Australian Government
Department of Health, Disability and Ageing

Private Health Sector Reform

Consultation Paper 1

2 July 2026

Contents

Overview

Australia's hospital system combines public and private providers and makes use of a range of funding arrangements to support access to hospital care based on clinical need, availability and patient choice.

Private health insurance (PHI) plays an important role within this system. Around 12.6 million Australians hold private hospital cover. Public patients also use private hospitals through arrangements including Department of Veterans' Affairs (DVA) contracts, compensation schemes and self-funding. Around 5 million hospitalisations occur in the private health sector each year, reflecting the scale and integration within the broader hospital system.

In Australia, PHI is 'community-rated', rather than 'risk-rated' like most forms of insurance. Private Health Insurers (insurers) cannot refuse to insure a person and must charge the same premium for the same level of cover, regardless of risk profile and likelihood of health service use. However, there are several types of private hospital cover that offer different benefits. Hospital cover policies classified as Gold, Silver, Bronze and Basic hospital tiers. Insurers offer (and consumers select) PHI cover for varied reasons. The type of cover selected by consumers is informed by numerous factors including personal health needs and perceptions around the value and affordability of available health cover.

In 2024, the Department of Health, Disability and Ageing (the department) examined the financial sustainability of the private hospital sector through the Private Hospital Sector Financial Health Check (the Health Check). The Health Check found that while parts of the sector continue to perform well, overall profitability has declined, largely because operating costs have increased faster than revenue. The Health Check also identified challenges in the delivery of private maternity and mental health services. In addition, private hospitals have been affected by major disruptions and continue to face ongoing pressures from inflation and workforce challenges.

Following the release of the Health Check, the Department established the Private Health Chief Executive Officer (CEO) Forum (the CEO Forum). The Minister for Health, the Hon. Mark Butler MP, asked the CEO Forum to specifically provide advice on changes to:

- improve access to hospital in the home care
- make maternity care more accessible and affordable
- improve access to mental health care
- make contract negotiations fairer, and
- reduce red tape and improve productivity.

The department is undertaking further consultation on proposed reforms to improve the private healthcare sector following feedback received through the CEO Forum.

This paper and future consultation papers seek feedback on the implementation arrangements needed to support those reforms. This will ensure, to the greatest extent possible, reforms can be factored into the 2027 Premium Round, which commences in mid-late 2026.

Consultation so far

In 2024, the department released a public summary of the Health Check. The Health Check found that the private hospital sector has and was expected to continue to face systemic challenges to its sustainability.

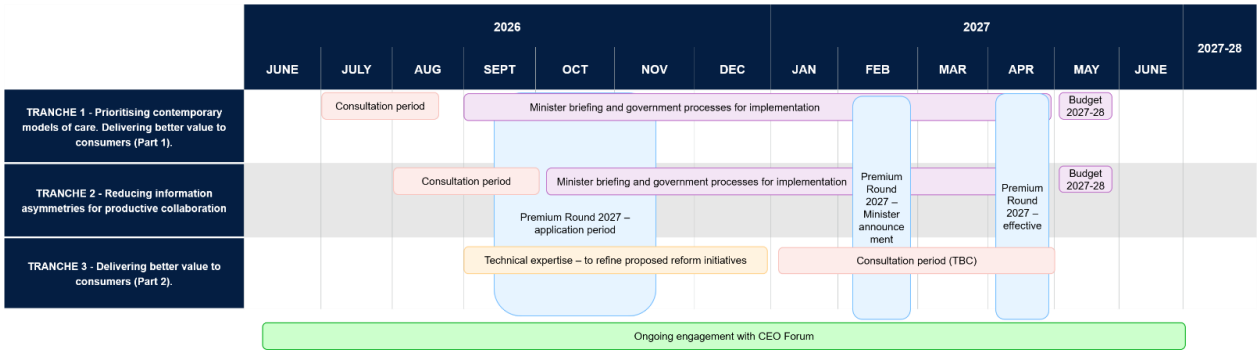
In late 2024, the department established the CEO Forum to identify and provide advice on short and medium-long term reform options. The aim being to improve the sustainability of the private health sector and result in better value for patients and the broader healthcare system.

In January 2025, the department released a consultation paper which sought feedback on short-term private health reform options. Since this time, the department has worked with the CEO Forum and key stakeholders to further refine the proposals presented in this consultation paper.

Members of the CEO Forum and other stakeholders have called for broad sector consultation prior to any implementation of reforms developed during 2025 and early 2026.

This consultation

This is the first in a suite of consultation papers which the department will release over the coming months. The following diagram provides an indicative timeline for the 3 tranches of consultation over the coming months:



The department anticipates that the primary audience for this consultation will include insurers, private hospitals, health professionals, consumer/patient advocates, medical device companies and jurisdictional government agencies.

These proposals do not represent government policy. Government will decide whether to implement any changes, including potential changes to MBS items.

The decision to create new or amend MBS items are informed by well-established clinical and economic assessment processes including appropriate consideration and advice by the Medical Services Advisory Committee (MSAC).

The department will use feedback received through this consultation process to inform advice to government for consideration.

The department encourages insurers to take the proposed reforms into consideration when developing new or amended products and premiums for the 2027 Premium Round (submissions due in November 2026). This paper covers the following elements (Tranche 1):

1. prioritising contemporary models of care including:
    1.1 mental health care
    1.2 maternity care
    1.3 Hospital in the Home (HITH), and
    1.4 Type C certification requirements: exemption criteria, and
2. delivering better value for consumers through:
    2.1 improving access to regional private hospitals
    2.2 PHI product simplification, and
    2.3 updating Risk Equalisation.

The paper seeks stakeholders' views on the prioritisation and indicative scheduling of each of the proposed reform initiatives at Appendix A.

Future consultations

The department will release further consultation papers on the following topics:

- reducing information asymmetries for productive collaboration (including sector compliance, codes of conduct and improving funding, cost and performance data transparency) (Tranche 2), and
- further measures to deliver better value for consumers, including further PHI product simplification and Risk Equalisation measures (Tranche 3). Feedback on Tranche 1 will help inform independent technical advice ahead of further consultation.

The first two consultation tranches will bring together proposed reform elements that the sector, including through the CEO Forum, have indicated are priorities. Stakeholders should note that proposals for the development of a Private National Efficient Price have not been considered by government and are not the subject of upcoming consultations. A separate consultation paper on improving the transparency of cost and performance data through regular collection and publication will be released in the coming months.

Concurrently, the department is consulting on reforms to specialist affordability. Additionally, the House of Representatives Standing Committee on Health, Aged Care and Disability is running an inquiry into access to and affordability of medical specialists in Australia.

What we invite you to do

We ask stakeholders to provide feedback on the proposed measures via the consultation hub. This paper sets out proposed reforms for implementation and asks questions about each reform throughout. Please consider these questions and any other comments about the matters raised in this consultation paper in your response. The department will use this feedback to refine the measures and support subsequent consultation.

Further, the department acknowledges there have been a significant number of studies and reports in recent years into PHI 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.

The department is interested in hearing from consumers of the private health sector. Many of the questions throughout the paper are technical in nature and directed at insurers, hospitals and health professionals. Additional questions consumers/patients and their advocates may wish to focus on include:

- will the proposed reforms reduce out-of-pocket costs for patients?
- will the proposed reforms improve access to safe, high quality contemporary models of private health care?
- will the proposed product simplification reforms make it easier to understand, choose and use PHI products?

The department continues to work closely with Consumers Health Forum of Australia and other consumer and patient representatives to hear the consumer's voice and prioritise outcomes in the consumer and patient interest.

The consultation period will run from 2 July 2026 to 13 August 2026. Feedback should be submitted via the consultation hub only. Feedback submitted via other means may be inadvertently missed and subsequently may not be taken into consideration.

Publishing of stakeholder submissions

The department will publish submissions. Respondents are asked to clearly identify specific elements of the response which they consider confidential and not for publication, as well as the reasons the specific elements are considered confidential.

You should note that confidential feedback may still be subject to access under freedom of information (FOI) laws. The FOI process includes consultation with a respondent prior to a decision about the release of information.

1. Prioritising contemporary models of care

The changing private health care landscape

The way Australians access and use private hospital care is changing, through:

- evidence-based clinical practice that has been sharpened by the insights of interdisciplinary data analysis
- improved understanding of recovery that has reduced the length of post-surgery hospital stays
- advances in digital and health technologies which bring 'virtual hospital' direct to the patient, and
- care provided in the home which improves recovery and frees up hospital beds for acute care patients.

Our regulatory framework links benefits eligibility to provider type. Only facilities that meet the Commonwealth definition of a hospital can provide or authorise services eligible for minimum hospital treatment benefits. However, the way care is delivered is evolving and there are new types of care which were unknown or rare 'hospital' definitions were added to the *Private Health Insurance Act 2007* (the PHI Act).

As Australia's population ages, early intervention through integrated systems can help meet growing needs for care within the available health, disability and aged care workforce. Consumer demand continues to grow for convenient, flexible access to personalised healthcare.

Our regulatory and benefit frameworks must continue to support patient access to contemporary models of safe, quality-assured care. We want Australia's world-class health system positioned to respond dynamically to support the revolution in care expected over the next 20 years. Stakeholder feedback is important for us to understand what is working and what can be improved.

Further information is available at Appendix B: Contemporary definitions of hospital treatment.

A patient's experience of contemporary care

In 2026, a patient's journey through injury or illness, treatment and recovery might include:

- GP and specialist visits, diagnostic procedures and pre-habilitation classes
- a surgical procedure and day stay in a hospital facility
- post-surgical recovery in a hotel-like medical environment ('medi-hotel'), or at home with daily health professional visits, remote monitoring and/or telehealth, and/or
- at-home post-surgical physiotherapy rehabilitation.

At each stage, eligible benefits payable and out-of-pocket may vary by the type of provider (hospital or other), even for seemingly identical services. The impact on access to care is explored in sections 1.1 Mental Health Care, 1.2 Maternity Care and 1.3 Hospital in the Home (HITH).

1.1 Mental health care

SUMMARY: Mental Health Care	
Proposed reform initiative for implementation	**Mechanism for implementation**
Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals.	Government to establish an exemption under section 19AB(3) of the Health Insurance Act 1973. Several operational guardrail options are presented for consideration.
Initiative 2: Increased access to contemporary models of mental health care.	Increase case conferencing to more than once per hospital admission through amendment of MBS items (see: Note).
Initiative 3: Private health sector to reconvene the Private Mental Health Alliance (PMHA).	Sector to reconvene PMHA.
Initiative 4: Review of risk equalisation arrangements.	Refer to Section 2 of this paper: Delivering better value for consumers.

Questions for stakeholder consideration

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

a) What difference would this reform initiative make for patients requiring access to mental health treatment?

b) Would this reform initiative support the viability of private mental health services?

c) Would this initiative impact upon other parts of the mental health system, including the mental health workforce? Please provide details.

d) Which of the proposed Operational guardrail options are suitable? Provide reason/s if a guardrail option is not supported.

e) Are there other issues to consider in the design or implementation of this reform initiative to improve its effectiveness, or to address risks? Please provide details.

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

f) What, if any, changes should be made to MBS case conferencing items? Please provide a justification and any supporting evidence for changes identified.

g) Are there other changes required to MBS items for inpatient psychiatry items to support contemporary mental health care? Please provide details

Initiative 3: Supporting the Sector to reconvene the Private Mental Health Alliance (PMHA)

h) If the PMHA were to be reconvened, what focus/es should it have? Please provide details

i) Noting the previous membership, which organisations should be included if the PMHA is reconvened?

Initiative 4: Review of risk equalisation arrangements.

See questions under Section 2 of this paper: Delivering better value for consumers

NOTE: *Any decision to create new MBS items or amend existing items would be subject to established Australian Government processes, including consideration through relevant advisory committees, expert clinical review mechanisms, and final approval by Government.*

1.1.1 Introduction

The Health Check reported growing pressure on private hospital mental health services is reducing patient access. This is partly due to challenges faced in recruiting and retaining psychiatrists for hospital-based work. The department has also received feedback that psychiatrists are generally better remunerated for services delivered outside the hospital setting which is further limiting the availability of hospital-based patient services.

In 2025, the CEO Forum (supported by a working group) examined a range of potential reforms aimed at improving patient access and strengthening the sustainability of private hospital mental health services. It was acknowledged that there is no single solution to resolve the sustainability challenges for private hospital mental health services, and that a suite of coordinated changes would be required to achieve meaningful improvement. The CEO Forum and working group considered potential options including:

- increasing workforce supply through the employment of overseas-trained psychiatrists
- adopting contemporary models of care, including multidisciplinary teams and telehealth
- sector-led governance reform, and
- changes to PHI Risk Equalisation arrangements to encourage prevention and reduce the cost of insurance for mental health (along with maternity care).

1.1.2 Progress on reforms to support mental health services

Inpatient telehealth psychiatry services

In November 2024, the Government introduced temporary MBS psychiatry inpatient telehealth items to enable psychiatrists to support the timely admission of patients to hospital for mental health treatment. This also enabled subsequent time-tiered telehealth video attendances for the patient in hospital.

A post-implementation review was conducted in 2025 to assess the effectiveness of these items in facilitating appropriate admissions and improving access to hospital care. The review, which included targeted stakeholder consultation, found that although uptake of the items has been relatively limited, feedback from stakeholders on the effectiveness of the arrangements was overwhelmingly positive. There was strong sector support for making the items permanent, with stakeholders noting that the current restriction—limiting subsequent consultations to one per week—was constraining continuity of care.

In the 2026-27 Budget, the Government decided to make the MBS psychiatry inpatient telehealth items permanent. It also agreed to revise the existing limit of one video consultation in a seven-day period, increasing this to two consultations per seven days. The current expectation for clinicians to conduct a face-to-face consultation with the patient within 48 hours will remain unchanged. The amended arrangements to MBS psychiatry inpatient telehealth items will take effect from 1 November 2026.

Sector-led guidelines

Until 2015, the Private Mental Health Alliance (PMHA) collaborated, regularly reviewed and maintained the *Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care* (the Sector Guidelines). The Sector Guidelines governed the delivery and funding of mental health programs for privately insured patients.

The Sector Guidelines provided direction on how private hospitals and insurers determined PHI benefits for hospital-based mental health care (including same-day, overnight services and services substituting for traditional inpatient care) and, where relevant, community and outpatient services. The department understands that, since 2015, the Sector Guidelines are being disregarded by some insurers and hospitals.

A working group of the CEO Forum identified there are opportunities to update the Sector Guidelines to better reflect contemporary clinical practice and improve patient access. The working group undertook a targeted review of the Sector Guidelines and proposed a series of updates, including:

- guidance to enable patient referrals to day programs by GPs, Addiction Medicine Physicians, Specialist Pain Medicine Physicians and nurse practitioners
- recognition of contemporary pharmacotherapy, procedural and behavioural therapies, and
- care delivered by clinicians including Addiction Medicine Physicians and Specialist Pain Medicine Physicians.

Former PMHA member organisations and other stakeholders are encouraged to consider the proposed changes. By 2026 it is expected the updated Sector Guidelines would be:

- endorsed by the sector
- disseminated across the sector, and
- referenced consistently in insurer-hospital agreements during 2026.

The working group also recommended that the PMHA be reconvened to conduct a comprehensive review of the Sector Guidelines, and to oversee an ongoing maintenance process for the Sector Guidelines. A reconvened PMHA could also support ongoing sector collaboration between patient groups, clinicians, private hospitals and private health insurers to support further expansion of contemporary models of care.

1.1.3 Proposed reform initiatives to support private mental health

The department seeks sector feedback on the proposed reform initiatives to improve patient access and support the sustainability of privately insured mental health care services:

- Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals
- Initiative 2: Contemporary models of mental health care, and
- Initiative 3: Reconvene the Private Mental Health Alliance (PMHA).

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

Problem

The Health Check highlighted challenges providers face recruiting and retaining psychiatrists for hospital-based work. Stakeholders have suggested overseas-trained psychiatrists could help to address this problem.

Context

Access to MBS benefits is required for psychiatrists to admit patients to private hospitals and for insurers to pay rebates. Under the Medicare moratorium, overseas-trained doctors are prevented from accessing Medicare rebates until they have been registered in Australia for over 10 years, unless they receive an exemption (i.e. for working in a DWS area). The Medicare moratorium is a longstanding policy to distribute overseas trained doctors to where they are needed.

As a result, many overseas-trained psychiatrists are generally unable to practice in private hospitals unless the hospital is in a DWS or the psychiatrist provides services after hours. With most private psychiatric hospitals in metropolitan areas, moratorium-restricted psychiatrists are effectively prevented from practising in these settings (until they complete their 10-year moratorium).

In January 2025, the department released a consultation paper including an option for potential Medicare moratorium exemptions. While some stakeholders (particularly private hospitals) expressed support for the proposal, others raised concern about potential impacts on regional services and public hospital mental health systems, including the:

- risk that a new exemption from the moratorium could draw overseas-trained psychiatrists away from regions classified as DWS, and
- exemption could also incentivise movement of psychiatrists from the public hospital system to the private sector, further exacerbating workforce pressures in regional areas and in public hospitals.

Action

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.

Objective

Increase the supply of overseas trained psychiatrists who can admit patients to private hospitals. The intention is that this would improve patient access to care and support the viability of private hospitals providing psychiatric care.

Details

An exemption would be established under section 19AB(3) of the HI Act for international medical graduate psychiatrists who admit and treat patients in declared private hospitals not in DWSs. Overseas-trained psychiatrists would have to apply for exemption for each private hospital location through a Medicare provider number application[i] (i.e. they would not be granted a single exemption to cover all private hospitals not located in a DWS).

Based on previous feedback on potential risks, several potential operational ‘guardrail’ options have been identified below.

Operational guardrail options

Feedback is sought on the suitability and effectiveness of the guardrails in supporting implementation of the proposed initiative.

Mental Health Reform Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals	
Potential guardrail options	
1. ***Restrict the exemption to admitted (inpatient) MBS services*** Psychiatrists can only access MBS benefits for services delivered to admitted patients (inpatients)	▪ Overseas trained psychiatrists would only be able to access MBS benefits for services delivered to admitted patients (inpatients) at private hospitals located outside a DWS. The exemption would not extend to non-admitted (outpatient) services at that hospital location. ▪ In practice, this would enable psychiatrists based in a DWS (e.g. an outer metropolitan area) to admit patients to a private hospital in a non-DWS area (e.g. an inner metropolitan area), treat those patients while they are admitted, and then provide any post-discharge (outpatient) care from their usual DWS practice location. ▪ This guardrail option is intended to prevent overseas-trained psychiatrists practising in DWS areas from relocating to establish room-based private practices within private hospitals in non-DWS locations.
2. ***Limit the exemption to new-to-Australia psychiatrists*** Design the exemption to support the recruitment of psychiatrists from overseas	▪ Overseas trained psychiatrists would be allowed to access MBS benefits for both admitted (inpatient) and non-admitted (outpatient) services delivered in a non-DWS location, where those services are associated with a private hospital. However, the psychiatrist would need to be a new-to-Australia doctor recruited overseas by the hospital. ▪ These psychiatrists could provide a full scope of care in the non-DWS location, including treating patients during admission and continuing care after discharge in an outpatient setting. ▪ The exemption would be available to overseas trained doctors who are either recognised specialist psychiatrists at the time of recruitment or recruited for fellowship training at the sponsoring hospital. ▪ Additional exemptions for these doctors could be available at multiple hospitals in non-DWS areas within a single hospital provider group (i.e. a hospital provider group with multiple private hospitals). Usual moratorium requirements would apply should the psychiatrist choose to leave the private hospital with whom they hold the exemption, or if they undertake additional work independently of the sponsoring hospital. ▪ This guardrail option is intended to support private hospitals recruit new-to-Australia psychiatrists and to boost the overall supply of psychiatrists.

Mental Health Reform Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals	
Potential guardrail options	

3. Cap exemptions applied at each individual private hospital
 	
Individual hospitals could access a maximum of 1-2 psychiatrists through the exemption.
	• A cap would be placed on the number of exemptions assigned to each private hospital in a non-DWS area. The cap could be set a 1 or 2 exemptions per hospital.
	• For context, in 2024-25 there were approximately:
	  ○ 60 private hospitals not in a DWS location which delivered mental health separations, and
	  ○ 300 overseas-trained psychiatrists who were serving a moratorium period in a DWS.
	• This guardrail option could minimise the risks of overseas-trained psychiatrists avoiding DWS areas or leaving public hospitals in favour of roles in metropolitan private hospitals.
	• This approach would present administrative challenges for private hospitals. Moratorium exemptions are granted to individual doctors through a Medicare provider number, rather than to facilities. Hospitals would have limited visibility of the exemptions associated with their facility, including when any hospital-level cap has been reached.
	• Additional issues may arise when a psychiatrist leaves a hospital and the departing psychiatrist fails to cancel their Medicare Provider Number for that hospital. This may preclude or delay the hospital from recruiting another overseas-trained psychiatrist.

4. Timeshare commitment to public-private practice Require overseas-trained psychiatrists to dedicate time in public and private settings.	▪ It has been suggested that an exemption could be tied to a requirement that overseas trained psychiatrists dedicate time to both public and private hospital settings. ▪ The department received feedback that there would be practical challenges operationalising a model where overseas-trained psychiatrists commit to sharing time between public and private hospital settings. The regulatory burden of these arrangements needs to be carefully considered.

Implementation and review

These exemption arrangements could be introduced for an initial period of 3 years, with a post-implementation review (at 12- to 24-months) to assess the effectiveness of the arrangements, including any negative or unforeseen consequences. Implementation for an initial period of 3 years would provide psychiatrists with sufficient time and certainty to establish private practice arrangements to support patients.

Extension or continuation of the arrangements would be subject to the Government's consideration of the review findings.

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

Problem

Stakeholder feedback has indicated sector funding arrangements have not kept pace with contemporary models of care, including use of multidisciplinary teams. The updated Sector Guidelines are being considered by sector peak bodies include proposed changes to support contemporary care, such as integrating other health workers (e.g. GPs, nurse practitioners and allied health providers) into insurer-funded hospital programs.

The department also received feedback that there are areas of the MBS which could be improved to support multi-disciplinary care, including case conferencing during a patient's admission to hospital. The department has been told that Hospital Purchaser Provider Agreements generally require weekly multi-disciplinary team case conferences to be undertaken during a patient's admission for psychiatric care. Stakeholders identified that MBS psychiatry items which include case conferencing are restrictive as they are capped to one service for each hospital admission.

Context

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient. The MBS includes a range of items for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital inpatients. These MBS items were introduced to improve the effectiveness of psychiatric case conferences and to ensure better coordinated care for patients by making it easier for psychiatrists to work with other health care professionals.

There are 3 MBS items for discharge case conferences conducted before the patient is discharged from a hospital (MBS items 861, 864 and 866). These items are payable not more than once for each hospital admission.

Action

Amend MBS items for case conferences by Consultant Psychiatrists allowing for multiple case conferencing services to be funded during a patient's admission to hospital for mental health treatment.

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

Problem

There is no collaborative forum where private mental health stakeholders can come together to discuss matters that affect the sector, creating a gap in sector-wide coordination and continuous improvement. This is particularly important in the context of ongoing review and oversight of the Sector Guidelines to ensure continued alignment with contemporary models of care and clinical practice.

Context

The Private Mental Health Alliance (PMHA) was a national industry alliance that operated, in various forms, from 1996 until 2016. The role of the PMHA was to address issues of funding, classification, quality of care, outcome measurement, consumer and carer participation and other topics affecting the private mental health sector. In 2015, PMHA membership comprised representatives from:

- Australian Medical Association
- Private Healthcare Australia
- the Australian Private Hospitals Association
- the Private Mental Health Consumer Carer Network (now Lived Experience Australia)
- the department, and
- the DVA.

The PMHA regularly engaged with a broader range of organisations to undertake ongoing process of review of the Sector Guidelines. These organisations included:

- The Royal Australian and New Zealand College of Psychiatrists
- The Royal Australian College of General Practitioners
- Australian College of Mental Health Nurses
- Australian Psychological Society
- Australian Association of Social Workers
- Occupational Therapy Australia.

Initiative 4: Review of risk equalisation arrangements

This reform initiative would involve consideration of different arrangements for benefits paid for the ‘Hospital psychiatric services’ clinical category to improve the attractiveness of mental health products for consumers. Further information on this reform initiative is in Section 2: Delivering better value for consumers.

1.2 Maternity care

SUMMARY: Maternity Care	
Proposed reform initiative for implementation	**Mechanism for implementation**
Initiative 1: Sector education.	Department and sector collaboration through workshops and resources.
Initiative 2: Increased access and choice to different models of maternity care.	Sector led.
Initiative 3: Shorter PHI waiting periods for pregnancy and birth.	Department consultation with sector and changes to the PHI Act.
Initiative 4: Review of product tier structure.	Refer to Section 2: Delivering better value for consumers.
Initiative 5: Review of risk equalisation arrangements.	
Initiative 6: Review of MBS items for paediatricians.	Amendment of MBS items (see: Note).

Questions for stakeholder consideration

Initiative 1: Sector education

a) Do you agree or disagree that sector education about innovative models of maternity care would help to raise awareness of models and build a clearer understanding of regulatory enablers? Why do you agree or disagree?

b) What mechanisms should be used to educate the sector?

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

c) Would you participate in the development and implementation of innovative models of care with other practitioners in the private maternity sector? Please provide details.

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

d) Do you agree or disagree the maximum waiting period should be reduced for the 'Pregnancy and birth' clinical category? Please specify why.

Initiative 4: Review of product tier structure

e) Do you agree or disagree the 'Pregnancy and birth' clinical category should be a minimum requirement of a product tier other than Gold?

See further questions under Section 2: Delivering better value for consumers.

Initiative 5: Review of risk equalisation arrangements

See questions under Section 2: Delivering better value for consumers

Initiative 6: Review of MBS items for paediatricians

f) Do you agree or disagree that there should be consideration of an amendment to the MBS item for paediatricians? Please specify why.

NOTE: *Any decision to create new MBS items or amend existing items would be subject to established Australian Government processes, including consideration through relevant advisory committees, expert clinical review mechanisms, and final approval by Government.*

1.2.1 Introduction

Consumers value choice and access to maternity care options. Several factors influence choice of maternity care models, including:

- the fees charged by medical practitioners for private pregnancy and birth services
- the cost/value proposition
- continuity of care, and
- available models of care.

There is limited choice regarding the type of care available during pregnancy and birth in the private sector. Innovative care models will make private maternity services more attractive and improve choice and access during pregnancy. Sector-wide collaboration is essential to design and implement new offerings. There are no regulatory barriers to the sector implementing innovative models of care, however other factors are limiting the diversity of models of care that are offered. This includes a lack of awareness by some in the sector of the ability to introduce new and innovative models of care that are best practice models. These models of care could include:

- shared care between pools of obstetricians and midwives
- shared care between an obstetrician and small group of midwives, and
- partnership models of care with an endorsed midwife and obstetrician partnership, where the endorsed midwife can primarily lead care.

1.2.2 Barriers to private sector maternity care access

Cost of private maternity services

Cost is a significant barrier to choice in maternity services. On average, the cost of using private obstetrician-led maternity care is more than $12,000 (including insurance premiums for Gold tier and out-of-pocket costs). This is compared with $726 for birth in the public system (including GP out-of-pocket costs, genetic testing and, if relevant, costs for home births).

System pressures

The birth rate for women of reproductive age (aged 15 to 44 years) in Australia has been decreasing:

- in 2024, the total fertility rate (TFR) was 1.481 babies per woman, lower than 2023 (1.499) and the rate 10 years ago (1.795 in 2014)[ii], and
- in 2024-24, there were 279,301 childbirth separations in hospitals in Australia. 21% of these births occurred in private hospital facilities, a decrease of births in private hospitals of 4.5 per cent from the previous year[iii].

This declining birth rate can impact viability of private maternity care services.

Cessation of private hospital services

Birth separations from private hospitals are decreasing at a greater rate than separations from public hospitals. This decrease is impacting a sector that is in financial stress and contributed to the closure of 10 private hospital maternity services between 1 July 2017 and 1 May 2025.

Potential further maternity service closures and declining birth rate will continue to challenge private maternity care which relies almost entirely on access to hospitals and one model of care (obstetrician-led). Some stakeholders have suggested that, without changes to the current approach and the implementation of more innovative, and potentially lower cost, models of care, private maternity will become unsustainable.

1.2.3 Proposed reform initiatives to PHI for maternity care

In considering the issues outlined above, the CEO Forum established a Private Maternity Working Group which primarily focused on:

- exploration of innovative mixed models, including midwife/obstetrician partnership where endorsed midwives can work to full scope of practice, providing greater choice on the model of maternity care, and
- amendments to risk equalisation to allow maternity costs to be shared across the insurance sector, resulting in lower cost maternity product options and thereby increasing the value proposition of maternity care options.

The department seeks sector feedback on the proposed initiatives to encourage adoption of innovative models of maternity care and welcomes views on other reform initiatives. The Private Maternity Working Group recommended the following initiatives.

Initiative 1: Sector education

Sector education could be used to raise awareness of models of private sector maternity care available and dispel myths about regulatory barriers to innovation. This may include workshops to facilitate discussions between sector participants concerning existing innovative models and provide opportunities for connection and engagement to discuss models.

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

This would involve the sector developing new and innovative models of care, including models that provide greater choice of care providers (i.e. endorsed midwives being involved in their care in partnership with an obstetrician).

Initiative 3: Shorter waiting PHI periods for private provided pregnancy and birth

Reviewing PHI waiting periods and early access to maternity care would involve consideration of mechanisms to facilitate shorter waiting periods for benefits for the ‘Pregnancy and birth’ clinical category. Insurers usually impose the maximum waiting period of 12 months for pregnancy and birth. However, they can reduce the waiting period at their discretion.

Initiative 4: Review of product tier structure

This would involve consideration of the 'Pregnancy and birth' clinical category as a minimum requirement of a product tier other than Gold. Further information on this reform initiative is in Section 2: Delivering better value for consumers.

Initiative 5: Review of risk equalisation arrangements

This reform initiative would involve consideration of different arrangements for benefits paid for the 'Pregnancy and birth' clinical category to improve the attractiveness of maternity products for consumers. Further information on this reform initiative is in Section 2: Delivering better value for consumers.

Initiative 6: Review of MBS items for paediatricians

Following birth, newborns are not typically admitted as a patient to the hospital unless they have a disease, injury or condition that requires management. However, it is common for there to be a professional attendance by a paediatrician to check on the health of the newborn without a hospital admission. If this occurs, the paediatrician will usually claim an MBS item for out-of-hospital treatment. Insurers are not permitted to pay benefits for out-of-hospital treatment where there is an MBS item. Sometimes patients report they are unaware the attendance is an additional payment which incurs an out-of-pocket cost.

If they have a disease, injury or condition that requires clinical management, a newborn may be admitted to hospital (i.e. through the Neonatal Intensive Care Unit, Special Care Nursery or be admitted under a paediatrician). This means the treatment provided is hospital treatment and the insurer will pay benefits.

The Private Maternity Working Group suggested changing MBS arrangements so the attendance by a paediatrician provided MBS benefits at a level that did not require out-of-pocket costs to the patient. This would also assist with the supply of paediatric specialists, particularly in rural and remote locations. It is the role of MSAC to consider the development of new MBS items, as well as significant changes to existing MBS items.

1.3 Hospital in the Home

SUMMARY: Hospital in the Home (HITH)	
Proposed reform initiative for implementation	**Mechanism for implementation**
Apply a minimum hospital benefit for HITH of $360 per day for an initial tranche of 3 treatment services: ▪ intravenous (IV) infusions ▪ complex wound care, and ▪ palliative care. MBS benefit for eligible medical services provided to the patient would be 75% of the Schedule item fee. Insurers would be required to pay the additional 25% of the Schedule item fee.	Department to amend the Benefit Requirements Rules. The Department is considering options for amending the Benefit Requirements Rules for this initiative. This paper outlines one option that is under consideration, but this is subject to final confirmation of approach.
Introduction of a telehealth item for HITH services (where relevant).	Amendment of MBS items (see: Note).
Questions for stakeholder consideration	
a) Is the amount of the proposed minimum hospital benefit for HITH appropriate (i.e. $360 per day)? If not, please provide a proposed alternate default benefit amount, including methodology and supporting data. b) Should the department consider different minimum hospital benefits for different types of HITH services, e.g. to recognise additional complexity? If yes, please provide proposed alternative benefit amounts, including your rationale and supporting data. c) Do you have any comments about the inclusion of IV chemotherapy as an eligible IV infusion in the initial tranche of HITH treatment services? Please provide detail on why or why not. d) Can hospitals and insurers implement this proposal as described? If not, please provide details on why, e.g. additional barriers not canvassed in this paper. e) Do you have any comments regarding the interaction of MBS and professional services attendance billing and the feasibility of this reform proposal? f) Do you have any further comments on the considerations raised under Section 1.3.3 that have not been provided in response to questions above? If yes, please provide details. g) Do the proposed changes have consequences which the department does not appear to have foreseen, based on the details in this paper? If yes, please provide details. h) Are there any further issues that the department should consider in relation to the proposed evaluation to measure the success of this proposal?	
NOTE: *Any decision to create new MBS items or amend existing items would be subject to established Australian Government processes, including consideration through relevant advisory committees, expert clinical review mechanisms, and final approval by Government.*	

1.3.1 Introduction

Hospital in the Home (HITH) is a well-established and recognised model of care, used both internationally and within Australia. While HITH is widely utilised across the public hospital system, its uptake in the private health sector remains relatively limited. Some HITH service delivery is occurring in the private hospital sector where insurers and private hospital providers have reached a contractual arrangement for the delivery of HITH services. However, such arrangements are not widespread, and privately insured patients generally have low access to HITH services.

Consultation undertaken by the department in 2025, including discussions through the CEO Forum, identified HITH offers a range of potential benefits for patients, providers, funders, and the broader health system. Stakeholders expressed strong support for reform to increase accessibility of HITH services for privately insured patients.

1.3.2 Option to expand HITH

To support the expansion of HITH services within the private health sector, it is proposed that a minimum hospital benefit be introduced under the Benefit Requirements Rules. This benefit would apply to HITH treatment services for privately insured patients that are provided by, or arranged with the direct involvement of, private hospitals.

The proposed benefit would represent the insurer's payment to the hospital for patient treatment and care that would otherwise attract an accommodation benefit if delivered on-site. The minimum hospital benefit for HITH would be separate to any MBS benefits that may be payable for medical services provided to the patient as part of their HITH treatment. Under this arrangement, insurers would be required to pay a daily minimum hospital benefit to private hospitals delivering HITH services, initially limited to a defined tranche of three treatment types (outlined below).

It is proposed that the minimum hospital benefit for HITH be implemented for an initial 3-year period. A formal review would be undertaken after 2 years to assess its effectiveness. Any decision to extend or modify the arrangements (including consideration of additional treatment service tranches) would be informed by the outcomes of this review and subject to the Government's consideration.

Under the proposal, the department anticipates that private hospital providers would have increased certainty of funding to invest in increasing their HITH service offerings, improving patient access to HITH treatment services. In the medium term, expansion of HITH across the private health sector may lead to private hospitals and insurers increasing their contracting for these services, reducing reliance on the minimum benefit. Contracting would allow providers and insurers to establish arrangements around such factors as patient eligibility and service standards.

The intended definition of a HITH service would align with the Australian Institute of Health and Welfare's Metadata Online Registry definition:

> *'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.'*[iv]

1.3.3 Proposed initial tranche of HITH treatment services for introduction

Previous engagement with stakeholders has identified an initial tranche of 3 treatment services as suitable to attract a minimum hospital benefit for HITH:

- intravenous (IV) infusions
- complex wound care, and
- palliative care.

Application of the minimum hospital benefit for HITH

The minimum hospital benefit for HITH would apply where:

- the patient is a privately insured (with the appropriate level of cover) receiving HITH treatment services of IV infusions; and/or complex wound care; and/or palliative care
- the HITH treatment service is provided by, or arranged with the direct involvement of the private hospital
- the private hospital, providing or arranging the HITH service, has been declared by the Minister to be a private hospital under section 121-5(6) of the PHI Act
- an admitted patient's movements between a physical hospital and their place of residence may not be linear. Admitted patients may receive the HITH treatment services at the beginning, middle or end of their episode of treatment, and
- if a patient receives more than one of the specified HITH treatment services at any time, the minimum hospital benefit will only be paid once per day (i.e. multiple minimum benefits for the same day(s) of HITH treatment will not be payable).

Exclusions – where the minimum hospital benefit for HITH would not apply

The minimum benefit for HITH would not apply where HITH services other than those specified in this proposal are delivered at person's place of residence (or other non-hospital treatment location).

Where a private hospital and insurer have established contractual arrangements for the provision of HITH treatment services incorporating any of the 3 services, insurer payments would be made in accordance with the relevant negotiated agreement. A minimum hospital benefit for HITH would not apply.

A provider that is not a declared private hospital would not be eligible to receive the minimum hospital benefit for HITH. Private hospitals would not be precluded from sub-contracting HITH services delivered on behalf of the hospital by another organisation. However, the declared private hospital would need to remain responsible for ensuring all relevant requirements associated with its declaration are met, including accreditation standards.

The minimum hospital benefit for HITH treatment services is not intended to apply to privately insured patients treated by a public hospital (i.e. services provided by a state/territory Local Hospital Network).

The minimum hospital benefit for HITH would not apply to hospital-substitute treatment, which the PHI Act defines as General Treatment.

Establishing the level of the minimum hospital benefit for HITH

Establishing an appropriate minimum hospital benefit requires consideration of a range of factors including:

- the cost of delivering the service and potential economies of scale
- the cost of treating a patient in the hospital location
- the cost of treating the patient in the home
- relativities to other minimum hospital benefit arrangements, and
- the potential impacts on premiums.

A minimum hospital benefit must balance each of these factors to ensure the service is financially sustainable for private hospitals and insurers. The department seeks feedback on a minimum hospital benefit for HITH being set at $360 per day.

1.3.4 Considerations identified by the department when implementing HITH

In developing the proposed approach to HITH implementation, the department has made the following policy considerations:

Consideration 1: IV infusions and chemotherapy

Chemotherapy is the treatment of disease by means of chemical substances or drugs, with injection into a vein (IV chemotherapy) the most common way to administer these medications[v,vi]. Chemotherapy treatments are usually given in a hospital or treatment centre. Depending on the prescribed treatment, some people may be able to receive their chemotherapy at home as HITH care.[vii]

Chemotherapy is a specialised treatment sometimes involving high-risk medications. Chemotherapy requires robust safety and quality and clinical governance protocols to be in place to protect the patient, and their carer/family and clinicians. Noting these issues, the department seeks stakeholder views on whether IV chemotherapy should be included as an eligible IV infusion in the initial tranche of HITH treatment services.

Consideration 2: Complex wound care

For the purposes of this proposal, the term ‘complex wound care’ refers to treatment for a break or tear in the skin that is clinically assessed as requiring admitted hospital wound management and treatment. Damage to the skin is often the result of an accident, surgery, a skin condition or an underlying condition like diabetes.

Uncomplicated post-operative wound care provided to a patient as part of normal aftercare following an operation or procedure, would not be considered as ‘complex wound care’ (refer to Issue 6: Aftercare below).

Consideration 3: Palliative care

Patients receiving palliative care at home have been shown to have increased quality of life and reduced need for hospital-based care. The department has received feedback that palliative care can be more resource intensive than other types of care provided as HITH treatment, such as IV infusions or wound care. The department seeks stakeholder feedback on whether HITH palliative care would require a different minimum benefit amount to be viable.

Consideration 4: MBS considerations

Under the proposal, services would be eligible for minimum hospital benefit where the patient receiving HITH services is an admitted hospital patient. The MBS benefit for eligible medical services provided would be 75% of the Schedule item fee and insurers would be required to pay the additional 25% of the Schedule item fee.

The intention is the HITH treatment services in this proposal would be substitutive for an individual patient (i.e. the patient would receive the same care in a hospital as they would in their own home). The introduction of a minimum hospital benefit for HITH is not expected to result in new or additional MBS services and/or costs.

Initial discussions with stakeholders have raised the potential interaction of these reforms with the MBS, particularly around telehealth access and professional services attendance billing during aftercare (see below).

Consideration 5: Telehealth

Except for a limited range of MBS inpatient telehealth psychiatry items, the MBS does not provide a benefit for telehealth services provided to an admitted hospital patient.

Under this proposal HITH treatment services will be delivered to admitted hospital patients. Existing Medicare arrangements would prohibit the payment of MBS benefits for telehealth services delivered to the patient as part of HITH treatment. Some stakeholders have provided feedback that restricting access to MBS benefits for telehealth services may limit the viability of HITH services.

Stakeholder are encouraged to outline their views on access to professional services attendance billing for telehealth to support the ongoing management of patients receiving HITH treatment services under this proposal.

Consideration 6: Aftercare

The MBS recognises aftercare as post-operative care and treatment provided to patients after an operation.[viii] Aftercare includes all attendances until recovery and the final check or examination of the patient. Aftercare can take place in a hospital, private rooms or a patient's home. Some MBS surgical items include a minimum aftercare period in their description or explanatory note. MBS fees for most surgical items in MBS Group T8 include an aftercare component.

Medicare billing rules specify that additional MBS attendance items for normal aftercare cannot be billed. During the aftercare period, a service considered 'not normal aftercare' may be billed (e.g. if the patient is seen for either an unrelated condition, or complications from the operation). When an item does not include aftercare, this is noted in the item description or explanatory notes of the MBS.

This proposal would not change existing MBS aftercare billing arrangements. This means that a practitioner providing normal aftercare to a HITH patient would not be eligible to bill these attendances to Medicare. The department is not considering any amendments to MBS aftercare billing arrangements as part of this proposal.

Consideration 7: Safety and quality and clinical service requirements

The safety and quality of healthcare services are of paramount importance. The proposed initiative would introduce a minimum hospital benefit payable to declared private hospitals. Eligible HITH services would be provided by, or arranged with the direct involvement of, private hospitals. These services would be required to meet the standards of safety, quality and clinical governance that apply to all care provided by that hospital.

Private hospitals delivering or arranging HITH services would remain accountable for ensuring that all aspects of the care they provide, including HITH programs, comply with the National Safety and Quality Health Service (NSQHS) Standards issued by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The Government does not prescribe clinical service requirements for other treatment categories where minimum hospital benefits apply, such as surgical, psychiatric or rehabilitation services. Consistent with this approach, the Government does not intend to establish specific clinical service requirements for the delivery of HITH treatment programs beyond the existing accreditation requirements. .

1.3.5 Implementation and timing

If agreed by Government, the department would implement the proposed initiative through an amendment to the Benefit Requirements Rules. A minimum hospital benefit for the first tranche of HITH services could potentially come into effect in line with new premium round changes on 1 April 2027. If the Government decides to implement the proposal it would be announced by late-2026, to enable insurers to incorporate this policy into their 2027 Premium Round submissions. The department expects the proposed draft Rule amendments to be issued for public consultation prior to implementation of the policy.

Following the rollout of the initial tranche of HITH services, an evaluation will take place to determine whether:

- changes have delivered the policy intent
- minimum hospital benefit for HITH was set at an appropriate amount for the 3 HITH treatment services rolled out in the initial tranche
- minimum hospital benefit for HITH should continue for the 3 HITH treatment services rolled out in this initial tranche, and
- further minimum hospital benefits for HITH should be implemented for additional HITH treatment services.

Work to develop the evaluation plan is ongoing, particularly around the timing of the evaluation. This will be dependent on the available data sources. The department will consult further on this in due course.

1.4 Type C certification requirements: exemption criteria

SUMMARY: Type C certification requirements: exemption criteria	
Proposed reform initiative for implementation	**Mechanism for implementation**
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.	Department to amend the Benefit Requirements Rules.
Questions for stakeholder consideration	
a) Do you support the proposal to implement two exemption criteria for Type C certification? Please provide reasons. b) Do you agree that implementing the proposed exemption criteria would meet the intent of the proposal to reduce administrative burden? Provide comments and supporting evidence. c) Can hospitals and private health insurers implement this proposal as described? If not, please provide details on why e.g. additional legislative barriers, exemption criteria not captured through ECLIPSE. d) Would you support the inclusion of any other exemption criteria, as part of a possible ongoing process? Provide details on other proposed criteria and supporting evidence. e) Do you support the proposal to reclassify MBS item 14245 from a Type C to a Type B procedure? Please provide reasons.	

1.4.1 Introduction

MBS items with the potential to be provided to privately insured patients as hospital treatment are allocated to hospital accommodation/procedure type classifications under the Benefit Requirements Rules. These classifications are:

- Type A – procedures requiring hospital treatment that includes part of an overnight stay
- Type B – procedures requiring same-day hospital treatment, and
- Type C – procedures that do not normally require hospital treatment.

Classification of MBS items into procedure types provides clarity in the administration of treatments across PHI policy tiers. It also facilitates claims and minimum benefit payments (accommodation payments) to hospitals.

The Benefit Requirements Rules and the Business Rules establish that Type C procedures do not normally qualify for minimum benefits for hospital treatment. Exceptions include circumstances where a patient receives hospital treatment that is either a *Certified Type C Procedure* or a *Certified Overnight Type C Procedure*. Schedule 3 Part 3 of the Benefit Requirements Rules identifies Type C procedures by MBS item number.

Previous consultation and CEO Forum discussions have highlighted the sector's general support to deliver administrative efficiencies and reduce the administrative burden associated with the certification process for Type C procedures. The department proposes implementing two 'exemption criteria' for the certification requirements for MBS items classified as Type C procedures under the Benefit Requirements Rules. Where an exemption criterion is applicable, the procedure would default to a Type B procedure, and no Type C certificate would be required. The proposed exemption criteria are:

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

The intent of the proposal is to reduce the administrative and cost burden related to the certification process for Type C procedures by implementing standing exemption criteria. The 'exemption criteria' would be applied to all relevant patients and would exempt clinicians from having to complete a Type C certificate for patients captured under the criteria.

Exemption criteria would lead to:

- a reduction in the number of certificates a treating doctor is required to produce
- minimisation of the time and resources allocated by clinicians, hospitals and insurers towards administrative processes
- possible improvement to hospital cash-flow, and
- greater certainty for consumers about access to care and expected out-of-pocket costs.

If agreed by Government, the proposed exemption criteria could be made by amendments to the Benefit Requirements Rules and implemented from 1 April 2027. Insurers should consider the impact of these changes on their 2027 Premium Round application.

The department would undertake post-implementation monitoring of MBS claims data would be undertaken to monitor for any unusual claiming practices.

1.4.2 Proposed exemption criteria

Patient is ≥ 75 years of age

A certification exemption is proposed for those patients aged 75 years and overdue to the increased complexity and higher risk associated with providing care to older patients. This frequently justifies care being delivered in higher acuity facilities where there is more support and clinical supervision.

Multimorbidity is common and becomes more common with age. In 2022, 76% of persons in Australia aged 75 and over were living with two or more long-term health conditions[ix]. For patients admitted to a private hospital and undergoing anaesthesia, the patient's physical status (determined by their ASA Classification) significantly increases for patients aged 75 years and older.

Patient care becomes increasingly complex when managing patients with multiple chronic conditions due to the potential effect on acute illnesses, treatment regimens and the overall

patient risk profile. Older age is also linked to increasing physical frailty, indicated by symptoms such as weakness, fatigue, slow movement, and increased risk of falls.

These factors contribute to a clinician's decision to treat an older patient in a hospital setting for a procedure that is generally considered not to require hospital treatment. Therefore, it is reasonable clinicians be given this discretion, given the relative frequency[x], without the need to explicitly justify through certification based on individual circumstances.

The procedure is conducted under general anaesthesia, regional anaesthesia or IV sedation

A certification exemption is proposed for patients who require their procedure be conducted under general anaesthesia, regional anaesthesia or IV sedation.

The Australian and New Zealand College of Anaesthetists (ANZCA) produces position statements on the best practice administration of anaesthesia and sedation, including:

- minimum safe facilities (including staffing, physical location, equipment, emergency medications)
- monitoring during anaesthetics, and
- post-anaesthesia care.

ANZCA provides guidance on safe patient management that:

- aligns with the procedure performed
- the anaesthesia or sedation technique
- the patient profile including age and co-morbidities
- the skills of nursing staff, and
- the facility environment.

If a clinician determines that a patient requires administration of general anaesthesia, regional anaesthesia or IV sedation as part of their treatment, this procedure would be performed in a hospital setting and a Type C certificate should not be required.

Other possible exemption criteria

The department would also like stakeholders to consider and provide general feedback on other feasible options for exemption criteria including, but not limited to:

- younger patients e.g. aged 5 years and under
- referred rural and remote patients e.g. a patient required to travel more than 100km to the service
- where the Type C procedure is considered adjunct to the primary reason for admission e.g. consultation or pathology items, where you would expect to see the Type C procedure co-claimed with a higher classified (A or B) MBS item, and/or
- the patient is admitted after a certain time (e.g. 3:00pm).

While not proposed for implementation at this time, other exemption criteria could be considered as part of an ongoing, later process.

1.4.3 Other – proposal to reclassify MBS item 14245 from a Type C to Type B procedure

This proposal is to reclassify MBS item 14245 from a Type C procedure to a Type B procedure, under the Benefit Requirements Rules.

Under the Medicare Benefits Schedule, item 14245 is classified as a 'Therapeutic procedure' and provides for:

> *'IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration – payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme.'*

MBS item 14245 is accompanied by explanatory note TN.1.19[xi] which includes reference to these drugs being associated with risk of anaphylaxis. Therefore, they must be treated by a medical practitioner and a medical practitioner must always be available during the infusion in case of an emergency.

Context

The department received a proposal seeking an exemption criterion for Type C certification where a 'patient receives a section 100 drug IV infusion under the Pharmaceutical Benefit Scheme (PBS) Highly Specialised Drug Program'. On examining the proposal, the department considered several matters, including:

- the underlying objective of implementing exemption criteria for Type C certification is to deliver efficiencies and reduce administrative burden, where exemptions generally align with clinical circumstances cited by clinicians for certification
- the exemption criteria seek to take into consideration the clinical circumstances surrounding the delivery of a Type C procedure, but do not question the underlying classification of individual MBS items as Type C procedures
- the proposal as put to the department stemmed from concerns regarding MBS item 14245, including clinical risks, patient access and unknown out-of-pocket costs, and inconsistent treatment by insurers when processing claims for benefits
- clinical advice on the level of clinical risk associated with administering immunomodulating agents, as well as the inclusion of Therapeutic Goods Administration approved Product Information on some specific medicines (i.e. statements that the medicine be administered in a hospital setting and with immediate access to the necessary medical personnel and full resuscitation facilities), and
- current clinical setting for delivery, with recent data indicating MBS item 14245 is normally performed in a hospital (with approximately 62% or over 16,000 procedures being performed in hospital in 2024-25) suggesting that in most cases, doctors are determining it is appropriate and necessary to treat patients in hospital.

Based on these factors, the department decided that an alternative proposal to reclassify the item from a Type C to Type B would be a more appropriate change than implementing an exemption criterion and could be applied more broadly to a class of medicines. This was based on the department's view that the underlying concern and current challenges mainly lie with the individual MBS item (PHI classification and item descriptor).

2. Delivering better value for consumers

2.1 Improving access to regional private hospitals

SUMMARY: Improving access to regional private hospitals	
Proposed reform initiative for implementation	**Mechanism for implementation**
Increase the second-tier benefits from 85% to 100% for established regional private hospitals.	Department to make changes to the Benefit Requirements Rules.
Questions for stakeholder consideration	
a) Should the proposed changes be implemented by government on a temporary or permanent basis? When should a post-implementation review be undertaken? b) When should government commence the proposed changes, noting the current annual processes for second-tier audit, categorisation and rate calculation? c) Provide feedback on the criteria for determining what should constitute an established regional hospital eligible for a higher second-tier default benefit (i.e. MM2 to MM7). d) Comment on the level of the proposed increase to the second-tier rate for established regional hospitals and estimated impact on private health insurance benefit amounts (e.g. should caps or other limits on out-of-pocket costs be applied under second-tier arrangements?). e) Are there any additional arrangements to support the effectiveness of the proposed changes that the department should consider, including audits of calculations and the publication of second-tier rates?	

2.1.1 Introduction

The Health Check found that some regional private hospitals in Australia are under significant financial pressure and risk closure, which:

- will reduce patient access to care with many of these facilities being the only private hospital in the area
- undermines the value of PHI for Australians living in regional and rural areas, and
- is likely to impact local public hospitals, including their workforce.

Increasing the second-tier default benefits from 85% to up to 100% is a short-term reform that may keep established regional private hospitals viable.

Default benefits aim to promote equity between consumers by providing a guaranteed level of financial support for hospital treatment. Default benefits also allow insurers to provide a level of differentiation between private hospitals via contracting.

Insurers are required to pay second-tier default benefits for most episodes of hospital treatment where the insurer does not have a negotiated agreement for that service with an eligible private hospital.

The Benefit Requirements Rules and Second-tier default benefits guidelines, mandate that the second-tier default benefit must be at least 85% of the average charge for the equivalent episode of treatment provided by a comparable private hospital that the insurer has a negotiated agreement within the same state.

The department uses the Modified Monash Model (MMM). For the purposes of this reform, private hospitals in MM2 to MM7 would be included (approximately 115 hospitals)[xii]. In 2024-25, the number of separations in these hospitals accounted for approximately:

- 14% of all private hospital separations, and
- 12% of all private hospital treatment associated revenues (noting that not all hospitals accessed second-tier benefits)[xiii].

Increasing the second-tier benefits to 100% for established regional private hospitals will:

- safeguard regional and rural consumers access to, and choice of, healthcare provider
- support retention of health workforce in regional areas and continued investment in regional private hospital services, and
- support continued value proposition of PHI for consumers in regional and rural areas.

To implement this reform, the department would need to change the calculation methodology detailed in the Benefit Requirements Rules. This change may also be accompanied by a requirement that the calculation use volume-weighting in determining second-tier default benefit rates to reflect actual claim volumes paid through each contract.

2.2 PHI product simplification

<table>
<tr><th colspan="2">SUMMARY: PHI Product Simplification</th></tr>
<tr><th>Proposed reform initiative for implementation</th><th>Mechanism for implementation</th></tr>
<tr><td>Initiative 1: simplifying PHI product structure</td><td rowspan="4">Changes to the PHI Act and associated PHI Rules.</td></tr>
<tr><td>Initiative 2: standardising the age threshold and associated eligibility for dependants</td></tr>
<tr><td>Initiative 3: excess and co-payment standardisation</td></tr>
<tr><td>Initiative 4: ensuring consistency across premium structures.</td></tr>
<tr><th colspan="2">Questions for stakeholder consideration</th></tr>
<tr><td colspan="2">a) Do you agree or disagree with (or are you unsure about) each of the reform initiatives below:
i. Initiative 1: simplifying PHI product structure
ii. Initiative 2: standardising the age threshold and associated eligibility for dependants
iii. Initiative 3: excess and co-payment standardisation, and
iv. Initiative 4: ensuring consistency across premium structures.
b) Do you have any specific comments on each of the reform initiatives raised?
c) Are there any other options or solutions that the department should consider?</td></tr>
<tr><td colspan="2">NOTE: this is the initial tranche of consultation on product simplification which will be used to inform independent technical expertise prior to further consultation.</td></tr>
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2.2.1 Introduction

Consumer groups have told us about the challenges with the affordability of PHI as premiums increase. Meanwhile, insurers report challenges with the sustainability of products as benefits paid and premiums increase.

Premiums are set according to factors such as:

- benefits paid, historical and forecast, arising from the cost of services and utilisation of services
- administrative expenses
- profit margin, and
- competition.

In circumstances where there are a substantial number of products and coverage combinations, there will generally be a smaller number of people covered by a product. This means fewer people who do not claim benefits to balance against the people who claim benefits, for a particular product which will likely increase:

- the uncertainty of the forecast benefits
- administrative expense burden, and
- the quantum of the profit margin.

A simpler product structure offers the opportunity for a broader pool of insured people for a particular product, and downward impact on premium increases for consumers.

The CEO Forum highlighted that the product offerings from insurers permitted under PHI product tiers can be unnecessarily complex and out-of-date and no longer meet the needs of consumers and insurers.

Australian Government PHI incentives also influence insurer product design and consumer choice. The structure of the PHI rebate, Lifetime Health Cover (LHC) and Medicare Levy Surcharge (MLS) can affect the affordability and complexity of products. Recognising the interaction between these incentives and product design is important when considering any future reforms.

2.2.2 Previous changes made to improve PHI product simplification

In 2019, a product tier classification system for hospital treatment products, based on clinical categories, was introduced. The system offers coverage at different levels, with Gold, Silver, Bronze and Basic product tiers. The intention of product tiers and clinical categories was to make PHI easier to understand and help people choose the cover that best suits their needs. What is, and is not, covered for each product tier is based on minimum standard clinical categories. This has ensured consistency in the definitions of covered treatment, allowing consumers to more easily compare products and transfer between insurers. However, the addition of ‘plus products’ has introduced a new level of complexity to the product tiers. This has resulted in a system that can be difficult to navigate, limiting the value of PHI and reducing accessibility.

In 2024, the Clinical Categories Review noted the clinical categories assisted consumers to better understand the services covered in their policy and to compare products more easily across the market. This review also identified where the categories could be further simplified and improved. The department will consider recommendations and stakeholder feedback as a part of the broader reform context.

In 2021, reforms extended the age of dependants. This allowed young adults to remain on a family policy until the age of 31 and removed age restrictions for dependants who have a disability. This change aimed to improve affordability for young adults and families, and to provide continuity of cover. However, the way it was implemented has resulted in unnecessary complexity in the product structure and insufficient coverage provided to dependant people with a disability who are aged over 31.

In 2025, the department consulted on proposals to address PHI product phoenixing. Phoenixing involves an insurer closing a product and opening a similar new product at a higher price point, avoiding Ministerial review of price changes. Legislation closing the loophole that allows phoenixing and similar behaviour is progressing through the Parliament.[xiv] Timing for passage of this legislation to protect consumers from unregulated PHI premiums is a matter for Parliament.

The inclusion of maternity in the Gold classification tier has resulted in premium pressure for these products. Reduced uptake of Gold products and the increase in Silver and Bronze products, means there is a growing cohort of policyholders who are not eligible for private health rebates for all treatments. This results in bill shock and a reliance on the public health system, further reducing the perceived value of private health insurance.

2.2.3 Proposed reform initiatives to PHI product simplification, sustainability, and affordability

There are still significant steps that could be taken to ease the burden on both consumers and insurers when it comes to product simplification, sustainability, and affordability. Reform initiatives proposed for implementation include, but are not limited to:

- Initiative 1: simplifying product structure
- Initiative 2: standardising the age threshold and associated eligibility for dependants
- Initiative 3: excess and co-payment standardisation, and
- Initiative 4: ensuring consistency across premium structures.

Each of the possible proposed reform initiatives is outlined below, noting that some initiatives may conflict with others. Stakeholders should note that this is the initial tranche of consultation on product simplification which will be used to inform independent technical expertise prior to further consultation.

Initiative 1: Simplifying PHI product structure

There are an estimated 5,000 different PHI products on the Australian market for consumers to select from. This makes the process of choosing a health insurance product unnecessarily complex and confusing for consumers.

Additionally, products tiers that provide a minimum coverage amount (e.g. Basic products) often have limited coverage. These products often offer and/or have higher out-of-pocket costs if they require hospital care. This not only causes consumer confusion about and lack of confidence in the value of PHI. It also undermines the objective of reducing pressure on public hospitals.

Further, some hospital treatment products appear to provide benefits for excluded general treatment services (e.g. ambulance, emergency department and hospital substitute). This can create further confusion for consumers about the scope of services they are covered for and whether they are covered by a hospital-only product or combined product.

A simplified product structure may provide consumers with more confidence about purchasing and retaining private health insurance. A larger and broader pool of insured people for a smaller range of unique products can facilitate a downward impact on premium increases for consumers.

PHI Product Simplification Reform Initiative 1: Simplifying product structure	
Possible solution/s	**Impact/s**
▪ Remove the flexibility of insurers to offer the Basic product tier or products of limited value to consumers. ▪ Remove the option for insurers to offer 'plus products'. ▪ Remove or consolidate some of the product tiers. ▪ Ensure insurers clarify communication about whether a consumer has a hospital-only product or a combined product. ▪ Clarify policy settings about whether ambulance, emergency department, and hospital substitute benefits should be considered hospital treatment or general treatment coverage.	▪ Reduce the number of products available for purchase. ▪ Simplify consumer consideration of products. ▪ Reduce insurer flexibility in designing products. ▪ Potential negative effect on PHI participation if there is no affordable product for people to take out to avoid LHC and MLS. This may impact affordability of future purchasing of PHI. ▪ Improves consistency and transparency to consumers on what is covered under hospital treatment products.

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

The changes to the age of dependants in 2021 resulted in foreseen complexities which have caused difficulties in access and portability for people with dependants. This includes there being significant variation in the way insurers apply the age threshold (e.g. 24 to 31 years) for dependants and associated eligibility criteria (e.g. students, non-students, income and relationship). Further, consumers have been left with limited choice when purchasing a product which provides coverage for a dependant person with a disability who is aged over 31.

PHI Product Simplification Reform Initiative 2: Standardise the age threshold and associated eligibility for dependants	
Possible solution/s	**Impact/s**
▪ Remove the flexibility of insurers to determine which age between 24 to 31 will be the maximum age. ▪ Require all insurers to offer products covering the insured group for a dependant person with a disability who is aged over 31.	▪ Will remove the flexibility of insurers to apply different eligibility criteria to dependants. ▪ Will reduce the number of insured groups for products. ▪ Will increase the ability of consumers to compare products across insurers and transfer between insurers. ▪ Will increase access to products for people with disability.

Initiative 3: Excess and co-payment standardisation

Some products require the payment of an excess and co-payment which can confuse consumers and conflict with the intention of the MLS exempt products to have a maximum annual excess.

An excess (also known as a 'front-end deductible') is an amount that the consumer is required to pay towards the cost of their hospital treatment. An excess may be in exchange for lower premium costs. An excess may be payable every time a consumer receives hospital treatment, or only the first time.

For a hospital policy, a co-payment is a set amount that a consumer is required to pay for each day they are in hospital, in exchange for lower premiums. Most co-payments have a limit on the number of days they apply per stay. It can also be called an overnight excess, daily excess or patient moiety.

The application of excesses and co-payments is not consistent across insurers or products. This makes it difficult for consumers to understand the total cost of their product, which can vary depending on the number of times they claim.

Further, there is inconsistency and perceived unfairness in the application of waiving excesses, with some consumers provided with exemptions (e.g. dependants) and others not.

PHI Product Simplification Reform Initiative 3: Excess and co-payment standardisation	
Possible solution/s	**Impact/s**
▪ Standardise the application of excesses and co-payments, e.g. the maximum annual excess also includes co-payments when calculated. ▪ Require all insurers to waive excesses in a manner consistent with community rating.	▪ Will reduce consumer confusion about potential out-of-pocket costs. ▪ Will ensure compliance with the community rating principles.

Initiative 4: Ensuring consistency across PHI premium structures and waiting periods

When selecting and maintaining a PHI product, the inconsistency and perceived unfairness of the following characteristics of policies further confuses and frustrates consumers:

- identical products being charged at different premiums (e.g. closed products may continue at one premium while new products with the same benefits are offered at a higher premium)
- inconsistent application of waiving waiting periods by different insurers
- inconsistent application of discounting available to consumers, the impact upon premiums for other consumers, and the additional complexity for products arising from the eligibility criteria, and
- single parents may pay substantially more than singles without children.

PHI Product Simplification Reform Initiative 4: Ensuring consistency across premium structures and waiting periods	
Possible solution/s	**Impact/s**
▪ Review and standardise the rules governing closed and new products, including how closed products transition into new products. ▪ Review and standardise the rules governing applying or waiving waiting periods. ▪ Simplify the eligibility criteria for discounting. ▪ Standardise the amount of discount, including how a discount is offered or removing the flexibility for insurers to offer discounts. ▪ Consider reforms to pricing rules for single parent policies to align with community rating principles.	▪ Will improve transparency around pricing of identical or comparable products. ▪ Will increase the ability of consumers to compare products across insurers and transfer between insurers. ▪ Will reduce insurer flexibility in marketing products. ▪ Will increase equity and accessibility among consumers such as single parents.

2.3 Risk Equalisation

<table>
<tr><th colspan="2">SUMMARY: Risk Equalisation</th></tr>
<tr><th>Proposed reform initiative for implementation</th><th>Mechanism for implementation</th></tr>
<tr><td>Initiative 1: Introduction of New Risk Equalisation pool arrangements for maternity and mental health care.</td><td rowspan="2">Changes to Private Health Insurance (Risk Equalisation Policy) Rules 2025.</td></tr>
<tr><td>Initiative 2: Recalibration of existing mechanisms for younger age cohorts covered by Gold tier.</td></tr>
<tr><th colspan="2">Questions for stakeholder consideration</th></tr>
<tr><td colspan="2">a) Do you agree or disagree with the proposed reform principles for Risk Equalisation? Discuss any concerns with specific principles.
b) Do you agree or disagree with the reform initiatives raised:
i. create new specific risk pools for maternity and mental health
ii. exclude maternity and mental health claims from existing aged-based pool (ABP) and high-cost claims pool (HCCP)
iii. extend existing ABP claim eligibility criteria to younger Gold tier members, and
iv. redefine Single Equivalent Units (SEUs) to exclude younger Gold tier members, possible exceptions to corporate products.
c) Do you have any specific comments on the proposed reform initiatives? This may include required lead times for implementation, required information, transparency and ease of calculation etc.
d) Are there any other options or solutions that the department should consider?
e) Do you have any comments on the goal of risk equalization and the interactions of this proposal with a future potential hybrid Risk Equalisation system including both risk sharing (retrospective) and risk adjustment (prospective) elements?</td></tr>
<tr><td colspan="2">NOTE: this is the initial tranche of consultation on Risk Equalisation which will be used to inform independent technical expertise prior to further consultation.</td></tr>
</table>

2.3.1 Introduction

The principle of community rating prevents insurers from discriminating between people choosing PHI cover based on their health or for any other reason referenced in the PHI Act. Risk Equalisation partially compensates insurers who have a riskier demographic profile by redistributing money from those insurers paying less than average benefits to those paying higher than average benefits. This supports the community rating principle. The Australian Prudential Regulatory Authority (APRA) administers the Risk Equalisation system, with the redistribution mechanism achieved via:

- aged-based pool (ABP): shares a proportion of actual claim costs for participants aged 55 years and older which increases with age (ranging from 15% to 82% of costs shared for the oldest members), and

- high-cost claims pool (HCCP): shares 82% of costs if someone claims more than $50,000 per year (excluding ABP amounts), which is not common[xv].

2.3.2 Proposed reform initiatives to Risk Equalisation

The department commissioned a study into PHI Risk Equalisation in 2021 and consulted on the findings in 2022.[xvi] Key findings identified that:

- limitations in the system have consequences for efficiency and risk selection, and
- issues would be better addressed using a hybrid Risk Equalisation system comprising of both risk sharing (retrospective) and risk adjustment (prospective) elements.

The CEO Forum established a working group to develop Risk Equalisation reform options, specifically to better support the affordability and availability of PHI products that cover maternity and mental health.

Stakeholders should note that this is the initial tranche of consultation on Risk Equalisation which will be used to inform independent technical expertise prior to further consultation.

Proposed reform principles

Prior to exploring options to Risk Equalisation reform, the CEO Forum considered the following principles to underpin reforms addressing maternity and mental health cover:

- maintain the overall size of the Risk Equalisation pool per Single Equivalent Unit (SEU)
- support community rating, particularly for products covering maternity and mental health
- reduce disincentives for insurers to offer comprehensive products
- improve affordability and sustainability of maternity and mental health cover
- minimise unintended consequences, including cross-tier distortions, and
- ensure reforms are implementable in the short to medium term, while aligning with longer term reform.

Increasing share of maternity and mental health claim costs between insurers

The CEO Forum working group identified the proposed reform initiatives below, recognising that neither is ready for implementation without consultation on the associated requirements and impacts. The reform initiatives are not intended to be mutually exclusive. The department is seeking feedback on whether one, both or selected subcomponents should be implemented (either as proposed or with suggested changes) and any additional or alternative options.

Making changes to the Risk Equalisation system is complex and resource-intensive in nature. If multiple reform initiatives are implemented, these will be done simultaneously.

Risk Equalisation Reform Initiatives		
Reform Initiative	**Requirements**	**Impact/s**
Initiative 1: New Risk Equalisation pool arrangements: a. maternity (Pregnancy and birth clinical category), and b. mental health (Hospital psychiatric services clinical category) A percentage (e.g. 25%, 50% or 75%) of eligible benefits to be included in these pools. Maternity and mental health claims should be excluded from existing ABP and HCCP to avoid potential double-claiming.	▪ Insurer data of proposed eligible benefits, extending to maternity and mental health clinical category, and by age.	▪ Creation of new Risk Equalisation pools may be more complex for insurers to implement than other options.
Initiative 2: Recalibration of existing mechanisms: a. extending ABP coverage to younger age cohorts covered by Gold tier products, from 0% to 15%* of eligible benefits, and b. redefining SEUs to exclude younger (for example, 0 to 54 years) Gold tier members, considering exceptions for corporate customers. * 15% is the lowest setting for the ABP applied to eligible benefits of persons aged 55-59.	▪ Hospital claims data by hospital product tier by age. ▪ Insured persons by hospital tier and age, split by corporate/non-corporate products.	▪ SEU recalibration using data that is not publicly available may be less transparent than the current process.
All initiatives	▪ Assessment of premium impacts across cohorts will also require premium by tier and age. ▪ Modelling of different settings and recalibrating the ABP to maintain overall pool size per SEU neutrality.	▪ Impacts will likely vary materially by insurer, product tier and age cohort. ▪ Involve a lead time of 1-2 years to allow for rule and system changes for the department, insurers and APRA. ▪ A transition period will give insurers an opportunity to adjust their business strategies to prepare for the changes.

Appendix A – Prioritisation and indicative schedule for proposed reform initiatives (Tranche 1)

	2026					2027					2027-28
	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	
Overarching activities		Premium Round 2027 – application period				Premium Round 2027 outcome		Premium Round 2027 – effective (1 Apr)	Budget 2027-28		
Prioritising contemporary models of care											
1.1 Maternity Care		**Initiative 1:** Sector education (department and sector collaboration) **Initiative 2:** Increased access and choice to different models of maternity care (sector led)									**Initiative 3:** Shorter PHI waiting periods for pregnancy and birth **Initiative 4:** Review of MBS items for paediatricians
1.2 Mental health care		**Initiative 1:** Overseas-trained psychiatrists (commencement start of 2027 Premium Round i.e. 1 April 2027)									
		Initiative 3: Reconvene PHMA (sector led)	**Initiative 2:** Increased access to contemporary models of mental health care								
1.3 Hospital in the Home (HITH)		Initial introduction of 3 HITH treatment services (commencement start of 2027 Premium Round i.e. 1 April 2027)									
1.4 Type C certification requirements: exemption criteria		Implement 2 exemption criteria (commencement start of 2027 Premium Round i.e. 1 April 2027)									
Delivering better value to consumers (Part 1)											
2.1 improving access to regional private hospitals		Increase the second-tier benefits to 100% for established regional private hospitals (commencement start of 2027 Premium Round i.e. 1 April 2027)									
2.2 PHI product simplification											**Initiative 1:** PHI Product simplification **Initiative 2:** Age threshold & dependents **Initiative 3:** Excess & co-payment standardisation **Initiative 4:** Consistent premium structures
2.3 Updating Risk Equalisation											**Initiative 1:** new arrangements for maternity and mental health care **Initiative 2:** Recalibration of existing mechanisms for younger age cohorts covered by Gold tier.

High priority | Moderate priority | Low priority

Appendix B – Contemporary definitions of hospital treatment

What is a 'private hospital'?

State and territory authorities regulate and monitor private hospitals, according to the permissions and approvals required under the laws unique to each jurisdiction. This includes determining:

- the health services to require licensing/registration to operate a private hospital (including those referred to in some jurisdictions as a 'day procedure centre')
- which national safety and quality accreditation standards each service must be assessed and report against as a condition of state licensing/registration, and
- enforcement actions for a service that does not comply with standards, including possible cancellation of operating licence/registration.

All jurisdictions in Australia, including the Commonwealth, require private hospitals to maintain accreditation to the NSQHS Standards. Accreditation is a quality assurance mechanism which ensures health services have the relevant systems in place to meet expected standards of safety and quality. The ACSQHC coordinates the development and maintenance of the NSQHS Standards under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. All jurisdictions and public and private health sector stakeholders participate in the process.

The ACSQHC:

- develops and maintains a range of national standards, including the NSQHS
- approves accrediting agencies to conduct assessments of health services against standards under the AHSSQA Scheme
- receives and reports on assessment outcomes data and significant risk notifications
- liaises with accrediting agencies and regulators, and
- reports to health ministers.

The NSQHS Standards are undergoing update to the third edition. The emphasis may change for the 8 standards components that includes clinical governance, partnering with consumers and recognising and responding to acute deterioration. Key aim is to protect the public from harm and improve the quality of health service provision.

Hospital declaration is the process where the holder of a state or territory licence/registration and accreditation to NSQHS Standards can choose to apply for Commonwealth recognition of their facility as a hospital.

What is a 'declared' private hospital?

The Minister for Health makes a written statement to declare that a facility is a hospital, meeting the legal definition of hospital under sub-section 121-5(5) of the PHI Act:

> *'A **hospital** is a facility for which a declaration…is in force.'*

The process of declaration includes checks confirming the facility meets:

- the quality assurance requirements for hospital treatment covered by a 'complying health insurance policy' (CHIP) (PHI Act ss63-10(f), s81-1), and
- the standards set out in the *Private Health Insurance (Accreditation) Rules 2011*.

Details of current declared hospitals are compiled in the List of Declared Hospitals (the Declarations List) including each hospital's unique Hospital Provider Number.

Hospitals must report de-identified separations data to insurers and the department, as a condition of declaration. Reasonable conditions on declaration ensure patients receive quality, safety and value for money hospital treatment appropriate to the cost of the resulting benefit payments.

Second-tier hospital benefits

Declared private hospitals can choose to apply for eligibility to access second-tier benefits and must include evidence of procedures in place for Informed Financial Consent.

Generally, insurers must pay second-tier default benefits for hospital treatment if they do not have a negotiated agreement with a hospital and the hospital is second-tier benefits eligible. This can be particularly important to regional hospitals as second-tier benefits are generally higher than minimum benefits (see: Section 2.1 Improving access to regional private hospitals).

What is 'hospital treatment'?

Under the PHI Act (s121-5):

> *'**Hospital treatment** is treatment (including the provision of goods and services) that is intended to manage a disease, injury or condition; and is by a person who is authorised by a ***hospital** to provide the treatment; or under the management or control of such a person; and is either provided at a hospital; or is provided, or arranged, with the direct involvement of a hospital.'*

Because a ***hospital*** is defined as a facility with a declaration in force, only a declared private hospital can provide or authorise services that meet the definition of ***hospital treatment***, eligible for benefits.

An insurance policy that covers hospital treatment must provide certain minimum benefits set out in the PHI Act (Division 72) including:

- PHI benefits of at least 25% of the Medicare Benefits Schedule (MBS) Item schedule fee, any applicable medical device or human tissue product, or hospital accommodation benefit.

Additional inclusions and exclusions are in the PHI Act s121-5 and the:

- *Private Health Insurance (Health Insurance Business) Rules 2018* (Business Rules)
- *Private Health Insurance (Complying Product) Rules 2015* (Complying Product Rules), and
- *Private Health Insurance (Benefit Requirements) Rules 2011* (Benefit Requirements Rules).

Patient qualifiers for hospital benefits may also apply (*Health Insurance Act 1973* s3 (HI Act)):

- patient does not include a newly-born child whose mother also occupies a bed in the hospital, with some exceptions, and
- "nursing-home type patient" refers to a patient in hospital who has been provided with accommodation and nursing care for a continuous period exceeding 35 days.

Public hospitals are also declared hospitals.

Eligibility for payment of a benefit of 75% of the MBS Item schedule fee applies to items delivered as hospital treatment. The HI Act also references the PHI Act definition of hospital treatment. A change to one can influence the outcome/s for both.

At present, the Declarations List is the sole, verified national list of private hospitals. The definition of hospital and the Declarations List are integrated in regulatory systems including:

- MBS benefits for hospital treatment
- classifications for procedure type hospital accommodation benefits
- data reporting specifications agreed nationally for comparable data over time
- approvals for PBS hospital suppliers
- reporting obligations for adverse medical device events, and
- insurers' checks to meet CHIP quality assurance requirements.

Changes to hospital licencing and registration pathways may impact a provider's ability to continue to meet the requirements for declaration under the PHI Act as a hospital, and subsequently patient access to benefits for the provision of hospital treatment.

Abbreviations and Acronyms

ABP	Aged-based pool
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHSSQA	Australian Health Service Safety and Quality Accreditation
ANZCA	Australian and New Zealand College of Anaesthetists
APRA	Australian Prudential Regulation Authority
the Benefit Requirements Rules	*Private Health Insurance (Benefit Requirements) Rules 2011*
the Business Rules	*Private Health Insurance (Health Insurance Business) Rules (2018)*
the CEO Forum	Private Health Chief Executive Officer (CEO) Forum
CHIP	Complying Health Insurance Policy
the Complying Product Rules	*Private Health Insurance (Complying Product) Rules 2015*
the department	The Department of Health, Disability and Ageing
DVA	The Department of Veterans' Affairs
DWS	District/s of Workforce Shortage
FOI	Freedom of Information
the Government	The Australian Government
HCCP	High-cost claims pool
the Health Check	Private Hospital Sector Financial Health Check
HI Act	*Health Insurance Act 1973*
HITH	Hospital in the Home
Hospitals	Private hospitals
Insurer/s	Private health insurer/s
IV	Intravenous
LHC	Lifetime Health Cover
the LHC Rules	*Private Health Insurance (Lifetime Health Cover) Rules 2017*
MBS	Medicare Benefit Schedule

MLS	Medicare Levy Surcharge
MSAC	Medical Services Advisory Committee
NSQHS	National Safety and Quality Health Service
PBS	Pharmaceutical Benefits Scheme
PHI	Private Health Insurance
the PHI Act	*Private Health Insurance Act 2007*
PMHA	Private Mental Health Alliance
SEU	Single Equivalent Unit
the Sector Guidelines	Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care
SIMGs	Specialist international medical graduates

Glossary

Clinical categories	Types of hospital treatments described in a standard way. If a policy covers a certain clinical category, then it must cover everything described as part of the category.
Community rating principle	Prevents private health insurers from discriminating between people based on their health or for any other reason referenced in the PHI Act.
Declared hospital	A facility for which a declaration by the Minister for Health and Ageing is in force under section 121-5(6) of the PHI Act, that it is a hospital.
Hospital in the Home	Admitted hospital care, utilising highly skilled staff, hospital technologies, equipment, medication, and safety and quality standards, to deliver hospital-level care within a person's place of residence or preferred (non-hospital) treatment location.
Medicare moratorium	Overseas-trained doctors who are non-GP specialists are required to work for at least 10 years in a DWS before they can provide services eligible for MBS rebates.
Phoenixing	When an insurer closes an existing product and opens a similar one at a higher price point, circumventing the Premium Round process.
Premium Round	An annual process where private health insurers apply for approval to change the premiums they charge policyholders.
Product tiers	The four tiers that private health insurers are required to use to classify their private hospital cover: Gold, Silver, Bronze or Basic.
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.
Transfers	When a person *transfers* to a policy (the *new policy*) from another policy (the *old policy*) as specified in Section 75-10 of the PHI Act.
Type A procedures	Procedures requiring hospital treatment that normally include an overnight stay
Type B procedures	Procedures that normally require same-day hospital treatment
Type C procedures	Procedures that do not normally require hospital treatment.

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[i] Services Australia processes applications for Medicare provider numbers. Further information is available at: https://www.servicesaustralia.gov.au/hw019
[ii] Australian Bureau of Statistics (2024), Births, Australia.
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[vii] Cancer Council. Chemotherapy | Cancer Council Australia
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[ix] Australian Institute of Health and Welfare (AIHW) (2025) Multimorbidity in Australia, How common is multimorbidity? - Australian Institute of Health and Welfare, Figure 4 Proportion of people living with multimorbidity by age group and sex, 2022
[x] Hospital Casemix Protocol 1, as at May 2026; In 2024/25, approximately one third of all separations, where the Type C procedure was the 'highest' claimed MBS item (i.e. there was no co-claimed Type A or B procedure), were delivered to patients aged 75 years and older.
[xi] TN.1.19: Item 14245 applies only to a service provided by a medical practitioner who is registered by Services Australia's CEO to participate in the arrangements made, under paragraph 100 (1) (b) of the National Health Act 1953, for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent. These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.'
[xii] Department of Health, Disability and Aged Care (2026) List of Declared Hospitals as at 30 April 2026.
[xiii] Hospital Casemix Protocol 1, as at June 2026, Departmental analysis on private hospital separations and charges by Modified Monash Model.
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