

SUBMISSION

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AMA response to private health sector reform consultation paper 1

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Introduction

The AMA welcomes the opportunity to respond to [Private health reforms consultation paper 1 — 2 July 2026.pdf](#).

Private health plays a critical role in our health system, with private hospitals covering more than 40 per cent of all hospital admissions, conducting more than two-thirds of planned surgeries and delivering around 25 per cent of babies who are born in hospital in Australia.

Private healthcare is a vital part of our health system, but it was never intended to be the only option. It exists to provide choice, not to compensate for a public system that cannot cope. Decades of underfunding of the public hospital system, the almost complete absence of public specialist outpatient clinics in some states and increasing wait times for surgery in the public system mean that many patients have no option but to turn to private specialist treatment.

The difficulty is that now, when many patients turn to the private health system for timely care, there is no private hospital option within reasonable driving distance of their residence.

As illustrated by data collected by the department's [Private hospital financial viability check](#) conducted in 2024, private hospitals have suffered rising costs relative to revenue in recent years, and many have closed, or been sold off. Shocks such as the COVID-19 pandemic and associated inflationary and workforce pressures have played a big part. Obstetrics and mental health are under particular pressure, and many private hospitals have closed their psychiatry and maternity units.

The AMA and its members are playing an active part in resolving these problems. However, we are concerned that little will change unless the government and private health insurers play their part in increasing the MBS and private health insurance rebate funding required to keep the private health system operational. We are also concerned that a failure to do so will undermine the value proposition of private health insurance to the extent that the number of Australians insured begins to decline. We are already seeing hundreds of thousands of Australians downgrading their private health cover for this reason, which can only further increase pressure on an underfunded public health system.

1. Prioritising contemporary models of care

1.1 Mental healthcare

The AMA suggests that the mental healthcare section of the consultation paper does not deal with key proposals previously put forward to the Department of Health, Disability and Ageing by the profession. This includes serious and costed proposals from the AMA on increasing MBS/private health insurer remuneration for psychiatrists for inpatient care (Attachment 1).

We believe this proposal enjoys significant support and, if implemented, would improve patient access to in-patient psychiatrist care, without adverse consequences for patients and other parts of the mental health system.

1.1.3 Proposed initiatives to support private mental health

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

The AMA recognises the difficulties that private hospitals have experienced in recruiting and retaining psychiatrists for hospital-based work. We also recognise that under current arrangements, access to MBS benefits is required for psychiatrists to admit patients to private hospitals and for insurers to pay rebates.

The AMA is also aware that under the existing Medicare moratorium, overseas doctors are prevented from accessing Medicare rebates until they have been registered in Australia for more than 10 years, unless they have been granted an exemption for working in a DWS (district of workforce shortage) area.

For many years, the AMA has argued that while these restrictions have worked to distribute international medical graduates (IMG) to areas of workforce need, they do not meaningfully support retention and instead encourage a transient workforce.¹ They are also unacceptably coercive to IMGs. The AMA has advocated for the gradual and careful phasing out of Section 19AB and the implementation of clear and innovative workforce incentives to replace it.

Although psychiatry was added to the expedited Specialist IMG pathway in December 2024, a relatively modest number of eligible psychiatrists have applied for this pathway since its inception. In the longer term, governments must work together to fund an adequate number of psychiatry training places given the department's own modelling in 2024 suggested a shortfall of 762.7 FTE psychiatrists.

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

It may make some difference, in that it may increase the supply of overseas-trained psychiatrists available to admit patients to private hospitals for psychiatric treatment.

However, the relevant MBS telehealth by video item (Item 92483) for new patients entering hospitals requires the psychiatrist to see the patient face-to-face well within 48 hours of a video admission. This is an important safety valve, both for the patient, and the psychiatrist. However, it will clearly not be possible under this proposal, where the psychiatrist is an overseas-trained doctor based in a DWS practice location, who is granted an exemption from the moratorium and is seeing a patient being admitted into a non-DWS based private hospital. A key question is who will indemnify the overseas-trained doctor if something goes wrong?

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

Potentially. However, the AMA's preferred solution is for a significant uplift to private inpatient MBS rebates, as detailed at Attachment 1. Our solution would immediately increase the supply of experienced psychiatrists willing to undertake private hospital inpatient work.

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

In the absence of effective incentives to work in regional and rural areas, this proposal risks significant unintended consequences. 19AB already directs overseas-qualified medical graduates towards working in areas of need, and if 19AB is amended for the psychiatrist workforce, then depending on the 'guardrail' options chosen, the proposal risks denuding the most under-served regional and rural communities of a psychiatry workforce.

(d) Which of the proposed Operational guardrail options are suitable? Please provide reasons if a guardrail option is not supported.

Guardrail option 1: Restrict the exemption to admitted patient MBS services

The key difficulty with the first proposed guardrail is that it would mean that eligible psychiatrists would need to assess, treat, and provide post-admission outpatient care to patients being admitted into metropolitan area private mental health units on the basis of telehealth only.

Guardrail option 2: Limit the exemption to new-to-Australia psychiatrists

This may be a preferable option in that it would be less likely to impact on the supply of psychiatrists in DWS areas.

Guardrail option 3: Cap exemptions so that individual private hospitals could access a maximum of 1-2 psychiatrists

This approach may minimise the risks of overseas-trained psychiatrists avoiding DWS areas or leaving public hospitals in favour of roles in metropolitan hospitals.

Guardrail option 4: Timeshare commitment to public practice

The AMA has some concerns about this proposal, even though it would reduce the strain on public hospitals in DWS areas, particularly if the department chose to apply it only to new immigrant psychiatrists with no previous time working in Australia. That is because public hospital patients are often those with the most serious mental health problems. Another key question is how and by whom this requirement would be policed.

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

See the above.

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.

The AMA supports to Royal Australian and New Zealand College of Psychiatrists (RANZCP) view that MBS items for case conferences should be modified to allow multiple case conferencing services to be funded during a patient's admission to hospital for mental health treatment.

The AMA would also welcome amendments to MBS case conferencing items to remove barriers to their effective use, such as making it possible for the conference to include just the psychiatrist and the patient's GP. By boosting collaborative care, this may aid in avoiding hospitalisation and re-admission rates.

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

Please see Attachment 1.

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

(h) If the PMHA were to be convened, what focus(es) should it have? Please provide details.

The AMA is already aware that the department wants a reconvened PMHA to update the existing [Guidelines for determining benefits for private health insurance purposes for private mental health care](#).

However, if the department is determined to push through changes to the existing s19AB moratorium, the AMA believes that the PMHA should also be closely involved in:

- supporting new overseas trained psychiatrists, some of whom may experience culture-shocks in their first years practicing in Australia
- monitoring and reporting to government on the impact and outcomes of s19AB changes.

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

If the PMHA is reconvened, all previous members should be included.

Naturally, the RANZCP should be included. In fact, the AMA would support as much psychiatry representation as possible on a reconvened PMHA, given that it is psychiatrists who are the 'gatekeepers' for serious mental illness.

Much of the talk coming from insurers about 'modern' mental healthcare relates to community psychosocial programs that will supposedly reduce the burden on private psychiatric units (and presumably, reduce their costs). This may help some people with mild depression and anxiety, and prevent some mild mental health problems from escalating, but it will not resolve the urgent need for private inpatient care for seriously mentally ill patients.

It should always be psychiatrists who decide which patients need in-patient admission, and those patients need to be assessed by psychiatry specialists who have the skills to provide an accurate assessment in each case.

Initiative 4: Review of equalisation arrangements

See the AMA response under item 2.3 Risk equalisation

1.2 Maternity care

Initiative 1: Sector education

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

The AMA does not agree that 'sector education' about 'innovative models of care' is necessary.

AMA representatives attended all meetings of the CEO Forum maternity working group, where it was clear that lack of knowledge of different models of care was not a key issue. Given this, the AMA is surprised by the statement 'factors...limiting the diversity of [maternity] care offerings include[ing] an apparent lack of awareness across the sector concerning existing innovative models of care' [including]

- shared care between pools of obstetricians and midwives
- shared care between an obstetrician and small group of midwives, and
- collaborative care with an endorsed midwife and obstetrician partnership (p.9).

The AMA's position statement on [Key_principles_for_private_maternity_funding.pdf \(134.98 KB\)](#) makes it very clear that we believe patient choice is the foundation of the private health system. We believe within accepted safety parameters, any patient whose private health insurance covers maternity care must be supported to choose the clinician they want to lead their maternity care and the setting/facility in which they wish to give birth.

To ensure accurate, up-to-date information on the quality and safety of different models of maternity care is available to both policymakers and the public, the AMA also believes the Australian Government should urgently fund standardised national data collection and independent analysis of maternity care model outcomes through a public national maternity clinical quality registry that includes a consumer search function.

While we are aware some pregnant women may prefer models of care that are not available in their closest private hospital, 'awareness' of the possibility of other models of care under existing regulations on the part of people working in the private health system is the least of the problems facing the private maternity sector.

For example, Cairns' only remaining private maternity service closed in 2023, and the city's public hospital would not allow local obstetricians to deliver babies there. This situation — which has nothing to do with lack of 'awareness' of other models of care among those working in the private health system — is mirrored across rural Queensland, which has the highest rate of perinatal deaths outside of the Northern Territory.

In NSW, there is one private hospital outside of the metropolitan area that provides obstetric care. In the past, in some areas of NSW, public hospitals would allow visiting medical officer obstetricians to perform private deliveries in the public system, but many of those VMO's have now retired and it is increasingly difficult to recruit.

In short, the private maternity sector is in crisis:

- More than 14 private maternity units across the country have closed in the past five years.
- Australian women are giving birth at older ages, which increases their risk of complications.

- The failure of private health insurers to index rebates for hospital services to the rising cost of care, and the very high premiums paid for 'gold tier' private health insurance policies has put such policies (the only private health insurance policies that provide no wait maternity care) out of reach of many women of childbearing age and their families.
- Many such women also cannot afford the out-of-pocket costs associated with private antenatal care.
- Given all the closures of local private maternity options, it is likely that some women who have appropriate private health insurance cover for maternity are unable to use it and are choosing public or community care instead because it is closer to home.
- Private hospital operators (particularly those operating outside capital cities) also face considerable challenges attracting and retaining the required specialised workforce, including specialist nurses, mid-wives, paediatricians, and anaesthetists.
- The declining birth rate on top of rising costs for equipment, staffing and facilities have all led to higher cost structures which is making the operation of private maternity units increasingly unsustainable.
- Projections suggest if nothing changes, by 2030 there won't be enough private births to keep remaining private maternity units open.

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

Any 'sector' education needs to be directed towards state governments and public hospital administrators who do not allow local obstetricians to deliver babies in local public hospitals where the patient wishes to keep using their own obstetrician and does not have a private hospital alternative.

Initiative 2: Increased access to and choice of 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.

The AMA is concerned the only question for stakeholders (p.8) under this heading is 'Would you participate in the development of innovative models of care with others in the sector?'

The AMA would expect there to be more questions that would allow stakeholders to express their concerns about these models. As the department is already aware, having attended the AMA maternity summit in mid-2025 with many clinician representatives, these concerns include, but are not limited to:

- the safety of these models, particularly for older women with higher risk pregnancies
- the scalability of these models
- their likely impacts on continuity of care
- the length of time it would take to get them up and running safely and effectively (particularly given inadequate funding and workforce) while more maternity units close in the meantime.

It is important to acknowledge that the same solution will not work in every hospital, given limitations to workforce supply that differ from place to place. In some hospitals, it will need to be a GP or GP-obstetrician working with an obstetrician; in others it will need to be midwives working with an obstetrician.

Given the almost complete lack of private maternity units outside major metropolitan areas in many states and territories, the Australian Government must make it a priority to negotiate with the states and territories to ensure that level four and five public hospitals allow private obstetricians to work there, so that patients have a choice.

Each of these concerns and more were raised by the AMA and private hospital representatives (some of whom are already providing models of care involving midwives) during deliberations of the CEO Forum maternity working group.

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

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

The AMA strongly agrees that there must be some mechanism whereby PHI policy holders who did not expect to fall pregnant and hence do not have (or cannot afford) no-wait gold tier maternity cover can purchase, or upgrade to a product that does offer such cover should they find themselves in need of it.

The obvious reason for this is the high proportion of pregnancies in Australia that are unplanned and come as a surprise to those who find themselves pregnant without the private maternity cover they may want or need if their pregnancy is likely to be high-risk.

The AMA would support options that could include:

- a once-in-a-lifetime upgrade offer to a private health insurance product that includes no-wait maternity cover at a discounted rate, subject to safeguards to prevent 'hit and run' customers having a significant adverse effect on an insurer's bottom line
- a one-off standalone maternity cover product for those who have not had private health insurance before but have suddenly found themselves with a baby on the way. Such a product would probably require the policy holder to pay in the order of half the cost, but the AMA would see it as appropriate for the Australian Government to provide a substantial subsidy to those who take out these products given that government would otherwise be paying the entire cost through the public maternity system.

Initiative 4: Review of product tiers 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?

Yes. See the AMA response under section 2.2 PHI Product simplification.

Initiative 5: Review of risk equalisation arrangements

The AMA supports the inclusion of maternity cover in risk equalisation arrangements, even though we are aware that it will only make a small (if significant) difference to PHI premiums for relevant products.

See our further response under section 2.3 Risk equalisation.

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.

Yes.

However, the question the department has posed here is both inadequate and misleading. As the department is aware, the problem with inadequate paediatrician rebates does not just relate to one MBS item.

There are also no paediatrician-specific MBS items for private neonate hospital attendances. This, on top of inadequate rebates for the existing MBS item, inadequate or non-existent private health insurer rebates, and declining conditions for visiting medical officer paediatricians is contributing to the massive undersupply of paediatricians in the private health system.

This undersupply is exacerbated by demand-side pressures, including rising rates of autism spectrum disorder and other developmental problems. Families can wait for up to two years to get an appointment with a paediatrician for children with such needs.

Private paediatricians enjoy private obstetric care work, because they recognise the importance of continuity of care for children. Private neonate and child attendances give them the opportunity to support a baby up to later in their childhood if need be, in a way they don't get a chance to do if working in the public system.

However, many private paediatricians are increasingly reluctant to do private neonate on-call work. That reluctance does not only stem from the inadequate remuneration paediatricians receive for private on-call neonate work. They also fear being called to a private delivery that they must attend occurring during an appointment for another young child who has been waiting too long for the care they need. In addition, they fear the push-back from patients on out-of-pocket costs caused by inadequate MBS and private health insurer rebates.

With the closure of many private maternity units, the limited supply of theatre time has also become an issue of concern, because those private maternity units that remain open are more likely to schedule caesarean births. This means a paediatrician may spend a whole morning attending, say, three caesarian deliveries, when they could probably have seen between 6–8 patients in their rooms during that time. This makes it impossible for them to run a viable private practice without charging significant out-of-pocket costs to patients. Most private paediatricians are aware that many families struggle with these costs, which places them in an impossible position.

For all these reasons, paediatricians want two things:

- more VMO, rather than staff specialist positions
- time-based MBS items that acknowledge the time-sensitive work that they do, and its value to the next generation.

Rebates for other clinicians working in the private maternity system

The AMA is concerned there is no similar question in relation to MBS items for other clinicians involved in private maternity care — most particularly obstetricians (antenatal consults) and radiologists — but also general practitioners, anaesthetists, gynaecologists, paediatricians, pathologists, physicians and psychiatrists. The inadequacy, or (in some cases) complete lack of these

rebates is threatening the viability of private models of maternity care and increasing out-of-pocket costs for patients.

For example, for private antenatal consults, the Medicare rebate is in the order of 13 per cent of what the government pays for a public hospital antenatal consult, so it is no wonder that consumers have concerns about out-of-pocket costs in the private system. While the blame for this is currently being piled onto private specialists, both by the government and the media, there is clearly a structural issue here with respect to Medicare rebates that the government is refusing to address.

As stated in the AMA's position statement on [Key_principles_for_private_maternity_funding.pdf \(134.98 KB\)](#) funding models and private insurance product rebates for private obstetric care should recognise the frequent after-hours and emergency presentations involved in such care and be corrected for gender bias.

MBS and insurer rebates for private specialist maternity care should also then be increased to address the funding shortfall caused by the Medicare indexation freeze (2013–2019) and appropriately indexed each year to the increasing costs of maternity care provision.

1.3 Hospital in the home

The AMA is pleased hospital in the home (HITH) reform proposals are included in this consultation paper, given that we have been strongly supportive of reform in this space for several years, as outlined in the AMA's

- 2023 [research report into out-of-hospital models of care in the private health system](#)
- 2024 position statement on [principles for private health insurance to cover out-of-hospital care](#)
- 2025 [submission](#) to the department's January–February 2025 consultation on short- to medium-term reform options for private health.

{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.

The AMA defers to the views of private hospitals on the adequacy of this benefit amount.

(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.

The AMA defers to the views of private hospitals and medical colleges and societies on the adequacy of benefit amounts for different HITH services.

(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.

No comment.

(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.

The AMA defers to the views of private hospitals and insurers on this question.

(e) Do you have any comments regarding the interaction of MBS and professional services attendance billing and the feasibility of this reform proposal?

The AMA recognises the statement in the consultation paper that the minimum proposed 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.

The AMA also recognises that initial consultations held by the department have raised the potential interaction of these reforms with the MBS, particularly around telehealth access and professional services attendance billing during aftercare. We recognise that under this proposal, HITH treatments will be delivered to admitted hospital patients, and that existing MBS rules would prohibit payment of MBS benefits for telehealth delivered as part of HITH treatment. We also recognise that some stakeholders have expressed concern that restricting access to MBS benefits for telehealth may limit the viability of HITH services.

With respect to these issues, the AMA defers to the views of medical colleges and societies and urges the department to engage in further consultations with those bodies.

(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.

No.

(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.

The AMA requests that the department takes careful note of all the points in the AMA position statement on [principles for private health insurance to cover out-of-hospital care](#).

h) Are there any further issues that the department should consider in relation to the proposed evaluation to measure the success of this proposal?

The AMA notes the department proposes to implement the minimum hospital benefit for HITH for an initial three-year period with a formal review to be undertaken after two years to assess its effectiveness, including consideration of whether further minimum hospital benefits for additional HITH treatment services should be included. The AMA also notes the department is still working on development of the evaluation plan, and that it will consult on this further in due course.

1.4. Type C certification requirements: exemption criteria

(a) Do you support the proposal to implement two exemption criteria for Type C certification? Please provide reasons.

Yes. Obviously, many patients aged 75 years or over have chronic conditions — and often, multiple complex comorbidities — that entail higher clinical risk and the need for overnight support and clinical supervision.

Likewise, any patient who, in the view of their treating clinician, needs IV sedation, regional anaesthesia or general anaesthesia to ensure the safety of a procedure should not be classified as a Type C patient. This is a matter of clinical safety.

These changes will reduce the number of Type C certificates that doctors are required to produce, reduce administrative burdens on clinicians, hospitals and insurers, and lead to greater certainty for patients with respect to access to care and out-of-pocket costs.

(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.

Changes proposed will help, but of course, they will not eliminate the administrative burdens so often imposed on private hospitals and clinicians by private health insurers, who often query or delay the payment of valid claims.

(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.

This question is best answered by private hospitals and private health insurers.

(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.

Yes. The AMA would support the inclusion of all the other exemption criteria mentioned in the paper:

- younger patients (e.g. aged five years and under)
- referred rural and remote patients (e.g. those required to travel more than 100km to obtain the service)
- patients for whom 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)
- patients admitted after a certain time of day (e.g. 3pm).

The reason the AMA supports the switch of such services from Type C to Type B procedures is obvious: it's primarily a matter of patient safety, but also a question of reducing unnecessary administrative work for clinicians. There is absolutely no reason that treating clinicians should be forced to fill in the currently required Type C exemption paperwork for such patients, and then (as frequently happens) be forced to fight with insurers over that exemption.

(e) Do you support the proposal to reclassify MBS item 14245 from a Type C to a Type B procedure? Please provide reasons.

Yes. The AMA would argue that the proposal the department has received to reclassify MBS item 14245 from a Type C to a Type B procedure is appropriate for all the reasons listed in the consultation paper (p.30).

2. Delivering better value for consumers

2.1 Improving access to regional private hospitals

Initiative: Increase the second-tier benefits from 85% to 100% for established regional private hospitals

(a) Should the proposed changes be implemented by government on a temporary or permanent basis? When should a post-implementation review be undertaken?

The AMA supports the proposed changes. Given the significant financial pressure faced by those regional hospitals that remain open for business, we would suggest that these changes should be implemented for at least a five-year period, if not longer.

However, we defer to the views of private hospitals on whether these changes should be temporary or permanent, and when it would be appropriate to conduct a post-implementation review.

(b) When should government commence the proposed changes, noting the current annual processes for second-tier audit, categorisation and rate calculation?

The AMA believes the changes should commence as soon as current annual processes for second-tier audit, categorisation and rate calculation will allow.

(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).

The AMA would support this change applying to all established hospitals in MM2 to MM7 areas.

(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?).

The AMA defers to the views of private hospitals on the likely adequacy of the level of the proposed increase to preserve their viability in the short-term.

With respect to the potential imposition of caps or limits on out-of-pocket costs in relation to these second-tier arrangements, the AMA notes that second-tier default benefits only apply where the hospital does not have negotiated agreement with the relevant private health insurer for the service or procedure in question. This is often because these smaller hospitals do not have the volume of services or power to negotiate an agreement that is fair and financially sustainable for the hospital.

Given these factors, the AMA would not support any rule change that allowed insurers to impose caps or limits on out-of-pocket costs in return for higher second-tier default benefits for regional hospitals.

(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?

The AMA strongly supports audits of insurer calculations, and the publication of second-tier rates. There is widespread concern that in the past, insurers have 'gamed' those calculations to reduce the amount they must pay out, often to the detriment of smaller hospitals that provide a lower volume of services.ⁱⁱ Given this, the AMA would also support a requirement that the calculation use volume-weighting to reflect actual claim volumes paid through each contract.

2.2 PHI product simplification

Initiative 1: Simplifying product structure

Initiative 2: Standardising the age threshold and associated eligibility for dependentsInitiative 3: Excess and co-payment standardisationInitiative 4: Ensuring consistency across premium structures

The AMA notes the department's statement (p.35) that this consultation is 'the initial tranche of consultation on product simplification' and that responses will 'inform independent technical expertise prior to further consultation'.

(a) Do you agree or disagree with (or are you unsure about) the reform initiatives above?

With respect to Initiative 1, the AMA is concerned that aspects of this proposal are not articulated with sufficient clarity, most particularly in the table at the top of p.36, where under 'possible solutions' (third dot point) the department lists 'remove or consolidate some of the product tiers'.

It is unclear what is being proposed here. The first two dot points in this table mention removing the capacity of insurers to offer 'basic tier products' and 'plus products', which already implies removal of the basic product tier and 'plus' products.

On p.35, the department also mentions the inclusion of maternity cover in the gold product tier has resulted in higher premiums for these products and reduced uptake, with a resulting greater uptake of silver and bronze products. However, the department makes no proposals about how to resolve this problem.

The department has already collected a significant amount of data and feedback on the question of which products should include no-wait maternity care, including through the CEO Forum, and responses to Finity proposals for amendments to PHI incentive policies. Given this, and the urgency of improving access to private maternity care, the AMA is disappointed that the department has not included concrete proposal about removal or consolidation of product tiers (beyond the removal of basic and plus products).

(b) Do you have any specific comments on each of the reform initiatives raised?

With respect to Initiative 1, the AMA would support further consideration of the removal of 'basic' tier products, given

- consumer confusion about high out-of-pocket costs associated with these products when they need hospital care, and the resultant lack of confidence in the value of PHI cited by the department
- the fact that as also noted in the consultation paper, these impacts also undermine the objective of reducing pressure on public hospitals.

The AMA would also support the inclusion of maternity care in silver tier products, given those of child-bearing age who may need maternity care are unlikely to need many of the other treatments covered by gold tier products at that stage of life, and hence often find themselves with no insurance for maternity care when they most need it.

The AMA also strongly supports proposed clarification of whether ambulance, emergency and hospital substitute benefits should be included under PHI hospital policies, or PHI general treatment policies. Ideally, these should be included in hospital, rather than general treatment policies, given that

- consumers would intuitively expect them to be included in hospital, not general treatment policies
- under Medicare Levy Surcharge provisions, consumers above a certain income level are penalised for not holding an eligible PHI hospital policy, but not for failing to take out a general treatment PHI policy.

(c) Are there any other options or solutions that the department should consider?

No comment.

2.3 Risk equalisation

In the private health sector, and in a context of community rated private health insurance, risk equalisation between private health insurers is designed to ensure that private health insurers do not game the system, cherry pick policy holders, or use predatory pricing. It redistributes premium funds between insurers based on the difference between an insurer's actual claim costs and the claims that would be expected for their policy holder demographic.

The AMA understands that this is an initial consultation on changes to current risk equalisation arrangements, following the deliberations and recommendations of the CEO Forum Risk Equalisation Working Group. We also understand that responses to this consultation will help inform independent technical advice ahead of a further planned consultation on this topic.

Accordingly, we will keep our comments brief, and in the case of some proposals, reserve our judgement until this later consultation.

(a) Do you agree or disagree with the proposed reform principles for Risk Equalisation? Discuss any concerns with specific principles

The AMA does not object to proposed reform principles.

(b) Do you agree or disagree with the reform initiatives raised:

I. create new specific risk pools for maternity and mental health

Agree. Theoretically, creating new specific risk pools for maternity and mental health should incentivise insurers to pay a bit more towards these claims, just as they do with cardiac and orthopaedic claims that are covered by the existing aged-based risk equalisation pool.

However, the AMA believes that some government investment in this pool is also likely to be required for it to have a meaningful impact.

II. exclude maternity and mental health claims from existing aged-based pool (ABP) and high-cost claims pool (HCCP)

Agree. This would be important to avoid potential double-claiming if new specific risk pools for maternity and mental health are created.

III. extend existing ABP claim eligibility criteria to younger Gold tier members

The rationale for this change is not clearly articulated in the consultation paper, so the AMA reserves its position on this change.

IV. *redefine Single Equivalent Units (SEUs) to exclude younger Gold tier members (possible exceptions to corporate products)*

The rationale for this change is not clearly articulated in the consultation paper, so the AMA reserves its position on this change.

(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

Again, the AMA believes some government investment in the new mental health and maternity risk pool is also likely to be required for it to have a meaningful impact.

(d) Are there any other options or solutions the department should consider?

The AMA has followed the work of the Risk Equalisation Group of the CEO Forum with great interest over the past year. We recognise that the conclusion of that group was that the changes proposed above would make only a small, but significant change to the affordability of private mental health and maternity care.

Supposedly, insurers cannot afford any other reforms that would make gold tier products/mental health care/maternity health care more affordable. The AMA does not accept this proposition.

Given that private health insurers made a combined profit of in excess of some \$2 billion in 2025, insurers can clearly afford to reduce premiums and waiting periods for gold tier products. What would clearly make a bigger difference is the government's adoption of a key AMA policy proposal, whereby insurers would be required to return 90 per cent of the policy premiums they are paid by consumers each year back to consumers in the form of benefits for treatment.

(e) Do you have any comments on the goal of risk equalisation and the interactions of this proposal with a future potential hybrid risk equalisation system including both risk sharing (retrospective) and risk adjustment (prospective) elements?

As the AMA made clear in its [December 2022 response](#) to a departmental consultation on risk equalisation, we totally oppose the introduction of prospective elements into the risk equalisation system without adequate safeguards for clinical independence or a fit-for-purpose regulator to ensure that the patient is central to the management of the private health system.

Prospective risk equalisation elements are likely to help insurers minimise costs but are also likely to reduce patient choice and the clinical autonomy of doctors, particularly given the lack of appropriate regulatory safeguards in place to prevent this outcome.

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ⁱ <https://www.ama.com.au/articles/international-medical-graduates-2015>

ⁱⁱ including in Ernst and Young's [study of private health insurance minimum and second-tier default benefit arrangements](#) commissioned by the department.