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Private Health Sector Reforms- Consultation Paper 1

Department of Health, Disability and Ageing

August 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,400 physicians and 9,800 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties which work within and across the private and public health sectors, including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

Contact Peter Lalli, Senior Policy & Advocacy Officer via policy@racp.edu.au for inquiries.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide feedback to the Department of Health, Disability and Ageing (the Department) *Private Health Sector Reforms - Consultation Paper 1* on measures to strengthen Australia's private health system.

As the College responsible for training and representing physicians in Australia across a range of settings and jurisdictions, we have a strong stake in reforms affecting workforce sustainability, models of care, patient access and the relationship between public and private health services.

Our submission focuses on reform proposals and selected questions of relevance to RACP members, including neonatal paediatric care, Hospital in the Home (HITH), Type C Certification requirements, and Second Tier benefits for regional private hospitals.

Recommendations for the Department

1. **Fast-track Medical Services Advisory Committee (MSAC) review of paediatric MBS items** for neonatal hospital-based care, in collaboration with the RACP Paediatric and Child Health Division, to better reflect contemporary clinical realities and the value of neonatal care involving paediatricians.
2. **Apply strong safeguards to expanding HITH models of care**, noting the critical need for appropriate funding, sound digital infrastructure, care escalation protocols, and patient safety mechanisms in this expansion.
3. **Maintain flexibility for telehealth use in HITH**, with consultation modalities determined by clinical judgement and patient need.
4. **Develop expanded criteria for Type C Certificate exemptions**, to include intravenous (IV) sedation and age-related fragility, alongside further relevant indicators of patient complexity across the life course.
5. **Lift the benefit threshold from 85% to 100% for private hospitals in regional, rural and remote areas**, where it would clearly maintain the viability of healthcare services and improve access to the physician workforce.
6. **Prioritise rural and remote private hospitals,** which may have lower levels of resourcing, higher operational sustainability risks, and for which there may be few alternative services and carefully monitor and consult on any future out-of-pocket cost implications of the proposal for patients.

Review of paediatrician MBS items for neonatal care

Do you agree or disagree that there should be consideration of an amendment to the MBS item for paediatricians? Please specify why.

MBS item reform to better align with contemporary clinical realities of paediatrician-led neonatal care in hospitals is a priority for the RACP and our Paediatrics and Child Health Division (PCHD) responsible for training and representing Australia's paediatricians.

We welcome the proposal to seek MSAC consideration of an amendment to paediatrician MBS items for neonatal health support in hospital settings.

As the consultation paper notes, the time paediatricians allocate to health checks for neonates in hospital settings is not comprehensively costed by insurers nor factored adequately in current Medicare design, despite being common practice in maternal and neonatal care to advise on clinical interventions, monitor indicators, and flag and exclude concerns.

Private health exclusions of neonatal care for babies not occupying a separate bed from the patient and MBS item rules and rebates misaligned with the complexities of neonatal care make such care administratively complex for paediatricians, and confusing and costly for patients. Specific issues include:

- MBS items 110/116 require two distinct episodes of care with specific time durations, an initial comprehensive assessment and a subsequent consultation, while neonatal care for well and unwell children, monitoring and allocation of paediatrician time can be continuous and thus not fitting well within item design parameters.
- Since rebate levels for items 110/116 are misaligned with the ongoing nature of paediatric clinical health checks and working models of paediatrician care, their use can leave patients with unexpected out-of-pocket costs for the overall care of a neonate.
- Time-based models for MBS items 160 and 161 do not reflect the varying degrees of clinical complexity, follow up and resourcing required for neonates at imminent risk of death.

The reform of MBS items must centre paediatricians as foundational to good clinical outcomes in complex pregnancies, for neonates born to patients with a chronic health condition, or where there are significant obstetric risks.

The proposed review must centre the best practice objectives of:

- **Reforming the MBS** to better facilitate paediatrician care for neonates at all points during a 'stay' in hospital after birth
- **Mitigating unmet need** for paediatricians in neonatal care
- **Reducing avoidable delays** to skilled neonatal care for children who may require it, and concerned caregivers
- **Integrating paediatricians** more seamlessly in birth delivery settings for responsive care, particularly where complexities might be involved or clinical needs intersect.

PCHD would welcome the opportunity to extend its expertise to MSAC for the proposed review.

Hospital in the Home (HITH) expansion

Can hospitals and insurers implement this proposal as described?

Consistent with the HITH expansion proposal, the RACP's evidence-based Model of Chronic Care Management urges governments across Australia to better design and fund rehabilitation at home, hospital-at-home units, early supported discharge, virtual care, remote monitoring, and community-based specialist care.

Our RACP submissions to the Independent Hospital and Aged Care Pricing Authority to the consultations of the 2024-25 and 2027-28 Pricing Framework for Australian Public Hospital Services also advocate for adequate pricing for ambulatory care programs, clinician outreach, in-reach, HITH programs, and innovative care models using telehealth and remote monitoring technologies.

The RACP supports HITH where it provides clinically appropriate hospital-level care, improves continuity of care, reduces avoidable in-hospital admissions and supports patient-centred care. We do however note HITH will not be appropriate for some patients due to the level of complexity, safety concerns, or inadequacies in the home environment.

The RACP argues that the practical success, safety, equity and viability of HITH will depend upon:

- **Fixing gaps in Australia's digital and information technology infrastructure** in regional, rural and remote areas as these now restrict remote monitoring and virtual care integration.
- **Appropriately factoring patient complexity in funding and pricing mechanisms**. Funding for HITH needs to account for disability, frailty, psychosocial complexity, mental illness, discharge complexity and community reintegration complexity.

- **Pricing rules and levels which account for the whole episode of HITH care**, inclusive of clinical outreach travel, consultation, escalation or monitoring, care coordination and interdisciplinary communication required.
- **Clear escalation pathways** to physicians for care for patients accessing HITH.
- **Appropriate community service planning** so that patients can access individual support and wrap-around care in the HITH set up.
- **Ongoing impact evaluation** that factors patient outcomes, safety indicators, utilisation patterns and equity impacts to carefully guide expansion at an appropriate scale.

Addressing these issues in the consultation report will demonstrate strong commitment to sustainable HITH rollout underpinned by a realistic view of expected challenges.

Do you have any comments regarding the interaction of MBS and professional services attendance billing and the feasibility of this reform proposal? Please comment on professional services attendance billing for telehealth to support the ongoing management of patients receiving HITH treatment services under this proposal.

The RACP position on the important role of telehealth in physician care applies across the public and private health sectors, service delivery designs, trainee and physician work settings and patient cohorts.

The RACP strongly advocates for telehealth guidelines which allow physicians to negotiate and decide on the consultation modalities they use with their patients, factoring in unique clinical needs, clinical safety, equity and access requirements of those patients. Our position centres the professional judgement of the physician, patient preference and circumstance and patient-centred communication in determining an appropriate consultation modality, whether in-person, phone, video, or a mix.

We do not support a one-size-fits-all consultation format for direct-patient care and caution against preclusion of telehealth for HITH.

The benefits of a flexible approach that encompasses telephone, video and in-person consultation modalities for HITH patients is clear in the following scenarios:

- Where geography, distance, travel, workforce constraints, or the logistics of facilitating a physician visit to the home render an in-person consultation difficult for HITH.
- Where a HITH patient requires immediate advice or care that is difficult to deliver on an in-person basis for physicians facing workforce challenges and patient case load or time constraints.
- Where a patient with a clinically indicated condition is accessing HITH as a specific alternative to in-person care due to insufficient hospital beds, and where rapid consultation is required.
- Where psychosocial conditions or vulnerabilities make it more appropriate for a physician consultation to occur remotely.

The proposed restriction on telehealth in HITH risks reducing patient choice or limiting care delivery flexibility for patients whose clinical needs can be safely managed by HITH remotely. It also risks compounding access barriers for patients in rural and remote settings, and for patients with disabilities or other challenges that prevent or restrict travel.

The RACP's submission to the Medicare Review Advisory Committee's *Post Implementation Review of MBS Telehealth items* summarises the results of our comprehensive review of the evidence base for delivering telehealth effectively. This review showed that telehealth – both via phone or video – generally provides equal clinical benefit to in-person care for many chronic and complex conditions and clinical encounters. As with in-person consultations, telehealth enables appropriate history taking, confirmation of patient understanding of their conditions, shared decision making, referrals and medication reviews. We draw attention to the relevant evidence included in our submission to this consultation.

Type C certification requirements: exemption criteria

Administrative load is one of the many drivers of workplace stress and burnout for physicians in clinical practice and we appreciate that the proposed reforms to the Benefit Requirements Rules aim to reduce this burden for the completion of Type C Certificates when balanced with patient monitoring, safety and clinical care considerations.

We cautiously support the two specific exemption criteria proposed and consider that advanced chronological age and procedural sedation represent only two of a more comprehensive set of patient complexity indicators which inform hospital resource allocation and use. For all patient cohorts and ages, as foreshadowed in our comments on HITH, disability, psychosocial complexity, chronic complexity, frailty, discharge complexity, care continuity, coordination complexity and level of family or carer support inform hospital resource allocation decisions. These factors should be considered for an expanded set of criteria that might trigger a Type B procedure benefit level. This would better reflect the practical nature and intensity of resource use involved in delivering appropriate physician care.

We caution that it will be necessary to consider in parallel the number of operational beds in the private hospital sector and any operational constraints which could limit the implementations of the proposed reform, particularly for patients facing hospital bed shortfalls, such as complex paediatric or older adult patients.

Improving access to regional private hospitals

The proposal as set out in the consultation paper is to increase second-tier benefit levels from 85% to 100% for established private hospitals in Modified Monash Model areas 2-7. We note this is intended as a short-term reform to keep established regional private hospitals viable in response to the Federal Government's standing concerns for the viability of regional private hospitals in Australia.

Against a backdrop of poorer health outcomes in rural and remote communities and pronounced physician workforce shortages, the RACP has published a *Regional, Rural and Remote Physician Strategy* (RRR Strategy), demonstrating our commitment to improve the distribution of the trainee physician and physician workforces in regional, rural and remote areas across workplaces and clinical settings.

Maintaining high quality, well-funded and operational hospitals is core to the objectives of our RRR strategy. Private hospitals in regional, rural and remote areas provide some of the non-traditional service settings for accredited training positions managed by the RACP under the Australian Government's Specialist Training Program, alongside rotational settings for jurisdictional specialist training places.

The consultation proposal to lift second-tier benefits from 85% to 100% for private hospitals in Modified Monash Model 2-7 areas has merit where it is clear it would maintain the viability of healthcare services in regional, rural and remote communities, and access to the physician workforce.

Initial implementation should prioritise rural and remote private hospitals which may have lower levels of resourcing, higher operational sustainability risks, and for which there may be few alternative services.

However, we stress the need for careful monitoring of potential cost implications of the proposal for patients. This is an important balancing factor in continuing to negotiate access and patient intake pressures across hospital settings, both public and private. Any cost-related disincentives on continuing private coverage could stand to increase the burden on public health systems and workforces and exacerbate patient treatment delays.

We also stress the importance of rigorously evaluating second-tier benefit level reforms, considering changes to clinical activity levels, service availability, patient satisfaction, travel requirements and costs, health workforce attraction and retention, and impact on communities and hospital services overall.

Summary remarks

With acknowledgement of several concerns expressed in this response, the RACP offers in-principle support for the proposed reforms.

We reiterate that private health reform should always support better patient outcomes, innovative models of care, overall health system sustainability, and access to the physician workforce. It must be underpinned by strong accountability and evaluation frameworks.

In reforming private health care, the Department must closely consider interactions between funding settings, service viability, workforce capacity and equitable access to care.

We look forward to ongoing engagement as the reform proposals progress. Please contact Peter Lalli, Senior Policy and Advocacy Officer, via the Policy and Advocacy unit at policy@racp.edu.au.