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Reform Opportunities and Committee Support Section
Via email: Private.Hospitals@health.gov.au

Dear Reform Opportunities and Committee Support Section,

Re: Submission to the Private Health Reforms - Consultation Paper 1

The Royal Australasian College of Surgeons welcomes the opportunity to comment on the Australian Department of Health, Disability and Ageing (the Department) Consultation Paper 1 on Private Health Reforms.
We understand that the consultation canvasses feedback on reforms for consideration for the 2027 Premium Round with most measures to commence on 1 April 2027. Of the seven items covered in Tranche 1, RACS will provide commentary on following:

- Type C certification exemptions,
- Hospital in the Home (HITH),
- regional second-tier benefits, and
- private health insurance (PHI) product simplification.

Introduction

RACS recognises the critical part private hospitals play in Australia's healthcare system. Private hospitals are an important complement to public hospitals in helping to meet demand for elective procedures. They perform a substantial share of the nation's surgery, accounting for 68% of all elective surgical admissions and 59% of all hospitalisations involving surgery in 2022–23.[1] Since the COVID-19 pandemic, they have played a role in clearing the significant backlog on public surgery waiting lists.[2,3] Despite this reliance, mounting pressure on profitability has driven a wave of closures. Australia has 637 private hospitals in 2026 (including day surgeries), down from 647 in 2020, of which the net decline masks approximately 80 closures over the period.[4]

This consultation carries strategic importance beyond private health insurance alone, as its proposals would reshape the private health system in detail. RACS endorses the core of the reform agenda, particularly its emphasis on the sustainable viability of regional hospitals, new care models, administrative simplification, PHI product reform and risk equalisation. However, it overlooks the surgical workforce, despite private hospitals deriving a large portion of their income from elective surgery and requiring a strong pool of specialists to remain sustainable.

Recent RACS surveys show many Fellows consider the private health sector essential for maintaining surgical access and easing pressure on public hospitals. In our survey of 737 Australian surgeons on the major barriers to accessing timely surgery, respondents identified inadequate public hospital funding, limited theatre access, declining PHI affordability, insufficient hospital beds, and a growing cohort of uninsured patients.[5] The viability of private hospitals cannot be separated from the financial sustainability of surgical practice, which faces mounting costs across staffing, indemnity, technology, compliance, accreditation, rental and consumables.

Reform should therefore be evaluated on the broader basis of capacity, patient access, workforce sustainability and hospital infrastructure, not on PHI settings alone. While we recognise this is the first of several tranches, the significance of surgery in the private sector must be examined, addressing operating theatre load, patient access to elective surgery, service sustainability and the financial viability of surgical services. The success of these reforms may be limited unless the government treats surgery as an essential element of a functioning private health system and addresses theatre capacity, workforce shortages, affordability, clinical governance and the viability of surgical practice.

Key recommendations

The recommendations of RACS' position are summarised below:

1. Support and expand the Type C certification exemptions to patients ≥75; procedures under general/regional anaesthesia or IV sedation and further broadening the criteria to include under-16s, rural/regional/remote patients, and adjunct procedures.
2. Cautious about possible unforeseen consequences resulting from the proposals related to HITH admissions for IV infusions, complex wound care and aftercare.
3. Extend MBS telehealth items for professional attendances to HITH inpatients to surgeons and other medical practitioners to ensure ongoing hospital care.
4. Support the permanent rollout of 100% second-tier default benefits for private hospitals in MM2-MM7 replacing the current 85% default.
5. Support PHI product simplification with the view that PHI products align coverage with clinical need and foreseeable complications and emergency care across the whole treatment journey.
6. Support the removal of Basic tier products and retention of Plus products.
7. Raise the dependent age threshold to 31, with a standardised definition for "dependents" across PHI products.
8. Standardise excess and copayment terminology to strengthen informed financial consent.

Type C certifications exemptions

RACS is supportive of the current proposals to include Type C certification exemptions for patients aged ≥ 75 years of age and procedures under general/regional anaesthesia or IV sedation. Current legislation (in accordance with the *Private Health Insurance (Benefits Requirements) Rules 2011*) requires a surgeon, who admit patients for procedures normally provided out of hospital, to complete a certificate in order for the cost of accommodation to be payable by the private health insurer. Confusion and lack of certification requirements have been cited as causes for delays and rejections of these certificates, amounting to additional workload and administrative stress for surgeons and their patients. Administrative processes and regulation are frequently reported as the source of high or extreme stress for surgeons in numerous RACS Census surveys.[6] Type C certification exemptions would therefore give administrative relief to surgeons and private hospitals, and result in fewer claim disputes. Additionally, these reforms should consider stating expected payment timeframes for hospital benefits attributed to Type C certification exemptions. This is to ensure patients and private hospitals are paid in a timely manner and not subject to unexpected delays.

RACS would strongly recommend that the exemption criteria for Type C certificates are expanded to include younger patients (under 16 years of age), rural, regional and remote patients who are required to travel to larger centres for treatment, and for procedures that are adjunct to the primary admission.

In consultation with the Australian and New Zealand Association of Paediatric Surgeons, we strongly advocate for an automatic exemption for under-16s from having to complete type C certificates for procedures that in adult practice can routinely be perform in clinics or rooms. The medical, therapeutic, developmental, social and psychosocial needs of children require health

services that differ from those of adults. There are issues of perioperative safety for the paediatric population who invariably require general anaesthesia and/or sedation for procedures that in the adult population would be performed in office settings without sedation or under local anaesthetic. These interventions and procedures include dressing changes, catheter interventions, subcutaneous administrations of medications and excisions of lesions. Consequently, it is critical to provide age-appropriate healthcare in a service designed, furnished and decorated to meet the needs and developmental age of children. Directly related to the age, comorbidities, child's size and complexity of the proposed procedure; as outlined in Australian and New Zealand College of Anaesthetists, Society for Paediatric Anaesthesia in New Zealand and Australia, FRACP and hospital clinical service framework guidelines.[7,8] In nearly every area of Australia, regional and urban, this level of safety and credentialled care can only take place in inpatient facilities (although as day stay patients) and rarely in standalone day-care facilities. This important exemption will certainly reduce delays and additional certification paperwork; but on a broader level highlights that the MBS and Private Health Insurance systems need to acknowledge and support appropriate paediatric-specific care.

The inclusion of rurality to the Type C certification exemption criteria would represent a significant reform. RACS discovered through our partnership with Medibank Private on Surgical Variance Reports that geography plays a role in overnight accommodation. We discovered that extended length of stay in hospitals where outliers existed for day procedures can be due to the complexity of an operation or the distance needed to travel for a patient. After risk adjustments were made in the analysis, RACS discovered that where patients were influenced by geography, overnight stays were preferable following procedures such as varicose veins treatment and hernia repairs for the elderly.[9,10]

Furthermore, RACS encourages the Department to expand the exemption criteria to include the categories listed in the *Criteria for Type C Banding Certification A GUIDE FOR MEDICAL PRACTITIONERS*. The guide was jointly developed and endorsed by the Australian Society of Plastic Surgeons, the Australasian College of Dermatologists, General Surgeons Australia and the Australian Medical Association.[11]

Hospital in the Home (HITH)

The consultation paper states that “the minimum hospital benefit for HITH would not apply to hospital-substitute treatment, which the *Private Health Insurance Act* defines as General Treatment”. This distinction appears somewhat artificial in the context of HITH. By design, HITH is a hospital-substitution model, providing care outside the hospital setting that would otherwise be delivered during an inpatient admission. While patients remain legally admitted to hospital, the fundamental purpose of HITH is to substitute hospital-based care with an alternative model of care in the community. Clinicians will appropriately utilise HITH only when they consider it to be a safe and effective substitute for continued care in a hospital bed.

Nevertheless, patients managed under the Hospital in the Home (HITH) program remain admitted patients and should therefore be able to access appropriate clinical review equivalent to that provided during an inpatient admission. If clinicians are expected to retain responsibility for these patients, there must be practical mechanisms available to support ongoing medical oversight. Routine home visits are generally not feasible, particularly across dispersed geographic areas, and alternative models such as telehealth should therefore be supported and appropriately funded.

However, RACS notes that under the current rules, patients admitted in the HITH program are not eligible for MBS telehealth benefits, with the exemption of telehealth psychiatry. In the absence of telehealth services, it is unclear who assumes clinical responsibility for HITH patients. Clinicians cannot reasonably be expected to assume responsibility for patients whom they are unable to review and whose care they are not directly involved in managing. Given that routine home visits are generally impractical, this creates a gap in clinical oversight. Although private hospitals may

choose to retain responsibility for patients admitted in HITH programs, a more robust and clinically appropriate approach would be to enable treating clinicians to review patients either in person or via telehealth.

Overall, RACS is cautious about the proposed change to apply a minimum hospital benefit for patients admitted in the HITH program of declared private hospitals for complex wound care, IV infusions and aftercare.

RACS is concerned about the proposed treatment and definition of complex wound care. Patients with stasis ulceration, severe lymphoedema with tissue loss, and other advanced vascular conditions frequently require bed rest as an essential component of treatment. Many of these patients have already failed outpatient management and derive significant clinical benefit from a period of hospitalisation. There is a risk that the HITH proposals could inadvertently limit access to appropriate inpatient care for these patients. It is essential that this proposal does not operate to displace complex vascular patients into a community setting in which appropriate care cannot be safely delivered.

In addition, many of these patients require IV antibiotic therapy, which under the proposed arrangements may increasingly be delivered through HITH. While community-based care is appropriate for selected patients, it is important that the proposal does not create incentives that encourage the transfer of patients with highly complex vascular and wound management needs outside hospital when their clinical needs are more appropriately met in an inpatient setting.

RACS is also concerned about the implications for the proposed treatment of aftercare services. The consultation paper proposes that HITH cannot be billed for standard post-surgical aftercare. However, viewed from another perspective, this implies that billing should remain permissible in circumstances where Medicare would ordinarily allow inpatient attendance billing. For example, if a patient is admitted with a complex ulcer and requires ongoing medical review, Medicare item numbers would typically apply to inpatient attendances despite no procedure having been performed. Where that patient is subsequently managed as an inpatient through HITH, it is unclear why equivalent clinical reviews conducted via telehealth should cease to attract remuneration simply because the location of care has changed.

Therefore, RACS is supportive of expanding MBS eligibility to telehealth provided to inpatients receiving HITH treatment services. Extending MBS telehealth items for professional attendances to HITH patients would provide a practical mechanism for maintaining clinical oversight, improving patient safety, and ensuring clear accountability for care, and ensure that the clinician retains responsibility of the HITH patient for their ongoing hospital care. Furthermore, if there is to remain clinician input to these HITH admitted patients, there should be requirements for daily updates to the specialist or GP. This is supported by findings arising from a RACS rapid review that investigated the factors that either prohibit or encourage the implementation and use of telehealth and examined patient and provider perceptions of telehealth services. The key benefits were time- and cost-savings, with the same quality of care compared to standard care. Clinicians were also satisfied with telehealth, reporting shorter consultation times and increased efficiency in providing postoperative routine care (e.g. symptom and wound monitoring).[12]

Regional second-tier benefits

RACS supports the proposal to increase second-tier benefits from 85% to 100% for established private hospitals located in the Modified Monash Model (MM) classification 2-7. Among regional and remote respondents (26% of survey respondents) to a recent RACS survey about access and sustainability of surgical services, the key priorities highlighted were improving access to surgical services in regional, rural and remote communities (34%) and increasing operating theatre capacity (33%), highlighting workforce and infrastructure challenges outside metropolitan centres.[13] A permanent mandate to increase second-tier benefits to 100% for approximately 115 established

hospitals in MM2-MM7 would represent a significant reform that helps safeguard the long-term viability of these critical services and workforce.

PHI product simplification

RACS in principle supports the proposal towards simplifying PHI products with the view that it brings greater value proposition to patients and clinicians. Specifically, RACS supports initiatives to remove the Basic tier, consolidate product tiers, standardise age thresholds and dependents' eligibility, and standardise excess and co-payments.

RACS is supportive of the removal of Basic tier products. Basic products generally limit hospital benefits to palliative care, rehabilitation and psychiatric services. While many patients often perceive themselves to be privately insured, their access to hospital treatment is restricted to a very narrow range of services. Moreover, PHI products should reflect the real-world clinical needs of medical conditions or treatment, rather than relying on narrow, artificial benefit classifications. In the current setting the tier classification system has created gaps between PHI products that should be avoidable. For example, diabetes care is a Bronze tier item whereas insulin pumps are covered under Gold policies. As modern diabetes care increasingly requires the use of a pump, the term "diabetes care" should be all encompassing in whatever tier is deemed most appropriate.

In the setting of a complication resulting from a procedure in that patient's appropriate tier, which results in emergency care which is usually only provided in a higher tier, that emergency care should be covered and the process of attaining reimbursement should be streamlined. In the current setting, if a patient with Bronze cover has a laparoscopic hernia or gynaecological operation that is complicated by an injury to a major blood vessel requiring emergency life-saving vascular surgery and quite possibly a prolonged ICU admission, the private health insurers can advise the patient, hospital and surgeon that the patient was not covered for that and refuse to pay. PHI products should focus on the entire treatment journey, including foreseeable complications and emergency interventions.

While RACS is supportive of abolishing Basic tier products, we are cautious about the removal of Plus products. Eliminating the Plus categories would restrict insurers' ability to offer enhanced products that better meet members' needs. An example is Doctors Health Fund's higher-tier product, which provides benefits up to the AMA fee schedule. This type of innovation improves member outcomes and should be preserved within the private health insurance framework.

RACS reiterates its previous recommendation to increase the age threshold to 31 years for dependents, along with a standardised eligibility criteria for "dependents".[14]

Standardisation of how copayments and excess is communicated to consumers is important to provide informed financial consent (IFC). Private hospitals are required to comply with the *Private Health Insurance (Health Insurance Business) Rules 2018* and the ACSQHC Advisory AS18/10 as part of the process to obtain IFC. When out-of-pocket costs occur, complete IFC must disclose which amounts are derived from the PHI policy, clinician(s) and hospital. RACS would support the initiative to standardise application and terminology of excesses and copayments as it would assist in the IFC process.

Closing remarks

RACS thanks the Department for the opportunity to contribute to this consultation and supports the direction of the Tranche 1 reforms. We reiterate, however, that the sustainability of the private health system rests on the sustainability of surgical services, and we encourage the Department to address theatre capacity, workforce shortages, affordability, clinical governance and the viability of surgical practice as the reform program progresses through subsequent tranches.

RACS would welcome the opportunity to work with the Department on the detail of these reforms in partnership with other specialist medical colleges and specialty associations.

For further information or to discuss this submission, please contact the Policy and Advocacy team at racs.advocacy@surgeons.org.

Sincerely,

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