Ramsay Health Care

Private Health Sector Reform

Consultation Paper 1

Ramsay Health Care Response

17 August 2026

Ramsay
Health Care

About Ramsay Health Care

From a single mental health facility opened by Paul Ramsay AO on Sydney's North Shore in 1964, Ramsay Health Care (Ramsay) has grown into Australia's largest private hospital operator and a global healthcare leader. Today, we care for more than 14 million patients annually across more than 500 locations in Australia, the UK and Europe.

In Australia, Ramsay operates a network of over 70 hospitals and day surgeries that provide services across the entire patient journey. Each year, we manage over 1.3 million admissions, including more than 100,000 public patients, perform almost 700,000 surgeries and manage 275,000 emergency presentations. Alongside acute medical, surgical, mental health and rehabilitation care, we also deliver vital services to the community through hospital-in-the-home and via our network of over 100 pharmacies.

Guided by our purpose, "People Caring for People," we place our people at the centre of everything we do. As Australia's fifth largest employer, Ramay employs over 35,000 people. This includes more than 19,000 nurses and midwives who work alongside our 9,000 partner doctors.

Ramsay's impact extends well beyond our wards. In FY25, we contributed $4.9 billion to the Australian economy, and we drive clinical innovation through a national program of over 280 clinical trials.

Australia's world-class health system relies on a strong public-private partnership. Currently, around 45% of Australians hold private hospital cover, with private hospitals delivering 70% of all elective surgeries and contributing $14 billion to GDP annually. Private hospitals relieve pressure on the public system, support patient choice and timely access to care and contribute to workforce development and clinical innovation. A strong, sustainable private hospital sector is essential, not only for the millions of Australians who rely on it each year, but for the sustainability of Australia's health system as a whole.

Ramsay Health Care

Reform Opportunities and Committee Support Section

Private Hospitals Branch

Australian Government Department of Health, Disability and Ageing

Submitted via the consultation hub

Re: Private health sector reform consultation paper 1

Dear Sir / Madam,

Thank you for the opportunity to submit a response to Consultation Paper 1 regarding proposed reforms to the private health sector.

As Australia's largest private hospital operator, Ramsay Health Care Limited and its subsidiaries (Ramsay) shares the Government's vision of a sustainable, transparent and patient-centric health system. The initiatives outlined in Consultation Paper 1 represent critical and timely opportunities to ensure our hospitals can continue their vital role in delivering high-quality healthcare to Australians.

Ramsay strongly supports the overarching objectives of this reform agenda. We view the prioritisation of contemporary care models, particularly in mental health and maternity, as a strategic imperative. Reforming the s19AB Medicare moratorium and modernising MBS case conferencing arrangements will help to restore clinical capacity and patient access to private mental health services. Similarly, we view the proposed PHI and waiting period reforms for maternity care, alongside the creation of a targeted Risk Equalisation pool, as crucial interventions to help stabilise a sector facing significant financial headwinds.

We also commend the Department's focus on enabling modernised care delivery and reducing administrative friction. The expansion of Hospital in the Home (HITH) in the private sector is a shared priority. As detailed in our submission, we are supportive of the introduction of a minimum hospital benefit for HITH, however this should be accompanied by necessary MBS reform to support appropriate clinical governance. Further, we welcome the intent to streamline Type C certifications, which will redirect thousands of administrative hours back to direct patient care.

Finally, Ramsay is supportive of targeted measures that aim to maintain regional access to private healthcare and enhance consumer trust in the sector. To restore genuine transparency and a guarantee that every PHI product sold delivers value to Australian consumers, Ramsay suggests the Department considers a fundamental redesign of the tiered system.

Ramsay is committed to being an active, constructive partner to the Government throughout this reform process. We look forward to ongoing dialogue and working collaboratively with the sector as these reforms are refined and implemented.

Should you require further information regarding our submission, please do not hesitate to get in contact.

Yours sincerely,

Natalie Davis

Group CEO and Managing Director

17 August 2026

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Executive summary

Ramsay welcomes the opportunity to provide feedback on the Australian Government Department of Health, Disability and Ageing's (the Department) proposed reforms to the private health sector.

As Australia's largest private hospital operator, we strongly support the overarching objectives of Consultation Paper 1. The initiatives outlined in the paper represent critical opportunities to alleviate acute structural and financial pressures on private hospitals, to empower patients by enabling choice and transparency, and to ensure the private sector can continue its essential role in relieving demand on Australia's increasingly overburdened public hospital system.

An overview of Ramsay's response to the reforms and initiatives proposed in Consultation Paper 1 is provided below.

1 Prioritising contemporary models of care

1.1 Mental health care

Ramsay **supports** the Department's proposed reforms to the private mental health sector as a critical pathway to secure the sector's long-term clinical and operational sustainability.

Managing 60% of all acute mental health admissions, private psychiatric hospitals are an essential pillar of Australia's health system. By supporting private mental health services to remain viable, these proposed reforms will enhance access and choice for Australians experiencing moderate-to-severe mental health conditions, while alleviating downstream emergency and outpatient pressures on an overburdened public hospital system. Specifically, Ramsay supports the proposed targeted amendment to the s19AB Medicare moratorium, modernising MBS inpatient case conferencing items to support contemporary multidisciplinary practice, and the strategic re-establishment of the Private Mental Health Alliance (PMHA). Together, these measures will help to safeguard the viability of private inpatient services and ensure timely, high-quality care for patients.

1.2 Maternity care

Ramsay **supports** the proposed maternity care reforms as a major step forward towards restoring the long-term viability of private maternity services across Australia.

The private maternity sector is currently facing acute financial and operational pressures, compounded by declining national fertility rates and a sharp drop in Gold-tier private health insurance (PHI) policy coverage. We welcome the proposed reforms that aim to address consumer affordability concerns and barriers to access. Specifically, reviewing and adjusting the waiting periods and product tier structure for pregnancy and birth will help to reduce arbitrary barriers to access, protect consumer choice and alleviate mounting operational and financial strains on private providers. Ultimately, stabilising private maternity viability will help to ensure that the private sector can continue its essential role in relieving acute demand pressures on the public hospital system.

Beyond PHI reform, Ramsay welcomes the opportunity to participate in the development of innovative and safe private maternity care models, recognising that consumer expectations are evolving and providing high-value, continuous care is essential to protect the sector's future sustainability. Additionally, we support the proposed MBS amendments for routine newborn paediatric assessments. These changes would help to improve financial transparency for young families and better support the retention of an essential specialist workforce, particularly in regional areas.

1.3 Hospital in the home

Ramsay welcomes the Department's proposed reforms to Hospital in the Home (HITH) services and **supports the overarching objective** of expanding consumer access to private, home-based acute care with the introduction of a minimum hospital benefit.

However, the proposed flat rate of $360 per day may be insufficient to support genuine, comprehensive hospital-level substitution. At this rate, providers will be restricted to delivering single-intervention treatments, precluding the viability of high-acuity, multidisciplinary services such as palliative care and complex intravenous (IV) chemotherapy. To ensure the private sector can safely scale these resource-intensive services, Ramsay recommends a two-tiered minimum benefit structure be considered. This could include a single-intervention tier at the proposed $360 per day and a comprehensive tier at approximately $650 per day. This structure would more accurately reflect the true costs of delivering high-quality, hospital-level care within a patient's home. Additionally, to ensure true equity of access, a distance-based loading should be considered to offset the significant logistical costs of delivering care to regional and rural patients.

For HITH models to be successfully implemented and embraced by medical practitioners, the introduction of a minimum benefit must be accompanied by concurrent Medicare Benefits Schedule (MBS) reform to allow medical specialists and Nurse Practitioners to safely govern and monitor admitted HITH patients remotely. Coupled with flexible regulatory pathways (such as remote checking for cytotoxic drugs) and dedicated innovation funding for digital infrastructure, these measures will help to ensure private HITH services are both clinically safe for patients and commercially sustainable for providers.

1.4 Type C certification requirements

Ramsay **supports** the Department's intent to modernise the Type C certification requirements framework through the introduction of two proposed standing exemption criteria and the reclassification of MBS item 14245 from a Type C to a Type B procedure.

In our view, the current case-by-case certification model places a disproportionate and unnecessary administrative burden on clinicians and hospital administrators, frequently forcing them to manually justify hospital admissions that are common clinical practice and mandated by national clinical safety guidelines. To fully realise the benefits of this proposed modernisation, the inclusion of two additional standing exemptions should be considered. First, a standing exemption for high-risk and highly complex patients, governed by a dynamically reviewed, Department-controlled definition. Second, an exemption for geographically isolated patients residing more than 100 kilometres from a hospital, for whom same-day discharge is often clinically unsafe.

By aligning private health insurance regulations with objective clinical risk factors, these reforms will help to reduce commercial friction between hospitals and insurers and allow the sector to redirect thousands of administrative hours back toward frontline patient care.

2 Delivering better value for consumers

2.1 Improving access to regional hospitals

Ramsay is **supportive** of targeted measures that aim to maintain regional access to private healthcare. However, any changes to the second-tier default benefit mechanism must be carefully considered to ensure that this reform acts as a genuine safety net for existing regional hospitals, rather than a mechanism that could distort the market or disincentivise commercial contracting.

To support implementation and avoid unintended consequences from this reform, Ramsay would support the publication of second-tier rates and the introduction of a "Better Off Overall Test" to ensure that no negotiated commercial agreement can leave a regional facility financially worse off than the baseline second-tier rates.

2.2 Product simplification

Ramsay **supports** the Department's proposed initiatives to simplify PHI products, including standardising age thresholds for dependants, excess and co-payment arrangements, and ensuring consistency across premium structures.

The proliferation of opaque product tiers, exclusionary so-called "junk" policies and unpredictable co-payments has fostered widespread consumer confusion and frequent "bill shock" that has ultimately eroded trust in the private healthcare sector. To restore genuine transparency and trust that every PHI product sold delivers reliable, tangible value to Australian consumers, a fundamental redesign of the current multi-tiered product structure (Bronze, Silver, Gold, and "Plus" variants) should be considered.

2.3 Risk equalisation

Ramsay **supports** targeted recalibrations to the Risk Equalisation (RE) system to uphold the principle of community rating and reduce commercial disincentives for insurers to offer comprehensive products.

Specifically, Ramsay supports the creation of a dedicated risk pool for maternity services to alleviate the disproportionate financial barriers currently facing young families seeking to access private maternity care. In doing so, the Department should consider tying RE reform to clinical categories, as opposed to specific product tiers, to avoid unintentionally removing subsidisation from more affordable products (e.g., Silver Plus policies that currently offer maternity cover). However, the material benefit of establishing a specific risk pool for mental health is less clear, noting that these claims are already dispersed across age cohorts and may be better supported by addressing structural loopholes, such as waiting period waivers.

3 Other considerations

Ramsay notes the Department's intention to undertake further sector consultation over the coming months on reducing information asymmetries for productive collaboration and delivering better value for consumers. Ramsay has suggested a number of other topics for the Department to consider for inclusion in these consultations, in addition to those raised in Consultation Paper 1. These include:

- A Commonwealth-led Ministerial process to establish multi-year public-private agreements to use excess private capacity for public patients, reducing elective surgery and emergency department wait times and the need for new public infrastructure
- A mandated minimum hospital benefit payout ratio from insurers to fund care without premium increases, noting payout ratios have fallen from 88% to 84% over recent years, while insurer profits rose 28%
- Expanded specialist and Nurse Practitioner training in private hospitals, including cross-sector rotational pathways and regional placements, through an expansion of the Private Hospital Training and Support and Specialist Training Programs
- Dedicated innovation and data-interoperability funding to accelerate digital transformation, increase productivity, secure clinical information sharing and infrastructure renewal across the system
- Improved access to Research and Development (R&D) tax incentives, leveraging the Government's 2026 Strategic Examination of R&D, to drive clinical innovation
- Federal support for nursing wage growth, to stabilise the workforce and mitigate the risk of sharp increases to PHI premiums
- A regulatory framework to preserve clinical independence and consumer choice and strengthen competition within the sector.

1 Prioritising contemporary models of care

This section outlines Ramsay's response to Part 1 of the Consultation Paper including:

1.1 Mental health care

1.2 Maternity care

1.3 Hospital in the home

1.4 Type C certification requirements

1 Prioritising contemporary models of care

1.1 Mental health care

Ramsay supports the Department's focus on reforming the private mental health sector to ensure its long-term clinical and operational sustainability. Delivering 60% of all acute mental health admissions[1], Australia's private psychiatric hospitals provide a vital complement to the public mental health system. Rather than viewing public and private mental health care as entirely separate systems, there is a critical opportunity to foster greater integration and collaboration across the Australian mental health system to ultimately enhance access and choice for Australians experiencing moderate-to-severe mental health conditions.

The initiatives proposed represent crucial opportunities to address workforce shortages and funding barriers that currently restrict patient access to high-acuity private mental health care. As detailed in the following section, Ramsay supports the proposed targeted amendment to the s19AB Medicare moratorium, modernising MBS inpatient case conferencing items to support contemporary multidisciplinary practice, and the strategic re-establishment of the Private Mental Health Alliance (PMHA). Together, these reforms will help to enhance patient choice, secure the viability of private psychiatric facilities, and alleviate downstream pressure on the broader public health system.

Ramsay's response to each of the Department's proposed initiatives and consultation questions is provided below. Additional comments and suggestions are also included on Page 11, for the Department's consideration.

Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals

Ramsay **supports** targeted amendments to the Medicare moratorium (s19AB) to enable overseas-trained psychiatrists (IMGs) to practice in private hospitals not located in a District of Workforce Shortage (DWS). Private mental health facilities are facing significant workforce constraints. Many private psychiatric beds are underutilised, not due to a lack of patient demand, but frequently due of a critical shortage of psychiatrists available to admit and manage patients. Expanding the eligible workforce pool is a vital step forward in safeguarding the sustainability of the private mental health sector and alleviating pressure on the public system.

Consultation question
a) What difference would this reform initiative make for patients requiring access to mental health treatment?

For patients requiring mental health treatment, this reform would directly translate to faster access to acute care and meaningful choice regarding where and how that care is provided.

Currently, patients experiencing moderate to severe mental health episodes often face extended wait times to access an admitting psychiatrist. By addressing the maldistribution of specialist psychiatrists and enabling IMGs to access MBS payments in non-DWS private settings, this reform would make a difference for patients in several ways:

- **Reduced inpatient and outpatient wait times:** The sector is currently seeing partial ward closures, and in some instances, complete closures of psychiatric hospitals, due to a critical lack of Medicare-eligible psychiatrists available to admit and manage private inpatients. This not only denies acutely unwell patients from accessing timely inpatient mental health care but can also drive wait times for outpatient psychiatric consultations in metropolitan areas. Expanding the pool of admitting psychiatrists in private hospitals in non-DWS areas would directly alleviate inpatient access blocks, which would also flow through to reduced outpatient wait times.

[1] Australian Institute of Health and Welfare. (2026). Admitted Patient Care 2024-25.

- **Access to complex care infrastructure:** Treatment for patients experiencing complex psychiatric conditions, such as eating disorders, addiction, and complex mood disorders, often relies on access to multidisciplinary teams, specialised day programs, and dedicated inpatient units. The 10-year moratorium uses a historical geographic tool (DWS) originally designed primarily to increase the supply of General Practitioners in rural and remote areas. Applying this same blunt instrument to highly specialised professions such as psychiatry does not take into consideration the infrastructure required for high-acuity inpatient mental health care. The facilities where this infrastructure is available are mostly concentrated in metropolitan and regional hubs, not necessarily in DWS postcodes. This reform would therefore help to ensure that patients can access inpatient specialist care where the necessary clinical infrastructure actually exists.
- **Enhanced patient choice:** By addressing the critical shortage of Medicare-eligible psychiatrists in private hospitals and improving the viability of private inpatient mental health services, patients will have improved choice regarding where they receive their treatment and who provides their care.
- **Reduced economic and social costs:** When patients with moderate to severe psychiatric illnesses experience delayed access to care, their conditions inevitably deteriorate. For the patient, this can lead to increased workplace absenteeism and long-term disability. Systemically, this deterioration can force patients to rely on public emergency services, which can drive avoidable presentations and shift pressure onto the already overstretched public mental health and hospital system. Ensuring timely access to private intervention can mitigate these downstream socio-economic impacts.

Consultation question
b) Would this reform initiative support the viability of private mental health services?

Yes, Ramsay believes this reform would be highly effective in supporting the clinical and economic viability of private mental health services.

The Section 19AB Medicare moratorium is currently the single largest structural barrier preventing highly qualified international non-GP specialists from supporting metropolitan private facilities. It directly impacts the capacity of the private psychiatric sector to manage the highest volume of mental health presentations, namely, high-prevalence, moderate-to-severe disorders.

By removing this barrier, the viability and sustainability of private mental health services would be supported by restoring capacity and stabilising occupancy. For hospital operators, financial and operational viability is directly tied to clinical capacity and occupancy. Currently, workforce shortages have forced private psychiatric hospitals to close partial wards, and in some cases shut down facilities entirely, due to a lack of Medicare-eligible psychiatrists available to admit and manage patients. Supporting IMGs to work in private inpatient settings in non-DWS areas would help to improve bed occupancy and facility utilisation, allowing providers like Ramsay to keep vital psychiatric wards open, run group day programs at full capacity and confidently invest in contemporary, multidisciplinary models of care.

Consultation question
c) Would this initiative impact upon other parts of the mental health system, including the mental health workforce? Please provide details.

Yes, this initiative would likely have a positive impact on the broader mental health system, beyond the private sector.

In addition to improved patient access and private hospital viability, this reform would likely trigger positive systemic shifts across the entire Australian healthcare landscape by stabilising the mental health workforce and optimising care delivery across both public and private sectors.

Anticipated impacts include:

- **Expanded training and supervision capacity:** The training pipeline for future Australian psychiatrists relies heavily on the availability of senior supervising consultants. By expanding the pool of senior IMG psychiatrists practicing in private hospitals, the private sector could significantly scale up its capacity to take on trainees. This would help to shift a portion of the long-term training and supervisory burden away from the overstretched public system and strengthen the future pipeline of the domestic medical workforce.
- **Improved retention of the broader mental health workforce:** Psychiatrists serve as the clinical anchors for inpatient mental health wards and programs. When psychiatrist shortages force ward closures, specialised mental health nurses, clinical psychologists, occupational therapists, and social workers face loss of employment or reduced clinical hours. Securing the operational viability of these units would directly support job security, skill development, and retention for the broader mental health workforce.
- **Reduced public system strain:** Recent data from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) highlights that the psychiatry workforce currently meets only 56% of national demand, placing immense pressure on public hospitals.[2] When patients cannot secure a timely private outpatient appointment and, where clinically indicated, a private psychiatric bed, they will often have no choice but to present to already overburdened public hospital emergency departments. By enabling IMG psychiatrists to practice in non-DWS private psychiatric hospitals, privately insured patients can be rapidly redirected into the private sector, which would directly ease the strain on public outpatient clinics and emergency departments.

Consultation question
d) Which of the proposed operational guardrail options are suitable? Provide reason/s if a guardrail option is not supported.

While Ramsay strongly supports the implementation of Initiative 1, any operational guardrails implemented alongside this reform must be designed carefully to ensure they do not inadvertently hinder the effectiveness of the reform. Our position on each of the proposed guardrails is outlined below.

Guardrail 1: Restrict the exemption to admitted (inpatient) MBS services

While Ramsay understands the policy intent behind this guardrail, we **do not support** it in its current form.

Inpatient mental health treatment fundamentally relies on a seamless transition between acute inpatient stabilisation and post-discharge community care. Forcing an overseas-trained psychiatrist to provide all post-discharge outpatient care from a DWS location could risk creating a highly fragmented care pathway. Patients who have been discharged from an inpatient stay in a non-DWS area would either need to travel, potentially significant distances, to see their treating clinician or transfer their care to a new outpatient psychiatrist during the highest-risk period of their care.

It is common for private psychiatrists operate a hybrid model where they have consulting rooms within or adjacent to private hospitals, enabling them to seamlessly manage both their inpatients and outpatients. Restricting MBS eligibility to inpatients only may inadvertently disincentivise overseas-trained psychiatrists from taking up admitting privileges altogether. The administrative and logistical burden of splitting a practice cleanly between an inpatient hospital in one area and an outpatient clinic in another area may outweigh the clinical benefits.

To balance the objective of protecting DWS areas while ensuring safe, continuous clinical care, the Department should consider the following:

[2] Royal Australian and New Zealand College of Psychiatrists. (2024). Crucial investment in mental health workforce missing in today's budget. https://www.ranzcp.org/news-analysis/crucial-investment-in-mental-health-workforce-missing-in-today-s-budget

1. **Allow overseas-trained psychiatrists to claim non-admitted MBS items at the non-DWS hospital location for a transitional period post-discharge**

Continuity of care is essential and protective after hospitalisation to manage the risks of relapse, medication non-adherence and re-admission. In line with established practice, including in the public sector, the following should be considered:

- **Short-term transitional support for up to 6 weeks post-discharge:** Overseas-trained psychiatrists should be able to claim non-admitted MBS items at the non-DWS location to provide short-term transitional support to all patients for up to 6 weeks after discharge from an inpatient admission. This would ensure clinical continuity during the highest-risk period of psychiatric care. Following a review at the end of 6 weeks, the admitting psychiatrist may then refer the patient to a DWS-located clinician for ongoing care if clinically appropriate. For patients who are deemed to be at a high risk of re-admission however, the admitting psychiatrist should be enabled to continue to provide medium-term support at the non-DWS location (see below).
- **Medium-term support, where clinically indicated:** For patients who are deemed to be at a high risk of re-admission following the initial 6 week post-discharge period, continuity of care should be maintained. In these instances, the admitting overseas-trained psychiatrist should be able to claim non-admitted MBS items at the non-DWS location for a period of up to 6 months post-discharge. This is in line with established practice in the public sector where relapse-prevention is promoted through structured care for up to 180 days post-discharge. For patients with complex, chronic conditions, such as schizophrenia or severe bipolar disorder, longer-term support may be required. In these cases, the admitting psychiatrist should be enabled to provide this care at the non-DWS location for up to 12 months.

2. **Allow overseas-trained psychiatrists to claim non-admitted MBS items at the non-DWS hospital location for consultations in connection with structured private hospital day programs**

Day programs can be effective alternatives to overnight admissions for many patients. To facilitate patient access to day programs, overseas-trained psychiatrists should be able to claim non-admitted MBS items at non-DWS hospital locations for consultations delivered in connection with structured day programs.

Guardrail 2: Limit the exemption to new-to-Australia psychiatrists

Acknowledging concerns regarding the potential cannibalisation of the existing overseas-trained psychiatry workforce, Ramsay **supports** the intent of this guardrail, provided it is implemented alongside complementary regulatory reforms.

The Department could also consider expanding the scope of the exemption to include Australian-trained IMGs, rather than limiting it strictly to fully trained psychiatrists who are new to Australia. Under this refined approach, the exemption would apply to:

- Overseas trained psychiatrists who enter Australia after [date of moratorium amendment]; and
- IMGs who may have entered Australia before [date of moratorium amendment] but attain their Royal Australian and New Zealand College of Psychiatrists (RANZCP) Fellowship after [date of moratorium amendment].

By limiting the exemption to new entrants and newly fellowed psychiatrists, this reform would aim to genuinely increase the national psychiatric workforce pool, rather than redistributing existing resources from DWS areas or public hospitals. As private hospitals would need to recruit directly from overseas, the success of this guardrail will be dependent on the efficiency of professional credentialing pathways. If this guardrail is adopted, it will be important for the Government to work concurrently with Ahpra and the RANZCP to ensure credentialing processes are efficient and do not cause delays. In line with other specialities, additional countries such as Ireland or New Zealand could also be added to Ahpra's Expedited Pathway for overseas-trained psychiatrists to further increase supply.

Supervision requirements would also need to be considered. Currently, new-to-Australia psychiatrists on the expedited specialist pathway must undertake a six-month period of supervised practice. Appropriate supervision may be challenging to secure in the private hospital environment, due to the existing workforce shortages. Alternate supervision arrangements or concessions may need to be considered to ensure this guardrail does not prevent new-to-Australia psychiatrists from working in private hospitals during their first six months and impede the boost to workforce supply that the private sector desperately needs.

Guardrail 3: Cap exemptions applied at each individual private hospital

Ramsay **supports** the concept of an exemption cap, however, the cap should not be static (e.g., one to two psychiatrists per individual hospital).

A static cap would not account for the operational differences that exist across different private sector facilities. For example, the psychiatry workforce required for a 10-bed psychiatric ward within a small medical/surgical hospital would be significantly different to a dedicated, standalone 120-bed private mental health clinic. If a cap is to be implemented, a proportional metric linked to the facility's licensed psychiatric bed capacity should be considered.

In addition, as the Department's consultation paper notes, managing a cap via individual Medicare provider numbers would create significant administrative burden and operational risks for hospitals. If a departing overseas-trained psychiatrist fails to cancel their provider number linked to a facility, the hospital would be unable to recruit another overseas-trained psychiatrist. This would effectively penalise the facility for the administrative failure of an individual clinician.

Guardrail 4: Timeshare commitment to public-private practice

Ramsay supports strengthening partnerships between public and private hospitals to coordinate service planning and improve patient access. However, Ramsay **does not support** this specific guardrail of mandating a public-private timeshare commitment for overseas-trained psychiatrists who gain an exemption to the s19AB moratorium. While we understand the desire for cross-sector support, enforcing this guardrail would create significant challenges from both an operational and administrative perspective, including:

- **Administrative burden:** The practical reality of split timeshare commitments between public and private hospitals is fraught with complexities. For a new-to-Australia psychiatrist, there would be significant challenges and administrative burden in navigating two employment contracts, different clinical governance frameworks, dual IT and credentialing systems and split medical indemnity liabilities.
- **Compromised continuity of care:** Patients admitted for inpatient mental health care frequently require consistent, daily review by their admitting clinician to adjust psychotropic medications, monitor acute risk (such as self-harm) and lead the multidisciplinary team (MDT) of nurses and psychologists. A mandated timeshare arrangement between employers would inherently fragment a clinician's roster. If a psychiatrist was legally required to be off-site at a public hospital for several days a week, this may create gaps in clinical governance, delays in treatment decisions, and ultimately it could lead to increased clinical risks or prolong the patient's length of stay in the private facility.
- **Deterrent for overseas-trained psychiatrists:** Australia competes with other nations, such as Canada, the UK and New Zealand, to attract top-tier clinicians in a highly competitive global market. International Medical Graduates seek stability and streamlined transition processes when making the decision to relocate to another country. Forcing an incoming specialist to secure, negotiate and juggle two separate employment contracts and jobs with two different employers will make Australia a less desirable destination and will potentially deter overseas-trained psychiatrists from relocating to Australia.

Enabling IMGs to work full-time in private hospitals will inherently support and reduce pressure on the public system, without the need for timeshare mandates. Every patient admitted and treated in a private psychiatric bed represents a patient who does not need to present to a public hospital Emergency Department.

Consultation question

e) Are there other issues to consider in the design or implementation of this reform initiative to improve its effectiveness, or to address risks? Please provide details

To ensure the initiative successfully addresses acute workforce shortages without creating new issues or unintended consequences, we recommend the following:

- **Streamlined administrative processes:** The success of this initiative hinges on avoiding overly complex administrative arrangements. If the process of securing an exemption or hospital-based Medicare provider number is administratively burdensome, it will deter both private hospital operators and IMG psychiatrists. The administrative mechanism for this exemption must be frictionless, transparent and fast-tracked to ensure hospitals can rapidly deploy specialists to where clinical demand is highest.
- **Linking exemptions to hospital-based practice:** To guarantee that this initiative directly addresses the issue it was designed for, the s19AB exemption should be linked to hospital-based practice. While IMGs should be permitted to claim non-admitted MBS items for post-discharge care (see response to guardrail 1, question d)), the intent of the exemption is to increase the psychiatry workforce within inpatient settings. Linking the exemption to hospital-based practice (e.g., through a hospital-specific Medicare provider number) would ensure that IMGs are actively admitting inpatients and running day programs, rather than simply utilising the exemption to open private outpatient consulting rooms in affluent metropolitan postcodes.
- **Structured implementation and review:** Ramsay supports the Department's proposed implementation and review process. A guaranteed initial period of at least three years will be crucial to provide incoming psychiatrists with the certainty required to establish stable practice arrangements and commit to supporting their patients.

Initiative 2: Increased access to contemporary models of mental health care

Ramsay supports Initiative 2, which seeks to amend Medicare Benefits Schedule (MBS) case conferencing arrangements to fund multiple case conferences during a hospital admission. Contemporary, high-acuity mental health care relies on a person-centred, MDT approach. However, the current "once per admission" MBS restriction serves as a structural barrier for consultant psychiatrists to engage in continuous, collaborative care.

Crucially, we suggest that this reform should be considered alongside a broader review of psychiatry MBS items to rectify remuneration disparities between inpatient and outpatient settings that threaten inpatient psychiatry workforce sustainability and private hospital viability. The review should also seek to address the current disparity in virtual care access between the public and private sectors. While telehealth consultations for inpatient and Hospital in the Home settings are standard practice in public hospitals, they currently remain unsupported in private settings due to MBS arrangements, artificially limiting flexible care delivery.

Consultation question

f) What, if any, changes should be made to MBS case conferencing items? Please provide a justification and any supporting evidence for changes identified.

Ramsay would support either:

- The removal of the "once per admission" restriction on current MBS discharge case conferencing items (861, 864, and 866) for consultant psychiatrists. This would allow for multiple case conferences to be funded throughout the duration of a patient's admission, such as once per week, or

- The establishment of a new item number for ongoing inpatient case conferencing for consultant psychiatrists, to allow for multiple case conferences to be funded throughout the duration of a patient's admission, such as once per week.

This change should be considered in response to two key issues with the current MBS case conferencing items for consultant psychiatrists, as outlined below.

1. Misalignment with contemporary best practice, National Standards and state guidelines

Restricting MBS funding to a single case conference at the point of discharge for consulting psychiatrists actively discourages psychiatry involvement in ongoing MDT collaboration during a patient's admission, which is contradictory to contemporary best practice, National Standards and clinical guidelines. Unlike a short-stay surgical admission where a single discharge planning case conference is often sufficient, contemporary mental health care relies on continuous collaboration amongst an MDT to support patient access to holistic, person-centred care.[3]

Additionally, the National Safety and Quality Health Service (NSQHS) Comprehensive Care Standard (Standard 5) mandates continuous, multidisciplinary risk assessment and shared care planning. To comply with NSQHS Standard 5, hospitals are required to continuously predict, prevent and manage acute psychiatric risks like self-harm and violence (Actions 5.31 to 5.34). The Standard also states that comprehensive care planning and risk mitigation should be undertaken through continuous multidisciplinary collaboration (Actions 5.5, 5.6, and 5.13).

Further, several state-level clinical guidelines explicitly recommend regular MDT collaboration. For example, the NSW Clinical Excellence Commission recommends MDT reviews occur daily or weekly, depending on the clinical specialty,[4] while the Queensland Health Clinical Services Capability Framework mandates that assessments and interventions delivered in inpatient mental health services reflect multidisciplinary input and are associated with a documented case review process.[5]

2. Misalignment with Hospital Purchaser Provider Agreement requirements

Hospital Purchaser Provider Agreements (HPPAs) with private health insurers explicitly require private hospitals to conduct and document weekly MDT case conferences to justify a patient's ongoing clinical need for an acute bed. However, the "once per admission" restriction on current MBS discharge case conferencing items means that consultant psychiatrists are not funded to participate in these mandated weekly meetings. This means psychiatrists must essentially donate their time to fulfill hospital contracting requirements, which acts as a significant disincentive for them to practice in the private hospital setting.

Consultation question

g) Are there other changes required to MBS items for inpatient psychiatry items to support contemporary mental health care? Please provide details

To support contemporary, high-quality mental health care and secure the viability of acute inpatient facilities, a review of Medicare benefits for inpatient psychiatric care should be considered. The current MBS items for psychiatric care actively discourage psychiatrists from working in acute inpatient settings, with outpatient care consistently yielding significantly higher comparative remuneration. Without adjustments that accurately reflect the complex reality of hospital-based psychiatric care, it will become increasingly difficult to attract psychiatrists to work in private inpatient settings.

[3] Royal Australian and New Zealand College of Psychiatrists. (2022). Collaboration to improve access and equity. https://www.ranzcp.org/getcontentasset/53606419-eae0-415d-ae95-87461375303f/dfc3d011-8f63-43f6-9ed8-4b444333a1d0/ranzcp-pre-budget-sub-to-federal-government-2023-2024.pdf?language=en-AU
[4] Clinical Excellence Commission. (2019). Multidisciplinary Team (MDT) with Patient Rounds. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/556041/MDT-with-Patient-Rounds-Guidance-Document-November-2019.pdf
[5] Queensland Government. (2022). Mental health services CSCF v3.2. https://www.health.qld.gov.au/__data/assets/pdf_file/0022/444370/cscf-mental-health.pdf

A recent survey of psychiatrists working within private psychiatric hospital undertaken by the RANZCP indicated that 28% of psychiatrists plan to leave their current private hospital role in the next two years, linking workforce sustainability directly to the pay disparity. To stem the flow of psychiatrists leaving the acute hospital system, the MBS schedule should be urgently reviewed and modernised.

New or adjusted inpatient items should be considered to ensure that psychiatrists are appropriately compensated for the time-intensive, multidisciplinary and administratively complex nature of contemporary private psychiatric inpatient care. This includes:

- Extensive collateral history gathering from multiple sources
- Family liaison and complex family discussions
- Participation in ward rounds and MDT meetings
- The heavy administrative and documentation burden associated with hospital compliance, risk management, and clinical governance.

Initiative 3: Private health sector to reconvene the Private Mental Health Alliance (PMHA)

Ramsay **supports, in principle,** the re-establishment of a collaborative, sector-wide body to drive structural policy, data, and funding reforms across the private mental health landscape. This support is conditional on the scope, role and authority of that body being defined at the outset.

We consider the reconvening of the PMHA as an opportunity to expand and reshape its role to better support not only the private mental health sector, but the broader Australian mental health system as a whole. There is significant and growing unmet need for mental health care in Australia. The Australian Institute of Health and Welfare (AIHW) report that over 4.3 million Australians aged 16 to 85 years experienced a mental disorder in the last year, yet fewer than half of that group (45.1%) saw a health professional for their mental health.[6] Affordability remains a barrier to access with 19.7% of people delaying or not seeing a health professional due to cost. This figure is even higher for those who needed to see a psychiatrist (25.4%) or a psychologist (25.3%).[7]

While government expenditure has increased 30% in real terms over the past decade, the Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement found that measures of mental ill health and suicide have not improved and that access barriers remain.[8] Ramsay supports the actions taken by the government to address this, including the expansion of Medicare Mental Health Centres and Medicare Mental Health Check-In to address critical service gaps. However, greater collaboration is required to meet demand, increase system capacity, and support more public and private investment. The Productivity Commission found the current National Mental Health and Suicide Prevention Agreement is not an effective mechanism for facilitating collaboration between governments and that service providers should play a bigger role in sector governance. The timing of these potential reforms with the work towards the next National Agreement presents an opportunity to consider both the public and private mental health system as a whole.

Ramsay suggests that a re-established sector body could be an important feature of the system to address fragmentation, workforce shortages, and service gaps by facilitating greater collaboration and alignment. For a reconvened body to be effective, it must not simply replicate past administrative frameworks and system silos. Instead, its design should reflect a modern strategic remit, drawing on multi-stakeholder strengths while structurally embedding core psychiatric expertise and consumer voices from the outset.

[6] Australian Bureau of Statistics (2023). National Study of Mental Health and Wellbeing.
[7] Australian Bureau of Statistics (2025) Patient Experiences, 2024–25 financial year.
[8] Productivity Commission (2025), Mental Health and Suicide Prevention Agreement Review.

Consultation question

h) If the PMHA were to be reconvened, what focus/es should it have? Please provide details

If reconvened, the PMHA's primary focus should be to address systemic, structural challenges across the private mental health sector and its interface with the public system, rather than acting purely as a collaborative body. The PMHA could report directly to the Health Chief Executive Forum, enabling reporting to Health Ministers' Meeting.

Ramsay suggests that the focus of PMHA should begin with the question of what mental health care Australians need and consider how to best co-ordinate, plan, and fund services that meet this need in an efficient and effective way. The PMHA should also look to use the private system's ability to innovate and scale rapidly to address issues and seek to provide industry consensus to expedite solutions and care for patients. Ramsay does not propose that the PMHA be a decision-making body but should have sufficient standing to provide comprehensive advice and guidance.

Ongoing review and maintenance of the Sector Guidelines is an appropriate function of the alliance, but it should not be the whole of its remit. The PMHA's remit should clearly define other functions, including:

- Clinical data, standards and outcomes
- System co-ordination and the public-private interface
- Patient-centred funding models
- Clinical and funding alignment
- Regulatory clarity, certainty and alignment
- Equity and access
- Innovation and knowledge exchange
- Collective, transparent governance.

The exact remit of the PMHA should be explicitly defined before its membership structure is confirmed. A body responsible only for the stewardship of clinical guidelines requires a vastly different structure and authority than one intended to address systemic funding, data, workforce, and macro-level system reform.

Consultation question

i) Noting the previous membership of the PMHA, which organisations should be included if the PMHA is to be reconvened?

The alliance began with the multi-stakeholder Support Program for General Practitioners and Private Specialists (SPGPPS) in 1996, which was restructured as the PMHA in 2007, before formally ceasing operations in 2016. Under its final 2015-16 Operating Guidelines, formal voting parties comprised the Australian Medical Association (AMA), the Australian Private Hospitals Association (APHA), Private Healthcare Australia (PHA), and the Australian Government, alongside dedicated patient and carer representation.

For successful re-establishment of the PMHA, membership design should retain effective structural features while correcting past omissions. On the assumption of a broader remit as described above, core membership should include:

- **Royal Australian and New Zealand College of Psychiatrists (RANZCP)**: The RANZCP should be included as a formal, core member. The College should have active involvement in the co-design of the body's structure and remit.

- **Australian Medical Association (AMA):** The AMA should retain a formal role within the alliance, recognising their advocacy for the broader medical profession. The AMA should not be treated as a substitute for the RANZCP however, as the two bodies represent distinct clinical interests and professional capabilities.
- **Clinical workforce:** The nursing and allied health workforce are central to the delivery of mental health care. Clinical representatives should be embedded as standing members to ensure their distinct clinical interests, capabilities and potential is considered.
- **Hospital and insurer representation:** Balanced participation must be maintained between private hospital operators and private health insurers to ensure that funding and operational realities are both considered.
- **Independent patient and carer representation:** Independent consumer and carer voices should be embedded as standing members, mirroring the successful elements of the original SPGPPS and later PMHA models.
- **Australian Government:** Formal representation from the Department is essential to align private sector initiatives with broader national mental health strategies and regulatory frameworks.
- **State and territory government representation:** Formal representation from state and territory Health departments is essential to examine the public-private interface. As with the CEO Forum, HCEF could nominate a suitable person to represent jurisdictions.

Other principles that could be considered for the re-establishment of the PMHA include the following:

- **Independent leadership:** The alliance should be led by an independent chair to prevent control or undue influence by any single stakeholder group.
- **Separation of authority from secretariat support:** While a specific organisation may host or fund the secretariat, this should be strictly separated from policy authority. The secretariat host should not acquire superior voting or policy rights.
- **Modernised administrative provisions:** The new structure should not automatically revive expired, rigid frameworks, such as dependence on the legacy AMA Agreement for Services or restricting membership strictly to financial contributors.
- **Defined review point.** The alliance's terms of reference should include a review of its effectiveness against its stated remit within three to five years of re-establishment.

Initiative 4: Review of risk equalisation arrangement

Please refer to Section 2.3.

Other comments

In addition to the proposed reforms and initiatives outlined in the consultation paper, Ramsay suggests the following could also be considered to further support the viability and sustainability of the private mental health sector:

- **State government commissioning of private mental health capacity:** The Federal Government, through the Health Ministers Meeting, could encourage state governments to enter multi-year public-private agreements, rather than short-term or ad hoc arrangements, to support increased capacity to the sector, provide faster access to care, and use existing private capacity instead of funding new public infrastructure.
- **Training expansion in private settings:** Extend the Specialist Training Program (STP) and the Private Hospital Training and Support Program (PHS) to train more healthcare workers, including psychiatrists and mental health nurses, in private hospitals. Private hospitals deliver a substantial share of mental health care yet remain under-used as training sites.

- **Telehealth in private hospitals:** Ramsay commends the Government for making the telehealth changes in the 2026-27 Budget. Ramsay recommends that further discussion take place to enable inpatient and hospital in the home telehealth consultations, which are currently not supported in private settings despite being standard practice elsewhere.
- **Nurse practitioners and scope of practice:** Incentives for in-hospital nurse practitioners to deliver therapeutic services and mental health consultations could be considered, including regional loadings to attract practitioners to regional hospitals.
- **Funding pathways for contemporary models:** Clear pathways should be established to expand and scale effective day, community and home-based mental health models from time-limited pilots into standard funding arrangements.

1.2 Maternity care

The private maternity sector is currently facing significant viability pressures, underscored by declining national birth rates and a sharp drop in Gold-tier private health insurance policy coverage. Ramsay supports and welcomes the proposed maternity care reforms as a critical step forward towards helping to restore the long-term viability of private maternity services across Australia.

In particular, reviewing and adjusting the waiting periods and product tier structure for pregnancy and birth will help to reduce barriers to access, stimulate patient demand, protect consumer choice and alleviate mounting operational and financial strains on private providers. Ultimately, stabilising private maternity viability will help to ensure that the private sector can continue its essential role in relieving acute demand pressures on the public hospital system.

Our response to each of the Department's proposed initiatives and consultation questions is provided below.

Initiative 1: Sector education

Consultation question
a) Do you agree or disagree that sector education about innovative models of maternity care would help to raise awareness of models and build a clearer understanding of regulatory enablers? Why do you agree or disagree?

Ramsay **agrees** that education would be valuable to support the sector to navigate areas of real and perceived regulatory friction to implementing innovative models of maternity care.

However, Ramsay disagrees with the consultation paper's premise that the primary issue is a lack of sector awareness regarding innovative models of maternity care. While education and workshops would be valuable for collaboration, there are real, structural barriers, primarily at the state legislative level, that impede private hospital operators from adopting alternative models of maternity care.

For example, in New South Wales, Schedule 2 of the *NSW Private Health Facilities Regulation 2017* sets out the licensing standards for different classes of facilities. As it stands, this regulation reinforces a medical-led model of care and does not recognise midwifery-led maternity services. This regulation effectively prevents Endorsed Midwives from gaining autonomous admitting rights for low-risk pregnancies and puts private hospital operators at risk of being penalised during state compliance audits if alternative models are adopted. In jurisdictions where Clinical Services Capability Frameworks are used (such as Queensland, Western Australia and South Australia), these same barriers do not exist as the legislation focuses on the safety of the facility rather than mandating who leads the care.

In addition to sector education, it would be helpful for the Department to provide clarity on how alternative models of maternity care fit within this national regulatory landscape. It would also be helpful for the Department

to support hospital providers in advocating for legislative reform and regulatory consistency across jurisdictions, including:

- Private health facility regulation reform to enable an expanded role for midwives and shared models of maternity care
- Alignment of state poisons regulations with national standards so that advanced practitioners are universally authorised to prescribe autonomously to their full scope, without secondary state-level approvals
- Providing certainty that private operators will be supported, not penalised, during compliance audits for implementing safe, innovative models of care.

Beyond regulation, there are other practical barriers to the viability of alternative maternity models. For a private hospital, safely operating a shared or midwifery-led model would require immediate access to specialised medical escalation pathways, such as on-call anaesthetists and obstetricians. Unlike the public hospital system, which maintains a resident, salaried medical workforce 24/7, private hospitals rely heavily on independent Visiting Medical Officers (VMOs). Securing reliable, on-call coverage from independent specialists to support a midwifery-led admission would introduce significant logistical and commercial complexities that will need to be addressed before such models can be sustainably scaled in the private sector.

Consultation question
b) What mechanisms should be used to educate the sector?

Ramsay suggests that educational mechanisms should move beyond general awareness campaigns and focus on practical design and implementation of innovative maternity models. Preferred mechanisms for education and collaboration within the sector include:

- **Workshops:** A series of workshops could be hosted by the Department, with attendees from across the sector, as well as State / Territory health departments, focussing on the structural enablers and barriers to innovative private maternity care models. These workshops should be used not only as an opportunity to provide clear guidance and education to the sector, but also to facilitate dialogue between the sector, the Department and State / Territory health departments regarding the real and / or perceived barriers to implementation that may require government intervention.
- **Sector co-design working groups:** Targeted working groups that bring together private hospital operators, obstetricians and Endorsed Midwives could also be convened to support the design of innovative maternity care models that are both clinically safe and commercially viable in a private hospital setting.

Initiative 2: Increased access and choice to different models of private maternity care

Consultation question
c) Would you participate in the development and implementation of innovative models of care with other practitioners in the private maternity sector? Please provide details.

Yes, Ramsay welcomes the opportunity to actively participate in the development of innovative maternity care models within the private sector. We recognise that consumer expectations are evolving, and providing high-value, continuous care is essential to the future sustainability of private maternity services.

However, from a clinical governance and patient safety perspective, Ramsay does not support the implementation of entirely independent, midwife-led models within private hospital settings. Our primary concern is the lack of robust, formalised escalation mechanisms in these models. As noted in our response to question a), unlike in the public hospital system where a resident medical workforce is always available to handle sudden intrapartum emergencies, private hospitals operate on a VMO model. If a patient is admitted under an

independent midwife without a designated obstetrician formally attached to their care, safely and rapidly managing acute, unforeseen clinical complications can become highly problematic and introduces significant clinical risk.

Instead, Ramsay supports, and is interested in helping to design, collaborative, shared-care arrangements between endorsed midwives and obstetricians. We believe the most viable and safe innovative models are those where an endorsed midwife and an obstetrician work in a formalised partnership. In these models, the midwife could provide continuity of care, while the obstetrician retains overarching clinical oversight and is immediately available for the delivery or any other emergency escalations as required. This type of model would aim to meet consumer demand for midwifery continuity of care, improve the overall cost and value proposition for young families, and most importantly, maintain the rigorous clinical safety nets and escalation pathways that patients expect when choosing a private hospital.

Initiative 3: Shorter PHI waiting periods for privately provided pregnancy and birth

Consultation question
d) Do you agree or disagree the maximum waiting period should be reduced for the “Pregnancy and birth” clinical category? Please specify why.

Ramsay **agrees** that the maximum waiting period for the “Pregnancy and birth” clinical category should be reviewed and reduced.

Shorter waiting periods would remove a significant barrier to entry to private maternity care for many consumers. The current 12-month waiting period is an antiquated policy setting that fails to reflect modern family planning and cost of living pressures. Under the current settings, individuals must upgrade to costly Gold-tier coverage well before conception. For women experiencing unplanned pregnancies, or those who conceive quickly, this strict timeline acts as an immediate lock-out from the private system, regardless of their capacity or desire to access private care.

Further, in the current cost-of-living environment, younger consumers are understandably reluctant to maintain expensive, top-tier cover for years "just in case" they fall pregnant. Reducing the waiting period (for example, to nine months or less) would allow the private health insurance sector to capture families at the exact moment they see tangible value in the product. This would also encourage higher participation rates in younger demographics, which would inject healthier consumers into the broader risk equalisation pool.

Removing this arbitrary barrier to entry would stimulate much-needed patient volume in private maternity wards, directly support the financial sustainability of these services and prevent further service closures. Crucially, every consumer empowered to access private maternity care represents direct relief for Australia's increasingly overburdened public health system.

Initiative 4: Review of product tier structure

Consultation question
e) Do you agree or disagree the “Pregnancy and birth” clinical category should be a minimum requirement of a product tier other than Gold?

Ramsay **agrees** that the “Pregnancy and birth” clinical category should be a minimum requirement of a product tier other than Gold.

Removing barriers to entry and increasing patient throughput is essential for preventing further closures of private maternity services. Restricting maternity coverage to the Gold tier creates an artificial and disproportionate financial barrier for younger consumers to access private maternity care. The Gold tier is inherently designed and priced to cover high-cost, high-acuity interventions predominantly required by older

demographics, such as joint replacements and cataract surgeries. By permitting “Pregnancy and birth” to be offered at lower tier levels, such as Silver, insurers could design more affordable and tailored products that genuinely appeal to the demographic that needs them.

In addition, maternity care is historically the "gateway" experience that introduces young families to the private hospital system. If consumers are priced out of private maternity care, the private sector loses the opportunity to demonstrate its value and risks losing these consumers to the public health system for decades, directly increasing the burden on the overstretched public system.

Initiative 5: Review of risk equalisation arrangements

Please refer to Section 2.3.

Initiative 6: Review of MBS items for paediatricians

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

Ramsay **agrees** that there should be consideration of an amendment to the MBS item for paediatricians, noting this requires further analysis and consideration from the Medical Services Advisory Committee (MSAC).

The routine newborn paediatric assessment is a known friction point in the private maternity experience and can undermine consumer confidence and the perceived value of private maternity care. In exploring potential solutions to this issue, the following should be considered:

- **Bespoke MBS item:** Consideration should be given to creating a bespoke MBS item for routine newborn assessments that either explicitly permits insurer co-funding without a formal neonatal admission or establishes a streamlined "routine admission" pathway for the newborn. This would resolve the "out-of-hospital" billing technicality for a service that is delivered inside a hospital.
- **Out-of-pocket fees:** Any reform that minimises unexpected out-of-pocket costs for consumers is welcomed. However, it should be noted that increasing the MBS benefit for paediatrician attendances would not necessarily lead to reduced out-of-pocket costs for consumers. Any amendments to MBS items should be supported by efforts to improve fee transparency for consumers, better support informed financial consent and strengthen consumer confidence. Ramsay would support initiatives that encourage paediatricians to utilise "no gap" or "known gap" arrangements for these specific routine checks.
- **Regional viability:** We agree with the Department’s assessment that resolving this funding gap would assist with the supply of paediatric specialists in private settings. For hospital operators, recruiting and retaining paediatricians to provide on-call cover and ward rounds in regional private hospitals is exceptionally challenging. Ensuring these specialists are adequately and seamlessly remunerated for routine newborn care would be a significant step forward in maintaining safe, sustainable private maternity services outside of major metropolitan centres.

1.3 Hospital in the home

Ramsay welcomes the opportunity to provide feedback on the Department's proposed reforms to Hospital in the Home (HITH) services. Ramsay supports the overarching policy objective of enhancing consumer access to services, particularly in regional areas, by expanding access to private HITH and establishing a minimum hospital benefit. However, the current proposal, anchored by a flat $360 per day minimum benefit rate, risks falling short of enabling genuine, comprehensive hospital-level care at home. To ensure the private sector can safely scale high-quality, home-based acute care, the funding model must accurately reflect the true costs of multidisciplinary teams, mobile clinical infrastructure, and complex patient acuity. Successful implementation will also rely on concurrent reforms to Medicare Benefits Schedule (MBS) telehealth items and appropriate clinical governance structures.

Ramsay's detailed responses to the Department's consultation questions on the proposed HITH reforms are provided below.

Consultation question
a) Is the amount of the proposed minimum hospital benefit for HITH appropriate (i.e. $360 per day)? If not, please provide a proposed alternate default benefit amount, including methodology and supporting data.

Ramsay supports the introduction of a minimum hospital benefit for HITH, however, we caution that a flat rate of $360 per day may only be appropriate for a narrow subset of services and could be insufficient to support a comprehensive HITH model.

While $360 per day would likely be suitable for single-intervention consultations, such as straightforward IV infusions or complex wound care, these interventions are typically classified and funded as Hospital Substitute Treatment (HST) rather than comprehensive HITH. When evaluating the appropriateness of this rate, the following should be considered:

- **Administrative and overhead deductions:** While $360 generally aligns with some current HST agreements, the hospital would need to retain a portion of this fee to cover administrative and governance requirements. This would reduce the net funding available to cover the actual provision of HITH services and would potentially make the $360 rate inadequate for sustaining high-quality, comprehensive HITH care.
- **Risk of "intervention-only" funding:** If the default benefit is set at a rate that is only adequate to cover single interventions, rather than a comprehensive care model, providers may be disincentivised from managing the complex, intersecting comorbidities that often accompany acute presentations. Failing to holistically manage these patients in the community would likely increase the risk of unplanned readmissions and transfers back to higher-cost acute hospital settings.
- **Fixed infrastructure and scale costs:** International benchmarking consistently demonstrates that HITH models carry high inherent capital costs, with data from the NHS Virtual Wards rollout illustrating the significant upfront investment required for IT infrastructure and mobile medical equipment.[9] Further, unlike a physical hospital ward, HITH models are highly sensitive to geography, with dispersed service areas increasing clinical travel time and overall operational overheads. Given Australia's highly dispersed population, these logistical costs would likely be further exacerbated.
- **Indexation**: Any agreed minimum benefit rate should be indexed annually against the health sector Wage Price Index (WPI) to ensure the model remains viable amidst rising clinical labour costs.

[9] Royal College of Nursing. (n.d.). The Virtual Ward: South Eastern Trust Case Study. https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Professional-Development/Research/Innovations/Burdetters-Case-Studies/Janice-Colligan-Case-Study.pdf

Consultation question

b) Should the Department consider different minimum hospital benefits for different types of HITH services, e.g., to recognise additional complexity? If yes, please provide proposed alternative benefit amounts, including your rationale and supporting data.

To ensure the private sector can safely deliver genuine acute hospital substitution for complex patients, Ramsay recommends that a two-tiered minimum hospital benefit structure that accurately reflects clinical acuity and resource intensity be considered.

The HITH Society of Australasia defines HITH as "acute inpatient equivalent care" that is delivered within a patient's residence with the same safety, technology and quality of care that would otherwise be provided within a hospital setting.[10] To ensure private hospital providers can sustainably absorb the operational and clinical risks associated with delivering HITH services that meet this definition, a tiered or weighted minimum benefit structure for high acuity care or specialised treatments should be considered.

A two-tiered model could include:

1. **Single intervention tier (proposed rate: $360 per day):** The single intervention tier would be appropriate for targeted, single-intervention treatments (e.g., daily IV antibiotics or complex wound management) managed under the governance of the admitting medical specialist.
2. **Comprehensive HITH tier (proposed rate: $650 per day):** The comprehensive tier would be appropriate for more complex, multi-service, or multi-disciplinary programs of care. This tier should encompass the most common HITH presentation DRGs (including but not limited to E61, E62, E65, F62, F63, J64, and L63). Patients admitted under the comprehensive tier would typically have a shorter length of stay compared to the single intervention tier.[11] Ramsay's proposed rate of approximately $650 per day reflects agreed market rates for these services.

Considerations for palliative care

As highlighted in the Department's consultation paper, palliative care can be more resource intensive than other types of home-based hospital care. Funding for palliative care at home needs to consider the progressive nature of a patient's palliative care pathway. The Palliative Care Outcomes Collaboration (PCOC) defines the four phases of palliative care as follows:

1. **Stable:** Patient problems and symptoms are adequately controlled by an established plan of care
2. **Unstable:** An urgent change in the plan of care or emergency treatment is required
3. **Deteriorating:** The care plan is addressing anticipated needs however requires periodic review
4. **Terminal:** Death is likely within days.[12]

During the stable phase, a patient may only require two to three home visits per week, however, as the patient progresses to the unstable phase and beyond, visits often scale to at least daily or sometimes multiple times a day. A $360 flat rate for all phases of palliative care would likely preclude the private sector from offering this vital, compassionate end-of-life care in the home. The single intervention tier rate ($360 per day) may be appropriate for patients who are in the stable phase of palliative care, while the comprehensive tier rate ($650 per day) would better reflect the higher frequency, intensity and cost of care required for the unstable, deteriorating and terminal phases.

[10] HITH Society Australasia. (2023). Definition of Hospital in the Home. https://www.hithsociety.org.au/post/definition-of-hospital-in-the-home.
[11] The average length of stay for current Hospital Substitution Treatment (HST) type services (such as IV antibiotics and wound care) is around 18 to 21 days. Admitted HITH services across the industry are lower at approximately 4 to 7 days (more akin to a physical hospital stay).
[12] Australian Institute of Health and Welfare. (n.d.). Palliative Care Services in Australia. https://www.aihw.gov.au/getmedia/9511ebc9-83fe-4aec-a1ea-7541387b8b47/aihw-pcsia-2022-palliative-care-outcomes-page.pdf.aspx

Consultation question

c) Do you have any comments about the inclusion of IV chemotherapy as an eligible IV infusion in the initial tranche of HITH treatment services? Please provide detail on why or why not.

Ramsay **supports in principle** the inclusion of IV chemotherapy as an eligible IV infusion, however, due to the increased complexity, recommend it be a later-phase service, rather than a core service in the first tranche.

Including chemotherapy directly aligns with the policy objective of shifting high-acuity care into the community where appropriate, while offering patients with increased choice regarding where they receive care. However, IV chemotherapy comes with increased infusion-related risks. Many patients have complex IV access ports, long infusion times and multiple cytotoxic medications for each treatment day. To ensure financial viability for private hospitals providing IV chemotherapy via HITH, the following should be considered:

1. Minimum benefit amount

While the introduction of a mandated minimum hospital benefit provides funding certainty to support investment in HITH, the proposed $360 per day baseline benefit may not be commercially viable for IV chemotherapy. Similar to palliative care, IV chemotherapy can involve substantial overheads due to specialised nursing hours, personal protective equipment (PPE) required for cytotoxic handling, and risk mitigation infrastructure.

One option would be to classify IV chemotherapy into either the single intervention tier (proposed rate: $360 per day) or comprehensive HITH tier (proposed rate: $650 per day) according to the type of chemotherapy administered. Non-cytotoxic chemotherapy, which typically involves biological agents with shorter infusion times, could be covered under the single intervention tier while cytotoxic, multi-drug therapy could be classified as comprehensive HITH.

2. MBS reform

Home-based acute care does not replace the patient's primary specialist, with all HITH chemotherapy treatments remaining under the supervision of the referring oncologist. To ensure home-based chemotherapy is delivered safely under the supervision of an oncologist, oncologists should be permitted to access MBS telehealth attendance items to conduct virtual consultations and monitor chemotherapy cycles remotely while the patient is admitted to the HITH program. Without reform, MBS restrictions may create barriers to specialist adoption and limit patient access to HITH programs.

3. Regulatory considerations

The administration of cytotoxic drugs is highly regulated due to the significant clinical risks to the patient and the occupational health and safety risks to healthcare workers and carers. While the overarching principles are guided by national bodies, the actual execution is governed by state-based legislation, hospital clinical governance policies, and national standards.

A critical regulatory barrier to HITH chemotherapy is the mandatory requirement for an independent double-check by two appropriately credentialed clinicians (typically two oncology Registered Nurses) prior to administration. Deploying two specialised nurses to a single patient’s home is highly resource-intensive and commercially prohibitive. For HITH chemotherapy to scale successfully, the regulatory and funding frameworks must formally recognise and support safe, digital alternatives, such as remote video-checking pathways where an on-site nurse completes the double-check with a senior clinician or oncology pharmacist via a secure telehealth link. As this regulation is primarily state-based and can vary by jurisdiction, it would be helpful for the Department to support hospital providers in advocating for legislative reform to enable digital alternatives to the double-check requirement and regulatory consistency across jurisdictions.

Consultation question

d) Can hospitals and insurers implement this proposal as described? If not, please provide details on why, e.g. additional legislative barriers not canvassed in this paper.

Some private health insurers have already agreed to cover the provision of admitted HITH services, suggesting there are few, if any, legislative barriers. However, there are a number of other barriers requiring consideration to support implementation, including:

1. Funding for HITH infrastructure

The proposed $360 flat daily rate assumes a standard acute substitution visit but does not acknowledge the upfront capital investment needed to operate a safe HITH program. To avoid unnecessary and expensive transfers back to a physical ward, a high-quality HITH program requires advanced clinical software and remote patient monitoring devices, which requires upfront investment that many providers, particularly smaller and regional ones, cannot fund within existing operating margins. The proposal does not canvas how these essential, non-accommodation clinical components will be funded under the minimum benefit rule.

Ramsay proposes the establishment of dedicated funding mechanisms to enable innovation and transformation. For example, this could mirror targeted digital investment programs such as Victoria's Business Acceleration Fund or international approaches such as the US Health Information Technology for Economic and Clinical Health (HITECH) Act, which provided incentives to accelerate electronic health record adoption. Alternatively, a proportion of PHI payments could be specifically allocated for innovation funding.

2. MBS reform

As highlighted in response to consultation question c), existing Medicare arrangements do not support professional services attendance billing via telehealth for admitted private hospital patients. This creates a significant barrier for referring physicians to monitor and manage their admitted HITH patients. Furthermore, it introduces a stark equity issue: patients in the public system can readily access HITH telehealth consultations with their specialists, while private patients cannot.

While it is intended that HITH treatments will remain under the close governance of the referring physician, without MBS reform, there is a significant risk that medical practitioners will resist utilising this pathway. To remove this barrier to HITH uptake, targeted MBS telehealth attendance items should be implemented specifically for clinicians managing patients admitted to an approved HITH program. Reforms should build on the current telehealth item numbers available to palliative care physicians, which demonstrate a safe, effective and practical model for delivering HITH services under an appropriate medical governance framework. Distinct items for initial, subsequent and complex consultations should also be considered.

3. Role of Nurse Practitioners

Contemporary HITH programs often rely on a multidisciplinary approach, which increasingly includes Nurse Practitioners (NPs), to enhance patient safety, access and program efficacy. Current Medicare regulations prohibit NPs from claiming MBS attendance and telehealth items for admitted hospital patients (which explicitly includes HITH patients). If the private sector is to successfully and safely scale HITH capacity amidst ongoing medical workforce shortages, targeted MBS item numbers for admitted HITH patients should be considered for Nurse Practitioners to enable providers to effectively leverage this highly skilled workforce.

Consultation question

e) Do you have any comments regarding the interaction of MBS and professional services attendance billing and the feasibility of this reform proposal?

As noted in response to consultation questions c) and d), without concurrent MBS reform this reform proposal is unlikely to be supported by medical practitioners, which would make private HITH models unviable. Targeted MBS telehealth attendance items should be implemented specifically for clinicians managing patients admitted to an approved HITH program.

Consultation question

f) Do you have any further comments on the considerations raised by the department under section 1.3.3 that have not been provided in response to questions above? If yes, please provide details.

Equity of access for regional and rural consumers should also be considered. While the establishment of a minimum benefit provides a crucial baseline for funding, a flat-rate approach does not adequately account for the geographical realities and logistical costs of healthcare delivery in Australia. Specifically, for patients who live more than 30 kilometres from their nearest private hospital, the cost of travel represents a significant structural and financial barrier to accessing care. This applies both to patients needing to travel to a facility for frequent episodic treatments and to the cost of mobilising specialised clinical staff to travel to the patient's home to deliver HITH services.

To ensure true equity of access, a specific distance-based loading could be considered. The additional loading could be applied to the minimum benefit for any patient whose primary residence is located more than 30km from the administering private hospital. This would help to offset the increased logistical costs associated with regional care delivery, such as extended staff travel time, fuel, and fleet maintenance. Most importantly, it would also help to ensure that Australians living in rural, regional and outer-metropolitan areas are able to access the same value from their private health insurance as those living in high-density metropolitan centres.

Consultation question

g) Do the proposed changes have consequences which the Department does not appear to have foreseen, based on the details in the paper? If yes, please provide details.

Based on the details in the consultation paper, Ramsay has not identified any unforeseen consequences related to this reform.

Consultation question

h) Are there any further issues that the Department should consider in relation to the proposed evaluation to measure the success of this proposal?

Ramsay supports a robust, data-driven evaluation of the initial HITH rollout. We suggest the following factors should be considered in the ongoing development of the evaluation plan:

1. Metrics for benchmarking

To conduct a meaningful evaluation, the funding and reporting structures must allow for an "apples-to-apples" comparison between HITH and physical ward admissions. The evaluation framework should explicitly consider the tracking and comparison of:

- Patient-Reported Outcome Measures (PROMs)
- Patient-Reported Experience Measures (PREMs)
- Standardised Clinical Indicator data
- Hospital Acquired Complications (HACs).

2. Measuring equity of access

Success of the rollout of the initial tranche of HITH services should not be defined simply by the volume of HITH services delivered, but also by who is receiving them. The evaluation framework must explicitly include measures regarding equity of access. Ramsay recommends that the Department establish a pre-implementation baseline and subsequently measure HITH uptake against Socio-Economic Indexes for Areas (SEIFA) quintiles and other key demographic considerations. This will ensure the evaluation actively monitors whether the reform is genuinely expanding access to vulnerable cohorts, or whether it is simply shifting the care setting for demographics that already experience high levels of healthcare access.

1.4 Type C certification requirements

Ramsay supports the Department's intent to modernise the Type C certification requirements framework through the introduction of standing exemption criteria and the reclassification of MBS item 14245 from a Type C to a Type B procedure. The current case-by-case certification model places a disproportionate and unnecessary administrative burden on clinicians and hospital administrators, frequently forcing them to manually justify hospital admissions that are common clinical practice and already mandated by national clinical safety guidelines.

By aligning private health insurance regulations with objective clinical risk factors, specifically advanced age, the necessity of procedural sedation, and the inherent risks of specialised pharmacological interventions, these reforms will help to reduce commercial friction between hospitals and insurers and allow the sector to redirect thousands of administrative hours back toward frontline patient care.

Ramsay's responses to each of the consultation questions on Type C certification requirements are provided below.

Consultation question
a) Do you support the proposal to implement two exemption criteria for Type C certification? Please provide reasons.

Ramsay **supports** the proposal to implement two standing exemption criteria for Type C certification under the *Private Health Insurance (Benefit Requirements) Rules 2011.* It is important to note however, that the two proposed exemption criteria should be treated as mutually independent, i.e. a patient would need to only satisfy one of the two criteria to qualify for the exemption.

The current case-by-case certification model places significant administrative burden directly onto clinicians who are required to manually complete each individual certification, in many cases to justify medical decisions that are clinically obvious. The process is also burdensome for hospital administration staff and leads to systemic inefficiencies, interrupted hospital cash flows and unnecessary out-of-pocket billing confusion for consumers. Implementing automated, evidence-based criteria to default appropriate cases directly to a Type B same-day hospital classification represents an overdue modernisation of subordinate private health legislation. Our rationale for supporting each of the proposed criterion is outlined below.

Support for Criterion 1: Patient is ≥ 75 years of age

Ramsay welcomes the inclusion of an aged-based exemption criteria for Type C procedures, which aligns with the clinical realities of physiological ageing and frailty. The Australian Commission on Safety and Quality in

Health Care (ACSQHC) *NSQHS Comprehensive Care Standard*[13] mandates that health services proactively identify and manage risks associated with frailty and cognitive impairment, which are factors that index heavily with the over 75 years demographic. In addition, the Australian and New Zealand College of Anaesthetists (ANZCA) *Perioperative Care Framework*[14] explicitly recognises that advanced age correlates with a higher risk of perioperative complications and recommends targeted functional impairment testing and multidisciplinary geriatric integration for older cohorts to mitigate risks.

Due to these inherent risks, older cohorts often require a higher level of care post-procedure, including specialised nursing observation, to rapidly identify and manage deteriorations. Community-based consulting rooms simply cannot support this level of care. A standing age-based exemption would formally acknowledge this risk and allow clinicians to focus on patient care rather than repetitive compliance paperwork.

Support for Criterion 2: Procedure conducted under general anaesthesia, regional anaesthesia or IV sedation

Ramsay also welcomes the inclusion of Criterion 2, as the method of anaesthesia, rather than just the nature of the procedure, is often the primary determinant of clinical risk and the need for hospital-level infrastructure. Administration of general anaesthesia, regional anaesthesia, or IV sedation introduces risks, including respiratory depression and cardiovascular instability, independent of the procedure performed. The ANZCA *Guideline on Procedural Sedation*[15] strictly mandates that whenever procedural sedation is administered, the facility must have dedicated airway monitoring personnel and immediate access to advanced resuscitation equipment. This requires hospital or accredited day-surgery level infrastructure and cannot be safely replicated in a standard consulting room. This proposed exemption would help to resolve the current disconnect between the classification of a procedure according to the surgical action and the risks arising from the anaesthesia or sedation required to perform it.

Consultation question

b) Do you agree that implementing the proposed exemption criteria would meet the intent of the proposal to reduce administrative burden? Provide details and supporting evidence.

Ramsay **agrees** that implementing the proposed exemption criteria would reduce administrative burden for clinicians, hospital administrators and private health insurers.

Implementing the proposed standing exemptions for age and anaesthesia / sedation would immediately reduce this burden by aligning the funding rules with objective clinical safety standards. To illustrate the scale of the current administrative burden, across Ramsay facilities in FY26 our clinicians manually completed:

- 714 Type C certifications for patients aged 75 years or older; and
- 4,194 Type C certifications for patients who underwent procedures that involved general anaesthesia, regional anaesthesia, or IV sedation.

Each of these certifications involved the treating clinician manually completing paperwork to certify and justify self-evident clinical decisions, diverting valuable specialist time away from direct patient care. Additionally, under the current rules, insurers frequently leverage the Type C classification to audit, question and delay valid hospital accommodation claims. This creates further administrative burden for our hospital administration teams

[13] Australian Commission on Safety and Quality in Health Care.(2026). Comprehensive Care Standard. https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/comprehensive-care-standard.
[14] Australian and New Zealand College of Anaesthetists. (2021). A framework for perioperative care in Australia and New Zealand. https://www.anzca.edu.au/getContentAsset/6959c2b4-64dc-4e7f-8341-8f74b72f1a14/80feb437-d24d-46b8-a858-4a2a28b9b970/The-Perioperative-Care-Framework-document.pdf?language=en&view=1
[15] Australian and New Zealand College of Anaesthetists. (2023). PG09(G) Guideline on procedural sedation 2023. https://www.anzca.edu.au/getContentAsset/3faa17f6-a6e0-4719-9992-9d67acef952b/80feb437-d24d-46b8-a858-4a2a28b9b970/PG09(G)-Sedation-2023.pdf

and clinicians and can contribute to adversarial relationships with insurers as well as out-of-pocket uncertainty for patients.

Removing the need for manual certification in these scenarios would help to reduce this commercial friction between hospitals and insurers, provide consumers with certainty regarding out-of-pocket costs, and allow thousands of administrative hours to be redirected back to direct patient care.

Consultation question

c) Can hospitals and private health insurers implement this proposal as described? If not, please provide details on why e.g. additional legislative barriers, exemption criteria not captured through ECLIPSE.

Yes, hospitals and private health insurers can readily implement this proposal as described. Ramsay foresees no legislative or system barriers to operationalising these standing exemptions, as the required data points are already captured and transmitted through existing digital billing infrastructure.

Specifically, both of the proposed exemption criteria can be automated via the standard ECLIPSE In-Hospital Claim (IHC) system:

- **Criterion 1:** A patient's age at the time of treatment can be easily derived by calculating the difference between Date of Birth and the Date of Admission (or Date of Theatre). Given that Date of Birth is a mandatory field within the ECLIPSE IHC framework, insurers possess the requisite data to fully automate the assessment of the age-based exemption.
- **Criterion 2:** The Australian Classification of Health Interventions (ACHI) contains distinct, established codes for general anaesthesia, regional anaesthesia, and IV sedation. As these ACHI codes are routinely transmitted as part of the standard ECLIPSE IHC, private health insurers would be able to program their claims systems to automatically recognise and assess this exemption criterion without requiring any supplementary manual documentation from the facility or clinician.

Consultation question

d) Would you support the inclusion of any other exemption criteria, as part of a possible ongoing process? Provide details on other proposed criteria and supporting evidence.

Yes, Ramsay supports the inclusion of additional exemption criteria as part of an ongoing, dynamic review process. While the currently proposed standing exemptions are a welcome step toward reducing administrative burden, the Type C classification framework remains rigidly focused on the mechanical nature of a procedure, often failing to account for the clinical context of the patient.

We recommend the inclusion of two additional standing exemptions:

1. **High risk / high complexity patients:** A standing exemption should be considered for patients who are at a higher risk of complication or who have a highly complex clinical profile. To ensure this exemption remains agile, fit-for-purpose, and safeguarded against misuse, we propose that the Department retains direct control over the definition of "high risk / high complexity". As a baseline, the definition could include individuals who:
    - Are in the third trimester of pregnancy
    - Are under the age of five years
    - Are undergoing multiple procedures (e.g., three or more) during the same episode of care
    - Have a chronic medical condition requiring active specialist or physician supervision during their treatment. This could include, but not be limited to:

- Hypertension
- Morbid obesity
- Renal failure or liver failure
- Diabetes
- Asthma / emphysema
- Peripheral vascular disease
- Epilepsy
- Coronary artery disease
- Anaemia or bleeding diathesis
- Dementia.

2. **Geographic isolation (patients residing >100km from the hospital):** Patients who need to travel significant distances to access private hospital care face unique logistical and clinical risks. For a patient living more than 100 kilometres from the treating facility, same-day discharge following a Type C procedure is often clinically inappropriate and unsafe. Should a post-operative complication, such as a haemorrhage, infection or adverse reaction to sedation, arise during transit or upon returning to a remote location, their distance from immediate acute care becomes a critical risk factor. An automatic day or overnight admission exemption for patients residing >100km away would provide a necessary safety net for regional and rural Australians, ensuring they are not disadvantaged by their postcode.

Implementing these two additional exemptions would further reduce the significant administrative burden on clinicians and hospital operators. Across Ramsay facilities in FY26, our clinicians manually completed:

- 1,615 Type C certifications for patients who met the proposed definition of high risk / high complexity;
- 383 Type C certifications for same day admissions for patients who reside >100km from the hospital; and
- 228 certifications for overnight admissions for patients who reside >100km from the hospital.

As noted in response to Question b), each of these certifications represents time spent by clinicians on redundant paperwork. Removing the need for manual certification in these scenarios would allow thousands of administrative hours to be redirected back to direct patient care.

Consultation question

e) Do you support the proposal to reclassify MBS item 14245 from a Type C to a Type B procedure? Please provide reasons.

Ramsay **supports** the Department's proposal to reclassify MBS item 14245 (and similar high-risk infusion items) from a Type C to a Type B procedure.

While an exemption criterion would have provided a partial fix, we agree with the Department's assessment that the core issue lies within the underlying classification of the item itself. Reclassifying these complex infusions as Type B procedures is a structurally sound regulatory decision that aligns funding frameworks with clinical reality. Our primary reasons for supporting this reclassification include:

- **Alignment with dispensing regulations:** There is currently a disconnect between how these drugs are dispensed and how their administration is classified. Under the PBS Highly Specialised Drugs Program (s100), the dispensing rules mandate that these medications be hospital-dispensed. It is therefore entirely appropriate and necessary that the safe administration and supervision of these drugs occurs in a hospital environment. Reclassifying the item to Type B would formally align the administration classification with existing dispensing mandates.

- **Clinical safety:** The administration of immunomodulating agents carries inherent and significant clinical risks, including severe systemic side effects such as anaphylaxis. As noted by the Therapeutic Goods Administration (TGA) Product Information for many of these medicines, they must be administered in a hospital setting with immediate access to specialised medical personnel and full resuscitation facilities. A Type B classification would acknowledge that the hospital infrastructure is a clinical necessity, not an optional preference.
- **Reducing administrative burden:** The Department's data demonstrates that the clear majority of MBS item 14245 procedures are already appropriately performed in a hospital setting. Reclassification to a Type B procedure would permanently remove the unnecessary administrative burden placed on clinicians and hospital administrators to manually certify and justify a standard, safe medical practice.

We also support the Department's view that this reclassification should be applied more broadly to other classes of high-risk medicines. Classifying procedures based on the clinical risk of the pharmacological intervention, rather than merely the action of inserting an IV, is a vital modernisation of the subordinate private health legislation.

2 Delivering better value for consumers

This section outlines Ramsay's response to Part 2 of the Consultation Paper including:

2.1 Improving access to regional hospitals

2.2 Product simplification

2.3 Risk equalisation

2 Delivering better value for consumers

2.1 Improving access to regional hospitals

Ramsay welcomes the opportunity to respond to the Department's proposed reforms aimed at improving access to regional hospitals. As a major private hospital provider across Australia, we are supportive of targeted measures that aim to maintain regional patient access. However, any structural changes to the second-tier default benefit mechanism must be carefully considered. Our primary concern is ensuring this reform acts as a genuine safety net for existing regional hospitals, rather than an unintended mechanism that distorts the market or disincentivises commercial contracting.

Our responses to each of the Department's consultation questions are outlined below.

Consultation question
a) Should the proposed changes be implemented on a temporary or permanent basis? When should a post-implementation review be undertaken?

If implemented, Ramsay's view is that the proposed changes should be a **targeted, temporary and reviewable** measure rather than a permanent structural baseline. A comprehensive post-implementation review should be undertaken at the two-year mark. This review will be critical to assess any unintended consequences of the changes, including:

- Whether the reform has inadvertently driven up PHI premiums and reduced the indexation pool available for hospital funding; and
- Whether the increased rate is genuinely supporting regional hospital viability or simply masking deeper, systemic issues including the ability for private hospitals to attract and retain specialised clinical workforce (e.g., maternity and anaesthetics) in regional and rural areas.

Consultation question
b) When should the proposed changes commence, noting the current annual processes for second-tier audit, categorisation and rate calculation?

The commencement of any changes should allow sufficient time to be factored into the standard annual premium pricing round. If this regulatory window is missed, commencement would likely need to be deferred by a further 12 months to the following premium cycle.

Consultation question
c) Provide feedback on the criteria for determining what should constitute an established regional hospital eligible for a higher second-tier default benefit (i.e. MM2 to MM7).

Ramsay supports the use of the Modified Monash Model (MM2 to MM7) to classify regional facilities. However, the definition of "established" must be tightly bound to fulfil the core policy intent of supporting the current footprint of comprehensive health care services in the regions, while ensuring that commercial contracting remains the primary pathway forward.

To protect incumbent infrastructure, prevent market dilution and ensure funding reaches facilities that provide broad community value, we recommend that an eligible facility must:

- Hold an active declaration as a private hospital prior to the date of the Rule changes;
- Hold an active, pre-existing Second-Tier status; and
- Deliver services that meet a minimum threshold of clinical scope and scale (e.g., multi-disciplinary, overnight facilities) and a minimum bed number (to be determined).

This eligibility criteria would ensure the changes act strictly as a safety net for vulnerable, existing operators providing comprehensive care, rather than creating a low barrier to entry for new, speculative entrants or limited-scope day facilities that have not invested in long-term regional clinical capability.

Consultation question

d) Comment on the level of the proposed increase to the second-tier rate for established regional hospitals and estimated impact on private health insurance benefit amounts (e.g. should caps or other limits in out-of-pocket costs be applied under second-tier arrangements?).

Ramsay **opposes** the introduction of arbitrary caps or limits on out-of-pocket (OOP) costs under second-tier arrangements. Healthcare is a highly capital-intensive sector and regional hospitals face complex, multi-decade capital replacement cycles for critical infrastructure (e.g., theatres, diagnostic imaging equipment). If a facility's revenue is capped or arbitrary OOP limits are introduced, this will reduce a facility's ability to invest in regional infrastructure and ultimately further deteriorate the commercial viability of regional facilities.

Unintended consequences from this measure should also be considered prior to implementation to ensure that increased funding for regional hospitals does not result in a zero-sum redistribution of the existing PHI premium pool. If insurers are mandated to pay higher default rates in regional areas, there is a risk that indexation for high-volume, highly efficient metropolitan hospitals may be suppressed in response. This potential cross-subsidisation would actively undermine the broader system and effectively punish large metropolitan tertiary hubs that handle high complexity cases. The funding for this regional safety net must therefore be recognised as a distinct, additive requirement to maintain regional access, and not be used as justification to constrain funding across the rest of the private hospital sector.

Consultation question

e) Are there any additional arrangements to support the effectiveness of the proposed changes, including audits of calculations and the publication of second-tier rates?

To support implementation and avoid unintended consequences, the following could be considered:

1. Publication of second-tier rates

Ramsay would support mandatory publication of second-tier benefit rates. This would help to ensure that eligible regional hospitals who are intended to benefit from these changes have visibility of the new calculated rates.

2. Introduction of a "Better Off Overall Test"

Under current *Benefit Requirement Rules*, a payor and hospital can contract at a rate lower than the second-tier default (except for psychiatric, rehabilitation and palliative care). To protect regional operators from asymmetric bargaining pressure, the Department could consider introducing a "Better Off Overall Test" framework, similar to Fair Work enterprise bargaining principles. This would ensure that no negotiated commercial agreement can leave a regional facility financially worse off than the baseline statutory second-tier rates.

2.2 Product simplification

Ramsay welcomes and supports the Department's proposed reform initiatives aimed at improving the simplicity, sustainability and affordability of Private Health Insurance (PHI) products. As Australia's largest private hospital operator, our clinicians and hospital administration staff often witness firsthand the negative impacts of the current, overly complex PHI framework. The proliferation of opaque product tiers, unpredictable co-payments and heavily exclusionary policies has fostered widespread consumer confusion, frequent "bill shock" and significant administrative friction across the sector.

Ramsay supports the Department's intent to streamline these structures. To genuinely restore consumer trust and ensure the long-term viability of the private health system, these reforms must move the market away from a "race to the bottom" and instead prioritise transparency, equitable access and guaranteed clinical utility.

Our responses to each of the Department's consultation questions are outlined below.

Consultation question
a) Do you agree or disagree with (or are you unsure about) each of the reform initiatives below: • Initiative 1: Simplifying product structure • Initiative 2: Standardising the age threshold and associated eligibility for dependants • Initiative 3: Excess and co-payment standardisation, and • Initiative 4: Ensuring consistency across premium structures.

Initiative 1: Simplifying product structure

Ramsay **agrees** with Initiative 1 to simplify PHI product structure. Ramsay supports all of the potential solutions proposed by the Department under this initiative, including removing the flexibility for insurers to offer products of limited clinical value and "plus" products that are often opaque and difficult for consumers to understand and compare across insurers.

Ramsay recommends a comprehensive review be undertaken of the design and operation of tiered products to improve affordability and transparency for consumers and address the unintended consequences that have arisen from the current system. In addition to the solutions proposed by the Department, this review and redesign should also consider clinical category standardisation. Currently, insurers apply their own interpretations of what is included or excluded within a clinical category, with some even offering partial clinical category coverage for some services. Allowing flexibility in the interpretation of clinical categories must be removed to ensure there is true clinical category standardisation.

Further, insurer coverage needs to be agile and regularly reviewed and updated to keep pace with clinical innovation. Currently, there are instances in our hospitals where clinicians are forced to either refer private patients to the public system or navigate long and complex "ex gratia" funding processes with PHIs simply because insurers refuse to cover innovative treatment approaches. A modernised product structure should ensure that evidence-based clinical innovations are able to be rapidly integrated into coverage definitions to maintain the value of private health insurance and ensure patients have timely access to the best available treatments.

Any redesign or simplification of PHI products should also be accompanied by efforts to improve consumer PHI literacy. Government resources such as *privatehealth.gov.au* should also be reviewed to ensure they are user-friendly and meet consumer needs.

Initiative 2: Standardising the age threshold and associated eligibility for dependants

Ramsay **agrees** with Initiative 2 to standardise the age threshold and associated eligibility for dependants. Ramsay supports both of the Department's proposed solutions under this initiative to promote consistency across insurers.

Initiative 3: Excess and co-payment standardisation

Ramsay **agrees** with Initiative 3 to standardise the application of excesses and co-payments. If a consumer elects to take on an excess in exchange for a lower premium, it should function as a single, transparent and standardised upfront deductible. Standardising this approach across the industry will significantly reduce consumer confusion and restore confidence in the value of private healthcare.

Additionally, Ramsay advocates for an outright ban on daily co-payments and tighter regulation around how excesses are applied, to protect both consumer trust and the principles of community rating. We recommend the Department consider the following:

- **Eliminate daily co-payments:** Daily co-payments are a significant driver of consumer confusion, bill shock and administrative waste. A patient's length of stay in hospital can often change or be unpredictable due to clinical complications or a slower-than-expected recovery. When PHI products include daily co-payments, the patient's out-of-pocket liability becomes difficult to accurately predict. This makes it challenging for hospitals to gain guaranteed Informed Financial Consent (IFC) prior to admission. Banning daily co-payments would help to ensure that patients know their exact maximum liability prior to admission, reduce financial anxiety and eliminate the administrative effort required for hospitals to re-calculate and collect payments from patients following discharge.
- **Shift responsibility for excess collection:** Currently, hospitals are burdened with acting as the collection agent for insurer-mandated excesses. In our view, hospitals should not be responsible for collecting this deductible on behalf of insurers. Insurers should be responsible for their own financial administration and should collect the excess directly from their members. Removing this requirement would significantly streamline hospital administrative processes and improve the admission experience for patients.
- **Accountability for "single bill" coordination:** Noting the administrative complexity for hospitals to co-ordinate a "single bill", it must be recognised that insurers are fundamentally responsible for purchasing healthcare services on behalf of their members. While Ramsay is supportive in principle of initiatives that provide consumers with a single, consolidated view of their healthcare costs, insurers are best equipped to purchase services across an episode of care and present the final, consolidated bill to their customers. This complex administrative coordination should not be shifted onto hospitals.
- **Protect community rating:** The Government must protect the principles of community rating by banning excess waivers based on length of stay or hospital category. Currently, some insurers waive excesses for day surgeries while enforcing them for overnight stays. This fundamentally disadvantages consumers whose health conditions, complex comorbidities or social circumstances (e.g., living alone, lack of at-home carer) require an overnight admission.
- **Prevent perverse clinical incentives:** Allowing differential excesses based on length of stay places financial pressure on consumers to push for same-day discharge for financial reasons, even when their treating clinician recommends an overnight stay for clinical reasons. Financial penalties should never dictate clinical decision-making.

Initiative 4: Ensuring consistency across PHI premium structures and waiting periods

Ramsay **agrees** with Initiative 4 to ensure consistency across premium structures and waiting periods. Ramsay supports each of the proposed solutions to ensure consistency, equity and transparency across premium structures and waiting periods.

Consultation question

b) Do you have any specific comments in relation to each of the reform initiatives raised?

Please refer to our response to question a).

Consultation question

c) Are there any other options or solutions that should be considered?

Australia's health system is among the best in the world because it is distinctly Australian. Both the public and private systems are built on a national commitment to fairness and equity. Community rating is the clearest expression of that in the private system to ensure that no Australian is charged more, or covered less, because of their health. It is a defining feature of the system and part of the social contract between government and the Australian people. Reforms to PHI products should be tested against this promise.

As noted in our response to question a), Ramsay recommends that the Department undertake a comprehensive review of the design and operation of tiered PHI products. This work should focus on resolving the unintended consequences from the current system and the erosion of value in the PHI market. The 2019 introduction of Bronze, Silver, Gold, and the subsequent proliferation of "Plus" variants, was intended to simplify the market but has instead institutionalised a "race to the bottom." Insurers are financially incentivised to aggressively carve out high-cost categories and market exclusionary "junk" policies that offer consumers no genuine clinical utility when acute care is required. However well-intentioned the current design may have been, it has ultimately created widespread confusion, leaving many consumers unaware that they are not appropriately covered when they need their insurance the most.

In general insurance, a policyholder is covered when an adverse event occurs. Under the current tiered structure, a consumer may hold hospital cover in good faith for years, only to discover at the point of admission that the condition they have developed sits outside their product. This functions less as insurance against illness than as a pre-purchased entitlement to a defined list of procedures. Reform should re-establish the proposition that if a person holds hospital cover, becomes unwell and requires hospital treatment, they are covered. This will support the private health system to better deliver on its promise to take pressure off public hospitals.

As part of a re-design, the Department should consider options for making products clearer, simpler and more consistent under the existing tier framework. An alternative approach would be to simplify the framework even further into a two-tier model (for example, a "limited" tier and "comprehensive" tier). Effective models used in countries with comparable health systems could provide a basis for this type of re-design. For example, the German private insurance market operates a legally mandated, highly standardised “basic tariff” that ensures a minimum clinical safety net, alongside more expansive comprehensive policies. Similarly, the United Kingdom’s private medical insurance market segments products into “core inpatient” and “comprehensive” cover, defining policies by the magnitude of care rather than clinical categories. Adopting a similar binary approach in Australia would permanently close the loopholes allowing for "partial" clinical coverage and ensure that every PHI product sold delivers genuine, reliable value to the Australian consumer.

Any re-design process should be supported by a structured, comprehensive review and extensive industry consultation and co-design. Changes would need to be considered alongside the settings that determine affordability and incentivise uptake, including the PHI rebate, Medicare Levy Subsidy, Lifetime Health Cover loading and risk equalisation arrangements. The complex interplay of these settings would require careful consideration and modelling to ensure that simplification improves the value of cover rather than simply its price and to ensure that government funding is appropriately targeted to support lower income Australians to take out insurance.

2.3 Risk equalisation

Ramsay **supports** the proposed reform initiatives to the risk equalisation system and the overarching goals of upholding the principle of community rating, reducing the commercial disincentives insurers face when offering comprehensive products, and ensuring the long-term sustainability of vital services like maternity and mental health. Specifically, Ramsay welcomes the proposed targeted recalibrations, including the creation of specific risk pools and the extension of the Age-Based Pool (ABP), to improve broader affordability.

Please find our detailed responses to the Department's consultation questions below.

Consultation question
a) Do you agree or disagree with the proposed reform principles for Risk Equalisation? Discuss any concerns with specific principles.

Ramsay **agrees** with the proposed reform principles. In particular, we support the principles to "reduce disincentives for insurers to offer comprehensive products" and to "improve affordability and sustainability of maternity and mental health cover".

Under the current regulatory settings, insurers face a commercial penalty for attracting members who require maternity and acute psychiatric care as these cohorts typically claim higher benefits. This has historically led to product designs and marketing strategies that attempt to subtly select healthier demographics, undermining the core tenet of community rating. A targeted recalibration of Risk Equalisation is essential to ensure that insurers are adequately compensated for covering high-value, high-need clinical services, thereby ensuring ongoing patient access to private hospital care.

We agree that reforms should "minimise unintended consequences," and we note that maintaining overall pool size per Single Equivalent Unit (SEU) is a sensible anchor to prevent sudden shocks to the broader insurance sector. However, we hold a specific concern regarding the enforcement of these principles. To genuinely support Community Rating, it must be mandated that every insurer offers cover for every clinical category on at least one product (i.e., all insurers must offer a comprehensive Gold product).

Consultation question
b) Do you agree or disagree with the reform initiatives raised:
i. Create new specific risk pools for maternity and mental health
ii. Exclude maternity and mental health claims from existing aged-based pool (ABP) and high-cost claims pool (HCCP)
iii. Extend existing ABP claim eligibility criteria to younger Gold tier members, and
iv. Redefine Single Equivalent Units (SEUs) to exclude younger Gold tier members, possible exceptions to corporate products.

i. Create new specific risk pools for maternity and mental health

Ramsay **supports** creating a specific risk pool for maternity. The restriction of maternity services to the Gold tier creates a significant financial barrier for young families. These younger members face the double-edged sword of the current RE system: they pay high premiums to fund the Age-Based Pool (ABP) redistribution for older members, but do not receive the same redistribution benefits for their own high-cost claims (maternity).

While supportive of the intent, we question the material benefit of a specific pool for mental health. Unlike maternity, mental health claims are spread more evenly across age cohorts. As the risk is already dispersed, creating a specific mental health pool is unlikely to have a material impact on accessibility or affordability, as the costs will largely smooth out at the existing ABP level. To meaningfully improve mental health affordability, RE

reforms must instead address structural loopholes, such as the financial impact of the mental health waiting period waiver.

ii. Exclude maternity and mental health claims from existing aged-based pool (ABP) and high-cost claims pool (HCCP)

Ramsay **agrees** with excluding maternity and mental health claims from existing aged-based pool (ABP) and high-cost claims pool (HCCP) into specific pools to ensure system integrity and prevent double-claiming.

iii. Extend existing ABP claim eligibility criteria to younger Gold tier members

Ramsay **agrees** with extending existing ABP claim eligibility criteria to younger Gold tier members, if the primary goal is broader Gold tier affordability rather than focusing strictly on specific clinical category affordability. The Gold tier currently operates at a loss across the sector; extending the ABP to younger members would provide structural support to the comprehensive product tier as a whole.

iv. Redefine Single Equivalent Units (SEUs) to exclude younger Gold tier members, possible exceptions to corporate products Extend existing ABP claim eligibility criteria to younger Gold tier members

Redefining SEUs to exclude this cohort may not functionally improve affordability for young people. Instead, the mathematical recalibration appears to disproportionately shift benefits toward older demographics, failing to address the core issue of generational cost-prohibitive pricing.

Consultation question

c) Do you have any specific comments in relation to each of the reform initiatives raised, including required lead times for implementation, required information, transparency and ease of calculation etc.

Please refer to our response to question b) for comments in relations to each initiative.

Overall, Ramsay cautions the Department against tying Risk Equalisation reform explicitly to product tiers (e.g., Gold tier) rather than clinical categories. Currently, there are dozens of PHI products in the market that offer benefits for pregnancy and birth and hospital psychiatric services on lower levels of cover (e.g., Silver plus products). If RE eligibility is limited strictly to Gold tier products, these more affordable coverage options will become ineligible for RE subsidisation, resulting in the unintended consequence of insurers withdrawing maternity and mental health coverage from these products, which would reduce consumer choice and further exacerbate the affordability crisis.

Consultation question

d) Are there any other options or solutions that the Department should consider?

Nil.

Consultation question

e) Do you have any comments on the goal of risk equalization and the interactions of this proposal with a future potential hybrid Risk Equalisation system including both risk sharing (retrospective) and risk adjustment (prospective) elements?

The primary goal of risk equalisation must be to uphold community rating by removing the financial penalty for insuring sick or high-needs members. The current retrospective (claims-based) system theoretically achieves

this however it is entirely retrospective. Ramsay is supportive of a long-term transition to a hybrid system that includes prospective (risk adjustment) elements. A prospective model would fundamentally shift the sector's focus from merely financing illness to actively managing health and investing in preventative health interventions.

3 Other considerations

This section outlines other topics and issues for the Department to consider as part of future sector consultation processes.

3 Other considerations

Ramsay notes the Department's intention to undertake further sector consultation over the coming months on reducing information asymmetries for productive collaboration and delivering better value for consumers. Ramsay has suggested a number of other topics for the Department to consider for inclusion in these consultations, in addition to those raised in Consultation Paper 1. These include:

- The Commonwealth leading **a Ministerial process to establish multi-year, public-private agreements** between state and territory health departments and private hospitals. These agreements should focus on leveraging excess capacity in the private system for public patients to reduce the need for Government investment in further public hospital infrastructure. Leveraging private capacity will support lower wait times in the public hospital system for planned surgery, and potential exists to work together to reduce ED waiting time on co-located sites.

  Alternatively, the Commonwealth could seek to leverage the Intergovernmental Agreement on National Competition Policy to incentivise states and territories to use the private hospital sector to provide faster access to high-quality elective surgery at a lower cost to government. Further opportunities also exist to consider the role private hospital capacity can play in reducing bed block in public hospitals due to a lack of capacity in aged care and disability services through use of existing bed stock or hospital in the home services.

- **Introducing a mandated minimum hospital benefit payout ratio** from PHIs to fund the cost of care delivery provided by private hospitals without increasing premiums. PHI hospital benefits payout ratios have declined from 88% pre-pandemic (2017-18 to 2018-19) to 84% in 2024-25. Meanwhile, over the same period, PHI profitability has increased by 28% while private hospital profits have fallen. Alternative approaches to rebalancing value capture could focus on mechanisms that enable PHIs and private hospitals to partner on innovation in clinical models and should be considered separately.

- **Extending existing funding and training pathways for specialist and Nurse Practitioner training** within private hospitals to recognise their critical service role and scope and support future supply of VMOs and advanced practice clinicians. For example, extending funding of the Private Hospital Training and Support program and the Specialist Training Program to provide flexible, role-based funding and remuneration for supervision can support trainee access and workforce supply. This should include expanding shared training with public hospitals particularly in specialties like orthopaedics where some procedures such as arthroplasties are predominantly delivered in the private sector. This would better align workforce development with service delivery patterns, support future VMO and advanced practice supply, and strengthen capacity in high-volume specialties and regional markets.

- **Expanding specialist college rotational training pathways** across public and private hospitals, including regional placements, to strengthen workforce supply and distribution. This would involve establishing shared education programs, cross-sector rotations, joint supervision arrangements and infrastructure-for-workload exchanges across the public and private systems. Implementation could include additional funding for training places under the Private Hospital Training and Support program and the Specialist Training Program, as well as explicitly funded positions in the public sector to facilitate joint placements, particularly in regional or co-located hospitals.

- **Establishing dedicated "innovation funding" mechanisms** to incentivise clinical innovation and productivity across the health system, particularly through digital transformation (electronic medical record, interoperability, automation, data platforms, cybersecurity) and infrastructure renewal and reconfiguration. Dedicated co-funded or pooled mechanisms would allow for and accelerate digital interoperability, data sharing and cyber resilience, which could lead to estimated productivity gains of more

than $5.4m per year across the health sector.[16] Legislative requirements on what must be covered by PHI could be extended to require PHIs to consider innovation and transformation in hospital payments.

- Improving private hospital access to, and certainty of **R&D tax incentives for eligible health research**, clinical trials, technology adoption, and service innovation activities, strengthening the role of private hospitals as partners in clinical innovation. Given private hospitals partner with specialists and provide care for a significant percentage of patient care in the health system, private hospitals are well-positioned to contribute to clinical innovation. The Australian Government has undertaken a Strategic Examination of Research and Development, with recommendations submitted in March 2026. These findings should be leveraged to ensure private hospitals are well positioned to benefit from any reforms to R&D incentives, consistent with the report's identification of health and medical research as a key national innovation pillar.
- **Enabling "patient centric" health data interoperability**, through sector wide adoption of modern secure digital standards including open EHR. This reform would address persistent fragmentation by allowing secure, real-time sharing of clinical information between providers, reducing duplication, delays, and inefficiencies.
- Aligning **funding for nursing salaries** with public sector EBA increases and/or Fair Work Commission value case, through a federal commitment to fund a proportion of wage growth, enabling private hospitals to remain competitive with the public system and stabilise the workforce. Alternatively, consideration could be given to a temporary increase in tax concessions or rebates to consumers to mitigate risk of policy downgrade or cancellation, given cumulative and significant wage cost pressure on hospitals that will need to be passed through to insurers.
- Strengthening consumer protections by developing **a regulatory framework to address vertical integration** in the private health insurance sector to prevent conflicts of interest where an insurer both funds and provides care. This would help to preserve clinical independence and consumer choice and strengthen competition within the sector.

[16] Productivity Commission. (2024). Leveraging digital technology in healthcare. https://www.pc.gov.au/inquiries-and-research/digital-healthcare/

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