Number of insured persons	2,595,121	*65+ insured persons as at June 2025; APRA quarterly stats*
Base utilisation rate	0.81	*Calculated utilisation rate; assumes utilisation rate remains the same over time*
Low utilisation rate scenario	0.40	*Assumes those who have dropped PHI were less likely to use it; half of the base rate*
Reported utilisation rate scenario	1.10	*AIHW reported; https://www.aihw.gov.au/hospitals/topics/admitted-patient-care/patient-demographics*
		Ignoring cases where patients choose to self-fund after dropping PHI
		Ignoring any potential downgrading of policies

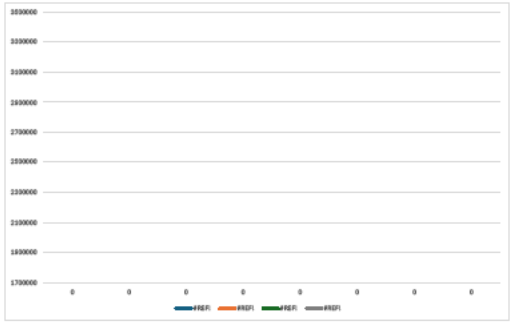
Part 1 Change in PHI-funded private hospital separations volume following the rebate cut

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Separations for older Australians (65+)										
Separations	1,741,268	1,873,392	1,952,880	2,097,111	2,231,208	2,373,879	2,525,674	2,687,174	s47E(d)	
Drop in insured older Australians (65+)										
Total drop in insured persons							8,051	44,324		
Drop in separations due to rebate cut										
Base utilisation rate	0	0	0	0	0	0	6,506	35,818		
Low utilisation rate scenario	0	0	0	0	0	0	3,220	17,730		
Reported utilisation rate scenario	0	0	0	0	0	0	8,856	48,756		
								For talking points (numbers to be rounded to the nearest 1,000)		
Separations for older Australians (65+) after drop										
Base utilisation rate	1,741,268	1,873,392	1,952,880	2,097,111	2,231,208	2,373,879	2,519,168	2,651,356	s47E(d)	
Low utilisation rate scenario	1,741,268	1,873,392	1,952,880	2,097,111	2,231,208	2,373,879	2,522,453	2,669,445		
Reported utilisation rate scenario	1,741,268	1,873,392	1,952,880	2,097,111	2,231,208	2,373,879	2,516,817	2,638,418		

HCPI separations for older Australians; 2025/26 to 2028/29 separations forecast using CAGR (2021/22 to 2024/25)

s47E(d)

	Base	Low	Reported
Utilisation rate	0.8	0.4	1.1
CAGR Separations growth	6%		



Part 2 Change in private hospital total PHI-funded charges following the rebate cut

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Total private hospital separations	3,472,597	3,681,871	3,784,789	3,986,586	4,174,297	4,370,847	4,576,652	4,792,147	s47E(d)	
Private Hospital charges										
Average private hospital charges (65+)	$ 3,727	$ 3,796	$ 3,880	$ 3,975	$ 4,062	$ 4,150	$ 4,240	$ 4,332		
Total private hospital charges (65+)	$ 6,490,377,843	$ 7,111,795,721	$ 7,576,981,592	$ 8,336,746,197	$ 9,062,307,198	$ 9,851,014,990	$ 10,708,365,343	$ 11,640,332,335		
Total private hospital charges (All patients)	$ 11,928,150,757	$ 12,886,005,754	$ 13,541,887,455	$ 14,596,604,657	$ 15,613,575,310	$ 15,613,575,310	$ 15,613,575,310	$ 15,613,575,310		
Reduction in private hospital charges after drop (65+)										
Base utilisation rate	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,584,149	$ 156,157,336		
Low utilisation rate scenario	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,653,671	$ 76,801,287		
Reported utilisation rate scenario	$ -	$ -	$ -	$ -	$ -	$ -	$ 37,548,144	$ 211,203,540		
Total charges in charges after drop										
Base utilisation rate	$ 11,928,150,757	$ 12,886,005,754	$ 13,541,887,455	$ 14,596,604,657	$ 15,613,575,310	$ 15,613,575,310	$ 15,585,991,161	$ 15,456,417,974		
Low utilisation rate scenario	$ 11,928,150,757	$ 12,886,005,754	$ 13,541,887,455	$ 14,596,604,657	$ 15,613,575,310	$ 15,613,575,310	$ 15,599,921,440	$ 15,536,774,023		
Reported utilisation rate scenario	$ 11,928,150,757	$ 12,886,005,754	$ 13,541,887,455	$ 14,596,604,657	$ 15,613,575,310	$ 15,613,575,310	$ 15,576,027,167	$ 15,402,371,770		
Proportional change in revenue										
Base utilisation rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.2%	-1.0%		
Low utilisation rate scenario	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%	-0.5%		
Reported utilisation rate scenario	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.2%	-1.4%		
Proportional change in insured separations										
Base utilisation rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%	-0.7%		
Low utilisation rate scenario	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%	-0.4%		
Reported utilisation rate scenario	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.2%	-1.0%		
								For talking points		

CAGR total private hospital charges (65+)	9%
CAGR total private hospital charges growth (all patients)	7%
CAGR total private hospital separations	5%

Part 3 Proportion of projected public hospital separations

	2019-20	2020-21	2021-22(a)	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31
Public hospital separations (AIHW)												
Public acute hospitals	6,716,770	6,956,417	6,827,068	7,117,715	7,468,059							
Public psychiatric hospitals	13,272	12,770	10,027	10,290	11,349							
Total public hospitals	6,730,042	6,969,187	6,837,095	7,128,005	7,479,408	7,879,441	7,884,823	8,095,698	8,312,213	8,534,519		
Proportion of all public hospital seps (highest utilisation scenario) in 2028-29										0.6%		
										For talking points		
CAGR total public hospital separations	3%											

s47E(d)

Part 4 Volume of separations that may be directed to public hospitals by service type

Top 10 service types for PHI-funded separations at private hospitals for patients aged 65+

ADRG	2024-25 proportions	Base	Low	Reported
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	10.3%	3,684	1,825	5,015
C16 Lens Interventions	6.6%	2,359	1,168	3,211
L61 Haemodialysis	6.5%	2,334	1,155	3,177
59 Bone Diseases and Arthropathies	5.6%	2,022	1,001	2,753
G48 Colonoscopy	4.9%	1,705	844	2,320
G46 Complex Endoscopy	3.5%	1,252	620	1,704
C03 Retinal Interventions	3.3%	1,183	585	1,610
68 Non-surgical Spinal Disorders	2.8%	991	490	1,348
G47 Gastroscopy	2.3%	823	407	1,120
Z40 Other Contacts with Health Services with Endoscopy	2.3%	811	401	1,104
Other	52.1%	18,655	9,235	25,395
Total	100.0%	35,818	17,730	48,756

Top 5 PHI-funded services and estimated number of separations of those expected to drop their PHI

ADRG	2024-25 proportions	Base	Low	Reported
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	10.3%	3.7k	1.8k	5k
C16 Lens Interventions	6.6%	2.4k	1.2k	3.2k
L61 Haemodialysis	6.5%	2.3k	1.2k	3.2k
59 Bone Diseases and Arthropathies	5.6%	2k	1k	2.8k
G48 Colonoscopy	4.8%	1.7k	0.8k	2.3k
		12,103	5,991	16,475
	33.8%	12.1k	6k	16.5k
		0.14%	0.07%	0.19%

For talking points

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Scenarios	Value	Description	Location
Low utilisation rate	0.40	Each insured person aged 65+ has 0.4 private separations per year - half of the base utilisation rate (reflects that people less likely to use PHI might be more likely to drop it)	Cell C9 in "Scenario Model - PHI"
Base utilisation rate	0.8	Each insured person aged 65+ has 0.81 private separations per year - based on calculated rate from 2024-25 data	Cell C8 in "Scenario Model - PHI"
Reported utilisation rate	1.10	Assumes that each insured person aged 65+ has 1.10 private separations per year - based on AIHW data	Cell C10 in "Scenario Model - PHI"

Additional parameter	Value	Description
Transfer proportion	100%	Proportion of "lost" private services that become public services. It can be at most 100%, and is likely less, as some people may choose to e.g. forgo elective surgeries. Set at 100% for now in lieu of sufficient data to estimate

RESULTS: SUMMARY				
% additional patient days in public sector	2027-28	2028-29	2029-30	2030-31
Low utilisation rate	0.05%	0.26%	s47E(d)	
Base utilisation rate	0.10%	0.52%		
Reported utilisation rate	0.13%	0.71%		

FROM PHI BRANCH CALCULATIONS

Metric	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31
Total people using each service type	65+	Private	1,952,880	2,097,111	2,231,208	2,373,879	2,525,674	2,687,174	s47E(d)	
Low utilisation rate: reduced private separations	65+	Private	0	0	0	0	3,220	17,730		
Base utilisation rate: reduced private separations	65+	Private	0	0	0	0	6,506	35,818		
Reported utilisation rate: reduced private separations	65+	Private	0	0	0	0	8,856	48,756		

CURRENT POLICY SETTINGS

			AIHW	Projected							Annual grow	3.32%
Total people using each service type	65+	Public	2,199,706	2,272,736	2,348,191	2,426,151	2,506,699	2,589,921	s47E(d)			
Total patient days per service type	65+	Public	8,476,167	8,757,576	9,048,328	9,348,732	9,659,110	9,979,792				
Total people using each service type	ALL	Public	14,365,889	14,842,837	15,335,619	15,844,762	16,370,808	16,914,319				
Total patient days per service type	ALL	Public	18,290,133	18,897,365	19,524,758	20,172,985	20,842,723	21,534,701				
Assumed separations per person*	65+	All	1.226	1.226	1.226	1.226	1.226	1.226				
Assumed patient days per separation**	65+	All	3.143	3.143	3.143	3.143	3.143	3.143				
Assumed separations per person*	ALL	All	0.474	0.474	0.474	0.474	0.474	0.474				
Assumed patient days per separation**	ALL	All	2.686	2.686	2.686	2.686	2.686	2.686				

Persons and patient days demand increasing using public hospital activity demand growth average from 2013-14 to 2022-23
Private and public refer to **patient election status**
Assumes total patient days per service type is the most appropriate metric for demand - however this does not account for complexity
* From AIHW data on separations per 1000 by age group, using ERP data to determine a weighted average for 65+. Assumed equal for all payment classes
** From AIHW data on separations and patient days, using ERP data to determine a weighted average for 65+. Assumed equal for all payment classes

SCENARIOS: DEMAND MOVING FROM PRIVATE TO PUBLIC

Assume demand from people aged 65+ who drop their PHI transfers from private patient (in either public or private hospitals) to public patient/public hospitals. The number of separations per person dropping PHI is defined in each of the three scenarios

Low utilisation rate	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31
Total separations change	65+	Public					3,220	17,730	s47E(d)	
Total separations change	65+	Private					-3,220	-17,730		

Base utilisation rate	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
Total separations change	65+	Public					6,506	35,818
Total separations change	65+	Private					-6,506	-35,818

Reported utilisation rate	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
Total separations change	65+	Public					8,856	48,756
Total separations change	65+	Private					-8,856	-48,756

Data sourced from PHI Branch - extracted from model provided on 21 May 2026

CALCULATED POLICY IMPACTS - PUBLIC HOSPITALS

			AIHW	Projected						
Low utilisation rate	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31
Additional separations - public	65+	Public	0	0	0	0	3,220	17,730	s47E(d)	
Additional patient days - public	65+	Public	0	0	0	0	10,122	55,724		
% additional separations	ALL	Public	0.00%	0.00%	0.00%	0.00%	0.04%	0.22%		
% additional patient days	ALL	Public	0.00%	0.00%	0.00%	0.00%	**0.05%**	**0.26%**		

Base utilisation rate	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
Additional separations - public	65+	Public	0	0	0	0	6,506	35,818
Additional patient days - public	65+	Public	0	0	0	0	20,448	112,576
% additional separations	ALL	Public	0.00%	0.00%	0.00%	0.00%	0.08%	0.45%
% additional patient days	ALL	Public	0.00%	0.00%	0.00%	0.00%	**0.10%**	**0.52%**

Reported utilisation rate	Age group	Service type	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29
Additional separations - public	65+	Public	0	0	0	0	8,856	48,756
Additional patient days - public	65+	Public	0	0	0	0	27,835	153,241
% additional separations	ALL	Public	0.00%	0.00%	0.00%	0.00%	0.11%	0.61%
% additional patient days	ALL	Public	0.00%	0.00%	0.00%	0.00%	**0.13%**	**0.71%**

WORKING

Estimated resident population, per age group and sex, June 2024

Age (years)	Males	Females	Total persons
65–69	652,904	706,658	1,359,562
70–74	560,093	614,016	1,174,107
75–79	464,365	508,777	973,142
80–84	283,276	328,766	612,036
85–89	155,219	207,873	363,092
90–94	61,134	101,424	162,558
95–99	15,707	33,566	49,273
100 and over	1,667	4,921	6,588
Total 65+	**2,194,357**	**2,506,001**	**4,700,358**

Separations per person aged 65+, by patient sex

Table 3.8: Separations per 1,000 population by sex(a) and age group, all hospitals, 2023–24

Age group (years)	Males	Females	Persons(b)
ALL	*455.74*	*490.65*	*473.57*
65–74	1,093.46	902.87	994.90
75–84	1,715.33	1,283.09	1,487.75
85+	1,848.00	1,304.75	1,521.06
65+	***1,385.70***	***1,085.72***	***1,226.21***

Patient days per separation

Table 3.1: Separations and patient days, by age group and sex(a), all hospitals, 2023–24

	Separations			Patient days			*Patient days per separation*		
Age group (years)	Males	Females	Persons(b)	Males	Females	Persons(b)	*Males*	*Females*	*Persons(b)*
ALL	*6,030,682*	*6,584,643*	*12,622,053*	*16,424,482*	*17,468,951*	*33,907,809*	*2.723*	*2.653*	*2.686*
65–69	616,787	566,184	1,183,760	1,526,810	1,356,193	2,883,820	2.475	2.395	2.436
70–74	687,179	601,602	1,289,476	1,768,440	1,576,611	3,345,833	2.573	2.621	2.595
75–79	713,853	599,980	1,314,488	1,978,731	1,796,650	3,776,076	2.772	2.995	2.873
80–84	511,400	424,938	936,601	1,656,385	1,606,791	3,263,483	3.239	3.781	3.484
85–89	282,040	270,765	552,848	1,167,340	1,331,698	2,499,131	4.139	4.918	4.520
90–94	106,092	127,350	233,446	561,547	764,335	1,325,893	5.293	6.002	5.680
95+	24,524	42,563	67,094	152,454	283,782	436,243	6.217	6.667	6.502
65+	***2,941,877***	***2,633,382***	***5,577,713***	***8,811,707***	***8,716,060***	***17,530,471***	***2.995***	***3.310***	***3.143***

Separations by funding source

Table S3.5: Separations, by age group and funding source, public and private hospitals, 2023–24

	Public hospitals				Private hospitals				All hospitals			
Age group (years)	Public patients	Private health	Other patients	Total	Public patients	Private health	Other patients(b)	Total	Public	Private	Other	Total
ALL	*6,494,097*	*804,976*	*180,335*	*7,479,408*	*309,157*	*4,203,282*	*630,206*	*5,142,645*	*6,803,254*	*5,008,258*	*810,541*	*12,622,053*
65–69	559,625	73,483	8,971	642,079	35,179	462,894	43,608	541,681	594,804	536,377	52,579	1,183,760
70–74	576,414	88,189	11,509	676,112	36,182	526,526	50,656	613,364	612,596	614,715	62,165	1,289,476
75–79	562,652	103,536	15,853	682,041	31,392	535,524	65,531	632,447	594,044	639,060	81,384	1,314,488
80–84	426,956	89,593	8,278	524,827	24,342	356,975	30,457	411,774	451,298	446,568	38,735	936,601
85-89	274,197	61,832	6,259	342,288	12,476	180,239	17,845	210,560	286,673	242,071	24,104	552,848
90-95	120,502	28,370	5,493	154,365	3,662	66,277	9,142	79,081	124,164	94,647	14,635	233,446
95+	32,907	7,774	5,659	46,340	807	13,384	6,563	20,754	33,714	21,158	12,222	67,094
65+	***2,553,253***	***452,777***	***62,022***	***3,068,052***	***144,040***	***2,141,819***	***223,802***	***2,509,661***	***2,697,293***	***2,594,596***	***285,824***	***5,577,713***

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Top 10 service types for PHI-funded separations at private hospitals for patients aged 65+
Source: HCP1 as at 28/04/26
Notes: Standard exclusions applied. Private hospitals based on derived hospital type. Patient age at time of admission. ADRG based on internal grouper, not supplied DRGs.

1a. ADRG as percent of separations

ADRG	2021/22	2022/23	2023/24	2024/25
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	10.8%	10.1%	10.0%	10.3%
L61 Haemodialysis	7.9%	7.3%	7.0%	6.5%
C16 Lens Interventions	6.6%	6.8%	6.8%	6.6%
I69 Bone Diseases and Arthropathies	4.6%	5.2%	5.5%	5.6%
G48 Colonoscopy	4.8%	4.9%	4.8%	4.8%
C03 Retinal Interventions	4.2%	3.9%	3.6%	3.3%
G46 Complex Endoscopy	3.3%	3.4%	3.4%	3.5%
I68 Non-surgical Spinal Disorders	2.5%	2.6%	2.7%	2.8%
Z40 Other Contacts with Health Services with Endoscopy	2.5%	2.5%	2.3%	2.3%
G47 Gastroscopy	2.2%	2.2%	2.2%	2.3%
OTHER	50.6%	51.1%	51.6%	52.1%

1b. ARDG separation count

ADRG	2021/22	2022/23	2023/24	2024/25
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	188,130	189,227	196,026	215,685
L61 Haemodialysis	136,938	136,471	137,628	136,637
C16 Lens Interventions	115,005	127,025	133,167	138,103
I69 Bone Diseases and Arthropathies	80,132	98,151	106,916	118,398
G48 Colonoscopy	83,437	91,345	94,503	99,808
C03 Retinal Interventions	73,872	72,331	69,741	69,249
G46 Complex Endoscopy	57,636	64,003	66,205	73,286
I68 Non-surgical Spinal Disorders	42,856	48,216	52,130	57,993
Z40 Other Contacts with Health Services with Endoscopy	43,588	46,570	45,705	47,473
G47 Gastroscopy	38,690	42,116	43,023	48,189
OTHER	880,984	957,937	1,007,836	1,092,290

Top 10 service types for PHI-funded separations at private hospitals for patients aged less than 65
Source: HCP1 as at 28/04/26
Notes: Standard exclusions applied. Private hospitals based on derived hospital type. Patient age at time of admission. ADRG based on internal grouper, not supplied DRGs.

2a. ADRG as percent of separations

ADRG	2021/22	2022/23	2023/24	2024/25
G48 Colonoscopy	6.2%	6.5%	6.7%	7.0%
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	6.7%	6.4%	6.4%	6.3%
G46 Complex Endoscopy	4.9%	5.3%	5.6%	6.1%
U60 Mental Health Treatment without ECT, Sameday	5.5%	4.9%	4.7%	4.7%
D40 Dental Extractions and Restorations	3.8%	4.0%	4.0%	4.1%
G47 Gastroscopy	3.3%	3.3%	3.3%	3.4%
N07 Other Uterus and Adnexa Interventions for Non-Malignancy	2.9%	2.8%	2.9%	2.8%
Z40 Other Contacts with Health Services with Endoscopy	2.5%	2.6%	2.5%	2.4%
L61 Haemodialysis	2.6%	2.4%	2.4%	2.2%
I69 Bone Diseases and Arthropathies	1.8%	1.9%	2.0%	2.0%
OTHER	59.8%	59.8%	59.4%	58.9%

2b. ADRG separation count

ADRG	2021/22	2022/23	2023/24	2024/25
G48 Colonoscopy	106,484	117,463	123,584	133,150
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	116,033	115,123	117,083	119,910
G46 Complex Endoscopy	84,902	96,498	103,238	114,991
U60 Mental Health Treatment without ECT, Sameday	95,718	88,888	85,988	89,671
D40 Dental Extractions and Restorations	66,150	72,781	73,421	76,755
G47 Gastroscopy	57,839	60,436	60,174	64,347
N07 Other Uterus and Adnexa Interventions for Non-Malignancy	49,810	51,144	52,426	53,764
Z40 Other Contacts with Health Services with Endoscopy	43,234	46,300	45,421	46,137
L61 Haemodialysis	44,923	44,066	44,624	40,717
I69 Bone Diseases and Arthropathies	30,578	34,652	37,159	37,419
OTHER	1,035,658	1,081,128	1,088,791	1,112,614

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Year	2025
MonthEnd	Jun

Row Labels	Sum of InsuredPersons
65	736675
70	652147
75	554302
80	353538
85	194876
90	80326
95	23257
Grand Total	**2595121**

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s22

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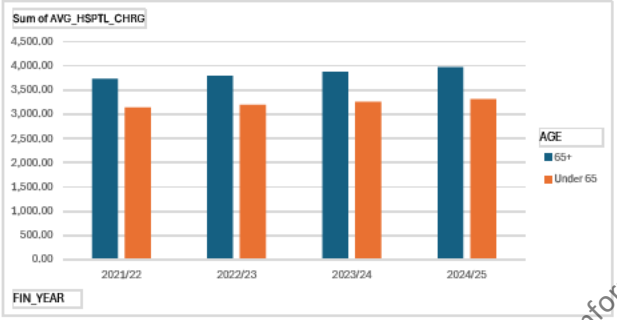
FIN_YEAR	AGE	AVG_HSPTL_CHR	TTL_HSPTL_CHRG	AVG_HSPTL_BNFTS	TTL_HSPTL_BNFTS	AVG_LOS	AVG_COM	sep_cnt
2021/22	65+	3,729.19	6,490,377,842.59	3,598	6,261,545,212	2.38	0.83	1,741,268
2021/22	Under 65	3,141.36	5,435,772,914.52	2,893	5,005,852,666	1.90	0.77	1,731,329
2022/23	65+	3,797.56	7,111,795,721.44	3,672	6,876,340,520	2.35	0.90	1,873,392
2022/23	Under 65	3,194.28	5,774,210,032.50	2,947	5,327,691,589	1.87	0.82	1,808,479
2023/24	65+	3,880.06	7,576,981,591.68	3,759	7,339,984,749	2.32	0.91	1,952,880
2023/24	Under 65	3,256.46	5,964,905,863.69	3,011	5,515,873,911	1.85	0.83	1,831,909
2024/25	65+	3,975.51	8,336,746,196.94	3,860	8,094,733,906	2.25	0.91	2,097,111.0000
2024/25	Under 65	3,313.17	6,259,858,460.41	3,065	5,791,855,960	1.80	0.83	1,889,475

	Column Labels					
	65+		Under 65		Total Sum of sep_cnt	Total Percent of seps
Row Labels	Sum of sep_cnt	Percent of seps	Sum of sep_cnt	Percent of seps		
2021/22	1,741,268	50.14%	1,731,329	49.86%	3,472,597	100.00%
2022/23	1,873,392	50.88%	1,808,479	49.12%	3,681,871	100.00%
2023/24	1,952,880	51.60%	1,831,909	48.40%	3,784,789	100.00%
2024/25	2,097,111	52.60%	1,889,475	47.40%	3,986,586	100.00%
Grand Total	7,664,651	51.35%	7,261,192	48.65%	14,925,843	100.00%

Row Labels	Sum of sep_cnt	Percent of seps
2021/22	3,472,597	100.00%
2022/23	3,681,871	100.00%
2023/24	3,784,789	100.00%
2024/25	3,986,586	100.00%
Grand Total	14,925,843	100.00%

Sum of AVG_H	Column Labels		
Row Labels	65+	Under 65	Grand Total
2021/22	3,729.19	3,141.36	6,870.56
2022/23	3,797.56	3,194.28	6,991.84
2023/24	3,880.06	3,256.46	7,136.52
2024/25	3,975.51	3,313.17	7,288.69
Grand Total	15,382.32	12,905.28	28,287.61

60000
238,530,780.68 This will need to be inflated for 2028/29
3300
5,100,000.00
16,830,000,000.00
0.014172952



Row Labels	Sum of TTL_HSPTL_CHRG
2021/22	11,926,150,757.11
2022/23	12,886,005,753.94
2023/24	13,541,887,455.37
2024/25	14,596,604,657.35
Grand Total	52,950,648,623.77

Sum of TTL_HS	Column Labels		
Row Labels	65+	Under 65	Grand Total
2021/22	6,490,377,842.59	5,435,772,914.52	11,926,150,757.11
2022/23	7,111,795,721.44	5,774,210,032.50	12,886,005,753.94
2023/24	7,576,981,591.68	5,964,905,863.69	13,541,887,455.37
2024/25	8,336,746,196.94	6,259,858,460.41	14,596,604,657.35
Grand Total	29,515,901,352.65	23,434,747,271.12	52,950,648,623.77

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FIN_YEAR	AGE	PYR_ID	sep_cnt
2021	65+	WC	7,407
2021	65+	UK	374
2021	65+	OT	8,597
2021	65+	IH	1,645,978
2021	65+	CP	81,375
2021	65+	SE	11
2021	65+	IN	117,066
2021	65+	DV	107,319
2021	65+	DE	97
2021	65+	TP	5,096
2021	65+	SI	201,605
2021	Under 65	CP	97,043
2021	Under 65	SE	31
2021	Under 65	TP	16,441
2021	Under 65	WC	76,779
2021	Under 65	DE	15,202
2021	Under 65	UK	553
2021	Under 65	DV	28,380
2021	Under 65	IH	1,723,051
2021	Under 65	SI	372,059
2021	Under 65	IN	111,442
2021	Under 65	OT	14,582
2022	65+	DE	123
2022	65+	TP	5,057
2022	65+	WC	8,516
2022	65+	CP	128,974
2022	65+	UK	543
2022	65+	SI	232,889
2022	65+	SE	3
2022	65+	IH	1,773,034
2022	65+	DV	105,386
2022	65+	IN	127,862
2022	65+	OT	9,226
2022	Under 65	UK	676
2022	Under 65	SE	39
2022	Under 65	IH	1,790,546
2022	Under 65	OT	17,425
2022	Under 65	TP	15,026
2022	Under 65	DV	29,990
2022	Under 65	SI	392,639
2022	Under 65	CP	129,781
2022	Under 65	IN	110,522
2022	Under 65	WC	77,941
2022	Under 65	DE	15,381
2023	65+	IH	1,865,341
2023	65+	SE	9
2023	65+	SI	248,201
2023	65+	DE	119
2023	65+	IN	132,499
2023	65+	DV	106,562
2023	65+	WC	9,193
2023	65+	OT	11,086
2023	65+	CP	128,080
2023	65+	UK	648
2023	65+	TP	4,816
2023	Under 65	TP	16,210
2023	Under 65	CP	127,022
2023	Under 65	IN	116,647
2023	Under 65	UK	754
2023	Under 65	WC	83,297
2023	Under 65	DE	16,838
2023	Under 65	OT	16,613
2023	Under 65	SI	382,684
2023	Under 65	SE	46
2023	Under 65	DV	33,628
2023	Under 65	IH	1,806,141
2024	65+	DE	102
2024	65+	OT	12,361
2024	65+	SI	236,557
2024	65+	SE	12
2024	65+	UK	513
2024	65+	CP	112,428
2024	65+	TP	5,980
2024	65+	DV	99,316
2024	65+	IH	1,875,420
2024	65+	IN	135,841
2024	65+	WC	9,915
2024	Under 65	UK	664
2024	Under 65	IH	1,770,260
2024	Under 65	IN	112,605
2024	Under 65	WC	85,851
2024	Under 65	DE	16,449
2024	Under 65	SI	353,184
2024	Under 65	TP	15,287
2024	Under 65	OT	20,514
2024	Under 65	SE	24
2024	Under 65	DV	34,092
2024	Under 65	CP	111,201

Sum of sep_cnt	Column Labels				
Row Labels	**2021**	**2022**	**2023**	**2024**	**Grand Total**
65+	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
CP	3.74%	5.39%	5.11%	4.52%	4.72%
DE	0.00%	0.01%	0.00%	0.00%	0.00%
DV	4.93%	4.41%	4.25%	3.99%	4.38%
IH	75.68%	74.14%	74.42%	75.37%	74.88%
IN	5.38%	5.35%	5.29%	5.46%	5.37%
OT	0.40%	0.39%	0.44%	0.50%	0.43%
SE	0.00%	0.00%	0.00%	0.00%	0.00%
SI	9.27%	9.74%	9.90%	9.51%	9.61%
TP	0.23%	0.21%	0.19%	0.24%	0.22%
UK	0.02%	0.02%	0.03%	0.02%	0.02%
WC	0.34%	0.36%	0.37%	0.40%	0.37%
Under 65	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
CP	3.95%	5.03%	4.89%	4.41%	4.58%
DE	0.62%	0.60%	0.65%	0.65%	0.63%
DV	1.16%	1.16%	1.29%	1.35%	1.24%
IH	70.17%	69.40%	69.47%	70.24%	69.81%
IN	4.54%	4.28%	4.49%	4.47%	4.44%
OT	0.59%	0.68%	0.64%	0.81%	0.68%
SE	0.00%	0.00%	0.00%	0.00%	0.00%
SI	15.15%	15.22%	14.72%	14.01%	14.78%
TP	0.67%	0.58%	0.62%	0.61%	0.62%
UK	0.02%	0.03%	0.03%	0.03%	0.03%
WC	3.13%	3.02%	3.20%	3.41%	3.19%
Grand Total					

PYR_ID	(Multiple Items)

Sum of sep_cnt	Column Labels				
Row Labels	**2021**	**2022**	**2023**	**2024**	**Grand Total**
65+	1,763,044	1,900,896	1,997,840	2,011,261	7,673,041
Under 65	1,834,493	1,901,068	1,922,788	1,882,865	7,541,214
Grand Total	**3,597,537**	**3,801,964**	**3,920,628**	**3,894,126**	**15,214,255**

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s22

From: s22
Sent: Friday, 5 June 2026 1:05 PM
To: s22
Cc: s22 s22 s22
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi s22

Thank you for sharing – your modelling looks good.

I like the idea behind the "transfer proportion". We could incorporate something similar in our modelling to estimate the proportion of those who may opt to self-fund care in private hospitals.

Thanks,
s22

OFFICIAL

From: s22 @Health.gov.au>
Sent: Tuesday, 2 June 2026 9:40 AM
To: s22 @Health.gov.au>; s22 @Health.gov.au>; s22 Health.gov.au>
Cc: s22 @Health.gov.au>
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

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Hi all

Thanks for all the info provided during and after our chat.

Sorry for the delay in getting back to you on this, but we've added a sheet in a separate version of your file below (Scenario – public hospital) that attempts to estimate the impact on public hospital demand. It considers each of your three utilisation scenarios, and how many additional separations and bed days in public hospitals this may lead to. We have also included a parameter "transfer proportion", that reflects the proportion of the estimated reduction in private admissions that will become public hospital admissions. We can't identify any real evidence to determine this parameter, so it's set at 100% for now. However, we think it's likely to be at least a little less, since e.g. someone dropping PHI may choose not to undergo an elective surgery, so that treatment does not occur in the public sector.

Happy to chat if any questions.

Cheers

s22

OFFICIAL

From: s22 @Health.gov.au>
Sent: Thursday, 21 May 2026 12:26 PM
To: s22 @Health.gov.au>; s22 Health.gov.au>
Cc: s22 @Health.gov.au>; s22 Health.gov.au>
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi s22 and s22

I have shared the PHI document discussed yesterday on Protected.

Link to our scenario model: Older Australians rebate cut 20260521.xlsx

Thanks,
s22

OFFICIAL

From: s22
Sent: Wednesday, 20 May 2026 9:47 AM
To: s22 @Health.gov.au>; s22
s22 @Health.gov.au>
Cc: s22 @Health.gov.au>; s22
<s22 Health.gov.au>
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

Hi s22

Thanks for reaching out. 4pm today works for us.

Thanks,
s22

From: s22 @Health.gov.au>
Sent: Wednesday, 20 May 2026 9:11 AM
To: s22 @Health.gov.au>; s22 @Health.gov.au>
Cc: s22 @Health.gov.au>; s22
s22 @Health.gov.au>
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

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Hi all

Would definitely be keen to chat further on this, maybe today/tomorrow if we can? Given estimates isn't far away and is clearly on the bosses' minds.

Looking at calendars, looks like 4pm today, 9am or 3pm tomorrow would work – happy to put something in if that suits.

Cheers
s22

OFFICIAL

From: KELLEHER, Brian <Brian.Kelleher@health.gov.au>
Sent: Wednesday, 20 May 2026 8:15 AM
To: O'BRIEN, Caitlin <Caitlin.OBrien@Health.gov.au>; MCBRIDE, Paul <Paul.McBride@health.gov.au>
Cc: s22 @Health.gov.au>; s22 s22 @Health.gov.au>; HAWKINS, Ross <Ross.Hawkins@health.gov.au>; s22 s22 @Health.gov.au>; s22 @Health.gov.au>; s22 s22 @Health.gov.au>
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi Caitlin, my view is s47C
Paul would be best placed to advise on what info has been provided to date for context and what if any further analysis / advice is being prepared for MO / Estimates so input can be best aligned.

In terms of the assessments that informed impact analysis, I will circulate a note in protected. s22 , s22 and s22 are the points of contact for s22 and s22 to discuss this work with.

Cheers
Brian

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From: O'BRIEN, Caitlin <Caitlin.OBrien@Health.gov.au>
Sent: Tuesday, 19 May 2026 4:54 PM
To: HAWKINS, Ross <Ross.Hawkins@health.gov.au>; KELLEHER, Brian <Brian.Kelleher@health.gov.au>; MCBRIDE, Paul <Paul.McBride@health.gov.au>
Cc: s22 Health.gov.au>; s22 @Health.gov.au>
Subject: FW: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi all

Some helpful analysis by s22 and s22 – noting that this plots an assumption of full conversion from private services to public.

@HAWKINS, Ross @KELLEHER, Brian – We are preparing a brief for the MO on s47C

Thanks, Caitlin

Caitlin O'Brien

Assistant Secretary, Public Hospitals Strategy Branch

Australian Government, Department of Health, Disability and Ageing
T: 02 5132 6644 | M: s22
E: caitlin.obrien@health.gov.au
Location: Level 6 Yaradhang Building
PO Box 9848, Canberra ACT 2601, Australia

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OFFICIAL

From: CORRIGAN, Maggie <Maggie.CORRIGAN@Health.gov.au>
Sent: Tuesday, 19 May 2026 3:03 PM
To: O'BRIEN, Caitlin <Caitlin.OBrien@Health.gov.au>
Cc: AITKEN, Richard <Richard.AITKEN@Health.gov.au>
Subject: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi Caitlin

We've done some thinking around the PHI rebate changes for people aged 65+ and what this might mean for public hospital demand.

KEY TAKEAWAY #1: The PHI rebate is likely to impact less than 1% of public hospital demand
The analysis from the private health team has been published by the Office of Impact Analysis. Government selected Option 2. The analysis states: "*For Option 2, if the decrease in private hospital separations estimated in the row above all transferred to the public hospital system, then these additional public hospital separations would represent* ***less than 1% of projected public hospital admissions in 2028-29****"* and *"Increased public hospital demand is considered to be a negative outcome from the perspective of public hospitals."* (p 30-31)

This relies on AIHW admitted patient data for 2023-24. I also did some basic analysis on an expected shift in demand between the private and public sectors under this shift, also using AIHW admitted patient data for 2023-24. It assumed:

- 44,000 people aged 65+ drop PHI entirely (as per ABC news reports)
- All these people only used private hospital before and all these people will only use public hospital after

- The people dropping PHI are a representative sample of those aged 65+. That is, they are not typically sicker/older/less healthy etc.

Those assumptions give an estimated **0.9% increase in annual public hospital admissions** from this policy change, which is consistent with the PHI team's analysis.

s47B(a), s47C

s47B(a), s47C

s47B(a), s47C

s47B(a), s47C

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s47B(a), s47C

[redacted]

Next steps

s47C

[redacted]

Happy to discuss.

Cheers

s22

s22

Assistant Director – Hospital Funding, Modelling and Reform Section

Public Hospital Strategy Branch

Portfolio Strategy Division | Systems Strategy Group

Australian Government Department of Health, Disability and Ageing

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s22

From: s22
Sent: Monday, 15 June 2026 9:48 AM
To: O'BRIEN, Caitlin
Cc: s22 s22
Subject: RE: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi Caitlin

A little more colour and movement of what we've been thinking on the PHI rebate changes for Australians aged 65+ on public hospital service use and demand. Happy to chat if you have any questions/thoughts.

Cheers
s22

++++++++++++++++++

s47C

s47C

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s47C [redacted]

When will we know what is happening?

- These impacts will be very difficult to measure. We will not have any public hospital data to track this until late 2027-28 at the earliest.

Next Steps:

- we will respond to QoNs as needed.
- We will work more with ERD to better understand their underlying PHI model and its assumptions.
- We will think more about people who drop to a lower level of PHI rather than dropping cover completely, as this is a key cohort we currently do not capture.

++++++++++++++++++++

OFFICIAL

From: O'BRIEN, Caitlin <Caitlin.OBrien@Health.gov.au>
Sent: Wednesday, 3 June 2026 11:03 AM
To: s22 [redacted] @Health.gov.au>
Cc: s22 [redacted] Health.gov.au>; s22 [redacted] s22 [redacted] @health.gov.au>
Subject: RE: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hey s22 [redacted] and s22 [redacted]

Ross wants a bit more colour and movement around s47C [redacted].

Thanks, s22 [redacted]

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From: s22 [redacted] @Health.gov.au>
Sent: Tuesday, 19 May 2026 3:03 PM
To: O'BRIEN, Caitlin <Caitlin.OBrien@Health.gov.au>
Cc: s22 [redacted] @Health.gov.au>
Subject: FYI: PHI rebate changes and public hospital demand [SEC=OFFICIAL]

OFFICIAL

Hi Caitlin

We've done some thinking around the PHI rebate changes for people aged 65+ and what this might mean for public hospital demand.

KEY TAKEAWAY #1: The PHI rebate is likely to impact less than 1% of public hospital demand

The analysis from the private health team has been published by the Office of Impact Analysis. Government selected Option 2. The analysis states: "*For Option 2, if the decrease in private hospital separations estimated in the row above all transferred to the public hospital system, then these additional public hospital separations would represent* ***less than 1% of projected public hospital admissions in 2028-29****"* and *"Increased public hospital demand is considered to be a negative outcome from the perspective of public hospitals."* (p 30-31)

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- 44,000 people aged 65+ drop PHI entirely (as per ABC news reports)
- All these people only used private hospital before and all these people will only use public hospital after
- The people dropping PHI are a representative sample of those aged 65+. That is, they are not typically sicker/older/less healthy etc.

Those assumptions give an estimated **0.9% increase in annual public hospital admissions** from this policy change, which is consistent with the PHI team's analysis.

s47B(a), s47C

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s47B(a), s47C

[redacted]

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Next steps

s47B(a), s47C

[redacted]

[redacted]

Happy to discuss.

Cheers
s22

s22
Assistant Director – Hospital Funding, Modelling and Reform Section
Public Hospital Strategy Branch

Portfolio Strategy Division | Systems Strategy Group
Australian Government Department of Health, Disability and Ageing
t: +61 2 5132 s22 | e: s22 health.gov.au

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s22

From: s22
Sent: Tuesday, 12 May 2026 3:38 PM
To: s22
Cc: s22 ; s22 ; MCBRIDE, Paul
Subject: RE: PHI rebate changes - potential impact on public hospital demand [SEC=OFFICIAL]
Attachments: Attachment P - PHI Rebate impact on hospital utilisation.docx; Comparison of Finity and Dept modelling.docx

OFFICIAL

Hi s22
Yes you have the right contact!
I've responded to your questions below and attached relevant docs for further reading. I'll send you the impact analysis in protected now.
Happy to meet if you wish to discuss further if you wish.

Cheers,
s22

OFFICIAL

From: s22 @Health.gov.au>
Sent: Tuesday, 12 May 2026 3:15 PM
To: s22 @Health.gov.au>
Cc: s22 @Health.gov.au>
Subject: PHI rebate changes - potential impact on public hospital demand [SEC=OFFICIAL]

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By the Department of Health, Disability and Ageing

OFFICIAL

Hi s22

I've been given your name as the person to talk to about the private health insurance rebate changes for over 65s – hopefully that is correct!
We are from the Public Hospital Strategy Branch, working on all things public hospital funding.

After the Minister's press club speech, we've started thinking about how the PHI rebate changes might affect public hospital demand (and overall costs to the Commonwealth/states) for over 65s. We assume some people will drop or downgrade hospital cover, and that this will lead to increased demand in the public sector. So we're keen to get a sense of what demand increase we might expect, so we can work that into our modelling/projections for the next few years.

We have a few general and a few specific questions, and would appreciate anything you can provide on these:

- How did you estimate how many people might give up their hospital cover as a result of this policy change (we've seen 44000 in the media – is this correct)? How confident is the team in

that estimate? s47C [redacted]

- Do you think this cohort will be representative of the broader 65+ cohort, or perhaps different, e.g. skew wealthier/younger/healthier? s47C [redacted]
- We noted this report was quoted in the media – do your team think this analysis is valid/appropriate? s47C [redacted]
- We heard about an impact analysis piece that would come out this week – is that correct? Are we able to see a copy? Yes the OIA will publish the impact analysis for the rebate change tomorrow. We will send you a copy in protected today.

Thanks in advance for your assistance, and happy to chat if anything is unclear.

Thanks
s22 [redacted]

s22 [redacted]
Assistant Director – Hospital Funding, Modelling and Reform Section
Public Hospital Strategy Branch

Portfolio Strategy Division | Systems Strategy Group
Australian Government Department of Health, Disability and Ageing
t: +61 2 5132 s22 [redacted] | e s22 [redacted] health.gov.au

The Department of Health, Disability and Ageing acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

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Data sources: AIHW hospital usage data for 2023-24, and estimated resident population at June 2024

POLICY SETTING: AS PER NOW					
Metric	**Age group (years)**	**Public**	**Private**	**Other**	**Total**
Total people using each service type	*65+*	2,199,706	2,115,954	233,096	4,548,755
Assumed separations per person*	*65+*	1.226	1.226	1.226	1.226
Assumed patient days per separation**	*65+*	3.143	3.143	3.143	3.143
Total patient days per service type	*65+*	8,477,594	8,154,816	898,344	17,530,750
POLICY SETTING: AS PER BUDGET					
Metric	**Age group (years)**	**Public**	**Private**	**Other**	**Total**
Total people using each service type	*65+*	2,243,706	2,071,954	233,096	4,548,755
Assumed separations per person	*65+*	1.226	1.226	1.226	1.226
Assumed patient days per separation	*65+*	3.143	3.143	3.143	3.143
Total patient days per service type	*65+*	8,647,168	7,985,242	898,344	17,530,750
DIFFERENCE					
Metric	**Age group (years)**	**Public**	**Private**	**Other**	**Total**
Total people using each service type	*65+*	44,000	-44,000	0	0
Assumed separations per person	*65+*	0	0	0	0
Assumed patient days per separation	*65+*	0	0	0	0
Total patient days per service type	*65+*	169,575	-169,575	0	0
ALL HOSPITAL DEMAND					
Metric	**Age group (years)**	**Public**	**Private**	**Other**	**Total**
Total people using each service type	*ALL*	14,365,889	10,575,539	1,711,555	26,652,983
Assumed separations per person	*ALL*	0.474	0.474	0.474	0.474
Assumed patient days per separation	*ALL*	2.686	2.686	2.686	2.686
Total patient days per service type	*ALL*	18,273,540	13,452,181	2,177,113	33,902,835
POLICY IMPACT ON ALL HOSPITAL DEMAND					
Metric	**Age group (years)**	**Public**	**Private**	**Other**	**Total**
Total patient days per service type	*ALL*	0.928%	-1.261%	0.000%	0.000%

Notes
Private and public refer to **patient election status** - so e.g. private includes private patients in public hospitals "Other" includes funding source of Self-funded, Workers compensation, Motor vehicle third party personal claim, Department of Veterans' Affairs, Other compensation, Department of Defence, Correctional facilities, Other hospital or public authority (without a Public patient election status), Other, Health service budget—no charge raised due to hospital decision (in private hospitals), and not reported.
Notes
Assume all 44,000 people age 65+ who drop their PHI were users of the private sector only (either at private hospitals, or as private in public), and that demand transfers completely to public patient/public hospitals
Notes
Notes
Notes
Assumes this is the most appropriate metric for demand - however this does not account for complexity

* From AIHW data on separations per 1000 by age group, using ERP data to determine a weighted average for 65+. Assumed equal for all payment classes

** From AIHW data on separations and patient days, using ERP data to determine a weighted average for 65+. Assumed equal for all payment classes

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By the Department of Health, Disability and Ageing

Estimated resident population, per age group and sex, June 2024

Age (years)	Males	Females	Total persons
65-69	652,904	706,658	1,359,562
70-74	560,091	614,016	1,174,107
75-79	464,365	508,777	973,142
80-84	283,270	328,766	612,036
85-89	155,219	207,873	363,092
90-94	61,134	101,424	162,558
95-99	15,707	33,566	49,273
100 and over	1,667	4,921	6,588
Total 65+	**2,194,357**	**2,506,001**	**4,700,358**

Separations per person aged 65+, by patient sex

Table 3.8: Separations per 1,000 population by sex(a) and age group, all hospitals, 2023–24

Age group (yea	Males	Females	Persons(b)
ALL	***455.74***	***490.65***	***473.57***
65–74	1,093.46	902.87	994.90
75–84	1,715.33	1,283.09	1,487.75
85+	1,848.00	1,304.75	1,521.06
65+	***1,385.70***	***1,085.72***	***1,226.21***

Patient days per separation

Table 3.1: Separations and patient days, by age group and sex(a), all hospitals, 2023–24

	Separations			Patient days			*Patient days per separation*		
Age group (yea	Males	Females	Persons(b)	Males	Females	Persons(b)	*Males*	*Females*	*Persons(b)*
ALL	***6,030,682***	***6,584,643***	***12,622,053***	***16,424,482***	***17,468,951***	***33,907,809***	***2.723***	***2.653***	***2.686***
65–69	616,787	566,184	1,183,760	1,526,810	1,356,193	2,883,820	*2.475*	*2.395*	*2.436*
70–74	687,179	601,602	1,289,476	1,768,440	1,576,611	3,345,833	*2.573*	*2.621*	*2.595*
75–79	713,855	599,980	1,314,488	1,978,731	1,796,650	3,776,070	*2.772*	*2.995*	*2.873*
80–84	511,400	424,938	936,601	1,656,385	1,606,791	3,263,483	*3.239*	*3.781*	*3.484*
85–89	282,040	270,765	552,848	1,167,340	1,331,698	2,499,131	*4.139*	*4.918*	*4.520*
90–94	106,092	127,350	233,446	561,547	764,335	1,325,891	*5.293*	*6.002*	*5.680*
95+	24,524	42,563	67,094	152,454	283,782	436,243	*6.217*	*6.667*	*6.502*
65+	***2,941,877***	***2,633,382***	***5,577,713***	***8,811,707***	***8,716,060***	***17,530,471***	*2.995*	*3.310*	*3.143*

Separations by funding source

Table S3.5: Separations, by age group and funding source, public and private hospitals, 2023–24

	Public hospitals				Private hospitals				All hospitals			
Age group (yea	Public patients	Private health	Other patients	Total	Public patients(a	Private health insurance	Other patients(b)	Total	Public	Private	Other	Total
ALL	***6,494,097***	***804,976***	***180,335***	***7,479,408***	***309,157***	***4,203,282***	***630,206***	***5,142,645***	***6,803,254***	***5,008,258***	***810,541***	***12,622,053***
65–69	559,625	73,483	8,971	642,079	35,179	462,894	43,608	541,681	*594,804*	*536,377*	*52,579*	*1,183,760*
70–74	576,414	88,189	11,509	676,112	36,182	526,526	50,656	613,364	*612,596*	*614,715*	*62,165*	*1,289,476*
75–79	562,652	103,536	15,853	682,041	31,392	535,524	65,531	632,447	*594,044*	*639,060*	*81,384*	*1,314,488*
80–84	426,956	89,593	8,278	524,827	24,342	356,975	30,457	411,774	*451,298*	*446,568*	*38,735*	*936,601*
85-89	274,197	61,832	6,259	342,288	12,476	180,239	17,845	210,560	*286,673*	*242,071*	*24,104*	*552,848*
90-95	120,502	28,370	5,493	154,365	3,662	66,277	9,142	79,081	*124,164*	*94,647*	*14,635*	*233,446*
95+	32,907	7,774	5,659	46,340	807	13,384	6,563	20,754	*33,714*	*21,158*	*12,222*	*67,094*
65+	***2,553,253***	***452,777***	***62,022***	***3,068,052***	***144,040***	***2,141,819***	***223,802***	***2,509,661***	***2,697,293***	***2,594,596***	***285,824***	***5,577,713***

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DFP 30 June 2021

Table 8 Estimated resident population, by age and sex at 30 June 2021

Age (years)	New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory	Australia
0	44,241	34,000	34,033	12,270	23,347	5,270	2,246	4,160	160,567
1	43,701	33,837	33,921	12,242	23,212	5,257	2,227	4,157	159,554
2	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
3	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
4	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
5	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
6	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
7	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
8	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
9	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
10	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
11	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
12	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
13	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
14	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
15	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
16	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
17	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
18	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
19	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
20	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
21	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
22	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
23	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
24	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
25	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
26	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
27	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
28	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
29	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
30	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
31	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
32	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
33	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
34	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
35	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
36	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
37	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
38	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
39	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
40	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
41	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
42	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
43	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
44	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
45	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
46	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
47	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
48	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
49	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
50	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
51	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
52	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
53	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
54	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
55	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
56	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
57	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
58	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
59	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
60	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
61	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
62	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
63	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
64	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
65	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
66	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
67	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
68	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
69	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
70	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
71	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
72	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
73	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
74	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
75	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
76	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
77	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
78	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
79	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
80	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
81	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
82	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
83	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
84	43,670	33,833	33,921	12,242	23,212	5,257	2,227	4,157	159,523
85 and over	1,087	1,181	1,162	301	1,000	131	55	98	5,015
Total	4,829,465	3,926,174	3,519,616	1,651,928	2,645,592	509,965	245,562	428,690	25,756,992

Age (years)	New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory	Australia
0	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
1	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
2	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
3	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
4	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
5	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
6	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
7	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
8	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
9	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
10	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
11	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
12	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
13	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
14	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
15	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
16	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
17	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
18	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
19	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
20	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
21	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
22	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
23	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
24	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
25	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
26	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
27	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
28	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
29	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
30	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
31	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
32	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
33	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
34	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
35	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
36	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
37	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
38	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
39	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
40	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
41	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
42	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
43	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
44	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
45	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
46	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
47	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
48	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
49	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
50	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
51	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
52	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
53	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
54	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
55	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
56	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
57	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
58	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
59	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
60	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
61	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
62	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
63	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
64	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
65	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
66	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
67	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
68	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
69	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
70	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
71	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
72	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
73	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
74	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
75	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
76	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
77	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
78	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
79	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
80	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
81	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
82	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
83	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
84	46,979	33,833	32,245	12,242	23,212	5,257	2,227	4,157	159,552
85 and over	1,087	1,181	1,162	301	1,000	131	55	98	5,015
Total	4,829,465	3,926,174	3,519,616	1,651,928	2,645,592	509,965	245,562	428,690	25,756,992

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By the Department of Health, Disability and Ageing

Admitted patient care 2023–24:
Who used these services?

Table 3.1: Separations and patient days, by age group and sex, all hospitals, 2023–24

Table 3.2: Separations, by Indigenous status, public and private hospitals, 2023–24

Table 3.3: Separations, by type of care and Indigenous status, all hospitals, 2023–24

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Table S3.5: Separations, by age group and funding source, public and private hospitals, 2023–24

Table S3.6: Acute separations, by age group, sex and same-day/overnight status, all hospitals, 2023–24

Table S3.7: Separations, by Indigenous status, public and private hospitals, states and territories, 2023–24

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Table S3.12: Separations by funding source and socioeconomic area of usual residence, public and private hospitals, 2023–24

Table S3.13: Selected separation statistics, for same-day acute and overnight acute separations, by socioeconomic area of usual residence, all hospitals, 2023–24

Technical Specifications 2023–24

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By the Department of Health, Disability and Ageing

Table 3.1: Separations and patient days, by age group and sex[(a)], all hospitals, 2023–24

	Separations			Patient days		
Age group (years)	Males	Females	Persons[(b)]	Males	Females	Persons[(b)]
0–4	236,427	176,704	413,149	698,308	546,625	1,245,016
5–9	99,034	76,481	175,522	149,781	117,576	267,365
10–14	80,049	66,753	146,853	140,633	139,934	280,629
15–19	109,285	144,765	254,417	237,245	331,717	570,090
20–24	125,720	236,385	362,543	329,593	496,644	827,394
25–29	144,930	336,279	481,641	413,399	732,229	1,146,908
30–34	177,623	444,808	622,758	466,561	976,834	1,444,447
35–39	210,077	421,952	632,238	537,177	898,729	1,436,364
40–44	240,849	348,706	589,778	626,963	737,693	1,365,056
45–49	276,167	331,222	607,658	680,274	709,601	1,390,233
50–54	386,459	419,220	806,054	929,154	913,017	1,842,653
55–59	437,892	430,735	868,879	1,045,366	958,225	2,003,960
60–64	564,269	517,245	1,081,861	1,358,250	1,194,047	2,552,661
65–69	616,787	566,184	1,183,760	1,526,810	1,356,193	2,883,820
70–74	687,179	601,602	1,289,476	1,768,440	1,576,611	3,345,833
75–79	713,855	599,980	1,314,488	1,978,731	1,796,650	3,776,070
80–84	511,400	424,938	936,601	1,656,385	1,606,791	3,263,483
85–89	282,040	270,765	552,848	1,167,340	1,331,698	2,499,131
90–94	106,092	127,350	233,446	561,547	764,335	1,325,891
95+	24,524	42,563	67,094	152,454	283,782	436,243
Total[(c)]	**6,030,682**	**6,584,643**	**12,622,053**	**16,424,482**	**17,468,951**	**33,907,809**

(a) For Tasmania, the gender data item has been reported instead of sex.

(b) Persons includes separations and patient days for episodes for which the sex of the patient was not reported.

(c) Total includes separations for which the date of birth was not reported.

Notes

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By the Department of Health, Disability and Ageing

Table 3.2: Separations, by Indigenous status, public and private hospitals, 2023–24

	Public hospitals	Private hospitals	Total
Aboriginal but not Torres Strait Islander origin	541,955	86,880	628,835
Torres Strait Islander but not Aboriginal origin	21,031	5,946	26,977
Aboriginal and Torres Strait Islander origin	29,204	5,937	35,141
First Nations people	*592,190*	*98,763*	*690,953*
Neither Aboriginal nor Torres Strait Islander origin	6,823,324	4,806,978	11,630,302
Indigenous status not reported	63,894	236,904	300,798
Total	**7,479,408**	**5,142,645**	**12,622,053**

Notes

Appendix information with notes on definitions and data limitations is available to download at the link below:

https://www.aihw.gov.au/reports-data/myhospitals/content/about-the-data

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Table 3.3: Separations, by type of care and Indigenous status, all hospitals, 2023–24

	First Nations people	Non-Indigenous Australians	Other Australians[(a)]	All Australians
Separations				
Same-day acute separations for dialysis	274,463	1,429,709	*1,456,037*	1,730,500
Other same-day acute separa ions	166,657	5,386,078	*5,559,041*	5,725,698
Total same-day acute separations	*441,120*	*6,815,787*	*7,015,078*	*7,456,198*
Overnight acute separations	220,239	3,874,222	*3,935,615*	4,155,854
Separations for care other than acute	29,594	940,293	*980,407*	1,010,001
All separations	**690,953**	**11,630,302**	***11,931,100***	**12,622,053**
Separations per 1,000 population[(b)]				
Same-day acute separations for dialysis	407.3	n.a.[(c)]	*46.0*	54.5
Other same-day acute separa ions	200.1	n.a.[(c)]	*192.7*	193.2
Total same-day acute separations	*607.4*	n.a.[(c)]	*238.6*	*247.7*
Overnight acute separations	260.8	n.a.[(c)]	*136.6*	140.6
Separations for care other than acute	38.4	n.a.[(c)]	*32.0*	32.4
All separations	**906.5**	**n.a.[(c)]**	***407.2***	**420.7**

(a) *Other Australians* Includes separations for which the Indigenous status was *Non-Indigenous* and *Not reported* .

(b) Separation rates are directly age-standardised using a highest age group of 65 and over. Therefore, standardised rates calculated for analyses by Indigenous status are not directly comparable with the rates presented in this report that use a highest age group of 85 and over.

(c) The population of Non-Indigenous Australians (denominator) is not available and so the rate of separations per 1,000 cannot be calculated.

Notes

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https://www.aihw.gov.au/reports-data/myhospitals/content/about-the-data

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By the Department of Health, Disability and Ageing

Table 3.4: Separations by Indigenous status, age group and sex[(a)], all hospitals, 2023–24

	First Nations people			Non-Indigenous Australians			
Age group (years)	Males	Females	Persons[(b)]	Males	Females	Persons[(b)]	Males
0–4	21,750	16,815	38,566	211,014	156,969	368,000	236,427
5–9	7,773	6,415	14,188	89,604	68,668	158,279	99,034
10–14	5,998	5,288	11,287	72,884	60,438	133,371	80,049
15–19	7,507	14,820	22,364	99,744	127,471	227,536	109,285
20–24	9,466	24,820	34,308	113,644	207,832	321,885	125,720
25–29	12,470	27,859	40,354	129,437	303,114	432,949	144,930
30–34	15,178	27,659	42,849	158,744	408,597	567,592	177,623
35–39	16,380	25,903	42,292	188,650	386,395	575,233	210,077
40–44	18,833	25,292	44,133	216,049	314,724	530,985	240,849
45–49	22,985	27,959	50,952	246,160	295,461	541,855	276,167
50–54	33,989	40,635	74,629	342,762	368,549	711,659	386,459
55–59	35,197	39,499	74,698	391,147	381,712	773,094	437,892
60–64	30,567	39,806	70,375	519,351	464,857	984,515	564,269
65+	54,102	75,829	129,931	2,810,360	2,489,880	5,302,425	2,941,877
Total[(c)]	**292,195**	**398,599**	**690,953**	**5,589,562**	**6,034,669**	**11,630,302**	**6,030,682**

(a) For Tasmania, the gender data item has been reported instead of sex.

(b) Persons includes separations for which the sex of the patient was not reported as male or female.

(c) Total includes separations for which the date of birth was not reported.

(d) All Australians includes those who did not report an Indigenous status

Notes

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Table 3.5: Selected separation statistics, by remoteness of area of usual residence, public and private hospitals, 2023–24

	Remoteness of area of usual residence					
	Major cities	Inner regional	Outer regional	Remote	Very remote	Total[(a)]
Public hospitals						
Separations	4,737,148	1,547,681	800,459	144,491	130,353	7,479,408
Separations per 1,000 population[(b)]	227.1	277.6	322.5	447.7	666.7	252.9
Separation rate ratio[(c)]	0.9	1.1	1.3	1.8	2.6	. .
Private hospitals						
Separations	3,893,182	876,856	296,527	31,163	30,189	5,142,645
Separations per 1,000 population[(b)]	183.0	144.1	113.9	94.0	150.5	168.3
Separation rate ratio	1.1	0.9	0.7	0.6	0.9	. .
All hospitals						
Separations	**8,630,330**	**2,424,537**	**1,096,986**	**175,654**	**160,542**	**12,622,053**
Separations per 1,000 population[(b)]	**410.1**	**421.7**	**436.3**	**541.8**	**817.2**	**421.1**
Separation rate ratio[(c)]	**1.0**	**1.0**	**1.0**	**1.3**	**1.9**	. .

(a) Total includes separations for which the remoteness area could not be categorised.

(b) Separation rates are directly age-standardised using populations by remoteness areas, which do not include persons with unknown or migratory area of usual residence. Therefore, the total standardised rates in this table differ from national rates presented elsewhere in this report.

(c) Separation rate ratio is calculated as the separation rate for the remoteness area divided by the national separation rate.

Notes

Appendix information with notes on definitions and data limitations is available to download at the link below:

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By the Department of Health, Disability and Ageing

Table 3.6: Selected separation statistics by socioeconomic area of usual residence[(d)], public and private hospitals, 2023–24

	Socioeconomic area of usual residence					
	1—Lowest	2	3	4	5—Highest	Total[(a)]
Public hospitals						
Separations	1,958,428	1,667,260	1,529,952	1,277,169	924,512	7,479,408
Separations per 1,000 population[(b)]	350.1	285.9	242.6	213.8	159.7	252.9
Separation rate ratio[(c)]	1.4	1.1	1.0	0.8	0.6	. .
Private hospitals						
Separations	650,905	821,394	1,070,831	1,171,113	1,412,415	5,142,645
Separations per 1,000 population[(b)]	111.3	134.9	163.8	192.1	234.8	168.3
Separation rate ratio[(c)]	0.7	0.8	1.0	1.1	1.4	. .
All hospitals						
Separations	**2,609,333**	**2,488,654**	**2,600,783**	**2,448,282**	**2,336,927**	**12,622,053**
Separations per 1,000 population[(b)]	**461.4**	**420.7**	**406.5**	**405.9**	**394.5**	**421.2**
Separation rate ratio[(c)]	**1.1**	**1.0**	**1.0**	**1.0**	**0.9**	. .

(a) Total includes separations for which the socioeconomic area could not be categorised.

(b) Separation rates are directly age-standardised using populations by socioeconomic areas. Separations for which the socioeconomic area could not be determined are excluded. Therefore, the total standardised rates in this table differ from national rates presented elsewhere in this report.

(c) Separation rate ratio is calculated as the separation rate for the soecioeconomic area divided by the national separation rate.

(d) In 2023–24, the SEIFA quintiles have been formed by assigning areas based on their IRSD score. This is different to past reporting where areas were weighted by their population when forming the quintiles

Notes

Appendix information with notes on definitions and data limitations is available to download at the link below:

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Table 3.7: Percentage change in separations by sex[(a)] and age group, all hospitals, 2019–20 to 2023–24

Age group (years)	Males		Females		Persons	
	Change since 2019–20 (%)	Average change since 2019–20 (%)	Change since 2019–20 (%)	Average change since 2019–20 (%)	Change since 2019–20 (%)	Average change since 2019–20 (%)
<1	10.9	2.6	14.4	3.4	12.4	3.0
1–4	20.6	4.8	21.8	5.1	21.1	4.9
5–14	21.3	5.0	21.7	5.0	21.5	5.0
15–24	5.6	1.4	2.7	0.7	3.9	1.0
25–34	8.6	2.1	7.1	1.7	7.6	1.8
35–44	15.1	3.6	17.6	4.1	16.7	3.9
45–54	8.0	1.9	9.6	2.3	8.9	2.2
55–64	10.7	2.6	11.1	2.7	10.9	2.6
65–74	7.4	1.8	13.7	3.3	10.3	2.5
75–84	25.3	5.8	25.1	5.8	25.2	5.8
85+	15.4	3.7	10.4	2.5	12.8	3.1
Total[(b)]	**13.1**	**3.1**	**13.4**	**3.2**	**13.3**	**3.2**

(a) For Tasmania, the gender data item has been reported instead of sex.

(b) Total includes separations for which the date of birth was not reported.

Notes

Note: Appendixes A and B for notes on data limitations and methods.

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Table 3.8: Separations per 1,000 population by sex[(a)] and age group, all hospitals, 2023–24

Age group (years)	Males	Females	Persons[(b)]
<1	687.0	571.2	630.8
1–4	213.0	161.6	188.0
5–14	106.6	90.2	98.6
15–24	136.1	236.5	184.8
25–34	164.5	400.3	282.3
35–44	244.5	410.7	328.4
45–54	407.5	448.9	428.7
55–64	673.6	609.4	641.0
65–74	1093.5	902.9	994.9
75–84	1715.3	1283.1	1487.8
85+	1848.0	1304.8	1521.1
Total[(c)]	**455.7**	**490.7**	**473.6**

(a) For Tasmania, the gender data item has been reported instead of sex.

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Table S3.1: Separations, by age group and sex[(a)], public hospitals, states and territories, 2023–24

Sex	Age group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Males										
	0–4	55,971	47,629	51,393	18,332	13,792	2,896	4,228	2,952	197,193
	5–14	36,262	34,432	33,898	12,668	9,095	2,370	3,018	1,979	133,722
	15–24	38,786	42,080	38,152	13,759	9,303	3,107	3,807	3,112	152,106
	25–34	54,406	65,041	51,317	20,286	14,390	4,817	4,986	5,475	220,718
	35–44	68,121	81,882	67,949	26,736	17,268	5,361	6,320	9,365	283,002
	45–54	100,230	115,783	97,845	38,431	27,228	8,746	8,627	16,321	413,211
	55–64	160,312	165,486	142,075	53,665	39,988	15,288	9,122	17,389	603,325
	65–74	194,941	207,908	166,649	65,480	48,929	20,596	11,439	10,615	726,557
	75–84	190,542	200,516	141,189	57,476	47,627	16,590	10,898	5,262	670,100
	85–89	51,766	49,854	34,429	14,699	14,646	3,997	3,190	629	173,210
	90–94	22,204	18,252	13,634	6,438	6,145	1,304	1,603	204	69,784
	95+	5,585	4,014	3,398	1,399	2,016	261	268	44	16,985
	Total[(c)]	*979,143*	*1,032,877*	*841,935*	*329,369*	*250,427*	*85,333*	*67,506*	*73,347*	*3,659,937*
Females										
	0–4	41,922	35,718	40,318	13,765	10,811	2,162	3,125	2,236	150,057
	5–14	27,368	26,553	26,925	10,537	6,931	1,885	2,332	1,662	104,193
	15–24	57,259	61,868	79,084	22,919	15,943	5,523	6,063	5,313	253,972
	25–34	128,069	141,772	150,983	46,500	32,142	9,829	16,599	12,533	538,427
	35–44	97,965	126,355	111,579	41,167	24,427	8,094	11,421	16,071	437,079
	45–54	88,606	119,840	103,257	37,879	23,175	9,286	7,634	23,247	412,924
	55–64	115,597	144,055	122,134	48,926	31,384	14,552	8,584	24,272	509,504
	65–74	154,041	162,919	139,247	55,647	38,871	16,201	9,397	15,289	591,612
	75–84	151,598	153,093	116,632	46,456	39,605	14,270	10,024	5,082	536,760
	85–89	52,125	45,875	34,975	15,104	13,530	3,303	3,399	674	169,075
	90–94	27,484	21,276	16,950	7,429	8,039	1,571	1,580	252	84,581
	95+	10,317	6,598	5,986	2,320	3,057	510	521	46	29,355
	Total[(c)]	*952,354*	*1,045,922*	*948,072*	*348,649*	*247,916*	*87,276*	*80,679*	*106,677*	*3,817,545*
All persons [(b)]										
	0–4	97,895	83,347	91,717	32,097	24,603	5,058	7,358	5,189	347,264
	5–14	63,634	60,994	60,823	23,205	16,026	4,257	5,357	3,641	237,937
	15–24	96,136	104,155	117,239	36,679	25,258	8,639	9,892	8,441	406,439
	25–34	182,518	207,021	202,302	66,789	46,543	14,652	21,627	18,043	759,495
	35–44	166,096	208,292	179,528	67,903	41,701	13,462	17,756	25,443	720,181
	45–54	188,839	235,655	201,102	76,310	50,407	18,040	16,271	39,575	826,199
	55–64	275,914	309,551	264,210	102,592	71,373	29,840	17,711	41,661	1,112,852
	65–74	348,985	370,838	305,896	121,127	87,804	36,797	20,840	25,904	1,318,191
	75–84	342,143	353,614	257,821	103,932	87,232	30,860	20,922	10,344	1,206,868
	85–89	103,891	95,731	69,404	29,803	28,176	7,391	6,589	1,303	342,288
	90–94	49,688	39,528	30,584	13,867	14,184	2,875	3,183	456	154,365
	95+	15,902	10,612	9,384	3,719	5,073	771	789	90	46,340
	Total[(c)]	**1,932,619**	**2,079,339**	**1,790,019**	**678,023**	**498,381**	**172,642**	**148,295**	**180,090**	**7,479,408**

(a) For Tasmania, the gender data item has been reported instead of sex.

(b) Persons includes separations and patient days for episodes for which the sex of the patient was not reported.

(c) Totals include separations for which the date of birth was not reported and sex was not reported as male or female.

Notes

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Patient days, by age group and sex[a], public hospitals, states and territories, 2023–24

Age group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
0–4	184,484	164,095	137,681	58,118	42,279	9,636	13,218	10,968	620,479
5–14	72,341	60,512	56,689	24,264	15,318	4,281	4,810	4,512	242,727
15–24	138,434	108,766	92,450	44,784	27,798	8,659	8,745	8,092	437,728
25–34	219,023	175,016	144,858	72,251	46,277	13,285	15,776	12,659	699,145
35–44	276,840	208,167	187,018	88,609	53,906	14,430	19,145	19,532	867,647
45–54	367,303	290,134	244,846	111,232	83,963	26,264	24,756	32,727	1,181,225
55–64	559,229	436,550	361,250	146,275	127,196	42,208	28,176	35,214	1,736,098
65–74	713,977	561,646	465,578	191,592	177,853	63,165	41,189	31,109	2,246,109
75–84	793,168	616,974	477,035	199,250	203,919	65,570	46,020	27,214	2,429,150
85–89	281,586	207,685	142,028	72,159	78,779	19,756	15,213	7,059	824,265
90–94	144,235	100,661	66,881	35,562	37,781	8,487	7,731	1,551	402,889
95+	37,399	24,879	16,539	11,426	12,138	2,246	1,560	194	106,381
Total[c]	*3,788,083*	*2,955,085*	*2,392,860*	*1,055,522*	*907,207*	*277,987*	*226,339*	*190,831*	*11,793,914*
0–4	143,805	124,955	112,811	45,470	33,900	8,065	9,998	7,415	486,419
5–14	63,052	52,477	50,307	24,724	13,310	3,683	4,146	3,558	215,257
15–24	157,319	136,966	151,159	69,752	38,411	13,397	12,759	11,834	591,597
25–34	346,173	308,415	262,248	113,818	77,027	24,655	33,675	25,226	1,191,237
35–44	289,682	275,025	216,857	99,926	63,143	25,483	24,380	30,414	1,024,910
45–54	292,001	268,685	220,882	98,429	66,259	22,447	21,239	39,093	1,029,035
55–64	387,061	368,928	291,349	121,582	102,567	37,217	27,355	39,697	1,375,756
65–74	566,601	457,908	371,048	156,200	142,017	50,801	35,131	32,586	1,812,292
75–84	712,573	553,647	402,144	177,006	188,179	59,157	41,487	19,189	2,153,382
85–89	316,310	235,711	152,968	79,514	84,791	22,240	18,602	5,129	915,265
90–94	184,849	134,326	84,459	45,681	51,555	12,692	9,391	4,375	527,328
95+	72,330	46,821	29,016	14,785	19,491	3,732	2,590	926	189,691
Total[c]	*3,531,773*	*2,963,864*	*2,345,250*	*1,046,887*	*880,651*	*283,569*	*240,753*	*219,442*	*11,512,189*
0–4	328,292	289,050	250,498	103,588	76,179	17,701	23,222	18,384	1,106,914
5–14	135,398	113,005	106,996	48,988	28,628	7,966	8,967	8,070	458,018
15–24	296,208	246,278	243,612	114,549	66,232	22,134	21,578	20,002	1,030,593
25–34	565,369	483,911	407,109	186,089	123,369	37,969	49,598	38,090	1,891,504
35–44	566,544	483,295	403,875	188,535	117,078	39,932	43,552	49,954	1,892,765
45–54	659,309	558,918	465,728	209,661	150,230	48,760	46,005	71,828	2,210,439
55–64	946,296	805,489	652,613	267,858	229,764	79,425	55,555	74,911	3,111,911
65–74	1,280,596	1,019,570	836,626	347,792	319,888	113,966	76,329	63,695	4,058,462
75–84	1,505,747	1,170,660	879,179	376,256	392,098	124,727	87,507	46,403	4,582,577
85–89	597,896	443,445	294,996	151,673	163,570	41,997	33,815	12,188	1,739,580
90–94	329,084	234,987	151,340	81,243	89,336	21,179	17,122	5,926	930,217
95+	109,729	71,700	45,555	26,211	31,629	5,978	4,150	1,120	296,072
Total[c]	**7,325,019**	**5,920,309**	**4,738,136**	**2,102,443**	**1,788,002**	**561,734**	**467,400**	**410,571**	**23,313,614**

a, the gender data item has been reported instead of sex.

ıdes separations and patient days for episodes for which the sex of the patient was not reported.

ɜ separations for which the date of birth was not reported and sex was not reported as male or female.

on with notes on definitions and data limitations is available to download at the link below:

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Table S3.3: Separations, by age group and sex[(a)], private hospitals, states and territories, 2023–24

Sex	Age group	NSW	Vic	Qld	WA	SA	Tas [(a)]	ACT	NT	Total
Males										
	0–4	12,975	8,695	8,317	4,847	2,589	n.p.	n.p.	n.p.	39,234
	5–14	14,602	9,847	10,458	5,602	2,870	n.p.	n.p.	n.p.	45,361
	15–24	24,938	21,468	19,228	8,589	5,566	n.p.	n.p.	n.p.	82,899
	25–34	29,748	26,221	23,322	11,787	6,789	n.p.	n.p.	n.p.	101,835
	35–44	49,891	38,789	40,177	22,693	10,311	n.p.	n.p.	n.p.	167,924
	45–54	72,929	55,395	61,510	34,199	15,348	n.p.	n.p.	n.p.	249,415
	55–64	116,591	87,008	100,052	52,278	26,991	n.p.	n.p.	n.p.	398,836
	65–74	172,558	120,889	148,806	64,620	46,533	n.p.	n.p.	n.p.	577,409
	75–84	162,006	116,393	151,739	58,332	44,745	n.p.	n.p.	n.p.	555,155
	85–89	30,784	24,683	29,539	11,317	8,499	n.p.	n.p.	n.p.	108,830
	90–94	10,565	8,528	9,606	3,829	2,523	n.p.	n.p.	n.p.	36,308
	95+	2,132	1,920	1,839	897	573	n.p.	n.p.	n.p.	7,539
	Total [(c)]	*699,719*	*519,836*	*604,593*	*278,990*	*173,337*	*n.p.*	*n.p.*	*n.p.*	2,370,745
Females										
	0–4	8,454	6,020	5,911	3,212	1,765	n.p.	n.p.	n.p.	26,647
	5–14	12,033	8,996	8,872	4,800	2,587	n.p.	n.p.	n.p.	39,041
	15–24	37,506	31,224	32,618	13,828	7,286	n.p.	n.p.	n.p.	127,178
	25–34	69,925	64,006	58,833	25,521	15,488	n.p.	n.p.	n.p.	242,660
	35–44	97,700	88,189	79,114	36,114	20,915	n.p.	n.p.	n.p.	333,579
	45–54	95,510	79,530	86,852	40,966	21,574	n.p.	n.p.	n.p.	337,518
	55–64	128,028	99,323	107,725	52,965	33,128	n.p.	n.p.	n.p.	438,476
	65–74	178,867	122,941	142,967	60,400	47,858	n.p.	n.p.	n.p.	576,174
	75–84	155,449	104,210	124,863	45,511	39,564	n.p.	n.p.	n.p.	488,158
	85–89	29,728	23,927	25,477	10,336	8,413	n.p.	n.p.	n.p.	101,690
	90–94	12,230	10,796	10,785	3,939	3,194	n.p.	n.p.	n.p.	42,769
	95+	3,798	3,415	3,281	1,085	1,212	n.p.	n.p.	n.p.	13,208
	Total [(c)]	*829,228*	*642,577*	*687,298*	*298,677*	*202,984*	*n.p.*	*n.p.*	*n.p.*	2,767,098
All persons[(b)]										
	0–4	21,431	14,717	14,228	8,059	4,354	n.p.	n.p.	n.p.	65,885
	5–14	26,641	18,870	19,330	10,402	5,460	n.p.	n.p.	n.p.	84,438
	15–24	62,666	52,878	51,849	22,419	12,869	n.p.	n.p.	n.p.	210,521
	25–34	99,809	90,404	82,161	37,315	22,334	n.p.	n.p.	n.p.	344,904
	35–44	147,633	127,038	119,297	58,811	31,431	n.p.	n.p.	n.p.	501,831
	45–54	168,469	134,949	148,362	75,165	37,447	n.p.	n.p.	n.p.	587,513
	55–64	244,667	186,345	207,777	105,243	60,631	n.p.	n.p.	n.p.	837,888
	65–74	351,450	243,838	291,773	125,020	95,818	n.p.	n.p.	n.p.	1,155,045
	75–84	317,497	220,606	276,602	103,843	85,172	n.p.	n.p.	n.p.	1,044,221
	85–89	60,517	48,612	55,016	21,653	16,945	n.p.	n.p.	n.p.	210,560
	90–94	22,795	19,325	20,391	7,768	5,720	n.p.	n.p.	n.p.	79,081
	95+	5,930	5,335	5,120	1,982	1,792	n.p.	n.p.	n.p.	20,754
	Total[(c)]	**1,529,505**	**1,162,917**	**1,291,906**	**577,680**	**379,973**	**n.p.**	**n.p.**	**n.p.**	**5,142,641**

(a) For Tasmania, the gender data item has been reported instead of sex.

(b) Persons includes separations and patient days for episodes for which the sex of the patient was not reported.

(c) Totals include separations for which the date of birth was not reported and sex was not reported as male or female.

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Patient days, by age group and sex[(a)], private hospitals, states and territories, 2023–24

Age group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
0–4	22,408	20,108	18,579	8,401	4,759	n.p.	n.p.	n.p.	77,829
5–14	15,282	10,208	11,552	5,740	2,909	n.p.	n.p.	n.p.	47,687
15–24	42,187	33,747	30,162	12,164	6,718	n.p.	n.p.	n.p.	129,110
25–34	57,424	48,281	42,680	17,194	9,010	n.p.	n.p.	n.p.	180,815
35–44	95,013	71,614	72,409	34,154	13,583	n.p.	n.p.	n.p.	296,493
45–54	131,916	99,669	109,729	49,610	21,740	n.p.	n.p.	n.p.	428,203
55–64	197,285	155,509	170,989	75,815	42,173	n.p.	n.p.	n.p.	667,518
65–74	300,567	241,015	283,718	107,882	76,846	n.p.	n.p.	n.p.	1,049,141
75–84	344,186	281,108	342,185	113,382	84,205	n.p.	n.p.	n.p.	1,205,966
85–89	96,450	86,145	95,225	31,871	21,864	n.p.	n.p.	n.p.	343,075
90–94	46,484	40,430	43,135	15,149	9,196	n.p.	n.p.	n.p.	158,658
95+	12,481	11,966	13,256	4,455	2,844	n.p.	n.p.	n.p.	46,073
Total[(c)]	*1,361,683*	*1,099,800*	*1,233,619*	*475,817*	*295,847*	*n.p.*	*n.p.*	*n.p.*	4,630,568
0–4	16,370	16,374	14,765	6,299	3,567	n.p.	n.p.	n.p.	60,206
5–14	13,159	9,788	9,975	4,897	2,665	n.p.	n.p.	n.p.	42,253
15–24	77,938	57,968	60,750	22,963	9,823	n.p.	n.p.	n.p.	236,764
25–34	152,884	143,097	123,868	52,815	27,130	n.p.	n.p.	n.p.	517,826
35–44	181,433	167,424	144,999	63,056	33,253	n.p.	n.p.	n.p.	611,512
45–54	170,474	149,381	152,886	64,346	33,524	n.p.	n.p.	n.p.	593,583
55–64	221,130	194,847	195,406	81,638	53,502	n.p.	n.p.	n.p.	776,516
65–74	332,747	272,438	283,323	105,959	83,993	n.p.	n.p.	n.p.	1,120,512
75–84	371,097	311,839	330,777	105,690	88,233	n.p.	n.p.	n.p.	1,250,059
85–89	116,017	111,119	110,610	37,351	27,920	n.p.	n.p.	n.p.	416,433
90–94	69,244	65,018	61,435	19,450	13,737	n.p.	n.p.	n.p.	237,007
95+	27,999	24,041	24,938	8,204	6,487	n.p.	n.p.	n.p.	94,091
Total[(c)]	*1,750,492*	*1,523,334*	*1,513,732*	*572,668*	*383,834*	*n.p.*	*n.p.*	*n.p.*	*5,956,762*
0–4	38,780	36,547	33,344	14,700	8,326	n.p.	n.p.	n.p.	138,102
5–14	28,447	20,023	21,527	10,637	5,577	n.p.	n.p.	n.p.	89,976
15–24	120,681	92,088	90,915	35,179	16,559	n.p.	n.p.	n.p.	366,891
25–34	210,657	192,055	166,554	70,095	36,199	n.p.	n.p.	n.p.	699,851
35–44	276,522	239,276	217,435	97,250	47,043	n.p.	n.p.	n.p.	908,628
45–54	302,424	249,151	262,615	113,956	55,789	n.p.	n.p.	n.p.	1,022,447
55–64	418,520	350,382	366,395	157,453	96,195	n.p.	n.p.	n.p.	1,444,710
65–74	633,400	513,469	567,041	213,841	162,273	n.p.	n.p.	n.p.	2,171,191
75–84	715,367	592,951	672,962	219,072	173,301	n.p.	n.p.	n.p.	2,456,976
85–89	212,473	197,268	205,835	69,222	49,817	n.p.	n.p.	n.p.	759,551
90–94	115,728	105,454	104,570	34,599	22,936	n.p.	n.p.	n.p.	395,674
95+	40,480	36,007	38,194	12,659	9,338	n.p.	n.p.	n.p.	140,171
Total[(c)]	**3,113,479**	**2,624,671**	**2,747,387**	**1,048,663**	**683,353**	**n.p.**	**n.p.**	**n.p.**	**10,594,168**

e separations for which the date of birth was not reported and sex was not reported as male or female.

des separations and patient days for episodes for which the sex of the patient was not reported.

e separations for which the date of birth was not reported and sex was not reported as male or female.

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By the Department of Health, Disability and Ageing

Table S3.5: Separations, by age group and funding source, public and private hospitals, 2023–24

Age group (years)	Public hospitals				Private hospitals			
	Public patients[(a)]	Private health insurance	Other patients[(b)]	Total	Public patients[(a)]	Private health insurance	Other patients[(b)]	Total
0–4	305,037	36,004	6,223	347,264	1,951	53,034	10,900	65,885
5–9	104,687	19,105	1,932	125,724	2,483	38,178	9,137	49,798
10–14	91,896	18,958	1,359	112,213	1,211	28,692	4,737	34,640
15–19	142,043	19,187	5,761	166,991	2,491	73,516	11,419	87,426
20–24	212,203	13,313	13,932	239,448	4,529	95,329	23,237	123,095
25–29	312,666	14,572	19,465	346,703	6,199	94,034	34,705	134,938
30–34	372,983	21,749	18,060	412,792	9,300	154,038	46,628	209,966
35–39	342,892	25,874	11,610	380,376	12,111	189,655	50,096	251,862
40–44	306,630	24,876	8,299	339,805	13,678	193,089	43,206	249,973
45–49	322,193	26,273	7,153	355,619	18,953	196,879	36,207	252,039
50–54	428,091	34,355	8,134	470,580	26,114	264,495	44,865	335,474
55–59	455,728	40,436	7,753	503,917	31,095	289,842	44,025	364,962
60–64	543,045	57,336	8,554	608,935	35,002	390,682	47,242	472,926
65–69	559,625	73,483	8,971	642,079	35,179	462,894	43,608	541,681
70–74	576,414	88,189	11,509	676,112	36,182	526,526	50,656	613,364
75–79	562,652	103,536	15,853	682,041	31,392	535,524	65,531	632,447
80–84	426,956	89,593	8,278	524,827	24,342	356,975	30,457	411,774
85-89	274,197	61,832	6,259	342,288	12,476	180,239	17,845	210,560
90-95	120,502	28,370	5,493	154,365	3,662	66,277	9,142	79,081
95+	32,907	7,774	5,659	46,340	807	13,384	6,563	20,754
Total[(c)]	**6,494,097**	**804,976**	**180,335**	**7,479,408**	**309,157**	**4,203,282**	**630,206**	**5,142,645**

(a) *Public patient* includes separations with a funding source of *Health service budget* (including *Health service budget due to Reciprocal health care agreements*) and *Health service budget—no charge raised due to hospital decision* (in public hospitals) and *Other hospital or public authority* (with a *Public* patient election status).

(b) *Other patients* includes separations with a funding source of *Self-funded*, *Workers compensation*, *Motor vehicle third party personal claim*, *Department of Veterans' Affairs*, *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a *Public* patient election status), *Other*, *Health service budget—no charge raised due to hospital decision* (in private hospitals), and not reported.

(c) Total includes separations for which the date of birth was not reported.

Notes

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Table S3.6: Acute separations, by age group, sex[(a)] and same-day/overnight status, all hospitals, 2023–24

	Same-day acute separations			Overnight acute separations		
Age group (years)	Males	Females	Persons[(b)]	Males	Females	Persons[(b)]
0–4	87,928	60,514	148,453	147,997	115,755	263,759
5–9	57,821	43,732	101,556	40,534	32,376	72,913
10–14	45,990	36,686	82,691	33,011	27,156	60,199
15–19	62,928	78,622	141,649	39,871	51,333	91,318
20–24	70,156	127,620	197,905	42,771	87,609	130,579
25–29	83,974	169,707	253,822	46,924	146,449	193,544
30–34	104,598	224,539	329,276	56,334	199,081	255,544
35–39	127,755	240,993	368,867	63,324	160,295	223,677
40–44	148,055	221,055	369,281	72,258	104,643	176,930
45–49	174,822	214,715	389,775	79,733	92,336	172,094
50–54	254,579	275,761	530,694	106,147	110,704	216,865
55–59	288,759	287,560	576,532	122,146	110,133	232,299
60–64	373,001	340,337	713,672	154,600	133,699	288,306
65–69	403,224	368,341	772,343	172,202	147,199	319,412
70–74	445,102	371,038	816,822	192,698	165,783	358,491
75–79	453,873	349,227	803,735	202,869	180,402	383,274
80–84	305,929	214,349	520,534	161,139	156,256	317,400
85–89	140,158	106,917	247,112	111,307	124,567	235,880
90–94	38,107	36,634	74,744	53,009	70,114	123,124
95+	6,604	9,815	16,426	13,957	25,669	39,626
Total[(c)]	**3,673,371**	**3,778,164**	**7,456,197**	**1,912,847**	**2,241,562**	**4,155,851**

(a) For Tasmania, the gender data item has been reported instead of sex.

(b) Persons includes separations for which the sex of the patient was not reported as male or female.

(c) Total includes separations for which the date of birth was not reported.

Notes

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Table S3.7: Separations, by Indigenous status, public and private hospitals, states and territories, 2023–24

	NSW	Vic	Qld	WA	SA	Tas[a]	ACT[a]	NT[a]	Total[b]
Public hospitals									
Aboriginal but not Torres Strait Islander origin	112,715	38,057	144,992	73,075	34,340	10,282	5,408	123,086	541,955
Torres Strait Islander but not Aboriginal origin	1,982	1,378	15,573	656	380	280	80	702	21,031
Aboriginal and Torres Strait Islander origin	3,269	3,282	16,877	1,949	1,136	1,090	256	1,345	29,204
First Nations people	*117,966*	*42,717*	*177,442*	*75,680*	*35,856*	*11,652*	*5,744*	*125,133*	*592,190*
Neither Aboriginal nor Torres Strait Islander origin	1,799,494	2,006,277	1,608,715	602,343	452,330	159,245	139,974	54,946	6,823,324
Indigenous status not reported	15,159	30,345	3,862	0	10,195	1,745	2,577	11	63,894
Total	*1,932,619*	*2,079,339*	*1,790,019*	*678,023*	*498,381*	*172,642*	*148,295*	*180,090*	*7,479,408*
Private hospitals									
Aboriginal but not Torres Strait Islander origin	17,047	3,350	17,450	40,844	3,649	n.p.	n.p.	n.p.	86,880
Torres Strait Islander but not Aboriginal origin	691	654	3,474	681	231	n.p.	n.p.	n.p.	5,946
Aboriginal and Torres Strait Islander origin	1,189	818	2,411	774	319	n.p.	n.p.	n.p.	5,937
First Nations people	*18,927*	*4,822*	*23,335*	*42,299*	*4,199*	*n.p.*	*n.p.*	*n.p.*	*98,763*
Neither Aboriginal nor Torres Strait Islander origin	1,426,277	1,133,083	1,178,199	535,381	353,412	n.p.	n.p.	n.p.	4,806,978
Indigenous status not reported	84,301	25,012	90,372	0	22,362	n.p.	n.p.	n.p.	236,904
Total	*1,529,505*	*1,162,917*	*1,291,906*	*577,680*	*379,973*	*n.p.*	*n.p.*	*n.p.*	*5,142,645*
All hospitals									
First Nations people	136,893	47,539	200,777	117,979	40,055	n.p.	n.p.	n.p.	690,953
Other Australians[d]	3,325,231	3,194,717	2,881,148	1,137,724	838,299	n.p.	n.p.	n.p.	11,931,100
Total	***3,462,124***	***3,242,256***	***3,081,925***	***1,255,703***	***878,354***	***n.p.***	***n.p.***	***n.p.***	***12,622,053***
Separations per 1,000 population[c]									
First Nations people	501.7	762.0	943.1	1,343.5	1,017.0	401.2	725.6	2,165.9	899.6
Other Australians[d]	358.7	424.5	489.2	366.9	383.4	241.7	301.2	314.8	400.7
Total	***363.3***	***427.5***	***505.8***	***394.3***	***395.6***	***248.9***	***308.3***	***753.7***	***414.1***
Separation rate ratio[e]	**1.4**	**1.8**	**1.9**	**3.7**	**2.7**	**1.7**	**2.4**	**6.9**	**2.2**

(a) For Tasmania, the Australian Capital Territory and the Northern Territory, separations per 1,000 population are for public hospitals only.

(b) Data for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory are included in the Total column.

(c) Separation rates are directly age-standardised using a highest age group of 65 and over. Therefore, standardised rates calculated for analyses by Indigenous status are not directly comparable with the rates presented in this report that use a highest age group of 85 and over. Other Australians includes separations for which Indigenous status was not reported.

(d) *Other Australians* includes separations for which Indigenous status was *Non-Indigenous* and *Not reported*

(e) The separation rate ratio is equal to the separation rate for First Nations people divided by the separation rate for other Australians.

Notes

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Table S3.8: Overnight separations, by Indigenous status, public and private hospitals, states and territories, 2023–24

	NSW	Vic	Qld	WA	SA	Tas[a]	ACT[a]	NT[a]	Total[b]
Public hospitals									
Aboriginal but not Torres Strait Islander origin	58,606	17,073	53,508	30,885	11,949	4,147	2,637	28,157	206,962
Torres Strait Islander but not Aboriginal origin	927	503	4,627	202	120	148	46	173	6,746
Aboriginal and Torres Strait Islander origin	1,750	1,273	6,077	954	529	450	140	484	11,657
First Nations people	61,283	18,849	64,212	32,041	12,598	4,745	2,823	28,814	225,365
Neither Aboriginal nor Torres Strait Islander origin	939,061	776,112	664,164	281,729	221,173	64,838	64,920	23,190	3,035,187
Indigenous status not reported	8,053	10,613	2,010	0	5,296	896	1,038	7	27,913
Total	1,008,397	805,574	730,386	313,770	239,067	70,479	68,781	52,011	3,288,465
Private hospitals									
Aboriginal but not Torres Strait Islander origin	4,996	1,435	4,645	1,360	793	n.p.	n.p.	n.p.	14,642
Torres Strait Islander but not Aboriginal origin	182	179	280	121	59	n.p.	n.p.	n.p.	884
Aboriginal and Torres Strait Islander origin	292	342	367	93	105	n.p.	n.p.	n.p.	1,350
First Nations people	*5,470*	*1,956*	*5,292*	*1,574*	*957*	*n.p.*	*n.p.*	*n.p.*	*16,876*
Neither Aboriginal nor Torres Strait Islander origin	322,538	350,992	314,508	140,808	93,371	n.p.	n.p.	n.p.	1,271,584
Indigenous status not reported	14,652	4,948	17,790		2,547	n.p.	n.p.	n.p.	41,707
Total	*342,660*	*357,896*	*337,590*	*142,382*	*96,875*	*n.p.*	*n.p.*	*n.p.*	*1,330,167*
All hospitals									
First Nations people	66,753	20,805	69,504	33,615	13,555	n.p.	n.p.	n.p.	242,241
Other Australians[d]	1,284,304	1,142,665	998,472	422,537	322,387	n.p.	n.p.	n.p.	4,376,391
Total	***1,351,057***	***1,163,470***	***1,067,976***	***456,152***	***335,942***	***n.p.***	***n.p.***	***n.p.***	***4,618,632***
Separations per 1,000 population[c]									
First Nations people	230.2	310.6	300.5	325.7	308.5	158.7	353.6	435.5	286.8
Other Australians[d]	140.9	152.4	170.6	138.5	149.4	101.8	139.4	133.6	149.2
Total	***144.1***	***154.0***	***176.3***	***145.5***	***153.5***	***104.6***	***143.1***	***215***	***153.7***
Separation rate ratio[e]	**1.6**	**2.0**	**1.8**	**2.4**	**2.1**	**1.6**	**2.5**	**3.3**	**1.9**

(a) For Tasmania, the Australian Capital Territory and the Northern Territory, separations per 1,000 population are for public hospitals only.

(b) Data for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory are included in the Total column.

(c) Separation rates are directly age-standardised using a highest age group of 65 and over. Therefore, standardised rates calculated for analyses by Indigenous status are not directly comparable with the rates presented in this report that use a highest age group of 85 and over.

(d) *Other Australians* includes separations for which Indigenous status was *Non-Indigenous* and *Not reported*

(e) The separation rate ratio is equal to the separation rate for First Nations people divided by the separation rate for other Australians.

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Table S3.9: Same-day and overnight acute separations per 1,000 population, by Indigenous status, all hospitals, states and territories, 2023–24

	NSW	Vic	Qld	WA	SA	Tas[a]	ACT[a]	NT[a]	Total[b]
First Nations people									
Separations									
Same-day acute separations	66,653	26,671	128,089	84,302	26,235	6,883	2,893	96,253	441,120
Overnight acute separations	59,195	18,334	63,618	31,355	11,971	4,278	2,457	27,466	220,239
Separations per 1000 population									
Same-day separations per 1,000 population[c]	257.0	450.6	628.1	1,017.4	702.4	241.6	365.9	1,729.4	607.4
Same-day separations per 1,000 population excluding dialysis[c]	121.6	285.1	270.3	169.1	188.1	162.8	265.6	218.9	200.1
Overnight separations per 1,000 population[c]	202.3	272.4	271.6	303.1	271.6	141.8	305.1	413.1	260.8
Non-Indigenous Australians									
Separations									
Same-day acute separations	1,666,119	1,982,308	1,664,545	711,409	476,172	93,360	74,557	31,662	6,815,787
Overnight acute separations	1,126,101	1,020,718	880,007	385,322	279,360	58,054	56,584	21,852	3,874,222
Indigenous status not reported									
Separations									
Same-day acute separations	57,461	39,198	64,147	0	24,299	821	1,498	4	199,291
Overnight acute separations	19,710	13,729	17,624	0	7,069	799	861	7	61,393
Other Australians [d]									
Separations									
Same-day acute separations	*1,723,580*	*2,021,506*	*1,728,692*	*711,409*	*500,471*	*94,181*	*76,055*	*31,666*	*7,015,078*
Overnight acute separations	*1,145,811*	*1,034,447*	*897,631*	*385,322*	*286,429*	*58,853*	*57,445*	*21,859*	*3,935,615*
Separations per 1000 population									
Same-day separations per 1,000 population [c]	*185.7*	*267.8*	*292.7*	*227.1*	*227.5*	*138.4*	*160.7*	*180.6*	*238.6*
Same-day separations per 1,000 population [c] *excluding dialysis*	*143.0*	*215.4*	*245.9*	*187.4*	*177.9*	*107.6*	*119.7*	*131.5*	*192.7*
Overnight separations per 1,000 population [c]	*126.6*	*138.6*	*154.6*	*126.6*	*133.8*	*91.6*	*121.9*	*125.6*	*136.6*
All Australians									
Separations									
Same-day acute separations	1,790,233	2,048,177	1,856,781	795,711	526,706	101,064	78,948	127,919	7,456,198
Overnight acute separations	1,205,006	1,052,781	961,249	416,677	298,400	63,131	59,902	49,325	4,155,854
Separations per 1000 population									
Same-day separations per 1,000 population[c]	187.6	269.2	303.9	247.5	235.6	142.8	164.0	538.1	247.7
Same-day separations per 1,000 population excluding dialysis[c]	142.5	216.1	247.7	187.2	178.4	110.1	122.4	156.8	193.2
Overnight separations per 1,000 population[c]	129.2	140.0	159.7	133.2	137.3	94.1	125.0	203.3	140.6

(a) For Tasmania, the Australian Capital Territory and the Northern Territory, separations and separations per 1000 population are for public hospitals only.

(b) Data for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory are included in the *Total* column.

(c) Separation rates are directly age-standardised using a highest age group of 65 and over. Therefore, standardised rates calculated for analyses by Indigenous status are not directly comparable to the rates presented in this report that use a highest age group of 85 and over.

(d) *Other Australians* includes separations for which Indigenous status was *Non-Indigenous* and *Not reported*

Notes

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Table S3.10: Separations by funding source and remoteness of area of usual residence, public and private hospitals, 2023–24

Remoteness area	Public patients[(a)]	Private health insurance	Other patients[(b)]	Total
Public hospitals				
Major cities	4,105,619	532,643	98,886	4,737,148
Inner regional	1,343,283	170,559	33,839	1,547,681
Outer regional	706,401	76,631	17,427	800,459
Remote	134,581	7,651	2,259	144,491
Very remote	126,909	2,506	938	130,353
Total public hospitals [(c)]	*6,494,097*	*804,976*	*180,335*	*7,479,408*
Private hospitals				
Major cities	188,434	3,253,007	451,741	3,893,182
Inner regional	64,732	691,639	120,485	876,856
Outer regional	25,010	221,389	50,128	296,527
Remote	7,798	19,814	3,551	31,163
Very remote	22,188	6,695	1,306	30,189
Total private hospitals [(c)]	*309,157*	*4,203,282*	*630,206*	*5,142,645*

(a) *Public patients* includes separations with a funding source of *Health service budget* (including *Health service budget due to Reciprocal health care agreements*) and *Health service budget—no charge raised due to hospital decision* (in public hospitals) and *Other hospital or public authority* (with a *Public* patient election status).

(b) *Other patients* includes separations with a funding source of *Self-funded*, *Workers compensation*, *Motor vehicle third party personal claim*, *Department of Veterans' Affairs*, *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a *Public* patient election status), *Other*, *Health service budget—no charge raised due to hospital decision* (in private hospitals), and not reported.

(c) Total includes separations for which the remoteness area could not be categorised.

Notes

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Table S3.11: Selected separation statistics, for same-day and overnight acute separations, by remoteness of area of usual residence, all hospitals, 2023–24

	Remoteness of area of usual residence					
	Major cities	Inner regional	Outer regional	Remote	Very remote	Total[(a)]
Same-day acute separations						
Separations	5,090,812	1,435,779	654,962	107,662	109,302	7,456,198
Separations per 1,000 population[(b)]	242.5	246.8	257.0	326.6	548.8	248.5
Separation rate ratio[(c)]	1.0	1.0	1.0	1.3	2.2	. .
Overnight acute separations						
Separations	2,750,722	840,105	391,248	63,340	48,591	4,155,854
Separations per 1,000 population[(b)]	131.4	150.5	159.6	200.4	253.6	140.34
Separation rate ratio[(c)]	0.9	1.1	1.1	1.4	1.8	. .

(a) Total includes separations for which the remoteness area could not be categorised.

(b) Separation rates are directly age-standardised using populations by remoteness areas, which do not include persons with unknown or migratory area of usual residence. Therefore, the total standardised rates in this table differ from national rates presented elsewhere in this report.

(c) Separation rate ratio is calculated as the separation rate for the remoteness area divided by the national separation rate.

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Table S3.12: Separations by funding source and socioeconomic area of usual residence[(d)], public and private hospitals, 2023–24

	Public patients[(a)]	Private health insurance	Other patients[(b)]	Total
Public hospitals				
1–Lowest	1,799,178	122,492	36,758	1,958,428
2	1,468,550	162,842	35,868	1,667,260
3	1,322,290	176,041	31,621	1,529,952
4	1,090,051	158,154	28,964	1,277,169
5–Highest	734,167	170,400	19,945	924,512
Total public hospitals [(c)]	*6,494,097*	*804,976*	180,335	*7,479,408*
Private hospitals				
1–Lowest	93,646	433,602	123,657	650,905
2	64,949	635,366	121,079	821,394
3	68,320	861,681	140,830	1,070,831
4	52,630	984,876	133,607	1,171,113
5–Highest	28,587	1,275,985	107,843	1,412,415
Total private hospitals [(c)]	*309,157*	*4,203,282*	*630,206*	*5,142,645*

(a) *Public patients* includes separations with a funding source of *Health service budget* (including *Health service budget due to Reciprocal health care agreements*) and *Health service budget—no charge raised due to hospital decision* (in public hospitals) and *Other hospital or public authority* (with a *Public* patient election status).

(b) *Other patients* includes separations with a funding source of *Self-funded*, *Workers compensation*, *Motor vehicle third party personal claim*, *Department of Veterans' Affairs*, *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a *Public* patient election status), *Other*, *Health service budget—no charge raised due to hospital decision* (in private hospitals), and not reported.

(c) Total includes separations for which the socioeconomic area of usual residence could not be categorised.

(d) In 2023–24, the SEIFA quintiles have been formed by assigning areas based on their IRSD score. This is different to past reporting where areas were weighted by their population when forming the quintiles.

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Table S3.13: Selected separation statistics, for same-day acute and overnight acute separations, by socioeconomic area of usual residence[c] all hospitals 2023–24

	Socioeconomic area of usual residence					
	1—Lowest	2	3	4	5—Highest	Total[a]
Same-day acute separations						
Separations	1,561,937	1,450,467	1,540,981	1,463,308	1,379,666	7,456,198
Separations per 1,000 population[b]	275.6	245.1	240.3	242.6	233 0	248.5
Separation rate ratio	1.1	1 0	1.0	1.0	0 9	. .
Overnight acute separations						
Separations	896,659	863,507	863,524	776,874	692,027	4,155,854
Separations per 1,000 population[b]	160.3	147 8	136.6	129.7	118.7	140.4
Separation rate ratio	1.1	1.1	1.0	0 9	0 8	. .

(a) Total includes separations for which SES group could not be categorised.

(b) Separation rates are directly age-standardised using populations by socioeconomic groups, which do not include persons in areas for which the socioeconomic group could not be determined. Therefore, the total standardised in this table differ from national rates presented elsewhere in this report.

(c) In 2023–24, the SEIFA quintiles have been formed by assigning areas based on their IRSD score. This is different to past reporting where areas were weighted by their population when forming the quintiles

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Technical specifications

1. Standard separations analysis
- Counts of separations exclude records for Newborn care (without qualified days), Hospital boarders and Posthumous organ procurement.
- Includes separations for patients who were separated between 1 July 2023 and 30 June 2024, including patients admitted before 1 July 2023.
- Unless o herwise specified, tables present data by state of hospitalisation, not state of residence of the pa ient.

2. Acute separations analysis
- Counts of separations include records for which he care type was reported as Acute,

or Newborn care (with at least one qualified day), or the care type was not reported.

3. Same-day/overnight status
- A separation is counted as a same-day separation if he patient was admitted and discharged on the same date.
- A separation is counted as an overnight separation if the patient was admitted and discharged on different dates.

4. Hospital sector
In some tables in this chapter, hospital types have been aggregated to hospital sector, where:
- *Public hospitals* include Public acute and Public psychiatric hospitals.
- *Private hospitals* include Private free-standing day hospital facilities and O her private hospitals.

(which also include private psychiatric hospitals).

5. Changes over time
In tables presenting five years of data, the average annual change over time is calculated using geometric progression.

6. Indigenous status
In tables presenting information on Indigenous status:
- First Nations people includes separations for patients whose Indigenous status was reported as:
  - –Aboriginal but not Torres Strait Islander origin.
  - –Torres Strait Islander but not Aboriginal origin.
  - –Bo h Aboriginal and Torres Strait Islander origin.
- Other Australians includes separa ions for which the Indigenous status of the patient was reported as:
  - –Neither Aboriginal nor Torres Strait Islander origin or
  - –Not stated/inadequately described.

7. Age-standardised rates
Age-standardisation of rates enables valid comparison across years and/or jurisdictions without being affected by the differences in age distributions.
- Separations per 1,000 population and patient days per 1,000 population are reported as directly age-standardised rates based on the Australian population as at 30 June of he year of interest. The Australian popula ion as at 30 June 2001 was used as the reference population.

In some tables, separation rates are accompanied by the standardised separation rate ratio (SRR). The SRRs are calculated by dividing the age-standardised separation rate for a popula ion of interest by the age-standardised separation rate for a comparison popula ion (the expected rate).
- For Indigenous status, he SRR is equal to the separation rate for First Na ions people divided by the separation rate for other Australians
- For analyses by state or territory of residence, remoteness areas and SES of area of residence, the SRR is equal to the separation rate for the state or territory of residence, remoteness area, or SES group, divided by he separation rate for Australia.

8. Suppression of private hospital information
- To preserve commercial confidentiality for the private hospitals in the Australian Capital Territory and the Northern Territory, the data for private hospitals in Tasmania, he Australian Capital Territory and he Northern Territory have been suppressed. As a result, any comparisons of private hospital activity by jurisdiction in the text do not include data for Tasmania, he Australian Capital Territory and the Northern Territory.
- It should be noted that there are not similar confidentiality concerns about the Tasmanian private hospital data (in aggregate) and he Tasmanian Department of Health would support the release of heir private hospital informa ion.

Table specifications
Table 3.1: Separations and patient days, by age group and sex, all hospitals, 2023–24
- Standard separa ions analysis.
- Age is calculated by subtracting the date of birth from the date of admission.
- Separations for which the sex was reported as intersex, indeterminate or was not stated/inadequately described are included in the *Persons* colum.
- Separations for which the date of birth was not reported are included in he *Total* row.
- Pa ient days are derived from he reported admission and separations dates. Excludes unqualified days for Newborns.

Table 3.2: Separations, by Indigenous status, public and private hospitals, 2023–24
- Standard separa ions analysis.
- Indigenous status, as described in specification 6.
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for First Nations people divided by separation rate for O her Australians.

Table 3.3: Separations, by Indigenous status and type of care, all hospitals, 2023–24
- Standard separa ions analysis.
- Indigenous status, as described in specification 6.
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for First Nations people divided by separation rate for O her Australians.
- Types of care

  Same-day acute separations for dialysis—Same-day/overnight status, as described in specification 3. Acute care separations as per specification 2, for which the AR-DRG was L61Z Haemodialysis.

  Other same-day acute separations—Same-day/overnight status, as described in specification 3. Acute care separa ions as per specifica ion 2, for which he AR-DRG was not L61Z.

  Overnight acute separations–Same-day/overnight status, as described in specification 3. Acute care separations as per specifica ion 2

  Separa ions for care other than acute–separations for which the care type was not reported as Acute or Newborn (with at least one qualified day), or not reported.

Table 3.4: Separations by Indigenous status, age group and sex, all hospitals, 2023–24
- See specifica ion for Table 3.1
- Indigenous status, as described in specification 6.

Table 3.5: Selected separation statistics, by remoteness area of usual residence, public and private hospitals, 2023–24
- Standard separa ions analysis.
- Remoteness of area of usual residence is based on the pa ient's area of residence (provided as Statistical Area level 2)
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for the remoteness area divided by the national separation rate.

Table 3.6: Selected separation statistics by socioeconomic area of usual residence, public and private hospitals, 2023–24
- Standard separa ions analysis.
- Socioeconomic area of usual residence is based on he patient's area of residence (provided as Sta istical Area level 2), aggregated into quintiles (20%) by population.
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for the socioeconomic area of residence divided by the national separation rate.

Table 3.7: Percentage change in separations by sex and age group, all hospitals, 2019–20 to 2023–24
- Standard separa ions analysis.
- Age is calculated by subtracting the date of birth from the date of admission.
- Separations for which the sex was reported as intersex, indeterminate or was not stated/inadequately described are included in the *Persons* colum.
- Separations for which the date of birth was not reported are included in he *Total* row.

Table 3.8: Separations per 1,000 population by sex and age group, all hospitals, 2023–24
- Standard separa ions analysis.
- Age is calculated by subtracting the date of birth from the date of admission.
- Separations for which the sex was reported as intersex, indeterminate or was not stated/inadequately described are included in the *Persons* colum.
- Separations for which the date of birth was not reported are included in he *Total* row.

Supplementary tables
Table S3.1: Separations, by age group and sex, public hospitals, states and territories, 2023–24
- See specifica ion for Table 3.1

Table S3.2: Patient days, by age group and sex, public hospitals, states and territories, 2023–24
- See specifica ion for Table 3.1

Table S3.3: Separations, by age group and sex, private hospitals, states and territories, 2023–24
- See specifica ion for Table 3.1

Table S3.4: Patient days, by age group and sex, private hospitals, states and territories, 2023–24
- See specifica ion for Table 3.1

Table S3.5: Separations, by age group and funding source, public and private hospitals, 2023–24
- See specifica ion for Table 3.1
- Funding source has been aggregated as follows:
  - Public patients includes separations wi h a funding source of:

    Heal h service budget (including Health service budget due to Reciprocal heal h care agreements)
    Heal h service budget—no charge raised due to hospital decision (in public hospitals)
    Other hospital or public authority (with a Public patient elec ion status)
  - Private health insurance includes separa ions wi h a funding source of Private health insurance
  - Other patients includes separations with a funding source of:

    Self-funded
    Workers compensation
    Motor vehicle third party personal claim
    Department of Veterans' Affairs
    Other compensation
    Department of Defence
    Correc ional facilities
    Other hospital or public authority (without a Public patient election status)
    Other
    Heal h service budget—no charge raised due to hospital decision (in private hospitals)
    Not reported.

Table S3.6: Acute separations, by age group, sex and same-day/overnight status, all hospitals, 2023–24
- Acute separations analysis
- Same-day/overnight status, as described in specification 3.
- See specifica ions for age and sex as for Table 3.1

Table S3.7: Separations, by Indigenous status, public and private hospitals, states and territories, 2023–24
- Standard separa ions analysis.
- Indigenous status, as described in specification 6.
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for First Nations people divided by separation rate for O her Australians.

Table S3.8: Overnight separations, by Indigenous status, public and private hospitals, states and territories, 2023–24
- Standard separa ions analysis.
- Indigenous status, as described in specification 6.
- Same-day/overnight status, as described in specification 3.
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for First Nations people divided by separation rate for O her Australians.

Table S3.9: Same-day and overnight acute separations per 1,000 population, by Indigenous status, all hospitals, states and territories, 2023–24
- Acute separations analysis
- Indigenous status, as described in specification 6.
- Same-day/overnight status, as described in specification 3.
- Includes age-standardised rates as described in specification 7.

Table S3.10: Separations by funding source and remoteness of area of usual residence, public and private hospitals, 2023–24
- Standard separa ions analysis.
- Remoteness of area of usual residence is based on the pa ient's area of residence (provided as Statistical Area level 2 for most jurisdictions)
- Funding source aggregated as specified for Table 3.5

Table S3.11: Selected separation statistics, for same-day and overnight acute separations, by remoteness area of usual residence, all hospitals, 2023–24
- Acute separations analysis
- Same-day/overnight status, as described in specification 3.
- Remoteness of area of usual residence is based on the pa ient's area of residence (provided as Statistical Area level 2 for most jurisdictions)
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for the remoteness area divided by the national separation rate.

Table S3.12: Separations by funding source and socioeconomic area of usual residence, public and private hospitals, 2023–24
- Standard separa ions analysis.
- Socioeconomic area of usual residence is based on he patient's area of residence (provided as Sta istical Area level 2 for most jurisdictions), aggregated into quin iles (20%) by population.
- Funding source aggregated as specified for Table3.4

Table S3.13: Selected separation statistics, for same-day acute and overnight acute separations, by socioeconomic area of usual residence, all hospitals, 2023–24
- Acute separations analysis
- Same-day/overnight status, as described in specification 3.
- Socioeconomic area of usual residence is based on he patient's area of residence (provided as Sta istical Area level 2 for most jurisdictions), aggregated into quin iles (20%) by population.
- Includes age-standardised rates as described in specification 7.
- Separation rate ratio is calculated as the separa ion rate for the remoteness area divided by the national separation rate.

Appendix informa ion with notes on defini ions and data limitations is available to download at the link below:
https://www.aihw.gov.au/reports-data/myhospitals/content/about-the-data

Contents

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Australian Government
Department of Health, Disability and Ageing

Dept/Agency Initiated Information Brief
MB26-001239
Version (1)
Date sent to MO: 29 May 2026

To: **Minister Butler**

Subject: **DEPT INITIATED BRIEF - CCR UNDER THE NHRA 2026-31**

Comments:			
Contact Officer:	s22	*Director, Public Hospitals Strategy Branch, PSD*	Ph: s22 Mobile: s22
Clearance Officer:	*Caitlin O'Brien*	*Assistant Secretary, Public Hospitals Strategy Branch, PSD*	Ph: (02) 51326644 Mobile: s22

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Key Issues:

1. On 10 April 2026, the National Health Funding Body (NHFB) provided a letter to the Treasurer on estimates for 2025-26 and 2026-27 National Health Reform Agreement (NHRA) funding. This letter is at **Attachment A**.

2. The letter includes forecasts of a new Commonwealth Contribution Rate (new CCR) metric devised by the NHFB. This new metric provides a higher CCR forecast for all states in 2026-27 compared to previous department forecasts shared with states.

3. The NHFB only forecasts 2025-26 and 2026-27 funding. **Table 1** includes these NHFB projections and adds our projections of the new CCR over the full five years. The table also includes CCR projections previously provided to states.

4. The national new CCR in 2026-27 is close to the glide path input rate for public hospital funding agreed by National Cabinet before diverging in future years.
   a. The CCR increases substantially from 2025-26 because of the commitment of $24.4 billion in additional funding over 5 years to 2030-31.
   b. New South Wales (39.49%) and Victoria (39.52%) are particularly close to the glide path rate in 2026-27. See **Attachment B** for more detail on CCR rates.

Table 1 – National forecasts for CCR and the glide path rate

	25-26	26-27	27-28	28-29	29-30	30-31
CCR forecasts provided to states (Jan 2026)	35.8%	37.0%	36.9%	36.8%	36.6%	37.1%
New CCR used by NHFB (May 2026)	35.5%	38.6%	38.6%	38.3%	37.9%	38.0%
Glide path input rate	N/A	40.5%	41.0%	41.5%	42.0%	42.5%

Background:
The Activity Based Funding Commonwealth Contribution Rate (ABF CCR) is defined in the new 2026-2031 NHRA to only reflect the ABF funding stream. This is the same as how CCR is defined in the current 2020-2026 NHRA.

The NHFB is now also reporting a new "overall" CCR. This includes all NHRA funding streams. The NHFB's new metric provides a higher forecast CCR than the ABF CCR. It is higher because the Commonwealth provides a higher proportion of other NHRA funding streams such as block funding and public health funding.

Sensitivities

s47B(a), s47E(d)

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s47B(a), s47E(d)

[redacted]

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Consultations: Across Portfolio Strategy Division.

Attachments:

A. Letter from NHFB to Treasurer

B. ABF CCR and overall CCR projections

Minister	**Minister Butler**
PDR Number	**MB26-001239**
Subject	**Dept Initiated Brief - Commonwealth Contribution Rates under the NHRA 2026-31**
Contact Officer	s22 02 5132 s22
Clearance Officer	Caitlin O'Brien 02 5132 6644 s22
Division/Branch	|Systems Strategy| Portfolio Strategy
Has Budget Branch been consulted if there are financial implications?	Not Applicable
Ensuring connected products across the Portfolio	Have disability/NDIS linkages been considered and outlined as relevant? YES ☐ NO ☐ N/A ☒ Have aged care linkages been considered and outlined as relevant YES ☐NO ☐ N/A ☒

Adviser/DLO comments:	Returned to Dept for: REDRAFT ☐ NFA ☐

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Attachment C

Modernising the Private Health Insurance (PHI) Rebate Q&As

Question	Answer
1. What is changing?	• This Budget the Government will return the rebate for older Australians back to the level paid for everyone else. • The government is simplifying the PHI rebate for all income tiers (Base tier and Tiers 1 and 2) with the Rebate entitlement to be determined only by income. The Government will remove all age-based rebate uplifts that currently apply to those aged 65yrs and over.
2. Why has the government only reduced the PHI rebate for older people?	• This measure makes PHI more equitable by ensuring that people's income (ability to pay) determines what level of support they receive from the government to subsidise their PHI, not their age. • People over the age of 65 years receive a greater level of assistance than younger people on similar incomes. • Those under 65 years, on average, pay more in premiums than they receive in benefits [see Q4]. Strong PHI participation amongst the young and healthy, facilitated in part through the PHI rebate, is critical for PHI to be affordable and sustainable, especially given increasing demographic pressures.
3. When will these changes come into effect? How long will the sector have to adjust?	• The changes will apply from 1 April 2027, with the start date coinciding with the start of the PHI premium year. • The sector will be able to factor in necessary adjustments into their 2027 premium round applications and consumers will have time to compare insurer offers before 1 April 2027 premium changes take effect.
4. Is this fair on older Australians?	• PHI is a choice made by individuals based on their personal financial circumstances and health needs in the context of Australia having a strong public health system under Medicare. • Older Australian will continue to be incentivised to hold PHI through the PHI Rebate (with those on lower incomes receiving a higher rate of financial assistance), Medicare Levy Surcharge and Lifetime Health Cover. • Those aged over 65 will on average continue to receive higher benefits than they pay in premiums. ○ Average benefits paid for hospital treatment (12 months to Dec-25): 0-64 years $826, 65+ years $4,494

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<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td></td><td>
Average premium after Rebate after the proposed change (single hospital-only, excluding corporate, as at 1 April 2026):
<table>
<tr><th rowspan="2">Selected hospital tiers</th><th colspan="4">Income tier (Rebate rate)</th></tr>
<tr><td>Base (24.118%)</td><td>Tier 1 (16.079%)</td><td>Tier 2 (8.038%)</td><td>Tier 3 (0%)</td></tr>
<tr><td>Silver</td><td>$1,638</td><td>$1,811</td><td>$1,985</td><td>$2,158</td></tr>
<tr><td>Silver Plus</td><td>$2,158</td><td>$2,387</td><td>$2,616</td><td>$2,844</td></tr>
<tr><td>Gold</td><td>$2,919</td><td>$3,229</td><td>$3,538</td><td>$3,847</td></tr>
</table>
Community rating will be maintained under this change i.e. all policyholder pay the same premium for the same policy, regardless of their gender, age or health status. Older Australians would therefore continue to be protected from higher premium costs that would be associated with risk-rated insurance by their claims being cross-subsidised by the premiums paid by younger and healthier policyholders.
The change will re-establish intergenerational equity in the PHI rebate system and will enable the government to redirect funding to important aged care initiatives.
</td></tr>
<tr><td>5. Don’t older Australian have higher costs as they age, if so how is removing this subsidy justified?</td><td>
Even after the proposed change, older Australians will still on average continue to receive more in benefits that they pay in PHI premiums [see Q4]. For younger Australians, that is not the case.
Younger Australians don’t incur the same level of health costs as older Australians and they receive less in PHI benefits than they pay in PHI premiums. They may also have other costs pressures like childcare, HECS debts, and mortgages.
This Government has been clear that changes made in this budget need to have a substantial focus on intergenerational responsibilities.
</td></tr>
<tr><td>6. How many people will be impacted?</td><td>
Approximately 3.2 million older Australians currently hold PHI and receive a Rebate rate that would be reduced to the rate received by the general population under this measure.
</td></tr>
<tr><td>7. How many older Australians will cancel their PHI in response to these changes?</td><td>
It is not possible to know the exact number of how many will cancel their policy in response to these changes.
The Department’s modelling shows a projected estimate of 0.4% (44,000) fewer people with PHI within two full years of the change (2028-29) than under current settings.
Notes: the 2nd full year was chosen to ensure a credible reflection of consumer choice, 12 months to December 2025 = over 316,000 more people insured (2% increase).
</td></tr>
</table>

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Question	Answer
	• The insured population aged 65+ and the total insured population are both expected to continue to grow, albeit at a slower rate than under the current arrangements.
8. Why did the independent study commissioned by the government predict that more people would drop PHI as a result of this type of change?	• The study commissioned by the previous government and developed by a third party (Finity) uses different assumptions and data, including about participation, claims values, and rebate expenditure. (More detail available at **Attachment D**.) • Nevertheless, in the context of the total number of insured people, both the department's modelling and the Finity study indicated there would be a marginal decrease in participation as a result of removing the higher Rebate rates for older people.

9. Will this change cost the government more in increased public hospital admissions than it saves, especially given the findings of the Offset Study by NEAA Associates?
 	
Note: PHA referred to this study in its 5 May 2026 media release[1]: 'In 2023, University of Newcastle researchers found that on average, the Australian Government saves $554 for each person it helps with its health insurance subsidies per year.'
	• To inform its modelling, Finity subcontracted NEAA Associates to determine the net impact of the premium rebates and the MLS policy on government spending, taking into account the savings (offsets) PHI yields for public sector medical spending (referred to as the Offset Study).
	• The authors of the Offset Study describe it as a 'static analysis' that take the market as is, with its (then) current enrolment, pricing, and PHI product characteristics.
	  ○ A static analysis ignores feedback from the system in response to any policy changes, e.g. how participation affects premiums and how in turn premiums affect participation.
	  ○ The authors noted that 'any change in policy, for example, a change in premium subsides would require a different [dynamic] analysis taking into account the system response to the policy change'.
	  ○ The base case assumed that public and private hospitals have the same efficiency levels and that all the utilisation by customers ceasing PHI cover would move from the private system to the public system. Sensitivity analysis of relaxing these assumptions (of lower cost per day in the public system and reduction in utilisation in the public system) reduced the estimated savings to the government.
	  ○ The Offset Study was not designed to factor in any benefits to the government of alternative uses of the Rebate funding. The money saved from the Rebate change will be used to **directly** fund important aged care services which will address delayed discharge and moderate pressure on public hospital services.
	  ○ In this regard, it is worth noting that the Rebate **indirectly** subsidises private healthcare through reduced PHI premiums. Of total premiums paid by policy holders in 2025, 85% was returned in

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[1] Seniors face health insurance bill shock of up to $1,600 a year under Government rebate changes - Private Healthcare Australia (PHA)

Question	Answer
	claims to members and 11% funds insurers' business expenses, leaving a net margin of 4%. The total net profit after tax of private health insurers in 2025 was $1.8 billion.
10. What are the impacts on pensioners for this change?	• The Rebate will continue to be means-tested, with those on lower incomes receiving a higher level of financial assistance. The change to the Rebate will mean that only income will determine the level of support, rather than different rates depending on age. • On average, people over 65 years of age receive more in benefits than they pay in premiums [see Q4] so there are still strong financial incentives to remain in PHI. • PHI is a choice made by individuals based on their personal financial circumstances and health needs. All Australian residents, regardless of whether or not they hold health insurance, are eligible to access healthcare treatments as public patients in a public hospital under Medicare. • Some older people may choose to downgrade their PHI cover. The department expects any downgrading would be in line the trend over the past several years of people 65+ downgrading from Gold to Silver. We don't expect to see significant downgrading from to lower levels of cover (Bronze/Basic) – less than 5% of older people with PHI currently hold Bronze or Basic cover, as these products do not typically provide value for this age cohort. • Potential reductions in the level of privately insured patients and/or reductions in coverage is expected to result in a marginal increase in demand for public hospital services, while noting that the overall number of people covered by PHI is expected to continue to grow. • Reinvesting the money from the Rebate in aged care capacity will help to address delayed discharge and relieve pressure on the public system.
11. How many pensioners are likely to be affected?	• The department is not aware of reliable and complete data on the number and type of pensioners in Australia who hold PHI. • In general, the department expects the number of full rate pensioners ($31k pa for singles or $47k for couples) holding comprehensive (Gold/Silver) hospital PHI to be limited based on their financial circumstances. • PHI is a choice made by individuals based on their personal financial circumstances and health needs and in the context of our strong public health system under Medicare. • Rebate entitlement is calculated based on income for surcharge purposes, which does not include superannuation income. Therefore, some people with low incomes for surcharge purposes (and therefore in the Base Tier) could have substantial superannuation balances.

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Question	Answer
	• *[If asked about the National Seniors Social Survey (NSSS) which indicates that 55% of pensioners hold PHI[2]]* The NSSS is a self-selected survey and is not weighed to be representative to the broader population.[3]

12. How much will this cost an average PHI holder who is impacted by this measure?	• The average impact on those 65yrs and older is less than a dollar a day.
	  ○ The average change in rebate per person in 2028-29 is -$252 for those aged 65+ years in the three affected income tiers (Base, 1 and 2).
	  ○ The actual impact for individuals will vary depending on their age, income and cost of their policy. [Note: A higher impact example: single 70 year old in the Base income tier with a $8,000/year Gold hospital and extras policy would face a reduction in their rebate of $643.]
	• *If asked* about the PHA estimate of an impact of up to $1,600:
	  ○ PHA stated this estimate was based on selecting the 'typical' couples policy cost listed on Canstar, multiplied by the sum of the reduction of the additional Rebate for a person aged 70 and older in the Base tier (8%) and the average gold policy increase on April 2026 as calculated by CHOICE (13.3%).
	  ○ The $1,600 is comprised of around $600 due to the Rebate change and $1,000 due to assumed premium increases to be charged by insurers on 1 April 2027.
	  ○ The average approved premium increase (weighted by insured persons) from the 2026 Premium Round is significantly less than the CHOICE figure presented. The difference between the percentages is because:
	  ▪ CHOICE only looked at the 5 largest insurer's products currently advertised for sale online. Premium Round included all products offered by all 28 insurers, including products closed to new members (members of which are more likely to be older Australians who have held the same policy for many years).
	  ▪ Premium Round data is weighed by persons per policy which presents a more accurate reflection of the price increase experienced by the average policyholder.
	  ▪ Note: Premium Round data indicates that the average approved premium increase (weighed by persons) across all Gold hospital products (including combined) effective on 1 April 2026 was 4.9%. The Premium Round data used to calculate this figure is

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[2] Why seniors love to hate private health - National Seniors Australia
[3] All about the National Seniors Social Survey (the NSSS) - National Seniors Australia

Question	Answer
	protected under the Private Health Insurance Act 2007 and is therefore not publicly available. The lower average increase than calculated by CHOICE reflects that insurers often try to protect their longstanding customers on closed products from significant price increases, and typically have higher premiums on their open products to respond to adverse selection. Premium Round data indicates that two-thirds of Gold hospital customers are on closed products. ○ Insurers will be required to apply to the Minister for premium changes to be implemented on 1 April 2027 and demonstrate that the requested changes are necessary to cover the benefits offered by each policy. ○ PHA also claimed that "Australians aged 70 and above with gold hospital cover could see premiums jump by more than 21 per cent from next April, compared to about 4 per cent for people under 65." ▪ The claim is based on comparing a person aged under 65 taking out a Silver hospital policy versus a person aged over 70 taking out a Gold hospital policy. A better comparison would focus on the same type of policy.
13. How much will this save?	• The reduction in expenditure on the Rebate compared with under current settings is estimated to be $3.0 billion between 2026-27 and 2029-30. • The Government is estimated to continue to spend over $7 billion a year on the Rebate, with a total of $30.2 billion between 2026-27 and 2029-30. • The change to the Rebate will allow $3.0 billion to be redirected to fund important Aged Care services.
14. The private hospital sector is struggling, surely this is a step in the wrong direction for the sector?	• It is expected that the measure will have a minor impact on participation in PHI. • The Department's modelling shows less than half a percent (0.4%) are expected to drop out by the end of 2028/29. This is a relatively small number when compared with the historical rate of annual take up of private health insurance, and the overall number of insured people is expected to continue to increase: ○ *Notes*: 12 months to December 2025 = over 316,000 more people insured (2% increase). • Through the private hospital viability check conducted in late 2024 and the subsequent Private Health CEO forum, it has become clear that there are a series of challenges facing the private health system. • The government is considering a range of options raised by the sector and will undertake consultation on further reforms to improve the private healthcare system.

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Question	Answer
15. What is the impact on the public hospitals? / Isn't this just going to increase elective surgery wait times in public hospitals?	• Potential reductions in the level of privately insured patients and/or reductions in coverage is expected to result in a marginal increase in demand for public hospital services, while noting that the overall number of people covered by PHI is expected to continue to grow (see **Attachment E** for more detail). • It is unclear how any increase in hospital admissions as a result of this change will be distributed across the health system. Some of these additional admissions may be delivered in the public hospital system, some in the private hospital system (patient self-funded) and some patients may elect to defer their care (which may be more likely with elective surgery than other types of care). • Those who drop or reduce their PHI cover may do so because their usage of PHI is below that of their peers, or because they are likely to seek treatment as a public patient regardless of whether they had PHI or not, and they don't see value in maintaining their previous cover. If so, this would moderate any resulting increase in public hospital admissions. • Based on the services that are more or less likely to be funded by PHI versus publicly funded, these additional admissions would be more likely to be elective rather than emergency or nursing home type stay/maintenance admissions. • The Government is delivering record funding to state and territory hospitals to support them in delivering health services like elective surgery. This includes $24.4 billion in additional projected NHRA funding over five years to 2030-31. In total, this will provide almost $220 billion in projected Australian Government public hospital funding over five years. • Reinvesting the money from the Rebate in aged care capacity will support more older people, including those living with dementia, to transition from hospital to more appropriate aged care settings.
16. What are you doing on specialists? Isn't this just going to make it harder and more expensive to see a specialist?	• The rising costs of specialist health care services remain a significant issue for many Australians. • Upgrades to the Medical Costs Finder will allow patients and their GPs to know in advance what their specialists might charge them. • The Minister has referred the issue to the House of Representatives Standing Committee on Health, Aged Care and Disability for Enquiry. The Committee is seeking submissions by October 2026. • The Government will consult on a range of options to address this issue with the sector over the coming months.

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Question	Answer
17. What will the Government be doing in addition to reducing the PHI Rebate, to ensure PHI provides value for money?	• The Government is considering a range of reform options that the sector has identified and will undertake consultation on further reforms to improve the private healthcare system. • While the Government can play a role in assisting the private health sector, it is primarily the sector's responsibility to work together, in the interests of consumers, to provide high quality value for money services and ensure the sector remains financially sustainable.
18. Who have you consulted on this change?	• The department did not consulted on the specific proposed changes to the Rebate due to the confidentiality required of Budget processes. • Consultation with stakeholders about PHI incentives, including Rebate settings, was undertaken in 2022 and 2023 and included insurers, healthcare providers, hospitals, consumers and other interested parties. • Feedback reflected through the 2022-2023 independent study and subsequent public consultation was considered in the development of this change.
19. Will this change exacerbate current issues with the financial sustainability of Gold hospital products?	• The Government acknowledges concerns around the cost and availability of Gold hospital products. • The Government has introduced legislation to outlaw 'product phoenixing' that particularly affects Gold hospital products. Product phoenixing occurs when insurers close a product and open an identical or similar product at a higher price point. • The Government is also considering a range of private health system reform options that the sector has identified. • Some affected consumers may respond to the reduced Rebate by choosing to reduce their level of PHI cover in line with their financial circumstances and health needs, by reducing hospital product tier or increasing excess. This could place additional pressure on public hospitals if consumers do not accurately assess their future health needs when choosing their level of cover. • Policyholders may compare private health insurance products and prices that suits their needs on the free and independent Private Health Insurance Ombudsman website at www.privatehealth.gov.au
20. How many people aged 65+ are likely to downgrade their cover as a result of this change?	• The department expects to see a continuing trend of downgrading from Gold to Silver. • Over the last 4 years (Dec 2021 to Dec 2025), the proportion of persons aged 65+ with hospital PHI has moved from predominantly Gold (-10.5% points) to a roughly equal proportion of silver (+8.5% points).

Proportion of 65+ insured people	Dec21	Dec22	Dec23	Dec24	Dec25
Hospital, including combined	89.2%	88.8%	88.5%	88.1%	87.8%

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Question	Answer

gold	52.7%	50.3%	47.9%	45.2%	42.2%
silver	32.7%	34.5%	36.4%	38.7%	41.2%
bronze	2.7%	2.8%	3.0%	3.2%	3.4%
basic	1.2%	1.2%	1.2%	1.0%	1.0%
General-treatment only	**10.8%**	**11.2%**	**11.5%**	**11.9%**	**12.2%**

- This trend is expected to continue and potentially increase based on advice from insurers about the sustainability of gold products, to be addressed through product reforms.
- We don't expect to see significant downgrading from Silver to lower levels of cover. Less than 5% of older people with PHI hold Bronze or Basic cover, as those products do not provide value for older Australians given their likely health needs.
- We therefore expect any significant downgrading reaction to rebate changes from people with Silver cover to be dropping hospital PHI altogether.
- The observed increase in the proportion of persons aged 65+ with general treatment only cover between 2021 and 2025 appears to reflect that people turning 65 during this period are more likely to hold general treatment only. There is no evidence of a change in behaviour towards general treatment only cover.

21. Why did the department only refer to impacts of the change to 2028-29?

- 2028-29 was chosen because the impacts, while expected to be minor, are likely to be most pronounced in the first two years.
- Two years provides sufficient time for consumers to feel the impact of the change and decide whether to remain in PHI.
- While the modelling extends this behavioural impact for the forward estimates, the accuracy is expected to decrease over time as assumptions about behaviour, economic conditions and policy settings become less certain over time.
- The larger impact in 2029-30 reflects the cumulative effect of behavioural responses over time, rather than a step change in a single year.
- The estimate of around 44,000 in 2028–29 represents the initial effect of the policy at a point in time. In subsequent years, the model assumes:
  - individuals aged 65+ continue to have a higher likelihood of downgrading or exiting cover under th new rebate settings; and

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Question	Answer
	○ these behavioural responses compound over time, progressively widening the gap relative to the baseline. As a result, the difference increases to around 78,000 by 2029–30. ○ As a result, overall participation continues to grow due to new (and returning) entrants, but at a slower rate than under the baseline.
22. What are the key sources of uncertainty in the estimates?	• The estimates are subject to uncertainty primarily due to the modelling of behavioural responses, which are based on historical relationships that may not fully reflect future behaviour under new policy settings In particular, the behavioural responses are: ○ estimated from historical data and may differ under changing policy or market conditions; ○ required extrapolation beyond observed data, and results may be less reliable where assumption fall outside historical experience; and ○ sensitive to model specification, parameter estimation and assumptions about how individuals respond to incentives. • Uncertainty increases over the forward estimates, as assumptions about future economic conditions, policy settings and consumer behaviour become less certain over time.
23. What will the impact be on regional hospitals?	• Through the private hospital viability check conducted by the department in 2024 and the subsequent Private Health Chief Executive Officer Forum, it has become clear that there are a series of challenges facing the private health system. • The Government has decided that maintaining inequitable Rebate settings is not a sustainable solution. • The effects of the Rebate change will vary across jurisdictions and by region, including where there is a higher proportion of older Australians. • The Government is considering a range of options raised by the sector and will undertake consultation on further reforms to improve the private healthcare system.

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Attachment F

Impact of the private health insurance (PHI) Rebate change on hospital utilisation

The department's analysis indicated that the projected insured population is expected to be approximately 44,000 (0.4%) fewer in 2028-29 as a result of the changes to the PHI rebate for older Australians, compared with under current settings. The insured population aged 65+ and the total insured population are expected to continue to grow, albeit at a slower rate than under the current arrangements.

This slower growth in the level of privately insured patients is expected to result in a marginally lower demand for private hospital services and marginally higher demand for public hospital services, compared with current settings.

Impact on private hospital utilisation

The impact on the private hospital system will depend on the extent to which these patients would have made use of the private hospital services funded by their private health insurance.

The estimated impact on total insured private hospital separations is projected to be a reduction ranging between a 0.4% and 1.0% in 2028-29.

This range of estimates is based on the following assumptions about the type of people who are likely to no longer take out PHI and the extent to which these people would have accessed a privately insured hospital treatment:

- Calculated utilisation rate (Base):
  - Based on APRA quarterly statistics and insured hospital separations data for 2024-25, the utilisation rate for this age group is estimated at approximately 800 separations per 1,000 insured persons[1].
  - Based on the calculated utilisation rate, the estimated reduction in total insured private hospital separations in 2028-29 is approximately 36,000, representing a decrease of 0.7% compared with current settings.
- Low utilisation rate (Low):
  - It may be argued the individuals most likely to discontinue private health insurance following the rebate reduction are those with low expectations of requiring private hospital services.
  - If the utilisation rate for this "low expected utilisation cohort" was assumed to be half of the calculated utilisation rate for the entire 65+ age group (making use of APRA published statistics), then the utilisation rate would be approximately 400 separations per 1,000 insured persons.
  - Based on this assumed low utilisation rate, the estimated reduction in total insured private hospital separations in 2028-29 is approximately 18,000, representing a decrease of 0.4% compared with current settings.

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[1] APRA Quarterly Statistics data as at June 2025; Hospital Casemix Protocol In-Patient (HCP1) data as at 28/04/2026.

- Reported utilisation rate (Reported):
  - The Australian Institute of Health and Welfare (AIHW) reports a hospital utilisation rate of approximately 1,100 hospital services per 1,000 population for this age group[2].
  - Based on the reported utilisation rate, the estimated reduction in total insured private hospital separations in 2028-29 is approximately 49,000, representing a decrease of 1.0% compared with current settings.
- Estimated change in top 5 PHI funded services:
  - The top 5 service types for PHI-funded separations at private hospitals for patients aged 65+ are shown in the below table, along with the estimated distribution of these separations under the three utilisation scenarios that may exit private hospitals and require to be delivered by the public system.

ADRG	Proportion of PHI funded separation*	Base	Low	Reported
R63 Chemotherapy/Pharmacotherapy for Neoplastic Disorders	10.3%	3.7k	1.8k	5.0k
C16 Lens Interventions	6.6%	2.4k	1.2k	3.2k
L61 Haemodialysis	6.5%	2.3k	1.2k	3.2k
I69 Bone Diseases and Arthropathies	5.6%	2.0k	1.0k	2.8k
G48 Colonoscopy	4.8%	1.7k	0.8k	2.3k
TOTAL	**33.8%**	**12.1k**	**6.0k**	**16.5k**
% of all separations at public hospitals**		0.14%	0.07%	0.19%

* Proportion based on 2024-25 HCP1 data accessed 28/04/2026
** Based on projected total public hospital separations of 8.5m in 2028-29

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Impact on public hospital utilisation

In each of the three utilisation estimates outlined above, the decrease in private hospital separations represents less than 1% of total projected public hospital separations in 2028-29 (AIHW's Admitted Patient Care, 2023-24).

Caveats

This analysis does not take into account:

- the extent to which people who drop their PHI choose to continue to access private hospital services without insurance (i.e. self-fund) or seek alternative treatments outside of the hospital system (for example access intra-vitral injections in doctors rooms or manage a joint complaint through physiotherapy etc, as opposed to surgery); and
- privately insured people who decide to downgrade their cover in line with their financial circumstances and health needs.
  - Cover reductions could include reducing their hospital product tier (such as from Gold to Silver, or Bronze to Basic, and are therefore not covered for as many clinical categories), dropping hospital cover altogether and only retaining general treatment PHI or by increasing the excess amount they would need to pay for hospital treatment.

[2] Patient demographics - Hospitals - AIHW; 2023-24

- It is possible that those who drop or reduce their PHI cover, do so because their usage of PHI is below that of their peers, or because they are likely to seek treatment as a public patient regardless of whether they had PHI or not, and they do not see value in maintaining their previous cover. If so, this would moderate any resulting impact on private and public hospital services.
- However, this reduction in coverage could result in a larger than these estimated impact if consumers do not accurately assess their likely future health needs when choosing their level of cover.

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Australian Government
Department of Health, Disability and Ageing

2026-27 Budget: Modernising the Private Health Insurance (PHI) Rebate – additional modelling detail

The 2026-27 Budget included a measure to align the PHI Rebate rate for older Australians with the level paid for the general population. From 1 April 2027, eligibility for the Rebate will be determined only by income, making it simpler and more equitable.

The below table shows the settings for the Rebate as at 1 July 2026, and the proposed rate changes from 1 April 2027 (in italics):

	PHI Rebate %			
Singles Tier threshold Families Tier threshold	< $105,000 < $210,000	$105,001-123,000 $210,001-246,000	$123,001-164,000 $246,001-328,000	>$164,001 >$328,001
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Age <65	24.118%	16.079%	8.038%	0%
Age 65-69	28.139 / *24.118%*	20.098 / *16.079%*	12.058 / *8.038%*	0%
Age 70+	32.158 / *24.118%*	24.118 / *16.079%*	16.079 / *8.038%*	0%

Notes: Income tiers presented are current for 1 July 2026 to 30 June 2027 and are subject to annual indexation on 1 July based on changes in AWOTE. The reset Rebate rates would be subject to annual indexation through the RAF on 1 April 2028 and subsequent years based on the difference between the CPI and the industry weighted average premium increase (however, the RAF would be set to 1 for 1 April 2027 to provide certainty of the rates to apply on 1 April 2027).

This document provides modelled estimates of insured people, Rebate expenditure and Rebate per person from the Department of Health, Disability and Ageing's "PHI Rebate Forward Estimates Model" that supported the Modernising the Private Health Insurance Rebate Impact Analysis (published on the Office of Impact Analysis's website[1]). The modelled estimates are presented for current Rebate settings and under the 2026-27 Budget measure. In the Impact Analysis, these were respectively referred to as *Option 1: Status Quo* and *Option 2: Equalise Rebate rates across ages for each income tier*. The difference provides the change between the estimates for the 2026-27 Budget measure scenario less the estimates under current settings.

The 'PHI Rebate Forward Estimates' model has been used for all PHI Rebate forward estimates and costings approved by the Department of Finance over the past 7+ years and is also used to model potential policy changes to Rebate settings. The model contains four input modules:

- demographic module – uses ABS population data to project population size, segmented by demographic characteristics relevant to PHI participation.
- economic module – projects future economic indicators
- participation module – analyses data on individual PHI holders (primarily Services Australia (SA) claims data linked with Australian Taxation Office (ATO) data) to assess propensity to change coverage types

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[1] www.oia.pmc.gov.au/published-impact-analyses-and-reports/modernising-private-health-insurance-rebate

- premiums module – analyses premiums data on individual PHI holders to project future premiums (SA data linked with ATO data, Treasury projections of CPI, premium round rates).

These feed into a forecasting module which projects the number of insured adults, premiums and Rebates. Further details on this model are available in the Impact Analysis.

Health's component of the projected rebate (published in *Budget 2026–27: Health, Disability and Ageing Portfolio Budget Statement*) is comprised of the modelled rebates plus ATO Tax Liability less ATO Tax Offset. Only the modelled rebate components are presented in the breakdowns by policyholder characteristics in this document.

Caveats and notes on the modelled outputs

Further, the following caveats are important to note in relation to the modelled outputs:

- The insured persons in the model are adults (18+ only) and do not include PHI dependents.
- Aggregate projections are more reliable than granular results, where variability can be significant and data limitations reduce predictive accuracy.
- Behavioural changes are estimated from historical patterns and are sensitive to model specification and parameter estimation.
- Outputs rely on assumptions about future economic conditions.
- Small differences in total population counts between baseline and scenario reflect rounding effects when disaggregating by various behavioural characteristics. There is no population change expected as a result of the policy.
- Modelled outputs are not directly comparable to other PHI membership data sources, such as from the Australian Prudential Regulation Authority (APRA), due to differences in underlying data sources, definitions, and modelling assumptions.

When interpreting the modelled outputs, it is worth noting the following:

- 2028-29 was chosen as the representative year for the Impact Analysis because the behavioral response in relation to PHI participation, while expected to be minor, is likely to be most pronounced in the first two years. By 2028-29, everyone has been exposed to the new rebate settings for a full financial year.
- The impact for each demographic group reflects the average age, income, and premium for the people that make up that group.
- The increase in insured people aged <65 years in the Base, Tier 1 and Tier 2 incomes tiers is due to the RAF being set to 1 on 1 April 2027 (i.e. the Rebate rate for these cohorts is assumed to be slightly higher than under current settings).

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Attachment E

Comparison of the Department's and Finity's modelling of the PHI Rebate

The department's modelling indicates the number of older Australian's likely to exit PHI as a result of this change is very small – around 0.4% (44,000) of the projected insured population in 2028 29[1]). Further, the total insured population is expected to continue to grow, albeit at a slower rate than under the current arrangements.

The study commissioned by the previous government and developed by a third party (Finity) uses different assumptions and data, including about participation, claims values, and rebate expenditure. Where relevant, the findings of that study, as well as stakeholder feedback in relation to the study, have been considered in the development of these changes.

Finity modelled several different scenarios for changes to the PHI Rebate in its 2022-2023 MLS and PHI Rebate Study[2] (provided at **Attachment J**).

- A comparison of the department's modelling and two of Finity's scenarios (the government's measure and the removal of the rebate entirely for people aged 65+ years, as reported in the media) are provided in the following table.
- Finity modelled a scenario in line with the government's measure, to remove higher rebates for 65+ years. Finity estimated that 91,000 would cease to hold PHI as a result of the reduced rebate for older people and there would be a resulting decrease in claims funded by PHI of $418 million to $547 million.

Overall, the following factors mean that comparing Finity's and the department's modelling should be done with caution:

- Finity's participation assumptions are based on economic experiment responses from 1524 people. By comparison, the department's PHI Rebate model includes a participation module that analysed data on all the individuals who have held a PHI policy in recent years and assessed their propensity to change coverage types depending on their behavioural characteristics (which included demographic characteristics, PHI incentive characteristics and premium characteristics and other assumptions are based on a survey).
    - The department's modelling is supported by the findings of a 2023 study which found that the Rebate rate uplift for older people in 2005 had a minimal impact on

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[1] The impact on the insured population in 2028-29 was chosen to ensure the effect of the Rebate change had fully flowed through to consumer PHI decisions in the modelling.

[2] https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/supporting_documents/Finity%20Consulting%20MLS%20and%20PHI%20Rebate%20Final%20Report.pdf

PHI participation. The study claimed this was because higher Rebate rates were targeting a group already strongly incentivised to purchase PHI and that, on average, the elderly tend to be less sensitive to changes in insurance prices than younger people.

- Finity assumed 8% of insured people were in Income Tier 3. By comparison, the proportion of people in income Tier 3 in the department's model (based on actual claims data) has increased from 12% in 2021-22 to a projected 14% in 2028-29. Given insured people in Tier 3 do not receive a Rebate, Finity's underestimate of the number of people in this Tier could have resulted in overestimating the participation and claims impacted by the Rebate changes.
- Finity claims that the PHI Rebate for older people provides value for government based on the difference between the high average claim costs and the Rebate paid for this cohort. This is in line with APRA data. If a higher rebate is being paid to people who would have taken out PHI regardless of whether they received the higher Rebate (because they derive sufficient value from PHI without the higher Rebate) then it is not a justifiable use of this government funding in a constrained Budget environment with higher competing priorities.
    - Finity's analysis indicates that the Commonwealth receives less value from the Rebate paid to those aged under 65 years with PHI, as the cost of the rebate is only slightly less than the estimated healthcare costs in a public hospital. However, the Rebate is intended to be an incentive to participate in PHI, and strong PHI participation amongst the young and healthy, facilitated in part through the PHI rebate, is critical for PHI to be affordable and sustainable, especially given increasing demographic pressures.
- Finity's model was based on people aged 25 years and older, while the department's model is for people aged 18 years and above (non-dependents).
- Finity's modelling was conducted in 2022 and early 2023. Developments in the PHI industry since that time include the following:
    - increases in PHI premiums through the 2024, 2025 and 2026 premium rounds
    - significant growth in out-of-pocket costs for healthcare, driven by increases in fees by medical specialists which is increasingly resulting in consumers choosing to go through the public system even if they have PHI
    - insurers are increasingly offering products with more exclusions and promoting higher excess options to allow people to choose products that align with their health and financial circumstances; this is encouraging consumers to downgrade products in response to increasing premiums and cost of living pressures rather than dropping PHI altogether.

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Comparison of modelling approaches and assumptions

	DHDA		Finity	
	Status quo	**Remove higher rebates for 65+ years**	**Status quo**	**Remove higher rebates for 65+ years**
Model description	Modelling of the PHI rebate change and impacts was conducted in 2026 using the "PHI Rebate Forward Estimates Model", which has been used for all PHI forward estimates and costings approved by the Department of Finance over the past 5+ years. The model uses Generalised Linear Models to predict whether people would buy PHI based on various different demographic characteristics like age, gender and income as well as PHI incentives like MLS and PHI rebate. This means the PHI costings were not assumptions based, but driven by statistical regression. The Participation Module of the PHI Rebate model analysed data on all the individuals who have held a PHI policy in recent years and assessed their propensity to change coverage types depending on their behavioural characteristics (which included demographic characteristics, PHI incentive characteristics and premium characteristics). Further details are provided in the Appendix.		The Finity rebate analysis was conducted in 2022 and projects insured persons by varying rebate parameters using the baseline 2019 demographic factors (age band, hospital product tier, income tier, family status, State) and the corresponding premiums, claims, Rebate and MLS payments. The participation assumptions were based on economic experiment responses from 1524 people (10 scenarios per person)[3]. Assumed removal of the Rebate reduces participation by 10% (19% for ages 65+, 7% for ages <65), smaller impacts for reductions in the Rebate (-4% for removal of additional rebate for ages 65+).	

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[3] https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/supporting_documents/MLS%20and%20PHI%20Rebate%20Study%20%20Information%20on%20Economic%20Experiment.pdf

	DHDA		Finity	
	Status quo	**Remove higher rebates for 65+ years**	**Status quo**	**Remove higher rebates for 65+ years**
Insured people (total for status quo, change from status quo for scenarios)	10.2m hospital (including combined), 11.4m any PHI, 18+ years (non-dependents) in 2028-29	-44,000 (-1.2%) of 65+ years with any PHI (almost all combined cover) compared with status quo	8.0m hospital, 25+ years (did not include people with general treatment only)	-91,000 (-4%) of 65+ years compared with status quo
Proportion of insured people by income tier	Base: 67%, Tier 1: 7%, Tier 2: 11%, Tier 3: 14% in 2028-29		Base: 75%, Tier 1: 8%, Tier 2: 9%, Tier 3: 8%	
Total premiums paid (total for status quo, change from status quo for scenarios)	$35,221m 2028-29	-$166m compared with status quo	$21,210m (hospital only, did not include general treatment premiums)	-$281m compared with status quo
Total Rebate paid	$6,967m 2028-29 Note: the model only projects rebates in respect of those who claim the rebates from a discount on the insurance premiums rather than from the ATO through their tax returns.	-$805.4 compared with status quo	$4,681m (hospital only, did not include rebate paid for general treatment products)	-$482m compared with status quo
Average premium paid	Average hospital premium per single insured (2025 premium year): Basic: $1,200, Basic Plus $1600, Bronze: $1,500, Bronze Plus: $1,800, Silver: $2,100, Silver Plus: $2,800, Gold: $3,700		Assumed premiums per single insured person: Basic: $1,400, Bronze: $1,700, Silver: $2,600, Gold: $3,100	
Total claims	Total claims for the 12 months to Dec 2025: $26,961m		$18,835m	Range of -$418m to -$547m

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	DHDA		Finity	
	Status quo	**Remove higher rebates for 65+ years**	**Status quo**	**Remove higher rebates for 65+ years**
Average claims	From APRA data, average claims for the 12 months to Mar 2025: $806 for <65 years, $4506 for 65+ years		The Finity model uses PHI insurer hospital claims data specifically collected for the study: $929 for <65 years, $3855 for 65+ years. For the cost to govt for treatment in a public hospital, the model assumes equivalent daily accommodation costs as private hospitals, medical costs are 25% lower and public prostheses costs are 37.5% lower. There are some differences vs APRA data ($798 for <65 years, $4010 for 65+ years), but the claiming relativities (65+ years claim ~5x more) are substantially the same, and do not affect the persons modelling.	

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Relevance of the Offset Study findings to the PHI Rebate measure

To inform its modelling, Finity subcontracted NEAA Associates to determine the net impact of the premium rebates and the MLS policy on government spending, taking into account the savings (offsets) PHI yields for public sector acute health system spending (referred to as the Offset Study, provided at **Attachment K**).

PHA referred to this study in its 5 May 2026 media release[4]: 'In 2023, University of Newcastle researchers found that on average, the Australian Government saves $554 for each person it helps with its health insurance subsidies per year.'

The results of the Offset study base case and sensitivity analysis are presented in the below table, with the main result that has been quoted in the media in bold:

Results of offset analysis	**Rebates less offset**	**Rebates + MLS less offset**
Base case: offset is hospital costs (assumed public and private hospitals have same cost per day), 25% of MBS fee, prostheses benefits are 60% higher in private system)	-$916	**-$554**
Sensitivity 1: assumed cost per day in public hospital is 80% of private hospital	-$678	-$316
Sensitivity 2: prostheses benefits are 80% higher in private system	-$900	-$538
Sensitivity 3: PHI induces higher utilisation ('moral hazard'), 90% of private utilisation would take place in the public system	-$773	-$411
Sensitivity 1-3 combined	-$545	-$183

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The authors of the Offset Study describe it as a 'static analysis', taking the market as is, with its (then) current enrollment, pricing, and PHI product characteristics.

- A static analysis ignores feedback from the system in response to any policy changes, e.g. how participation affects premiums and how in turn premiums affect participation.
- The authors noted that 'any change in policy, for example, a change in premium subsides would require a different [dynamic] analysis taking into account the system response to the policy change'.
- As shown in the above table, the base case assumed that public and private hospitals have the same efficiency levels and that all the utilisation by

[4] Seniors face health insurance bill shock of up to $1,600 a year under Government rebate changes - Private Healthcare Australia (PHA)

customers ceasing PHI cover would move from the private system to the public system. Sensitivity analysis of relaxing these assumptions (of lower cost per day in the public system and reduction in utilisation in the public system) reduced the estimated savings to the government.

- Further, the Offset Study notes the net social cost of the extra social resources associated with an individual enrolling in PHI due to higher utilisation and cost in PHI is also a consideration. 'Moving an older person into PHI saves the government money but costs society. This "double-edged sword" of PHI plays in heavily to the question of government policy towards the subsidy to PHI.'

The Offset Study was not designed to factor in any benefits to the government of alternative uses of the Rebate funding.

- It is worth noting that the Rebate **indirectly** subsidises private healthcare through reduced PHI premiums. Of total premiums paid by policy holders in 2025[5], 85% was returned in claims to members and 11% funded insurers' business expenses, leaving a net margin of 4%. The total net-profit-after-tax of private health insurers in 2025 was $1.8 billion.
- The money saved from the Rebate change will be used to **directly** fund important aged care services.

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[5] APRA Quarterly PHI Membership and Benefits Report, and Performance Statistics Reports, December 2025.

Appendix: DHDA PHI Rebate Forward Estimates Model

A brief description of each module of the Model follows:

Demographic Module

The projection of the number of insured adults requires a projection of the population that is eligible to take up this insurance. The population size and its growth are influenced by various factors such as birth rates and mortality rates as well as rates of migration. In addition to these, the characteristics of the population also play an important role in determining the take-up of insurance. For example, an ageing population will require more healthcare services, on average. Families planning for children are more likely to take up or upgrade insurance policies to include hospital cover. The incomes of individuals will determine whether insurance is affordable for them and how influential they find government incentive schemes.

The Demographic Module (built in SAS) took the most recent projection of the population of Australia from the Australian Bureau of Statistics (ABS) and updated it to reflect any deviations between the projections and the current population. It then used various other sources of information such as Census sample files and ATO sample files to disaggregate the projections. The output of this module was the projected population size, segmented by the various demographic characteristics that may be significant in determining the level of participation in PHI.

The demographic characteristics that are significant in explaining policyholder behaviour included:

- Age/age band – the older population may have a higher demand for PHI because of their increasing needs for healthcare. There may be a spike in demand for PHI at age 30 because of the operation of the Lifetime Health Cover loading (LHC).
- Gender – males may have different demand for PHI than females for various reasons.
- State/jurisdiction – PHI premiums may differ by state and affect premium affordability and therefore the demand for PHI.
- SEIFA (socio-economic indicator) – those with a higher indicator will be more able to afford PHI and may have a higher demand.
- Family status – families may have a higher demand than singles. Couples at child bearing age may have a higher demand for family cover.
- Income/income band – those with higher income may be more able to afford PHI.
- Dependent children (or number of dependent children) may increase the demand for PHI cover.

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Economic Module

The Economic Module (built in Excel as part of the Forecasting Module) contains a projection of the various indicators of economic activity that will impact on the rebate projections. These include:

- Consumer Price Index (CPI), which will directly impact on the rebate percentage through the rebate adjustment factor (RAF). It will also be used in the indexation of income to measure changes in real purchasing power. Similarly, it will be used in the indexation of PHI premiums to express their real rate of growth (above the cost of living).
- Average Weekly Earnings (AWE), for the purposes of inflating income over time as well as the definition of the income tier bands in the rebate/MLS tables.

Premiums Module

The Premiums Module (built in SAS) analysed the premiums data on the individuals who have had a PHI policy in recent years. The main purpose of this analysis was to estimate premium growth rates that can be applied to current premium levels to project future premiums. The output from the analysis included:

a. the average annualised premium per insured adult in each behaviour segment;

b. the historical annual premium growth rates by state (jurisdiction), family status and coverage type;

c. the proportion of insured adults by state, family status and coverage type;

d. the average 'non-annualised' premium per insured adult in each behaviour segment (to be used for General only cover); and

e. the insured adult population in each behaviour segment per financial year.

The analysis of item a) for consecutive years allowed item b) to be calculated. Item b) formed an initial basis for the selection of future premium growth rates by state, family status and coverage type. Item c) allowed the growth rates to be summarised at an industry level (by weighting the growth rate in each segment according to the proportion of insureds in each segment). The industry growth rate was then compared against APRA figures for reasonableness. The selected growth rates were then calibrated if required.

Items a), d) and e) were used as inputs into the Forecasting Module. For General only cover, the average premiums used were the 'non-annualised' version due to the way in which the number of General only insureds were counted.

Note that the average premium growth rates from b) encapsulated multiple factors. These include the intrinsic increases due to increases the cost of providing health care

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over time, upgrading/downgrading within coverage types etc. In particular, it included the impact of the ageing population – where progressively more insureds will be paying higher premiums that provide more comprehensive cover as they grow older. We have selected the future growth rate as the average of the growth rates observed in the latest two years. However, since the model explicitly allows for the impact of the ageing of the PHI population, before applying this growth rate, an adjustment was made to the rate to only account for the remaining sources of growth.

Participation Module

The Participation Module (built in SAS and Teradata) analysed data on all the individuals who have held a PHI policy in recent years and assessed their propensity to change coverage types depending on their behavioural characteristics (which included demographic characteristics, PHI incentive characteristics and premium characteristics).

Forecasting Module

The Forecasting Module (built in SAS and Excel) brought together all the inputs from the Demographic, Economic, Premium, and Participation modules to forecast for the next ten years:

- the probabilities of transition between coverage types;
- the number of adults in each demographic segment and coverage type (General, Hospital, Combined and No Cover);
- the projected premiums paid; and
- the projected rebate amounts.

Note that the model only projects insureds, premiums and rebates in respect of those who claim the rebates from a discount on the insurance premiums rather than from the ATO through their tax returns. Therefore, rebates from the ATO are added to the projections from the model when total rebates are required. Also, this model does not allow for rebates that are paid to insureds who misdeclare their income tiers when claiming their rebate from insurers. Therefore, to estimate the rebates that Health pays, these amounts are added.

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PORTFOLIO STRATEGY DIVISION
BUDGET ESTIMATES MAY 2026
DEPUTY SECRETARY BRIEF

PRIVATE HEALTH INSURANCE REBATE

BUDGET

PHI Rebate expenditure estimates, as at the 2026-27 Budget ($ million)

	2025-26 (Estimated Actual)	2026-27 (Estimate)	2027-28 (Estimate)	2028-29 (Estimate)	2029-30 (Estimate)	Total *2026-27 to 2029-30*
Total (incl. Budget save)	7,849.4	7,888.2	7,396.5	7,449.9	7,502.3	30,236.9
Total w/out Budget save	*7,849.4*	*8,094.2*	*8,266.8*	*8,380.9*	*8,489.7*	*33,231.6*
Budget save	*0.0*	*-206.0*	*-870.3*	*-931.0*	*-987.4*	*-2,994.7*
Annual increase in total spend		38.9	-491.8	53.4	52.5	-347.0
% growth	-	0.5%	-6.2%	0.7%	0.7%	

Sources: Budget 2026-27 Health, Disability and Ageing Portfolio Budget Statement (p. 76) and Budget 2026-27 Treasury Portfolio Budget Statement (p. 234).

PHI REBATE CHANGES

- On 22 April 2026, the Minister announced changes to the private health insurance Rebate to align the rate for older Australians to the level paid for the general population. From 1 April 2027, eligibility for the Rebate will be determined only by income, making it simpler and more equitable.
- Departmental modelling indicates that:
  - the average cost for affected individuals is less than a dollar a day, or $252 per year. The impact for consumers will vary depending on their age, income and the cost of their policy (see **Attachment A** for examples).
  - the impact on PHI participation is anticipated to be minimal, with the projected insured population expected to drop out of PHI to be around 0.4% (44,000) fewer in 2028-29 compared with current arrangements
  - the insured population aged 65+ and the total insured population are expected to continue to grow, albeit at a slower rate than under the current arrangements
  - the proportion of the insured population aged 65+ is currently 31%. Under the proposed changes, this is expected to increase slightly, to 32% in 2028-29.
  - it is not possible to estimate those that may downgrade their cover, however we note this change may exacerbate the current trend of people downgrading from Gold to Silver (we don't expect to see significant downgrading from Silver to lower levels of cover – see Table 5 and question 20 in **Attachment B** for further details).
- Additional modelling outputs are at **Attachment C**, prepared Q&As for the Rebate save are at **Attachment B** and the Impact Analysis for the Rebate change is at **Attachment D**.
- The money saved, estimated to be $2,994.7m between 2026-27 and 2029-30, will be redirected to fund the following important Aged Care services:
  - provide targeted capital subsidies for residential aged care, providing additional funding for supported residents for newly built or refurbished homes

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- increase the accommodation supplement and structural changes to introduce new tiers, and additional payment for homes with more than 60% supported residents
- deliver 20 additional Specialist Dementia Care units and expand the Hospital to Aged Care Dementia Support Program
- expand access to the Support at Home program and make improvements to the program so that it is fairer and more affordable for older Australians.

- The current Rebate settings and the proposed changes (italics) are set out in the table below:

	Income Tiers (1 July 2026 to 30 June 2027)*			
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Singles Tier threshold Families Tier threshold	< $105,000 < $210,000	$105,001-123,000 $210,001-246,000	$123,001-164,000 $246,001-328,000	>$164,001 >$328,001
	MLS %			
	0%	**1%**	**1.25%**	**1.5%**
	PHI Rebate % (current from 1 April 2026/*proposed from 1 April 2027*)^			
Age <65	24.118/*24.118%*	16.079/*16.079%*	8.038/*8.038%*	0/*0%*
Age 65-69	28.139/*24.118%*	20.098/*16.079%*	12.058/*8.038%*	0/*0%*
Age 70+	32.158/*24.118%*	24.118/*16.079%*	16.079/*8.038%*	0/*0%*

*Income tiers will be current for 1 July 2026 to 30 June 2027 and would continue to be subject to annual indexation on 1 July based on changes in AWOTE.

^The reset Rebate rates would be subject to annual indexation through the RAF on 1 April 2028 and subsequent years based on the difference between the CPI and the industry weighted average premium increase (however, the RAF would not apply on 1 April 2027).

- Under the current Rebate settings, the average premiums after Rebate differ by age:

Key statistics, single person ($)				
	Base	**Tier 1**	**Tier 2**	**Tier 3**
Aged <65 years				
Average premium after Rebate – Basic	933	1,031	1,130	1,229
Average premium after Rebate – Bronze	1,204	1,331	1,459	1,586
Average premium after Rebate – Silver	1,638	1,811	1,985	2,158
Average premium after Rebate – Gold	2,919	3,229	3,538	3,847
Average benefit paid by insurers	826			
Aged 65-69 years				
Average premium after Rebate – Basic	883	982	1,081	1,229
Average premium after Rebate – Bronze	1,140	1,267	1,395	1,586
Average premium after Rebate – Silver	1,551	1,724	1,898	2,158
Average premium after Rebate – Gold	2,765	3,074	3,383	3,847
Average benefit paid by insurers	2,969			
Aged 70+ years				
Average premium after Rebate – Basic	834	933	1,031	1,229
Average premium after Rebate – Bronze	1,076	1,204	1,331	1,586
Average premium after Rebate – Silver	1,464	1,638	1,811	2,158
Average premium after Rebate – Gold	2,610	2,919	3,228	3,847
Average benefit paid by insurers	5,099			

- Under the proposed Rebate settings, the average premium after Rebate will not vary by age:

Key statistics, single person ($)				
	Base	**Tier 1**	**Tier 2**	**Tier 3**
Average premium after Rebate – Basic	933	1,031	1,130	1,229
Average premium after Rebate – Bronze	1,204	1,331	1,459	1,586
Average premium after Rebate – Silver	1,638	1,811	1,985	2,158
Average premium after Rebate – Gold	2,919	3,229	3,538	3,847
Average benefit paid by insurers, 0-64 years	826			
Average benefit paid by insurers, 65-69 years	2,969			
Average benefit paid by insurers, 70+ years	5,099			

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Sources: Premiums – Private Health Insurance Ombudsman PHIS data, at April 2026. Singles hospital-only products, excluding corporate products. Benefits – APRA Membership and Benefits data, December 2025. 2025 hospital benefits paid and average hospital persons by age.

- The MLS and PHI Rebate study[1] commissioned by the previous government and developed by a third party (Finity) uses different assumptions and data, including about participation, claims values, and rebate expenditure. Where relevant, the findings of that study, as well as stakeholder feedback in relation to the study, have been considered in the development of these changes.
- Comparisons of Finity's and the department's modelling should be done with caution:
  - Finity's participation assumptions are based on economic experiment responses from 1524 people. By comparison, the department's PHI Rebate model includes a participation component that analysed data on all the individuals who have held a PHI policy in recent years and assessed their propensity to change coverage types depending on their behavioural characteristics.
  - Finity assumed 8% of insured people were in Income Tier 3. By comparison, the proportion of people in income Tier 3 in the department's model (based on actual claims data) has increased from 12% in 2021-22 to a projected 14% in 2028-29. Given insured people in Tier 3 do not receive a Rebate, Finity's underestimate of the number of people in this Tier could have resulted in overestimating the participation and claims impacted by the Rebate changes.
  - Finity claims that the PHI Rebate for older people provides value for government based on the difference between the high average claim costs and the Rebate paid for this cohort. However, if a higher rebate is being paid to people who would have taken out PHI regardless of whether they received the higher Rebate (because they derive sufficient value from PHI without the higher Rebate) then it is not a justifiable use of this government funding in a constrained Budget environment with higher competing priorities.
  - See **Attachment E** for further details.
- There are concerns the Rebate changes will be a 'false economy' because hospitalisations for older people are higher compared to the general population and those who drop PHI will then rely on the public system.
  - Slower growth in the level of privately insured patients (while noting that the overall number of people covered by PHI is expected to continue to grow) is expected to result in a marginally lower demand for private hospital services and marginally higher demand for public hospital services, compared with current settings.
  - The estimated impact on total insured private hospital separations, compared with current settings, is projected to be a reduction ranging between a 0.4% and 1.1% in 2028-29, depending on assumptions about the type of people who are likely to no longer take out PHI and the extent to which these people would have accessed a privately insured hospital treatment. It is possible that those who drop or reduce their PHI cover, do so because their usage of PHI is below that of their peers, or because they are likely to seek treatment as a public patient regardless of whether they had PHI or not, and they don't see value in maintaining their previous cover.
  - If the decrease in private hospital separations estimated above all transferred to the public hospital system, then all estimated impact scenarios of additional public hospital separations would represent less than 1% of projected public hospital admissions in 2028-29.

This analysis does not take into account the extent to which people who drop their PHI:

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[1] Available at https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/.

        - choose to continue to access private hospital services without insurance (i.e. self-fund) or seek alternative treatments outside of the hospital system, or
        - would have received treatment in a public hospital even if they had PHI
    - See **Attachment F** for further details.
- It is worth noting that the Rebate **indirectly** subsidises private healthcare through reduced PHI premiums. Of total premiums paid by policy holders and subsidised by the government in 2025, 85% was returned in claims to members and 11% funds insurers' business expenses, leaving a net margin of 4%. The total net profit after tax of private health insurers in 2025 was $1.8 billion.
    - By comparison, the money from the Rebate will be redirected to **directly** fund important aged care services.
- On 5 May 2026, Private Healthcare Australia issued a media release stating that some retirees will face annual premium increases of more than $1,600 from 1 April 2027.
    - PHA claimed this estimate was based on selecting the 'typical' couples policy cost listed on Canstar, multiplied by the sum of the reduction of the additional Rebate for a person aged 70 and older in the Base tier (8%) and the average gold policy increase on April 2026 as calculated by CHOICE (13.3%). The $1,600 is comprised of around $600 due to the Rebate change and $1,000 due to assumed premium increases to be charged by insurers on 1 April 2027.
    - The average approved premium increase (weighted by insured persons) from the 2026 Premium Round is significantly less than the CHOICE figure presented. The difference between the percentages is because:
        - CHOICE only looked at the 5 largest insurer's products currently advertised for sale online. Premium Round included all products offered by all 28 insurers, including products closed to new members.
        - Premium Round data is weighed by persons per policy which presents a more accurate reflection of the price increase experienced by the average policyholder.
        - Note: Premium Round data indicates that the average approved premium increase (weighed by persons) across all Gold hospital products (including combined) effective on 1 April 2026 was 4.9%. The underlying Premium Round data used to calculate this figure is protected under the *Private Health Insurance Act 2007* and is therefore not publicly available. The 4.9% (which can be mentioned) being lower than the average increase calculated by CHOICE reflects that insurers often try to protect their longstanding customers on closed products from significant price increases, and typically have higher premiums on their open products to respond to adverse selection. Premium Round data indicates that two-thirds of Gold hospital customers are on closed products.
    - Insurers will be required to apply to the Minister for premium changes to be implemented on 1 April 2027 and demonstrate that the requested changes are necessary to cover the benefits offered by each policy.
    - PHA also claimed that "Australians aged 70 and above with gold hospital cover could see premiums jump by more than 21 per cent from next April, compared to about 4 per cent for people under 65."
        - The claim is based on comparing a person aged under 65 taking out a Silver hospital policy versus a person aged over 70 taking out a Gold hospital policy. A better comparison would focus on the same type of policy.

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PRIVATE HEALTH SECTOR REFORM

- The Government is committed to improving the affordability and value of private health insurance for consumers and the contribution it makes to the Australian healthcare system.

- Through the private hospital viability check conducted by the department in late 2024 and the subsequent Private Health CEO forum, it has become clear that there are a series of challenges facing the private health system.
- The Government is considering a range of reform options that the sector has identified.
- While the Government can assist the PHI and private hospital sector, it is the sector's responsibility to work collaboratively in the interests of consumers, to deliver high quality value for money services and ensure the sector remains financially sustainable.

PRIVATE HEALTH INSURANCE REBATE (PHIR) CLAIMS SYSTEM AND AMENDING LEGISLATION

- On 1 April 2026, amendments to the *Private Health Insurance Act 2007* (the PHI Act) and the *Private Health Insurance (Incentives) Rules 2012 (No.2),* regarding administration of the private health insurance rebate (PHIR) premiums reduction scheme, came into effect.
- The amendments ensure that provisions in the PHI Act are aligned with the PHIR registration and claims processing system administered by Services Australia, and ensures the validity of participant registrations and claims for payment under the scheme.

KEY FACTS AND FIGURES – PHI REBATE SAVE

Table 1: Current Rebate settings and the proposed change from 1 April 2027 (italics)

	Income Tiers (1 July 2026 to 30 June 2027)[1]			
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Singles Tier threshold Families Tier threshold	< $105,000 < $210,000	$105,001-123,000 $210,001-246,000	$123,001-164,000 $246,001-328,000	>$164,001 >$328,001
	MLS %			
	0%	**1%**	**1.25%**	**1.5%**
	PHI Rebate % (current from 1 April 2026/*proposed from 1 April 2027*)[2]			
Age <65	24.118/*24.118%*	16.079/*16.079%*	8.038/*8.038%*	0/*0%*
Age 65-69	28.139/*24.118%*	20.098/*16.079%*	12.058/*8.038%*	0/*0%*
Age 70+	32.158/*24.118%*	24.118/*16.079%*	16.079/*8.038%*	0/*0%*

[1] Income tiers will be current for 1 July 2026 to 30 June 2027 and would continue to be subject to annual indexation on 1 July based on changes in AWOTE.
[2] The reset Rebate rates would be subject to annual indexation through the RAF on 1 April 2028 and subsequent years based on the difference between the CPI and the industry weighted average premium increase (however, the RAF would not apply on 1 April 2027).

Table 2: Expected change in number of insured people (non-dependents) in 2028-29 by age and income tier compared to status quo

	18-64 years	**65+ years**	**Total**
Base Tier	1,809	-42,001	-40,192
Tier 1	118	-835	-717
Tier 2	97	-1,477	-1,380
Tier 3	-4	-11	-15
Total	2,020	-44,324	-42,304

Source: Department PHI Rebate Forward Estimates model, published in the Impact Analysis (**Attachment C**).

Notes: The increase in insured people aged <65 years in the Base, Tier 1 and Tier 2 incomes tiers is due to the RAF being set to 1 on 1 April 2027 (i.e. the Rebate rate for these cohorts is assumed to be slightly higher than under Status Quo). The decrease in insured people in Tier 3 is due to people in Tier 2 dropping out in 2027-28 who would have otherwise moved to Tier 3 in 2028-29 due to income tier indexation.

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Table 3: Average premiums after Rebate, current settings

Key statistics, single person ($)	Base	Tier 1	Tier 2	Tier 3
Average annual single hospital-only premium after Rebate, aged <65 years, Apr 2026				
Basic	933	1,031	1,130	1,229
Basic Plus	1200	1,327	1,454	1,581
Bronze	1,204	1,331	1,459	1,586
Bronze Plus	1,376	1,522	1,668	1,813
Silver	1,638	1,811	1,985	2,158
Silver Plus	2,158	2,387	2,616	2,844
Gold	2,919	3,229	3,538	3,847
Average annual single hospital-only premium after Rebate, aged 65-69 years, Apr 2026				
Basic	883	982	1,081	1,229
Basic Plus	1,136	1,264	1,391	1,581
Bronze	1,140	1,267	1,395	1,586
Bronze Plus	1,303	1,449	1,595	1,813
Silver	1,551	1,724	1,898	2,158
Silver Plus	2,044	2,273	2,501	2,844
Gold	2,765	3,074	3,383	3,847
Average annual single hospital-only premium after Rebate, aged 70+ years, Apr 2026				
Basic	834	933	1,031	1,229
Basic Plus	1,073	1,200	1,327	1,581
Bronze	1,076	1,204	1,331	1,586
Bronze Plus	1,230	1,376	1,522	1,813
Silver	1,464	1,638	1,811	2,158
Silver Plus	1,930	2,158	2,387	2,844
Gold	2,610	2,919	3,229	3,847
Average annual hospital benefit paid by insurers, 2025				
0-64 years	826			
65+ years	4,494			
65-69 years	2,969			
70+ years	5,099			
All years	1,586			
Medicare Levy Surcharge (MLS) liable if no PHI, 2026-27				
MLS (range)	0	1,050 - 1,230	1,538 - 2,050	2,460+

Sources: Premiums – Private Health Insurance Ombudsman PHIS data, at April 2026. Singles hospital-only products, excluding corporate products. Benefits – APRA Membership and Benefits data, December 2025. 2025 hospital benefits paid and average hospital persons by age.

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Table 4: Average premiums after Rebate, new settings, compared with average benefits paid

Key statistics, single person ($)	Base	Tier 1	Tier 2	Tier 3
Average annual single hospital-only premium after Rebate, Apr 2026				
Basic	933	1,031	1,130	1,229
Basic Plus	1200	1,327	1,454	1,581
Bronze	1,204	1,331	1,459	1,586
Bronze Plus	1,376	1,522	1,668	1,813
Silver	1,638	1,811	1,985	2,158
Silver Plus	2,158	2,387	2,616	2,844
Gold	2,919	3,229	3,538	3,847
Average annual hospital benefit paid by insurers, 2025				
0-64 years	826			
65+ years	4,494			
65-69 years	2,969			
70+ years	5,099			
All years	1,586			
Medicare Levy Surcharge (MLS) liable if no PHI, 2026-27				
MLS (range)	0	1,050 - 1,230	1,538 - 2,050	2,460+

Sources: Premiums – Private Health Insurance Ombudsman PHIS data, at April 2026. Singles hospital-only products, excluding corporate products. Benefits – APRA Membership and Benefits data, December 2025. 2025 hospital benefits paid and average hospital persons by age.

Table 5: Proportion of insured persons aged 65+ by coverage type and hospital product tier

Proportion of 65+ insured people	Dec-21	Dec-22	Dec-23	Dec-24	Dec-25
Hospital/Combined	89.2%	88.8%	88.5%	88.1%	87.8%
Gold	*52.7%*	*50.3%*	*47.9%*	*45.2%*	*42.2%*
Silver	*32.7%*	*34.5%*	*36.4%*	*38.7%*	*41.2%*
Bronze	*2.7%*	*2.8%*	*3.0%*	*3.2%*	*3.4%*
Basic	*1.2%*	*1.2%*	*1.2%*	*1.0%*	*1.0%*
General treatment only	10.8%	11.2%	11.5%	11.9%	12.2%

Source: APRA HRF605 private health insurance reform data, December 2021 to 2025

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Notes on Table 5:

- Over the last 4 years (Dec 2021 to Dec 2025), the proportion of persons aged 65+ with hospital PHI has moved from predominantly Gold (-10.5% points) to a roughly equal proportion of silver (+8.5% points).
    - This trend is expected to continue and potentially increase based on advice from insurers about the sustainability of gold products (to be addressed through consultation on potential PHI Reforms).
- Less than 5% of older people with PHI hold Bronze or Basic cover, as those products do not provide value for older Australians given their likely health needs. We therefore do not expect to see significant downgrading to these tiers.
- The observed increase in the proportion of persons aged 65+ with general treatment only cover between 2021 and 2025 appears to reflect that people turning 65 during this period are more likely to hold general treatment only. There is no evidence of a change in behaviour towards general treatment only cover.

Table 6: Number of people aged 65+ years by specified categories

Category	All persons		Persons with PHI	
	Number	Time reference	Number	Time reference
Aged 65+ years	4.8 million	Jun 2025[1]	3.0 million	Dec 2025[4]
Aged 67+ years	4.3 million	Jun 2025[1]	n/a	-
Age pensioners – total	2.7 million	Mar 2026[2]	1.2 million	calculated[5]
Age pensioners – full-rate	1.7 million	Mar 2026[2]	n/a	-
Age pensioners – part-rate	1.0 million	Mar 2026[2]	n/a	-
Aged 65+ not receiving age pension	*2.2 million*	*calculated*[3]	n/a	-

Sources:

[1] ABS, 3101.0 National, state and territory population, September 2025, Table 59, www.abs.gov.au/statistics/people/population/national-state-and-territory-population

[2] DSS Benefit and Payment Recipient Demographics - quarterly data, March 2026, www.data.gov.au/data/dataset/dss-payment-demographic-data. Note the sum of part and full rate does not match the total; the total includes 17,975 people who are zero rate, suspended and undetermined/manual rate. Note, the annual full-rate age pension (before tax) is $31k per single or $47k per couple.

[3] Aged 65+ years at June 2025 less total age pensioners at March 2026. Note, the calculation is based on estimates at different time periods.

[4] APRA HRF605 private health insurance reform data, December 2025

[5] Calculated using the proportion of pensioners with PHI in 2020-21. The proportion was sourced from Person Level Integrated Data Asset (PLIDA), 2020-21 financial year, DOMINO Benefits history, ATO Private Health Insurance Rebate data, ABS DataLab. Findings based on use of PLIDA data.

ATTACHMENTS:

- Attachment A: Cameos
- Attachment B: Modelling outputs and explanation s47C
- Attachment C: Rebate save Q&As
- Attachment D: Impact Analysis – Modernising the Private Health Insurance Rebate
- Attachment E: Comparison of Finity and Department modelling
- Attachment F: Impact on hospital utilisation

Contact officer:	s22	Created: 5/5/26
Contact officer number:	02 5132 s22 // s22	Updated: 29/05/2026
Clearance Officer:	Ross Hawkins	Cleared: 16/05/2026
Division:	Portfolio Strategy Division	

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23 March 2026

The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme
Deputy Leader of the House

via Email minister.butler@health.com.au

This document has been released under the Freedom of Information Act 1982 (Cth.) By the Department of Health, Disability and Ageing

Dear Minister

Private Health Insurance Rebate for Australians over 65

I note the government's intention to reduce the Private Health Insurance Rebate (the Rebate) for Australians over 65 years. I understand the government is seeking savings to help address cost pressures in aged care, and I appreciate the intergenerational equity arguments you have put forward.

However, the practical effects of requiring aged pensioners and people with very low incomes to either pay more for their private health insurance or drop their cover means this policy may require adjustments.

Private Healthcare Australia (PHA) recommends retaining higher rebates for Australians who earn under $55,000 per annum and removing the age differentials at each Rebate level.

Overall, 39% of Australians with private health insurance have an income under $55,000. The vast majority of these are older Australians, profoundly affected by the government's policy changes. Many of these people have incomes under $30,000 and are living in regional areas. They are already doing it tough in the cost-of-living crisis, particularly with rising fuel costs.

While I recognise the government's equity arguments for reducing the Private Health Insurance Rebate for people over 65 years to the same rate as those under 65, the practical effect of this broad-brush policy is to make private insurance unaffordable for thousands of vulnerable Australians on very low incomes. While I note the government's modelling suggests only 44,000 people will drop their cover, these will be the most vulnerable with high care needs. We also expect tens of thousands more people to reduce their coverage.

There's a large cohort of older Australians with chronic health conditions who rely on private care, paying a very high proportion of their meagre incomes to get the health care they need to stay as active members of the community. The public hospital system is not delivering the care they need in a timely manner, and they rely on private care to manage their health.

The data provided by Finity to your department's recent review suggests it is uneconomical to reduce the rebate and push people who need a lot of care out of the private system. Making health insurance unaffordable for these older Australians will result in more crowded emergency departments, more pressure on public hospital beds and longer waiting lists.

I fully understand the intergenerational equity arguments, and reducing the rebate for older Australians on six-figure incomes makes sense. There are many older Australians on high incomes who do not need the extra support. PHA recommended reducing the rebates for high-income retirees in our Budget submission, and we recommended the benefits to be redistributed to very low-income Australians by increasing the rebates for people earning under $55,000 per annum.

However, the government's plan to simply cut the Private Health Insurance Rebate for low-income older Australians will shift costs to the public system, as these Australians are much more likely to require health care.

Private Healthcare Australia recommends the government consider a policy package with the following elements:

- Increase the Medicare Levy Surcharge (MLS) for high income Australians;
- Remove the age differentials for the Rebate while introducing a new rebate level for people earning under $55,000 (or $110,000 for couples and families) of 28%;
- From 2027, trim the Rebate levels for other income levels to whole numbers (24%,16%, 8%) to add to the revenue target, and maintain whole number rebate levels going forward; and
- Start reducing the cost base for private health care by reducing the high prices of medical devices from 1 July 2026.

Our initial estimates suggest this package would provide around 70-75% of the targeted revenue while significantly improving equity. It would protect all low-income Australians from a price shock for their private health insurance and ensure that the taxpayers would not be required to pay more to public hospitals for care than the Federal Government would save from cutting the rebate.

Our data suggests the number of people under 65 who are earning under $55,000 with private health insurance is small, so adding these people into the pool with a 28% rebate will be more than offset by reducing the rebate for people over 70 years. This also meets the government's objectives of improving generational equity.

More than half a million high income earners do not have private health insurance, even though they have the means to contribute to their own healthcare costs instead of relying solely on Medicare. We recommend increasing the Medicare Levy Surcharge to 1.5% for Tier 1 earners, and 3% for Tier 2 and 3 earners. Increasing the MLS will place downward pressure on premiums and improve insurers' risk pools, providing a more stable foundation to meet the needs of a growing and ageing population. Higher participation in private health insurance would also help reduce pressure on emergency departments and public hospitals, supporting broader government economic and health system priorities.

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As the costs of healthcare are growing rapidly, the government also needs to take action on the most overpriced part of the private system, medical devices. Many medical devices are 30%-100% more expensive in Australia compared to other markets. As a first step, bundling device pricing and benchmarking against New Zealand prices for the most common devices would save consumers around $300 million per annum.

I would welcome an opportunity to meet with you to outline our concerns with the announced policy and provide alternatives which meet the government's objectives of improving equity, capturing revenue, and improving access to health care.

Yours faithfully,

s47F

Dr Rachel David
Chief Executive Officer
Private Healthcare Australia

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By the Department of Health, Disability and Ageing

Senate Committee: Community Affairs Committee

QUESTION ON NOTICE

Budget Estimates 2026-2027
Outcome: 2 - Individual Health Benefits

PDR Number: SQ26-002771

Question Subject: Private Health – Impact Analysis

Please ensure that the **Question Subject** is appropriate. This section is populated directly from PDMS and should not be changed. If you require a change to the Question Subject please contact the Senate Estimates team.

Type of Question: Written

Senator: Anne Ruston

Question:

1. The IA notes the 'success metric' for the policy is the proportion of the population does not reduce by more 1% over the first two years.
2. How was the 1% figure determined?
3. How many policy holders does this represent?
4. Is this a gross or net figure (i.e. just people dropping or people joining minus people dropping?)
5. If the number of people who drop their cover exceeds 1%, does that constitute a policy failure?
6. What are the Government's plans if this occurs?
7. The IA notes the 1% as been chosen to account for the possible impacts of external factors, such as higher than expected cost of living pressures that differ from the modelled assumptions.

a. Did the Department's explicitly include the recent inflation spike in its modelling assumptions?

b. Did the Department explicitly include the changes to negative gearing, trusts and capital gains tax in its modelling assumptions?

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Senate Estimates Questions on Notice
Clearance Sheet

DETAILS	
Responsible Minister:	Minister Mark Butler
Hearing:	Budget Estimates
Committee:	Community Affairs Committee
Senator:	Anne Ruston
PDR Number:	SQ26-002771
Topic:	Private Health – Impact Analysis
Due to Parl Coord:	03 July 2026
Due Date to Cttee:	24 July 2026
Division/Agency:	|Systems Strategy| Portfolio Strategy
Clearance Officer: (FAS or above)	Name: Celia Street Work No: 02 5132 3759 Mobile No s22
Contact Officer: (drafting officer – EL or above)	Name: Kellie Gavin Work No: 02 5132 s22 Mobile No: s22
Date sent to MO	**(MPS Use Only)**
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Comments:

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Senate Committee: Community Affairs Committee

QUESTION ON NOTICE

Budget Estimates 2026-2027
Outcome: 2 - Individual Health Benefits

PDR Number: SQ26-002811

Question Subject: Private Health Rebates

Type of Question: Written

Senator: Jacqui Lambie

Question:

1. How many Tasmanians aged 65 and over will be affected by the proposed changes to the private health insurance rebate? Please also include the following information:
   a) How many are aged pensioners; and
   b) How many are full-rate pensions?

2. What modelling has been done on the likely effect on Tasmanian elective surgery waiting times?

3. What assessment has the Department made of the effect of these changes on older Australians on fixed incomes, including pensioners and self-funded retirees with modest incomes?

4. Can the Department release the assumptions and state-by-state modelling behind the proposal, including any modelling on pensioners, drop-outs, downgrades, public hospital demand and regional impacts?

5. Has the modelling specifically assessed the impact on public hospital demand and waiting times if participation among older Australians declines?

6. What assumptions have been made about the impact on smaller and ageing jurisdictions such as Tasmania, where public hospital capacity is more constrained?

7. Which private health insurers, consumer groups and state and territory governments were consulted prior to the decision, and what concerns were raised?

8. Were regional and ageing jurisdictions such as Tasmania consulted separately?

9. What transitional arrangements or safeguards are in place for retirees on fixed incomes who may experience affordability pressures as a result of these changes

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10. Has any additional Commonwealth funding been allocated to states and territories to manage potential increases in demand arising from this change?

Answer:

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Senate Estimates Questions on Notice
Clearance Sheet

DETAILS	
Responsible Minister:	Minister Mark Butler
Hearing:	Budget Estimates
Committee:	Community Affairs Committee
Senator:	Jacqui Lambie
PDR Number:	SQ26-002811
Topic:	Private Health Rebates
Due to Parl Coord:	03 July 2026
Due Date to Cttee:	24 July 2026
Division/Agency:	|Systems Strategy| Portfolio Strategy
Clearance Officer: (FAS or above)	Name: Celia Street Work No: 02 5132 3759 Mobile No s22
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Senate Committee: Community Affairs Committee

QUESTION ON NOTICE

Budget Estimates 2026-2027
Outcome: 2 - Individual Health Benefits

PDR Number: SQ26-002906

Question Subject: Private Health Care changes

Type of Question: Spoken, Hansard page 18, 03 June 2026

Senator: Anne Ruston

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Question:

Senator RUSTON: Well, could you clarify that for me. Maybe I didn't hear that. Have you modelled the likelihood of people who drop out of actually self-funding? How do you analyse the cost of this change on the public health system?
Mr McBride: Ms Street mentioned before that, in 2028-29, 44,000 fewer people will have private health insurance than would have otherwise had it. Over that time, the number of people on private health insurance will still grow, and the number of people on private health insurance who are over 65 will continue to grow. So it's not a reduction in the numbers on private health insurance; it's a reduction in the growth of the numbers on private health insurance. Notwithstanding that, the growth will be lower than it would have otherwise been. If all those 44,000 people went to public hospitals—and we don't think they would—then that would represent less than a one per cent increase in public hospitals. The reason why we don't think they would is that some people will self-fund, some people would have gone through the public system anyway if they went through accident and emergency, and some people would have chosen public provision of care anyway.
ACTING CHAIR: We'll rotate once you wrap up a question.
Senator RUSTON: The simple question is: have you modelled the impact on the public system of this policy change?
Senator Gallagher: He's just answered that.
Senator RUSTON: No, he hasn't.
Senator Gallagher: Yes, he has. That's the evidence.
Senator RUSTON: Well, could you answer it.
Senator Gallagher: Private health insurance membership continues to grow over time. It grows slightly less, in the order of about 44,000. If every one of those 44,000 became unwell and went to a public hospital—all of them—in one year and there were no other factors, then there would be a very modest increase in public hospital activity. That is obviously extremely unlikely to occur. It wouldn't occur. That's the evidence that you've been given today.
Senator RUSTON: My question, then, to follow on from what you've just said, Minister, is: could you provide me with what that actual impact is. You're saying it's only going to be

modest. If you think it's only going to be modest—
Senator Gallagher: It's less than one per cent. If every one of those 44,000—
Senator RUSTON: One per cent of what? What is less than one per cent?
Senator Gallagher: Of public hospital activity overall.
Senator RUSTON: Where is that?
Mr Comley: We'll take it on notice, Senator, but I think we just want to emphasise that that's if every single one of them used private rather than public, they all went to the hospital in one year and none of them self-insured at that point in time.
Mr McBride: Or would have gone to public anyway.
Mr Comley: Yes. We'll take on notice what we can provide to provide you with greater evidence than that, but you would have to heavily, heavily discount even that high-level number.

Answer:

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Senate Estimates Questions on Notice
Clearance Sheet

DETAILS	
Responsible Minister:	Minister Mark Butler
Hearing:	Budget Estimates
Committee:	Community Affairs Committee
Senator:	Anne Ruston
PDR Number:	SQ26-002906
Topic:	Private Health Care changes
Due to Parl Coord:	03 July 2026
Due Date to Cttee:	24 July 2026
Division/Agency:	|Systems Strategy| Portfolio Strategy
Clearance Officer: (FAS or above)	Name: Celia Street Work No: 02 5132 3759 Mobile No: s22
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Senate Committee: Community Affairs Committee

QUESTION ON NOTICE

Budget Estimates 2026-2027
Outcome: 2 - Individual Health Benefits

PDR Number: SQ26-002921

Question Subject: Impact of Rebate change on public hospitals

Type of Question: Spoken, Hansard page 48-49, 03 June 2026

Senator: Anne Ruston

Question:

Senator RUSTON: Earlier you answered questions from Senator Roberts regarding the one per cent. Do you have that in terms of what it means in dollars, people and beds?
Mr Hawkins: No. We've got it in real numbers. We think, as we've said, it's under one per cent; it's kind of that 44,000.
Senator RUSTON: But when you say 'one per cent', what does that mean in dollars?
Mr Hawkins: When we've taken the average activity across public hospitals and applied that number to it, it's less than one per cent of that activity.
Senator RUSTON: But what is that in dollars?
Mr Hawkins: I'd have to take that on notice.

Additional context from Hansard for the above question about the question from Senator Roberts regarding the one per cent (to be deleted before being cleared):

Senator ROBERTS: And older Australians will be paying more, which is a point that I'll get to in a minute, and this is during a cost-of-living crisis. Currently, how many seniors, effectively, will be forced to pay more for private health cover or enter the public system? Do you have any modelling?

Mr Hawkins: As we discussed this morning, 3.1 million people will be affected by the change in the rebate. We also put on record—we talked about this at length this morning—that our modelling would suggest that potentially about 44,000 might drop out of having cover and, therefore, would then no longer engage with the PHI system.

Senator ROBERTS: That's what I was after. What would be the effect of the extra load being placed on the public health system? Hospitals are already short of beds now.

Mr Hawkins: As I've said, our modelling would indicate that it's a less than one per cent impact on the public health system and, again, as we went through in quite a lot of detail this morning, that would be spread across the system, with not everyone needing to use the system at any one time. Also, we might find that people decide to opt out of PHI but then self-fund any care that they need.

Senator ROBERTS: We're already critically short of beds in many hospitals due to mass immigration. Post COVID injections, cancer detection has increased dramatically. Cancer deaths have decreased, because of treatment. But the available beds have decreased. This is going to add more strain to the public health system.

Ms Street: An additional $24.4 billion has also been invested into the public health system, bringing it up to

$220 billion over the five years. So, yes, there might be some 'additional' but, as we've said, it would be less than one per cent. We think that estimation is at the higher end, because we do think, potentially, people will self-select into private, or they may be people who are less likely to use the services anyway, so a number of

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factors contribute to that number. So we think this investment and this measure will have a minimal impact on that element.

Senator ROBERTS: What would be the total value of the extra premiums raised by those who choose to stay in the private health system?

Mr Hawkins: We've calculated that there will be an average impact of $250 on those who will have their rebate reduced. Everyone was to have access to the rebate, but it's the size of the rebate that is reducing, and our average calculation is about $250.

Senator ROBERTS: How much does the government plan to save by refusing to rebate premiums for older Australians, or by cutting them back?

Mr Hawkins: By cutting the rebate, we are looking at $3 billion.

Senator ROBERTS: Has the government modelled the extra cost to the public system by absorbing older Australians, who are more likely to require major healthcare in their elder years?

Mr Hawkins: No, we do not have that specific level of modelling. But as I've said, we have looked at and modelled what we think the impact would be, and that's under one per cent.

Senator ROBERTS: What about the chronic shortage of beds, doctors, nurses, specialists and allied health professionals in public hospitals?

Senator Green: That's veering a little bit into outcome 1, Public hospitals. But I've got Caitlin O'Brien from our public hospital team here, if you want to talk about the investment that the government is putting in through the NHRA agreement that we've put in place. Do you want to cover that?

Ms O'Brien: As Ms Street has said, an additional $219.6 billion over five years has been invested into the state- and territory-run public hospital system. Your questions in relation to workforce capacity and beds are best directed to state and territory governments who, under the National Health Reform Agreement agreed on 30 January, are very clearly listed as the stewards of their system.

Senator ROBERTS: Would you not have assessed that, though, before making the changes?

Ms Street: As we've indicated, we think the 'additional' is less than one per cent, and we think that estimation is at the higher end. So, in terms of the fiscal impact, it will depend on the services that people need and the conditions that they're seeking treatment for.

Senator Green: The officials have made this point but, again, we're investing almost $25 billion into the hospital system over the next five years.

Senator ROBERTS: Minister Clare O'Neill said, reportedly, that the budget is deliberately hitting older people. It's a tax grab because you're paying for so much waste in government.

Senator Green: I don't think that's what Minister O'Neill would have said. I think you might be verballing her.

Senator ROBERTS: I'm just going on reports. It is a fact that the budget is also hitting young people. What I'm getting at is that this is a cover for the massive waste within your government spending, and now you're going to ask older people to share in that.

Senator Green: No. We are making record investments in once-in-a-generation reforms in aged care and healthcare. That includes investing almost $25 billion into public hospitals, funding the states and territories to do the very important work that they do in making sure that the public hospital system is free.

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Senate Estimates Questions on Notice
Clearance Sheet

DETAILS	
Responsible Minister:	Minister Mark Butler
Hearing:	Budget Estimates
Committee:	Community Affairs Committee
Senator:	Anne Ruston
PDR Number:	SQ26-002921
Topic:	Average premiums
Due to Parl Coord:	03 July 2026
Due Date to Cttee:	24 July 2026
Division/Agency:	|Systems Strategy| Portfolio Strategy
Clearance Officer: (FAS or above)	Name: Celia Street Work No: 02 5132 3759 Mobile No: s22
Contact Officer: (drafting officer – EL or above)	Name: s22 Work No: 02 5132 s22 Mobile No s22
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Senate Committee: Community Affairs Committee

QUESTION ON NOTICE

Budget Estimates 2026-2027
Outcome: 2 - Individual Health Benefits

PDR Number: SQ26-002922

Question Subject: Gold premiums

Type of Question: Spoken, Hansard page 50, 03 June 2026

Senator: Anne Ruston

Question:

Senator RUSTON: I think you've also said that you thought people might reduce their cover from gold to silver-plus, even though you haven't modelled the financial impact on that potential change. I know that we've talked about this anecdotally, but I'm keen to know what services under gold older Australians draw on.
Mr McBride: Are you asking for the top five conditions that people seek treatment for in private hospitals?
Mr Hawkins: I can give you those. We've done some analysis, just in terms of what ADRGs are used.
Senator RUSTON: What are ADRGs?
Mr Hawkins: The Diagnosis Reference Groups. If you like, they are kinds of groupings. We do need to be a little careful about what's included and unpacked underneath those. Chemotherapy and pharmacotherapy are one group. Then there are lens interventions.
Senator RUSTON: Eyes?
Mr Hawkins: Eyes. Then there are hemodialysis, bone diseases and colonoscopies. They are the most utilised services.
Senator RUSTON: So not hip replacements?
Mr Hawkins: No. That's generically.
Mr Comley: Just to be helpful, perhaps I can say that I think Mr Hawkins was asked—I don't want to put words into Senator Ruston's mouth—for which services must you have gold coverage? You have been given the five that are generically used by higher age groups.
Senator RUSTON: I don't think I have that in front of me.
Mr Hawkins: I'd have to take that on notice and, specifically, go back to what's utilised under gold.
Senator RUSTON: You stated earlier that you believe that people would drop from gold to silver-plus because they'd probably still be able to access the services that they want, but you don't know what those services are.
Mr McBride: No. I guess that one of the issues—we've acknowledged this before—is that there's a price pressure on gold and, to a large extent, that is being driven by the costs of mental health and maternity. So, some insurers have been offering older Australians a silver-plus product, which covers all their key needs but not psych and maternity, so they

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can offer—
Senator RUSTON: We understand about psych and maternity, but do you need to have gold cover to get hips and knees replaced?
Mr McBride: Some silver-plus products offer that.
Senator RUSTON: How many?
Mr McBride: I don't have a count, but they are out there. Insurers have been actively writing to senior Australians to promote some of these silver-plus products.
Senator RUSTON: What would be the main thing that an older Australian would use their gold cover to access; would it be joint replacements?
Mr Hawkins: In essence, I think we've agreed to take questions such as this on notice, in order to make sure that we're giving you accurate advice.

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Senate Estimates Questions on Notice
Clearance Sheet

DETAILS	
Responsible Minister:	Minister Mark Butler
Hearing:	Budget Estimates
Committee:	Community Affairs Committee
Senator:	Anne Ruston
PDR Number:	SQ26-002922
Topic:	Gold premiums
Due to Parl Coord:	03 July 2026
Due Date to Cttee:	24 July 2026
Division/Agency:	|Systems Strategy| Portfolio Strategy
Clearance Officer: (FAS or above)	Name: Celia Street Work No: 02 5132 3759 Mobile No: s22
Contact Officer: (drafting officer – EL or above)	Name: Kellie Gavin Work No: 02 5132 s22 Mobile No: s22
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Comments:

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Senate Committee: Community Affairs Committee

QUESTION ON NOTICE

Budget Estimates 2026-2027
Outcome: 2 - Individual Health Benefits

PDR Number: SQ26-003081

Question Subject: Rebate change modelling and analysis

Type of Question: Spoken, Hansard page , 03 June 2026

Senator: Anne Ruston

Question:

Senator RUSTON: Is there any way in which you can provide us with the granular detail about how you achieved all the assumptions? I've read the impact analysis, and it doesn't provide any of the kind of detail that we're talking about now. I'd like to understand what the assumptions were and how you costed each of them, and how you modelled the value proposition of each of them. It seems to me that there is not a lot of information behind why you've reached the conclusions that you have reached: that one per cent is your threshold mark and the 44,000. Your assumptions contradict much of what has been put in the Finity report, so are we able to actually get that information? It was mentioned in the impact assessment that it was done under a particular model, and it refers to the model but, when I go onto the APH website, I can't find that model.
Ms Street: We're happy to take that on notice in terms of the provision. I understand that we also have a freedom of information request from you that goes to some of this as well. So we will try to pull that information together, in terms of the discussion about what's in the model, the modelling and the elements that go behind that impact analysis.
Senator RUSTON: So you cannot provide me with your actual modelling analysis so that we can have a look at it?
Ms Street: We'll take that on notice.
Mr Comley: We're happy to take this on notice. I just want to reiterate this issue about what we think is both modelling and analysis; they are not necessarily the same thing. There are—
Senator RUSTON: Provide them both.

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Senate Estimates Questions on Notice
Clearance Sheet

DETAILS	
Responsible Minister:	Minister Mark Butler
Hearing:	Budget Estimates
Committee:	Community Affairs Committee
Senator:	Anne Ruston
PDR Number:	SQ26-003081
Topic:	Rebate change modelling and analysis
Due to Parl Coord:	03 July 2026
Due Date to Cttee:	24 July 2026
Division/Agency:	|Systems Strategy| Portfolio Strategy
Clearance Officer: (FAS or above)	Name: Celia Street Work No: 02 5132 3759 Mobile No: s22
Contact Officer: (drafting officer – EL or above)	Name: Kellie Gavin Work No: 02 5132 s22 Mobile No s22
Date sent to MO	**(MPS Use Only)**
MO Advisor	**(MO Use Only)**
Noted in Minister's Office:	Noted **Signature**_____ **Date** ____/____/____

Comments:

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Overview | Assumptions | Execute | Reports | Save | Advanced

Scenario Name:	Rebate change costing (Option 3)
Date:	2026-27 Budget
Purpose:	This costing model reflects Option 3: Equalise Rebate rates across ages for low-middle incomes and remove Rebate for higher incomes (Tier 2).
Method:	Change rebate percentage starting from 1st April 2027 in tab "A6 Rebate"
Notes:	Outside of changing the rebates, all model assumptions align with 2026-27 Budget baseline.

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Overview | Assumptions | Execute | Reports | Save | Advanced

Economic

- Economic
- RAF
- Premium
- Income Tiers
- MLS
- Rebate

Historical and Adopted Future Inflation Rates

Year ending 30 June	CPI Rate	AWE Rate
2015	1.5%	2.0%
2016	1.0%	2.2%
2017	1.9%	1.8%
2018	2.1%	2.7%
2019	1.5%	3.1%
2020	-0.3%	4.8%
2021	3.8%	1.4%
2022	6.2%	1.9%
2023	6.0%	3.9%
2024	3.8%	4.6%
2025	2.1%	4.5%

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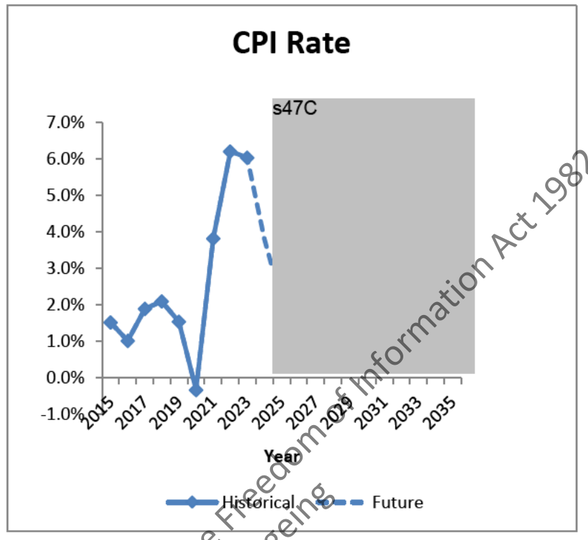

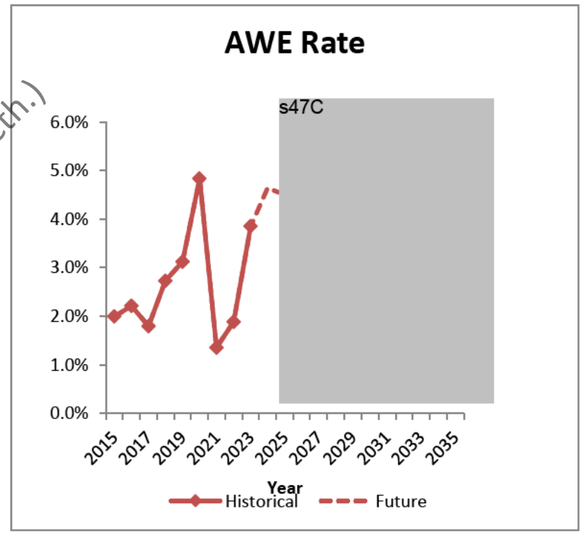

CPI: Use series "Headline consumer price index - Percentage change over year to June qtr"
AWE: Use series "Average weekly earnings (survey basis) - Percentage change over year to June qtr"

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Overview | Assumptions | Execute | Reports | Save | Advanced

- Economic
- RAF
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Rebate Adjustment Factor

Premium round growth rates used to calculate RAF during projection.

Year ending 30 June	Premium round growth rate
2015	6.18%
2016	5.59%
2017	4.84%
2018	3.95%
2019	3.25%
2020	2.92%
2021	2.74%
2022	2.70%
2023	2.90%
2024	3.03%
2025	3.73%
2026	4.41%

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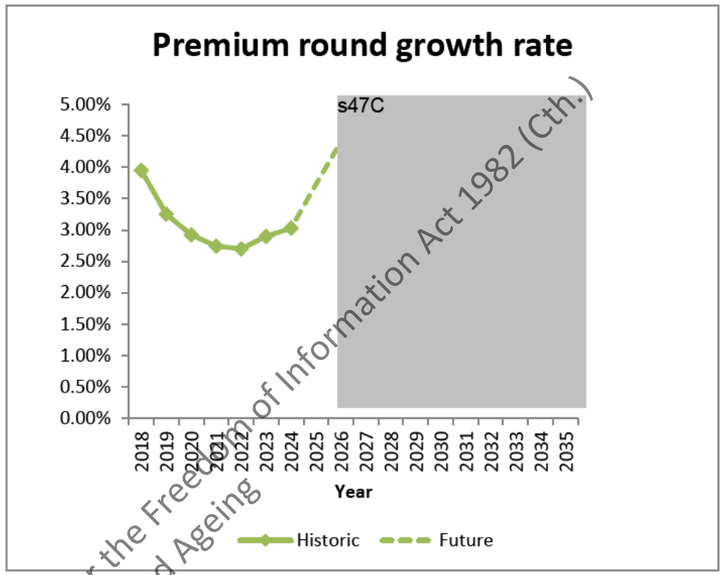

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These values are the published weighted average premium growth published by the Department at the end of the Premium Round.

RAF = 1	YEAR
Start 1 APRL	2099
END	2099

2021

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