.

2. Removal of 'Plus products' and the consolidation of product tiers

Removing the capacity for insurers to offer 'Plus products' would limit consumer choice, potentially reducing the attractiveness and affordability of PHI. While these changes may reduce the number of products available, we are concerned these changes could:

- reduce consumer choice and flexibility in selecting products aligned to individual needs
- increase the risk of under-insurance where consumers opt for lower-cost products that do not provide appropriate coverage
- reduce affordability by limiting opportunities for consumers to tailor their cover
- increase the likelihood of members downgrading their cover or exiting PHI altogether.

'Plus products' are one of the few mechanisms that insurers can use to differentiate market offerings with product flexibility playing an important role in attracting and retaining consumers at different life stages. Restricting that flexibility may have unintended consequences for participation and affordability, particularly where consumers are unable to find products that appropriately balance cost and coverage.

Rather than reducing the range of products available, we believe that product simplification efforts should focus on improving transparency, comparability and consumer understanding. This could be achieved through clearer product disclosure, more consistent terminology across insurers, standardised communication of key policy features, and enhanced consumer decision-support tools.

3. Clarifying hospital vs combined product coverage

Bupa supports initiatives that improve consumer understanding of key product features, including:

- clearer distinction between hospital-only and combined products
- more consistent terminology across insurers
- improved disclosure of product inclusions, exclusions and limitations.

These measures would make products easier for consumers to understand, compare and select, while preserving consumer choice, promoting competition and maintaining affordability within the PHI system.

4. Ambulance, Emergency Department and Hospital Substitute Services

Bupa supports clarification of policy settings regarding ambulance services, emergency department treatment and hospital substitute treatment.

In relation to ambulance coverage, many sources of consumer confusion arise from differences in ambulance funding and eligibility arrangements across states and territories, rather than from insurer administration of ambulance claims. Variation in the treatment of emergency and non-emergency transport, air and road ambulance services, and coverage for interstate residents can create complexity for both consumers and private health insurers. In addition, reciprocal arrangements between jurisdictions may change over time without a consistent process for notifying insurers.

Greater consistency across jurisdictions and insurers would improve consumer understanding and comparability. Commonwealth Government leadership will be important in establishing nationally consistent arrangements.

Recommendation 12: The Government should retain Basic and 'Plus' products, strengthen product disclosure and terminology, and pursue greater consistency in areas such as ambulance coverage. Any simplification of private health insurance products should focus on improving transparency, comparability and consumer understanding, while preserving consumer choice, affordability and the integrity of risk pooling arrangements.

Initiative 2: Standardising the age threshold and associated eligibility for dependants

Bupa recognises that variations in dependant eligibility rules across insurers can create confusion for consumers and present challenges when transferring between insurers. Greater consistency in eligibility arrangements has the potential to improve transparency, portability and consumer experience. We support measures to improve consistency in dependant eligibility arrangements, including consideration of a standardised age threshold and clearer eligibility requirements across insurers. We support requiring all insurers to cover dependants with a disability over age 31, recognising that this would spread the need to consider cost-sharing and equity implications across the insured population. At the same time, it is important that insurers retain an appropriate degree of flexibility to design products that reflect the needs and characteristics of their membership base. Establishing a minimum industry requirement would improve access, consistency and equity for people with disability and their families while supporting continuity of insurance coverage.

Recommendation 13: Introduce greater consistency in dependant eligibility arrangements across insurers, including a standardised age threshold and a minimum requirement for all insurers to cover dependants with a disability beyond age 31. These reforms would improve transparency, portability and equity for consumers while preserving sufficient flexibility for insurers to design products that meet the needs of their membership base.

Initiative 3: Excess and co-payment standardisation

1. Standardising excess and co-payments

Bupa supports improved consistency and transparency in the application of excesses and co-payments but does not support reforms that remove important affordability levers or unnecessarily constrain insurer flexibility.

Excesses and co-payments are important product design features within the PHI system, enabling consumer choice, supporting affordability and encouraging continued participation in PHI. We recognise that excess and co-payment arrangements can be difficult to understand for consumers particularly when they differ between insurers. Accordingly, Bupa supports measures that improve transparency, consistency and consumer understanding, including:

- greater consistency in the terminology used to describe excesses and co-payments
- standardised disclosure of excess and co-payment arrangements across insurers
- clearer presentation of the circumstances in which excesses and co-payments apply

We do not support reforms that mandate standardised excess levels or materially limit insurers' ability to use excesses and co-payments as legitimate product design features. Excesses can make PHI more affordable for consumers by reducing premiums and providing greater choice across different levels of cover. Restricting this flexibility may reduce the availability of affordable products and may have unintended consequences for PHI participation and risk pooling.

2. Excess waivers

Bupa supports greater consistency and transparency in excess waiver arrangements across insurers however, we do not support an outright ban on excess waivers. Removing all flexibility in relation to excess waivers may create unintended consequences for consumers and limit insurers' ability to design products that respond to member needs. Rather than prohibiting excess waivers, Bupa supports consideration of principles-based reforms that improve consistency, transparency and fairness while preserving appropriate insurer flexibility.

Recommendation 14: The Government should not implement reforms that mandate standardised excess levels, materially limit insurers' ability to use excesses and co-payments as legitimate product design features or implement an outright ban on excess waivers.

Initiative 4: Ensuring consistency across premium structures

Bupa does not support additional restrictions on the management of closed and new products beyond those proposed through the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026*. The proposed phoenixing reforms are intended to address concerns regarding product closures and transitions. Further restrictions may:

- reduce insurers' ability to respond to changing market conditions and evolving consumer needs
- reduce competition and product innovation within the PHI market
- limit insurers' ability to redesign or modernise products over time

Bupa therefore considers that any additional reforms in this area should be evidence-based and demonstrate a clear consumer benefit that outweighs potential impacts on competition and product flexibility.

Bupa supports simplifying discount arrangements and improving consistency across insurers where doing so improves transparency, comparability and affordability for consumers. While discounting can assist insurers to attract and retain members, variation in discount structures can make it difficult for consumers to compare products and understand the true cost of cover. Any reform should consider:

- whether the current 12 per cent discount cap remains appropriate?
- whether multi-year discount arrangements provide meaningful consumer benefits?
- opportunities to improve transparency through more consistent discounting arrangements across insurers?

Reforms should prioritise simplicity and transparency for consumers while preserving affordability, competition and appropriate flexibility for insurers.

Bupa would welcome further clarification regarding the policy intent of potential reforms to single-parent pricing arrangements. The consultation paper notes that single-parent policies may attract higher premiums than policies covering a single adult. However, these pricing differences generally reflect the inclusion of an additional insured person/s under the policy. Further consultation and analysis would

be beneficial to better understand the intended policy outcome and the potential impacts of any proposed changes on affordability, equity and product design.

Recommendation 15: The Government should not introduce additional restrictions on the management of closed and new products beyond those proposed through the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026.*

Recommendations to support the simplification and sustainability of product tiers

1. ***Strengthen risk pooling in Gold:*** Bupa believes further consideration should be given to mechanisms that strengthen risk pooling within Gold products and reduce anti-selection. Potential reform options include:
    - Review the current mental health waiting period waivers, which enable members to purchase lower-tier products and subsequently upgrade to Gold within 2 months before claiming. This drives anti-selection and results in immediate high-cost claims.
    - Introduce longer waiting periods for high-cost categories such as psychiatric and pregnancy to reduce short-term claiming behaviour and stabilise the risk pool.
    - Introduce co-payments for psychiatric services to ensure members accessing high-cost services contribute more directly to their care.
    - Consider annual caps on psychiatric claims to manage high claims in Gold products whilst maintaining access to psychiatric care.
    - Introduce post-claim loadings (like Lifetime Health Cover) linked to psychiatric claims for members who claim without prior coverage.
2. ***Review 2019 product tier reforms:*** While supporting minor, technical reform, we believe that the Government should commission an independent review of the 2019 product tier reforms before implementing further structural reforms to the product tier system. This review should:
    - Examine if the reforms have delivered on their stated objectives of improving transparency, comparability and affordability outcomes for consumers.
    - Use independent, sector wide data to assess the impact of reforms on premiums and a sustainable risk pool.
3. ***Prioritise reforms that reduce the cost of care:*** The Government should prioritise reforms that reduce the overall cost of care to manage underlying cost drivers including:
    - Expanding access to alternative, lower cost models of care such as Hospital in the Home (HITH), virtual care and community-based mental health programs.
    - Investing in community-based care pathways for mental health to shift use away from high-cost inpatient episodes toward more sustainable care models.
    - Enabling PHI to play a more active preventive care role through allowing outpatient psychiatric care to be covered on Extras products.

4. ***Consider product tier inequity:*** The Commonwealth Government should address the structural inequalities of clinical categories and product tiers and increase product flexibility through excesses and co-payments. This would include:
    - Reviewing the design of clinical categories to address structural inequities, particularly those that disproportionately impact women. The current concentration of pregnancy and assisted reproductive services exclusively in Gold products creates a structural imbalance, where members requiring these services face significantly higher lifetime premium costs compared to those accessing equivalent male health services available across lower tiers.
    - Removing regulatory restraints on excess levels to enable insurers to provide products with higher excess. Expanding allowable excess and co-payment options would enable more tailored product offerings, allowing members to trade off upfront affordability against out-of-pocket costs where appropriate.
5. ***Consider broader reforms to support PHI viability:*** The following broader system reforms were identified to support product reform and enable the long-term viability of PHI.
    - Reform to Risk Equalisation (RE) by making RE prospective rather than retrospective. This could improve alignment between pricing, member risk and insurer behaviour.
    - Review participation incentives and portability rules including the Lifetime Health Cover Loading. This would encourage longer term engagement with PHI and prevent customers switching between insurers for the “best price”, undermining risk pooling.

2.3 Risk Equalisation

Introduction

Bupa supports a review of Risk Equalisation policy settings but is unclear of the problem statement these specific reforms proposed are set to solve. We are concerned the proposed options put forward in the consultation paper appear to be tactical solutions without sufficient financial modelling, which risks having long-term implications for the sector.

Any proposed reform to Risk Equalisation must look at holistic reforms such as prospective Risk Equalisation. This could drive efficiency via hospital contracting and product choices, that result in optimal premium rates for customers and drive overall productivity for the PHI sector. The current challenge for PHIs is that consumers are demanding choice, supported by community rating, with minimal accountability on how costs are funded and the long-term impact on premiums. A one-off reduction in gold premium rates will not reduce the out-of-pockets impacting consumers, the slowing demand for private treatment and underlying claims inflation.

In response to the two reform areas identified in the consultation paper, specifically mental health and maternity, Bupa acknowledges that while these need to be addressed, the proposed measures alone will not sufficiently address the underlying issues.

Assessment of the Proposed Risk Equalisation Reform Principles

Bupa does not support the proposed initiatives outlined in the consultation paper. Bupa understands that the technical application of risk equalisation is to largely equalise (i.e. by adjusting with risk equalisation payments or receipts) the average claims cost per Single Requirement Unit (**SEU**) for all age cohorts. With the introduction of product tiers in 2019, risk equalisation should therefore equalise the average claims cost per SEU by product tiers.

The rationale for applying special adjustments only to maternity and mental health claims, and not to other claim types, is unclear. Bupa also notes that the age-based factors have not been reviewed since 2007, meaning claim rates after risk equalisation are no longer equalised for all age cohorts.

Bupa understands that initial feedback will be used to inform independent technical expertise before any further consultation. Bupa recommends that the subsequent tranche of analysis be performed by the Productivity Commission.

Bupa does not support creating a separate risk pool for maternity and mental health. If the Government proceeds with the retrospective risk equalisation system Bupa advocates for maternity and mental health claims to be included in the existing high-cost claims pool, whereby the $50,000 threshold is lowered to capture a wider net of “large claims”. Given the significant time, cost and effort required to implement changes over a two-to-three-year period, Bupa would instead support transitioning to prospective risk equalisation.

Initiative 1: Introduction of new risk equalisation pool arrangements for maternity and mental health

One of the main drivers leading to a decrease in the demand of maternity services is the OOP costs associated with maternity care. The changes to Risk Equalisation proposed in this paper do not appropriately address this.

Under current policy settings, maternity services are uninsurable due to portability, short waiting periods, high and unconstrained costs, significant OOP pocket expenses, and limited incentives for customers to remain on Gold cover once they have used the service. Current anti-selection settings

are inadequate and can create inequitable outcomes, as they allow members to claim for foreseeable, high-cost services rather than primarily protecting against unexpected health events, which is the core purpose of insurance. Previous attempts by private health insurers to establish no-gap pregnancy programs have resulted in commercial failure driven by anti-selection.

Once customers have accessed these services, they have less incentive to remain on Gold cover and may choose to downgrade when that level of cover is no longer needed. This behaviour undermines community rating and increases the cost of Gold products. Over time, it threatens the sustainability of Gold cover and unfairly shifts the cost of downgrades onto members who choose to remain insured at that level.

Mental health is also challenging to insure due to the global prevalence across all age groups in the past 30 years, its chronic nature, and the limited effectiveness of current measures to reduce anti-selection. This creates pressure on the insurance operating model, as the Australian PHI system cannot underwrite or adjust for this risk via pre-existing conditions.

Importantly, Bupa believes the proposed initiatives do not address the shift of mental health costs from the public system to the private sector. Mental health costs are further affected by anti-selection and arbitrage. For example, a patient may pay less by buying a Basic hospital product and then upgrading to Gold cover under the lifetime mental health waiting period waiver, allowing them to claim for in-hospital psychiatric care with minimal delay.

Risk Equalisation is not the only policy setting that can lead to greater participation across maternity and mental health. Bupa believes the Department should consider alternate options as well to improve the commercial viability of maternity and mental health services such as:

1. Increasing transparency of private hospital performance, including profitability by clinical modalities such as maternity and mental health services.
2. Review the lifetime waiver of waiting periods for mental health upgrades.
3. Review incentives (LHC, youth discount, PHI rebate and MLS) as well as discounting and commissions rules to reduce anti-selection including:
    - Increasing the MLS surcharge to reduce non-compliance.
    - Increasing the PHI rebate for younger policyholders, which will assist affordability.
    - Making the youth discount compulsory and increasing the 10% maximum discount.
    - Restricting discounts to restore community rating. Discounts are inconsistent across insurers, channels as well as between new and existing customers, and encourage churn which leads to higher management expenses.
4. Capping comparator commissions to 12 per cent to align with the OSHC business. Commissions contribute to lowering the claims ratio.
5. Restore LHC to lifetime and review the 2 per cent loading setting to reflect the claims curve.

These broader reform opportunities would support stronger participation in private health insurance by improving affordability, reducing anti-selection and encouraging more people to maintain cover over the long-term. In turn, this would enable more consumers to access private health services when they need them, while strengthening the sustainability of the insurance pool.

Bupa supports the exclusion of maternity and mental health claims from existing aged-based pool (ABP) and high-cost claims pool (HCCP) to prevent maternity and mental health claims not being double-counted.

Recommendation 16: The Government should not introduce new Risk Equalisation pool arrangements for maternity and mental health care but should pursue a holistic reform pathway for risk equalisation, with a transition to prospective risk equalisation as the preferred long-term approach. This would better align pricing, risk and insurer behaviour, support more efficient hospital contracting and product design, and improve productivity across the PHI sector.

Initiative 2: Recalibration of existing mechanisms for younger age cohorts covered by Gold tier

Bupa does not support extending the existing ABP claim eligibility criteria to younger Gold tier members. Bupa notes that this option is the least challenging to implement as it re-uses current reporting mechanisms. However, the methodology is imprecise and may result in unintended consequences as mental health impact all age groups, not only younger members.

We do not support redefining Single Equivalent Units (SEUs) to exclude younger Gold tier members, possible exceptions to corporate products. It is unclear how this option would operate. For example, this implies the separate age-based factors will be required by Gold and non-Gold products, and it is unclear what happens if a member changes product tier during the quarter.

Recommendation 17: The Government should not recalibrate existing mechanisms for younger age cohorts covered by Gold tier.

Alternative Risk Equalisation options and recommendations

While Bupa welcomes the Department's review of Risk Equalisation, we are concerned the current proposals focus on incremental changes to a system that requires more fundamental reform. Given the significant investment required to implement any changes, this review presents an opportunity to prioritise a prospective Risk Equalisation model that would provide greater certainty, better support prevention and innovation, and create a more sustainable foundation for the sector.

Bupa would not support minor modifications to the existing retrospective framework. The proposed changes are largely untested and risk significant complexity, cost and customer disruption without addressing the underlying limitations of the current system. Rather than pursuing a series of tactical reforms, Bupa urges the Department to bring forward a prospective approach that delivers lasting benefits for consumers, insurers and the broader health system. A single, comprehensive reform pathway would provide greater certainty for consumers and industry, avoid the disruption associated with multiple rounds of change, and establish a more sustainable foundation for a competitive, innovative and affordable private health insurance system. Bupa would support a hybrid approach during the transition period as set out in the table below.

Table 1 - Proposed approach to Risk Equalisation

	Year 1	Year 2	Year 3	Year 4	Year 5

Retrospective (as is)	80%	60%	40%	20%	0%
Prospective	20%	40%	60%	80%	100%

Throughout the transition, Bupa believes the reforms must have the following guardrails:

- Monitoring of success criteria metrics.
- Interim review process
- Contingent plans if outcomes are materially adverse and divergent from forecasts, to restore confidence and planned outcomes. This may include a pause or reversal of the transition.

Bupa considers that any reform to the Risk Equalisation system should be guided by a clear and coherent set of principles that support the long-term sustainability of private health insurance, promote affordability and value for policyholders, and strengthen participation across the sector. Reforms should be transparent, practical to implement, and targeted at addressing the underlying structural challenges within the current framework, rather than simply redistributing costs between insurers. In assessing potential reform options, the following principles should be considered:

1. Reforms to Risk Equalisation should continue to support and strengthen the principle of community rating.
2. Reforms should improve the affordability of PHI for younger Australians, including those aged 40 years and under, relative to the current arrangements.
3. Reforms should minimise unintended consequences for consumers, insurers and the broader health system.
4. Reforms should be practical and capable of implementation within the next three years.
5. Any reforms should include appropriate transition arrangements to ensure PHI participation rates are maintained throughout the implementation period.
6. The Risk Equalisation framework should remain simple, transparent and easy for consumers and policyholders to understand.
7. Reforms should deliver a material improvement in PHI participation over the medium term (three to five years) and support greater efficiency and productivity across the PHI sector.

The Department should consider the following matters in advance of any further consultation on Risk Equalisation reform:

1. The technical working group that previously considered Risk Equalisation reform should be reconvened under an enhanced governance and transparency framework to support stakeholder confidence in the reform process.
2. Detailed financial modelling should be provided for each reform option to enable insurers to assess the likely impacts and trade-offs. This modelling should include, where feasible, impacts on premium trajectories, the number of policyholders affected by premium increases, policy lapses and discontinuance rates, insurer transfers, and overall PHI participation.
3. Further information is required regarding implementation pathways, transitional arrangements and indicative timelines for each reform option.

4. Risk Equalisation reform should be considered as part of a broader package of private health insurance reforms, rather than as the primary mechanism for addressing sector-wide challenges and participation risks.
5. To support transparent and evidence-based consultation, the Department provide access to the underlying financial models and assumptions used to assess each reform option, including spreadsheet-based modelling where appropriate.
6. Each reform option should be assessed against a clearly articulated set of reform principles to ensure consistency, transparency and accountability in decision-making.
7. Implementation timeframes should be aligned with insurers' premium-setting and regulatory approval processes. Sufficient transition periods, including at least two premium cycles where appropriate, should be provided to minimise disruption to consumers and the broader PHI sector and to support effective implementation.

The Department should commission the Productivity Commission to undertake independent analysis of the proposed Risk Equalisation options, including detailed assessment of financial, consumer and participation impacts, supported by transparent modelling and assumptions. Any reform should be assessed against clear, consumer-focused principles, including improving PHI participation, maintaining community rating, enhancing affordability for younger consumers and minimising unintended consequences across age cohorts and product tiers. Reform should be considered as part of a broader package to strengthen the sustainability of the private health sector and be supported by robust governance, insurer engagement, appropriate transition arrangements, clear success measures, review points and mechanisms to adjust the reform pathway if outcomes differ materially from expectations.

Recommendation 18: The Government should commence independent modelling of the proposed Risk Equalisation reforms over the next 12 months, with a view to implementing evidence-based changes that improve consumer value, support innovation and strengthen the long-term sustainability of the private health insurance system. This modelling should form part of a broader Risk Equalisation agenda through a transparent consultation process with insurer access to modelling and implementation analysis. Reforms should include appropriate transition arrangements, review points and safeguards to monitor outcomes and address unintended consequences.