Australian Government
Department of Health and Aged Care

Private Health Reform Options – Consultation Paper

January 2025

1 Introduction

The private hospital sector is an important part of Australia's health care system. The sector is diverse, with variations in size, location, types of services delivered, business models and agreements with private health insurers and other funders.

As at 1 December 2024, there were 631 private hospitals. Around 82% of private hospitals are in metropolitan locations, 10% in regional centres and 8% in rural towns. Australia's private hospitals cover more than 40% of all hospital admissions and deliver approximately 70% of elective surgeries.[1]

In 2022-23, 41.2% (5 million) of hospitalisations occurred in private hospitals, an increase from 40.3% (4.6 million) from 2018-19. Over 74% of patients in private hospitals had stays less than 24 hours.[2]

In 2023-24, private health insurers paid benefits of approximately $18 billion that funded approximately 5 million hospital treatments. As at 30 September 2024, approximately 12.3 million people were insured for hospital treatment.[3]

Australia's private hospital and health sector, supported by private health insurance, offers a range of benefits to patients, the community, health professionals, governments and the broader health system. These benefits include:

- providing consumers with choice about their health care
- providing a workforce value proposition to attract health care providers, including in the regions
- taking pressure off the public hospital system
- bringing additional funding to support the operation and sustainability of the overall healthcare system.

In Australia, private health insurance is 'community-rated', rather than 'risk-rated' like most forms of insurance. Private health insurers cannot refuse to insure any person, and must charge everyone the same premium for the same level of cover, despite their risk profile and likelihood of using health services. There are different types of private hospital cover that offer different benefits, with private hospital policies classified into Gold, Silver, Bronze and Basic hospital tiers. Private health insurers offer, and consumers select private health insurance cover for different reasons. The type of cover selected by consumers is informed by various factors including personal health needs and perceptions around the value and affordability of available health cover.

In early 2024, high-level evidence and stakeholder feedback provided to the Australian Government raised financial viability concerns for the private hospital sector, which could potentially impact the health system and patient outcomes. In response to this, the Department conducted the Private Hospital Sector Financial Health Check (the Health Check) to establish a robust evidence base and gain insights into the current state of the private hospital market and the viability of the sector.

The Health Check found that while parts of the sector have remained strong, there has been a reduction in profitability over time as costs have risen faster than revenue. The Health Check

[1] Australia's hospitals at a glance, Hospital activity, available at: https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance

[2] Australia's hospitals at a glance, Hospital activity, available at: https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance

[3] Quarterly private health insurance statistics, available at www.apra.gov.au/quarterly-private-health-insurance-statistics

concluded that there is substantial work for private health insurers and private hospitals to do to ensure the sector's long-term viability. Further information on the Health Check is available at: https://www.health.gov.au/resources/collections/private-hospital-sector-financial-health-check-resources

1.1 Private Health Chief Executive Officer Forum and sector engagement

The Australian Government has established the Private Health CEO Forum to identify and provide advice on short and medium-long term reform options that will improve the sustainability of the sector and result in better value for patients and the broader healthcare system.

The CEO Forum membership and Terms of Reference have been published on the Department of Health and Aged Care's website: https://www.health.gov.au/committees-and-groups/private-health-chief-executive-officer-forum

The Minister attended the first meeting of the CEO Forum on 13 December 2024, outlining his expectations and presenting a short-list of options for reform for sector feedback, both in terms of whether the proposal should be pursued and if so, how it should be implemented. Further information on the Minister's reform options is included in his media release of 13 December 2024: https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/working-collaboratively-to-underpin-private-hospital-viability?language=en

In addition to the CEO Forum, the department will consult with stakeholders across the private health sector on their views about future options. This consultation paper is the first in a series of consultation opportunities for the private health sector and the community to provide feedback.

2 Private Hospital Reform Options

This paper outlines a selection of short-term private health reform options on which the department is seeking feedback. The options are not presented as endorsed government policy, rather they are draft proposals for feedback on both whether the proposal should be pursued and if so, how it should be implemented.

The short-term reform options outlined in this paper have been identified through recent engagement with the private health sector and on the basis that they:

- can contribute to alleviating financial pressures on private hospitals and improve the value of private health insurance without putting pressure on policyholders' premiums;
- are able to be agreed immediately by Government; and
- can be substantially progressed or fully implemented within 6 months.

The consultation process on the Private Health Reform Options outlined in this paper will run from 7 January 2025 until 31 January 2025. This will enable the department to present the consultation feedback at the CEO forum which is scheduled for early March to consider reform options for immediate implementation.

The department will undertake further consultation with stakeholders in early 2025 on longer term reforms to strengthen the private hospital sector's sustainability and the value it provides patients. These consultations will examine potential alternate arrangements for the approval of private health insurance premiums and potential approaches and applications for an independently determined

national private price for services delivered by private hospitals. Opportunities will also be provided for stakeholders to identify other reform options for consideration.

The department acknowledges there have been a significant number of studies and reports in recent years into private health insurance and private hospital regulatory arrangements from a wide range of stakeholders. The department encourages stakeholders to reference these studies when providing feedback on the reform options outlined in this document. Recent studies and associated reports conducted by the department are available on the Consultation Hub: https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/

The department notes that it has also commenced consultation on the regular collection of private hospital financial data to support enhanced monitoring of the private hospital sector. Information on this consultation process is available at: https://consultations.health.gov.au/private-hospitals-branch/7183e999

2.1 Second-Tier Default Benefits – short-term reform proposal

Purpose:
Support private hospital and private health insurer negotiations by improving integrity of second-tier default benefit calculations and increase the level of support provided by second-tier default benefits for established regional hospitals.

Outline:
Update the calculation methodology for second-tier benefits to make use of volume weighting of contracted services to determine each insurer's second-tier default benefit schedules. The proposed change to the calculation methodology will address the potential for artificially low second-tier default benefit rates from the inclusion of insurer-hospital contracted prices for services that are not delivered / delivered at significant volumes by a hospital.

Revise the second-tier hospital categorisation and benefit calculation methodologies to increase the second-tier default benefits payable to established non-metropolitan hospitals offering a wide range of services from 85% to 100% of the insurer's contracted rate.

Implementation:
Amend Schedule 5 of the *Private Health Insurance (Benefit Requirement) Rules 2011*.

Issues for stakeholder feedback:
- Whether the proposed changes are implemented on a temporary or permanent basis and the period by which a post implementation review should be undertaken.
- The commencement of the proposed changes, noting the current annual processes for second-tier audit, categorisation and rate calculation.
- The criteria for determining what constitutes an established regional hospital eligible for a higher second-tier default benefit, noting the department regularly makes use of the Modified Monash Model (MMM)[4] for geographic definitions.
- The level of the proposed increase to the second-tier rate for established regional hospitals and estimated impact on private health insurance benefit amounts. There are around 110 hospitals in

[4] https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

MMM2 or above areas. The number of separations these hospitals account for approximately 14% of all private hospital separations and approximately 12% of all private hospital revenues. We note that not all of these hospitals accessed second tier benefits.
- Any additional arrangements to support the effectiveness of the proposed changes, including audits of calculations and the publication of second-tier rates.

2.2 Payment terms and administrative costs – short-term reform proposal

Purpose:
Improve private hospital cash flows and reduce administrative costs across the sector.

Outline:
The Minister for Health and Aged Care has challenged the sector to investigate and provide feedback on whole of sector approaches to:
- implementing a moratorium on private hospitals' benefit claims that remain unpaid by private health insurers, which have exceeded a reasonable payment period (e.g. 45 business days) and are not subject to formal contractual dispute proceedings. Noting benefits paid by insurers to hospitals would remain subject to the usual contractual post payment audit and compliance processes.
- adopting a consistent approach to the period of time that post payment audit processes, initiated by the insurer can be commenced within, for example 2 years, noting this timeframe aligns with the Medicare Benefits Schedule compliance arrangements.
- standardising administrative, reporting and compliance contract terms in Hospital Purchaser Provider Agreements that ensure payment integrity but also enable consistent and streamlined claiming and payment of benefits for services delivered by hospitals irrespective of the private health insurer that the patient holds a policy with.

Implementation:
Private health insurers and private hospitals adopt sector wide guidelines and implement through amendments to Hospital Purchaser Provider Agreements.

Issues for stakeholder feedback:
- The extent to which a sector self-regulatory approach is viable, including how consensus arrangements may be identified, maintained and updated.
- The contribution the department or another third party may play in facilitating industry agreement on standardised contractual terms.
- The potential for regulatory changes to assist in the introduction of standardised arrangements and / or to address issues that give rise to significant disputes about claims for benefits such as hospital certification requirements.

2.3 Hospital in the Home – short-term reform proposal

Purpose:
Improve patient access to established clinically beneficial Hospital in the Home programs and address funding certainty for providers of this care.

Outline:
The sector in collaboration with the department identifies by early 2025 an initial tranche of well-established clinically beneficial Hospital in the Home programs. All insurers will then be required to provide a minimum level of funding for their policyholders to access these mandated programs, subject to:
- the patient holding an appropriate level of cover; and
- the provider of the program meeting appropriate accreditation and service quality standards.

Following the identification and implementation of the first tranche of mandated Hospital in Home programs the department will engage with the sector on examining processes for the addition of further programs.

Implementation:
Amend the *Private Health Insurance (Benefit Requirement) Rules 2011*.

Issues for stakeholder feedback:
- What priority conditions, if any, should the mandated Hospital in the Home programs focus on and why?
- What evidence should be required to demonstrate that a specific Hospital in the Home program is:
  - well established; and
  - clinically beneficial?
- What are the appropriate arrangements for determining and requiring service providers to meet appropriate accreditation and service quality standards?
- Should the provision of the mandated Hospital in the Home programs be limited to any particular type of healthcare providers / facilities?
- What is the appropriate mechanism for determining the minimum contribution that insurers will be required to pay to the service provider for delivering the mandated Hospital in the Home programs?
- What factors should be taken into account in determining the number of Hospital in the Home programs included in the first tranche and what if any conditions should be placed on the period of time these programs will be mandated?
- What if any other regulatory arrangements may need to be changed to support the implementation, operation and financial sustainability of this reform option?

2.4 Mental Health

Purpose:
Improve access to mental health care, by increasing the supply of internationally educated psychiatrists able to admit patients to private mental health hospitals.

Outline:
The Health Check identified private hospital mental health services are under pressure in part due to the difficulties faced by operators of private mental health hospitals in attracting and retaining psychiatrists prepared to work in a private hospital setting.

Current regulatory arrangements require that an overseas trained psychiatrist must work in a District of Workforce Shortage (DWS) for at least 10 years before being able to access Medicare rebates (the 10-year moratorium)[5]. Access to MBS is essential for a psychiatrist to be able to admit patients to and practice in a private hospital and obtain rebates from private health insurers.

An option to address the workforce shortage is to amend the 10-year moratorium requirement under Section 19AB of the *Health Insurance Act 1973*, to support:
- appropriate care to be provided to the patient, including post discharge care; and
- continued or potentially enhanced provision of acute mental health services by public hospitals, potentially through resource sharing between private and public hospitals.

[5] Department of health and Aged Care (www.health.gov.au/topics/doctors-and-specialists/what-we-do/19ab/moratorium#the-10year-moratorium)

Issues for stakeholder feedback:

- Should an amendment to the 10-year moratorium include provisions requiring that overseas trained psychiatrists dedicate time in both public and private hospital settings? If yes, what is the ideal balance of clinical work hours that should be performed in public hospital roles and in private hospitals?
- If the proposed amendment to the 10-year moratorium were implemented, should it apply to overseas trained psychiatrists currently practicing in Australia, or be limited to cohorts entering Australia following the amendment?
- Should the proposed amendment of the moratorium operate for a time-limited basis? If yes, for what time period should the amendment to the moratorium operate?
- Are there any potential risks or unintended consequences associated with the introduction of the proposed reform option? If so, do you have any suggestions to reduce or limit the impact?

2.5 Maternity Care

Purpose:

To make privately insured maternity care more accessible and affordable, by including maternity cover as a standard inclusion across a greater number of policies, instead of only 'Gold' level policies.

Outline:

Currently, private hospital insurance for the clinical categories of 'Pregnancy and birth' and 'Assisted reproductive services' are a mandated coverage requirement for the Gold product tier. Cover for 'Miscarriage and termination of pregnancy' is mandated for Bronze, Silver and Gold product tiers.

If a policy meets the minimum requirements of a tier, but also includes additional coverage, such as 'Pregnancy and birth' then it can be called a 'Plus' policy – for example, Bronze Plus or Silver Plus.

The government sets the maximum waiting periods that insurers can impose for a policyholder to hospital treatment benefits, which is currently specified as being up to 12 months for pregnancy and birth (obstetrics). Further information on product tiers and hospital treatment waiting periods is available at: https://www.privatehealth.gov.au/health_insurance/howitworks/index.htm

Implementation:

Amend the *Private Health Insurance (Complying Product) Rules 2015.*

Issues for stakeholder feedback:

- Which private health insurance product tier(s) should provide coverage for the 'Pregnancy and birth' clinical category to enable improved access and affordability for policyholders?
- What are the implications for policyholders and the health system in retaining the current arrangements and the implications associated with a change, including the impact on premiums and the value proposition of private health insurance.
- If you consider the clinical category of 'Pregnancy and birth' should be a mandatory inclusion in another product tier(s)? Do you consider the related clinical categories of 'Assisted reproductive services' and 'Miscarriage and termination of pregnancy' should be included in the same product tier(s) as 'Pregnancy and birth' or remain in the currently assigned product tier?
- What other changes, if any, to existing private health insurance product rules and regulatory arrangements may be required to make the addition of cover for maternity care in lower product tiers provide value to the patient and be sustainable for the sector?

2.6 Changes to Risk Equalisation arrangements to support improved access to mental health and maternity care

Purpose:

Improve access to more affordable private health insurance coverage for mental health and maternity care through amendments to the Risk Equalisation regime.

Outline:

The purpose of Risk Equalisation is to support the community rating principle legislated under the *Private Health Insurance Act 2007*. Insurers are not allowed to risk rate premiums. Risk Equalisation partially compensates insurers with a riskier demographic profile by re-distributing money from those insurers paying less than average benefits to those paying higher than average benefits.

The current risk equalisation regulations include an age-based pool (ABP) which shares a subset of actual costs for participants above the age of 55. The proportion of claims pooled increases with age, with over 80% of costs shared for the oldest members. There is also a high-cost claims pool (HCCP) which shares 82% of costs if someone claims more than $50,000 per year, which is not common[6].

Private health insurance claims for maternity care delivered in a private hospital, such as for the birth of a baby, and psychiatric care are generally not subject to risk equalisation, unless the claim costs reach $50,000 in a year.

Issues for stakeholder feedback:

- In-principle, do you support changes to the Risk Equalisation regime to equalise some or all of the benefits insurers pay for mental health and maternity care?
- Based on your experience and/or understanding of private health insurance claims for mental health and maternity care, what Risk Equalisation parameters should be considered or further examined (for example, patient age, benefit amount(s), types of treatment)?
- What information, data or modelling does the private health sector require to assess the impact of amendments to the Risk Equalisation arrangements on private health insurance premiums, product offerings and to inform government on the timeframe for implementing the proposed changes?
- What other changes may need to accompany amendments to the Risk Equalisation arrangements to support improved patient access to mental health and maternity services?

3 How to respond

The department is seeking feedback on the Private Health Sector Reforms identified in this consultation paper. The consultation period concludes **31 January 2025**. Feedback can be provided through our consultation hub or emailed to private.hospitals@health.gov.au

Thank you in advance for your engagement and participation.

[6] Finity Consulting, Risk equalisation: Final report for the Department of Health and Aged Care (2022), available at: https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/