Protecting Australia's Dual Healthcare System

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Avant
By doctors for doctors

Protecting Australia's dual healthcare system

Australia's healthcare system rests on a fundamental principle: timely, equitable access to quality care for all. Our dual public-private model represents an architecture that has evolved with the aim of maximising capacity, patient choice, and fiscal sustainability. These attributes have seen Australia's health system recognised internationally for its outcomes and efficiency. Ensuring that our health system continues to function at its peak and is safe, just, efficient and sustainable should be a high national priority not only from the perspective of health outcomes but also to underpin our national productivity.

Private hospitals serve as an essential "safety valve" – performing two thirds of all elective procedures (1.8 million annually) – reducing demand on public hospitals and allowing them to focus on emergency care, complex cases, and medical training. This symbiotic relationship is enhanced by carefully calibrated incentives with the private health insurance (PHI) rebate at its core. It forms part of a complex yet critical architecture that makes up Australia's dual healthcare system including private and public hospitals as well as private health insurance.

Avant Mutual – Australia's largest doctor-owned organisation with over 95,000 members – engaged DeltaPearl Partners to analyse the rebate's true impact, not in isolation but as part of the broader healthcare ecosystem. Our economic analysis reveals the PHI rebate saves the government more than it costs. Despite evidence of its value the rebate has steadily eroded over the past decade, contributing to private hospital closures and unprecedented public waiting lists. Strengthening the rebate would reduce overall government healthcare costs while preserving access for all Australians. The alternative – continued erosion – risks leading to unsustainable demands on the public hospital system at greater expense.

The role of private health insurance

Private health insurance spreads risk across the population, converting potentially catastrophic costs to an individual – for example, a $30,000 surgical procedure – into manageable monthly premiums. This makes private healthcare accessible to millions of middle-income Australians, not just those in higher socioeconomic groups.

The PHI rebate represents exceptional value at $7.6 billion annually – just 2.8% of total health expenditure. Every Australian who holds PHI with hospital cover reduces public hospital demand, shortens public hospital waiting lists, and lowers government healthcare costs.

Australia's regulatory framework – community rating, risk equalisation, and guaranteed acceptance – ensures private care remains accessible and sustainable. However, this framework depends on balanced participation across all age groups. Young, healthy Australians are essential to maintain the risk pool: when they relinquish PHI the entire system becomes vulnerable.

This carefully balanced system, however, faces mounting pressure from policy decisions that threaten its fundamental economics.

The economic case for the private health insurance rebate

Our analysis reveals the PHI rebate delivers exceptional returns – every dollar invested saves more than a dollar in public hospital costs.

We modelled four scenarios over the next decade:

- **Removing the rebate entirely:** 8 million people would drop coverage, shifting $74.3 billion to public hospitals. Net cost to government: $30.7 billion.
- **Partial removal:** 3.7 million would reduce coverage, shifting $33.7 billion publicly. Net cost: $11.1 billion.
- **Freezing current rates:** 1 million would maintain or upgrade coverage. Net benefit: $1.6 billion.
- **Reinstating original rates:** 3 million would upgrade coverage. Net benefit: $4.6 billion.

The evidence shows reducing the rebate costs more than it saves, with states and territories bearing the burden. Strengthening it reduces overall government healthcare expenditure while improving access for all Australians

Table 1. Long-run annual impact of each policy scenario on net government expenditure to maintain health outcomes

	Rebate expenditure	Public hospital expenditure	Net governmental expenditure	Return per $1 spent / saved on rebate
Scenario 1 – Full rebate removal	-$4.4 billion	+$7.9 billion	+$3.5 billion	-$1.80
Scenario 2 – Partial rebate removal	-$2.3 billion	+$3.6 billion	+$1.3 billion	-$1.57
Scenario 3 – Freezing rebate rates	+$0.8 billion	-$1.0 billion	-$0.2 billion	$1.25
Scenario 4 – Reinstating rebate rates	+$2.4 billion	-$2.9 billion	-$0.5 billion	$1.21

Source: DeltaPearl Partners *The Value of the Australian Government Rebate on Private Health Insurance*

The hidden erosion: 19% decline since 2014

In 2014, the government introduced the Rebate Adjustment Factor (RAF) – a mechanism that has eroded the rebate's value to individuals by a cumulative 19%, impacting the cost of private health insurance. By capping rebate growth below premium inflation, the RAF ensures that costs shift steadily from government to consumers.

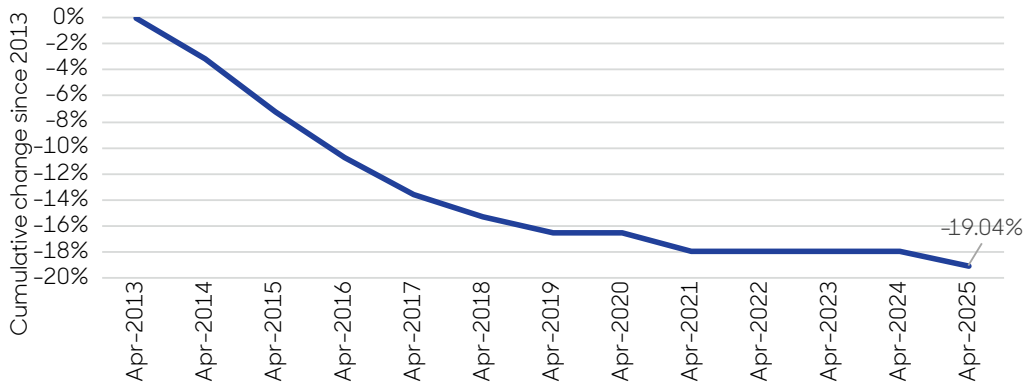
The impact is significant:

- Rebate rates have fallen from 30% to 24.28% for under-65s
- Middle-income families face substantially higher out-of-pocket costs
- Young Australians increasingly cannot afford coverage

The timing compounds the problem: when medical inflation peaks and families most need support, the RAF delivers the largest cost increases.

Commonwealth rebate spending has decreased 6% in real terms since 2014. However, our modelling shows these federal savings are offset by increased costs in state and territory hospitals and longer surgical waiting lists. The reduction in federal expenditure translates to higher overall government healthcare costs across all jurisdictions.

Figure 2. Cumulative percentage change in rebate rates since 2013



Source: DeltaPearl Partners *The Value of the Australian Government Rebate on Private Health Insurance*

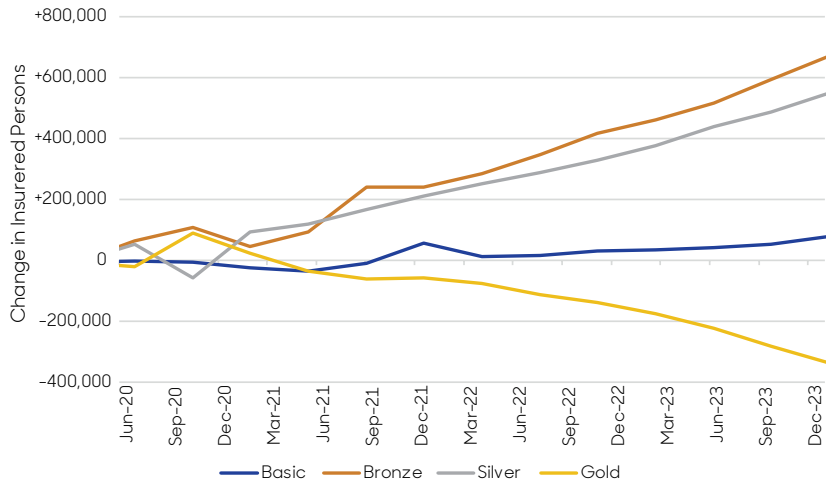
Since the standardised PHI tier system began in 2020, many Australians have moved from Gold to Bronze coverage to manage premium costs. This trend is particularly noticeable among younger participants, whose involvement helps balance the insurance risk pool.

This shift affects service accessibility. Maternity care, which requires Gold or Silver Plus coverage, has become less affordable for many middle-income families. This trend creates a challenging cycle:

- Reduced coverage levels decrease private hospital utilisation
- Some hospitals close less viable services
- Lower patient volumes can increase per-unit costs
- Premium pressures lead to further downgrades

This resembles the insurance 'death spiral' pattern – as healthier members opt for basic coverage, the cost of comprehensive plans increases, potentially making them unaffordable for remaining members. The tier slide reflects both individual financial pressures and broader system sustainability concerns.

Figure 4. Cumulative change in PHI policy holders in each product tier



Source: DeltaPearl Partners *The Value of the Australian Government Rebate on Private Health Insurance*

Visible system impacts: Hospital closures and public sector strain

The combined effects of rebate erosion and tier slide are now evidenced by service closures across Australia. Since 2018, 18 private maternity units have ceased operations with analysts suggesting private maternity services could disappear by 2030 without policy changes. Mental health facilities face similar pressures despite growing demand.

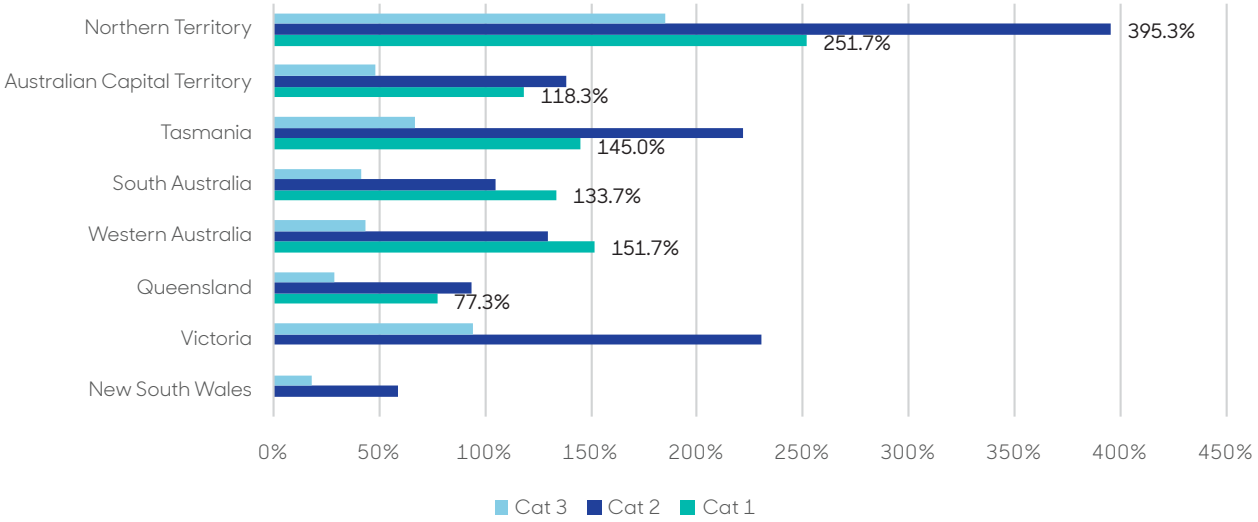
Private hospital closures create immediate pressure on public hospitals, for example:

- The Darwin Private Hospital closure of maternity services in June 2025 is expected to increase Royal Darwin Hospital's maternity load by 13 per cent.
- Regional areas are particularly affected by this trend, with some jurisdictions such as the Northern Territory and parts of Tasmania losing all private maternity options.
- Public hospital waiting lists are worsening, with some procedures exceeding recommended waiting times by over 300 per cent.

The Darwin and Hobart examples (with maternity services closing August 2025) illustrate a broader challenge. Public hospitals often lack the infrastructure, staffing, and funding to absorb transferred demand.

Workforce considerations add further complexity. Although some hospital and healthcare staff may transition to work in public facilities, others may leave healthcare altogether, potentially worsening existing shortages. This pattern suggests systemic pressures that extend well beyond individual hospital decisions to affect healthcare capacity nationally.

Figure 5. Average percent of time (days) public hospital elective surgery wait time over medically recommended wait times, by jurisdiction, 2023–24



Source: DeltaPearl Partners *The Value of the Australian Government Rebate on Private Health Insurance*

Hidden public hospital waiting lists

Official surgical waiting lists tell only part of the story. The complete patient journey often involves multiple queues:

- GP appointments: 20% of patients wait 1–2 weeks
- Specialist consultations: ranging from 1.5 years in Queensland to 6.5 years in South Australia
- Surgical waiting lists: from 1.2 years in NSW to 2.9 years in the NT

Combined, patients may wait up to 7.9 years for elective surgery in South Australia – well beyond clinical recommendations. As private capacity decreases, these timeframes are likely to extend further.

Risks to quality health outcomes

This can only lead to poorer health outcomes. A declining private health system increases the pressure on public hospitals and the primary care sector, reduces patient access to care and increases its cost. For example, a recent analysis of maternity services found that if all births currently occurring in private hospitals transferred to Australian public hospitals it would add an additional $1.7 billion expenditure annually.

Delays in obtaining care due to expanding waiting lists or lack of access will lead to delays in diagnosis and treatment, and increased social costs through loss of productivity. An overburdened and stressed system leads to an overburdened and stressed workforce, increasing the risk of error.

From research to policy reform

Australia's healthcare system faces a defining moment. Our economic analysis demonstrates that strengthening the PHI rebate is essential but is not sufficient as a standalone measure. The rebate operates within a complex ecosystem facing multiple pressures including workforce shortages, service closures, market concentration, and pricing opacity.

These interconnected challenges require a comprehensive reform approach.

Six principles for reform

The following framework explores how targeted interventions in these areas could create conditions where rebate investment delivers maximum benefit for all Australians. These principles are offered as a starting point for an important public policy conversation our healthcare system needs.

Principles	Description	Areas for exploration
1. Equity and fair access	Promote parity in workforce support, service quality, and funding between public and private hospitals to ensure all patients and clinicians have equitable access to care and sustainable working conditions.	• Provide wage support for nurses in private hospitals to match public sector pay, improving workforce attraction and retention. • Increase funding for in-patient psychiatry services in private settings to improve access and care continuity. • Consider removing the 10-year moratorium for internationally educated psychiatrists accessing Medicare benefits. • Fund medical training placements in private hospitals to ensure equitable career development and build clinical capacity.
2. Innovation and flexibility in financing	Support the creation of modern, patient-driven funding models to increase participation in private health and improve cost sustainability.	• Immediately investigate freezing Private Health Insurance rebate rates at current levels to halt the 19% erosion caused by the Rebate Adjustment Factor since 2014. • Undertake a review into flexible self-funding mechanisms for private healthcare to support the development and piloting of innovative products such as Health Savings Accounts, particularly their applicability to low and middle income earners. Review would need to consider taxation arrangements, eligibility criteria, impacts on PHI viability, partnership arrangements (e.g. banking) among other considerations.
3. Strategic investment in critical health infrastructure and access.	Build capacity through workforce development, IT upgrades, and facility improvements.	• Investigate the introduction of a Hospital Access Guarantee for rural and regional communities, informed by the Universal Coverage Obligation style funding mechanism to ensure the continuity and quality of essential private hospital services in areas with no viable public alternative. • Commonwealth subsidy attached to the UCO would be pooled and shared among the private hospital operators based on set criteria.
4. Transparency and accountability in pricing	Introduce nationally consistent frameworks and negotiation guidelines for pricing for privately funded hospital services to reduce fragmentation, improve transparency, and prevent negotiation impasses between insurers and providers.	• Introduce national efficient pricing (NEP) for PHI-funded hospital services (excluding MBS/doctor fees), guided by an independent authority (e.g. IHACPA). • Establish a structured mediation or arbitration mechanism, triggered when contract negotiation between insurers and providers fail, using NEP as a default minimum pricing benchmark. • Establish an independent authority to oversee premium setting, ensuring fairness and transparency. • Mandate public disclosure of specialist fees to ensure patients have access to clear, comparable cost information prior to treatment, improving transparency and informed decision-making. • Roll-out education for clinicians on informed financial consent aimed at improving patient understanding of likely costs. • Improve public awareness of DHDA information on out-of-pocket costs through a public education campaign.
5. Regulating vertical integration	Establish fair market conditions by placing limits on PHI investment in clinical service delivery.	• Investigate the impacts of vertical integration by private health insurers on patient care, the viability of the private hospital sector, competition within PHI, and insurer market power.
6. Shared responsibility for sustainable private health system	Ensure the long-term sustainability of the private health sector through structured collaboration between government, insurers, and providers, with shared accountability for reform and system efficiency.	• Establish a government-led Private Healthcare Reform Council, to replace existing CEO Forum to co-design reforms with insurers, providers, clinicians, indemnity providers and consumer representatives but with a clear terms-of-reference focussed on common goals, proper DoHDA resourcing and ministerial reporting. • Chaired by an independent party such as a former Department Secretary, judicial figure, former Minister.

These principles aim to address several of the current challenges by:

- Improving transparency and accountability in private health insurance pricing and funding.
- Addressing concerns around vertical integration and market concentration.
- Supporting medical training and sustainable workforce conditions.
- Ensuring equitable access to quality care across public and private settings.
- Establishing long-term viability of the private hospital sector as a key pillar of Australia's health system.

Why Avant commissioned this research

As Australia's largest medical defence organisation, Avant represents more than 95,000 doctors – over half the nation's medical workforce spanning general practice and every specialty. As a member-owned mutual, we experience at first-hand how healthcare system pressures affect those delivering care at the frontline.

Our members work across both sides of the dual healthcare system. Many provide services in private hospitals while others work exclusively in public hospitals, where they face the daily reality of overwhelming demand. Our GP members depend on a functioning private non-GP specialist network to ensure timely referrals for their patients.

This research matters because our members experience the human cost of policy decisions in their consulting rooms and operating theatres. They see and experience the system's stress points before they are reflected in official statistics.

As their mutual, we have a responsibility to provide evidence-based analysis that illuminates these challenges and points toward solutions. Our comprehensive range of services – from medical indemnity to practice management support – means we understand the full ecosystem in which doctors work. We actively promote quality, safety and professionalism in medical practice, for and in partnership with members, investing in extensive education and risk advisory services to help them navigate the systemic challenges they face.

This research represents our commitment to advocating for a healthcare system that allows our members to do what they do best: provide excellent care to all Australians.

We are grateful for the assistance of Delta-Pearl Partners – a leading economic advisory and modelling firm – for conducting this research on our behalf.

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