

The Senate

Community Affairs Legislation
Committee

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

October 2026

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Abbreviations

AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
APRA	Australian Prudential Regulation Authority
COTA	Council on the Ageing Australia
CPI	consumer price index
EM	Explanatory Memorandum
ICESCR	International Covenant on Economic, Social and Cultural Right
LHC	Lifetime Health Cover
MLS	Medicare Levy Surcharge
NSA	National Seniors Australia
PHI	private health insurance
PHI Act	<i>Private Health Insurance Act 2007</i>
the bill	Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026
the committee	Community Affairs Legislation Committee
the Department	Department of Health, Disability and Ageing
the Melbourne Institute	Melbourne Institute of Applied Economic and Social Research
the Minister	Hon Mark Butler, Minister for Health and Ageing
the rebate	private health insurance rebate
the statement	Statement of Compatibility with Human Rights

List of recommendations

Recommendation 1

2.86 The committee recommends the bill be passed.

Chapter 1

Information about the bill

Referral

- 1.1 On 25 June 2026, the Minister for Disability and the National Disability Insurance Scheme and the Minister for Health and Ageing, the Hon Mark Butler MP (the Minister), introduced the Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026 (the bill) to the House of Representatives.¹
- 1.2 On the same day, the Senate referred the provisions of the bill to the Community Affairs Legislation Committee (the committee) for inquiry and report by 7 October 2026.²

Purpose of the bill

- 1.3 The bill would amend the private health insurance rebate (the rebate) set out in the *Private Health Insurance Act 2007* (the PHI Act) to remove the higher rebates paid for people aged 65 and over.³
- 1.4 Removal of the additional aged-based rebate was announced in the 2026–27 Budget. The Budget measure is estimated to save \$3 billion over the four years leading up to 2029–30 which would be invested into aged care services including:
 - providing targeted capital subsidies for residential aged care, providing additional funding for supported residents for newly built or refurbished homes;
 - increasing the accommodation supplement and structural changes to introduce new tiers, and additional payment for homes with more than 60 per cent supported residents;
 - delivering twenty additional Specialist Dementia Care units and expand the Hospital to Aged Care Dementia Support Program; and
 - expanding access to the Support at Home program and make improvements to the program so that it is fairer and more affordable for older Australians.⁴

¹ *House of Representatives Votes and Proceedings*, No. 67, 25 June 2026, p. 815.

² *Journals of the Senate*, No. 53, 25 June 2026, p. 1871.

³ Explanatory Memorandum (EM), p. 1.

⁴ EM, pp. 10–11.

- 1.5 The amendment would result in the means-tested rebate being calculated by income alone, with individuals on a lower income receiving a higher rebate.⁵
- 1.6 In his second reading speech, the Minister noted:
- the higher rebate for people aged 65 and above means two houses on the same income receive different levels of government rebate based only on their age. This is in addition to older people's health insurance claims already being cross-subsidised by younger policyholders under community rating, which means everyone pays the same premium for the same policy, regardless of their gender or their health status.⁶
- 1.7 As such, the purpose of the amendment is to 'address intergenerational inequity, simplify, and better target the rebate for private health insurance premiums'.⁷

Background

Australian health care system

- 1.8 Australia has both a public and private health system that operates in a complementary way to provide health care to millions of Australians.
- 1.9 Medicare is Australia's universal health insurance scheme. It 'subsidises some or all of the costs of various medical services, including services delivered in public and private hospitals'.⁸ Medicare allows all Australians to have equitable access to health care when they need it, regardless of their location, ability to pay or if they hold private health insurance cover or not.
- 1.10 The public health system is supported by private health which provides a way to manage health care costs for services not covered by Medicare including costs associated with ambulance services, most dental services, optical aids and other specialist services. It also provides policy holders with the option to avoid public system waiting lists and the ability to choose their own doctor.

⁵ EM, p. 1.

⁶ The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 3.

⁷ The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 3.

⁸ Australian Institute of Health and Welfare, 9 July 2026, www.aihw.gov.au/reports/australias-health/health-system-overview (accessed 10 September 2026).

Private health care in Australia

- 1.11 Around 15.4 million people rely on private health insurance (PHI) in Australia to support their access to healthcare.⁹ In the 2025 calendar year, \$31.9 billion was spent on insurer premiums with \$27.2 billion in benefits paid.¹⁰
- 1.12 Depending on the tier of insurance, PHI products can offer coverage for hospital care, medical services and general treatment, pharmaceutical and ambulance services.¹¹ PHI providers offer hospital cover, extras, combined cover and ambulance only cover.
- 1.13 Quarterly private health insurance membership and benefits data from the Australian Prudential Regulation Authority (APRA) note that ‘at 30 June 2026, 12,823,752 people, or 45.8% of the population, were covered by hospital treatment cover’ while ‘15,525,399 people or 55.5% of the population had some form of general treatment cover’ (known commonly as extras cover).¹² Individuals may hold both hospital treatment cover and some form of extras cover and these figures should be read as such.
- 1.14 PHI in Australia is community rated rather than risk rated. This means insurers must offer PHI products at the same price to all customers regardless of their individual risk factors such as age, health status or claims history.¹³
- 1.15 The Explanatory Memorandum (EM) notes that strong PHI participation, especially amongst young and healthy individuals and with an ageing

⁹ EM, p. 10.

¹⁰ Australian Prudential Regulation Authority, *Quarterly private health insurance statistics December 2025*, 27 February 2026, www.apra.gov.au/news-and-publications/apra-releases-quarterly-insurance-statistics-december-2025 (accessed 10 September 2026).

¹¹ Private Health Insurance Ombudsman, *Overview of Health System*, www.privatehealth.gov.au/health_insurance/what_is_covered/index.html (accessed 10 September 2026).

¹² Australian Prudential Regulation Authority, *Quarterly private health insurance membership and benefits summary - June 2026*, 27 August 2026, www.apra.gov.au/quarterly-private-health-insurance-membership-and-benefits-summary-june-2026#toc-membership-and-coverage (accessed 10 September 2026). See also, at the public hearing on 23 September 2026, representatives from the Department of Health Disability and Ageing noted ‘from a broad departmental basis, we believe that having a blend between the private and the public system has served us well. I think we have about 15.7 million people with private health insurance. It is a growing industry, so we see more people taking up cover. It plays a fundamental role in Australia’s health system’. Mr Paul McBride, Assistant Secretary, Private Health Strategy Branch, Department of Health, Disability and Ageing, *Committee Hansard*, 23 September 2026, p. 44.

¹³ Private Healthcare Australia, *Private Health Insurance Community Rating System*, www.privatehealthcareaustralia.org.au/consumers/private-health-insurance-community-rating-system/ (accessed 10 September 2026).

population of PHI holders, 'is critical to PHI affordability and takes pressure off the public health system'.¹⁴

History of the PHI rebate

- 1.16 PHI is not compulsory; however, a number of government incentives and measures exist to encourage take-up including the Medicare Levy Surcharge (MLS)¹⁵, Lifetime Health Cover (LHC)¹⁶ and the PHI rebate.¹⁷
- 1.17 The EM notes 'individuals with PHI make a significant contribution to financing the cost of their own health care and to funding the Australian healthcare system' and in 'recognition of this valuable contribution' the PHI rebate was created to provide financial incentive to eligible consumers.¹⁸
- 1.18 The PHI rebate was introduced in 1999 by the Howard Government.¹⁹ The initial rebate provided a 30 per cent discount for all policy holders regardless of age or income and increased again in 2004.²⁰ The introduction of the PHI rebate 'was associated with a 2 percentage point increase in the proportion of the Australian population holding PHI' with the higher age based rebate in 2005 having a more modest impact of 0.9 per cent to 2.7 per cent depending on the age of the policy holder.²¹
- 1.19 Further changes came into place in 2005 with higher rebates provided for older Australians – 35% for those aged 65 - 69; and 40 per cent for those 70 years and older. In 2012, the Gillard Government introduced income testing with those on incomes above a certain indexed threshold receiving a lower rebate or no rebate at all.²²

¹⁴ EM, p. 10.

¹⁵ Private Health Insurance Ombudsman, *Medicare Levy Surcharge*, www.privatehealth.gov.au/health_insurance/surcharges_incentives/medicare_levy.htm (accessed 10 September 2026).

¹⁶ Private Health Insurance Ombudsman, *Lifetime Health Cover*, www.privatehealth.gov.au/health_insurance/surcharges_incentives/lifetime_health_cover.htm (accessed 10 September 2026).

¹⁷ Private Health Insurance Ombudsman, *Australian Government Private Health Insurance Rebate*, www.privatehealth.gov.au/health_insurance/surcharges_incentives/insurance_rebate.htm (accessed 10 September 2026).

¹⁸ EM, p. 12.

¹⁹ Department of Health, Disability and Ageing, submission 43, p. 7.

²⁰ The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 3.

²¹ Department of Health, Disability and Ageing, submission 43, p. 14.

²² The Hon Tanya Plibersek MP, Minister for Health, 'Means-test is historic victory for working Australians', *Media Release*, 15 February 2012.

1.20 Additional changes in 2014 had the rebate calculated as the difference between the consumer price index (CPI) and industry weighted average increase in premiums.²³ This resulted in a lower rebate over time.

1.21 Current PHI rebate and MLS setting as of 1 July 2026 are as follows:

Table 1.1 Rebate and MLS settings as at 1 July 2026

	Income Tiers			
Singles Tier threshold	< \$105,000	\$105,001-123,000	\$123,001-164,000	>\$164,001
Families Tier threshold	< \$210,000	\$210,001-246,000	\$246,001-328,000	>\$328,001
	PHI Rebate %			
	Base Tier	Tier 1	Tier 2	Tier 3
Age <65	24.118%	16.079%	8.038%	0%
Age 65-69	28.139%	20.098%	12.058%	0%
Age 70+	32.158%	24.118%	16.079%	0%
	MLS %			
	0.0%	1.0%	1.25%	1.5%

Source: EM, p. 12.

1.22 PHI incentives have remained largely unchanged for the last two decades with the EM describing them as currently ‘suboptimal’. The EM identifies the PHI rebate settings in particular as both:

- complex due to the multiple rates calculations by both age and income criteria; and
- poorly targeted and inequitable with the same rebate amount applying to older Australians even if they share the same income levels as a younger Australian and would likely still maintain PHI coverage without a higher rebate.²⁴

1.23 In his second reading speech, the Minister noted that the Government invests approximately \$8 billion a year in the rebate to assist in making PHI more affordable and to reduce pressure on the public health system.²⁵ The Minister also went on to note:

...older Australians are more likely to retain private health insurance, and they receive significantly higher benefits on average than younger Australians. This means the inequitable targeting of the rebate simply does not align with its purpose to incentivise take-up. And the current model is simply not the best way to spend taxpayers' dollars on behalf of older

²³ Department of Health, Disability and Ageing, submission 43, p. 7.

²⁴ EM, p. 13.

²⁵ The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 3.

Australians when there is a significant need to expand access to aged-care services.²⁶

Financial impact statement

- 1.24 The EM states that the financial impact for the Commonwealth will be a reduction in expenditure of -\$2,994.7m for the four years up to 2029–2030.²⁷ There will also be an ongoing reduction in expenditure.²⁸

Key provisions of the bill

- 1.25 The key change to the PHI Act will remove the current higher PHI rebate for eligible policy holders aged 65 and over with changes to take effect on 1 April 2027.²⁹

Schedule 1 - amendments

Item 1 – paragraphs 22-15(1)(b) and (c)

- 1.26 Existing paragraphs 22-15(1)(b) and (c) will be replaced with a single paragraph 22-15(1)(b) which will amend the legislation so that the same percentage and calculation methods apply to individuals above and below the age of 65.³⁰
- 1.27 Proposed paragraph 22-15(1)(b) ‘points back’ to paragraph 22-15(1)(a) which ‘makes provision for calculating the rebate percentage for people aged under 65’. To make this clear, Item 1 adds a note underneath paragraph 22-15(1)(b).³¹
- 1.28 The above changes are made to ensure pre-existing references to income tier thresholds, their respective annual indexation calculations and rebate percentages are retained.³²

Item 2 – subsections 22-15(2), (3) and (4)

- 1.29 These subsections set out how the rebate will be calculated by reference to PHI income tiers. This item will remove ‘redundant’ references to higher rebate percentages for people aged 65 and over.³³ The bill will not change the income

²⁶ The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 3.

²⁷ EM, p. 1.

²⁸ EM, p. 1.

²⁹ EM, p. 3.

³⁰ EM, p. 3.

³¹ EM, p. 3.

³² EM, p. 3.

³³ EM, p. 4.

tiers or their indexation with rebate percentages published annually after indexation on the Department of Health, Disability and Ageing's website.³⁴

Item 3 – subsections 22-15(5A)

- 1.30 This item updates the reference to rebate percentages that are subject to annual indexation calculation so that it no longer refers to the higher rebate percentages for people aged 65 and over.³⁵

Item 4 – Subsection 22-15(6)

- 1.31 This subsection provides that 'for the purpose of rebate calculations, any part of a PHI premium related to the lifetime health cover loading set out in Division 34 of the PHI Act is not to be considered'. This item updates the reference to the rebate calculation so it no longer refers to the higher percentages for older people that will be removed by item 1 of this bill.³⁶

Item 5 – section 22-25 (and consequential amendments)

- 1.32 This section allowed for a higher rebate for an older person to continue to apply to another person under the same PHI policy in circumstances where the older person may no longer be covered by the policy.³⁷ This would no longer apply with the higher rebate percentage for people aged 65 and over being removed by item 1 of the bill. Item 5 removes the redundant section.³⁸

Item 7 – Application provision

- 1.33 This item provides that the amendments in this bill that remove the higher rebate percentages for older people will apply to amounts of premium paid on or after 1 April 2027 regardless of if it is calculated with the rebate applied by the insurer or the rebate is claimed later through a tax offset.³⁹

Consideration by other committees

- 1.34 Both the Parliamentary Joint Committee on Human Rights and the Senate Standing Committee for the Scrutiny of Bills made no comment on the bill.⁴⁰

³⁴ Department of Health, Disability and Ageing, *PHI 21/25 Private health insurance rebate adjustment factor effective 1 April 2025*, 26 February 2025, www.health.gov.au/news/phi-circulars/phi-2125-private-health-insurance-rebate-adjustment-factor-effective-1-april-2025?language=en (accessed 9 September 2026).

³⁵ EM, p. 4.

³⁶ EM, p. 4.

³⁷ EM, p. 4.

³⁸ EM, p. 4.

³⁹ EM, p. 5.

⁴⁰ Parliamentary Joint Committee on Human Right, *Report 9 of 2026*, 12 August 2026, p. 17 and Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 8 of 2026*, 1 July 2026, p. 3.

Compatibility with human rights

- 1.35 The bill's Statement of Compatibility with Human Rights (the statement) noted the bill is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.⁴¹
- 1.36 The statement notes the bill engages the following human rights:
- Right to Health - Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR); and
 - Right to Social Security – Article 9 of the ICESCR.⁴²
- 1.37 The bill also engages with the rights of equality and non-discrimination contained in articles 2, 16 and 26 of the International Covenant on Civil and Political Rights.⁴³
- 1.38 The statement concludes that the bill is 'compatible with human rights as it maintains the right to health, the right to social security and the right of equality and non-discrimination'.⁴⁴

Conduct of the inquiry

- 1.39 In accordance with its usual practice, the committee advertised the inquiry on its website and invited relevant individuals and organisations to make submissions. The date for the receipt of submissions was 21 August 2026, and the committee received 665 submissions, which are listed at Appendix 1.
- 1.40 The committee held four public hearings:
- 3 September 2026 in the Gold Coast;
 - 4 September 2026 in Sydney;
 - 11 September 2026 in Canberra; and
 - 23 September 2026 in Perth.

Acknowledgements

- 1.41 The committee thanks the organisations and individuals who contributed to the inquiry by making written submissions and appearing as witnesses at the public hearings.

⁴¹ The bill's statement of Compatibility with Human Rights is contained within the bill's EM. EM, Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026, *Statement of Compatibility with Human Rights*, p. 6.

⁴² EM, p. 7.

⁴³ EM, p. 7.

⁴⁴ EM, p. 8.

Chapter 2

Views on the bill

- 2.1 This chapter considers the views on the Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026 (the bill) and its proposed amendment to the private health insurance rebate (the rebate).
- 2.2 The chapter begins with discussing the intent of the bill, including addressing intergenerational inequity, simplifying the rebate, and redirecting savings from the proposed change to much needed aged care services.
- 2.3 The chapter examines the range of concerns received in evidence. It concludes with the committee's view and recommendation on the bill.

Intent of the bill

- 2.4 There was broad recognition provided in evidence of the bill's intent to address the need to increase investment in aged care.¹

Intergenerational inequity

- 2.5 The Melbourne Institute of Applied Economic and Social Research, University of Melbourne (the Melbourne Institute) supported the bill's purpose noting that removing the higher PHI rebate for people aged 65 and over 'corrects a poorly targeted subsidy'.² They argued that the bill 'will improve inequity' and that financial support should target those most in need based on their income rather than age.³
- 2.6 In their submission, the Synod of Victoria and Tasmania, Uniting Church in Australia noted that they see the bill as a 'small positive change to address inequality in Australia's private health insurance system'.⁴
- 2.7 The Australia Institute supported the purpose of the bill and pointed to the existing generational 'cross-subsiding' that is present in the current system with

¹ See, for example, Day Hospitals Australia, *Submission 294*, [p. 1]; Australian Medical Association, *Submission 19*, p. 2; Queensland Health, *Submission 45*, [p. 1]; Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 4 September 2026, p. 16; Mr Nicholas John Bailey, Senior Executive, Healthcare Funding and Policy, Medibank *Committee Hansard*, 4 September 2026, p. 28.

² Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 3].

³ Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 6].

⁴ Uniting Church in Australia, Synod of Victoria and Tasmania, *Submission 23*, p. 2.

younger Australians (who generally have lower claims) cross-subsidise the higher claims of older Australians.⁵

- 2.8 In their submission, the Department of Health, Disability and Ageing (the Department) set out that the bill will enable a ‘simplified and more equitable’ distribution of government financial support of PHI.⁶
- 2.9 Inquiry participants acknowledged the Government’s objective of addressing intergenerational inequity, simplifying, and better targeting the rebate for private health insurance premiums.⁷
- 2.10 For example, Medibank ‘recognised’ the Government’s goal to improve intergenerational inequity and noted their support of the ‘long term sustainability of expenditure’.⁸ However, they drew attention to the role private health insurance (PHI) plays in the Australian health system and their ‘strong interest in ensuring any reforms are carefully considered and do not unintentionally reduce participation among older Australians’.⁹
- 2.11 Bupa also noted the Government’s objective of addressing intergenerational inequity but argued that ‘focusing solely on removing support from older Australians does not address the underlying structural challenges facing private health insurance participation’.¹⁰
- 2.12 Council on the Ageing Australia (COTA) acknowledged the bill’s ‘objective of creating a simpler and more consistent rebate structure’ but noted they ‘are concerned that age neutrality does not necessarily equate to inequity’.¹¹

Funding Aged Care

- 2.13 As described by the Minister for Health, Disability and Ageing, the Hon Mark Butler (the Minister), ‘savings from this rebate change will provide important support for older people through improvements that are absolutely necessary to aged care’.¹²

⁵ The Australia Institute, *Submission 20*, p. 3.

⁶ Department of Health, Disability and Ageing, *Submission 43*, p. 4.

⁷ See, The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 3.

⁸ Medibank, *Submission 33*, p. 2.

⁹ Medibank, *Submission 33*, p. 3.

¹⁰ Bupa, *Submission 8*, p. 5.

¹¹ Council of the Ageing Australia, *Submission 25*, p. 4.

¹² The Hon Mark Butler MP, Minister for Health and Ageing, *House of Representatives Hansard*, 25 June 2026, p. 4.

- 2.14 A number of submitters acknowledged and supported the Government's 'commitment to strengthen Australia's aged care system and the significant investment required to meet the needs of an ageing population'.¹³
- 2.15 Both the Australia Institute and the Melbourne Institute supported the redirection of the proposed savings from the bill to fund aged care services¹⁴ as a 'more direct and effective way to alleviate pressure on public hospitals'.¹⁵
- 2.16 At a hearing on 3 September 2026, Dr Duckett who expressed support for the bill and the re-investment of funding into aged care pointed out that:
- ...with improved funding of aged care, improved expansion of community support and improved expansion of residential aged care, I think there will be direct and obvious benefits to states in the provision of public hospital care.¹⁶
- 2.17 The Australian Medical Association (AMA) 'welcomed' the recognition that there is an urgent need for increased aged care funding, arguing however, that it should not come at the expense of older Australians who hold PHI.¹⁷
- 2.18 HBF, in their evidence to the committee at a public hearing on 23 September 2026, noted they 'support sustainable funding for aged care' noting however, that the change will see increases to healthcare costs for older Australians at 'the stage of life when they need it most'.¹⁸

Potential impacts on public and private health care

- 2.19 The committee received a breadth of evidence on potential impacts the bill may have on both the public and private health care systems.¹⁹

¹³ See, for example, Medibank, *Submission 33*, p. 2; Queensland Health, *Submission 45*, [p. 1].

¹⁴ Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 3].

¹⁵ The Australia Institute, *Submission 20*, p. 4.

¹⁶ Dr Stephen Duckett, *Committee Hansard*, 3 September 2026, p. 26.

¹⁷ Australian Medical Association, *Submission 19*, p. 2.

¹⁸ Dr Lachlan Henderson, Chief Executive Officer, HBF Health, *Committee Hansard*, 23 September 2026, p. 12.

¹⁹ See, for example, Australian Private Hospitals Association, *Submission 1*; Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*; Catholic Health Australia, *Submission 44*; Day Hospitals Australia, *Submission 294*; Department of Health, Disability and Ageing, *Submission 43*.

Balancing the demand on the public and private health systems

- 2.20 Inquiry participants raised concerns about potential unintended consequences a rebate change may have across the health system – including the impacts on the viability of private hospitals and pressure on public hospitals.²⁰
- 2.21 Members Health Fund Alliance observed the change may result in a risk of ‘shifting healthcare demand from privately funded settings into already stretched public hospitals, with consequences for all Australians who rely on timely access to care’.²¹
- 2.22 Similarly, the Australian Private Hospitals Association (APHA) raised concerns with the potential impacts on patients in both the private and public hospitals.²²
- 2.23 The AMA drew attention to the role PHI plays in ‘supporting patient choice, sustaining private hospitals and specialist services, and relieving pressure on public hospital’.²³
- 2.24 The Melbourne Institute submitted that the evidence base supporting removal of the higher rebate is ‘sound’ and directly addressed the ‘likely objection’ that any reduction in PHI coverage would ‘overload’ public hospitals.²⁴
- 2.25 Research undertaken in 2024 by academics from the Melbourne Institute used ‘linked hospital administrative data and an instrumental-variables design’ to estimate the relationship between PHI coverage and public hospital waiting times and found that a ‘one percentage-point increase in the PHI coverage rate reduces public elective waiting times by about 0.34 days (0.5%) on average’.²⁵ They noted that this is ‘statistically significant but practically small’.²⁶

²⁰ See, for example, Medibank, *Submission 33*, p. 4; Bupa, *Submission 8*, pp. 4-6; Ms Kristina Green, General Manager, Member Experience, HIF Australia, *Committee Hansard*, 23 September 2026, p. 13; Mr Paul Lupo, Chief Executive Officer, St Lukes, *Committee Hansard*, 4 September 2026, p. 32; Ms Patricia Sparrow, Ms Patricia, Chief Executive Officer, Council on the Ageing Australia, *Committee Hansard*, 3 September 2026, p. 2; Ms Tricia Matthias, Executive Director, System Policy Branch, System Policy and Planning Division, Queensland Health, *Committee Hansard*, 3 September 2026, p. 12; Andrea, *Committee Hansard*, 3 September 2026, p. 34.

²¹ Members Health Fund Alliance, *Submission 30*, p. 4.

²² Australian Private Hospitals Association, *Submission 1*, pp. 9 and 13.

²³ Australian Medical Association, *Submission 19*, p. 2.

²⁴ Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 3].

²⁵ Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 5].

²⁶ Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 5].

- 2.26 The Department, drawing on the Melbourne Institute's research, noted they expect any impact on public health hospitals to be 'marginal'²⁷ with the Government continuing to provide 'record' funding for public hospital services as part of the National Health Reform Agreement.²⁸
- 2.27 The Department also noted in their submission that:
- The relationship between PHI status and forecasting public hospital activity is not straightforward. Many people with PHI are already treated in public hospitals and only some of them elect to be treated privately. Whether a patient receives care through a public or private hospital is not solely determined by whether they hold PHI. Care decisions are influenced by service availability, urgency and type of care, patient preferences and hospital admission practices. This means changes in PHI participation do not translate directly into equivalent changes in public hospital demand.²⁹
- 2.28 The Department acknowledged 'the financial and operational pressures facing parts of the private hospital sector and the concerns raised by some stakeholders about hospital viability' noting these challenges are 'influenced by a range of factors'. The Department advised that the Government is 'actively considering these issues through a broader program of private health sector reform'.³⁰

Specialist health care

- 2.29 A number of specialist health societies and colleges drew the committee's attention to potential impacts on access to address health matters that are 'overwhelmingly a condition of older age'.³¹ These health issues often require timely treatment, including cataract surgery, cancer, vascular issues and colorectal issues.³²
- 2.30 The Australian and New Zealand Society of Vascular Surgeons noted the role PHI plays in providing 'additional capacity' to the health system, particularly for vascular surgery. They argued that the 'private sector is not simply an alternative funding mechanism' but a way to manage the demand on surgical specialities.³³

²⁷ Department of Health, Disability and Ageing, *Submission 43*, p. 2.

²⁸ Department of Health, Disability and Ageing, *Submission 43*, p. 11.

²⁹ Department of Health, Disability and Ageing, *Submission 43*, p. 23.

³⁰ Department of Health, Disability and Ageing, *Submission 43*, pp. 22–23.

³¹ The Australian Society of Ophthalmologists, *Submission 10*, p. 3.

³² See, for example, The Australian Society of Ophthalmologists, *Submission 10*, Australian and New Zealand Society for Vascular Surgery, *Submission 24*; Colorectal Surgical Society of Australia and New Zealand, *Submission 26*, p. 2.

³³ Australian and New Zealand Society for Vascular Surgery, *Submission 24*, p. 9.

- 2.31 The Colorectal Surgical Society of Australia and New Zealand echoed this view in their submission, arguing for the importance of timely treatment and removing the pressure from public surgery waiting lists.³⁴
- 2.32 COTA added to this and noted their concern that changes to coverage and the potential consequences of delayed treatment may have on the 'day to day function and quality of life' for older Australians.³⁵
- 2.33 Similarly, National Seniors Australia (NSA) expressed concern that there is 'limited understanding about the impact of the rebate cut on the public health system' including wait times for elective surgeries.³⁶
- 2.34 Michelle, who provided evidence as part of the lived experience panel at the 23 September 2026 hearing in Perth, shared the importance of timely access to treatment:

...immediate clinical intervention for life-threatening illnesses saved my husband's life. Because he had private health insurance, he was able to have surgery that was not readily available in the public system for a life-threatening illness. His cancer was robotically removed, and he was home within 10 days as compared to much longer waits in the public system.³⁷

Access to health care not covered by Medicare

- 2.35 Multiple submissions raised potential impacts on timely access to health care services, and treatments and products that are not covered by Medicare – many which carry high costs.³⁸
- 2.36 For example, at a hearing in Sydney on 4 September 2026, Judy told the committee:

When you're 70, waiting months for treatment isn't just an inconvenience; it can mean losing mobility, losing independence or facing complications that could have been avoided. I have a medical procedure scheduled for next Thursday. Because I have private health insurance, I can have it done straight away with a doctor I know and feel comfortable with. I trust him, and that trust matters when you're dealing with health issues at my age. If I were relying on the public system, I'd be waiting much longer—potentially

³⁴ Colorectal Surgical Society of Australia and New Zealand, *Submission 26*, p. 2.

³⁵ Council on the Ageing Australia, *Submission 25*, p. 14.

³⁶ National Seniors Australia, *Submission 47*, p. 3.

³⁷ Michelle, private capacity, *Committee Hansard*, 23 September 2026, p. 21.

³⁸ See, for example physiotherapy, chiropractic treatment, home nursing, dental treatment, orthodontics, speech therapy, glasses and contact lenses. Department of Health, Disability and Ageing, *Extras and ambulance cover*, 24 December 2019, www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers/extras-and-ambulance-cover#extras-cover (accessed 23 September 2026).

months. That delay could not be just inconvenient; it could also affect my health and my quality of life.³⁹

2.37 In their submission, Brian and Margaret Crawford shared:

My wife and I are 80yo and 77yo respectively and have maintained PHI for our entire married lives including for our 3 children. In the past 20 years both of us have undergone major surgeries involving lengthy rehabilitation periods. Thanks to our private health cover, treatment was almost fully covered by our PHI with minimal waiting or delays. Maintaining our PHI has been critical to our ongoing health and well-being, and we need to maintain it more than ever at our stage of life.⁴⁰

2.38 The Australian Dental Association asked the committee to consider ‘the potential implications’ on older Australian’s access to oral healthcare especially if higher net premium costs ‘influence decisions to downgrade or discontinue private health insurance, including dental extras cover’.⁴¹

2.39 The Deafness Forum noted their support for the ‘efficient use of public health resources’ but had concerns on how the proposed changes could impact access to these services and products.⁴²

2.40 The Deafness Forum asserted that many older Australians experiencing hearing loss and who rely on assistive technology (cochlear implants and hearing aids) hold relevant policies and extras cover as a ‘means of financial protection against out-of-pocket expenses’.⁴³

Potential impacts on PHI participation: dropping or downgrading cover

Impacts on participation

2.41 Evidence received in hearings⁴⁴ and a number of submissions⁴⁵ raised the potential impacts of the change to the rebate would have on policyholders cancelling their coverage or downgrading to more ‘affordable’ options.

³⁹ Judy, private capacity, *Committee Hansard*, 4 September 2026, p. 56.

⁴⁰ Brian and Margaret Crawford, *Submission 167*, [p. 1].

⁴¹ Australian Dental Association, *Submission 40*, [p. 1].

⁴² Deafness Forum Australia, *Submission 9*, [p. 2].

⁴³ Deafness Forum Australia, *Submission 9*, [p. 2].

⁴⁴ See, for example, Ms Patricia Sparrow, Chief Executive Officer, Council on the Ageing Australia, *Committee Hansard*, 3 September 2026, p. 1; Mrs Kate Williams, Managing Director, Health Insurance, Bupa, *Committee Hansard*, 4 September 2026, p. 28; Dr Lachlan Henderson, Chief Executive Officer, HBF Health, *Committee Hansard*, 23 September 2026, p. 12; Dr Brigid Corrigan, President, Australian Society of Plastic Surgeons, *Committee Hansard*, 23 September 2026, p. 26.

⁴⁵ See for example National Seniors Australia, *Submission 47* p. 3; Medibank, *Submission 33*, p. 4; Australian Private Hospitals Association, *Submission 1*, p. 11; St Lukes, *Submission 28*, p. 7.

2.42 Many private individuals told the committee that they were considering downgrading or dropping their covers if premiums were to significantly rise, thus becoming unaffordable.⁴⁶

2.43 Private health insurers warned the committee about the potential negative impacts on affordability and costs of premiums noting, in particular, the commencement of the changes aligning with the April 2027 industry premium changes.⁴⁷ For example, Medibank posited that:

If participation in comprehensive products declines, the costs associated with these services will become concentrated among a smaller pool of customers. This could place upward pressure on premiums for remaining policyholders, further reducing affordability and potentially contributing to a cycle of ongoing downgrades and declining participation in comprehensive cover. The impacts may be particularly pronounced for pensioners and lower-income older Australians, who often have less capacity to absorb increases in insurance costs and are more likely to be living on fixed incomes.⁴⁸

2.44 HCF asked the committee to consider how the bill may improve or worsen 'affordability, participation and access to care' for older Australians.⁴⁹

2.45 Professor Zhang, from the Melbourne Institute, provided evidence at a public hearing on 4 September 2026 on potential impacts on participation noting historical responses to changes to the rebate:

In 2012, the rebate became means tested, so those on lower incomes got more, which was great. Back then, there was similar private polling that asked people how they were going to respond, and a population of 1.6 million—based on that polling—said they were going to drop private cover, but in reality it didn't happen. Actually, the number of people increased after that means testing. So I think that number very likely overstates how people will respond.⁵⁰

2.46 In their submission, the Department acknowledged that the change to the rebate may have some policyholders reviewing their level of PHI cover to choose a product that 'better matches their financial circumstances and expected health needs'.⁵¹

⁴⁶ See, for example, Michelle, private capacity, *Committee Hansard*, 23 September 2026, p. 20; Handley, private capacity, *Committee Hansard*, 3 September 2026, p. 35; Ron, private capacity, *Committee Hansard*, 3 September 2026, p. 35; Judy, private capacity, *Committee Hansard*, 4 September 2026, p. 56.

⁴⁷ See, for example, HCF, *Submission 22*, p. 4; Bupa, *Submission 8*, p. 5; Medibank, *Submission 33*, p. 3.

⁴⁸ Medibank, *Submission 33*, p. 4.

⁴⁹ HCF, *Submission 22*, p. 4.

⁵⁰ Professor Yuting Zhang, Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Committee Hansard*, 4 September 2026, p. 6.

⁵¹ Department of Health, Disability and Ageing, *Submission 43*, p. 16.

2.47 The Department noted that a general trend of downgrading is occurring across the PHI market:

...for people aged under 65, the proportion of insured people holding Gold cover fell from 25.2% to 17.9%, while both Silver and Bronze cover increased [and for] for people aged 65 and over, the proportion of insured people holding Gold cover fell from 52.0% to 41.2%, while Silver cover increased from 33.2% to 42.1% (for a total of over 83% on Gold or Silver). Bronze and Basic cover among people aged 65 and over remained low and broadly stable.⁵²

2.48 The Department's PHI Rebate Forward Estimates Model projected that in 2028-29, there will be around 44,000 fewer adults aged 65 and over holding insurance compared to the current rebate settings.⁵³ Further, it stated that regardless, PHI participation is expected to grow by 3.5 per cent between 2025-26 and 2028-29 resulting in the proposed rebate changes having only a 'limited marginal effect on participation'.⁵⁴

Impacts on access to specialists

2.49 Some submitters raised concerns that older Australians who may downgrade their cover from Gold may lose access to specialist services and clinical categories regularly accessed by older people including joint replacements and cataract surgery.⁵⁵

2.50 NSA noted that Gold Cover includes the above health care procedures that are often relied on by older Australians.⁵⁶ NSA argued that downgrading coverage to Silver Cover may result in policyholders not having coverage for those surgeries and needing to rely on higher out of pocket costs for treatment.⁵⁷

2.51 Evelyn shared with the committee at a public hearing that:

...at this stage of life, many people are needing joint replacements, they're needing cataract work and they're needing even more serious surgery. They're on waiting lists. They can't get to that in a public space. When you change the way the private system is able to access these facilities or these services, you are impacting all Australians—my children, your children.⁵⁸

⁵² Department of Health, Disability and Ageing, *Submission 43*, p. 16.

⁵³ Department of Health, Disability and Ageing, *Submission 43*, p. 11.

⁵⁴ Department of Health, Disability and Ageing, *Submission 43*, p. 11.

⁵⁵ Dr Lachlan Henderson, Chief Executive Officer, HBF Health, *Committee Hansard*, 23 September 2026, p. 12; Dr Brendon, Director, Policy and Research, National Seniors Australia, *Committee Hansard*, 3 September 2026, p. 6; Mr Peter Fahey, Chief Executive Officer, St Vincent's Private Hospital Lismore, *Committee Hansard*, 4 September 2026, p. 50.

⁵⁶ National Seniors Australia, *Submission 47*, p. 3.

⁵⁷ National Seniors Australia, *Submission 47*, p. 3.

⁵⁸ Evelyn, private capacity, *Committee Hansard*, 4 September 2026, p. 35.

- 2.52 A number of lived experience witnesses provided information about the need to have PHI for ongoing treatments. Handley, at a hearing in the Gold Coast shared with the committee that:

My wife has to go into hospital every three months and have a stent change. It's a semi major operation. It's something which obviously, if you had to try and bear that pressure yourself, you'd never do it. We could never pull out of private health. We just absolutely need it.⁵⁹

- 2.53 The Department acknowledged this risk but noted that older Australians may be able to maintain suitable hospital cover for these services by moving to a suitable Silver Plus policy.⁶⁰
- 2.54 The Department noted that a 'range of PHI products will remain available, including Silver Plus products that cover services commonly used by older Australians. All Australian residents also retain access to treatment as public patients in public hospitals under Medicare, regardless of whether they hold PHI'.⁶¹

Potential impacts on individuals on fixed or low incomes

- 2.55 A number of submissions raised concerns that the proposed changes will have a financial impact on customers aged 65 and older, particularly those on low or fixed incomes.⁶²
- 2.56 The committee heard that monitoring the potential impacts on people on low income will be important so targeted measures could be considered in the future. The Melbourne Institute, whilst not recommending any amendment to the bill, pointed out that price sensitive is 'concentrated among lower-income older Australians' and suggested the Government monitors this cohort closely.⁶³
- 2.57 Medibank supported 'further assessment of effects on affordability, participation and customer outcomes, including consideration of targeted measures or transitional arrangements to protect financially vulnerable customers'.⁶⁴
- 2.58 Consumers Health Forum, supported the bill's change to the rebate test and noted the following in regard to supporting those on low incomes:

⁵⁹ Handley, private capacity, *Committee Hansard*, 4 September 2026, p. 37.

⁶⁰ Department of Health, Disability and Ageing, *Submission 43*, p. 18.

⁶¹ Department of Health, Disability and Ageing, *Submission 43*, p. 21.

⁶² See, for example, Medibank, *Submission 33*, p. 3; Members Health Fund Alliance, *Submission 30*, p. 4; Council on the Ageing Australia, *Submission 25*, p. 8.

⁶³ Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Submission 2*, [p. 3].

⁶⁴ Medibank, *Submission 33*, p. 4.

Financial stress, chronic disease, disability, where you live—all of these things can affect whether you can actually get the health care you need. We think there's a strong case for treating people on the same income in the same way, rather than providing a larger subsidy simply because one person is older.⁶⁵

- 2.59 The Department noted that the rebate will continue to be income tested with individuals on lower incomes receiving the highest level of support through the rebate.⁶⁶

The department acknowledges that the Rebate changes will place additional financial pressure on some lower-income households, including full-rate age pension recipients. However, the change will maintain the income-tested Rebate and align support for age pensioners with that provided to younger people on similar incomes, including those receiving other forms of income support.⁶⁷

Potential impacts on regional and rural health care services

- 2.60 PHI providers, health providers, peak bodies and individuals raised concerns with potential disproportionate impacts on health care services in regional Australia.⁶⁸

- 2.61 In her submission, Linda Boden, who lives on the northwest coast of Tasmania shared with the committee that she is:

...extremely concerned for my future and how I will be able to afford the rising costs of basic necessities and very frightened that after all the years I have been paying for Private Insurance when I might need it the most, I will not be able to afford it.⁶⁹

- 2.62 The Australian Private Hospitals Association (APHA) noted their concern with potential uneven service impacts across regional hospitals.⁷⁰

- 2.63 Bupa posited that 'even modest reductions in insured patient numbers could affect the financial viability of regional health services and reduce local healthcare access'.⁷¹

⁶⁵ Dr Elizabeth Deveny, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 4 September 2026, p. 43.

⁶⁶ Department of Health, Disability and Ageing, *Submission 43*, p. 20.

⁶⁷ Department of Health, Disability and Ageing, *Submission 43*, p. 21.

⁶⁸ See, for example, Bupa, *Submission 8*, p. 5; Colorectal Surgical Society of Australia and New Zealand, *Submission 26*, p. 5; St Lukes, *Submission 28*, p. 2; Catholic Health Australia, *Submission 44*, p. 11; Private Healthcare Australia, *Submission 16*, p. 2; Mr Peter Fahey, Chief Executive Officer, St Vincent's Private Hospital Lismore, *Committee Hansard*, 4 September 2026, p. 49.

⁶⁹ Linda Boden, *Submission 249*, [p. 1].

⁷⁰ Australian Private Hospitals Association, *Submission 1*, p. 10.

⁷¹ Bupa, *Submission 8*, p. 5.

- 2.64 Evidence provided at hearings and a number of submissions noted particular impacts on the regional health systems like Tasmania.⁷² In their submission, the Premier of Tasmania acknowledged the record funding Tasmania has received under the 2026-31 National Health Reform Agreement Addendum to support their health system but asked the committee to consider the potential consequences the bill may have on the 'heightened' risks and 'significant pressures' in the Tasmanian public health system.⁷³
- 2.65 The Department acknowledged the impacts on some PHI policy holders but argued that the objectives of the reform are to 'ensure government funding is directed to areas where it is most likely to influence participation decisions or support other health, disability and aged care priorities'.⁷⁴
- 2.66 The Department 'assessed the reform proposed in the Bill best balanced these objectives while moderating impacts on policyholders, insurers and overall participation in PHI'.⁷⁵

Modelling of potential impacts and calls for additional consultation

- 2.67 A number of submitters including PHI providers and peak bodies queried the Department's modelling and undertook their own analysis, internal modelling or sought independent analysis of the potential impacts on premium increases, and the potential dropping or downgrading of coverage.⁷⁶
- 2.68 A number of organisations and PHI providers also undertook polling or surveying on potential behavioural responses to the proposed change.⁷⁷
- 2.69 The Parliamentary Budget Office, in response to a request from Dr Monique Ryan MP, undertook additional modelling that provided a 'breakdown of the savings associated with the proposed changes to the Private Health Insurance (PHI) Rebate rates for those 65 years and older – as per the 2026-27 Budget measure Modernising Private Health – by: Individuals 65 years and older

⁷² See, for example, Catholic Health Australia, *Submission 44*, p. 15; Mr Ben Harris, Director, Policy and Research, Private Healthcare Australia, *Committee Hansard*, 4 September 2026, p. 20; Christine, private capacity, *Committee Hansard*, 3 September 2026, pp. 33–34.

⁷³ Premier, Jeremy Rockliff MP and Minister for Health, Mental Health and Wellbeing, the Hon Bridget Archer MP, *Submission 31*, [p. 2].

⁷⁴ Department of Health, Disability and Ageing, *Submission 43*, p. 10.

⁷⁵ Department of Health, Disability and Ageing, *Submission 43*, p. 10.

⁷⁶ See, for example, HCF, *Submission 22*, pp. 5–6; Catholic Health Australia, *Submission 44*, pp. 7–9; National Seniors Australia, *Submission 47*, p. 3; Private Healthcare Australia, *Submission 16*, p. 9.

⁷⁷ See, for example, HCF, *Submission 22*, p. 5; Private Healthcare Australia, *Submission 16*, pp. 13–14; St Lukes, *Submission 28*, p. 2; Ms Kristina Green, General Manager, Member Experience, HIF Australia, *Committee Hansard*, 23 September 2026, p. 13; Dr Lachlan Henderson, Chief Executive Officer, HBF Health, *Committee Hansard*, 23 September 2026, p. 12.

receiving the Age Pension; and Individuals 65 years and older not receiving the Age Pension’.⁷⁸

- 2.70 A number of submissions identified a need for ‘adequate’ and more ‘specific’⁷⁹ consultation by the Department with the key stakeholders including private health providers, the PHI sector and the community.⁸⁰
- 2.71 The AMA acknowledged the constraints on consultation for Budget measures but argued the nature of the proposed changes warranted consultation. They requested that ‘further independent analysis of the projected fiscal and health system impacts’ occurs as well as a ‘detailed assessment of the effects on private hospital viability and public hospital demand’.⁸¹
- 2.72 The APHA argued the ‘Department’s assessment of the impact on private hospitals’ was ‘inadequate and was not tested through consultation with the sector’.⁸² They noted existing financial pressure in the private hospital sector and their concerns the rebate and consequential policy holder coverage change could have.⁸³
- 2.73 Professor Zhang, from the Melbourne Institute, cautioned the committee about the accuracy of the different methods used to quantify potential consumers’ behaviours.⁸⁴
- 2.74 Further, Professor Zhang spoke to their peer-reviewed evidence regarding the impact of the bill at the 4 September 2026 public hearing noting the Melbourne Institute:
- ...evaluated whether increasing private health insurance coverage reduces wait times in the public system. We found that the effect is very small. A one per cent increase in private health insurance coverage reduces public hospital waiting times by about eight hours on average. The bill is unlikely

⁷⁸ Parliamentary Budget Office, *Pensioners private health insurance rebates*, 14 September 2026, www.pbo.gov.au/publications-and-data/publications/costings/pensioners-private-health-insurance-rebates (accessed 18 September 2026).

⁷⁹ Australian Private Hospitals Association, *Submission 1*, p. 7.

⁸⁰ See, for example, Members Health Fund Alliance, *Submission 30*, p. 6; Australian Medical Association, *Submission 19*, p. 2.

⁸¹ Australian Medical Association, *Submission 19*, p. 4.

⁸² Australian Private Hospitals Association, *Submission 1*, p. 4.

⁸³ Australian Private Hospitals Association, *Submission 1*, p. 9.

⁸⁴ Professor Yuting Zhang, Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Committee Hansard*, 4 September 2026, p. 5.

to cause substantial pressure on the public system. In short, this bill corrects a subsidy that is poorly targeted, and is supported by evidence.⁸⁵

2.75 The Department noted they have undertaken a ‘consultation process with the sector as to what we could do in gold and product tiering more broadly’⁸⁶, ‘various consultations with RANZCOG, NASOG and a range of different providers and we spoke to private health insurers and to hospitals’⁸⁷ and ongoing consultation on a range of related issues.

2.76 The Department also provided additional context on the modelling undertaken noting that the rebate model looked at a wide range of input variables including:

...the ABS estimated resident population file, which has populations from 2022 to 2071. We look at also the 2021 census confidentialised unit record files data. That helps us understand dependent children, income data and also socioeconomic index levels for their area where people are living. The 2022 ATO sample file and rebate claim data from Services Australia gives us premiums, rebates, coverage types and transition types, so changes in coverage type from one year to another. ATO data from returns give us policy ID and fund numbers, which link to age band, gender, postcode, family status, income tier and number of dependent children. We also get private health insurance statements 2012 to 2025, which have the funds, product names, product status, policy types and premiums. We also get a range of economic parameters from Treasury and the ABS—things like the CPI and average weekly earnings, which all feed into the model to understand the different factors that might help explain and therefore predict whether or not a price change will lead to someone removing and exiting from private health insurance.⁸⁸

Committee view and recommendation

2.77 The committee thanks all inquiry participants for their contributions. The committee acknowledges the extensive engagement of many older Australians who provided submissions and appeared at hearings.

2.78 Currently, the Government is investing approximately \$8 billion in the rebate to help keep private health insurance more affordable. Since 2004, people aged 65 and above have been receiving an increased rebate solely based on their age regardless of their income.

⁸⁵ Professor Yuting Zhang, Melbourne Institute of Applied Economic and Social Research, University of Melbourne, *Committee Hansard*, 4 September 2026, p. 4.

⁸⁶ Mr Ross Hawkins, First Assistant Secretary, Portfolio Strategy Division, Department of Health, Disability and Ageing, *Committee Hansard*, 11 September 2026, p. 16.

⁸⁷ Mr Andrew Lalor, Assistant Secretary, Modelling, Partnerships and Evaluation Branch, Department of Health, Disability and Ageing, *Committee Hansard*, 23 September 2026, p. 44.

⁸⁸ Mr Duncan Young, First Assistant Secretary, Evidence and Research Division, Department of Health, Disability and Ageing, *Committee Hansard*, 11 September 2026, p. 7.

- 2.79 The committee notes that the proposed amendment to the *Private Health Insurance Act 2007* will result in policyholders paying the same premium for the same policy regardless of their age. The committee welcomes that the estimated \$3 billion in savings over the four years from 2026–27 will be invested into aged care initiatives, including delivering more residential aged care beds and more Support at Home packages.
- 2.80 The committee acknowledges that many submitters are worried about the financial impacts this reform may have on them. The committee is reassured that the rebate will remain means tested. Older Australians on low income will receive a higher rebate, on par with younger Australians.
- 2.81 The committee heard from insurers that lower-cost PHI products remain available and appropriate for the services older Australians generally seek.
- 2.82 Importantly, through Medicare, universal access to treatment as a public patient in public hospitals is central to the health system and is available to all Australians. The committee also notes that the evidence indicates the higher age-based rebate has a limited effect on participation. The Departmental modelling projections have PHI participation continuing to grow under the proposed changes to the rebate, albeit at a slightly slower rate than under current arrangements.
- 2.83 The committee acknowledges the concerns from a range of submitters about the potential unintended impacts the reform may have on the health system, especially in the regions. The committee encourages the Department to monitor the impacts of the reform.
- 2.84 Additionally, the committee notes the call for further consultations and modelling from a range of submitters. The committee is confident that the Department will continue to consult with a range of stakeholders as the reform is implemented and savings are invested in critical aged care services.
- 2.85 The committee is of the view that the \$3 billion in estimated savings will contribute to addressing delayed discharge from hospitals and ultimately relieve pressure on the public hospital system. The committee sees this bill as an important step within the suite of health reforms currently underway by the Government.

Recommendation 1

- 2.86 The committee recommends the bill be passed.**

Senator Ellie Whiteaker

Chair

Labor Senator for Western Australia

Australian Greens dissenting report

- 1.1 The Australian Greens thank the organisations and individuals who made submissions to the Community Affairs Committee during the inquiry into this bill. We also thank the committee secretariat for their hard work during this inquiry.
- 1.2 The Government has stated that one of the objectives of this bill is to increase intergenerational equity. This is a goal the Greens support. However, we have significant concerns about whether reducing the private health insurance rebate for all people aged over 65, and redirecting those funds into aged care services, will achieve that objective.
- 1.3 Of particular concern are the impacts of these changes on specific cohorts, particularly the financial impact on people over 65 who are on low incomes, including pensioners and part-pensioners.
- 1.4 Pensioners and part-pensioners generally live on fixed incomes and have limited capacity to absorb additional costs. The committee heard that many may struggle to meet higher private health insurance premiums, potentially forcing people to downgrade their level of cover or to cut back on other essentials such as heating, cooling and putting food on the table.
- 1.5 The inquiry also heard about the broader systemic impacts of these changes, including the potential to place additional pressure on an already stretched public hospital system.
- 1.6 The committee heard that increased demand for public hospitals as a result of these changes, combined with chronic under-resourcing of the public health system, could negatively affect patient care and increase waiting times. For many older people, waiting months or years for essential procedures, such as joint replacements, is not a viable option. Yet without additional support for people doing it tough, or further investment in the public health system, this may be the reality they face if this bill proceeds.
- 1.7 There are other choices available to the Government to increase investment in aged care and the public health system, without shifting additional costs onto the older people who are least able to afford them.
- 1.8 The Australian Greens have a policy position of redirecting public funds that are currently used to subsidise private health insurance, including the tax rebates, to the public health system. The Government has not linked the revenue enabled by this bill to investment in the public health system.
- 1.9 After participating in this inquiry, the Greens have serious concerns about the bill in its current form.

- 1.10 We welcome constructive engagement with the Government on amendments that would address these concerns and ensure the bill does not cause unintended harm to older people, particularly those on low and fixed incomes.

Senator Jordon Steele-John
Greens Senator for Western Australia

Coalition dissenting report

- 1.1 Coalition Senators thank the organisations and individuals who provided written submissions to the inquiry and provided evidence at public hearings.
- 1.2 These submissions and testimonies from doctors and other clinicians, State and Territory Governments, private hospitals, insurers and, importantly, the older Australians directly impacted expose glaring flaws in the Government's proposed Bill and related policy.
- 1.3 The overwhelming weight of evidence presented to this inquiry leaves no doubt that this policy will achieve only two things:
 - Inflicting financial and emotional hardship on more than 3.2 million older Australians in the middle of a cost-of-living crisis, including about 2 million over-65s who live on less than \$37,000 a year; and
 - Damaging Australia's public-private hybrid healthcare system, eroding the viability of private hospitals and driving more patients into public hospitals already under severe strain.

Failure to consult

- 1.4 The committee heard consistent evidence from all stakeholders that the Albanese Government and the Department failed to consult with affected stakeholders until after the proposed changes had been announced.
- 1.5 This includes within Government as evidence provided by the Australia Prudential Regulatory Authority (APRA) indicated they were not consulted about this change despite the potential prudential risks caused by policy holders dropping or downgrading their policies.
- 1.6 Recent documents released under Freedom of Information also show the Public Hospital Branch of the Department of Health was not engaged to undertake modelling into the potential impact on the public hospital system until after Minister for Health and Aged Care announced the proposal publicly.
- 1.7 To the knowledge of Coalition Senators, that modelling has not been shared publicly, with States and Territories or with the committee.
- 1.8 The Office of Impact Analysis assessed the Government's Impact Analysis as only adequate. The OIA stated that 'the IA would have benefitted from further consultation'.

Modelling limitations

- 1.9 The Government's Impact Analysis was limited, only modelling the number of individuals likely to abandon private health insurance completely and failed to analyse the number of older Australians who would downgrade their cover and, therefore, the consequences of those downgrades. Catholic Health Australia,

which undertook its own substantial modelling, estimated one in five affected over-65s will change their level of cover, vastly more than the one-in-75 assumed by the Government, with about 665,000 downgrades to occur over the first three years of full operation.

- 1.10 As many of these submissions noted, individuals being forced to downgrade their cover would no longer be covered for key services and procedures relied upon by older Australians including joint replacements and cataract surgery which are only required to be offered in Gold. Should these individuals need access to these common procedures, they would now be forced to rely on the public system. The Department acknowledged this risk in its submission to the inquiry yet chose not to model the consequences.
- 1.11 In addition, the Department, and therefore the Ministers responsible for this policy, did not know the number of Age Pensioners impacted by the decision until stakeholder pressure forced them to analyse the number as part of this inquiry. The Department put the figure at 1.2 million while the Parliamentary Budget Office estimated 1.5 million Age Pensioners would be impacted, accounting for about half the revenue generated by the Government.
- 1.12 Coalition Senators also note the Government's Impact Analysis findings are in direct contrast to the Independent Report on the PHI Rebate produced by Finity Consulting in 2023, commissioned by the Department, that found the additional PHI rebate for over 65s provides "good value" and removing the age-based uplift would result in declining value for Government. The Finity Report modelling also estimated that if the additional rebates for over 65s were removed, the number of insured participants would drop by over 1%, which is more than double what is now being claiming by the Minister, the Prime Minister and the Department.
- 1.13 The Government also did not model the broader financial impact or second order consequences of this policy on any stakeholders, including older Australians, State and Territory Governments, private health insurers, private hospitals, Australian Taxpayers or the overall health care system.

Failure to assess impact

Older Australians

- 1.14 Inconceivably, the Albanese Government chose not to assess the number of Age Pensioners that would be impacted until several months after the policy was announced, with the Department conceding it only did so following pressure from stakeholders. The Department put the figure at 1.2 million Aged Pensioners, while the Parliamentary Budget Office estimated 1.5 million Age Pensioners would be impacted. Even now, the Department admits it does not have reliable data on the number of Age Pensioners with private health insurance.

- 1.15 Coalition Senators are also deeply concerned that the PBO predicts half the cost burden of the rebate cut will be borne by Age Pensioners. It seems unconscionable that when considering a policy change of this magnitude, the Minister would fail to assess the impact on the most vulnerable.
- 1.16 The Government has also failed to assess the overall financial impact amongst older Australians who retain their private health insurance. No formal modelling or data was presented to the committee outlining what older Australians will likely forgo in order to cover increased insurance costs. In the current cost of living crisis, Coalition Senators are gravely concerned by evidence presented to the committee by older Australians and their advocates that those impacted will have to forego other essentials such as meals, heating and cooling and social interaction which could have a detrimental impact on their health and wellbeing and result in avoidable or premature interactions with the health and aged care systems.

Younger Australians with Private Health Insurance

- 1.17 Coalition Senators reject the Government's claims that this measure restores intergenerational equity. Many other features of Australia's tax and transfer system are targeted at specific stages of life such as paid parental leave, childcare subsidies and Family Tax Benefits for which Australians over 65 are not eligible.
- 1.18 The Department's own evidence to the committee conceded 96 percent of over 70s hold either Gold or Silver cover, compared with just 59 percent of under 65s, demonstrating that older Australians are already contributing more toward their healthcare than younger Australians.
- 1.19 This rhetoric also fails to recognise that retired Australians have limited, if any, capacity to adjust their income in response to premium rises, having to absorb the cost by foregoing other daily living expenses.
- 1.20 In addition, there are no material benefits to younger Australians stemming from this policy. In fact, evidence provided to the committee reveals that older Australians abandoning or downgrading their cover will lead to higher premium increases for all policy holders. In particular, it will place further pressure on Gold products which the Department itself noted are under strain. Gold cover is used by younger Australians needing chronic disease care, mental healthcare and those wanting to access maternity care through the private system. Younger Australians in the public system will also be forced to wait longer for treatments such as joint replacements or other procedures commonly used by older Australians.
- 1.21 Importantly, the policy also breaks the contract between all Australians and the Government which says that if you contribute to your healthcare costs when you are younger through private health insurance, the Government will assist you to maintain it as you age. The committee heard stories from older Australians, most of whom had held private cover for over 40 years, who had

been encouraged to take out private health care when they were younger as the “right thing to do.”

- 1.22 The committee heard evidence about the impact on the 'sandwich generation'. Many in this group already pay for their own private health insurance and often their children's cover as well. Under this policy, they will now face pressure to help pay for their parents' cover too. They will also be denied the additional rebate when they reach retirement themselves. HIF supported this evidence with polling by Core Data. It showed that more than 2 in 5 West Australians aged 18 to 54 would consider helping an older relative pay for their private health insurance if the rebate changed.

Public Hospitals

- 1.23 Coalition Senators note that State and Territory Governments as well as doctors and clinicians have raised significant concerns with this proposal, specifically warning that it will place additional pressure on public hospitals by increasing both planned surgery wait lists as well as the number of stranded patients. No State and Territory has provided any public support for the Federal Government's proposal.

- 1.24 The submission from the South Australian Department of Health noted:

A 1% increase across public hospital admissions could have a material impact if additional demand is concentrated in particular specialties, hospitals, regions, or procedures already experiencing capacity constraints. This is particularly relevant given the Regulatory Impact Statement (RIS) identifies any additional activity transferring from the private to the public system would be more likely to involve elective rather than emergency care.

- 1.25 Similar concerns were shared by Queensland Health that provided their own modelling estimating that even if the Federal Government's modelling and assumptions were correct, the number of additional public episodes in Queensland alone would be in the thousands with the additional cost to state taxpayers in the millions. These costs rise significantly if the Commonwealth's modelling proves to be an underestimation, which many stakeholders regard as likely.

Private Hospitals

- 1.26 Coalition Senators are also seriously concerned that this measure is likely to impact the viability of a number of private hospitals, including possible closures, and will place financial strain on the system as a whole through reduced planned surgery activity.
- 1.27 The Australian Private Hospitals Association noted in its submission the Government's Impact Analysis gives very little attention to private hospitals, even though they deliver 44 per cent of all the admitted episodes of care to people aged 65 and over in Australia. For cancer care, the figure is even higher with the Private Cancer Physicians of Australia highlighting the private system

treats approximately 50 per cent of the estimated 169,000 Australians diagnosed with cancer each year.

- 1.28 The APHA also noted older patients are concentrated in services such as ophthalmology, orthopaedics, cardiac care and rehabilitation. For a hospital that specialises in these types of surgeries the impact could be disproportionate and much more significant than the average. Also, those hospitals that are already close to being unviable, losing even a small share of these patients may be enough to threaten its future.
- 1.29 These concerns were echoed by Catholic Health Australia that highlighted: “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.”
- 1.30 The committee heard directly from the CEO of St Vincent’s Private Hospital Lismore that nearly three quarters of their admissions in that hospital were patients over the age of 65. The hospital predicted that if this change were to proceed, 10 to 15 per cent of privately insured over-65 patients in the regional area will move away from private treatment. This drop in patient numbers and the associated drop in revenue would put the entire hospital at risk of closure.
- 1.31 Similar examples were highlighted in other jurisdictions.

A concerning precedent

- 1.32 Coalition Senators note the small number of stakeholders/groups that did support the Government’s bill also expressed support for the removal of the rebate in its entirety. One went as far to reject the general concept of private health outright. This suggests the Albanese Government is engaging in an ideological crusade against private health at a time where a strong private health system is needed more than ever to support the overburdened public health system.
- 1.33 Given Labor’s track record of undermining private health, all Australians should be deeply concerned about the Government’s plans to make further cuts in this area. The Albanese Government must clarify whether it shares these views and is pursuing this measure to initiate a full-scale closure of private health in this country.

Final comments and recommendation

- 1.34 Coalition Senators consider this policy and associated Bill to be unfair, rushed, ill-conceived and detrimental to the health and wellbeing of older Australians and Australia’s health system.
- 1.35 Coalition Senators categorically reject the Government's false choice between funding aged care and supporting older Australians with private health cover.

A government that believes it must cut health funding to pay for aged care is a government that has lost control of its own budget. This is particularly galling given the Government has botched the implementation of its own aged care reforms and is now using that failure to justify this ill-considered measure.

- 1.36 This policy is nothing more than a cost shift, and its consequences will flow through the health and aged care systems. It is a case of 'robbing Peter to pay Paul' because older Australians who can no longer afford their cover will be pushed towards more expensive care, either in public hospitals or through the government-funded aged care system.
- 1.37 This policy will also have a profound impact on vulnerable older Australians. As noted by several stakeholders and the lived experience panels, older Australians keep private health insurance not simply because they prefer it but because they cannot afford to be without it.
- 1.38 They often have serious and ongoing health needs and public hospital waiting times may be too long to safely manage those conditions.
- 1.39 To make private health insurance even more expensive on top of the standard premium increases that have risen to a near decade high under this Government is unconscionable.

Recommendation 1

- 1.40 **Coalition Senators, therefore, recommend that the Bill not be passed.**

Senator the Hon Anne Ruston
Member
Liberal Senator for South Australia

Senator Chris Gatenby
Member
Liberal Senator for Tasmania

Appendix 1

Submissions and additional information

Submissions

- 1 Australian Private Hospitals Association
- 2 Melbourne Institute of Applied Economic and Social Research, University of Melbourne, Prof Yuting Zhang
- 3 Publica
- 4 Mr Roger Ruhle
- 5 Mr John Forrest
- 6 Name Withheld
- 7 Mr Ian McInnes
- 8 Bupa
- 9 Deafness Forum Australia
- 10 The Australian Society of Ophthalmologists (ASO)
- 11 National Automotive Leasing and Salary Packaging Association (NALSPA)
- 12 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- 13 Tasmanian Association of State Superannuants
- 14 National Council of Women Western Australia (NCWWA)
- 15 Urological Society of Australia and New Zealand (USANZ)
- 16 Private Healthcare Australia
- 17 South Australian Department for Health and Wellbeing
- 18 Australian Society of Plastic Surgeons
- 19 Australian Medical Association
- 20 The Australia Institute
- 21 Latrobe Health Services
- 22 HCF
- 23 Uniting Church in Australia, Synod of Victoria and Tasmania
- 24 Australian and New Zealand Society for Vascular Surgery (ANZSVS)
- 25 Council of the Ageing Australia (COTA)
 - 25.1 Supplementary to submission 25
- 26 Colorectal Surgical Society of Australia and New Zealand (CSSANZ)
- 27 Australian Orthopaedic Association
- 28 St Lukes
- 29 Australian Society of Orthopaedic Surgeons (ASOS)
- 30 Members Health Fund Alliance
- 31 Premier, Jeremy Rockliff MP and Minister for Health, Mental Health and Wellbeing, the Hon Bridget Archer MP
- 32 Australian Unity
- 33 Medibank

- 34 Name Withheld
- 35 Mr anthony fairbairn
- 36 Name Withheld
- 37 Dr Mary Scott
- 38 DR Brian Bowring
- 39 Name Withheld
- 40 Australian Dental Association
- 41 Mr Mark Morante
- 42 Mrs Melissa Lonergan
- 43 Department of Health, Disability and Ageing
- 44 Catholic Health Australia
- 45 Queensland Health
- 46 Mr Mervin Saultry
- 47 National Seniors Australia
- 48 Mr Michael Sanderson
- 49 Mrs Robyn Presser
- 50 Name Withheld
- 51 Name Withheld
- 52 Mrs Jan Garden
- 53 Name Withheld
- 54 Name Withheld
- 55 Dr Peter Carey
- 56 Name Withheld
- 57 Name Withheld
- 58 Name Withheld
- 59 Mr Jon Peck
- 60 Name Withheld
- 61 Name Withheld
- 62 Mr Stephen Mead
- 63 Mrs Lyndall Senft
- 64 Name Withheld
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- 70 Confidential
- 71 Mr Andrew Smith
- 72 Mr Alan Carleton
 - 72.1 Supplementary to submission 72
- 73 Name Withheld
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80	Mr Serge Mezzavia
81	Ms Helen Hayes
82	Name Withheld
83	Mr Noel Moore
84	Ms Kim Thompson
85	Name Withheld
86	Name Withheld
87	Name Withheld
88	Ida Beryl Logie
89	Richard and Lynette Parker
90	Terry and Pam Thompson
91	Ms Jan Greentree
92	Name Withheld
93	Name Withheld
94	Mr Rod Cahill
95	Ms Janine Licandro
96	Ms Andrea Kanserski
97	Mr Richard Fernee
98	Ms Judy West
99	Ms Heather Davis
100	Name Withheld
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102	Name Withheld
103	Ms Elizabeth Ashen
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105	Ms Glen Turner
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107	Ms Jenny Johnson
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112	Ms Chantal McPherson
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118	Mr Ron Ray OAM

- 119 Mr Ron Ray OAM
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 • 120.1 Supplementary to submission 120
121 Name Withheld
122 Mr Grant Gale
123 Ms Catherine Mapley
124 Mr Eric Evans
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126 Name Withheld
127 Name Withheld
128 Name Withheld
129 Name Withheld
130 Ms Christine Needham
131 Name Withheld
132 Name Withheld
133 Ms Patricia Brown
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147 Name Withheld
148 Mr Keith Deguet
149 Mrs Janice Deguet
150 Confidential
151 Name Withheld
152 Mr Mark Jerram
153 Name Withheld
154 Mr John Friend
155 Ms Joyce Williamson
156 Name Withheld
157 Mr David and Maree Munday
158 Name Withheld
159 Mr Gareth Matthews
160 Ms Robin Jones

161 Ms Kerry O'Connor
162 Name Withheld
163 Mr Peter Berry
164 Mr Douglas and Jenny Barnes
165 Ms Elizabeth Fulham
166 Name Withheld
167 Mr Brian & Margaret Crawford
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172 Mr Allen Trainer
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174 Mr Terence McCarthy
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246 Mr James Macdonald

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248 Ms Vivianne Saunders
249 Ms Linda Boden
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251 Ms Janeen Bester
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253 Name Withheld
254 Mr Donald McGinty
255 Name Withheld
256 Mr Jeff Irwin
257 Mr Peter Shires
258 Name Withheld
259 Phillip and Lorraine O'Keeffe
260 Daryl and Teresa Stewart
261 David and Christina Galloway
262 Name Withheld
263 Bruce and Nita Murray
264 Mr Ian Such
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266 Mr Graham King
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268 Name Withheld
269 Ms Christine Holden
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276 Ms Claire Lucas
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296 Mr Paul Heyward
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299 Ms Jenny Hilder
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301 Ms Donna Bullock
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305 Mr Ken Walters
306 Mr Peter Douglas
307 Ms Suzanne Linford
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310 Ms Anne Coleman
311 David & Henrietta Houghton
312 Mr Andrew Bowen
313 Mr Dallas Clark
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316 Mr Ken Golden OAM
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324 Ms Christine Dixon
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328 Mrs Gillian Fitzgerald
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331 Ms Kathy Gatenby

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336 Julie and Phil Whitmore
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338 Ms Andrea Whittle
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340 Ms Julie-Anne Scott
341 Raemar McCormick
342 Ms Margaret McGee
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344 Name Withheld
345 Ms Karen Cupit
346 Mr Sriram Bhagavath
347 Name Withheld
348 Ms Gaylene Cooper
349 Name Withheld
350 Mr John Paterson
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352 Murray John and Sandra Naismith
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354 Robert and Gloria Schnierer
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360 Ms Debbie Fabian
361 Barry & Karen Pinnington
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371 Mr Emile Jansen
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374 Mr Paul Power

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382 Mr Graham Irvine
383 Miss Lynette Chandler
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401 Mr Tom Gilchrist
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417 Mr Christopher Pisani

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431 Mr Leonard Pryce
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441 Mr Trevor Simpson
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447 Mrs Vicki Cass
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454 Les & Ann Fordham
455 Name Withheld
456 Pirkko and Ted Sims
457 Andrew and Irene Aves
458 Stewart Richmond and Lorraine Richmond
459 Jaroslava Gressieux
460 Doug & Wendy Richardson

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462 Zdravko Ruzic
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465 Ms Wendy Leach
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467 Ms Lynette Young
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473 Mrs Fiona Bullen
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477 Mrs Shirley Simpson
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481 Mr Rae Smith
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483 Mr Laura Boase
484 Mrs Cynthia Wagner
485 Ms Rose Richardson
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492 Mrs Lynda Pearson
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494 Mr Stanley Hunter
495 Ms Antonietta Brooke
496 Mr George Chapman
497 Mrs Lorraine Taylor
498 Name Withheld
499 Mr Michael Lim
500 Mr Scott Breust
501 Name Withheld
502 Mr. Alan Neems
503 ms Margaret Jennings

504 Mr William Tobin
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516 Mr Philip Jacobs
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519 Ms Pamela Harper
520 Mr Christopher Doig
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522 Mr Brian and Mrs Sue Bassett
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524 Mr Barry Mason
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529 Mrs Merlene Hodgson
530 Elizabeth and John Brooks
531 Ms Helen Hensler
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533 Ms Lynette Collis
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536 Name Withheld
537 Mr Malcolm Ball
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538 Lynda Adams and Geoff Adams
539 Name Withheld
540 Ms Wendy Williams
541 Mrs John Pearson
542 Name Withheld
543 Mr Paul Reid
544 Antoinette and Uli Schoen
545 Mr Dean Owen

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547 Michael and Diane Howard
548 Name Withheld
549 Miss Marion Perry
550 Ms Bernice Leafe
551 Ms Angela Williams
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554 Michael and Judith Delaney
555 Name Withheld
556 Peter and Valerie Hosking
557 Mr Daniel Ferguson
558 Dr Leila Kavanagh
559 Ms Judith White
560 Name Withheld
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563 Mr David Inger
564 Thomas and Margaret Ainsworth
565 Ms Marie Ruming
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657 Name Withheld
658 Name Withheld
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661 Name Withheld
662 Mr Peter Onus
663 Confidential
664 Name Withheld
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Answer to Question on Notice

- 1 Answer to question taken on notice by Westfund at a public hearing on 4 September 2026; received 7 September 2026.
- 2 Answer to question taken on notice by Private Healthcare Australia at a public hearing on 4 September 2026; received 9 September 2026.
- 3 Answer to question taken on notice by National Seniors Australia at a public hearing on 3 September 2026; received 9 September 2026.
- 4 Answer to question taken on notice by National Seniors Australia at a public hearing on 3 September 2026; received 3 September 2026.

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- 5 Answer to question taken on notice by Private Healthcare Australia at a public hearing on 4 September 2026; received 9 September 2026.
 - 6 Answer to question taken on notice by COTA Australia at a public hearing on 3 September 2026; received 10 September 2026.
 - 7 Answer to question taken on notice by the Australian Dental Association at a public hearing on 3 September 2026; received 10 September 2026.
 - 8 Answer to question taken on notice by the Synod of Victoria and Tasmania, Uniting Church in Australia at a public hearing on 3 September 2026; received 10 September 2026.
 - 9 Answer to question taken on notice by Professor Yuting Zhang, Melbourne Institute of Applied Economic and Social Research at a public hearing on 4 September 2026; received 10 September 2026.
 - 10 Answer to question taken on notice by Consumers Health Forum of Australia at a public hearing on 4 September 2026; received 11 September 2026.
 - 11 Answer to question taken on notice by St Lukes at a public hearing on 4 September 2026; received 11 September 2026.
 - 12 Answer to question taken on notice by Medibank at a public hearing on 4 September 2026; received 11 September 2026.
 - 13 Answer to question taken on notice by Bupa at a public hearing on 4 September 2026; received 11 September 2026..
 - 14 Answer to question taken on notice by Queensland Health at a public hearing on 3 September 2026; received 14 September 2026.
 - 15 Answer to question taken on notice by The Australia Institute at a public hearing on 11 September 2026; received 18 September 2026.
 - 16 Answer to questions taken on notice by the Australian Prudential Regulation Authority at a public hearing on 11 September 2026; received 22 September 2026.
 - 17 Answer to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 11 September 2026; received 22 September 2026.
 - 18 Answer to questions taken on notice by the Australian Unity at a public hearing on 23 September 2026; received 28 September 2026.
 - 19 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
 - 20 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
 - 21 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.

- 22 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 23 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 24 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 25 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 26 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 27 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 28 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 29 Answers to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 30 Answer to question taken on notice by RANZCOG at a public hearing on 23 September 2026; received 1 October 2026.
- 31 Answer to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.
- 32 Answer to questions taken on notice by the Department of Health, Disability and Ageing at a public hearing on 23 September 2026; received 1 October 2026.

Tabled Documents

- 1 Senator the Hon Anne Ruston, media release, tabled at public hearing on 11 September 2026.

Appendix 2

Public Hearings and Witnesses

Thursday 3 September 2026

Bilinga Room

Rydges Gold Coast Airport

Lot 5a, Terminal Drive

Gold Coast

National Seniors Australia

- Dr Brendon Radford, Director, Policy and Research
- Mr Luke Smith, Policy and Engagement Adviser

Council of the Ageing Australia (COTA)

- Ms Patricia Sparrow, Chief Executive Officer

Queensland Health

- Ms Tricia Matthias, Executive Director, System Policy Branch, System Policy and Planning Division

Uniting Church in Australia, Synod of Victoria and Tasmania

- Dr Mark Zirnsak, Senior Social Justice Advocate

Dr Stephen Duckett, Private capacity

Deafness Forum Australia

- Ms Rhonda Locke, Chief Executive Officer

Australian Dental Association

- Ms Jay Moran, Senior Public Affairs Manager

Lived experience panel

- Andrea
- Christine
- Evelyn
- Handley
- Peter
- Ron

Friday 4 September 2026

Riley Room

Rydges Sydney Central

28 Albion Street

Sydney

Lived experience panel

- Ken
- Mary

Melbourne Institute of Applied Economic and Social Research, University of Melbourne

- Professor Yuting Zhang

HCF

- Ms Julie Andrews, Chief Officer, Member Health
- Ms Lorraine Thomas, Managing Director and Chief Executive Officer

Private Healthcare Australia

- Dr Rachel David, Chief Executive Officer
- Mr Ben Harris, Director, Policy and Research

Members Health Fund Alliance

- Mr Brenton Baldwin, Head, Policy and Research
- Mr Mark Genovese, Chief Executive Officer
- Mr Matthew Koce, Chief Executive Officer
- Mr Dario Molina, Chief Executive Officer
- Mr Ian Whitehead, Chief Executive Officer

Bupa

- Mrs Kate Williams, Managing Director, Health Insurance

Medibank

- Mr Nicholas John Bailey, Senior Executive, Healthcare Funding and Policy

St Lukes

- Mr Paul Lupo, Chief Executive Officer

Australian Medical Association

- Dr Danielle McMullen, President
- Mr Luke Toy, General Manager, Policy and Advocacy

Royal Australian College of General Practitioners (RACGP)

- Dr Rebekah Hoffman, NSW and ACT Faculty Chair

Colorectal Surgical Society of Australia and New Zealand (CSSANZ)

- Associate Professor Cherry Koh, Councillor

Consumers Health Forum of Australia (CHF)

- Dr Elizabeth Deveny, Chief Executive Officer

Catholic Health Australia

- Dr Katharine Bassett, Director, Health Policy

St Vincent's Private Hospital Lismore

- Mr Peter Fahey, Chief Executive Officer
- Miss Kathryn Harms, Director, Finance

Lived experience panel

- Judy

Friday 11 September 2026

Main Committee Room

Parliament House

Canberra

Department of Health, Disability and Ageing

- Mr Ross Hawkins, Acting Deputy Secretary, Systems Strategy Group
- Mr Andrew Lalor, Assistant Secretary, Modelling, Partnerships and Evaluation Branch
- Mr Paul McBride, Assistant Secretary, Private Health Strategy Branch
- Mr Duncan Young, First Assistant Secretary, Evidence and Research Division

Treasury

- Mr Felix Donovan, First Assistant Secretary, Social Policy Division
- Mrs Isobel Sloan, Assistant Secretary, Health, Disability and Ageing Branch

The Australia Institute

- Dr Luke Slawomirski, Senior Postdoctoral Research Fellow

Australian Prudential Regulation Australia (APRA)

- Ms Andrea Dry, Head of Insurance Risk
- Mr Peter Kohlhausen, Executive Director, Policy and Advice

Wednesday 23 September 2026

Doubletree Northbridge

100 James Street

Northbridge

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

- Dr William Milford, Member

Australian and New Zealand Society for Vascular Surgery (ANZSVS)

- Dr Mark Jackson, Immediate Past President
- Dr Roxanne Wu, President

Day Hospitals Australia

- Mrs Jane Griffiths, Chief Executive Officer

HBF

- Mr Blake Delcanho, General Manager, Products
- Dr Lachlan Henderson, Chief Executive Officer

Australian Unity

- Mrs Rebecca Harwood, Chief Executive Officer and Group Executive, Health Insurance

HIF

- Ms Amanda Bell, General Manager, Member Experience
- Ms Kristina Green, Chief Marketing and Product Officer
- Mr Troy Sheahan, Chief Strategy, Member and Growth Officer

Lived experience panel

- Joanne
- Michelle
- Mary

Private Cancer Physicians of Australia

- Dr Ian Irving, Director

Australian Society of Plastic Surgeons

- Dr Brigid Corrigan, President

Department of Health, Disability and Ageing

- Mr Ross Hawkins, First Assistant Secretary, Portfolio Strategy Division
- Mr Andrew Lalor, Modelling, Partnerships and Evaluation Branch
- Mr Paul McBride, Assistant Secretary, Private Health Strategy Branch
- Mr Duncan Young, First Assistant Secretary, Evidence and Research Division

Department of Finance

- Ms Natasha Cole, First Assistant Secretary, Social Policy Division, Budget Group
- Ms Nhi Nguyen, Assistant Secretary, Data Governance and Analytics Branch, Governance and Grants Division, Governance and Resource Management Group
- Mr Paul Pfitzner, First Assistant Secretary, Budget Policy and Delivery Division, Budget Group

- Ms Katherine Power, Acting Assistant Secretary, Health Branch, Social Policy Division, Budget Group