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21 August 2026

Catholic Health Australia Submission: Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026

Thank you for the opportunity to provide Catholic Health Australia's (CHA's) views on the *Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026* (the Bill). CHA is Australia's largest non-government provider of health, aged and community care services – operating hospitals in every state and the Australian Capital Territory, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, alongside extensive community and residential aged care.

CHA's members were founded by religious congregations who went to the places where care was hardest to provide and least profitable to deliver – and in many of those communities, our members remain the only provider today. CHA therefore approaches this Bill from this position, and as a peak body whose members deliver private hospital, public hospital and aged care services, and who will feel both the direct and the indirect effects of this Bill.

While CHA acknowledges the Government's objectives of intergenerational equity in the rebate and increased investment in aged care, a measure must be judged by whom it affects, and this one falls hardest on precisely the people our members exist to serve – Age Pensioners and low-income retirees, the frail and the very old, residents of aged care, and communities in regional and rural Australia.

The consequences extend to the services those communities rely on. The Bill withdraws revenue from a private hospital sector that recorded a \$756 million operating loss in 2024-25, and it does so unevenly: the impact concentrates in standalone regional facilities where older patients make up the majority of admissions and where there is no alternative private provider.

CHA's central concern is that these consequences have not been examined. Downgrade behaviour was not modelled. The public hospital flow-on cost, DHDA says, cannot be reliably quantified. No distributional analysis of the affected cohort has been published, no regional analysis, no facility-level analysis, and the states that will absorb the displaced demand were not consulted. The Parliament is being asked to accept that this measure will not harm vulnerable older Australians, on the basis of analysis that does not ask the question.

CHA therefore encourages the Government to complete the evidence base before the Bill proceeds, and to consider this measure within the context of its own private health reform process rather than ahead of it. CHA also recommends the Government give consideration to protecting those least able to absorb the change, consult the states and territories that will bear

the displaced demand, and replace the current success metric with a review capable of detecting harm.

CHA would welcome the opportunity to discuss this submission further. If you wish to discuss anything, please contact Dr Katharine Bassett, Director of Health Policy, on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'KB', with a small horizontal line at the end.

Dr Katharine Bassett
Director of Health Policy
Catholic Health Australia



Catholic Health Australia

Submission: Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026

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Catholic Health Australia

www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

CHA members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Executive summary

The *Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026* (the Bill) removes the age-based uplift to the Private Health Insurance Rebate for Australians aged 65 and over from 1 April 2027. Catholic Health Australia (CHA) acknowledges the Government's objectives of intergenerational equity in the rebate and increased investment in aged care. Our concern is that the Bill's costs do not fall evenly across the 3.36 million Australians it is estimated to affect. On DHDA's own modelling and on CHA's analysis, they concentrate among the most disadvantaged members of that group: Age Pensioners and low-income retirees, the over-75s, frail residents of aged care, and regional and rural communities with no alternative provider. These are the cohorts CHA members were established to serve, and this submission is made on their behalf.

The Bill's costs fall on the Australians least able to bear them. DHDA's own modelling shows 95 per cent of projected cover losses occur in the lowest income tier. CHA's analysis (which adds the downgrade response DHDA did not model) estimates approximately 710,000 affected over-65s, roughly one in five, will change their relationship with cover, of whom approximately 155,000 will move to cover that materially reduces their access to hospital care. Approximately 900,000 of the affected cohort earn under \$55,000 a year and approximately 350,000 under \$30,000. The over-75s face double the rebate reduction of the 65–69 cohort while claiming the highest benefits of any age group. A substantial number of aged care residents and home care recipients hold private hospital cover and rely on it for the elective procedures that most affect function in later life; where that access is lost, functional decline accelerates and entry to residential care is brought forward. And in regional Australia, where around 70 per cent of insured over-65s live, losing effective cover does not mean switching provider but joining a public waiting list. For this cohort the decision is effectively irreversible: Lifetime Health Cover loadings mean an exit at 70 cannot be undone at 73.

The evidence base does not support the Bill as drafted. The Parliament cannot presently test whether these concerns are well founded, because the analysis that would settle them has not been produced. Downgrade behaviour – approximately 94 per cent of the total behavioural response – was not modelled. Public hospital flow-on cost "cannot be reliably quantified". No distributional analysis of the affected cohort has been published, despite DHDA holding the linked Services Australia and Australian Taxation Office data required to produce it, and despite the Bill being justified on equity grounds. No regional or facility-level analysis was undertaken. State governments were not consulted, and the health ministers of New South Wales, Queensland and Tasmania have since formally raised concerns. The Office of Impact Analysis rated the Impact Analysis "Adequate" rather than "Good Practice", and DHDA's success metric is set approximately seven times above its own modelled response, meaning it will be met even if the measure causes substantially greater harm than projected.

The claimed saving is substantially offset by costs shifted elsewhere. CHA estimates approximately \$675 million per year in flow-on costs to public hospitals at steady state (scenario range \$325 million to \$1.0 billion). Over the forward estimates, states bear approximately \$1.1 billion of that, which is conservative as it does not account for states already at the National Health Reform Agreement (NHRA) funding cap. Further costs return to the aged care system as delayed elective surgery accelerates entry to residential care. Roughly two-thirds of the headline saving is consumed by costs the measure itself creates. The Bill also contracts private hospital revenue by an estimated \$275–415 million per year across the CHA

member network, landing on a sector that recorded a \$756 million operating loss in 2024-25, and concentrated in the standalone regional facilities least able to withstand it. St Vincent's Private Hospital Lismore projects that the Bill would be a contributing factor to the closure of the hospital – the only private hospital serving approximately 310,000 people in the Northern Rivers (and ~400,000 from Coffs Harbour to the Gold Coast). Actuarial modelling commissioned by DHDA itself reached a comparable conclusion before the Bill was drafted: \$482 million in rebate savings against \$547 million in additional public hospital costs.

The measure is presented as a saving that funds better care for older Australians. On the evidence available, it moves cost rather than removing it, and it does so by reducing the healthcare access of low-income and vulnerable older people, including, in some regional communities, by removing the only private hospital they have. CHA encourages the Government to complete the evidence base before the Bill proceeds: modelling downgrade behaviour, quantifying the public hospital flow-on and its distribution between the Commonwealth and the states, publishing distributional analysis of the affected cohort, assessing the regional impact, and consulting the states that will fund the displaced demand. Where that analysis confirms the response concentrates among low-income older Australians, the Government should give consideration to protecting those least able to absorb the change. CHA also recommends this Bill be considered within the Government's own private health sector reform process rather than ahead of it, and that the current success metric be replaced with an independent post-implementation review capable of detecting harm within a meaningful timeframe.

Background

Catholic Health Australia (CHA) is the peak body for Catholic health, community and aged care services in Australia, and represents the largest grouping of non-government health and aged care providers in the country. CHA is unique among peak bodies in representing members who operate across all three of the sectors the *Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026* (the Bill) will affect: private hospitals, public hospitals, and aged care.

CHA members' private hospital footprint covers around 68 facilities operated by Mater, Calvary, St Vincent's Health Australia, St John of God Health Care, UnitingCare Queensland, Cabrini Health, St Vincent's Private Hospital Lismore and Ozcare. Together, CHA members deliver approximately 30 per cent of private hospital care in Australia, including a disproportionate share of regional and rural private hospital services. In many of these communities, the CHA member facility is the only private hospital in the catchment. CHA members' public hospital footprint covers 18 public hospitals delivering approximately 5 per cent of Australia's public hospital care under contract with state health systems, operated by Mater, Mercy Health, Calvary, St Vincent's Health Australia and St John of God. CHA members' aged care footprint covers approximately 12 per cent of residential aged care facilities and 20 per cent of home care packages nationally, spanning residential aged care, home care, Support at Home, community aged care and palliative care services across every state and territory.

This footprint gives CHA a distinctive perspective on the interconnected effects of the Bill. CHA members experience both sides of the public-private cost shift: their public hospitals will absorb the demand transfer their private hospitals lose. They also sit on both sides of the aged care interface, as providers of the care the rebate savings are intended to fund and as providers absorbing the additional demand the measure will generate through delayed elective surgery access for residential aged care residents and community-based aged care recipients. That operational vantage point allows CHA to speak to second-order effects – flow-on to public hospitals, accelerated home care to residential aged care transitions, and impact on Support at Home objectives – that peak bodies with a single-sector focus cannot.

This footprint also determines who CHA members care for. They are not-for-profit organisations founded by religious orders to serve people the market serves poorly, and they continue to do so: their patients and residents are disproportionately older, on low incomes, and living in regional and rural communities where no alternative provider exists. This is the population the Bill affects most directly, and it is on their behalf that CHA makes this submission.

The Bill's costs fall on the Australians least able to bear them

Key message: the Bill's behavioural impact is not spread evenly across 3.36 million affected over-65s. It concentrates – by income, by age, and by geography – in the most vulnerable segments of the affected cohort. Each concentration is demonstrated below using the Department of Health, Disability and Ageing's (DHDA's) own data supplemented by CHA analysis.

Ninety-five per cent of projected cover losses occur in the lowest income tier

DHDA's modelling projects 44,313 people will drop cover by 2028-29.¹ The distribution of those losses is uneven: 42,001 (95 per cent) occur in the Base income tier, those earning under \$101,000 as a single or \$202,000 as a family.²

Table 1: Projected cover losses among affected over-65s by income tier, 2028–29³

Income tier (65+)	Cohort size	Projected exits	Share of exits
Base tier (single <\$101k)	2,998,008	42,001	95%
Tier 1 (\$101–123k)	136,931	835	2%
Tier 2 (\$123–164k)	221,188	1,477	3%
Total 65+	3,356,127	44,313	100%

Within the Base tier, the burden concentrates further down the income distribution. The academic literature DHDA itself cites finds low-income elderly are several times more price-responsive than higher-income elderly, meaning the exits will cluster among those on the lowest incomes within an already low-income tier.⁴ The Government has not published the number of affected over-65s receiving the Age Pension, so the size of the cohort most exposed cannot presently be established.

This distribution is inconsistent with the Bill's stated equity rationale. A Bill justified on the ground that rebates should reflect income rather than age applies an identical change to an Age Pensioner on \$28,000 and a self-funded retiree on \$95,000 – and its costs fall overwhelmingly on the former.

CHA's assessment is that the true figure will be higher than 44,313. DHDA's projection applies a cohort-average elasticity to the whole Base tier, but the literature it relies on finds price-

¹ Department of Health, Disability and Ageing, *Impact Analysis OIA26-11374*. Retrieved 21/08/2026 from: <https://oia.pmc.gov.au/published-impact-analyses-and-reports/modernising-private-health-insurance-rebate>

² Department of Health, Disability and Ageing, *Impact Analysis OIA26-11374*. Retrieved 21/08/2026 from: <https://oia.pmc.gov.au/published-impact-analyses-and-reports/modernising-private-health-insurance-rebate>

³ Department of Health, Disability and Ageing, *Impact Analysis OIA26-11374*. Retrieved 21/08/2026 from: <https://oia.pmc.gov.au/published-impact-analyses-and-reports/modernising-private-health-insurance-rebate>

⁴ Liu, J., & Zhang, Y. (2023). Elderly responses to private health insurance incentives: Evidence from Australia. *Health Economics*, 32(12), 2730-2744.

responsiveness varies sharply by income within the elderly population. Applying the elasticity range that literature associates with low-income elderly to the bottom income quartile of Base tier over-65s produces an additional 10,000–15,000 exits.⁵ However, the analysis in this submission adopts DHDA's figure of 44,313 without adjustment. CHA has taken the deliberately conservative course of building its estimates on the Department's own modelled figure rather than a higher one, so that the conclusions that follow do not depend on contesting the Department's exit projection.

An estimated one in five affected over-65s will change their cover – not one in seventy-five

DHDA's 44,313 figure counts only people who abandon cover entirely. It does not count people who downgrade, which is a gap DHDA acknowledges. Downgrading is the more likely response for older Australians attached to cover they have held for decades but facing affordability pressure.

CHA has estimated the downgrade response using DHDA's own affected-cohort denominator and observed downgrade patterns from APRA quarterly data following past premium shocks: approximately 665,000 downgrades over the first three years of full operation. Combined with DHDA's drops figure, approximately 710,000 affected over-65s (roughly one in five) will change their relationship with private health insurance cover. DHDA's published estimate captures 6 per cent of this response.⁶

The clinical significance depends on where downgraders land, and the affordability mechanism drives them toward harm. On typical Gold cover, the rebate change alone adds approximately \$600 per year for a couple aged 70 or over and approximately \$300 for a single,⁷ on top of the annual premium increase, which for Gold cover ran to 13.3 per cent in 2026 against an industry

⁵ DHDA's projection of 44,313 exits implies a price elasticity of demand of approximately -0.16 , derived by applying the modelled exit rate of 1.40 per cent in the Base tier against the effective premium increase that tier faces (approximately 8.7 per cent, weighted across the 65–69 and 70-plus age bands). That elasticity sits within the range found in the academic literature and represents a cohort average across the whole Base tier. The literature DHDA cites finds price-responsiveness among the elderly varies materially by income, with low-income elderly substantially more responsive than the cohort average. CHA applies an elasticity of -0.25 to -0.35 to the bottom income quartile of Base tier over-65s – approximately 750,000 people – while retaining the Department's cohort-average elasticity for the remainder of the tier. Against the same 8.7 per cent effective premium increase, this produces an additional 10,000 to 15,000 exits above the Department's projection. The estimate is confined to the exit margin and does not include downgrade behaviour. It is reported as upside risk and is not incorporated into any of the estimates in this submission, which use DHDA's figure of 44,313 without adjustment.

⁶ The estimate applies DHDA's own denominator of 3,356,127 directly affected over-65s. Downgrade rates are derived from observed behaviour in APRA quarterly private health insurance statistics following past premium increases, adjusted downward to reflect the lower price-responsiveness characteristic of the over-65 cohort. This produces a central estimate of approximately 665,000 downgrade actions over the first three years of full operation, within a range of 470,000 to 880,000, which is equivalent to roughly 7 per cent of the affected cohort taking some downgrade action each year. The estimate is decomposed by type of downgrade: extras-only reductions (40 per cent of the response), excess increases (20 per cent), hospital tier downgrades (25 per cent), exclusions added (12 per cent) and switches to minimal cover (3 per cent). This composition is calibrated against the trend in policies carrying exclusions in APRA data. The distinction matters: only the final three categories – approximately 265,000 people, or 90,000 a year – involve a change to hospital cover, and only those categories carry consequences for access to hospital treatment. The remaining 400,000 adjust extras or excess and retain their hospital cover unchanged.

Combined with DHDA's projection of 44,313 exits, the total behavioural response is approximately 710,000 people, of whom DHDA's published estimate captures 6 per cent. The Impact Analysis states that downgrade behaviour was not modelled. Full parameters are documented in CHA's supporting analysis, available to the Committee on request.

⁷ Applying an 8 percentage point rebate reduction to typical Gold cover premiums of approximately \$3,790 (single) and \$7,580 (couple) as published by Canstar.

average of 4.41 per cent. A downgrade only relieves that pressure if it saves a comparable amount – and the material savings come from products that exclude the high-cost categories older members actually use: joint replacement, cataracts, cardiac procedures. The downgrade that solves the affordability problem is the downgrade that creates the access problem. CHA estimates between 45,000 and 260,000 people (central estimate approximately 155,000) will move to cover that materially reduces their access to hospital care.⁸ This dynamic is already established in the market: 71.5 per cent of hospital policies now contain exclusions,⁹ and Gold-tier cover has contracted sharply: 440,000 fewer Gold policies since the March 2020 quarter, covering 907,000 fewer Australians, with Gold's share of hospital policies falling from 40.4 per cent to 28.5 per cent. Over the same period the market grew by 758,000 policies – the contraction is migration to Silver and Bronze, not a decline in membership.¹⁰ The Bill amplifies a trend that is already eroding the cover of older Australians.

In addition, the Government has suggested this concern is overstated because downgraders will move from Gold to Silver Plus and retain meaningful cover. That reassurance does not survive contact with the products actually on the market. "Silver Plus" is not a defined level of cover: it means only that a product includes something beyond the Silver minimum, and insurers choose which categories to add. Joint replacement and cataract surgery are Gold-tier categories, so a Silver Plus product may include them or exclude them entirely – and both are sold under the same tier label. For example, HCF's Hospital Standard Silver Plus excludes cataracts and joint replacements; HBF's Silver Hospital Plus includes both.¹¹ The distinction is not incidental to price: those categories are among the principal drivers of Gold premiums, so a Silver Plus product retaining them costs only modestly less than Gold and delivers little of the saving a member is downgrading to achieve. The products that produce a saving large enough to offset the rebate change are precisely those that shed the procedures older Australians most commonly need. A policyholder acting rationally on price is therefore steered toward the

⁸ The estimate counts three groups: people who drop cover entirely (44,313, per DHDA's modelling); people who downgrade to a hospital product excluding clinical categories commonly required by over-65s; and people who switch to minimal or "junk" cover providing no effective hospital protection. Extras-only reductions and excess increases are excluded, as those policyholders retain their hospital cover.

Of the approximately 665,000 downgrades in the central estimate, 165,000 are hospital tier downgrades and 20,000 are switches to minimal cover. Not every tier downgrade reduces access: the effect depends on whether the destination product retains the clinical categories the member is likely to need. Because tier labels do not determine this – a Silver Plus product may either retain or exclude joint replacements and cataracts – CHA treats destination as the principal uncertainty and bounds it with three scenarios:

- Lower bound (approximately 45,000): downgrades are predominantly cover-preserving, retaining high-use categories. Reduced access arises almost entirely from exits and minimal-cover switches.
- Central estimate (approximately 155,000): 44,313 exits, plus approximately 90,000 tier downgrades landing in excluding products (55 per cent of tier downgrades, weighted to the trend in policies carrying exclusions in APRA data), plus 20,000 switches to minimal cover.
- Upper bound (approximately 260,000): 85 per cent of tier downgrades land in excluding products, with downgrade volumes at the upper end of the estimated range.

The destination share is the largest single uncertainty in the estimate. It is ultimately an empirical question that insurer product-level data on downgrade destinations would resolve; CHA does not hold that data and recommends the Committee seek it.

⁹ Australian Prudential Regulation Authority (2026). *Quarterly Private Health Insurance Statistics, March 2026*. Retrieved 19/08/2026 from: <https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics>

¹⁰ Department of Health, Disability and Ageing (2026). *Private health insurance reform data quarterly trends report*. Retrieved 21/08/2026 from: <https://www.health.gov.au/resources/publications/private-health-insurance-reform-data-quarterly-trends-report?language=en>

¹¹ Private Health Information Statements, PrivateHealth.gov.au: HCF Hospital Standard Silver Plus (PolicyID HCF/H31G/TMAZ1D, statement issued 1 April 2026); HBF Silver Hospital Plus. Both accessed August 2026.

destinations that carry the greatest clinical risk, and the tier label offers no protection against that outcome.

The over-75s – those with the greatest clinical need – are hit hardest

The rebate cut for over-75s is approximately 8 percentage points – double the cut for the 65–69 cohort – and falls on the segment with the highest clinical need. Private health insurance beneficiaries aged 75–84 receive around 340 per cent of average member benefits; those aged 85+ receive around 418 per cent.¹² CHA's working analysis indicates a coverage reduction of approximately 1.9 per cent in the over-75 segment – around 35–40 per cent above the cohort average.¹³

The clinical consequences of delayed elective surgery in this cohort are well documented: delayed cataract surgery increases falls and fractures; delayed joint replacement accelerates mobility loss; delayed cardiac procedures increase mortality. For aged care residents and home care recipients who hold private hospital cover, the loss of timely elective surgery access has a further consequence: accelerated functional decline that drives earlier and deeper dependence on the aged care system. CHA estimates approximately 2,500–4,500 residential aged care residents per year will face delayed elective surgery under the Bill, and approximately 800–1,200 additional residential aged care entries per year will occur through accelerated home care transitions.¹⁴

¹² Australian Prudential Regulation Authority (2026). *Quarterly Private Health Insurance Statistics, March 2026*. Retrieved 19/08/2026 from: <https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics>

¹³ The rebate change is not uniform across the affected population. Australians aged 65–69 lose approximately 4 percentage points of rebate (28.139 per cent to 24.118 per cent at the Base tier), while those aged 70 and over lose approximately 8 percentage points (32.158 per cent to 24.118 per cent). The effective premium increase for the older group is therefore roughly double that faced by the younger group. DHDA's modelling produces a Base tier exit rate of 1.40 per cent, applied across the affected cohort as a whole. Because exit rates respond to the size of the price change, disaggregating by age band produces a materially higher rate for the group facing the larger increase. Applying DHDA's own implied elasticity separately to each age band's effective premium increase, and weighting by cohort size, yields an exit rate of approximately 1.9 per cent among over-75s – approximately 35 to 40 per cent above the cohort average. This is a redistribution of DHDA's projected exits across age bands rather than an increase in the total. It matters because over-75s have materially higher hospital utilisation than the 65–69 cohort, so a given number of exits concentrated in that group produces greater consequences for both the individuals affected and the public hospital system than the cohort-average figure implies.

¹⁴ *Delayed elective surgery for residential aged care residents*. The estimate applies the behavioural response modelled in this submission to the subset of residential aged care residents holding private hospital cover, then applies observed elective surgery utilisation rates for that population. Residents who drop cover or downgrade to a product excluding the relevant clinical category face public waiting lists rather than timely private admission. The procedures at issue are concentrated in cataract surgery and joint replacement – the two highest-volume elective procedures in this age group, and among the categories most commonly excluded from downgraded policies. The range of 2,500–4,500 per year reflects the destination scenarios used throughout: the lower bound assumes downgrades are predominantly cover-preserving, the upper bound assumes they concentrate in products excluding high-cost categories. *Accelerated entry to residential care*. Delayed cataract surgery and joint replacement are established contributors to falls, immobility and functional decline among older people, and functional decline is a principal driver of transition from home-based care to permanent residential care. The estimate applies a transition-acceleration rate to the cohort of home care and Support at Home recipients holding private hospital cover who are affected by the measure, producing approximately 800–1,200 additional permanent residential care entries per year at steady state. The estimate captures acceleration of entries that would otherwise occur later, not entries that would never have occurred.

Aged care datasets do not record the private health insurance status of recipients, and no linked dataset exists. Both estimates therefore rest on CHA's application of APRA hospital cover participation rates to aged care population counts published by AIHW GEN. CHA recommends that the Committee seek linked data from the Department, which holds both aged care program data and PHI participation data.

Regional communities carry a disproportionate share of the burden

Approximately 70 per cent of over-65s with private hospital cover live outside inner metropolitan areas; approximately 21 per cent – 705,000 people – live in rural electorates.¹⁵ Three features of regional Australia compound the Bill's impact there:

- **Older catchments:** In several regional catchments the over-65 population share is roughly double the national average of 17 per cent: Fraser Coast 31 per cent, Bundaberg 25 per cent, Sunshine Coast 25 per cent, Northern Rivers 22 per cent, Launceston 21 per cent.¹⁶
- **Lower and more pension-reliant incomes:** Regional retirement incomes are structurally lower than metropolitan incomes, and regional retirees are more likely to receive a full or part Age Pension. Private Healthcare Australia's analysis finds regional over-65s with private health insurance are "predominantly mixed income (part pension and/or superannuation)"¹⁷ – precisely the price-sensitive cohort in which the behavioural response will concentrate.
- **No alternatives:** In many regional catchments the CHA member facility is the only private hospital, and the public hospital is already at capacity. A regional over-65 who loses effective cover does not switch provider – they join a public queue. In Lismore, Category 3 elective patients already wait up to 12 months.

For regional Australians, private hospital cover is not a discretionary luxury – it is frequently the only mechanism for timely access to elective care. The Bill prices the lowest-income members of these communities out of that access.

For older Australians, dropping cover is effectively irreversible

DHDA's modelling treats a dropped policy as a reversible market decision. For the affected cohort, it is not – because of the Lifetime Health Cover rules the Parliament itself designed to penalise late entry. A person who drops hospital cover for more than the permitted 1,094-day lifetime gap becomes liable for LHC loadings on re-entry: 2 per cent of premium for every year of age over 30, capped at 70 per cent. A 70-year-old pensioner who drops cover in 2027 because of this Bill and seeks to rejoin at 73 – when a knee deteriorates or a cataract matures – faces the maximum loading: re-entry premiums up to 70 per cent higher than the premiums they could not afford in the first place. Members who held cover for ten continuous years and had their loading removed become liable again on re-entry.

The consequence is that the exits this Bill causes are one-way doors. An affected pensioner cannot correct the decision later, and nor can a future government: restoring the rebate after the fact would not restore the cover of those who left, because the LHC loading stands between

¹⁵ CHA analysis; ABS Census of Population and Housing, population by age and Commonwealth Electoral Division; APRA private health insurance membership statistics; and the affected cohort of 3,356,127 over-65s per DHDA's Impact Analysis, Table 11. Remoteness classified per the ABS Australian Statistical Geography Standard; electorate classification per AEC demographic ratings.

¹⁶ Australian Bureau of Statistics, *Regional Population by Age and Sex*, 2024, ABS, Australian Government; CHA analysis. Shares calculated for Local Government Areas and Statistical Areas Level 3 corresponding to each catchment.

¹⁷ Private Healthcare Australia, *Health insurers urge government to continue rebate discounts for Australians over 65s on low incomes, including aged pension*, media release, 23 April 2026, <https://privatehealthcareaustralia.org.au/health-insurers-urge-government-to-continue-rebate-discounts-for-australians-over-65s-on-low-incomes-including-aged-pension/>

them and re-entry. This is why the missing analysis matters now rather than at review. For the cohort this Bill affects, a policy error cannot be unwound.

The evidence base does not support the Bill as drafted

Key message: the Parliament is being asked to legislate without knowing the Bill's true consequences. Every major gap set out below is acknowledged by DHDA itself, evident from the absence of analysis in the published Impact Analysis, or documented by the Government's own quality assurance function. None is a matter of sector opinion.

Sector analysis undertaken to address these gaps has been the subject of criticism, while the underlying departmental analysis remains unpublished. The sector has estimated downgrade behaviour because DHDA did not model it; estimated public hospital cost shift because DHDA has indicated it cannot be reliably quantified;¹⁸ and estimated the distributional profile of the affected cohort because no such breakdown has been published. CHA acknowledges these estimates carry uncertainty, and has been explicit about the assumptions and ranges applied. DHDA holds more granular data than is available to the sector, and is accordingly better placed to test or refine these estimates. CHA would welcome the publication of departmental analysis on any of these questions. In its absence, the sector's estimates constitute the quantification currently available to the Committee.

DHDA did not model 94 per cent of the behavioural response

The largest analytical gap is stated in DHDA's own words:

*"These estimates do not take into account privately insured people who decide to downgrade their cover... this reduction in coverage could result in a larger than estimated reduction in private hospital separations if consumers do not accurately assess their likely future health needs when choosing their level of cover."*¹⁹

As set out previously, the unmodelled downgrade response is approximately 15 times larger than the modelled drops – approximately 94 per cent of the total behavioural response. DHDA has published no analysis of the single most consequential question for assessing the Bill: what proportion of downgraders will land in products that exclude joint replacement, cataracts and cardiac procedures. The Bill's central behavioural estimate therefore describes a small fraction of what the policy will actually do.

Three decades of rebate changes show where the response will appear – and DHDA modelled the wrong margin

When means testing of the rebate was introduced in 2012, modelling commissioned by the private health insurance sector and based on a survey of consumer intentions forecast that up to 1.6 million people would drop cover and up to 4.3 million would downgrade over five years, against Treasury's estimate of 25,000 exits. Participation in fact remained stable and rose

¹⁸ Department of Health, Disability and Ageing, *Impact Analysis OIA26-11374*. Retrieved 21/08/2026 from: <https://oia.pmc.gov.au/published-impact-analyses-and-reports/modernising-private-health-insurance-rebate>

¹⁹ Department of Health, Disability and Ageing, *Impact Analysis OIA26-11374*. Retrieved 21/08/2026 from: <https://oia.pmc.gov.au/published-impact-analyses-and-reports/modernising-private-health-insurance-rebate>

slightly.²⁰ However, the 2012 episode carries a second lesson that is routinely omitted when the first is cited. The drops forecast was wrong; the downgrades forecast was directionally right – just slower than predicted. In the decade following the 2012 means testing and the 2014 introduction of the Rebate Adjustment Factor (which has eroded the base rebate from 30 per cent to around 24 per cent of premiums),²¹ the response arrived on the intensive margin: the share of hospital policies carrying exclusions or restrictions rose from 48 per cent at December 2012 to 71.5 per cent at March 2026, and members shifted progressively toward products with narrower cover.²² Peer-reviewed analysis of the 2012 reform confirms empirically that rebate reductions produce downgrading even where they do not produce exits.²³ The consistent pattern across every rebate reduction since 2012 is: no participation cliff, followed by a three-to-five-year erosion of the depth of cover. DHDA has modelled the margin where history says nothing happens, and has not modelled the margin where history says everything happens.

The introduction of the age-based uplift in 2005 – the exact mirror image of this Bill – is also instructive, in both directions. Liu and Zhang (2023) found the 2005 rebate increases produced only modest gains in take-up (a 5 percentage point increase for 65–69s lifted take-up by less than 1 percentage point), implying older Australians are not highly price-responsive on average. CHA accepts that evidence; it is why we accept DHDA's drops figure.²⁴ But the same study found the demand response was several times more elastic among low-income elderly – and that asymmetry is the reason the 2012 precedent does not transfer to this Bill:

- 2012 tested the least price-sensitive cohort; this Bill targets the most price-sensitive. Means testing removed rebates from high earners, who face the Medicare Levy Surcharge if they drop cover and can readily absorb the premium change. This Bill's impact concentrates in Base tier over-65s – pensioners and low-income retirees with no MLS backstop (most fall below MLS thresholds) and no capacity to absorb the increase.
- A removal is not the 2005 experiment run backwards. The behavioural evidence – including the outsized effect of the Lifetime Health Cover penalty relative to the rebate – shows people respond far more strongly to losses and penalties than to equivalent gains. The muted response to the 2005 gain does not imply a muted response to its removal from members who have priced it into fixed retirement budgets for two decades.
- The market context is different. The 2012 change landed in a stable market. This Bill lands in a market under affordability pressure – payout ratios falling, the largest premium increase in eight years – among a cohort managing acute cost-of-living pressure on fixed incomes.

²⁰ Deloitte, *Economic Impact Assessment of the Proposed Reforms to Private Health Insurance*, report prepared for the Australian Health Insurance Association, 2011. Available at: <https://privatehealthcareaustralia.org.au/research/economic-impact-assessment-of-the-proposed-reforms-to-private-health-insurance/>

²¹ Australian Government Department of Health, Disability and Ageing, *PHI 12/26 Private health insurance rebate adjustment factor effective 1 April 2026*. Retrieved 21 August 2026 from: <https://www.health.gov.au/news/phi-circulars/phi-1226-private-health-insurance-rebate-adjustment-factor-effective-1-april-2026>

²² Australian Prudential Regulation Authority (2026). *Quarterly Private Health Insurance Statistics, March 2026*. Retrieved 19/08/2026 from: <https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics>

²³ Kettlewell, N., & Zhang, Y. (2024). Financial incentives and private health insurance demand on the extensive and intensive margins. *Journal of Health Economics*, 94, 102863.

²⁴ Liu, J., & Zhang, Y. (2023). Elderly responses to private health insurance incentives: Evidence from Australia. *Health Economics*, 32(12), 2730-2744.

Recent academic work supports this reading. A 2026 study by Zhang, Staub and Kettlewell – using linked administrative data to isolate the rebate effect for the first time – estimates 14,821–42,498 drops from this measure, which is broadly consistent with DHDA's figure.²⁵ However that study, like DHDA's modelling, measures exits, not downgrading. On the drops margin, DHDA, the academic evidence and CHA agree. The unaddressed question – the question three decades of policy history says is the one that matters – is what happens to the depth of cover held by low-income older Australians. History also explains why DHDA's Year 2 success metric will not detect the answer: the post-2012 and post-2014 erosion took three to five years to accumulate, well beyond the measurement window DHDA has set for itself.

The fiscal case rests on a cost DHDA says it cannot quantify

"The exact fiscal impact on public hospitals cannot be reliably quantified. It will depend on factors including how many people drop or downgrade their private health insurance cover, whether those people would have sought private hospital care in the absence of the change, and the extent to which they instead seek treatment in the public system."

The Bill's headline saving – \$2,994.7 million over the forward estimates – is presented without any offsetting estimate of the demand it transfers to public hospitals. The Department is not without evidence on the question. Finity Consulting, engaged by DHDA to review the effectiveness of the MLS, Rebate and LHC, found that the rebate paid to over-65s "creates a strong participation incentive", that private health insurance funds more treatment than the rebate costs, by more than \$900 per person on average, most pronounced among older Australians, and estimated that removing PHI rebates for over-65s "would reduce the claims funded by PHI by \$2.3 billion, which exceeds the PHI Rebate paid to the group."²⁶ In other words, DHDA's own commissioned actuaries found the over-65 rebate is leveraged: it supports more privately-funded care than it costs, and removing it removes more privately-funded healthcare than it saves. On that basis Finity recommended that rebates for older Australians be increased rather than reduced, conditional on holding Silver-tier cover or above, which is the tier most likely to include the procedures that cohort requires. Finity's report predates this measure and models full removal rather than removal of the age-based uplift alone, so the \$2.3 billion figure does not transfer directly. But the leverage principle does, and it is nowhere addressed in the Impact Analysis. Sector analysis scaling Finity's findings to the partial reduction now proposed estimates approximately \$482 million in rebate savings against approximately \$547 million in additional public hospital costs.²⁷

The states that will bear the cost were never consulted

The Impact Analysis contains no evidence of consultation with state and territory governments – the governments that will absorb the public hospital demand the Bill displaces. The

²⁵ Staub, K.E. and Zhang, Y. (2026), *Separating the Effects of Tax Penalties and Subsidies on Private Health Insurance Demand*, Melbourne Institute Working Paper No. 09/26, Melbourne Institute of Applied Economic and Social Research, The University of Melbourne.

²⁶ Finity Consulting (2023). *Review of MLS, PHI Rebate, and LHC*. Retrieved 20/08/2026 from: <https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/>

²⁷ Members Health Fund Alliance, media release, 12 May 2026, citing independent actuarial modelling scaling the Finity findings to the measure proposed in the 2026-27 Budget. Retrieved 20 August 2026 from: <https://membershealth.com.au/>

consequences of that omission are now visible: the health ministers of New South Wales, Queensland and Tasmania have all formally raised concerns about the Bill.

- **NSW Health Minister Ryan Park** has said the Commonwealth is "already putting our system under enormous pressure, with older people stranded in our hospitals and unable to leave" because they cannot access aged care places, and that it is now "adding to this pressure by sending even more people into our public hospitals".²⁸
- **Queensland Health Minister Tim Nicholls** has warned the change will mean "more pressure on Queensland hospitals, more pain on the ramp and less access to health services for all Queenslanders".²⁹
- **Tasmanian Health Minister Bridget Archer** has written to the federal Health Minister calling on him to "reconsider" the legislation.³⁰

CHA's central estimate is that states will bear approximately \$1.1 billion in unfunded cost shift over the forward estimates. This estimate is itself conservative. It applies the usual NHRA cost-sharing arrangements, under which states fund approximately 55 per cent of growth in public hospital activity. However, several states have already reached the National Health Reform Agreement (NHRA) funding cap, meaning that additional activity above the cap is funded 100 per cent by the state. The \$1.1 billion estimate does not account for this additional exposure.

That fiscal transfer was designed without the participation of the governments bearing it. The Commonwealth has proposed a change to the private health insurance rebate that will generate additional public hospital demand, without consulting the governments that will be required to fund and deliver that additional care.

No distributional, regional or facility-level analysis was undertaken

The Impact Analysis treats the affected cohort as a single group. It contains no breakdown of the affected cohort by income within the Base tier; no analysis of how many affected over-65s are Age Pensioners; no assessment of the differential price response of low-income members; no analysis of the geographic distribution of impact; and no assessment of the viability implications for regional private hospitals – despite DHDA's own 2024 Private Hospital Sector Financial Health Check finding that there has been a sustained reduction in sector profitability.

The Government's own quality assurance function found the analysis wanting

The Office of Impact Analysis rated the Impact Analysis "Adequate" – not "Good Practice" – under the Australian Government Guide to Policy Impact Analysis, noting it "would have benefitted from further consultation." DHDA's success metric for the measure compounds the problem: it requires participation to fall by no more than 1 percentage point over two years – a

²⁸ State health ministers unite against controversial private health cuts, *The Senior*, August 2026. Retrieved 21 August 2026 from: <https://www.thesenior.com.au/story/9325752/federal-government-phi-changes-seniors-face-rebate-cuts/>

²⁹ State health ministers unite against controversial private health cuts, *The Senior*, August 2026. Retrieved 21 August 2026 from: <https://www.thesenior.com.au/story/9325752/federal-government-phi-changes-seniors-face-rebate-cuts/>

³⁰ State health ministers unite against controversial private health cuts, *The Senior*, August 2026. Retrieved 21 August 2026 from: <https://www.thesenior.com.au/story/9325752/federal-government-phi-changes-seniors-face-rebate-cuts/>

threshold set approximately seven times above the modelled response, which will be met under almost any scenario, including scenarios involving substantially greater harm than modelled. The metric cannot distinguish a policy working as intended from a policy failing.³¹

The market has moved since the modelling was done

The Impact Analysis assumes a stable market baseline, and its central premise – that older Australians are relatively insensitive to price and will retain cover regardless – rests on evidence generated under materially different economic conditions. The academic work DHDA relies on for the low-elasticity finding examines behaviour in the mid-2000s, a period of rising real incomes and comparatively modest premium growth. The affected cohort now faces a sustained cost-of-living environment in which retirement incomes have not kept pace with the cost of essentials, and in which discretionary and semi-discretionary household spending has already been compressed. Price sensitivity is not a fixed property of an age group; it is a function of the budget constraint the household is operating under, and that constraint has tightened materially since the behaviour DHDA relies on was observed.

Current APRA data indicates the market baseline has also moved. Insurer payout ratios have fallen well below the Government's stated 90 per cent expectation,³² and the 2026 premium increase of 4.41 per cent is the highest in eight years.³³ Participation itself remains stable – 12.79 million Australians held hospital cover at March 2026, of whom 2.67 million were aged 65 and over – which means any contraction that follows this measure will be a policy-induced departure from a stable base rather than the continuation of an existing decline.³⁴ Introducing the Bill against a cohort whose price sensitivity is likely higher than the historical evidence implies means the behavioural response may exceed rather than match DHDA's modelling.

The Bill removes one component of an integrated architecture – ahead of the Government's own review of that architecture

The current private health insurance incentive settings are not a collection of independent levers. The Medicare Levy Surcharge (1997), the rebate (1999), Lifetime Health Cover (2000) and the age-based uplift (2005) were built as an integrated architecture to arrest the collapse in participation that preceded them – from almost 80 per cent of the population before the introduction of Medibank in 1975 to a low of 30.3 per cent in 1998.³⁵ Since the architecture was completed, participation has held between roughly 44 and 47 per cent for a quarter of a

³¹ Department of Health, Disability and Ageing, *Impact Analysis OIA26-11374*, Table 2 (evaluation and review).

³² Australian Prudential Regulation Authority (2026). *Quarterly Private Health Insurance Statistics, March 2026*. Retrieved 19/08/2026 from: <https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics>

³³ Australian Government Department of Health, Disability and Ageing, *PHI 12/26 Private health insurance rebate adjustment factor effective 1 April 2026*. Retrieved 21 August 2026 from: <https://www.health.gov.au/news/phi-circulars/phi-1226-private-health-insurance-rebate-adjustment-factor-effective-1-april-2026>

³⁴ Australian Prudential Regulation Authority (2026). *Quarterly Private Health Insurance Statistics, March 2026*. Retrieved 19/08/2026 from: <https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics>

³⁵ Duckett, S. and Nemet, K. (2019). *The History and Purposes of Private Health Insurance*, Grattan Institute Working Paper No. 2019-01. Retrieved 21 August 2026 from: <https://grattan.edu.au/wp-content/uploads/2019/07/918-The-history-and-purposes-of-private-health-insurance.pdf>

century.³⁶ Finity's review for DHDA observed that, as far as it was aware, there has never been a holistic review of the three instruments together.

This Bill removes one component of that architecture, in isolation, without that holistic review – and while the Government's own Private Health Sector Reform consultation process is running in parallel. Consultation Paper 1 closed on 20 August 2026; Papers 2 and 3 are yet to be released. CHA has engaged constructively with that process, which is designed to consider precisely the structural settings this Bill alters. Legislating a permanent change to the incentive architecture before the Government's own reform process has reported inverts the proper sequence: the reform process should inform the legislation, not inherit its consequences.

The claimed saving is substantially offset by costs shifted elsewhere

Key message: the Bill does not eliminate the cost of caring for older Australians – it moves that cost from the Commonwealth rebate line to public hospitals, state budgets, regional communities and the aged care system. CHA has undertaken the quantification DHDA did not. The results indicate the true net saving is far smaller than the headline \$2,994.7 million, and the costs land on the parts of the system least able to absorb them.

Approximately \$675 million per year flows onto public hospitals – mostly onto the states

CHA's bottom-up estimate anchors on APRA's reported average annual hospital benefits per insured over-65 of approximately \$4,200, applies DHDA's own modelled drops figure, and adds the downgrade response using three explicit scenarios for where downgraders land. Under the central scenario (downgrade destinations following observed APRA patterns after past premium shocks), flow-on cost to public hospitals reaches approximately \$675 million per year at steady state – comprising drops (~\$220m), downgrades to excluding products (~\$245m), effectively uninsured members (~\$75m), deferred care (~\$75m), and indirect system effects (~\$60m). The scenario range is \$325 million (cover-preserving downgrades) to \$1.0 billion (affordability-driven downgrades). Even the most conservative scenario – which takes only DHDA's own drops figure plus minimal downgrade effects – produces \$325 million per year in flow-on costs.

As outlined previously, under the NHRA, states fund approximately 55 per cent of growth in public hospital activity, and 100 per cent of activity above the NHRA funding cap, which several states have reached. Distributing the central estimate across jurisdictions by share of the affected over-65 cohort produces the allocation below, which applies the 55 per cent share throughout and therefore understates exposure for capped states. New South Wales, Victoria and Queensland carry the largest absolute exposure; Tasmania and South Australia the highest per-capita exposure, given their older populations and more limited public substitution capacity.

³⁶ Australian Prudential Regulation Authority (2026). *Quarterly Private Health Insurance Membership and Coverage Statistics*. Retrieved 21 August 2026 from: <https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics>

Table 2: Estimated annual and four-year public hospital flow-on cost by jurisdiction, central scenario³⁷

State	Annual flow-on cost (steady state)	State share (~55%)	4-year state cost
New South Wales	~\$220m	~\$120m	~\$350m
Victoria	~\$170m	~\$95m	~\$275m
Queensland	~\$150m	~\$85m	~\$245m
South Australia	~\$60m	~\$35m	~\$100m
Western Australia	~\$45m	~\$25m	~\$75m
Tasmania	~\$15m	~\$10m	~\$30m
ACT / NT	~\$15m	~\$5m	~\$15m
Total	~\$675m	~\$375m	~\$1,090m

As outlined above, this estimate is consistent with the sector analysis scaling Finity's findings to this measure (\$547 million in public hospital costs against \$482 million in rebate savings),³⁸ and with the concerns now formally raised by three state health ministers. The costs also fall on CHA's own public hospital members – an estimated \$40–70 million per year absorbed by facilities including Calvary Mater Newcastle, Mater Hospital Brisbane, St Vincent's Sydney and Melbourne, and St John of God Midland – through activity-based funding that lags cost by 18–24 months.

Private hospital revenue contracts by \$275–415 million per year – concentrated where it can least be absorbed

CHA estimates the Bill will reduce private hospital revenue across our member network by \$275–415 million per year at steady state – a volume contraction of 2–3 per cent network-wide

³⁷ The estimates in this table are built bottom-up from published government data, anchored wherever possible on the DHDA's own figures. The steady-state annual flow-on of approximately \$675 million comprises three components: former policyholders who drop cover entirely (using the Department's own modelled figure of 44,313 exits from the measure's Impact Analysis, without adjustment); policyholders who downgrade to hospital products excluding the procedures older Australians most commonly require; and deferred care arising from higher excesses. Unit costs draw on APRA's average annual hospital claims cost per insured over-65 (approximately \$4,200), IHACPA's National Efficient Price data for public hospital separations, and AIHW separation cost data by age band. The estimate is deliberately conservative. It does not assume every affected person requires hospital care in a given year – utilisation probabilities are built into each component – nor that every episode reaches a public hospital, with an allowance for patients who self-fund or forgo care. Downgrade behaviour, which the Department has acknowledged was not modelled in its Impact Analysis, is bounded by three destination scenarios; the figures shown reflect the central scenario, with a range of approximately \$325 million to \$1.0 billion per year. Allocation across states reflects ABS population data by age, APRA hospital cover participation by jurisdiction, and the location of private hospital capacity. The state share applies the NHRA's funding split for growth in public hospital activity, under which states fund approximately 55% – a floor rather than a ceiling, as a state that has reached the NHRA funding cap receives no additional Commonwealth contribution for marginal activity and bears 100% of the cost. Four-year figures apply a phasing profile aligned to the savings trajectory in the Portfolio Budget Statements. Full parameters and assumptions are documented in CHA's supporting analysis and are available to the Committee on request.

³⁸ Finity Consulting (2023). *Review of MLS, PHI Rebate, and LHC*. Retrieved 20/08/2026 from: <https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/>

at the central scenario, but 4–6 per cent in regional facilities where over-65s comprise 70–80 per cent of insured separations. Half the impact concentrates in three service lines – joint replacement, cataracts and cardiac procedures – the elective specialties most commonly excluded from downgraded cover. The impact is back-loaded: approximately 75 per cent of the steady-state effect arrives within nine months of the 1 April 2027 commencement. Queensland carries the highest absolute exposure; Tasmania the highest per-capita exposure.

Table 3: Estimated annual revenue impact on CHA private hospital members, by state³⁹

State	Est. annual revenue impact	Most exposed CHA member facilities
QLD	\$85–130 million	Mater Private Bundaberg, St Stephen’s Hervey Bay, Buderim Private; regional Mater network (Rockhampton, Mackay, Townsville)
NSW	\$65–100 million	St Vincent’s Private Lismore, St Vincent’s Private Northside; Calvary Riverina, St Vincent’s Griffith
VIC	\$55–85 million	St John of God Geelong, Ballarat, Bendigo, Warrnambool
SA	\$25–40 million	Calvary Adelaide, Calvary North Adelaide, Calvary Central Districts
WA	\$20–32 million	St John of God Bunbury, St John of God Geraldton
TAS	\$15–22 million	Calvary Lenah Valley, St John’s Hobart, St Luke’s and St Vincent’s Launceston (highest per-capita exposure of any state)
ACT	\$10–14 million	Calvary John James, Calvary Bruce Private
TOTAL	\$275–415 million	

Private hospitals deliver 44 per cent of all admitted episodes of care for Australians aged 65 and over, and just under half of all private hospital episodes, 49.5 per cent in 2024-25, are delivered

³⁹ The estimates in this table apply CHA’s modelled behavioural response to the actual patient profile of CHA member facilities. The starting point is the same behavioural analysis underpinning the public hospital figures: the Department of Health, Disability and Ageing’s own modelled figure of 44,313 policy exits, adopted without adjustment, combined with CHA’s estimate of downgrade behaviour – which the Department has acknowledged was not modelled in its Impact Analysis – at the central of three destination scenarios. That response translates to an estimated 2–3% reduction in privately insured separations across the network at steady state, rising to 4–6% in regional facilities where patients aged 65 and over comprise 70–80% of insured separations. Revenue impacts are then estimated at service-line level using member facility data on catchment demographics, case-mix and service-line revenue, with the impact concentrated in the procedures over-65s most commonly require and downgraded policies most commonly exclude – principally cataract surgery and joint replacement, followed by cardiac procedures, endoscopy and rehabilitation. State allocation reflects the location of the approximately 68 CHA private hospital facilities, the over-65 concentration of each facility’s catchment (ABS Census and regional population data), and private hospital cover participation by age and jurisdiction (APRA). Facility-level data provided by St Vincent’s Private Hospital Lismore – where patients over 65 account for more than 70% of admissions and around 75% of that cohort is privately insured – was used to ground-truth the catchment-level estimates against actual admission, revenue and bed-day figures. The range shown reflects the central destination scenario. Where downgrades prove predominantly cover-preserving, the network impact contracts to approximately \$135–200 million per year; where they concentrate in products excluding high-cost categories, it exceeds the top of the range. Full parameters are documented in CHA’s supporting analysis and are available to the Committee on request.

to that cohort.⁴⁰ The contraction therefore lands on a sector with limited financial headroom to absorb it. Private hospitals recorded an operating loss of \$756 million in 2024-25, the fifth consecutive year of decline,⁴¹ and DHDA's own Financial Health Check found a sustained reduction in sector profitability as costs rose faster than revenue, and identified obstetrics and mental health as services providers were increasingly unable to offer.⁴² Metropolitan facilities and multi-hospital networks retain some capacity to manage a volume reduction through cross-subsidisation and case-mix adjustment, though that capacity is limited on already negative margins. Standalone regional facilities have neither option: they serve the oldest catchments, cannot rebalance case-mix because the demographics of the catchment determine it, and have no local private alternative to absorb displaced volume.

St Vincent's Private Hospital Lismore faces potential closure

The largest private rural hospital in NSW, operated by the Diocese of Lismore since 1921, draws 73 per cent of its admissions and 79 per cent of its bed days from patients aged 65 and over – 75 per cent of whom hold private hospital cover. The hospital's own analysis projects that the Bill could reduce its privately insured over-65 patients by 10–15 per cent: 1,200–1,800 Northern Rivers residents no longer treated each year, and an annual revenue reduction of \$2.6–3.9 million on a not-for-profit cost base. St Vincent's Lismore's conclusion is unambiguous: the impact of the Bill could be a contributing factor to the closure of the hospital. The Northern Rivers – approximately 310,000 people (and ~400,000 from Coffs Harbour to the Gold Coast), in a region still recovering from the 2022 floods, where 36 per cent of the Lismore electorate is aged 65+ – would lose its only private hospital. The displaced demand lands on a public hospital already managing 11,000 presentations a quarter with Category 3 elective waits of up to 12 months.

Calvary's Tasmanian network: sole-provider services in the oldest state

Calvary operates all four of Tasmania's Catholic private hospitals, with combined exposure of \$15–22 million per year – the highest per-capita exposure in the country. Several services are the sole private provider of their kind: St John's operates the only private rehabilitation unit in Hobart; St Luke's the only private mental health facility in the state's north. A service that becomes unviable in Tasmania is not absorbed by a competitor – it is lost, as the 2025 closure of Hobart Private's maternity unit demonstrated. Public substitution capacity is among the weakest in the country: around a third of Tasmanian elective surgery patients are not treated within clinically recommended times, against a national average of 19 per cent, and the public system already carries the highest elective admission rate in Australia at 39.2 per 1,000 population against a national average of 29.1.⁴³ Displaced demand lands on the Royal Hobart and Launceston General hospitals, which have no headroom to absorb it.

The Wide Bay corridor: single providers serving the oldest catchments in Australia

⁴⁰ Australian Institute of Health and Welfare (2026). *Admitted patient care 2024–2025*. Retrieved 21/08/2026 from: <https://www.aihw.gov.au/hospitals/topics/admitted-patient-care>

⁴¹ Australian Bureau of Statistics (2026). *Australian Industry, 2024-25*. Retrieved 21 August 2026 from: <https://www.abs.gov.au/statistics/industry/industry-overview/australian-industry>

⁴² Australian Government Department of Health and Aged Care (2024). *Private Hospital Financial Viability Health Check – Summary*, October 2024. Retrieved 21 August 2026 from: <https://www.health.gov.au/resources/publications/private-hospital-financial-viability-health-check-summary>

⁴³ Australian Institute of Health and Welfare (2025). *Elective surgery: Waiting list activity, 2024–25*. Retrieved 21 August 2026 from: <https://www.aihw.gov.au/hospitals/topics/elective-surgery/waiting-list-activity>

St Stephen's Hospital Hervey Bay (the only not-for-profit private hospital on the Fraser Coast, where 31 per cent of the population is 65+) and Mater Private Bundaberg (25 per cent) carry combined exposure of \$9–14 million per year against small regional cost bases. The corridor has already consolidated once – St Stephen's Maryborough campus closed in 2014 – leaving no local private alternative if either facility contracts. The public hospitals in Hervey Bay and Bundaberg are already under sustained demand pressure.

The sector has already run this experiment: private maternity

The consequences of eroding the insured revenue base beneath a regional service are not hypothetical – they are observable, now, in private maternity. Eighteen private maternity units have closed since 2018, thirteen of them in the past three years,⁴⁴ leaving whole regions – Far North Queensland, the Central Coast of NSW – with no private maternity capacity at all. The mechanism is fully documented: as the insured revenue base eroded, services became unviable and closed; insured women were left paying premiums for services that no longer exist; obstetricians left regional towns entirely because they could not sustain practice without private work – removing them from the local public hospital as well; and displaced demand landed on public maternity units that specialist bodies describe as so stretched they discharge mothers within hours of delivery. Not one of the eighteen closed units has reopened.

This Bill applies the same erosion mechanism to the over-65 insured revenue base – which, for the regional facilities identified above, represents a far larger share of revenue than maternity ever did. At St Vincent's Lismore, over-65 patients account for 73 per cent of admissions; no private maternity unit ever approached that share. The maternity precedent demonstrates both the mechanism and its endpoint: service withdrawal from regional communities is, in practice, permanent.

The Bill also raises the cost of maternity cover for younger families

The maternity precedent is not only a warning about regional service withdrawal. It is a live risk this Bill creates for a cohort the measure does not touch.

Pregnancy and birth is a Gold-tier clinical category. Gold is the smallest and most expensive tier, and its pricing depends on the size and composition of the pool holding it. Older members are a substantial part of that pool, because Gold is the only tier that covers joint replacement, cataracts and cardiac procedures – the categories over-65s use most.

If the Bill moves older members off Gold and into Silver Plus products excluding those categories, the Gold pool contracts and its remaining members are, on average, higher-claiming. Under community rating an insurer cannot recover that by charging older members more; the cost is spread across everyone holding the product. Those left most exposed are the members who hold Gold for the one reason it cannot be substituted – maternity cover. A younger family holding Gold to access private obstetrics would face premium increases driven by a rebate change that does not apply to them.

The timing compounds the risk. Private maternity is already contracting because its insured base is eroding, and none of the eighteen closed units has been replaced. A measure that raises the cost of the only tier covering birth, while the number of women holding that cover is already

⁴⁴ CHA analysis based on public reporting.

falling, accelerates that contraction – as a second-order effect that appears nowhere in the Impact Analysis.

A parallel the Parliament has already drawn

The Senate's 2024 inquiry into bank closures in regional Australia found that regional and remote communities are more dependent on face-to-face services and that branch closures are devastating to them, and recommended that the Government recognise access to financial services as an essential service.⁴⁵ It would be incongruous for the Parliament to protect regional communities' access to bank branches while legislating a measure that erodes the revenue base of the regional hospitals serving the same communities.

The Bill partially consumes the aged care saving it is intended to deliver

The Bill's stated purpose is to fund aged care. Its design works against that purpose. A substantial proportion of residential aged care residents and home care and Support at Home recipients hold private hospital cover, and rely on it for timely access to the elective procedures that most affect function in later life – principally joint replacement and cataract surgery. Where that access is lost through dropped or downgraded cover, patients join public elective waiting lists. Delay to these procedures is an established contributor to falls, immobility and functional decline, and functional decline is a principal driver of transition from home-based care into permanent residential care. Each such transition brought forward generates Commonwealth aged care outlays that offset part of the saving the Bill is designed to produce. This also works directly against the Support at Home reform objective of keeping older Australians living independently for longer.

The saving is not hypothecated to aged care

There is a further difficulty with the Bill's framing. The measure is presented as funding aged care, but nothing in the Bill directs the saving there. Commonwealth savings measures are not hypothecated: the reduction in rebate expenditure returns to consolidated revenue, where it is available for any purpose the Government of the day determines. The aged care investments announced alongside the measure are separate Budget decisions, and they remain available to be varied or reversed by this or any future government independently of the rebate change. The Health Minister has said the saving will re-establish intergenerational equity in the rebate system, with funding freed up to be directed to aged care programs – but that is a statement of intent, not a legislative commitment. The Committee should therefore assess the measure on what the Bill actually does: it removes a defined benefit from a defined group of older Australians, and the destination of the resulting saving is not fixed by the legislation.

Netting it out: the true saving is a fraction of the headline

The \$2,994.7 million headline saving over the forward estimates is stated without any offsetting cost. On CHA's central scenario, approximately \$1.1 billion returns as state-borne public hospital costs and approximately \$900 million as Commonwealth-borne public hospital costs

⁴⁵ Senate Rural and Regional Affairs and Transport References Committee (2024). *Bank closures in regional Australia*, Final Report, 24 May 2024. Retrieved 21 August 2026 from: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Rural_and_Regional_Affairs_and_Transport/BankClosures/Report

(the 45 per cent NHRA share) with further outlays in aged care as delayed elective surgery accelerates entry to residential care. Roughly two-thirds of the headline saving is therefore consumed by costs the measure itself creates, leaving a consolidated government saving of the order of \$700–800 million rather than \$3 billion.

What remains is less a saving than a transfer. The Commonwealth's own position stays clearly positive, because it retains the full rebate saving while bearing only 45 per cent of the public hospital cost, and none of it where a state sits at the NHRA funding cap. The states carry approximately \$1.1 billion they were not consulted on and did not budget for. The cost falls, in the first instance, on low-income older Australians who lose access to care, and in the second, on the state health systems that must absorb them.

This should not surprise DHDA. Its own commissioned review found that the rebate paid to over-65s supports more privately-funded care than it costs, as outlined above. The over-65 rebate is the most leveraged component of the rebate architecture, because it is paid to the cohort with the highest claims. Removing the age-based uplift removes that leverage precisely where it does the most work, which is why the offsetting costs identified in this section consume so much of the headline saving.

Recommendation

Before the Committee reports, CHA encourages DHDA to publish quantified modelling of downgrade behaviour and its destinations; quantified modelling of the public hospital flow-on cost, including its distribution between the Commonwealth and the states; distributional analysis of the affected cohort by income and Age Pension status; and an assessment of the regional impact, including the viability of regional private hospitals and the capacity of the public hospitals that would absorb displaced demand. Where that analysis confirms the behavioural response concentrates among low-income older Australians, as DHDA's own modelling indicates, the Government should give consideration to measures that protect those least able to absorb the change. The Government should also consult the states and territories that will fund and deliver that demand, replace the current success metric with an independent post-implementation review reporting no earlier than 2030, and consider this measure within its own private health sector reform process rather than ahead of it.