Private health 2025-26 Pre-budget Submission

AMA

CHAPTER 3: PRIVATE HEALTH

Problem statement

The private health system is an essential component of Australia's healthcare system, offering patients access to a wider range of services and reducing demand on the public sector. One of the unique strengths of the Australian healthcare system is the equilibrium that exists between the public and private sectors, which work in partnership to provide high-quality healthcare to Australians. The equilibrium relies on a strong private healthcare sector which complements the public sector to:

- reduce demand on the public health system, with approximately 70 per cent of all elective surgeries conducted in the private system[1]
- enable consumers to have more control over their healthcare, including selecting their preferred practitioner, accessing care more quickly (through reduced wait times for elective treatment), and having access to a wider range of services outside of the public sector
- encourage innovation and quality improvement in healthcare services.

Australia's unique private health insurance system offers 'community rating' (two people on the same product pay the same premium, regardless of differences in expected claim cost/risk), which allows all Australians to 'buy into' the high-quality private system, regardless of their age or pre-existing health conditions.

The past couple of years have shown how quickly a sector can come under financial pressure. In the lead up to the COVID-19 pandemic, insurers were increasingly under fiscal threat as participation rates had dropped for 20 successive quarters and their outlays were continuously increasing. Through the pandemic participation rates have now climbed for several successive quarters and outlays have decreased due to the impact of lockdowns and workforce shortages.

As costs increase across the sector, patients are looking for more affordable treatment options. This means more patients are downgrading to lower levels of cover. This feeds through to slower total premium growth than headline premium increases suggest as nationwide coverage levels are 'hollowed out'.

Over time this has eroded, as the rebate was effectively frozen when government indexed it by the Consumer Price Index rather than premium growth since April 2014.[2] The value of the average rebate has therefore fallen from 30 per cent in April 2013 to 24.61 per cent in April 2024.[3]

The 'PHI rebate adjustment factor' is a very important factor which effectively determines what proportion of the PHI premium is paid by the government for those with lower incomes below $97,000 (Tier 0). The calculation of the factor is hidden from the public and is only alluded to by the ATO:

*"The rebate adjustment factor is a percentage of the **increase in the consumer price index** (CPI) and the average **annual premium price increase**. It is calculated by the Department of Health."*[4]

In the past two years, where CPI has been higher than premium growth, the rebate factor should have increased. The final rebate factor has instead remained constant at 24.61 per cent.[3] This has been a silent reduction in rebate when compared to what should have been expected.

Notwithstanding the recent increase in insurance uptake, those over 60 years of age are set to become the largest insured population in the foreseeable future, with many younger and healthier Australians increasingly opting for reduced cover. This is due to several factors, including:

- Further reductions in the private health insurance rebate.
- Many consumers no longer see the value for money of private health insurance. In a survey, 76 per cent of people identified as not having private health insurance but being able to afford it, gave "premiums too expensive/out of pocket costs too high" as the main reason for not having private health insurance.[5] Payout ratios (amount paid in premium relative to amount received through benefit claims) among for-profit providers (average of 82 per cent of hospital premiums returned as hospital benefits) are also lower than not-for-profit providers (average of 90 per cent of premiums returned as benefits), with 66 per cent of all those insured with for-profit funds.

- Premium growth (61 per cent) has outstripped income growth (29 per cent) over the past decade. Income growth for younger people remains below that of older people though it has improved compared with the past decade. Across the latest five years, among 21–34-year-olds, wage growth is around 90 per cent of that of overall wage growth.
- Private health insurance is one of many costs facing younger people as they struggle to repay education debts, contribute to superannuation, save for a house deposit, and pay high rent, and there is a lack of incentives to engage young members.

These factors are resulting in a shift in demographic composition of the insured pool, placing insurers and the private health system more broadly under increased financial pressure.

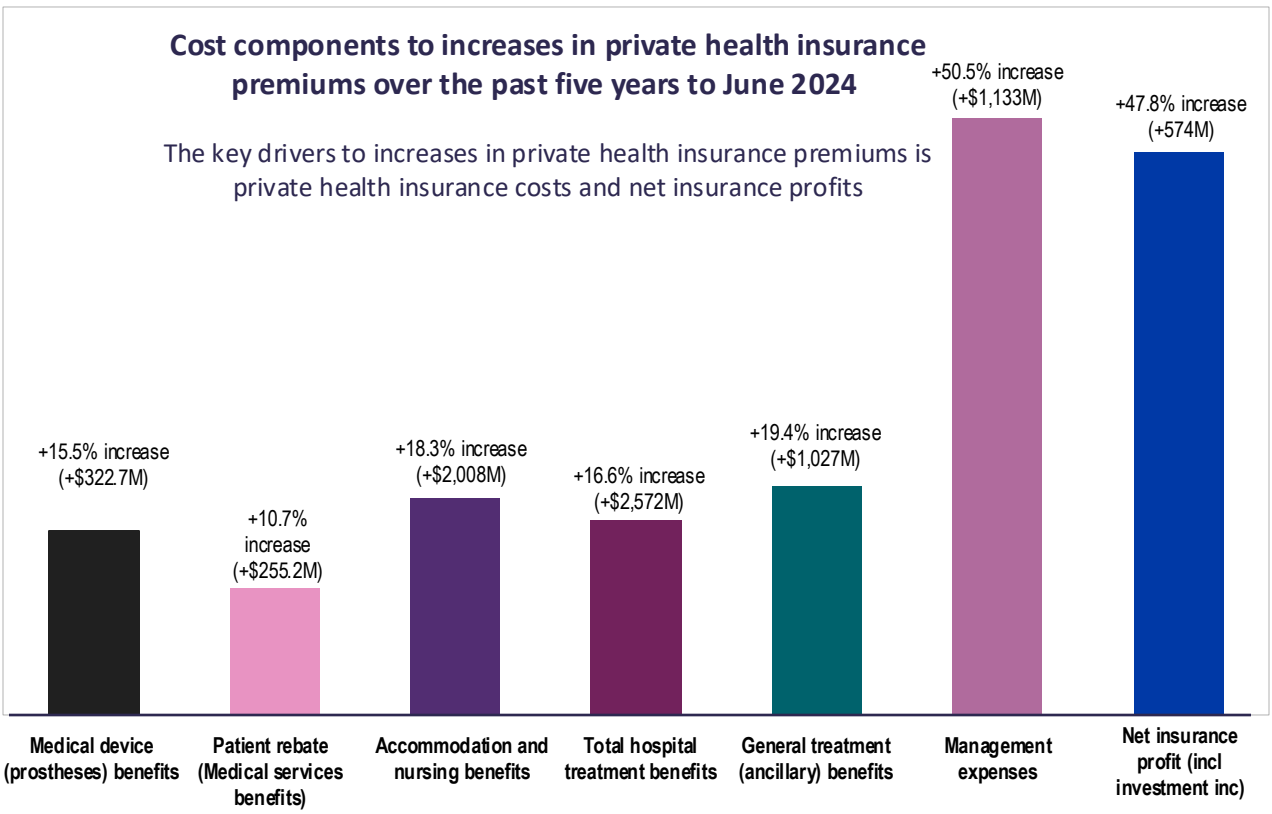

Figure 3.1: Cost growth by category of expenditure within private health insurance

Figure 3.1, above, demonstrates the key drivers to increases in private health insurance premiums are private health insurance costs, in particular management expenses, and net insurance profits. It is important to note all insurers, including not-for-profits, must retain a small amount of profit to stay viable.

In addition to the affordability of private health insurance, there are now substantial questions about the sustainability of the private health system. In the wake of a spate of closures to private hospitals, particularly maternity service closures, the federal government undertook a review into the financial viability concerns of the private hospital system. The AMA has welcomed the review (and the subsequent announcement of a CEO's forum), noting the closure of services has left patients without access to private health services, which does little to encourage continuing insurance uptake. It also puts further pressure on public services to 'pick up the slack' of these closures and further exacerbates the already extensive public waiting lists for essential surgery and a logjammed public hospital system.

Policy proposals

Establish a private health system authority

This section draws on the AMA research report, *A whole of system approach to reforming private healthcare*, with some of the modelling adapted and extended to give estimates between 2024–25 and 2027–28.

The current regulatory arrangements were designed at a time when private health insurance was in a relatively healthy position with strong membership, when most insurers operated on a not-for-profit basis, and when private hospitals had a greater profit margin. While the arrangements are effective at protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare, there are limited mechanisms in place that ensure the private health system is changing in a lasting way as government policy intends. There are also limited whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors are considered and balanced.

The AMA is still calling for the establishment of an independent and well-resourced private health system authority (the authority) to fill the gaps in the current regulatory environment and oversee the private healthcare system. This 'independent umpire' would have the capacity, objectivity, and expertise to ensure the system evolves as government policy intends, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors. It would also create a platform for all the players in the sector to come together and agree on the necessary once-in-a-generation reforms which are required to ensure the future viability of private healthcare in Australia. Refer to the AMA's discussion paper, *A whole of system approach to reforming private healthcare*, for more information.

Risks and implementation

An independent authority would consolidate regulatory functions previously carried out by other parts of government/agencies so they operate in a more cohesive and effective way (including relieving the Department of Health and Aged Care of its conflicted role as regulator and policy maker). It would also incorporate new functions and skills to fill the gaps in the current regulatory environment, as well as supporting the regulatory and advisory functions currently performed by other agencies. There would be some costs transferred from other agencies for existing functions carried out, as well as additional costs for new functions that would be required. Sufficient transition time and resource should be allocated to make sure this is done effectively. However, overall costs are not anticipated to be high.

Risks of not taking action

The current private health regulatory and legislative framework is complex and is limiting innovation and reform. Additionally, the mechanisms in place that ensure the private health system is changing in a lasting way as government policy intends are limited and ad hoc. There are also limited whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors are considered and balanced. The private health system is already lagging when it comes to reform — for example, reform to out-of-hospital models of care as outlined in the AMA's research report, *Out-of-hospital models of care in the private health system* — and this will only continue if the regulatory and legislative frameworks remain not fit-for-purpose. Additionally, the gaps in regulation impact patients through unexpected out-of-pocket costs, restricted choice, and additional complexity.

Timeframe and costing

The direct cost of an independent authority which currently doesn't exist is difficult to estimate. At present, the Australian Prudential Regulation Authority (APRA) provides prudential regulation of private health insurers. APRA reports that its total operating expenditure for the 12 months to 30 June 2024 was $237.0 million.[6] APRA also collected $240 million in levies to recover costs, $10.4 million was directly attributed to revenue levied against private health insurers. Using the number of private health insurers it prudentially regulates (30 during 2023–2024).[6]

This role currently performed by APRA is only one of an expanded set of roles envisioned for the proposed authority, and therefore additional funds would be required to fulfil these extra functions. The total annual cost of the proposed authority is estimated in the table below, which includes the $10.4 million cost reallocated from assuming responsibilities from APRA.[6]

An additional $11 million is estimated to be required to establish the new authority and consult with stakeholders regarding its ongoing roles and responsibilities. If cost recovery was undertaken, this $11 million would be the only net cost to government between 2025–26 and 2028–29.

Table 7: Cost of a private health system authority

	2025–26	2026–27	2027–28	2028–29	Total
Establishment cost ($m)	11				11
Ongoing cost ($m)	31.7	33.2	34.7	36.4	135.9
Total cost to government ($m)	**42.7**	**33.2**	**34.7**	**36.4**	**146.9**

Policy proposals

Mandate a minimum payout

This section draws on the AMA report, *The repeat prescription for private health insurance*, with some of the modelling adapted and extended to give estimates between 2025–26 and 2028–29.

Private health insurers will generally aim to set premium levels to cover the expected costs of benefits (that is, coverage paid for members' medical treatment), plus the fund's management costs. As a result, if management expenses as a proportion of payments are higher, a smaller proportion of premiums is being spent on treatment. Naturally, such calculations are complex, but it is likely that a greater proportion of premiums being paid towards benefits is one indicator of value and return on investment.

Management expenses comprise the amount of premiums per policy that are used to manage the business of the fund. All funds have management expenses and depending on their position in the market and whether they are for-profit, they can have varying marketing costs, salaries, overheads and profit margins that need to be built into these expenses.

Currently there is no policy regarding the proportion of premiums (consumer and federal government investment combined to purchase a policy) that should be returned in the form of health services, and there is considerable variability in funds returned as benefits between insurers.[7] To improve the value proposition of private health insurance, there should be a mandated minimum return amount (e.g. 90 per cent) to the health consumer for every premium dollar paid. There needs to be a standardised return that is higher than the current private health insurance industry average.

Risks and implementation

The federal government increasingly has a role in promoting private health insurance, particularly in light of its involvement in recent reforms to private health insurance, as well as its contributions to support access to private health insurance (such as the private health insurance rebate). As the Department of Health and Aged Care is both the policymaker and regulator, there is the possibility that this conflict of interest may impact reforms (such as a minimum payout) if issues arise throughout implementation. The establishment of an independent private health system authority could potentially mitigate this risk. Additionally, it is likely that some private health insurers may resist a mandated minimum payout as it could impact viability, and a private health system authority would be well placed to identify an appropriate minimum payout that ensures insurers remain viable.

Risks of not taking action

Negative media coverage about the lack of value in private health insurance, coupled with a focus on the profit margins of the for-profit providers erodes the perceived value of private health insurance in the eyes of the community. Additionally, many private hospitals are struggling to remain viable. This is something that needs to be urgently addressed, especially if the federal government is called upon to invest additional taxpayer funds in the private health system. Australians therefore need assurances that their investment in private health insurance is going to be returned in the form of appropriate coverage for services, when it is needed.

Unbelievably, since the AMA first called for this reform, the payout ratio has dropped a further 2 per cent of the base hospital premium paid as hospital benefits. The latest APRA 'Quarterly private health insurance performance statistics' has hospital treatment benefits paid of $18.3 billion, while premium revenue is $21.7 billion, summed across the past four quarters, meaning the payout ratio is now 84 per cent. In addition, **funds can now return a much higher investment income from premiums than the recent past, further enhancing their profitability**.

Timeframes and costings over four years

The direct cost to government of an increase in the minimum payout ratio is zero. There would however be indirect costs — the first being that additional private health insurance policies would cost the government for additional private health insurance rebate outlays. The second component would be lower rebate outlays via a reduction in the base premium. A behaviour shift towards more private health insurance policies would mainly be seen among those currently not subject to tax penalties or incentives — those earning $97,000 or less — but also towards those that are less likely to claim given people with high expected claims would likely already have a policy.

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

The policy itself would not encourage as many people over the age of 65 and those subject to the Medicare levy surcharge to take out private health insurance as these people already receive a larger benefit on average (through greater use) or a much larger price incentive through existing policies. As a result of the continued decline in the baseline of the proportion of premiums paid out in benefits, this policy has switched from a previously estimated cost to the government of $589 million in the last Budget submission to now a net save for the government of $448 million over the four years 2025–26 and 2028–29.

Table 8: Impact of implementing a 90 per cent minimum payout ratio

	2025–26	2026–27	2027–28	2028–29	Total
Direct change in premium (%)	-6.62	-6.62	-6.62	-6.62	
Additional private health insurance policies	296,230	294,259	290,456	288,549	
Additional rebate for additional policies ($m)	166	163	159	156	643
Reduction in rebate from lower premiums ($m)	-275	-274	-271	-271	-1,091
Total cost to government ($m)	**-109**	**-111**	**-113**	**-115**	**-448**

Policy proposals

Increase the Medicare Levy Surcharge

This section draws on the AMA report, *The repeat prescription for private health insurance*, with some rework of the modelling adapted and extended to give estimates between 2025–26 and 2028–29.

Originally introduced in July 1997 for income earners over $50,000, the 1 per cent Medicare levy surcharge (MLS) aimed to encourage those that could afford it, to take up private health insurance. At the time, an income of $50,000 was the threshold for the highest income bracket of taxation, a marginal rate of 47 per cent. The comparable threshold is now $190,000 where marginal tax is paid at 47 per cent (45 per cent marginal tax rate and 2 per cent Medicare levy). The additional MLS rate is now levied at the rates of 1 per cent, 1.25 per cent or 1.5 per cent depending on taxable income.[8] The key policy principle behind the MLS was that higher income earners who did not have private health insurance were penalised with a higher surcharge. This position has been eroded by the federal government which has frozen and applied low indexation to the threshold over many years. This was only recently unfrozen in 2023–24. Until recently, we have seen the growth in premiums outstripping low wage growth, which has compounded the impact. For some cohorts, there is a perverse outcome of the MLS being applied to people at a lower income than originally intended. However, the amount levied is less than the rate likely to be paid for a reasonable private health insurance product, due to increased premiums. The AMA is calling for the MLS levels and thresholds to be reconsidered, to determine what settings are required to deliver on the policy intent. It should be noted the Department of Health and Aged Care has undertaken a significant amount of work on the private health insurance policy levers (including the MLS), and further details of the AMA's response can be found in the *AMA submission to Department of Health and Aged Care consultation on PHI Incentives and Hospital Default Benefits Studies*.

Risks and implementation

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

It is critical that any changes to policy levers are carefully calibrated given that settings for each of the policy levers have a powerful impact on the equity, efficiency, and effectiveness of the others. They also have a powerful impact on the viability of other foundational policy settings that are out of scope for this consultation, including community rating, a mixed public/private system, and the clinical autonomy of medical practitioners. It is also critical that any changes made improve the value proposition of private health for patients.

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

Risks of not taking action

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

Timeframes and costings over four years

For the purpose of this costing, the AMA has demonstrated the impact of increasing the MLS to 2 per cent for those earning $116,001 or greater. The total cost to government across the forward estimates is an estimated cost of $1.19 billion. This policy cost estimate does not include any increase in the private health insurance rebate.

Table 9: Impact of increasing Medicare levy surcharge to 2 per cent for people earning $116,001 or greater

	2025–26	2026–27	2027–28	2028–29	Total
Additional private health insurance policies	555,867	594,562	634,542	690,642	
Rebate for additional private health insurance policies ($m)	73	78	83	89	323
Reduction in Medicare levy surcharge revenue ($m)	302	335	370	426	1,433
Reduction in average premium (%)	3.0	3.3	3.5	3.9	
Save (Clawback of rebate) from lower premium ($m)	-124.8	-135.1	-145.2	-160.2	-565
Total cost to government ($m)	**250**	**278**	**308**	**355**	**1,191**

CHAPTER 3 REFERENCES

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