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Royal Australasian College of Surgeons (RACS)
Response to Consultation – Changes to Increase Patient Choice under the 2026–2031 National Health Reform Agreement (NHRA) Addendum
Patient Election and Rights of Private Practice (RoPP)

Submitted to:
Benefits Integrity Division
Department of Health, Disability and Ageing
NHRACompliance@health.gov.au

Dear Mr Williams,

The Royal Australasian College of Surgeons (RACS) would like to thank the Department of Health, Disability and Ageing for allowing RACS to provide commentary on the reforms related to patient election and Rights of Private Practice (RoPP) that were included in the *2026-2031 National Health Reform Agreement (NHRA) Addendum*.

RACS also acknowledge the findings of the *Mid-Term Review of the 2025-2026 NHRA Addendum* that indicated there were discrepancies in the application of patient electing processes for non-admitted patients, and multiple funding schemes contributing to the same episode of care (Department of Health, Disability and Ageing [DHDA] 2026a, pp. 1-2; DHDA 2026b; pp. 1-2).

1. RACS Position

RACS is supportive of the spirit of these reforms but is concerned that if implemented as described, they could create unintended consequences. RACS would be open to further discussion with the department.

RACS supports reforms which improve the transparency of health services to enable patients to have a better understanding of services provided to them and how to make informed decisions. RACS recognises that informed financial consent includes ethical, legal and practical considerations and involves obligations to stakeholders beyond the medical practitioner (Attinger 2024). RACS has been a strong supporter of the improved provision of informed financial consent and recognises that patients are increasingly likely to expect to receive sufficient information about the costs of their health care and how they can access that financing. Published guidelines from RACS and other sources are available to assist discussions between patients and their healthcare provider and understand the fees associated with their treatment (RACS 2019, AMA 2024, Commonwealth Ombudsman 2026). In achieving these objectives, RACS is also supportive of the Department's aim to enhance

patient choice, improve stewardship across the health system and to provide a more equitable public hospital funding (DHDA 2026b, p. 1).

However, the way in which the objectives are achieved can be critically important. As surgery is complex by nature, it not only involves moving between the public and private systems but also involves the interaction of many different health professionals, the patient's circumstances will often change, and clinical urgency may be different from when the decision to perform surgery was made. If administrative processes assume that care is delivered in a predictable way throughout each stage of surgery, this will create friction with the way care is actually delivered. For these reasons, RACS supports reforms in principle but requests that any amendments be carefully implemented in a way that is holistic and inclusive of all parties impacted.

2. Expanded Patient Election – Support with Important Safeguards

RACS endorses enhanced patient choice in all treatment pathways, not just in hospitalised care, and to support patients at every step (DHDA 2026a, p. 1; DHDA 2026b, pp. 1-2). RACS also concurs with the rationale for the proposals whereby patients need to distinguish between Government funding for their care (via the NHRA) and privately funded care (via Medicare, Private Health Insurance and Co-Payment). Patients should benefit from a consistent approach to the administration of their elective procedures, thereby making it easier for them to understand the funding available for their treatment. As a result, the likelihood of there being incomplete funding arrangements should be reduced. The term "single course of treatment" must also be defined more clearly before it will become operational. The NHRA Addendum specifies that where there are multiple episodes of clinically related treatment, a patient has the option to select from among these many, or any combination of these, episodes according to their preference and without regard for the outcome of treatment (NHRA Addendum 2026, clauses J31-J33, p.173). In addition, the administrative pathways of surgical treatment need to be aligned with the administrative processes for other incidents of surgical care.

More than one patient will be initially referred to a public hospital outpatient clinic, have their imaging done at an outside facility, experience a decline in health and then present privately to minimise their wait time. Some patients may require extra procedures as a result of unexpected findings or complications. These scenarios are indicative of surgical practices, rather than exceptions. RACS understands that the Department has indicated that implementation guidelines will be collaboratively developed with jurisdictions and that no administration will begin until all guidelines are complete (NHRA Addendum 2026, clauses J31-J33, p.173). RACS supports this approach. RACS believes that implementation guidelines should include specific surgical examples and allow clinically appropriate flexibility in circumstances where there is an increase in urgency, time to wait, complexity, or to allow for change to the patient's condition.

3. Patient Financial Election is not a Substitute to Informed Financial Consent

RACS considers informed financial consent a priority(RACS 2019). RACS believes that patient election reform will enhance patients' comprehension of the financial options available to them (DHDA, 2026b p.2). There are critical distinctions between informed financial consent and patient financial election. Patient election represents the funding pathway under which care will be provided. Informed financial consent is concerned with whether a patient understands the cost, consequence, and implications of their treatment. The distinction is important. The NHRA correctly states that patients should not be guided toward a specific choice, and that they should be given sufficient and relevant information that supports their ability to make informed decisions (NHRA

Addendum 2026, clauses J35-J40, pp.173-174). RACS is in strong agreement with the principles of the NHRA.

However, the process for generating documentation from administrative systems to create patient election should not override the processes that clinicians use to ensure they have provided patients with informed financial consent. When providing informed financial consent for surgical procedures, consent includes the potential for uncertain outcomes due to procedure complications, any additional tests or investigations necessary for decision making, the use of prosthetic devices, collaborating with other health professionals and unexpected outcomes during the surgical procedure itself. Each of these issues is a significant part of delivering safe and ethical surgical services. Ultimately, RACS recommends the development of explicit, national guidance confirming that the provision of patient election documentation complements the informed financial consent process conducted by the surgeon who will be performing the surgical procedure on the patient.

4. Rights of Private Practice (RoPP) – Clarity Required

RACS appreciates the Department's intent regarding increased national consistency of Rights of Private Practice arrangements to align with National Health Reform Agreement obligations (DHDA 2026a, p.2; DHDA 2026b, pp.2-3). The College recognises that differences across states and territories have resulted in lower-than-expected compliance levels with the requirements established by the Commonwealth, and clearer minimum standards may lead to better governance and compliance. However, implementation must not result in the transfer of administrative responsibilities from hospitals to clinicians. The Department advises that processes to allow patient's electing to go to private specialist rooms may affect all specialist room practices, regardless whether the specialist has diagnostic facilities, practice management systems or provides private billing (DHDA 2026b, p.3).

RACS recognizes that the development of Rights of Private Practice (RoPP) agreement forms and processes in various Australian jurisdictions has developed separately and over a long period, and the nature of these RoPP agreements has become integrated into the delivery of outpatient specialist care services, workforce delivery, and patient access pathways. RACS appreciates the government's aim to enhance the integrity of government funding, reduce the inappropriate overlap of Australian Government and State/Territory funding arrangements, and apply the patient election process in a consistent and transparent manner. It needs to be acknowledged that not all instances where funding is mixed between public and private sources has arisen from either an inappropriate practice or deliberate attempt to shift costs between taxpayer-funded public health systems and private health insurance arrangements. Instead, in many jurisdictions, patients transition between public and private health services at different stages during their treatment for reasons including clinical urgency, waiting times, affordability, availability of services, geographic access and personal choice. These transitions are often examples of the legitimate choice for patients and facilitate timely access to required services.

Different models for outpatient surgery exist in different jurisdictions. Public outpatient surgical programs have numerous potential options for the provision of appropriate care for their patients, such as the use of private surgical offices or shared public/private programs. RACS is concerned that by using a restrictive, clearly-definable understanding of "course of treatment", we may unintentionally create a barrier to patient movement between public and private health systems, as long as there is a medically warranted reason to do so. For example, a patient could have a surgical consultation at a private surgeon's office, have their procedure completed at a public hospital due to financial constraints from being required to pay for their surgery at a private surgeon's office, and receive post-operative follow up at the same private surgeon's office. Hybrid pathways are very prevalent and often offer the most effective and patient focused avenue for

access to surgical services. RACS realises that not all jurisdictions consistently apply the process of patient election to choose their provider or that patients do not always possess enough information to make fully informed decisions regarding their surgical treatment. RACS believes that increasing transparency, accountability and patient-decision-making must be the focus of reforms.

RACS is concerned there is potential the expectation will be that the surgeon will be responsible for collecting, maintaining or transmitting election data. This would represent a significant change in the level of responsibility to be held by the surgeon. Surgeons must always be accountable for making clinical decisions (including obtaining informed consent) and should not be expected to manage systems of hospital election. The NHRA correctly identifies RoPP as agreements entered into by the practitioners, and hospitals, and not an arrangement between the Commonwealth and the providers of care (NHRA Addendum 2026, clauses J41-43, p.174). RACS recommends that the implementation of these arrangements maintains this distinction, and that hospitals continue to be accountable for the operational requirements of compliance audit with these processes.

5. Data Governance and Visibility of Care Pathways

The RACS observes the Department's intention to create a uniform method of information sharing for future access to election status and treatment options for patients across different states and territories (DHDA 2026b, p. 3). This type of enhancement in information sharing will improve the transition from one clinician to another while lowering the amount of duplicated clinical service being provided to a single patient.

However, the implementation of these reforms will raise some significant questions about governance. RACS has previously stated that substantial support is needed for the interpretation of clinical activity, and that the process for creating transparency reform legislation will require safeguards for procedural fairness, verification from clinicians and clinical interpretation *in context* (RACS 2025a, RACS 2016). Most surgeons work across different sites and will each have different case-mix compared with their colleagues based on their individual practice and patient complexity, which is reflected in their clinical outcomes (ACSQHC 2024, RACS 2023, Wurdemann 2022). RACS does not believe that election-related data should be permitted to evolve into indirect measures of clinical performance for individual specialists or clinicians for any other purposes than they were originally intended to be used.

The College recommends that if any new types of reporting frameworks are to be developed in the future, they must have strong government regulations in place, specific limitations on the secondary use of these data and meaningful clinical engagement in developing these types of reporting frameworks.

6. Rural, Regional and Workforce Impacts

RACS is pleased to see that the Department acknowledges that there are unique rural and remote implications (DHDA 2026a, p.2) and therefore surgery is an important issue in this respect. Many regional services rely on integrated public and private models. Services require flexibility in the workforce with shared infrastructure, and also face administrative burdens which may result in a disproportionate impact. The NHRA also acknowledges that there are unique rural delivery arrangements, and that patients can continue to access care from their own “local needs and priorities” (NHRA Addendum 2026 p.7). Through the Rural Health Equity Strategic Action Plan and subsequent actions, RACS is acutely aware of health inequities in regional, rural and remote communities, and the challenges faced by surgeons, other specialists and hospital staff in these locations (AIHW 2025, RACS 2025b). In light of this, RACS supports dedicated transition support and an assessment of the rural impact before the introduction of the new model.

7. Interaction with Broader Health System Reform

It would appear that reforms mentioned above are being made in conjunction with larger reform projects to improve financial consent, to develop a system that enables consumers to find out about the medical costs involved in providing services from the health care sector, and to increase transparency within all health care systems. The Department had stated that their reforms are not intended to change the remuneration packages offered by providers to health care professionals (DHDA 2026b, p.2). In addition, health system reforms very seldom occur in a vacuum. RACS has work on private hospital sustainability which demonstrates that the current models of surgical delivery are experiencing heightened pressures to deliver surgical services, greater levels of incentives for delivering surgical services, and concerns regarding the viability of smaller hospitals and the availability of delivering lower volume services (RACS 2026). Stresses on private healthcare may delay or deter patients from seeking elective procedures and ultimately push more patients back to the public hospital system (Keneally 2024). Therefore, it will be important to monitor how these reforms are implemented to ensure that access to services is not inadvertently limited or that consumers do not experience discouragement to participate in care models that are based on both public and private sectors.

8. Conclusion

RACS supports the Government's goal of enhancing patients' options, improving informed monetary approval, and maintaining the integrity of funding in public hospital care. Surgical care, on the other hand, has a dynamic system of progressively changing patient trends that require adaptability, consistent governing standards, and execution out of a clinical framework. RACS endorses reform in-principle but believes refinements of the reform model(s), the establishment of a national framework, and the delivery of monumentally incremental reforms are requirements to enhance rather than artificially limit patients' access to surgical care. RACS looks forward to working with the Department in the future and to be involved in future implementation and co-design initiatives.

Yours sincerely,

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President
Royal Australasian College of Surgeons (RACS)

Royal Australasian College of Surgeons

RACS is the leading advocate for surgical standards, professionalism and education in Australia and Aotearoa New Zealand. The College represents close to 8,000 surgeons, and 1,300 surgical trainees and specialist international medical graduates (SIMGs). As a not-for-profit organisation, RACS funds surgical research, advocates for members and patients, and supports healthcare, as well as providing surgical education in the Indo-Pacific. RACS trains surgeons in 9 main specialties: Cardiothoracic, General Surgery, Neurosurgery, Orthopaedics, Otolaryngology Head and Neck, Paediatrics, Plastic and Reconstructive, Urology and Vascular Surgery.

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