MANDALA

Reducing out-of-pocket costs for Australian healthcare consumers

MARCH 2025

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Note: All dollar figures are Australian dollars unless indicated otherwise.

Executive summary

The cost-of-living crisis is hitting consumers hard, especially when managing their healthcare...

$1.1B out-of-pocket
Consumers are paying 16% of the total amount charged for private medical care in out-of-pocket fees.

12% growth in cost
Out-of-pocket costs have grown by 12% in the last year, up from an annual growth of 1% per year for the past 9 years.

ACT is worst off
Consumers in the ACT paying the highest out of pocket costs, $312 above the national median.

...Without change, consumers could find themselves paying $1.6B in out-of-pocket costs by 2030...

4% annual growth
would see consumers paying $72 more than the median out-of-pocket cost in 2023.

330,000 delay care
in 2030 due to cost. 14% of those who need to see a specialist will delay, with 21% of 25–34-year-olds avoiding care.

$7,292 cost of delay
In the case of a hip replacement, 172-day delay in the public system results in significant indirect costs.

...Out-of-pocket cost growth is driven by a lack of competition, price transparency and consumer protections as well as inflation...

Surprise billing
is common amongst consumers, with extent of hidden costs unknown due to limited consumer protections.

Cost double by 2030
without mitigating factors such as competitive pressures and consumer protections.

+$640M added cost
to consumers without price transparency, with further savings possible with the Medical Costs Finder website implemented as recommended.

Australia has a dual public-private healthcare system, where privately insured consumers receive choice and quality care, but often incur out-of-pocket costs

Components of cost within Australia's healthcare system

System	Location	Payer	Description
Public healthcare system	In hospital	MEDICARE	Medicare will pay the Medicare Benefits Schedule fee for a service, meaning the consumer does not pay for the services covered by Medicare. This includes both medical and hospital services (such as accommodation).
		CONSUMER	Consumers will pay for ancillary services and medication costs.
	Out of hospital	MEDICARE	Medicare will pay the Medicare Benefits Schedule fee for a service.
		CONSUMER	General Practitioners who do not bulk bill will charge consumers an out-of-pocket fee for a service.
Private healthcare system	In hospital	MEDICARE	Medicare will pay 75% of the Medicare Benefits Schedule fee for consumers receiving care in a private hospital.
		PRIVATE HEALTH INSURANCE (PHI)	PHI benefits will cover at least the remaining 25% of the Medicare Benefits Schedule fee, for consumers with PHI cover. Insurers negotiate on behalf of consumers to secure lower fees for services covered by PHI.
		CONSUMER	Consumers will pay any additional fees for medical and hospital services charged by practitioners above the Medicare Benefits Schedule fee. Consumers will pay for ancillary services provided within specialist rooms as a part of their hospital stay.
	Out of hospital	MEDICARE	Medicare will pay 85% of the Medicare Benefits Schedule fee for consumers receiving care from a private specialist.
		CONSUMER	PHI cannot provide a benefit for out-of-hospital private services, meaning consumers are responsible for the additional cost above the Medicare Benefits Schedule fee.

Glossary

TERM	DEFINITION
Australian Refined Diagnosis Related Groups (AR-DRG)	A classification that provides a clinically meaningful way to relate or group the number and type of patients treated in admitted acute episodes of care to the resources required in treatment.
Bulk billing	Consumers do not pay for a service and a health practitioner will bill Medicare for the service, accepting the Medicare benefit as full payment for the service.
Invisible costs	The payments consumers make that are not captured in official statistics such as private health insurance and Medicare records.
Known gap agreement	When an insurer has an agreement with the hospital, a consumer will pay an agreed amount according to the insurance policy.
Medicare Benefits Schedule (MBS)	Lists a wide range of consultations, procedures and tests, and the Schedule fee for each of these items. The Schedule fee is the amount the Government considers appropriate for one of these services.
No agreement	When an insurer does not have an agreement with the hospital, a consumer will pay the out-of-pocket cost set by the practitioner, which may be high.
No gap agreement	When an insurer has an agreement with the hospital, a consumer will pay no out-of-pocket cost for hospital charges.
Out-of-pocket costs	The difference between the amount a doctor charges for a medical service and what Medicare and any private health insurer pays. Out of pocket costs are also called gap or patient payments.
Private Health Insurance premiums	Fees a consumer pays to the insurer in exchange for health insurance cover.
Private patient	Person admitted to a private hospital, or person admitted to a public hospital who decides to choose the doctor(s) who will treat them or to have private ward accommodation. This means they will be charged for medical services, food and accommodation.
Public patient	A patient treated at no charge in a public hospital (or provided with care by a private hospital on behalf of a public hospital).
Separation	An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.
Specialist Medical Practitioner	Doctor who received further training in a medical specialty, such as surgery or psychiatry. Medical Specialists are accredited by the Professional Associations. General Practitioners are not included within the specialist medical practitioner group for this report.
Visible costs	Costs for health services which are captured through private health insurance and Medicare records.

Source: AIHW

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2 Without change, consumers could find themselves paying $1.6B in out-of-pocket costs by 2030

3 Out-of-pocket cost growth is driven by a lack of competition, price transparency and consumer protections as well as inflation

Consumers paid $1.1B in visible out-of-pocket costs in FY23, contributing 16% of the total amount charged for private medical care

Cost for healthcare services provided in the private sector are paid in part by Medicare, private health insurers and by the consumer. The consumer contributions to private healthcare are visible out-of-pocket costs. These are the costs that consumers must pay when the amount covered by Medicare and insurers is less than the fee charged by a provider.

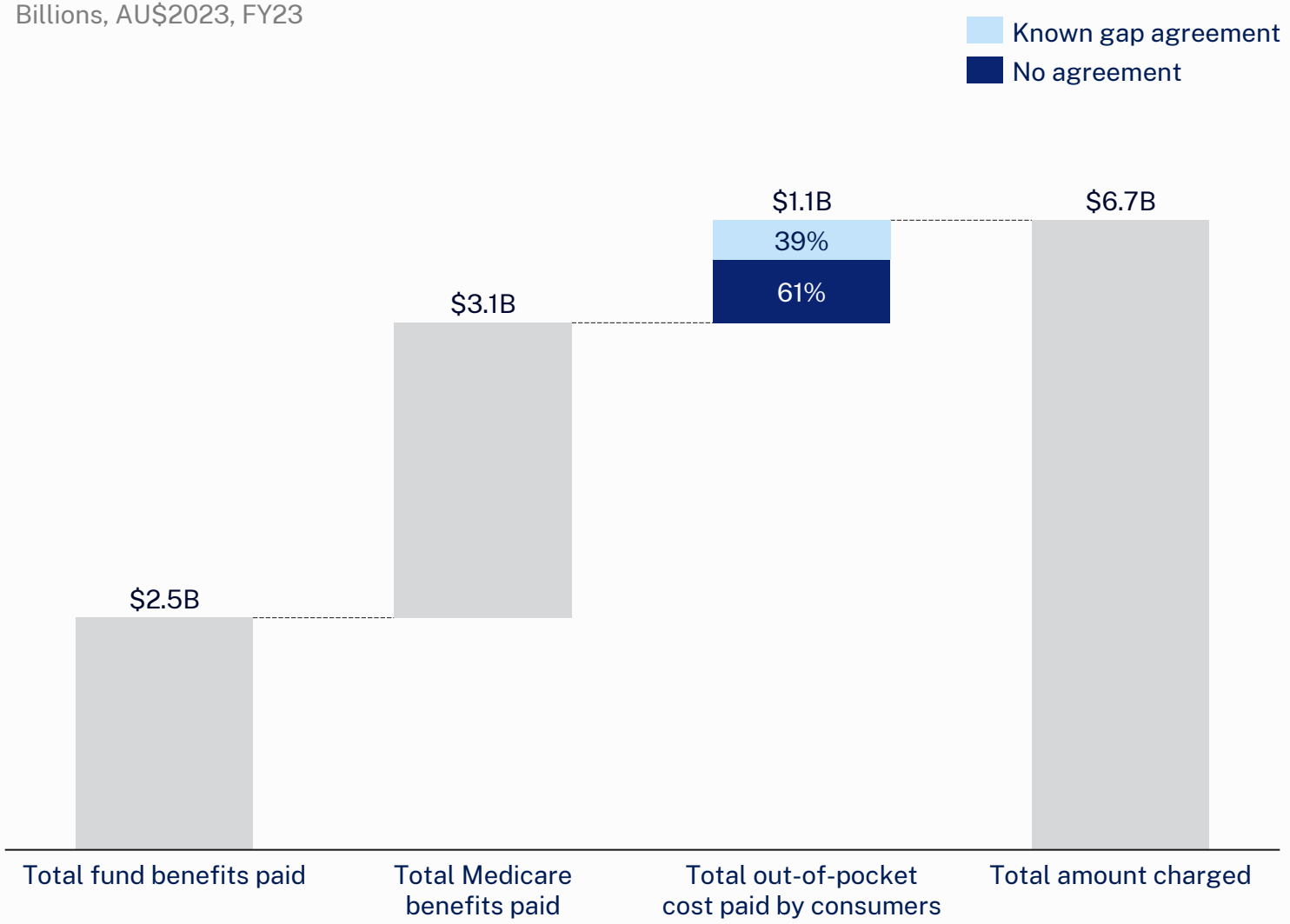
The Commonwealth is prohibited from regulating specialist fees, which enables providers to set their own prices. Australia is unlike other countries who also have a fee-for-service healthcare model, such as France and Canada where fees for private specialist are regulated.

While most providers have agreements with private health insurers to charge no gap or a known gap to consumers (92% in FY23), there is a small portion who do not. This 8% of providers are responsible for charging 61% or $0.7B of the total gap paid.

Consumers also face 'invisible' out-of-pocket costs – these are payments consumers make that are not captured in official statistics as they fall into grey areas. These include charges for things like booking and administrative fees, a process known as 'side-billing' which in many cases is illegal though currently poorly enforced.

Total costs of in-hospital medical services paid by private health insurance

Billions, AU$2023, FY23



Source: APRA (2024) Quarterly Private Health Insurance Medical Services December 2023. Mandala analysis.

Consumers are paying more as inflation rises, with health inflation growing by 23.4% since 2020

The steep rise in inflation since 2020 is placing real pressure on consumers. In the last quarter of 2022 inflation reached 7.8% p.a., the highest level since 1990.

Increasingly consumers are cutting back on discretionary spending, with pressure on households balancing rising mortgage repayments following 13 successive rate rises, high fuel prices, and insurance premium growth (particularly general and motor) from successive natural disasters nationwide.

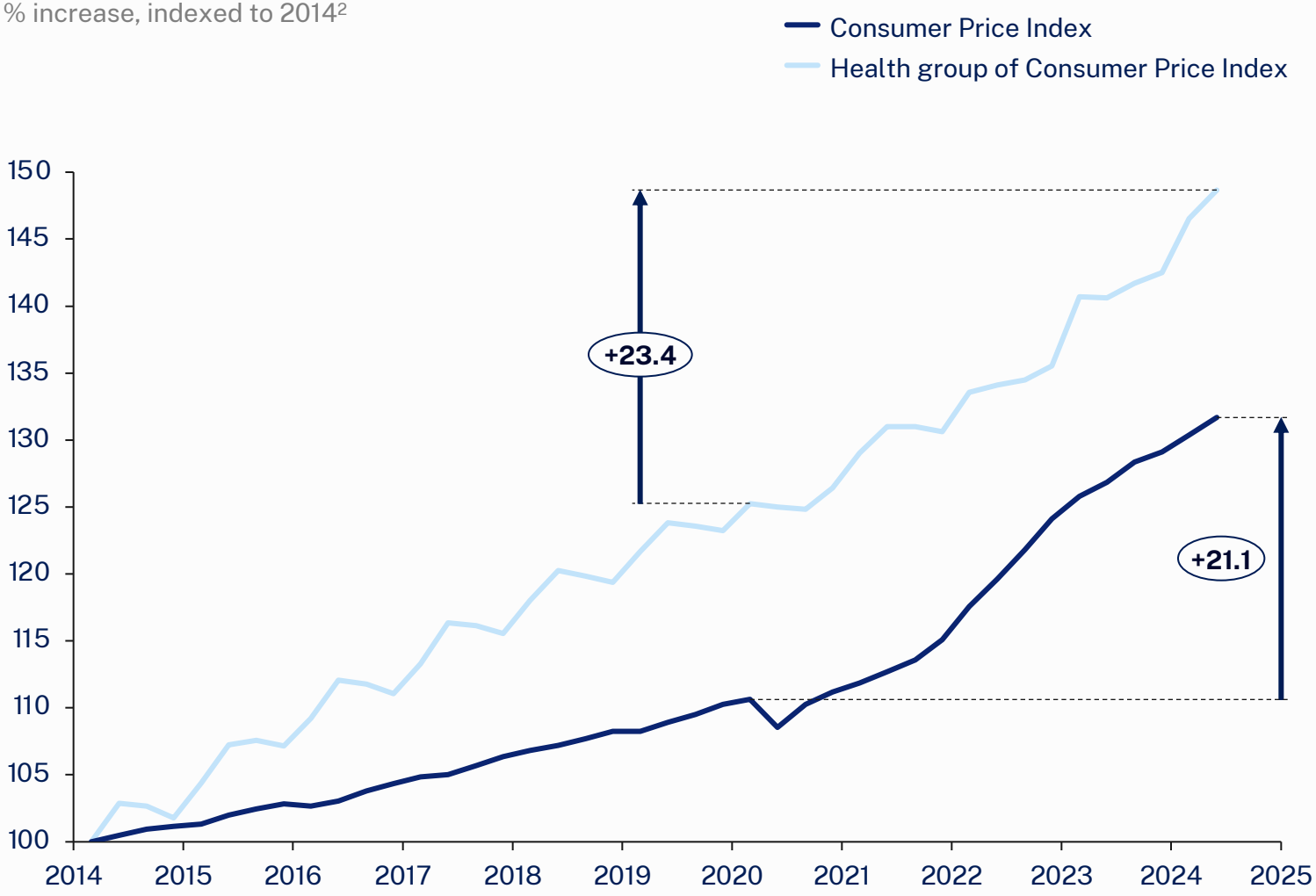
Healthcare inflation in particular has risen significantly by 23.4 per cent between since 2020 while general inflation has risen by 21.1 per cent over the period.

Evidence has shown that the current inflationary environment is being driven strongly by supply-side factors, with an estimated 50% of headline inflation to the 12 months to September 2022 driven by supply side drivers.1

Critical to addressing supply-side inflation is ensuring that policy settings maximise and promote competition and productivity across the economy to ease price pressures on consumers over time.

Quarterly Consumer Price Index (CPI) increase

% increase, indexed to 2014[2]

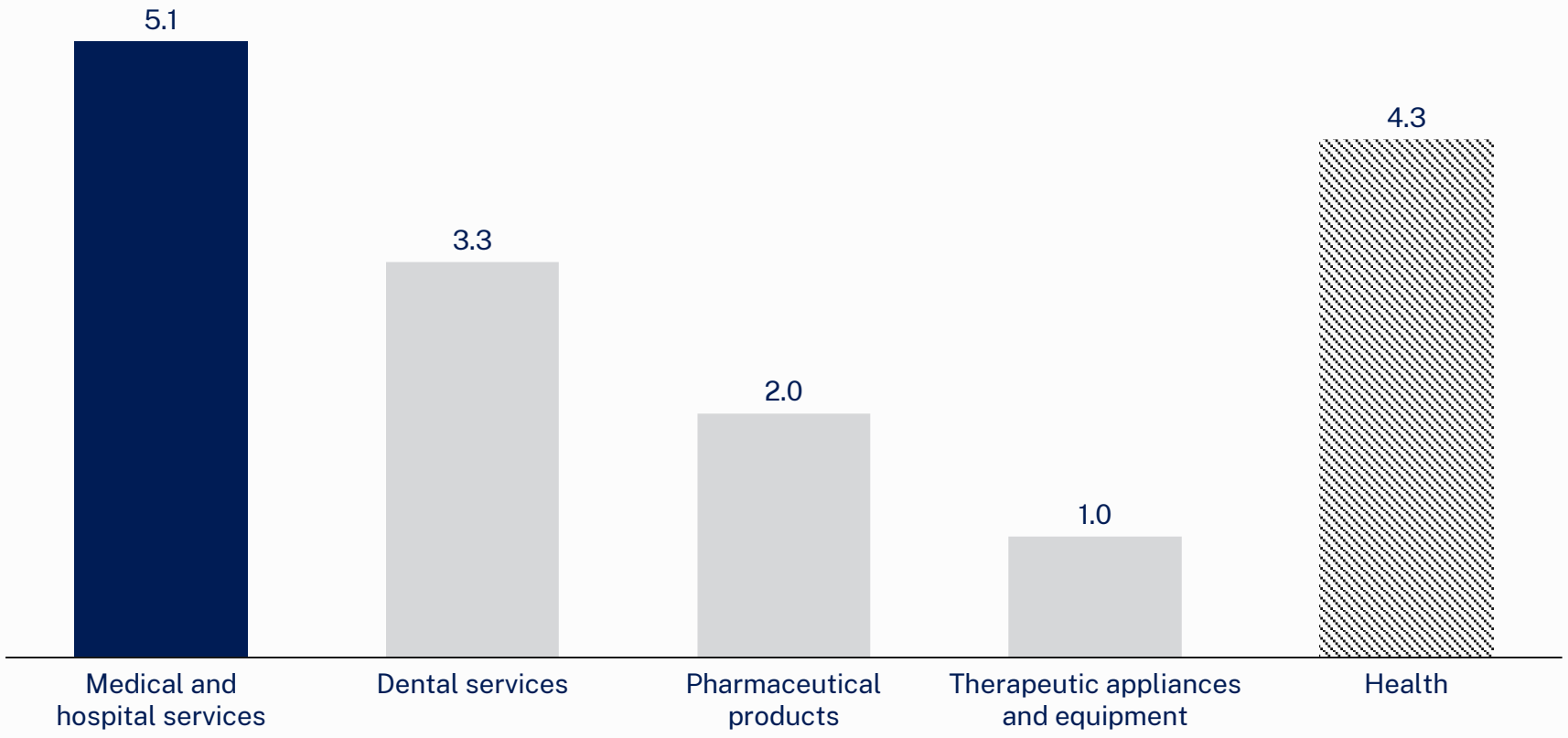


Notes: The health group of Consumer Price Index is one of 11 groups which is the first level of disaggregation of CPI (ABS, 2017).
Source: 1. Mandala Partners (2024) Surf, Shop, Save: Online retail helps lower the cost-of-living 2. Australian Bureau of Statistics (2024) Consumer Price Index

Medical and hospital services the fastest growing component of health, with an annual CPI growth rate of 5.1%, compared to overall health inflation of 4.3%

Annual inflation rate of the expenditure classes of the health group of CPI since 2021

CPI growth rate (%, p.a.) since 2021[1]



The health group within CPI includes costs for essential health goods and services like pharmaceutical products, therapeutic appliances and equipment, medical, hospital and dental services. The health group of CPI grew by 4.3% per year since 2021.

Medical and hospital services experienced the greatest price increase of the health CPI group at 5.1% average annual CPI growth since 2021.

As a result of growing healthcare costs, consumers increasingly report pressure affording care. 71% of Australians have delayed or cancelled a healthcare appointment in the last year, with cost being the biggest factor.[2] For those seeking specialist care, 28% avoided a specialist after a GP referral because of cost pressures.[2]

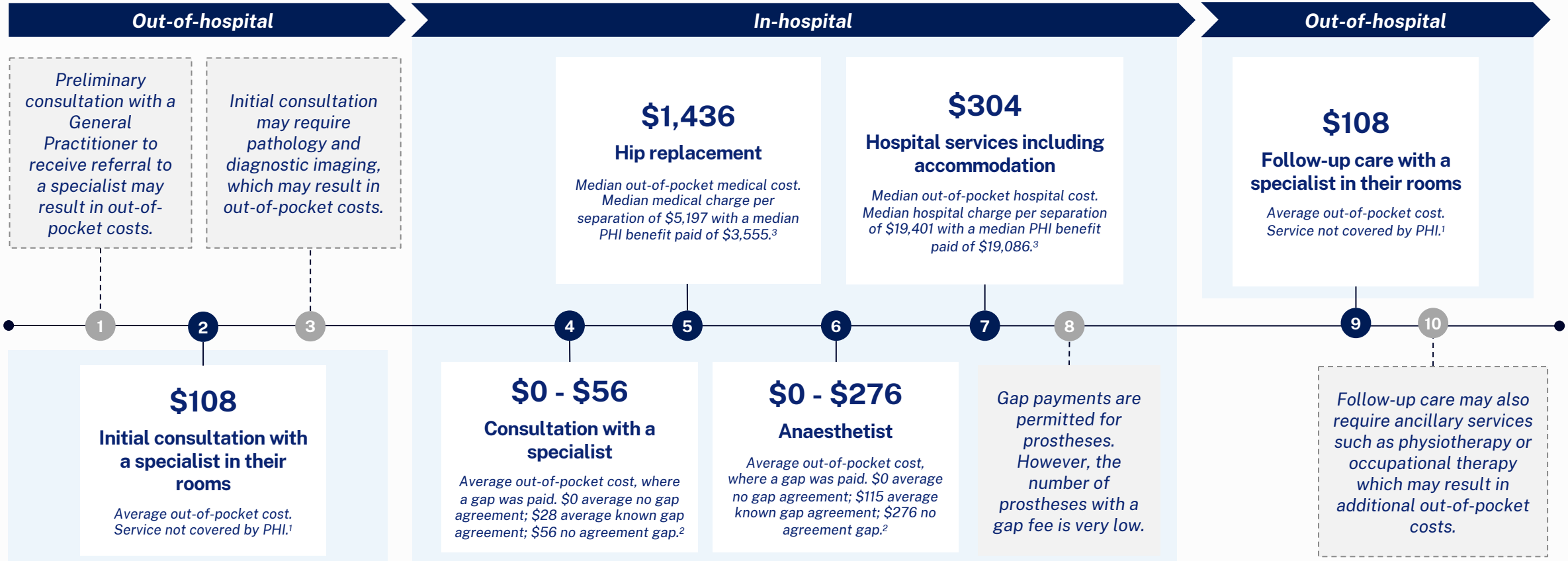
Notes: The expenditure classes are groups of similar goods and services which sit below the sub-groups and groups within CPI. Pharmaceutical products and therapeutic appliances and equipment are within the sub-group of medical products, appliances and equipment. Medical and hospital services and dental services are within the sub-group of medical, dental and hospital services. The two sub-groups form the health group of CPI (ABS, 2017).

Source: 1. ABS (2024) Consumer Price Index 2. Commonwealth Bank (2024) CommBank Patient Experience Insights 2024

Consumers face out-of-pocket costs across the healthcare journey, but in-hospital and specialist costs are some of the highest

Illustrative healthcare journey for a consumer undergoing a hip replacement without complication or comorbidity

FY23

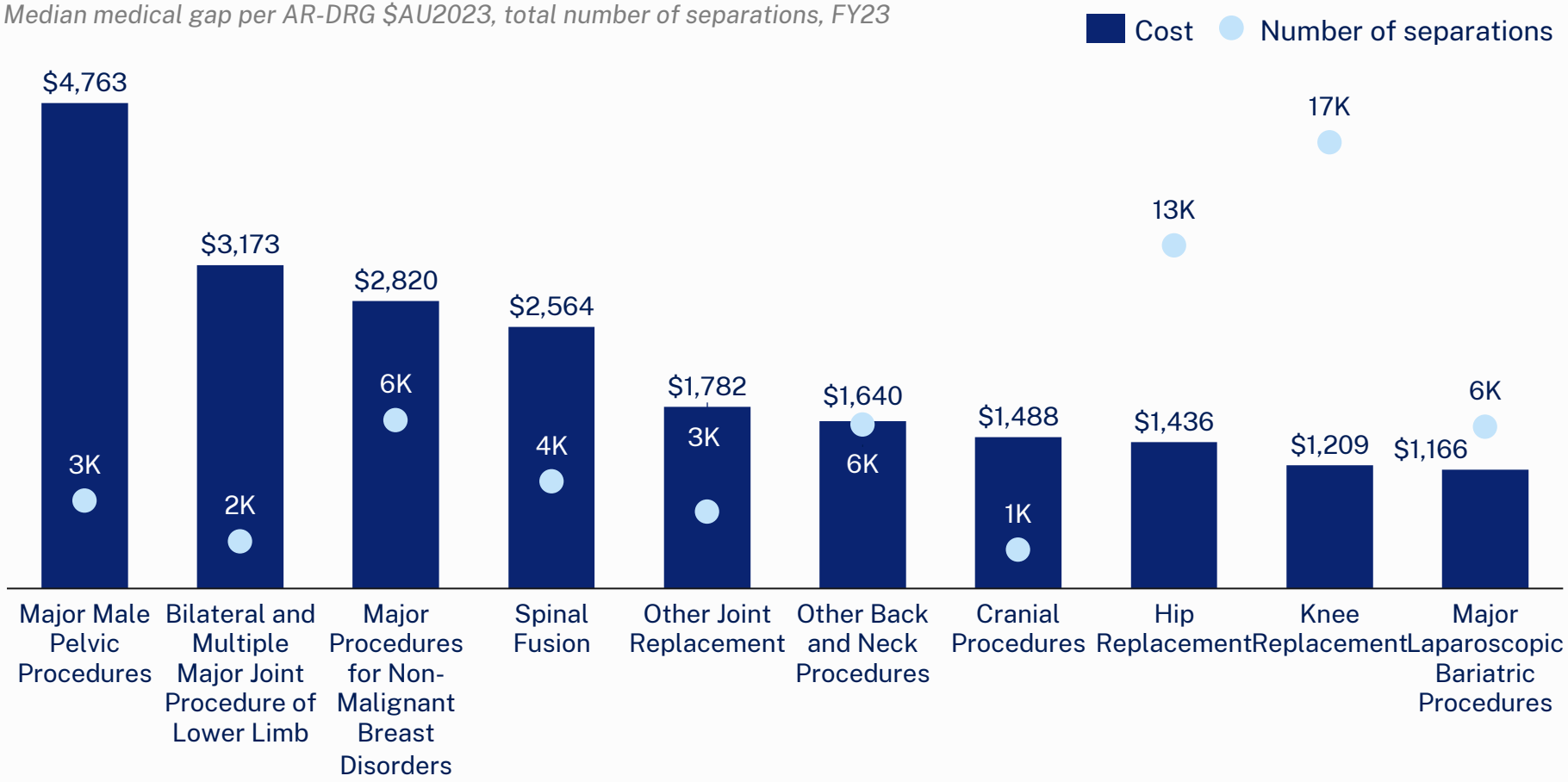


Notes: AR-DRG used: Hip Replacement W/O Catastrophic CC (I03B)
Source: 1. Medicare annual statistics – State and territory (2009–10 to 2022-23) Table 2: Financial Year Out-of-Hospital Medicare Statistics by Broad Type of Service and State 2. APRA (2024) *Quarterly Private Health Insurance Medical Services December 2023*. Mandala analysis. 3. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

High frequency procedures including hip and knee replacements attract high visible out-of-pocket costs

Visible out-of-pocket medical costs for high frequency separations with high out-of-pocket costs

Median medical gap per AR-DRG $AU2023, total number of separations, FY23



The procedures listed in Exhibit 5 represent the 10 most common procedures within the identified group where a larger share of the cost is passed on to the consumer, meaning there is an out-of-pocket cost burden for the patient.

These 10 common medical procedures make up 527,150 procedures performed in Australia in FY23. Knee replacement and hip replacement surgeries are the most common procedures within this group, making up 27% and 21% respectively of total separations.

Consumers nationwide incurred $130M in out-of-pocket medical costs for these 10 procedures in FY23. Overall, consumers incurred $504M in out-of-pocket medical costs for procedures without complication or comorbidity in FY23. This group of 10 procedures accounts for 26% of this out-of-pocket cost.

Notes: Public hospital data excluded. Procedures with complication or comorbidity excluded. Medical procedures are classified by separations according to the Australian Refined Diagnosis-Related Groups (AR-DRG) version 7.0.
Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

Visible out-of-pocket costs have grown significantly in the last year, with an annual increase of 12%

A 12% increase in the last year comes after a CAGR of 1% for the period FY14 to FY22, with out-of-pocket costs increasing from $198 to $214 over the nine-year period.

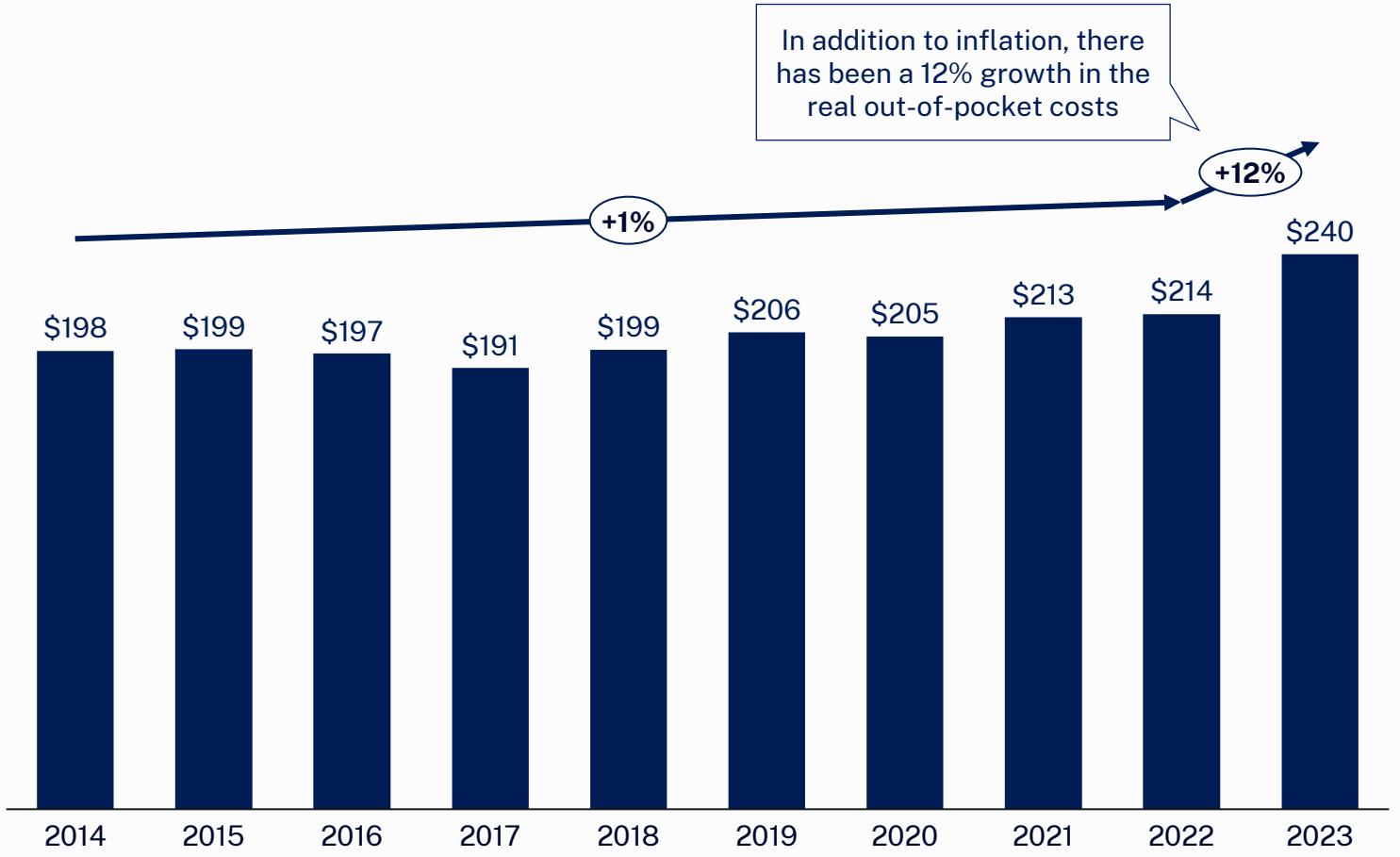
Following this steady increase, consumers faced a significant increase in the median out-of-pocket cost for in-hospital medical services from $214 to $240 within a year.

In a period when consumers are experiencing rising cost-of-living pressures, out-of-pocket costs for medical services have increased significantly.

The increase in out-of-pocket cost over time in real terms means the consumer is paying more in 2023 than they would have in 2014 for the same procedure.

Median out-of-pocket cost for in-hospital medical services without complication or comorbidity

Median $AU23, FY14 - FY23



Notes: Data from public hospitals excluded.
Source: APRA (2024) Quarterly Private Health Insurance Medical Services December 2023. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

Visible out-of-pocket costs are not distributed evenly, with people in the ACT paying $312 above national average

Visible out-of-pocket costs vary significantly across the country. In the ACT, the median visible out-of-pocket cost for a medical service is $591. This is 146%, or $312, higher than the national average of $240. Within states and territories further variation exists with discrepancy in prices between electorates.

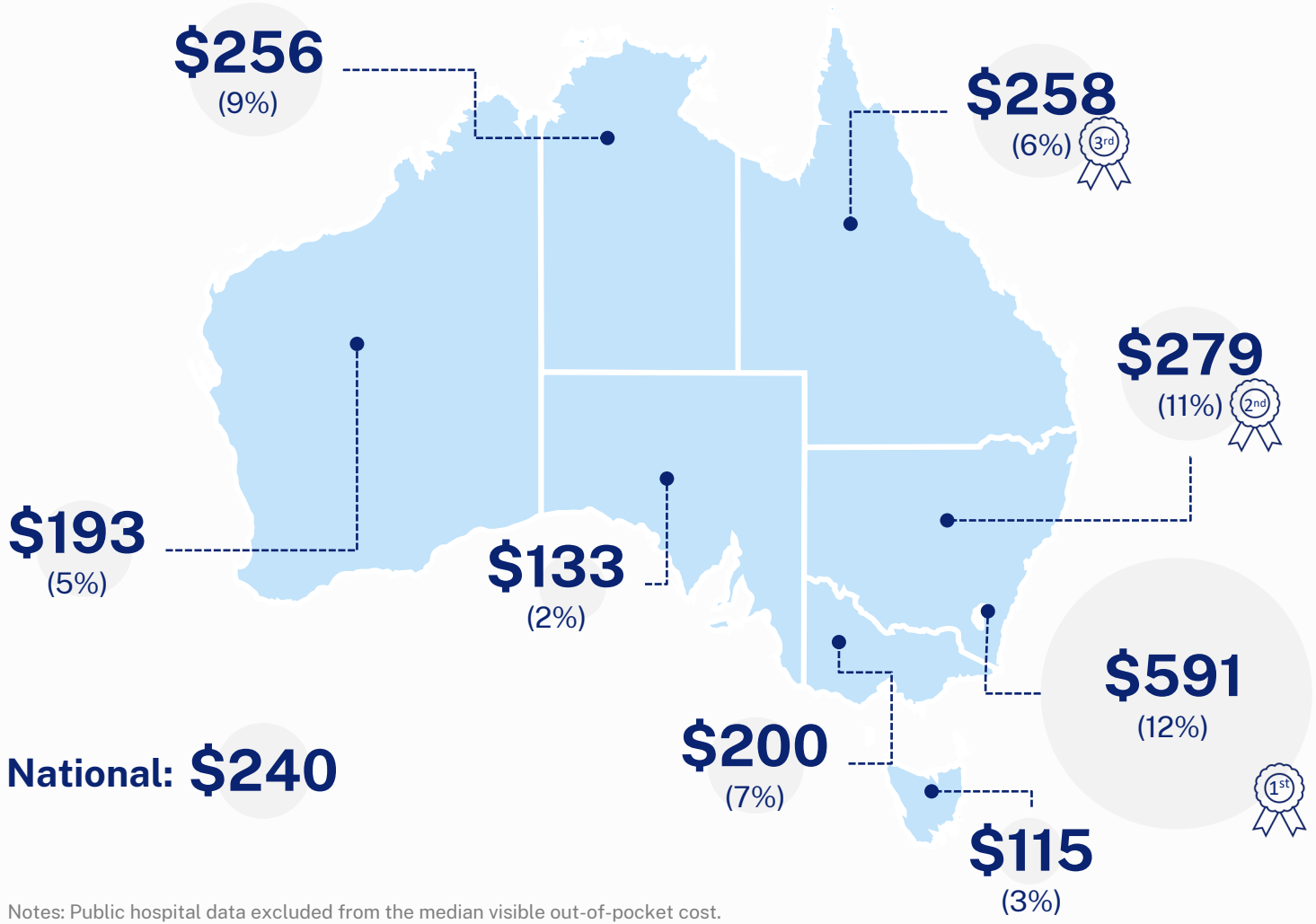
The inconsistency between states creates issues of health equity. An ACT consumer is worse off than a TAS consumer, as they incur higher out-of-pocket costs. Some consumers may be priced out of the private healthcare market in their home state, resulting in deferred care or further pressure being placed on the public system. Some consumers report travelling to other states to receive care at a lower cost.

The ACT and NT are smaller healthcare markets with fewer specialists. The lack of competition and price transparency likely contributes to the high average out-of-pocket costs in these territories.

The ACT, followed by NSW, has the highest proportion of services which are not covered under an agreement between private health insurers and the practitioner. Consumers in these markets are likely to pay higher out-of-pocket fees as a result. The proportion of no agreement services has declined from 23% in the ACT and 27% in NSW in FY14.

Median visible out-of-pocket costs by state and territory

AU$ (% of services with no agreement), FY23[1]

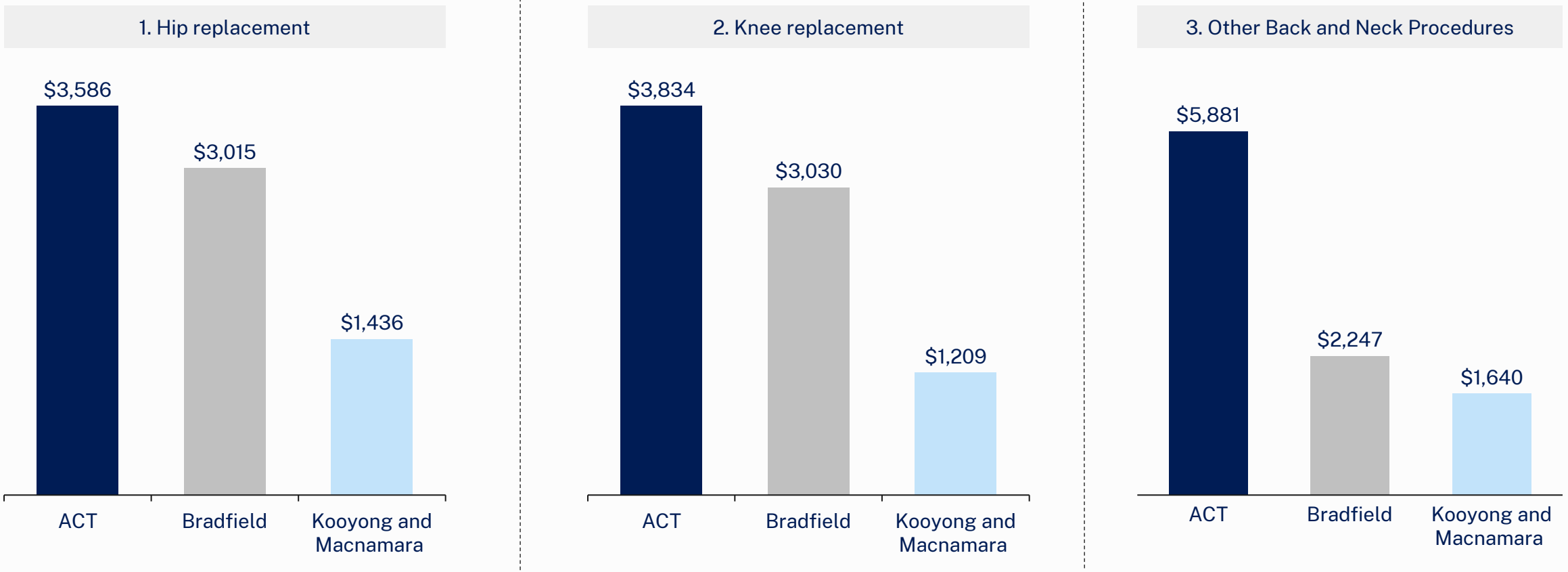


Notes: Public hospital data excluded from the median visible out-of-pocket cost.
Source: 1. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis. 2. APRA (2024) Quarterly Private Health Insurance Medical Services December 2023.

For the most common procedures in the ACT, consumers are paying more in out-of-pocket fees than consumers in comparable electorates in NSW and VIC

Costs for the top three most common procedures in the ACT, compared electorates in NSW and VIC

Median medical gap per AR-DRG $AU2023, FY23



Notes: Electorates are comparable by median weekly personal income. Hip replacement AR-DRG: I03B - Hip Replacement W/O Catastrophic CC. Knee replacement AR-DRG: I04B - Knee Replacement W/O Catastrophic or Severe C. Other Back and Neck Procedures AR-DRG: I10B - Other Back and Neck Procedures W/O Catastrophic or Severe CC
Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis

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Consumers will face an out-of-pocket cost of over $300 if costs continue to grow, adding up to $1.6B in additional costs

If out-of-pocket costs continue to grow at 4% to 2030, median out-of-pocket cost will grow from $240 in 2023 to $312 by 2030. In real terms, this is $72 higher than the current median out-of-pocket cost.

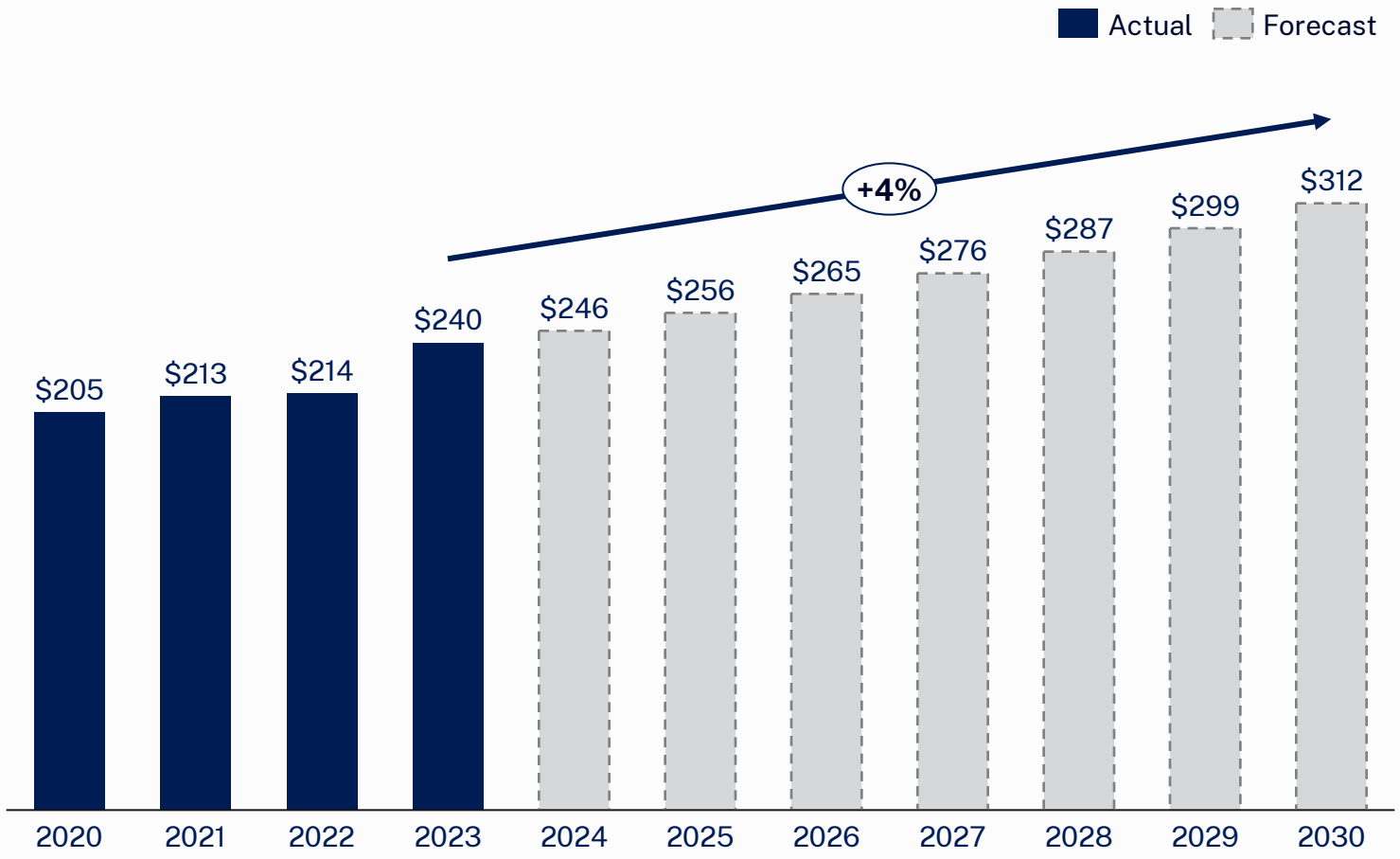
This increase will contribute to a total of $1.6 billion in additional out-of-pocket costs for consumers by 2030.[1]

Out-of-pocket growth will continue to be a product of key drivers including inflation, limited supply of medical specialists and a lack of price transparency. If left unchanged, these drivers will continue to place upward pressure on out-of-pocket costs.

Based on historical changes in out-of-pocket costs for specific procedures, it is anticipated that out-of-pocket growth will not be consistent across all areas of the private healthcare market. The median out-of-pocket cost across all procedures is low when compared to the out-of-pocket cost for many of the high-cost procedures.

Out-of-pocket cost for medical services

Median cost per separation for in-hospital medical treatments, $AU23, FY20 to FY30[2]



1. The $1.6 billion estimate is based on projected out-of-pocket costs and the projected number of separations, maintaining the current cost distribution between medical specialists and other related expenses. 2. Data from public hospitals excluded.

Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

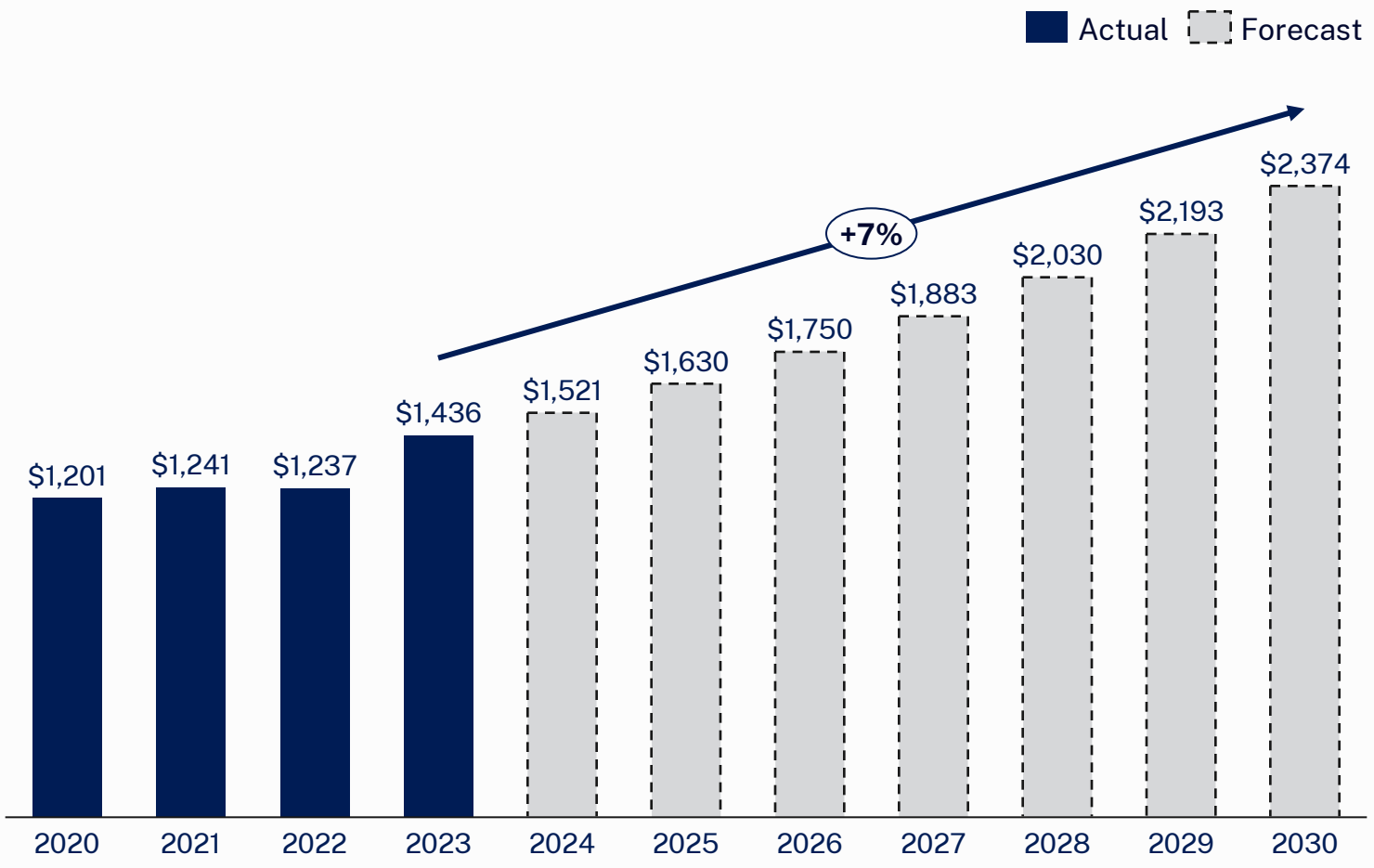
Out-of-pocket costs for hip replacements expected to increase by 7% each year to above $2,300 by 2030

As the Australian population ages, the demand for surgeries such as total hip replacements and total knee replacements will increase. Based on historical cost growth, the out-of-pocket cost of a total hip replacement is projected to grow by 9 per cent each year. In real terms, by 2030, consumers will be expected to pay an out-of-pocket cost of $2,374. This represents an increase of $938 over seven years.

The growth rate of 7% is modelled based on the expected growth rate of a group of procedures which are high frequency with a high proportion of the cost passed onto the consumer in the form of out-of-pocket costs. This means that consumers across a range of common procedures such as knee replacements, bariatric procedures and breast procedures are expected to follow a similar trajectory of cost increases to 2030.

Out-of-pocket cost for total hip replacement services

Median cost per separation for in-hospital medical costs, $AU23, FY20 to FY30



Notes: Hip replacement AR-DRG: I03B - Hip Replacement W/O Catastrophic CC. Forecast based on assumption that a hip replacement will grow at the rate of the broader group as high frequency procedures with high out-of-pocket costs.
Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

As costs rise, an additional 330,000 consumers will delay or avoid accessing specialist care by 2030

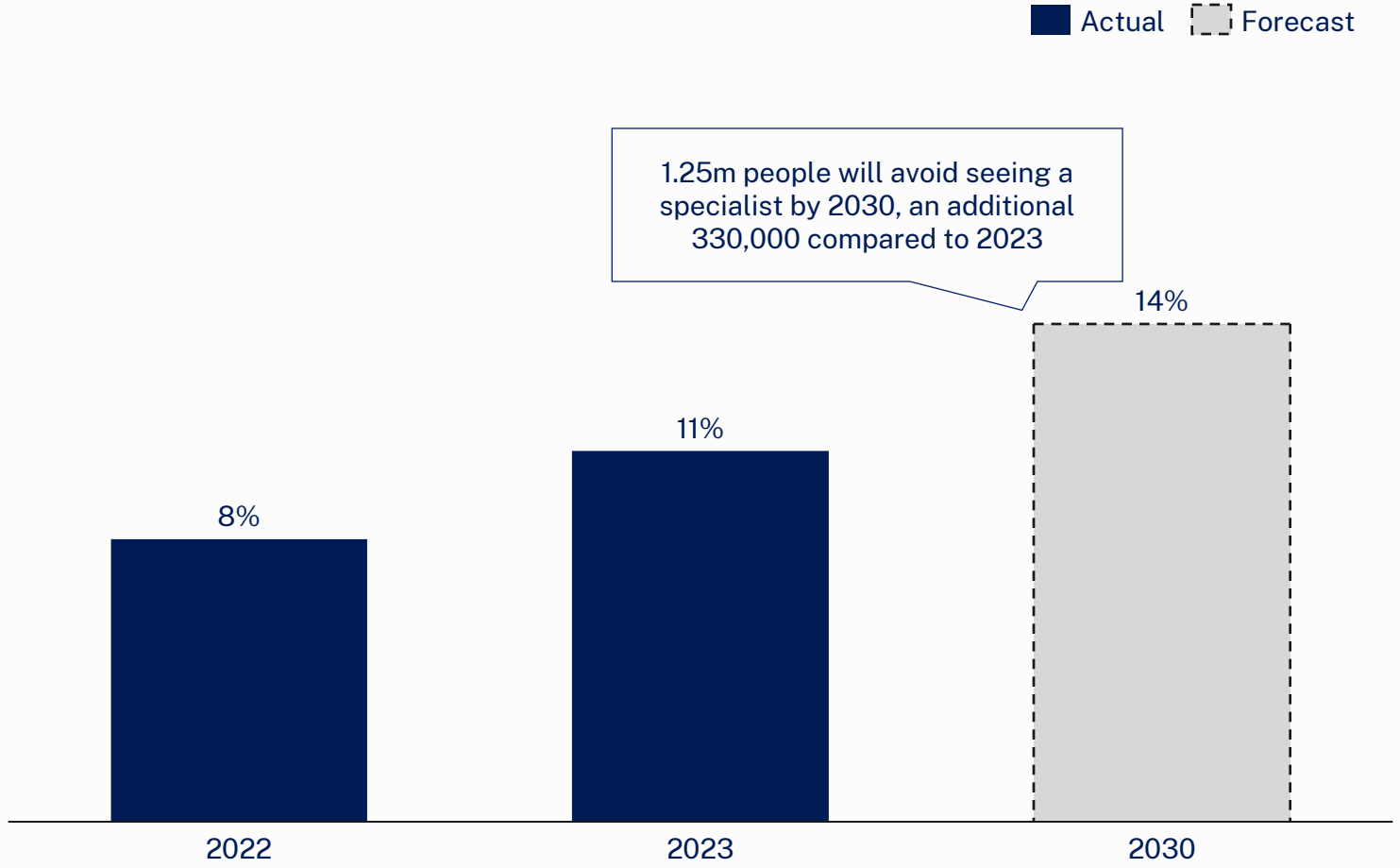
Between 2022 and 2023, median out-of-pocket costs increased by 12 per cent. Over this same period, the proportion of people who needed to but delayed or did not see a specialist due to cost increased from 8 per cent to 11 per cent.

Out-of-pocket costs are expected to rise by 7 per cent to 2030. Based on the historical impact of cost on delay or avoidance of care, by 2030, 14 per cent of people who need to see a specialist will delay or avoid care due to cost. This represents 1.25m people delaying or avoiding seeing a specialist in 2030. By 2030, over 330,000 people will avoid care in addition to the number who already avoid care in 2023.

Consumers cited consultation fees being too high (15%) and out-of-pocket expenses being too much (14%) as the top two reasons for delaying or cancelling an appointment in the past 12 months.1

Proportion of people who needed to but delayed or did not see a specialist due to cost

% of people 15 and over who needed to see a specialist[2]



Notes: The 2030 figure of people who avoid or delay care accounts for an expected population growth rate of 1.4% each year (ABS, 2022). The proportion of people who delayed or avoided seeing a specialist in 2021 has been excluded for the purpose of forecasting, as it indicates an outlier as people catch up on specialist care they delayed in 2020 due to the pandemic.
Source: 1. Commonwealth Bank (2024) CommBank Patient Experience Insights 2024 2. Australian Bureau of Statistics (2024) Patient Experiences, 2022-23; Table 10 and Table 12.2. Mandala analysis.

Young people are more likely to avoid seeing a specialist as costs rise, with 21% of 25–34-year-olds expected to avoid care by 2030

Private health insurance coverage rates continue to rise across all age groups. Between 2021 and 2024, the number of 25–34-year-olds with private health insurance increased by 3% year on year. The number of 15-24 years old with private health insurance also grew by 3% year to year.

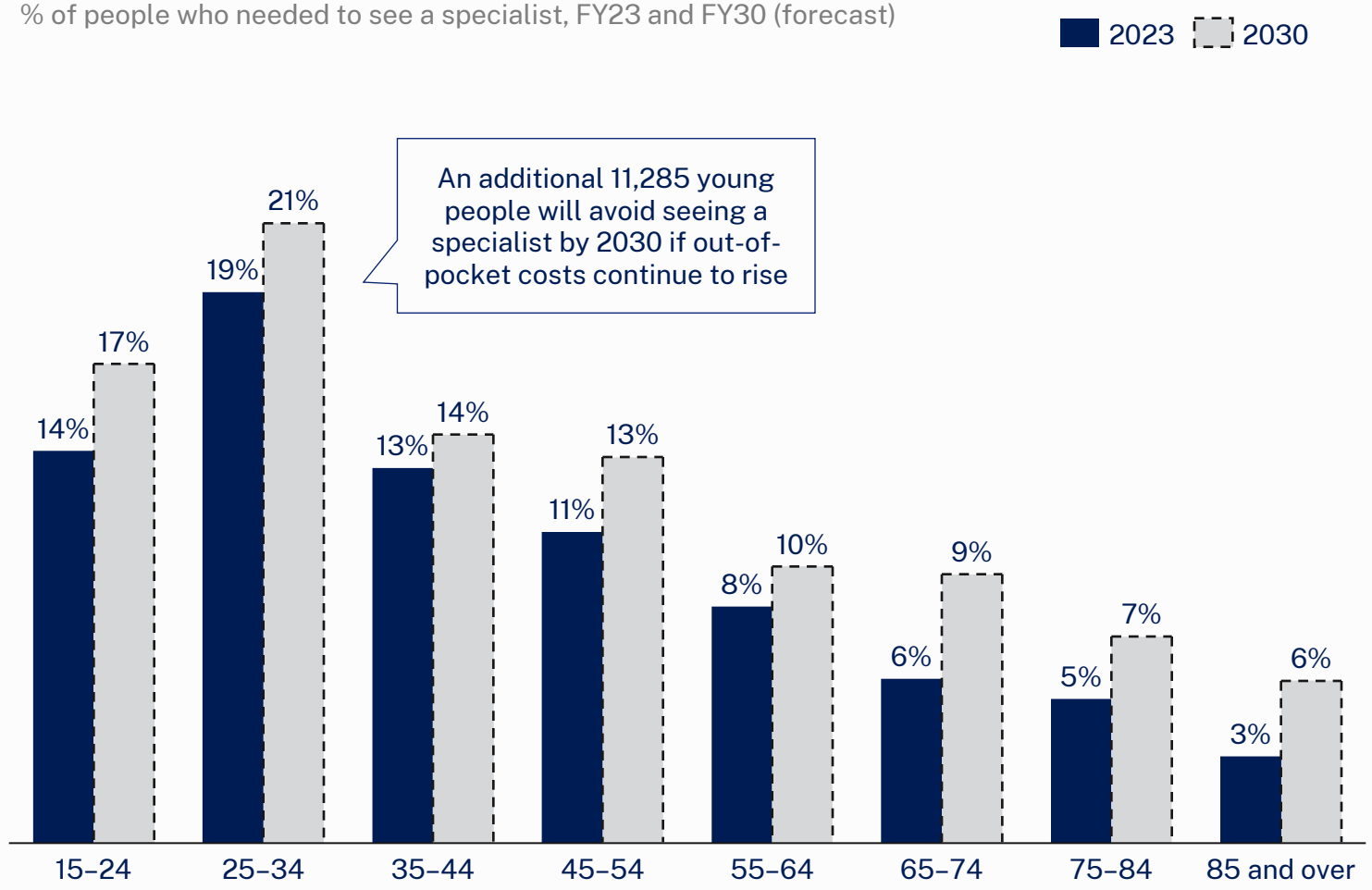
While the number of young people with private health insurance continues to rise, more young people will avoid seeing a specialist due to the high out-of-pocket costs they have to pay in addition to what is covered by Private Health Insurance.

Cost pressures will affect consumers differently. The proportion of people who needed to but did not see a specialist is higher for individuals who live in more disadvantaged areas (13 per cent, compared to 9 per cent for the least disadvantaged areas). Consumers in inner regional areas are also more likely to avoid seeing a specialist due to cost than consumers in other areas.

In the intersection of these groups; young people in disadvantaged, inner regional areas, these impacts will compound, and it is expected that the proportion of people who will avoid or delay care in this cohort to be even higher.

Proportion of people delaying or avoiding seeing a specialist by age group

% of people who needed to see a specialist, FY23 and FY30 (forecast)



Notes: The 2030 figure of people who avoid or delay care accounts for an expected population growth rate of 1.4% each year (ABS, 2022). The proportion of people who delayed or avoided seeing a specialist in 2021 has been excluded for the purpose of forecasting, as it indicates an outlier as people catch up on specialist care they delayed in 2020 due to the pandemic.
Source: Australian Bureau of Statistics (2018-19 to 2022-23) Patient Experiences, 2018-19 to 2022-23. Mandala analysis.

In the case of a hip replacement, delaying care by choosing to use the public system would cost someone an extra $7,292

As out-of-pocket costs rise along with the overall cost of living, consumers may opt to receive care through the public system. While the public system offers care without out-of-pocket costs, care is delayed as elective surgery in the public system has a median wait time of 49 days, with median wait times for common procedures such as hip replacements as high as 172 days.[1]

Delaying care can result in progression of condition or further complications, which may result in increased healthcare costs to treat a more progressed or complicated condition. Delays in receiving a hip replacement results in higher likelihood of revision surgery.[2]

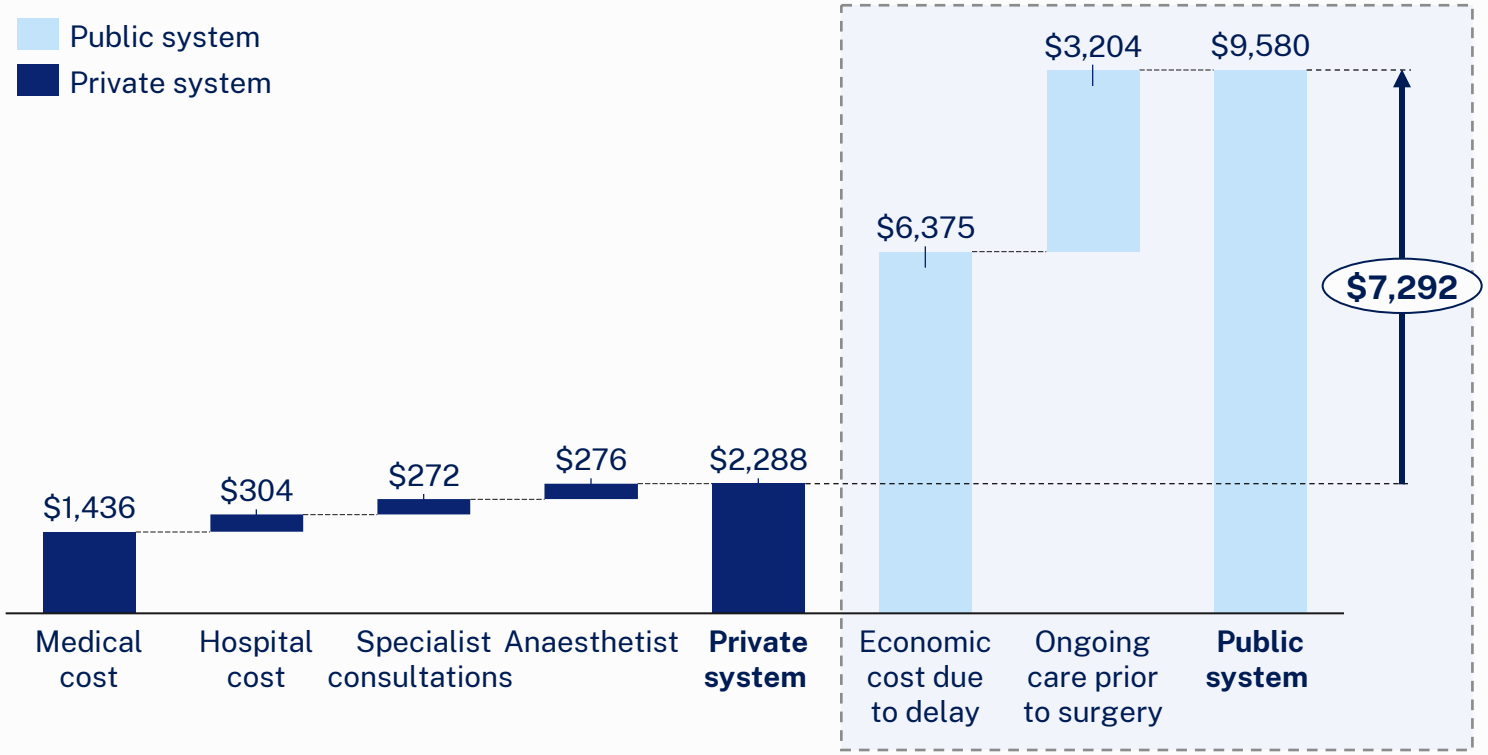
Delayed care results in consumers experiencing the symptoms of poor health for longer. When surgeries such as a hip or knee replacement are delayed, consumers experience a deterioration of their quality of life over time.[3]

It may result in consumers not being able to carry out daily activities. For consumers who suffer from Osteoporosis, 67% of people take time off work and miss an average of 72 days a year, impacting their income and overall productivity.[4] Consumers also incur ongoing cost of carers, aids and other financial costs associated with managing a health condition.

Illustrative case study

$AU23

Salma is 60 years old and has been diagnosed with Osteoarthritis and requires a hip replacement to continue to work and live a normal life. She has private health insurance, but due to the high out-of-pocket cost quoted by her specialist, she chose to use the public system. This results in a 172 day wait for elective surgery.



Notes: Assumes 10 days of paid sick leave. Additional leave days beyond this are unpaid. (Fair Work)
Source: 1. AIHW (2023) Elective surgery access 2. Holzapfel, D.E., Meyer, M., Thieme, M. et al. (2022) 3. Cooper, G.M., Bayram, J.M. & Clement, (2024) 4. Zurich (2018, 2024) Cost of Care 5. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

Across the top 20 electorates for hip replacements there may be nearly 7k people affected by these price rises, representing over $11m in lost economic opportunities

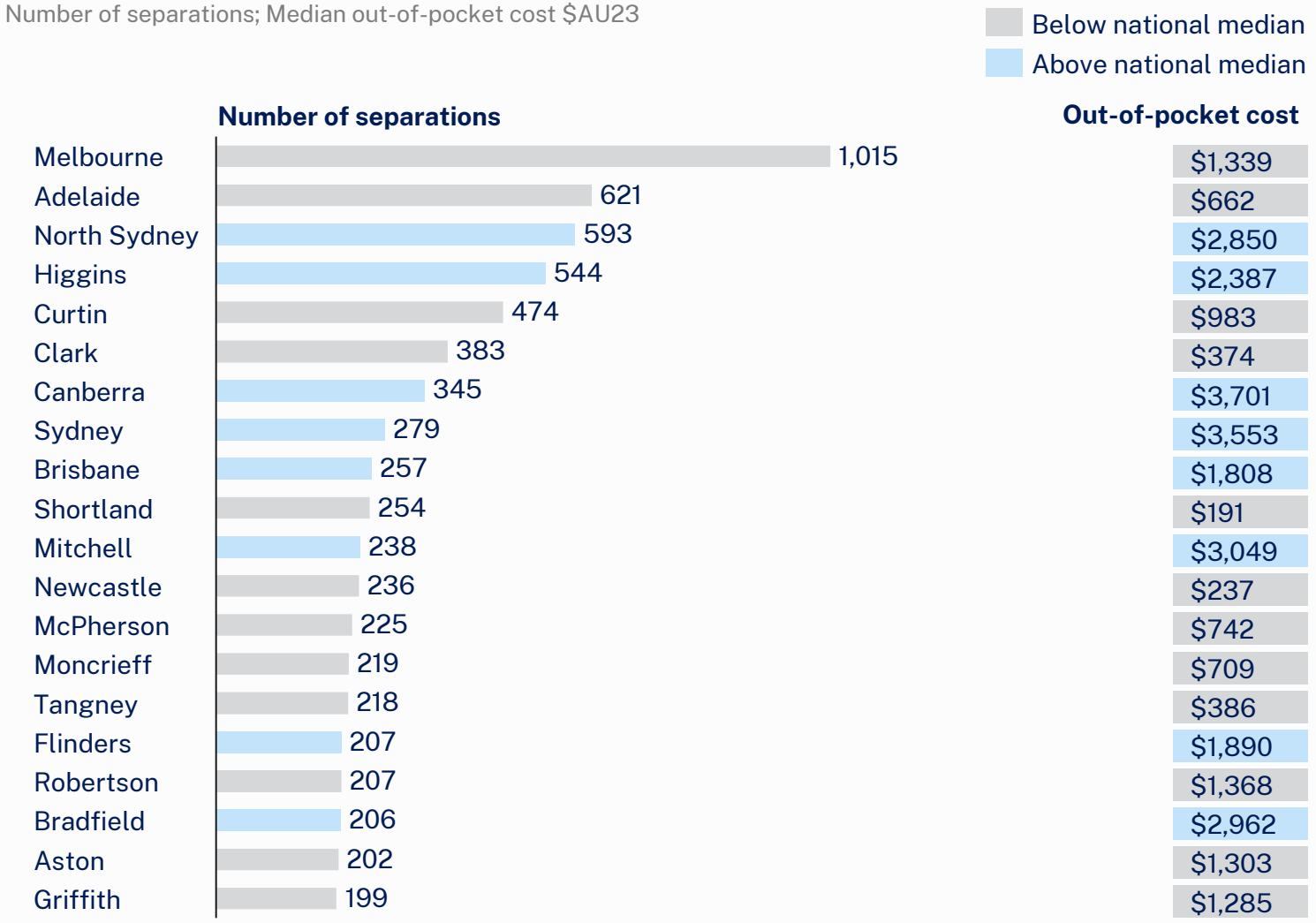
Total hip replacements represent 1% of all separations in the private healthcare system in 2023. The 20 electorates in which the highest number of hip replacements took place in 2023 account for a total of 6,922 total hip replacements, or 54% of all total hip replacements in Australia. This represents over $11m in out-of-pocket costs paid by residents of these ten electorates.

When expanded to the whole country, in 2023, Australians spent $18.4m on the medical costs for a total hip replacement in the private system. Total hip replacements are just one of over 400 procedures performed each year in Australia's private healthcare system.

When all procedures are considered, Australian consumers are spending $1.1B each year on out-of-pocket, in-hospital medical costs. This is much higher when out-of-hospital, out-of-pocket costs are considered as well.

20 electorates where the greatest number of hip replacements took place

Number of separations; Median out-of-pocket cost $AU23



Source: 1. ABS (2023) 5682.0 Monthly Household Spending Indicator Table 01. 2. ABS (2023) Patient Experience 3. Westpac (2024) Consumer Sentiment Index April 2024 4. Commonwealth Bank (2023) Household Spending Intentions – June 2023.

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2. Without change, consumers could find themselves paying $1.6B in out-of-pocket costs by 2030

3. **Out-of-pocket cost growth is driven by a lack of competition, price transparency and consumer protections as well as inflation**

Limited price transparency, workforce constraints, rising inflation and limited regulation are the key drivers of out-of-pocket costs

Rising inflation, limited workforce and resource availability and limited price transparency in several jurisdictions drive up out-of-pocket costs. These drivers can be quantified through modelling to determine the contribution of each driver to rising out-of-pocket costs.

The absence of regulation is not able to be quantified through modelling of costs in the private healthcare market. The absence of an ability to regulate prices enables practitioners to charge high prices.

Alongside high out-of-pocket costs, consumers may be exposed to surprise billing practices. These include split billing, charging a booking and administrative fees or charging high out-of-pocket costs which are not disclosed beforehand.

Many of these billing practices result in hidden costs which are not captured by official statistics such as Medicare or private health insurance records or result in consumers being caught out with higher-than-expected bills.

Drivers of out-of-pocket costs

	Driver	Description
Modelled	Price transparency	• **Limited price transparency results in higher cost.** The NT and ACT have limited price transparency and have higher median out-of-pocket costs. • **Lack of transparency restricts ability to compare.** Consumers are unaware of prices charged by other specialists in the market and may pay a higher price than they may have done if they have full price transparency.
Modelled	Workforce and resources availability	• **Major cities have higher out-of-pocket costs.** The limited number of specialists in each field often choose to live in major cities. • **Limited supply drives up the price.** There are limitations on training capacity at universities and in hospitals as well as limitations placed on specialist training programs managed by the specialist medical colleges.
Modelled	Input cost transferred to the consumer	• **Inflation drives up the input costs.** As inflation rises, the cost to provide specialist medical services increases. • **Practitioners pass on the rising costs to consumers**. This drives up the out-of-pocket costs paid by consumers.
Not modelled	Limited regulation	• **Specialist prices cannot be regulated.** Commonwealth Constitution restricts the ability to regulate private specialist prices. • **Consumer protections are limited to voluntary guidelines**. This includes guidelines such as informed financial consent. • **Non-compliant billing behaviours.** There is limited visibility on extent of non-compliant billing practices, but these contribute to cost.

Specialists can freely set prices, as government regulation of private specialist fees is prevented and there is limited price transparency for consumers

The Commonwealth Constitution restricts the regulation of private medical specialist fees…

- **75% of private specialist fees are subsidised.** The Australian Government subsidises specialist services through the Medicare Benefits Schedule (MBS).
- **The MBS schedule fee is the amount deemed appropriate for a service.** The MBS sets out a schedule fee for consultations and procedures. The schedule fee is set by the Government.
- **Specialists are free to charge above the MBS.** The Australian Constitution prohibits the civil conscription of doctors which also prohibits the government regulating medical fees. As a result, there is no upper limit on what specialists can change.
- **Consumers pay the remaining out-of-pocket costs.** Consumers are left to pay any remaining cost after the MBS rebate and private health insurance coverage.

…and there is no mandated price sharing mechanism for consumers to access reliable information about prices

- **Consumers have limited visibility.** This prevents consumers comparing prices, often leading to higher prices.
- **The Medical Costs Finder website aims to increase transparency.** It was established to enable consumers to see the cost of specialist medical services.
- **Interpretation of privacy rules limits what data is available online.** The Medical Costs Finder website uses the Hospital Protocol Casemix data. Data is not shown where there are fewer than 10 separations or fewer than three reporting hospitals.[1]
- **NT and ACT have limited price transparency.** There is no data available for the NT and limited data available for the ACT.
- **Relies on voluntary submission of data.** Specialists can voluntarily upload fees to the Medical Costs Finder website, but this is not mandated. There is limited data uploaded by practitioners.

Policy solutions should focus on increasing price sharing and transparency

Source: 1. Department of Health and Aged Care (2022) HCP annual report – 2021-2022.

Despite the limitations of the Medical Costs Finder website, areas with some price transparency mechanisms have lower out-of-pocket costs

The Medical Costs Finder website provides an example of the benefits price transparency. States and territories with some data available on the Medical Costs Finder website have lower median out-of-pocket costs than areas with limited or no data available.

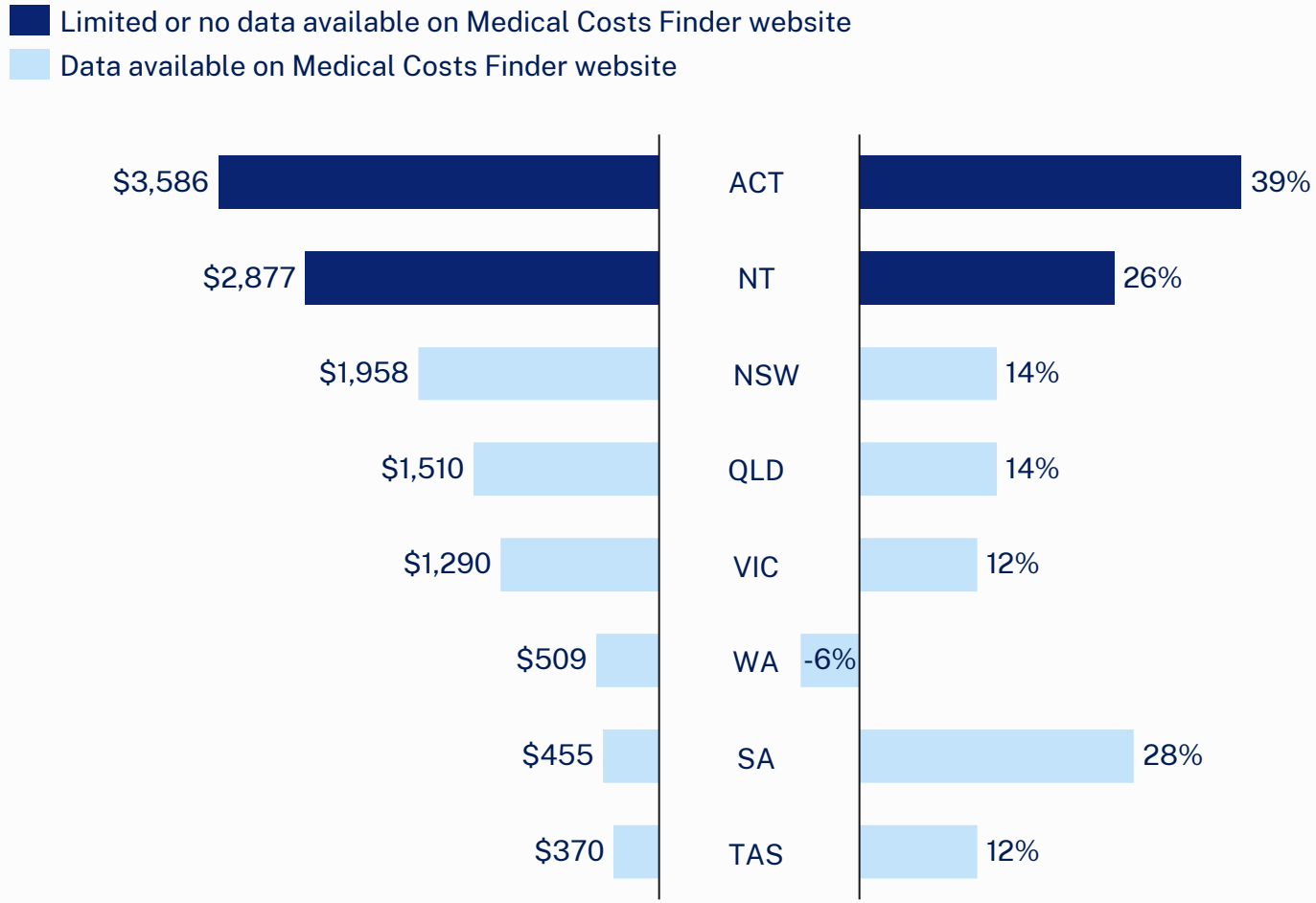
There is limited data available in the ACT and no data available in the NT on the Medical Costs Finder website. The two locations have the highest medical out-of-pocket cost compared to the other states and territories.

There is limited ability for consumers to compare the price they are quoted in the absence of price transparency. Consumers may unknowingly pay a higher price than they would in other states where they can compare prices between specialists. When consumers see a specialist, there is a considerable information asymmetry between a consumer and specialist. This can result in consumers feeling uncomfortable discussing the cost of services or seeking additional opinions before proceeding with treatment.

The decline in cost in WA could be explained by several factors which may include price transparency. It may also be a result of WA having the highest private health insurance coverage in the country or the high proportion of 'no gap' or 'known gap' agreement services.[2,3]

Out-of-pocket costs for a total hip replacement

Median cost, $AU23, FY23; % change in out-of-pocket cost FY22 to FY23[1]



Notes: Hip replacement AR-DRG: I03B - Hip Replacement W/O Catastrophic CC. Public hospital data excluded.
Source: 1. Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis. 2. APRA (2024) Quarterly Private Health Insurance Membership Coverage March 2024. Coverage of hospital treatment, March 2024. 3. APRA (2024) Quarterly Private Health Insurance Medical Gap March 2024, March 2024.

Mark-ups, market structure and barriers to entry are key indicators to understand competition in the private specialist market

Common ways to measure competition in a sector	Can we measure this in the medical specialist market?
1 Mark-ups *In competitive markets, firms typically face pressure to keep mark-ups low to attract customers and maintain market share.*	✓ Out-of-pocket costs represent the mark-up placed on specialist medical services above the MBS rebate, however access to this information is limited reducing the pressure to keep mark-ups low.
2 Market structure *Includes the number, size, and distribution of firms, the degree of product differentiation, and the nature of competition between firms.*	✓ Workforce data shows the geographical distribution of specialists. ✓ Specialist medical college data shows the number of specialists in each field.
3 Barriers to entry *In regulated markets like the medical specialist market, potential barriers to entry are overly onerous accreditation processes.*	✓ Number of places in medical schools and specialist medical colleges shows the barriers to accreditation.
4 Consumer choice and access *Ability for patients to choose a specialist promotes competition.*	▪ Access to a specialist requires a GP referral and the choice of specialist is up to the referring GP's discretion. ▪ Patients face a significant information asymmetry that hinders choice.
5 Quality of good or services delivered *Quality indicators promote competition in a sector.*	▪ There are no indicators of healthcare quality such as clinical outcomes or patient satisfaction with specialist care.
6 Industry concentration *Measures the extent to which market share is concentrated between a small number of firms.*	▪ Medical specialists often operate as independent, small businesses with limited visibility over their market share due to a lack of data sharing.

States and territories with fewer specialists per 1,000 residents pay higher out-of-pocket costs

The supply of medical specialists is controlled by the specialist medical colleges and training capacity at universities and within hospitals. Medical specialists make up 12% of the total medical workforce.

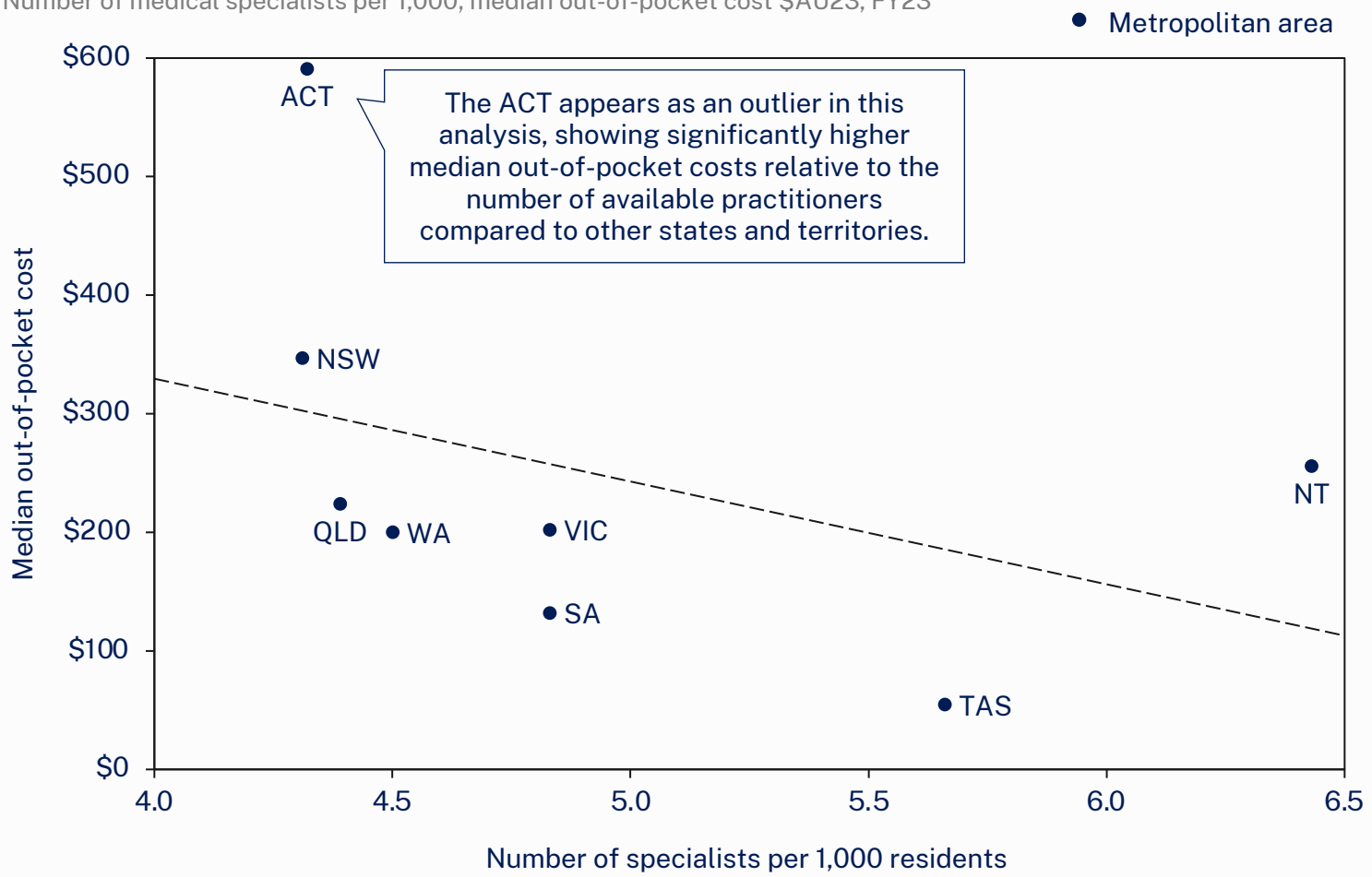
The number of specialists per 1,000 residents varies across the states and territories, as well as by electorate within states and territories. The metropolitan area of Tasmania has the second highest proportion of medical specialists per capita. This corresponds with the lowest out-of-pocket cost charged to consumers. Areas with higher number of specialists per capita tend to have lower out-of-pocket cost.

By looking at all specialists, procedures delivered in hospitals in regional areas have lower median out-of-pocket costs than metropolitan areas. This does not necessarily mean that people who live in regional areas pay lower costs for the same services. Instead, they are likely to have to travel to a metropolitan hospital to see the specialist they need. Many types of specialist are only available in metropolitan areas and more complex procedures are likely to be delivered in the larger, metropolitan hospitals.

Areas of higher disadvantage have a lower proportion of the overall number of medical specialists in each state and territory. This limits the choice that consumers have over which specialist they see.

Medical specialists and median out-of-pocket cost charged in metropolitan areas

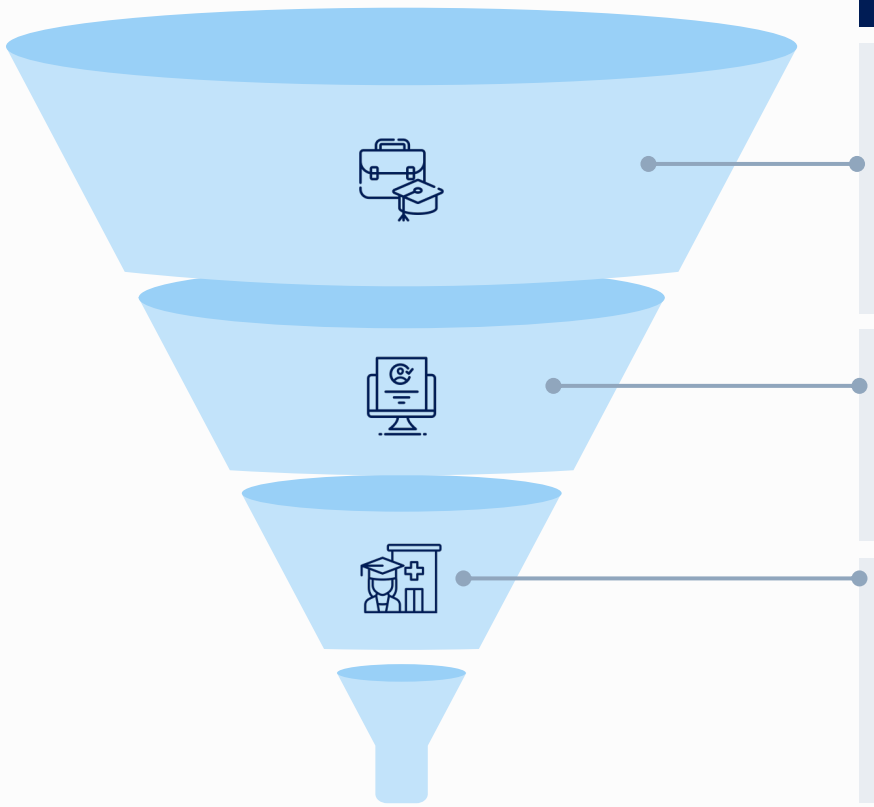
Number of medical specialists per 1,000; median out-of-pocket cost $AU23, FY23



Notes: Metropolitan areas are defined according to the Commonwealth Electorate classification of 'inner' and 'outer' metropolitan areas as determined by the Australian Electoral Commission. Costs are calculated based on the location of the medical services provided, regardless of the patient's residential location. Data from public hospital data excluded. Number of specialists exclude general practice.
Source: ABS Census 2021; DHAC Health Workforce Data; DHAC (accessed via PHA) Hospital Casemix Protocol data; Mandala analysis..

The supply of medical specialists is constrained at three key points along the accreditation pathway, creating high barriers to entry into the profession

Illustrative diagram of the medical specialist accreditation pathway, with three key blockers to supply



Practicing medical specialist

BLOCKERS TO THE SUPPLY OF MEDICAL SPECIALISTS

Training capacity in medical school and hospitals delivering internships

- Domestic students must complete a four-to-six-year University medical course to receive a provisional registration.
- Places at University medical schools are limited due to teaching and training capacity.
- University graduates must then complete an intern year under their provisional registration.
- Training capacity in hospitals also constrains the number of medical students admitted each year.

Accreditation through Ahpra

- On completion of the intern year, domestic medical graduates apply for a general registration with Ahpra to ensure they meet the requirements for accreditation.
- International medical graduates are required to complete additional exams and periods of supervision to receive a registration in Australia. This is often a complex, length and costly process.

Accreditation through the specialist medical colleges

- Medical practitioners undertake several years of training as a Resident Medical Officer prior to commencing training in a select speciality.
- The specialist medical colleges set limits on the number of trainees accepted into specialist training programs each year.
- Specialist medical colleges are responsible for setting exams and accrediting specialists.

Source: Mandala analysis

Distribution of specialists is not proportional to the population, with the highest proportion of surgeons in SA and the lowest in the NT

The specialist medical colleges in Australia are responsible for accreditation of medical specialists and decide how many specialists they will accredit each year. For example, 406 surgical trainees sat the fellowship exam with the Royal Australasian College of Surgeons (RACS) in 2023.1

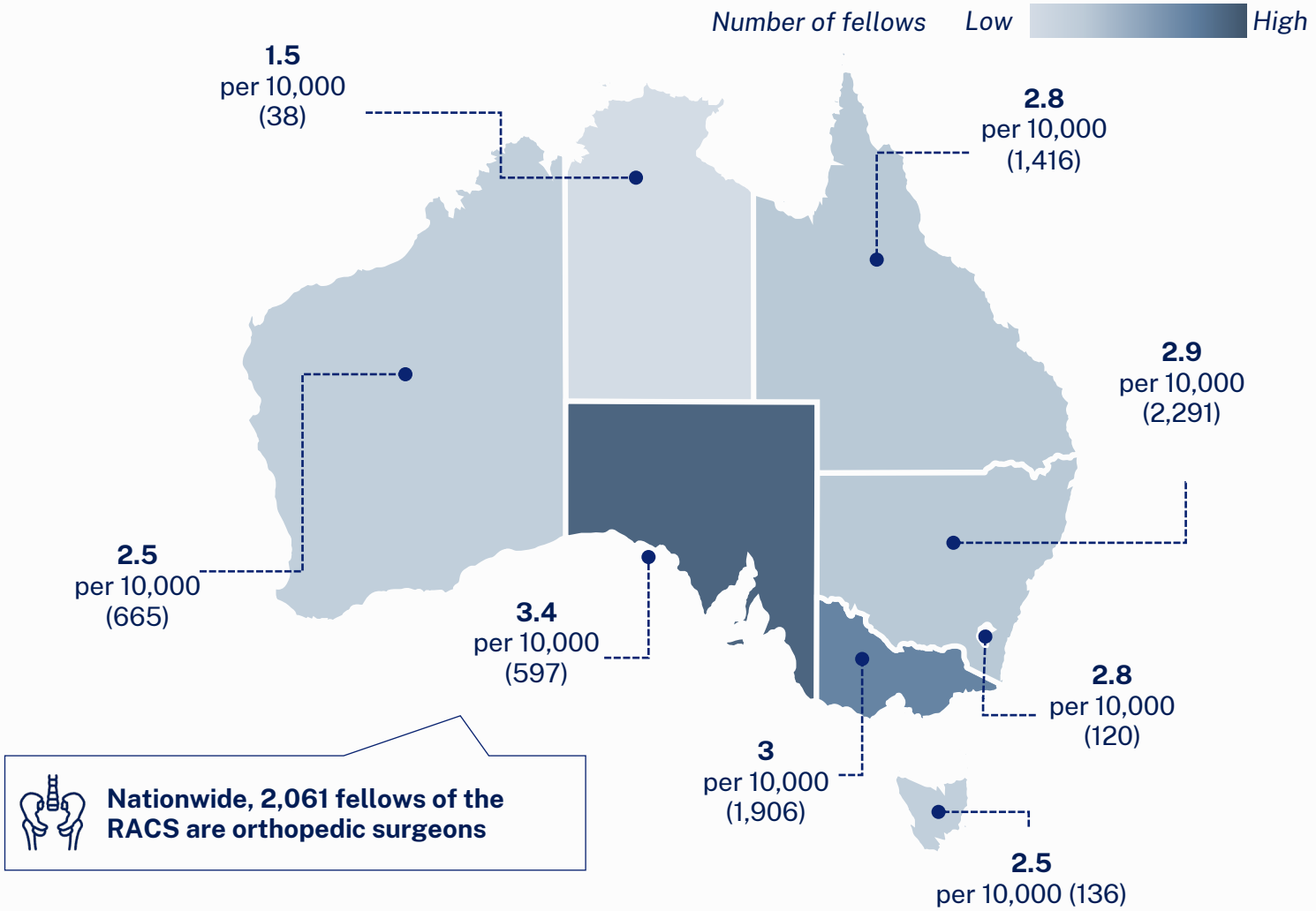
Within each specialty, there are often sub-specialties. This means the number of practitioners with the training to provide a specific procedure is a smaller proportion of the already limited group of specialists. Nationwide, there are only 2,061 orthopaedic surgeons, who are responsible for performing several procedures including hip replacements.1

With limited numbers of specialists, they often have well established referral pathways from GPs. This means they can use their market power to charge high costs. GPs referring consumers to a particular specialist are often unaware of the prices the specialist charges.

The distribution of specialists is not proportional to the population within each state and territory. After a long pathway to qualify as a specialist, many choose to work in affluent areas throughout the country. This leads to a concentration of specialists in areas with a higher ability to pay, further driving up costs.

Surgery fellows accredited with the Royal Australasian College of Surgeons (RACS)

Number of fellows per 10,000 residents (total number of fellows), FY23

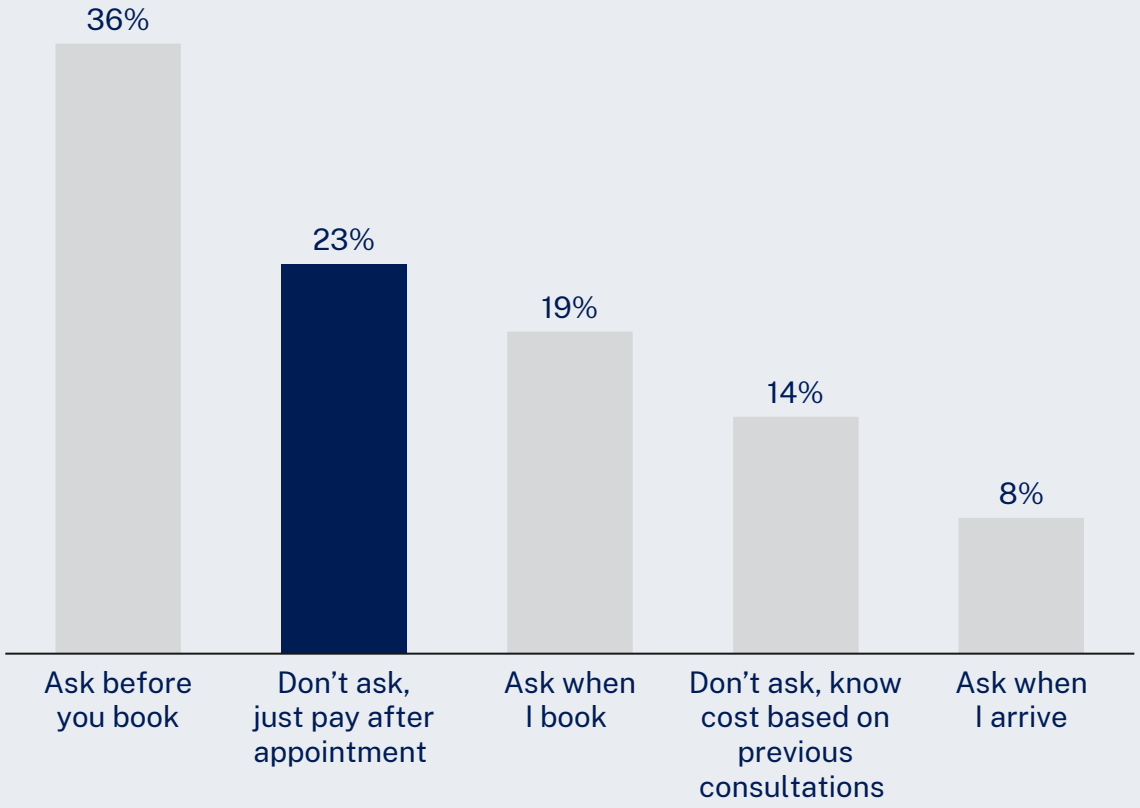


Source: Royal Australasian College of Surgeons (2023) Annual Report. Mandala analysis.

Almost 1 in 4 consumers are not aware of fees prior to the appointment with a specialist ...

Patient enquiries about fees and charges for medical specialists

Proportion who saw a medical specialist, 2024

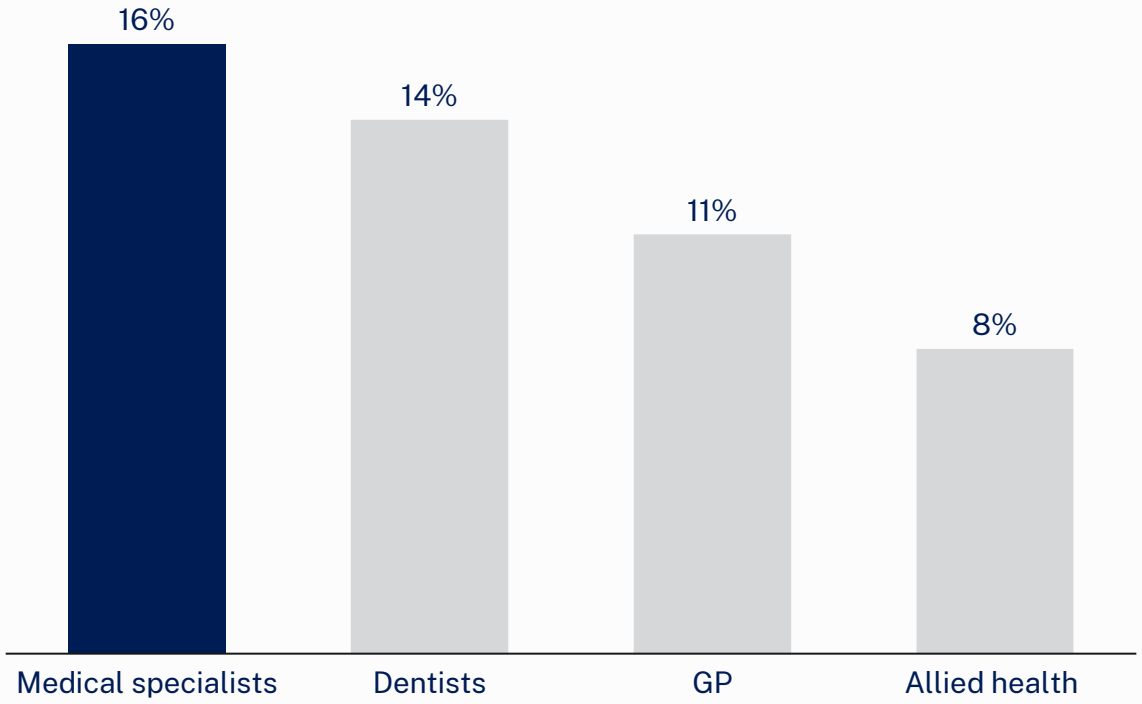


Source: CommBank Patient Insights Report (2024); Survey sample, n = 1,127

... and 16% of consumers report bill shock from seeing a specialist

Bill shock due to unexpected charges or out-of-pocket expenses

Proportion who saw each type of provider that experienced bill shock, 2024



Source: CommBank Patient Insights Report (2024); Survey sample, n = 1,127

Current consumer protections do not prevent 'surprise billing' resulting in consumers facing hidden costs of an unknown magnitude

Current consumer protections are limited, with bodies including the Australian Medical Association (AMA) recommending the practice of informed financial consent. Informed financial consent is where practitioners and consumers collaborate to ensure a consumer is provided with information about medical fees prior to treatment. However, this is a recommended practice and there are no consequences for not adhering to this procedure.

In circumstances where informed financial consent is not practices prior to a consumer receiving care, consumers may experience surprise billing or split billing. Surprise billing is the practice of charging a booking or administration fee. Split billing is where the full cost of the service is not disclosed to various payers including the consumer, their health fund and Medicare. These are hidden cost which further drive up the out-of-pocket costs above what is captured in official statistics.

Policy measures to address out-of-pocket costs must address both the visible and hidden costs consumers face in the private health system.

Causes of bill shock and policy solution

TYPES OF BILL SHOCK	DESCRIPTION	POLICY SOLUTION
Lack of disclosure of high out of pocket costs prior to treatment	Patient may not be aware of the additional charges associated with assistance in surgery or pathology services which may come with high out-of-pocket costs	**Legislated informed financial consent:** • Consumers are not liable for costs which are not disclosed prior to receiving treatment • Penalties apply where split billing occurs, and full costs are not disclosed to all payers
Split billing	Not disclosing the full cost of the service to various payers by billing Medicare, the health insurer and the patient separately without each other's knowledge	
Charging a booking or administrative fee	Claiming these charges as separate services, avoids the requirements under contractual obligations to charge no-gap or a known gap	
Unexpected change in the scope during treatment	Surgical complications may result in unexpected costs for additional services. While complications are rare, consumers need to be aware of the possible complications and associated costs.	

Source: PHA (2021) Combatting surprise billing in Australia

Three key drivers have been modelled to understand the contribution of each to the growing out-of-pocket cost by 2030

Cost driver	Operation within the model	Driver performance	Net impact on costs
Price transparency	• Price transparency refers to the availability of information about the prices of medical procedures, allowing consumers to make informed decisions about their healthcare options. • Increased price transparency can decrease out-of-pocket costs as consumers can choose more cost-effective options. • The introduction of a limited Medical Costs Finder website where some information for procedures is available is used as a proxy for price transparency.	• Interpretation of suppression rules impact the disclosure of detailed cost information in regions with smaller populations, such as the ACT and NT.[1]	**Upward pressure**
Workforce and resources availability	• Workforce and resources availability refer to healthcare providers and hospital resources available to patients. • An increase in the number of practitioners per capita increases competition among providers, which reduces out-of-pocket costs. • An increase in hospital resources indicates reduced out-of-pocket costs as the supply of services can better meet demand.	• Medical practitioners per capita increased 7% between 2015 and 2020.[2] Excluding GPs, the medical practitioners per capita increased by 3% between 2022 and 2023. • Since 2018, hospitals beds per capita decreased an average of 0.6% every year.[3]	**Downward pressure**
Input cost transferred to the consumer	• Cost of inputs transferred to the consumer involve the extent to which the costs of healthcare inputs are passed on to consumers. • The driver is measured by the Consumer Price Index (CPI). An increase in CPI indicates higher inflation, which leads to higher costs of healthcare inputs being transferred to consumers. This occurs as the prices charged by providers outpace the MBS rebate and PHI refunds, increasing out-of-pocket costs to consumers.	• Inflation is still high and is falling more slowly than expected, at 3.8% in 2024. The Reserve Bank of Australia expects inflation to reach 2.5% in 2026.[4] • The 2023-24 budget included additional indexation funding for the MBS, amounting to $1.5 billion over the forward estimates.[5]	**Upward pressure**

There are other drivers such as demand for services and lack of consumer protections which have not been modelled but will drive out-of-pocket costs.

1. According to Hospital Casemix Protocol (2024), where there are less than 10 separations or fewer than 3 reporting hospitals, or one hospital accounts for at least 85% of separations or two hospitals account for at least 90% of separations, all disclosure is suppressed to maintain confidentiality. When a confidential value could be calculated using other information provided, the value is made confidential in associated tables. Admitted Patient Care statistics for the ACT, NT and Tasmania are not are typically not reported due to confidentiality reasons.
Source: 2. DHAC (2024); 3. AIHW (2024); 4. RBA (2024); 5. Budget 2023-2024 (2024), AIHW (2024); Mandala analysis

By 2030, out-of-pocket costs could more than double without mitigating factors like competitive pressures and consumer protections

In isolation, the increase in the cost of inputs would lead to $2.10 of out-of-pocket costs for every dollar spent, meaning the costs would more than double without any mitigating factors.

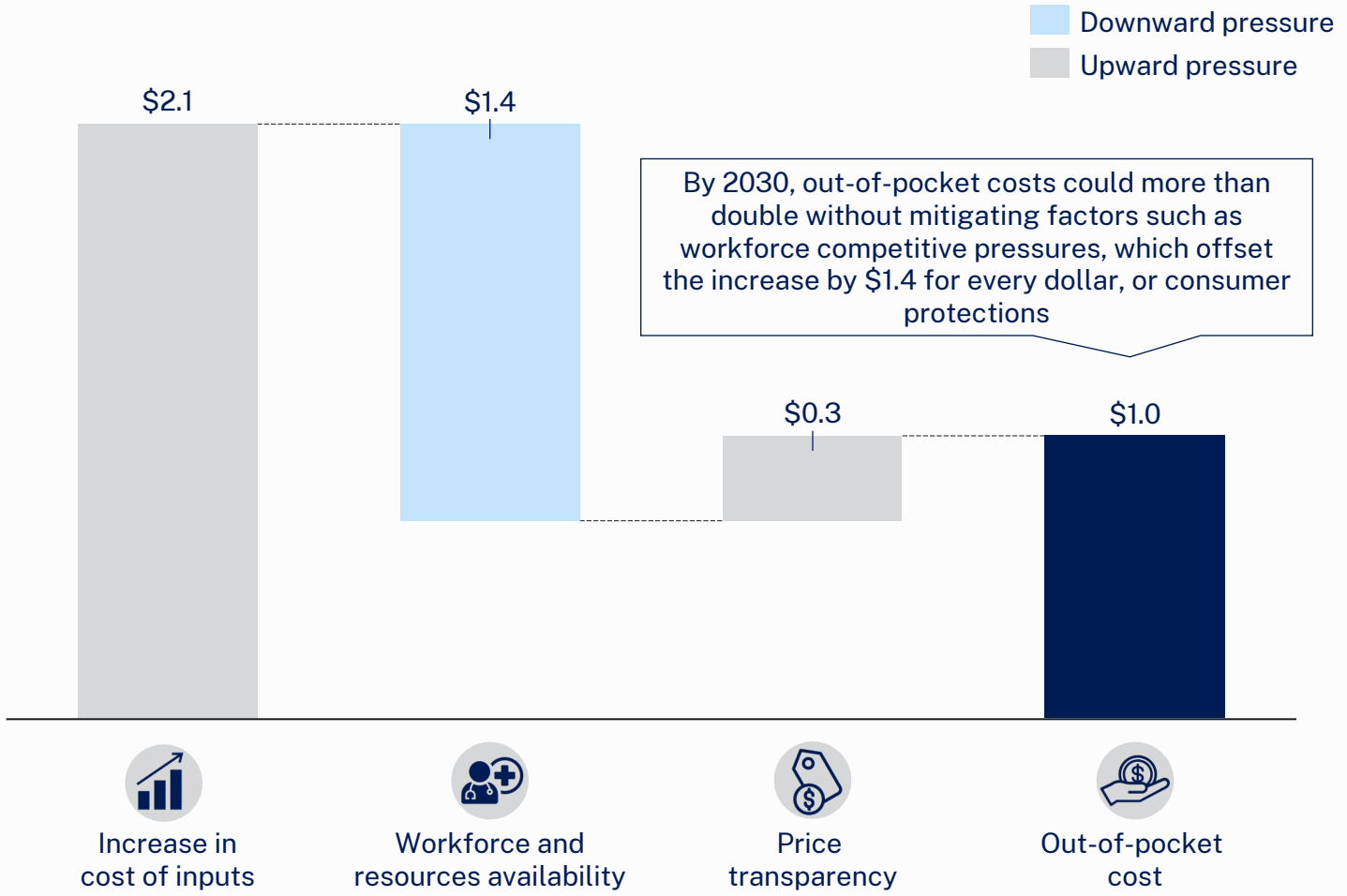
A lack of price transparency contributes 30 cents of every dollar to out-of-pocket costs. Enhancing the Medical Costs Finder website website to align more closely with the original recommendations could help increase transparency.

The competitive environment, captured by workforce and resources availability, offsets the costs by $1.40 for every dollar, reducing the overall impact on out-of-pocket costs.

While a lack of consumer protections cannot be directly modeled, it significantly contributes to increasing out-of-pocket costs. Strengthening consumer laws around surprise billing and mandating informed financial consent are crucial steps to improve consumer protections. Additionally, improving compliance activities within the Department of Health and Aged Care to prevent practices such as side billing and split billing, as well as charging booking fees, is essential.

Contribution of drivers to out-of-pocket costs by 2030

Breakdown of factors affecting out-of-pocket costs per dollar, $AU23



Notes: Data from public hospitals excluded.
Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.

Without price transparency, consumers will pay an additional $640 million in out-of-pocket costs by 2030

In the absence of any price transparency, consumers are expected to pay an additional $640 million in out-of-pocket costs.

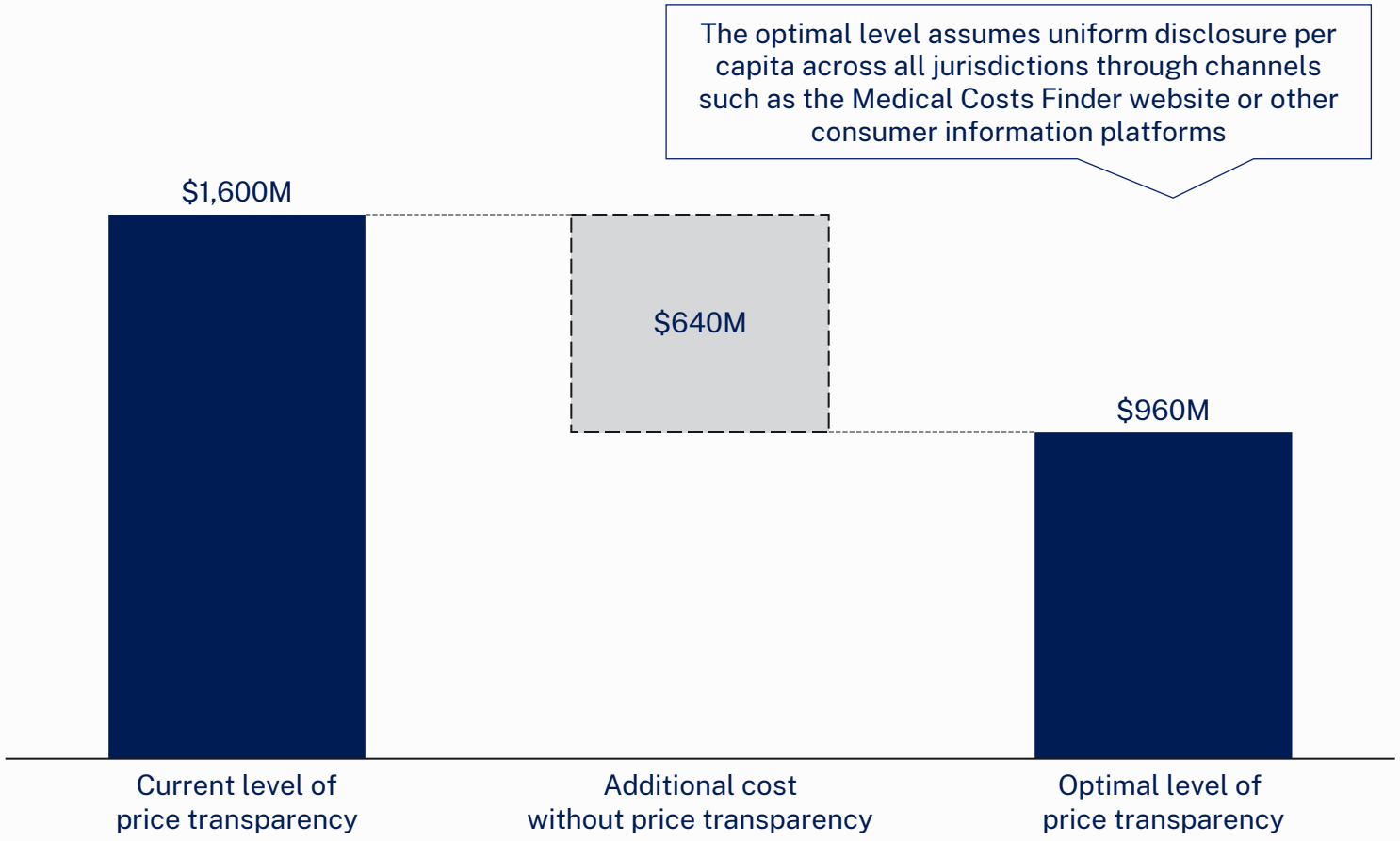
The Medical Costs Finder website website provides a useful example of the benefits of some price transparency on reducing out-of-pocket cost. While there are limitations on the usefulness of the Medical Costs Finder website website in the current state, it does show that areas with increased transparency have lower out-of-pocket costs.

For example, in May 2024, the website shows that for hip replacement surgeries, the typical out-of-pocket cost for patients with private health insurance is $1,000, with Medicare covering $1,900 and insurers covering $1,800. The website also reveals discrepancies in out-of-pocket costs across states, with the ACT showing high cost ($4,000) and the NT not being represented.

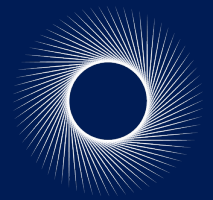
It is anticipated that if the Medical Costs Finder website was to be implemented in full as recommended, the impact of increased price transparency on reducing out-of-pocket costs would be even larger. The Medical Costs Finder website was recommended for implementation in the Ministerial Advisory Committee on Out-of-Pocket Costs report.

Projected out-of-pocket cost paid by Australians with and without price transparency

Total out-of-pocket cost projected by 2030, $AU23



Notes: The total additional cost of $1.6 billion encompasses all out-of-pocket expenses faced by private patients for in-hospital services. It is estimated based on projected out-of-pocket costs and the projected number of separations, maintaining the current cost distribution between medical specialists and other related expenses. Data from public hospitals excluded.
Source: Department of Health and Aged Care (accessed via PHA) Hospital Casemix Protocol data. Mandala analysis.



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