Catholic Health Australia

2026

OUR POSITION

Enabling equitable access to Hospital in the home across the private sector

BACKGROUND

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate over 90 hospitals in each Australian state and in the Australian Capital Territory, providing around 30 per cent of private hospital care and 6 per cent of public hospital care, in addition to extensive community and residential aged care. CHA Members also provide approximately 13 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care services.

CHA not-for-profit health, community and aged care providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care. CHA champions reforms aligned with the healing ministry of Christ and the work of Catholic congregations around the country.

The aim of our position statements is to outline CHA's policy and advocacy priorities on key issues that are essential to the mission and values of its members.

A more in-depth analysis of our policy positions is available through our government submissions.

POSITION

Australia's private hospitals are under increasing strain. Demand for services continues to grow, driven by the latent effects of COVID-19, alongside the longer-term trends of population ageing and the changing burden of disease. At the same time, financial performance is in decline, as operating profits continue to be squeezed by cost-push inflation, unfunded capital expenditure, and increasingly unsustainable funding models.

These pressures will only intensify. An ageing population will add an estimated 4.1 million extra patient days across both private and public hospitals by 2035,[1] whilst the growing prevalence of chronic, non-communicable disease will mean that patients require more continuous and integrated care – needs that current episodic models are not designed to meet.

In responding to these challenges, private hospitals must look beyond the traditional supply-side levers of infrastructure investment and workforce capacity. Solutions will instead require more adaptive and innovative models of care that – by utilising advances in digital health – can deliver high-quality services beyond 'bricks-and-mortar' (BAM) hospitals.

Out-of-hospital (OOH) models such as Hospital in the home (HITH) represent a key component of this shift. HITH is an inpatient equivalent model that delivers hospital-level care in a person's home. It promotes greater choice by allowing patients to decide *where* and *how* they receive their care, whilst offering potential benefits to private hospitals by unlocking latent capacity and reducing capital expenditure.

CHA has long advocated for HITH as an effective and necessary solution to easing pressures on the health system.[2] Yet HITH continues to be underutilised in the private sector. Under current financial arrangements, private hospitals are disincentivised from delivering HITH at scale, while inconsistent governance and 'managed care' models have further stymied adoption.

Addressing these issues will be key to unlocking the significant potential of HITH. To do so, we recommend that the Commonwealth Government:

1. introduce a default benefit anchored to a defined relationship with the BAM default benefit rate
2. strengthen governance frameworks
3. implement mechanisms to safeguard patient choice and clinical autonomy

What is Hospital in the home (HITH)?

HITH is “acute inpatient equivalent care, utilising highly skilled staff, hospital technologies, equipment, medication, and safety and quality standards, to deliver hospital-level care within a person’s place of residence or preferred (non-hospital) treatment location”.[3]

While HITH falls under the broader category of OOH care, it differs from other services in that the patient remains formally admitted to the hospital, which retains full clinical governance and medical responsibility for the episode of care.[4]

Specifically patient care should be as equivalent as possible to the care received in a BAM hospital ward in terms of access to services and providers.

This distinguishes HITH from other forms of OOH care – such as post-acute nursing, rehabilitation in the home, and community-based palliative care – which operate at different levels of acuity, governance, and cost, and may warrant separate benefit arrangements.

HITH first came to prominence in the 1990s, with Victoria leading the way amongst Australian states.[5] Yet despite its early promise, interest has fluctuated, leading to a patchwork of programs and definitions that vary in both scope and operationalisation. This has left the significant potential of HITH models unrealised.

Nonetheless, the Hospital in the Home Society of Australasia definition (above) provides a nationally consistent reference point for addressing this fragmentation.

What does the evidence suggest?

Research consistently shows HITH to be a safe and clinically effective alternative to BAM hospital care, with studies suggesting lower readmission rates,[6] shorter lengths of stay,[7] reduced 30-day mortality rates,[8] and high satisfaction (>80 per cent) amongst patients and providers.[9, 10]

This is supported by a recent Cochrane review, which indicated that HITH is comparable to BAM hospital care in terms of clinical outcomes and self-reported health status.[11]

Evidence also demonstrates strong economic benefits, although this varies according to the model used.[12] For example, one international study reported lower average costs per patient episode, alongside reduced health costs post-discharge.[13]

In palliative care, a collaboration between Bupa and St Vincent’s Private Hospital Brisbane (a CHA member) found that patients offered genuine choice and enhanced home-based palliative support were significantly more likely to die in their preferred location, with 90 per cent doing so over the course of the study. [14]

Notably, whilst palliative care involves different clinical requirements and service intensity to acute HITH, this study demonstrates the value of supporting patient choice in how and where hospital level care is delivered.

These findings are complemented by a 2023 economic analysis, carried by Nous on behalf of CHA.[15]

What does the evidence suggest? (cont.)

The report found that HITH care was cheaper than in-hospital care per day, and even in cases where episodes ran longer than an equivalent inpatient stay, costs were still unlikely to exceed in-hospital care.

It estimated that a default benefit of $330 (≈$420-450 in 2026 prices) may be adequate for lower-acuity home-based services delivered from an existing hospital base.

This figure reflects the marginal cost of delivering certain HITH programs from within an existing hospital – nursing visits, consumables, travel, and pharmacy – rather than the full cost of running acute inpatient equivalent care.

For true acute HITH, which requires 24-hour clinical oversight, on-call medical cover, and escalation pathways to manage patient deterioration, the cost of delivery is likely to be higher. Benefit rates should reflect this.

A more practical approach would be to anchor HITH benefit rates to a defined discount off the BAM default bed day rate. A matched costing study of 924 episodes across 31 Victorian hospitals found that HITH was consistently cheaper than in-hospital care for appropriately selected patients, with the cost differential most evident where the entire episode was delivered at home, after adjusting for clinical complexity.[16]

This suggests that a modest discount to the BAM rate would be cost-saving for the system, viable to providers, and offer a sustainable pricing mechanism in the long-run.

The challenge now is to deliver high-quality HITH at scale. A recent report by Private Health Australia suggested that expanding OOH services – including but not limited to HITH – could generate up to $1.3bn in annual savings across the system.

Unlocking this will require a more strategic approach to HITH across the private sector, centred around a default benefit, strengthened governance frameworks, and greater leadership from the Commonwealth government.

What is a default benefit and why is it needed?

A default benefit is a financial mechanism which mandates the benefit amount that an insurer is required to pay a provider for a hospital (or equivalent) admission. The default benefit operates through two levels:[17]

- **Minimum benefit** – the baseline benefit amount that an insurer must pay for a hospital (or equivalent) admission covered under a private health insurance (PHI) policy
- **Second-tier benefit** – the benefit amount paid to second-tier eligible hospitals where no existing contract between insurer and hospital is in place

While second-tier benefits operate as a discretionary pricing mechanism within insurer control, a default benefit functions as a *system safeguard*.

It ensures equitable access for private patients, upholds continuity of care (even in the absence of a contractual arrangement), supports provider viability, and incentivises insurers to contract with private hospitals – thus curbing further vertical integration and 'managed care' models.

What is a default benefit and why is it needed? (cont.)

Currently, no such safety net exists for HITH. This means that private patients may not be covered for their admission if their insurer does not have a contract arrangement with that private hospital.

The absence of a default benefit can lead to inconsistent and sometimes clinically inappropriate outcomes for patients.

For example, providers have reported variation in funded drug delivery methods, discontinuation of established home-based services, and barriers to HITH referral from private emergency departments.

Many insurers refuse to contract hospitals for HITH services, with some not supporting activity outside of their own direct or subcontracted care models, and others citing unsubstantiated claims regarding benefit outlay, quality, and necessity of HITH.

Consequently, private hospitals are disincentivised from investing in HITH capacity at scale, as doing so would carry excess financial risk in the absence of baseline returns. This has resulted in broad underutilisation of HITH in the private sector, with more than 8 in 10 of HITH admissions, and 9 in 10 HITH days, taking place in public hospitals.[18]

Extending a default benefit to HITH is consistent with the findings of the Private Hospital Financial Health Check,[19] as well as the recommendations made in the EY report.[20]

This would not replace contracting or introduce price regulation but rather establish a baseline return that enables private hospitals to scale HITH services with confidence, while also reducing the need for capital expenditure on additional BAM hospital capacity.

Moreover, this reform supports the Commonwealth government in meeting broader national policy commitments, including the National Health Reform Agreement, National Digital Health Strategy, Strengthening Medicare agenda, their productivity agenda, and the goal of delivering more care in the community.

Most importantly, it reflects what Australians want: research shows overwhelming support for patients and their doctors – not insurers – deciding when HITH is safe and appropriate.[21]

How should a default benefit be implemented?

The Commonwealth Government should introduce a default benefit for all HITH programs where there is strong clinical and implementation evidence regarding the efficacy, equitability, safety, and quality of delivering inpatient equivalent care at home.

Any default benefit must be structured around a clear, nationally recognised definition of what HITH is, with the Hospital in the Home Society of Australasia offering a useful starting point.[22]

This will establish a default standard of service, whilst also mitigating potential risks of 'gaming' [23] and other perverse incentives by ensuring that HITH functions as a *substitute* for inpatient care within defined episode of care.

How should a default benefit be implemented? (cont.)

Whilst the initial tranche of services should be well-established and clinically mature, the default benefit framework itself should be condition-agnostic. This enables progressive expansion based on clinical evidence and the judgement of the treating clinician, rather than requiring any legislative amendments each time a new condition is added.

First steps for implementation

Implementation should occur in stages, beginning with a limited set of clinically mature HITH services where there is strong evidence of safety, clinical efficacy and cost-effectiveness. Initially, this should focus on services already offered in Australia (in both private and public hospitals) which will form a baseline standard for implementation.

This staged approach allows for progressive expansion as data accumulates, workforce capability develops, and system confidence grows. A roadmap should be developed to set out the growth of HITH services over time, with an annual review process in place to assess potential additions.

Benefit setting

The default benefit should reflect the range of clinical complexity and resource requirements across HITH service types.

CHA proposes a base default benefit with additional supplements where services involve medical governance, specific cost-differentiators (e.g., infusion therapies), or are substantively different in nature (e.g., palliative care).

We recommend anchoring benefit rates to a defined relationship with the BAM default bed day rate – as discussed in the evidence section – which would create a self-adjusting mechanism and reduce the need for repeated renegotiation.

Transitional arrangements may be required to support hospitals currently delivering HITH under suboptimal or informal contracting models. These arrangements should ensure continuity of care for existing patients while new benefit settings are established, preventing service disruption during the transition period.

Clear timelines and transition pathways should be communicated to providers and insurers to support orderly implementation.

When implementing a default benefit, policymakers should be deliberative in designing a mechanism that does not preclude insurers from innovating or contracting for enhanced HITH models.

However, a default benefit must ultimately establish clear guardrails to prevent insurer-led care substitution that undermines clinical governance, fragments accountability, or limits patient choice.

Insurer involvement should complement, not replace, hospital-led clinical models, with the hospital retaining responsibility for admission, care coordination, and discharge.

How should a default benefit be implemented? (cont.)

Enabling reforms

Current MBS items for virtual consultations also present a barrier to HITH referral. During Covid, temporary MBS telehealth items demonstrated that remote specialist consultations with admitted patients could be delivered safely and effectively, with several remaining in place.

The Commonwealth should review existing items to confirm they cover admitted HITH patients, and introduce new items where any gaps remain. This should be supported by appropriate record-keeping requirements.

The framework should also allow flexibility for allied health services within a HITH episode to be delivered virtually where clinically appropriate, ensuring that benefit structures do not inadvertently require face-to-face delivery for all disciplines.

What does effective governance look like?

Given the additional challenges that come with delivering inpatient care in HITH locations,[24] effective governance is essential for ensuring services are acceptable, effective, equitable, and safe for both patients and providers.

However, as the Australian Medical Association (AMA) and others have identified,[25] there is currently a lack of standardised rules and regulations governing HITH and other OOH models in the private health system.

HITH – as a substitute for acute in-patient care – should be subject to the same standards that govern BAM hospitals, namely the National Safety and Quality in Health Care Standards (NSQHS). [26] The hospital should also retain full clinical governance and medical responsibility for the patient across the episode of care.

All HITH programs must therefore adhere to the NSQHS as a benchmark for high-quality care, with providers requiring accreditation from the Australian Council on Healthcare Standards (ACHS) as a prerequisite.

To incentivise this, eligibility for default benefit funding should be limited to HITH programs operated by, or on behalf of, accredited private hospitals.

By holding HITH services to the same standards as BAM hospital care, providers can demonstrate clinical accountability and quality assurance. This removes any legitimate basis for insurers to refuse contracting on safety and quality grounds.

Minimum service requirements should be established, including daily nursing review, 24-hour escalation pathways to manage patient deterioration, and access to face-to-face medical care where clinically required. Clear lines of clinical responsibility should also be in place throughout the episode of care, and benefit structures should reflect the full cost of meeting these requirements.

Finally, HITH providers should participate in standardised data capture and reporting arrangements to support monitoring and evaluation of key service metrics such as episode length, outcomes and readmissions. Any learnings should be incorporated into existing governance frameworks to promote best practice.

How should we safeguard patient choice and clinical autonomy?

Safeguarding patient choice and clinical autonomy should be a central aim of any reform to HITH financing and governance arrangements.

Enhanced patient choice is a key function of the private system.[27] This extends beyond the selection of an insurer or product type to encompass decisions about how, where, when, and by whom care is delivered.

Similarly, clinical autonomy – the ability of healthcare professionals to exercise independent judgement in the best interests of patients – is a foundational principle of medical practice, underpinning the acceptability, effectiveness, and quality of care. These principles must apply equally whether a patient is treated in hospital or at home.

Under current arrangements, both are constrained. The absence of a clear national definition has resulted in fragmented eligibility criteria, creating uncertainty for clinicians and patients and enabling non-clinical factors to influence admission decisions.

These opaque practices are a design flaw of current financing and governance arrangements. CHA believes that if HITH is to expand in a way that serves patients rather than commercial interests, then certain principles must be embedded into any framework:

Clinical-led decision-making

The decision to offer HITH, or to continue care in an inpatient setting, should rest with the treating medical practitioner in consultation with the patient, based on clinical assessment and patient preference.

This approach aligns with long-standing concerns within the medical profession that payer-driven or administratively determined models of care risk undermining both patient choice and clinical autonomy.

Any governance framework for HITH should therefore explicitly prohibit insurers from directing or unilaterally determining whether a patient receives care via HITH rather than in hospital.

Nationally consistent service definition

A nationally recognised definition of HITH – preferably the Hospital in the Home Society of Australasia definition[28] – supported by minimum eligibility criteria anchored in clinical assessment, would provide clarity and reduce the scope for arbitrary exclusion or selective application.

Separation of funding and clinical gatekeeping

While insurers have a legitimate role in benefit administration, they should not control or operationalise clinical eligibility criteria, admission thresholds, or decisions about intensity of care.

Clinical governance responsibility should sit with providers and treating clinicians, supported by clear escalation pathways that allow patients to return to inpatient care where clinically indicated, without delay or insurer veto.

Funding reconciliation should occur after care decisions are made, rather than through pre-approval mechanisms that may impede timely or appropriate care.

How should we safeguard patient choice and clinical autonomy? (cont.)

Voluntary, informed, and reversible participation

Patients should be provided with clear, accessible information about the nature of HITH, including care responsibilities, visit frequency, escalation processes, and the option to decline or discontinue HITH without disadvantage.

Choice should be supported by continuity of clinical oversight and clearly defined arrangements for medical review and escalation, ensuring that care quality and safety are maintained outside the hospital setting.

Clinically-led dispute resolution

Where disagreements arise about HITH eligibility or appropriateness, resolution should be timely and clinically informed. Reliance on complaints-based processes alone is insufficient, as these are inherently reactive and may place an unreasonable burden on patients and clinicians to challenge decisions after harm or exclusion has already occurred.

Consideration should be given to independent, clinically led dispute resolution pathways for disagreements relating to eligibility, step-down decisions, or cessation of HITH, particularly where there is disagreement between insurers and treating teams.

Transparency and accountability

Reporting requirements – such as HITH referral and acceptance rates by diagnosis and insurer, rates of transfer back to inpatient care, and patient-reported outcome or experience measures – can support system-level oversight and identify patterns that may indicate inappropriate restriction or use.

These data would support accountability while respecting the clinical independence of individual care decisions. Such accountability should apply to all parties operating within the HITH framework.

The Private Health Insurance Ombudsman has an important role in consumer protection and monitoring insurer conduct. However, it is not designed to act as a primary safeguard of clinical autonomy.

Ombudsman-based oversight may complement broader governance arrangements by identifying systemic issues or recurring disputes, but the protection of patient choice and clinical judgement ultimately requires clear regulatory settings, clinician-led governance, and structural separation between funding and clinical decision-making.

Why is Commonwealth action needed?

The regulation of private health insurance benefits, default benefit settings, and national safety and quality standards all sit within Commonwealth jurisdiction.

The barriers to expanding HITH and other non-admitted hospital care types in the private sector – fragmented definitions, inconsistent eligibility criteria, and the absence of a default benefit – are problems of national regulatory design. They cannot be resolved by individual providers, states, or market forces alone.

Why is Commonwealth action needed? (cont.)

Without Commonwealth intervention, fragmentation will persist. Insurers, providers, and states will continue to pursue divergent models that undermine scale, equity, and system efficiency.

Failure to act will further entrench cost-shifting between public and private systems, exacerbate pressure on state-funded hospitals, and undermine the Commonwealth's own objectives around private health insurance participation and affordability.

Reform also presents an opportunity. HITH and other non-admitted hospital care types offer broader system benefits that extend beyond the immediate episode of care.

By enabling flexible, multidisciplinary models of care, HITH can improve workforce utilisation, reduce burnout associated with acute ward settings, and support greater use of advanced practice nursing and allied health roles.

It can improve equity of access for populations who face barriers to traditional hospital care – including older people, culturally and linguistically diverse communities, and people with disability.

For regional and rural areas, hybrid and virtual HITH models may provide access to specialist-led inpatient care that would otherwise require travel or transfer.

Without reform, these benefits will not materialise. Private HITH will remain fragmented, insurer-led, and marginal.

Private hospitals will continue to prioritise BAM capacity in the absence of any other appropriate funding model for HITH services, which in turn escalates bed pressure, increases wear and tear, and ageing of capital equipment.

In this scenario, insurers will increasingly pursue vertically integrated managed care models, constraining patient choice and clinical autonomy, while public hospitals absorb growing demand that could otherwise be safely managed at home.

That is why Commonwealth action matters. Without it, the promise of HITH – better care, in the right place, on the patient's terms – will remain unrealised.

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