Patient Centred Care:
Making Hospital in the Home a reality

Position Statement

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Introduction

Hospital in the Home (**HITH**) is a proven clinical care model that enables patients to receive hospital level care in the comfort of their home. For many patients, this means recovering in a setting that supports dignity, independence and connection to family and carers, while still receiving high quality, clinically appropriate hospital care. HITH can shorten time spent in hospital (shortened hospitalisation) or, where clinically suitable, avoid hospital admission altogether (full substitution for hospitalisation).[1]

Evidence shows that HITH delivers substantial patient outcomes, including lower mortality and readmission rates alongside higher levels of patient and carer satisfaction.[2] It also supports health system sustainability through substantial cost savings whilst delivering the equivalent or improved patient outcomes.[3] HITH has particular benefits for people living in rural and regional communities, enabling patients to remain in their local communities and supporting the sustainability of small, rural health services.[4]

Despite these benefits, access to HITH remains inconsistent, particularly for privately insured patients. Australia remains behind comparable jurisdictions in the adoption of HITH programs, partially due to regulatory settings that limit the uptake of HITH programs.[5] Target reform Medicare telehealth settings and default benefits is essential if HITH is to become a mainstream option for privately insured patients.

In 2025, Catholic Health Australia and Bupa undertook a co-design process with sector leads to identify the key elements needed to make HITH default benefits reform, a practical and sustainable solution. Based on the outcome of this process Bupa calls on the Commonwealth Government to adopt the following recommendations:

1. Enabling easier patient referral to HITH programs by introducing dedicated Medicare Benefits Schedule (**MBS**) telehealth items for admitted patients participating in accredited HITH programs
2. Prioritising reform to private health insurance default benefits to enable better access to an initial trance of well-defined and widely delivered HITH programs
3. Ensure patient safety and care quality with hospital level governance and accreditation requirements
4. Establish minimum service definitions for different HITH models to ensure patient safety, reliability, and equivalence with inpatient care, while allowing flexibility to meet individual clinical needs.
5. Structure HITH benefits to support sustainability and patient outcomes

Bupa believes that these feasible reforms would support patient choice, improve outcomes, strengthen health system sustainability, allowing hospital care to be delivered in the most appropriate setting without compromising safety, quality or accountability.

[1] Caplan G *et al*, 'A meta-analysis of "hospital in the home"' (2012) 197(9) *Medical Journal of Australia* 512.
[2] Ibid.
[3] NSW Department of Health, *Evidence Brief: Hospital in the Home* (NSW Government, 18 June 2024) 2; Private Healthcare Australia, *There is no place like home: reforming out-of-hospital care* (May 2023) 1.
[4] Glenister K *et al*, 'Facilitators and barriers to provision of hospital in the home: does geographical location matter? A scoping review' (2025) 25 *BMC Health Services Research* 875.
[5] Private Healthcare Australia, *There is no place like home: reforming out-of-hospital care* (May 2023) 9.

Recommendation 1: Enabling easier patient referral to HITH programs

A key obstacle in progressing access to HITH programs is that the MBS settings for virtual consultations disincentivise patient referral to HITH and constrain operational efficiency. Virtual care is integral to safe, effective HITH care enabling treating specialists to review patients in at-home settings.

Being unable to claim an MBS consultation disincentivises a Visiting Medical Officer (**VMO**) from referring a patient into a HITH program. This hinders the introduction of a service that Private Health Insurance (**PHI**) customers are seeking and which the sector requires to respond effectively to sustained fiscal pressures. It is also a barrier to clinical governance requirements as the VMO cannot review their patient other than in person.

The introduction of specific MBS telehealth items for admitted hospital patients participating in HITH would encourage the referral of patients into these programs. Any new MBS telehealth items must be supported by strict record keeping requirements and should only be able to be used by HITH referring professionals who are supporting continuity of care for patients transferred from in patent hospital settings.

Recommendation 2: Prioritise reform to default benefits to enable better access to an initial tranche of well-defined and widely delivered HITH programs

Bupa believes the Government should prioritise reform for an initial tranche of priority conditions. These conditions represent well established forms of acute inpatient substitution that are already widely delivered across Australian public and private health systems. They are supported by a strong clinical evidence base, clear patient eligibility criteria, and mature models of care meaning patients can be confident that they are receiving true in hospital substitution. The proposed initial priority conditions include:

- Intravenous (IV) antibiotics and infusion therapies
- Cellulitis and infection management
- Complex wound care, including vacuum-assisted dressings
- Palliative and end-of-life care

These conditions have demonstrated equivalent or improved clinical outcomes compared with inpatient care. This includes similar or lower mortality and readmission rates, reduced hospital acquired complications, and higher levels of patient satisfaction.[6] Australian hospital data indicate that patients receiving HITH care in these clinical areas experience lower in hospital mortality and lower 28-day readmission rates, particularly for infection related groups, reinforcing its role as a scalable acute substitute rather than a niche service.[7]

Prioritising reform for this initial tranche of HITH conditions will enable hospitals to establish or scale existing programs minimising implementation risk. This phased approach provides a pragmatic foundation for reform, creates certainty for providers and insurers, and supports future expansion to additional conditions once funding, data, and regulatory settings are proven to be effective.

[6] Ong BS, Ngian VJJ, Yeong C and Keighley C, 'Out of hospital and in hospital management of cellulitis requiring intravenous therapy' (2019) 12 *International Journal of General Medicine* 447–453; Lin CP and Chu WM, 'Home-based palliative care: benefits, challenges, opportunities and future directions in a super-aged society' (2025) 28(3) *Journal of Hospital Palliative Care* 81–88.
[7] Montalto M, McElduff P and Hardy K, 'Home ward bound: features of hospital in the home use by major Australian hospitals, 2011–2017' (2020) 213(1) *Medical Journal of Australia* 22–7.

Recommendation 3: Ensure patient safety with hospital level governance and accreditation requirements

Bupa believes that to be eligible for default benefits, HITH services must meet the same foundational criteria, quality, governance and reporting requirements as admitted hospital settings. A core component of HITH is that it provides equivalent care to hospital admission without compromising patient safety or quality of care. As such, benefit eligibility should be contingent on demonstrable alignment with nationally consistent hospital safety and quality frameworks.

This includes:

- Accreditation to the National Safety and Quality Health Service (**NSQHS**) Standards
- Reporting against validated safety and quality indicators suitable for HITH, for example those outlined in the HITH Society Australasia Position Statement and Australian Council of Healthcare Standards (**ACHS**) clinical indicators for HITH.

Any services that are proposed to receive minimum default benefits must demonstrate either:

- current accreditation to NSQHS Standards as part of a hospital-wide assessment; or
- the capacity to meet NSQHS Standards if not currently accredited, confirmed by assessment or audit within 12 months.

The Australian Commission on Safety and Quality in Health Care (**ACSQHC**) produces audit, monitoring and reporting tools. We recommend HITH-specific guidance and audit tools be developed in relation to the operation of HITH services to help services interpret the standards and demonstrate compliance. These could incorporate relevant Clinical Care Standards for specific service types and, in time, support accreditation of HITH services directly.

Recommendation 4: Ensure HITH services meet minimum service definitions and inclusions

Agreed minimum service expectations are essential to make sure HITH services are safe, reliable and provide meaningful benefit for patients. These standards help protect the quality and integrity of care, ensuring people receive the right level of support at the right time, regardless of where they live. Minimum service definitions should recognise that HITH is not a single service model and that different types of HITH care have different goals and clinical requirements requiring standards to be tailored to each service type.

While not every element of care will be clinically necessary for every patient, services must have clear systems in place to provide these supports when they are needed. This ensures flexibility for individual patient needs without compromising safety, quality, or continuity of care.

- **Home-based acute-inpatient level care substitution:** For patients receiving acute care in their own home, services must meet a level of care equivalent to an in-hospital admission. This includes daily face-to-face nursing care to monitor the patient's condition and deliver treatment. There should also be regular medical assessment and review by the VMO clinically required. Patients must have access to clear 24-hour escalation pathways, so urgent concerns can be addressed at any time. In addition, services should provide access to hospital level interventions, diagnostic testing, and

multidisciplinary care, such as allied health input, to ensure comprehensive and coordinated treatment.

- **Home-based palliative and end-of-life:** Palliative and end-of-life HITH services must time limited and delivered as a substitute for acute inpatient admissions, with a focus on comfort, dignity and symptom management. These services should include daily face-to-face nursing care to assess symptoms, manage medications and support patients and families. Regular medical review must also be provided when clinically appropriate. There must be clear 24-hour escalation pathways so that patients and carers can access urgent clinical advice or support at any time, particularly during periods of rapid change or distress.

Recommendation 5: Structure HITH benefits to support sustainability and patient outcomes

Benefit determinations for HITH services should be carefully designed to reflect the specific type of care being delivered and the real costs involved in providing that care safely and effectively. A single, uniform payment approach is unlikely to account for the differences in intensity, duration and clinical complexity across HITH service types. Instead, benefits should align with the care profile of each service, supporting both quality patient outcomes and sustainable service delivery.

- **Acute substitution:** include daily nursing visits, with variable thresholds for clinically indicated medical consultations (e.g. daily, weekly, more than weekly but less than daily).
- **Palliative and end-of-life care:** consider a per-visit nursing benefit (recognising lower frequency in early phases and higher frequency close to end of life or for complex needs).

Additional loadings must be considered for:

- Culturally appropriate care and support for dying on Country (e.g., involvement of Aboriginal and Torres Strait Islander healthcare workers and liaison officers, and community collaboration)
- Respite care for family carers
- Allied health and other wrap-around supports
- Radiology and hospital diagnostics

Benefits must be defined and calculated in appropriate categories including the everyday costs of delivering care, allied health, medical supplies and pharmaceuticals for the purposes of delivering HITH services. The including of services such has prosthesis and pharmacy payable through alternative sources, capital infrastructure and radiology and hospital diagnostics in benefit setting would limit the ongoing sustainability of HITH services.