Private Patients in Public Hospitals

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Private Patients in Public Hospitals

Executive Summary

In both the National Health Reform Agreement and the Australian Health Care Agreements, the Commonwealth and States agreed that people can choose to be a private patient in a public hospital and that the public hospitals can charge for these private patients at a fee set by each State.

This paper examines the situation of privately insured patients in public hospitals (hereafter referred to as private patients, noting that this specifically excludes other non-public patients such as the self-insured, compensable, DVA, etc.). The paper examines the trends over the last ten years and the factors causing the considerable growth in private patients.

From 2005-06 to 2010-2011 public patients in public hospitals increased by 16%, whilst over the same period private patients in public hospitals increased by 50%, an average increase of 8.5% p.a. By 2010-11, 10.0% of all patients in public hospitals were private patients, compared to 7.8% in 2005-2006.

$864 million in accommodation fees was paid by private health funds to public hospitals in calendar year 2012, a 17.6% increase on the prior year. On top of this accommodation fee, private patients brought in an estimated $123 million in prostheses payments and $384 million in medical fees which in the case of salaried medical staff are retained by the public hospital. In total there was therefore an estimated $1.37 billion of additional revenue in 2012 from private patients.

The paper concludes that the public hospital drive to increase the number of private patients is a direct result of the capped Commonwealth and State funding arrangements that have been in place for the last decade. The Commonwealth provides block funding which is capped and the States also with limited budgets provide the public hospitals with capped expenditure budgets. Recognising that additional uncapped revenue can be obtained from private patients the State governments then encourage the public hospitals to maximise the number of private patients they can attract each year.

As a result of this encouragement from their State governments the public hospitals proactively market to their captive audiences of vulnerable people after they have fallen ill and been admitted to the hospital. Driven by State determined budget constraints on the number of public patients, public hospitals in some States also encourage their surgeons to admit their private patients to the public hospital giving them priority of access over public patients.
The public hospital practice of encouraging patients to elect to use their private health insurance is strongly supported by doctors as they also benefit from this practice. Once a public hospital convinces a patient to go private the treating doctor can then bill the patient directly. These funds ($384M in 2012) are then either fully or partially donated to the hospital and held in a special account for the purchase of equipment, attendance at conferences or retained by the doctor.

The estimated $123 million in prostheses charges to private health funds is highly profitable for the public hospitals as these are at private or near private hospital rates as mandated by the Commonwealth but the purchase price is at public rates. The resulting 2012 profit to public hospitals is estimated to be $55 million.

The incentive for public hospitals to persuade patients to elect to be private does not stop at obtaining additional revenue from the private health funds. It also unlocks money direct from the Commonwealth bypassing the States. Once a patient elects to be private, 75% of all scheduled medical fees can be billed to the Commonwealth, and this includes surgeons, anaesthetists, diagnostic radiology and pathology. The component of medical fees from the Commonwealth is estimated to be $256M, two thirds of the total medical revenue received.

With all these additional revenue streams it is not surprising that the recruitment of private patients by public hospitals is wide spread and growing. The use of facilities and staff paid by tax payers to raise money in direct competition with privately funded facilities is of considerable concern to private hospitals and private radiology practices.

States set the fees payable by private patients to maximize this additional revenue from the provision of services to private patients in public hospitals. However as a privately insured person is fully entitled as any Australian to free service in a public hospital, the person is unlikely to accept being admitted as a private patient if their private health fund will not pay their full costs. This puts a constraint on the fees set by the States and often requires the public hospitals to waive any out of pocket costs these patients might incur.

If the doctor is a specialist who works full-time at the hospital, there is usually no out-of-pocket medical charge. The doctor’s fee is covered by the private health fund and Medicare. However, if the doctor is a Visiting Medical Officer there may be an out-of-pocket expense that will have to be paid by the patient to the doctor. In these cases the public hospital sometimes guarantees to the patient that there will be no out-of-pocket payment to either the hospital or the doctor. To ensure there is no medical out-of-pocket payment public hospital sometimes direct their VMO’s not to charge above the fees set by the private health funds.

The recruitment of private patients is possible as there is a legislative loop hole which allows public hospitals to proactively persuade patients to use their insurance after they have arrived at the hospital despite the patient having entered the hospital with no intention to use their private health insurance.
The National Health Reform Agreement requires that public hospital staff don’t direct patients to elect to be private, but makes no statement limiting the extent of pressure that can be put on privately insured patients. As a result public hospitals now employ marketing people who direct the admission staff and visit the patients in hospital to convince them to use their private health insurance.

This is analogous to state schools recruiting fee paying students from private schools and charging them for attendance. The difference is that with health the person takes out health insurance in advance and it is the insurance company that pays. Whilst with most insurances there is an incentive not to do this as the person would then have an increase in their insurance rating having made a claim, health insurance legislation in Australia doesn’t permit such action.

Information obtained directly from patients at some public hospitals reveal cases where patients have been asked to be a private patient and very strongly encouraged to do so. In some cases the patients have not realised they were signing an election to be treated as a private patient and in others they were pursued subsequent to discharge despite providing written advice that they did not want to use their private health insurance.

The practice of public hospitals converting public patients to private patients after they have already been admitted was recently confirmed by the Victorian Health Minister David Davis who denied that private patients were taking beds that could be used by the 55,000 people on Victoria’s waiting list, saying that hospitals asked about patients’ insurance status only after they had been admitted, making it impossible to give priority to those able to pay. However if this is the case in Victoria, it is certainly not the case in NSW where public hospitals are known to put pressure on their doctors (Visiting Medical Officers in particular) to admit private patients promising them immediate access to the hospital in preference to public patients.

The shift from Commonwealth Block funding to Activity Based Funding in July 2014 will change State government incentives to recruit private patients as not only will the Commonwealth contribution for public and private patients be dependent on the patient’s Diagnosis Related Group (DRG), but the amount that the Commonwealth pays for private patients relative to what it pays for public patients will vary with each DRG. Dependent on the DRG the payment to the States for private patients will be discounted to between 37% and 93% of the amount paid for public patients.

The Commonwealth initiative is directed at ensuring both private and public patients receive the same total revenue from all non-State government revenue sources, namely: the Commonwealth’s Activity Based Funding, MBS payments, and private health fund payments. If the States adopted this approach for their own public hospital funding it would mean that apart from unintended variations at the DRG level brought about by the fact that health fund accommodation payments remain per diem, public patients would then be given the same priority as private patients.
It is expected however that the States will wish to continue to encourage the conversion of public patients to private patients post July 2014 to supplement State government expenditure to the maximum extent possible. The other reason the States are expected to continue this behaviour is that surgeons receive a higher income from private patients and the States believe that this is important in order to recruit and retain highly experienced surgeons in their public hospitals.

The Commonwealth discount for private patients will reduce the State’s incentive to encourage private patients but the extent to which this will change behaviour is as yet unknown as this discount only applies to 45% of the National Efficient Price.

Key to public hospital behaviour will be the extent to which the States pass on the Activity Based Funding (ABF) arrangements introduced by the Commonwealth to their hospitals. If the States all move to ABF funding arrangement for their public hospitals, passing on the Commonwealth DRG level private patient discount then it is expected that public hospitals will respond by being more selective in their private patient recruitment practices, focusing on those DRGs which bring in the most lucrative returns.
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In this paper the term private patients refers to private patients with private health insurance. There are a couple of instances where in quoted material the term private patient can mean non-public which includes self-funded patients and in some cases also patients funded by DVA, worker’s compensation or third party motor vehicle. Where this occurs it will be evident from the quoted material.
Introduction

The arrangements governing private patients in public hospitals are set out in the National Health Reform Agreement and the Australian Healthcare Agreements before that. These are further expanded on in the Private Patients’ Hospital Charter and numerous State government guidelines and gazettes. The public hospitals in each State individually customise these rules in brochures, pamphlets and forms written for the patients at their hospitals.

The National Health Reform Agreement permits the State governments to introduce whatever incentives they wish to encourage public hospitals to recruit private patients.

Each State government independently decides how much to pay its public hospitals for public and private patients in public hospitals. It is common for the public hospitals to be paid less for private patients than public patients in recognition of the additional revenue available to public hospitals from the private health funds and Medicare. In calculating the discount for private patients some State governments also take into account not just the accommodation fees from the private health funds but also the amounts paid for prostheses which can provide a significant additional revenue source for the public hospitals.

As an alternative to discounting the payment for each private patient, some States set a fixed annual budget on the assumption that the hospital will attract a set minimum number of private patients, and it is then up to the hospital to achieve this target. In some States, such as NSW, the surgeons are directed to complete their surgery lists with their own private patients as the hospital has insufficient budget for further public patients.

In Victoria the practice until recently has been to set a private patient revenue target for each hospital and deduct this from the budget provided to each hospital, with the effect that if the target is not reached then the hospital budget is reduced. If the target is exceeded the hospital was able to keep the private patient revenue without any further reduction in State government payment. Since then Victoria has introduced a scheme where it pays private patients 76% of what it pays public patients. In South Australia the arrangement is further refined with the percentage reduction for private patients dependent on the patients Diagnosis Related Group.

In addition to defining the amounts that the public hospitals will be paid for private patients, the State governments also publish the accommodation rates that public hospitals can charge private patients.

Ultimately it is up to the individual public hospital to decide to what extent they will respond to the State government incentives to recruit private patients. Most public hospitals have created additional positions with the specific task of marketing and recruitment of private patients at their hospital.
Whatever the mechanism adopted by the State the objective remains the same. This is to supplement the State government expenditure on public hospital to the maximum extent possible. In some states the public hospitals are left with a balancing act as they can be financially penalised for either not recruiting enough private patients or for exceeding the budgeted total number of public and private patients. Exceeding the total number of budgeted patients can incur additional cost without any compensating revenue from the State government.

National Health Reform Agreement

In 2011, COAG agreed to the National Health Reform Agreement, introducing significant changes to the previous National Healthcare Agreements. The implementation of this agreement will take several years, culminating in the introduction of uncapped Activity Based Funding by the Commonwealth from July 2014. From 1 July 2014 the Commonwealth will meet 45 per cent of the efficient growth of public hospital services, increasing to 50 per cent from 2017-18.

Under the National Health Reform Agreement, the price for acute hospital services will determined by the Independent Hospital Pricing Authority. Previously public hospital funding had been provided on a block grant or Special Purpose Payment (SPP), leaving States to meet the full costs of any increases over and above the indexation provided under the SPP.

The Business Rules for health providers operating under the National Health Reform Agreement are provided in Schedule G of the National Health Reform Agreement. The specific rules that determine the differential treatment of public and private patients in a public hospital are in essence as follows:-

- That inter alia no accommodation, medical, surgical or implanted prostheses charges can be raised for public patients.
- That private patients may be charged an amount for public hospital services as determined by the State, with the exception of pharmaceutical services.
- That election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission.
- That private patients have a choice of doctor and all patients will make an election based on informed financial consent.
- That an eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes.
- That hospital employees will not direct patients towards a particular choice.

These rules collectively set the scene for the differential treatment of patients that present at a public hospital with private health insurance.
Private Patients’ Hospital Charter

The Department of Health and Ageing publishes a Private Patients' Hospital Charter as a guide to what it means to be a private patient in a public hospital, a private hospital or day hospital facility.

The charter states that a private patient has the right to choose their own doctor, and to decide whether to go to a public or a private hospital that their doctor attends. The charter states that a person with private health insurance can choose to be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital.

The charter makes no reference to the need for the patient to sign a patient election form before they can be treated as a private patient in a public hospital. However the charter does state that as a patient with private health insurance, all hospital treatment and medical bills may be covered by the private health fund, or there may be some out-of-pocket expenses, an ‘excess’ or co-payment.

The charter provides no comment as to why someone with private health insurance would want their private health fund to pay for the public hospital services.

Statistics – Growth Trends


The following table depicts the broad categories of service provided by public and private hospitals in terms of the number of separations. Separations refer to the episode of admitted care, which can be from admission to discharge or beginning or ending in a change in type of care such as from acute to rehabilitation.
There are approximately 660 diagnostic categories of patients treated in acute hospitals. Private hospitals treat patients in 653 of these categories. The exceptions are liver transplant, multiple organ transplant, heart transplant, lung transplant, neonatal cardiac/vascular surgery, severe full thickness burns and HIV infection with catastrophic complicating conditions.

In regard to total separations approximately 60% of patients were treated in public hospitals and 40% in private hospitals. However as seen in the statistics below 10.5% of the patients in a public hospital in 2101-11 were private patients. Whilst both hospitals cover the majority of DRGs, public hospitals provide more childbirth, and emergency services.

The following graph is derived from data in both this report and the proceeding year’s AIHW report published in April 2011.
The graph shows the annual national growth of public and private patients in public hospitals from 2006-07 to 2010-11 measured by separations. Public patients are patients treated as public patients, and do not include patients paid for by DVA, Motor vehicle claims, workers compensation, etc. Private patients are patients paid for by private health insurance and do not include self-funded patients.

- Between 2005-06 and 2010-2011, public patients separations in public hospitals increased by 16%, whilst over the same period private patients in public hospitals increased by 50%.
- Between 2005–06 and 2010–11, public patient separations in private hospitals increased by 1.2% on average each year, while private patient separations in private hospitals increased by 6.9% on average each year.
- Between 2005–06 and 2010–11, public patient separations in public hospitals increased by 3.0% on average each year, while those funded by Private health insurance increased by 8.5%.
- The proportion of patients that used their private health insurance in either a public or private hospital out of the combined total of public and private patients in 2010-2011 was 42.5% not far below the proportion of privately insured persons within the Australian population, currently 46.6%. This is unchanged from the previous year where 42.5% used their insurance. This suggests that the great proportion of people with private health insurance use their insurance when admitted to a hospital.
- In 2010-11 (the most recent year of available AIHW data), 10.5% of patients in public hospitals were private patients.

The following graph shows the proportion of privately insured cases in public hospitals in each State. The data is provided by the Private Health Insurance Administration.
Council (PHIAC). PHIAC data is more up to date than AIHW data as it is based on claims paid by private health funds which are submitted quarterly.

The high proportion in NSW is of considerable concern to the NSW government. It reflects among other things how successful the NSW Local Health Districts and hospitals have been at recruiting private patients in NSW. This recruitment occurs both after the patient has arrived at the hospital expecting to be treated as a public patient, and by the surgeons who have been requested by the public hospital to find private patients to complete their lists.

Infrastructure NSW has recently expressed concern that the proactive practices of the Local Health Districts and hospitals to recruit private patients as a means of generating additional operating revenue is causing an unnecessary increase in the demand for investment in public hospitals. Infrastructure NSW conclude that less use of public hospital beds by private patients would provide additional hospital beds for public care, reducing waiting times and reducing the need for new capital expenditure.

Another factor affecting the proportion of cases in public hospitals funded by private health funds could be the accessibility of public and private hospitals in each State. A
rough proxy for accessibility is provided by the number of public and private hospitals and public and private beds in each State.

The following table taken from AIHW Australian Hospital Statistics 2010-2011 provides the number of public and private hospitals in each State.

| Table 4.3: Public and private hospitals\(^{(a)}\), states and territories, 2010–11 |
|----------------------------------|----------|------|------|------|------|------|------|------|
|                                  | NSW      | Vic  | Qld  | WA   | SA   | Tas  | ACT | NT  |
| Public hospitals                 |          |      |      |      |      |      |     |     |
| Public acute hospitals           | 218      | 150  | 166  | 93   | 78   | 22   | 3   | 5   | 735 |
| Public psychiatric hospitals     | 8        | 1    | 4    | 1    | 2    | 1    | 0   | 0   | 17  |
| Private hospitals                |          |      |      |      |      |      |     |     |
| Private free-standing day hospital facilities | 91       | 85   | 53   | 34   | 28   | 2    | 9   | 1   | 303 |
| Other private hospitals          | 86       | 81   | 53   | 24   | 31   | 6    | 3   | 1   | 285 |
| Total                            | 403      | 317  | 276  | 156  | 139  | 31   | 15  | 7   | 1,340 |

There were 1,340 hospitals in Australia in 2010–11. The 752 public hospitals accounted for 68% of hospital beds (57,772) and the 588 private hospitals accounted for about 32% of beds (28,000 private hospital beds based on 2009–10 data).

The number of public and private overnight beds in each State provided by these hospitals is shown below. The number of overnight beds determines the number of patients that can be treated for overnight cases in each Sector.

<table>
<thead>
<tr>
<th>Over Night Beds</th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>17560</td>
<td>11217</td>
<td>8927</td>
<td>4607</td>
<td>4486</td>
<td>1009</td>
<td>774</td>
<td>628</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>6019</td>
<td>6524</td>
<td>5616</td>
<td>2478</td>
<td>1690</td>
<td>636</td>
<td>345</td>
<td>100</td>
</tr>
<tr>
<td>% Private Beds</td>
<td>26%</td>
<td>37%</td>
<td>39%</td>
<td>35%</td>
<td>27%</td>
<td>39%</td>
<td>31%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Apart from the Northern Territory which only has one private hospital, NSW has the lowest percentage of private hospital beds consistent with NSW having the highest proportion of private patients being treated in public hospitals.

Victoria, has the third highest proportion of private patients in public hospitals, and the third highest proportion of private beds at 37%.

Tasmania, which has the second highest proportion of private patients in public hospitals, has the equal highest % of private beds at 39%.

This suggests that the correlation between the number of private hospital beds and the proportion of private patients in public hospitals is not that strong. In other words the relative lack of availability of beds in private hospitals does not appear to be a good indicator of the number of private patients in public hospitals. In the context of the other factors driving the number of private patients in public hospitals, namely the relative determination of public hospitals to find private patients, this finding is not surprising.
The following graph derived from PHIAC data clearly shows the significant and consistent annual growth in the number of cases where the patient has elected to be treated as a private patient in a public hospital.

The annual growth is primarily driven by the increased focus and resources public hospitals are applying to the task of converting public patients to private patients after the patient has already arrived at the public hospital. The majority of these are emergency patients as elective patients with private health insurance covering the treatment they need generally prefer to go straight to a private hospital rather than sitting on a public hospital waiting list for an indeterminate time. The growth is also due to more doctors choosing or being encouraged by the public hospital to treat their private patients in a public hospital, but this factor is seen to be less significant.

This success (from a public hospital perspective) is in large part being caused by the additional positions they have created within the public hospitals with duties specifically targeted at converting patients to elect to be a private patient. The following is an extract from the job description for a private patient administration position “to liaise with patients and multi-disciplinary staff to maximise hospital revenue through eligible admitted patients utilising their private health cover”.

One such job description has as its top two priorities: 1) Liaise with private patients to ensure they receive the program incentives. 2) Visit public patients, especially those flagged as having private health insurance, to encourage them to convert to private. With an increasing number of these positions being created it is no wonder the growth is occurring.
The following graph also derived from PHIAC data shows the significant growth in payments made by private health funds to public hospitals.

![Graph showing Public Hospital Accommodation Benefits Funded by Health Funds](image)

*Public Hospital Accommodation Benefits Funded by Health Funds*

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments (in millions)</th>
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<tbody>
<tr>
<td>1999</td>
<td>$1,000,000,000</td>
</tr>
<tr>
<td>2000</td>
<td>$1,050,000,000</td>
</tr>
<tr>
<td>2001</td>
<td>$1,100,000,000</td>
</tr>
<tr>
<td>2002</td>
<td>$1,150,000,000</td>
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<tr>
<td>2003</td>
<td>$1,200,000,000</td>
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<tr>
<td>2004</td>
<td>$1,250,000,000</td>
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<td>2005</td>
<td>$1,300,000,000</td>
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<td>$1,550,000,000</td>
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<tr>
<td>2011</td>
<td>$1,600,000,000</td>
</tr>
<tr>
<td>2012</td>
<td>$1,650,000,000</td>
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17.6% growth 2011 to 2012

Whilst the national trend is fairly smooth the growth in payments in individual States is not.

There has been for example a very large increase in Queensland in 2011 and 2012 as shown by the following graph again taken from PHIAC data. In interpreting this graph it is important to recognise that this is based on actual payments made by private health funds. Sudden spikes can therefore be caused by variations in the time between completion of an episode and actual payment. This is always more marked at a State level. Nevertheless the trend in 2011 and 2012 suggests a marked increase in private patients in Queensland public hospitals.
It is likely that the upsurge in 2011 and 2012 is caused by the public hospital guidelines the Queensland Governments introduced for optimising health revenue and a concerted effort by hospitals to adhere to these revenue optimising guidelines. The marked upsurge also reflects that Queensland was coming off a reasonably low base compared to where other States were in 2010.

The growth is consistent with a policy change introduced by the Finance Branch of Queensland government in September 2010\(^v\). The policy statement stated the following:-

*Hospital Admissions staff and Patient Option Liaison Officers who are unable to convert patients are now able to further influence the decision making process by:*

(i)  *discounting the front-end deductible upon their private patient election so that no excess/co-payment is payable;* and

(ii)  *offering a range of non-clinical products free of charge when the patient elects to be treated as a private patient, including: TV rental, Newspapers, Car parking for spouse/partner/parent, Meals for spouse/parent, Local phone calls and Toiletry kits.*

The following graph shows the public hospital benefits paid by private health funds as a proportion of the total hospital benefits paid for both public and private hospitals in each State in 2010, 2011 and 2012. The data is based on PHIAC data.
There has been significant growth in the proportion of public hospital benefits paid by private health funds in all States other than WA. The most significant growth is in Queensland where, as mentioned above, there has been considerable effort made by the State government and the public hospitals to optimise the revenue from non-government sources.

**Benefits and Rights of All Australians**

Australians take out private health insurance in the full knowledge that there is a public hospital option. Why then do they get insured? PHIAC endeavours to answer this question in their website [www.PHIAC.gov.au/why-get-insured](http://www.PHIAC.gov.au/why-get-insured) providing the statement:-

"While all Australians and permanent residents have access to Medicare and the public health system, private health insurance gives you more choices about your treatment, and it can help pay for things that the public system doesn’t cover" and,

*Private Health Insurance Provides Choices: A privately insured patient can decide to be treated in a public or a private hospital, can choose their own doctor and is often provided with flexibility with the timing of their procedure or treatment.*

The PHIAC statement puts the emphasis on having choice. Putting aside the financial penalties for not taking out insurance, it could be argued that the reason Australians do take out private health insurance, is not so much that they want choice between public and private (as they may not have a choice when it comes to wanting treatment), it is
because they are concerned that they won’t get access to a public hospital when they need it.

Taking out private health insurance simply increases their chances of getting into hospital when they need it. It gives them peace of mind against the backdrop of frequent newspaper articles bemoaning the long delays people are experiencing getting into public hospitals. The lack of equivalent articles with respect to delays in getting in to private hospitals speaks volumes.

Australians would not willingly pay for their private health insurance if they knew in advance that in fact they could readily get into a public hospital for their care when they need it. Whilst there is an interest in being able to get a doctor of their choice, surveys show that Australians are aware that the standard of care in public hospitals is generally excellent regardless of the treating doctor.

Whilst Australians that take out private health insurance do so for the flexibility it gives them, there is no expectation that they will use their private health insurance in a public hospital. Why would they? They know that they are fully entitled to go to a public hospital without their insurance. They did not take out private insurance so that they could use it at a public hospital.

If a privately insured person is admitted to a public hospital without having been directed there by a doctor of their choice they are simply exercising their right as a tax paying Australian citizen. This was an option available to them prior to taking out private health insurance and remains there after taking insurance.

The fact that privately insured patients claim on their insurance at a public hospital is invariably because they are persuaded by the public hospital admittance staff who have been directed to ask the question: Have you got private health insurance? There is almost only one motive for this question being asked, and that is to obtain additional revenue for the public hospital. Whilst the patient may get a free newspaper or access to a private room as a result of agreeing to use his/her private health insurance, these benefits are blatantly there to entice the patient to agree. The cost to the health funds and Medicare should the patient succumb to electing to be a private patient are many times the cost of the newspapers and free TV, etc. The private rooms are also available for public patients. Giving these in preference to a private patient is a questionable practice.

In the majority of cases the public hospital leans on the patient to elect to be treated as a private patient after they arrive at the public hospital. This is hardly acceptable behaviour as the patient has now already committed to attend the public hospital with no intention to use their private health insurance, and is undoubtedly in a stressed and vulnerable position.

It is unlikely that it will occur to the patient that he/she will be paying for the hospital care twice, once through their contribution to taxes and once through the payment of
health insurance premiums. Even if this does occur to them they are hardly in a position to present a coherent case or argue against the very people their wellbeing (and possibly life) depends on, as to why they should not use their private health insurance.

Expecting a patient with private health insurance to pay for his/her public hospital care because he has private health insurance is similar to expecting someone to pay for public schooling because they took out a financial savings plan to cover the cost of private schooling but elected to go to a public school. In virtually all cases the insurance was taken out to cover the cost of private hospital care not public hospital care.

It could be argued that the patient elects to be a private patient when presenting themselves at a private hospital and a public patient when presenting themselves at a public hospital - with the exception being if there admittance at the public hospital was pre-arranged by a doctor of their choice.

People with private health insurance make an independent decision to go to a public hospital for several reasons, such as the following:-

- A belief that for in critical emergency it is best to go to a public hospital
- The lack of a nearby private hospital with emergency care facilities
- The private health insurance product they have purchased has an exclusion for the treatment they now need
- They wish to avoid paying the Excess fee or Front End Deduction
- They wish to avoid paying the doctor’s out of pocket fees

And for all these reasons they understand that they are entitled to make this decision to attend a public hospital just like any other person with or without insurance cover.

The other reason a person with private health insurance may elect to go to a public hospital is because their specialist prefers to operate in a public hospital. In this case they will probably be admitted as a private patient as to do otherwise would deny the specialist from receiving fees for the treatment he provides. The surgeon may decide to treat his/her patients in a public hospital for convenience or because if he does not do so the public hospital has told him/her that the public hospital has no budget for public patients and he/she will risk having their surgery lists reduced if they don’t comply.

**Patient Election Standards**

There are Commonwealth Patient Election Standards governing the process of patient election at a public hospital. For example in order to conform to the National Health Reform Agreement the patient must be told that he can nominate a doctor of his own choice. And only if the patient agrees to this can they be made a private patient.
The choice of doctor however means very little for a patient that has already arrived at the hospital as more often than not the patient will not know one specialist from another. In any case the choice is normally limited to those specialists in attendance at the hospital – particularly if it is an emergency admittance. In the case of emergency the doctor that is nominated is the doctor who is “on take” at that particular moment. At some small hospitals there may be only one doctor on duty and then the choice is limited to this one doctor.

The doctors on the other hand are keen to be chosen by the patient as the nominated doctor as then they can both bill the private health fund and Medicare. A Visiting Medical Officer would typically receive a minimum of 25% more for operating on a private patient than what they would earn from the public hospital hourly rates.

If the doctor is salaried and his/her contract requires 100% of the Medicare fees to be paid to the public hospital, then it is the hospital rather than the doctor that benefits. Either way it is a win-win situation for the hospital and doctor as in those cases where the doctor donates his Medicare fees to the public hospital this is invariable in exchange for a higher salary.

Overall there is thus very small benefit to the patient in electing to go private but a significant financial benefit to the doctors and hospitals. What the patient may see is greater continuity of care from the one doctor as it is in this doctor’s interest to provide this.

National Health Reform Agreement- Public Hospital Admitted Patient Election Forms

Some of the Business Rules for health providers operating under the National Health Reform Agreement were mentioned in the introduction. These, with underlining now added, were:-

- That inter alia no accommodation, medical, surgical or implanted prostheses charges can be raised for public patients.
- That private patients may be charged an amount for public hospital services as determined by the State, with the exception of pharmaceutical services.
- That election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission.
- That private patients have a choice of doctor and all patients will make an election based on informed financial consent.
- That an eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes.
• That hospital employees will not direct patients towards a particular choice.

In schedule G4, under the heading “Public Hospital Admitted Patient Election Forms” the following further rules are provided pertaining to the patient election forms:—

“States agree that while admitted patient election forms can be tailored to meet individual State or public hospital needs, as a minimum, all forms will include the following statements:—

(a) all eligible persons have the choice to be treated as either public or private patients.
(b) a private patient may be treated by a doctor of his or her choice and may elect to occupy a bed in a single room. Any patient who requests and receives single room accommodation must be admitted as a private patient.
(c) a patient with private health insurance can elect to be treated as a public patient;
(d) admitted public patients will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services;
(e) private patients will be charged at the prevailing hospital rates;
(f) private patients may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered;
(g) private patients are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital;
(h) evidence that the form was completed by the patient before, at the time of, or a soon as practicable after, admission.;
(i) a statement that patient election status after admission can only be changed in the event of unforeseen circumstances.;
(j) a statement signed by the admitted patient acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision;
(k) a statement signed by the admitted patient authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund; and
(l) where an election is not made, these patients will be treated as public patients and the hospital will choose the doctor.

Concerns with the Business Rules pertaining to patient election

1) The business rules state that “On admission, the patient will be given the choice to elect to be a public or private patient”
   a) Why is this necessary? As the patient has presented at a public hospital couldn’t the patient be admitted as a public patient, and only if the patient asks to be treated as a public patient, then the patient election form is presented.
   b) If there is a question to be asked, isn’t the question to be asked whether the patient is prepared to be treated by doctors chosen by the hospital, and if not which doctor do they wish to be treated by?
c) The requirement that the patient will be given the choice provides the opportunity for the public hospitals to lead with the question “Do you have private health insurance?” A positive answer to this question qualifies the person for special attention by the admission staff who have been directed get the person to use their health insurance. An alternative phrase could have been “On admission, the patient has the choice to elect to be a public or private patient”. With this wording there is no implication that the public hospital should be proactive in giving a choice to the patient, it is instead the responsibility of the patient to initiate the request to be a private patient.

2) The phrase "will be exercised in writing before, at the time of, or as soon as possible after admission" is fine in principle, but given that hospitals sometimes chase patients several days after admittance to change their election status, the words “but in any case within the first 24 hours” could be added.

3) Why do the business rules state that “Any patient who requests and receives single room accommodation must be admitted as a private patient.” Surely a public patient should have the right to request and receive a single room if one is available, given that the single room was built using State government capital.

4) The election standards should require that the patient be alerted to the possibility that his case could be covered by another third party insurer and that if this is the case his/her health insurance will not cover the hospital costs. For example, if a hip fracture was caused by a motor vehicle accident, tripping over at the shops, falling down the stairs at home or at a friend’s house, or at a factory at work then the claim would be covered by a third party insurer rather than a private health fund case.

**Strengthening the patient election standards**

1) The above minimum standards for election could be strengthened by including statements along the following lines in the business rules:-
   a) The hospital must not offer inducements to entice the patient to elect to be a private patient that are not also available to public patients.
   b) Where additional services such as TV, newspapers, meals for family members, etc. are offered then the charge for these additional services must be clearly stated.
   c) Private Health Insurance is primarily designed to cover the costs of treatment at a private hospital. Given all eligible Australians have a right to free treatment at
a public hospital, private health funds should not be expected to pay for public hospital services for their members.

2) The above minimum standards for election could be strengthened by including statements along the following lines in the Patient Election Forms:-
   i) The quality of care you receive will be in no way compromised if you elect to be treated as a public patient.
   ii) If you elect to be treated as a private patient at a public hospital then this will increase the costs of private insurance and ultimately lead to higher premiums for privately insured members.”
   iii) You are not required to pay for your patient care at this public hospital as a public patient, however if you elect to be a private patient then you will be responsible for all charges. Your private health fund may reimburse you for some of the charges dependent on your cover.
   iv) You acknowledge that the hospital charges you will be responsible for as a private patient are not commensurate with the additional services you receive as a private patient (TV, Newspaper, choice of doctor) but include basic services available to public patients.
   v) In making a decision as to whether to elect to be private consideration should not be given to any benefit (financial or otherwise) that might accrue to the public hospital.
   vi) You acknowledge that the hospital has offered no inducements that are not also available to a public patient at a cost.

Recruitment of Private Patients

State Government Actions to Encourage Recruitment of Private Patients

There is no suggestion in the Health Reform Agreement that the State governments should encourage patients to elect to be treated as a private patient to increase hospital revenue and/or reduce State costs. It is also not the intention that this be so. This is clear from the statement in the rules that public hospitals must not “direct” patients one way or another. It is also clear from the concept of “revenue neutrality” expressed subsequently in documents prepared by the Independent Hospital Pricing Authority.

Nevertheless the incentive for State governments to encourage public hospitals to increase revenue by enticing patients to elect to be private is there as this not only provides additional revenue from the private health funds but also shifts the cost from
the State to the Commonwealth as the Commonwealth funds Medicare and pays 30% to 45% of private insurance costs through the rebate.

The incentive is likewise there for the public hospitals as it means they get additional revenue over and above the payments received from the State governments.

**Victorian Government**

Prior to July 2011 the Victorian government set private patient revenue targets annually for each hospital. As an incentive public hospitals could retain the private patient revenue above these targets. However the revenue target was effectively deducted from State government funding to the hospital, such that it was imperative that the hospital achieves a sufficient number of patients who elect to use their private health insurance so that the revenue target for private patients was met. Failure to obtain the required number of private patients meant revenue loss for the hospital. As making a loss was not a desirable outcome the decision was made that post July 2011 the public hospitals would be able to keep 100% of revenue generated from private patients.

Consistent with this approach the price paid by the Department for private patients was reduced to 76% of the public price. The current inpatient rates for Victorian public hospitals retain this 76% reduction as can be seen in the Victorian Policy and Health Funding Guidelines, shown below:

As can be seen in the table the WIES price for private patients is 76% of the price for public patients. WIES is the Victorian government's Weighted Inlier Equivalent Separation which is the DRG based unit of costing used for inpatient acute cases in public hospitals.

The Victorian government still sets an overall target for private and public patients as a budget setting measure. Funding for throughput above the target is provided at 33% of the below target rate up to 2% above target and then funding ceases. Any recruitment of private patients that would not otherwise go to a public hospital thus means less capacity for public patients.
DVA and TAC continue to be funded to actual activity and therefore attract additional funding for throughout above target at the rates in the above table. DVA, TAC and WorkSafe are not included in the throughput targets.

The Victorian Government provides comprehensive information on the public/private rights of patients in its web site www.health.vic.gov.au in a document “Fees and Charges for Acute Health Services in Victoria”. This closely reflects the agreements entered into with the Commonwealth.

**New South Wales**

The precise financial arrangements between the NSW government and the NSW Hospitals with respect to private patients have not been able to be ascertained. Suffice to say however the incentives for public hospitals to convert patients to private are very strong and must have been there for at least a decade based on evidence of public hospital behaviour in NSW and the fact that NSW public hospitals have more private patients than any other State.

In a NSW Technical Paper “The Next Step – Funding Reform”, it is stated that adjustments are made to the National Weighted Activity Unit (NWAU0 for private patient service and accommodation to account for other revenue sources for treating private patients such as payments by private health funds and reimbursement through the Medicare Benefits Schedule (MBS). But there is no more detail than this on the payment arrangements between the State government and the public hospitals. The mechanism and size of the adjustments is not known.

**Queensland Government**

The Queensland government has produced guidelines for optimising health revenue. These guidelines with an effective date of 1/7/12 through to 30/6/2015 state that revenue generated from patient treatment over set target levels will be retained by the HHS (Hospital and Health Services).

The Queensland government’s submission to the Independent Hospital Pricing Authority (IHPA) comments on some of the adverse effects of this policy: “In the case of accommodation services, the private health insurance default bed day rate overstates the amount of revenue received by public hospitals. According to the latest Private Health Insurance Administration Council data (September quarter 2011), 79% of private hospital insurance policies in Queensland now have an excess and copayment. Standard practice in public hospitals is for the hospital to waive the excess or co-payment.”

However it should be noted that the private health insurance default bed day rate does not overstate the amount of revenue received by public hospitals at all. What is happening is that the public hospital is choosing to pay the excess for the patient which
is an additional cost to the hospital which is entirely discretionary. It is being paid to the patient as a form of inducement.

The Queensland government has produced a guide for its public hospitals titled “Guide to Optimising Own Source Revenue”. This document, document Number # QH-GDL-004:2012 with effective date 1/7/2012 provides in a section called “Patient Election Forms” information that health services staff need including the requirement to provide all inpatients with the booklet “Your Rights and Responsibilities” which comprehensively outlines the rights to be treated as a public or private patient among other things. These documents are consistent with the agreement entered into between the Commonwealth and the States in regard to the question of private patients in public hospitals.

The Queensland government has been aware of this opportunity for a long time (but perhaps slow to react) as a PricewaterhouseCoopers report, commissioned by Queensland Health in 1999, recommended hospitals routinely waive or pay insured patients’ front-end deductibles (FEDs) - effectively their insurance excess - to potentially raise a further $20-$30 million to each year at the expense of private health funds.

**South Australia**

The South Australia government has probably the most sophisticated private patient payment arrangements of any State. Instead of discounting the public patient price across the board as done in Victoria for private patients, the cost weigh is varied at the DRG level. In this way the private patient payment discount can be adjusted not just for the accommodation charges but also for prostheses costs. This allows greater equivalence in the payments for public and private patients. As an illustration the weight for the implantation of an AICD without complication is 4.9 for a public patient and 1.39 for a private patient. This means that in SA the payment from the government to the public hospital for a private patient is only 28% of the payment for a public patient, a reduction of 72%. This is because the expensive defibrillator for a private patient is paid by the private health fund. For States that don’t discount at the DRG level the financial returns in treating a patient needing a defibrillator as a private patient is very high as not only is the defibrillator paid for by the private health fund but the government payment is not reduced to take this into account. By comparison in SA a hernia procedure without complication receives a weight of 0.88 for a public patient and a weight of 0.55 for a private patient – a reduction of 37% as opposed to 72% for an AICD implantation.

An important advantage of the SA approach is that it removes the very significant incentive that exists to treat private patients with high prostheses costs. Instead the incentive to treat private patients is evenly spread evenly over all DRGs.
With respect to encouraging patients in public hospitals to elect to be private their policies are the same as in other states. The purpose of SA revenue optimisation strategy is stated to be: “To implement appropriate processes and controls to optimise hospital revenue, including maximising the number of patients who elect to use their private health insurance to be treated as private patients”.

**Surveys of Patient Choice & Election Processes**

The Australian Bureau of Statistics conducted a survey of patient experiences, the results of which were published in July 2010 in a paper titled “Health Services: Patient Experiences in Australia”. The paper provides useful statistics on the percentage of privately insured people choosing to be treated as a private rather than public patient. A representative sample of 7,124 households completed the survey. The results of the survey were that:

- 46% of people with private health insurance that were admitted to hospital had been given the choice to be treated as a public or private patient on their most recent visit.
- 24% of people with private health insurance chose not to be treated as a private patient on their most recent visit.
- 84% of people with private health insurance felt that they had been given enough information to make a choice.

A 2002 Australian Health Review Paper reported on the results of a study conducted at the Austin & Repatriation Medical Centre which examined the reasons for privately insured patients electing not to use their private health insurance in public hospitals, and methods by which they might be overcome. The findings were that only 25% of the patients with insurance indicated that being able to choose their treating doctor was benefit enough to influence their choice of going private rather than public, 47% indicated that there was no incentive to use their PHI as they received no extra benefits and 37% indicated that they thought it was “a waste” of PHI and not value for money. As a result of these and other findings the Austin & Repatriation Medical Centre concluded that there were potential gains by appealing to patients’ sense of community by emphasising the contribution of private patient revenue to the financial viability of the hospital.

Another patient survey was also done by a private health fund of 357 patients who had “elected” to be treated as a private patient in three NSW and two Queensland hospitals in the second half of 2012. The purpose of the survey was to determine whether an “appropriate election process” had been followed by the hospital. 96 (27%) of the surveys were returned with varying responses and comments.

- Overall from the five hospitals that was surveyed only 50% of persons answered that they were given the correct process and information in regard to being admitted as a private patient. 37% of persons answered they were not given the correct process.
- In many cases it was clear that the ‘election process’ was being abused by the Public Hospital. It is still common for many hospitals to ask: “which Fund are
you with” rather than ask: “Are you electing to be a public or private patient”. This is completely contrary to the agreement entered into between the States and the Commonwealth, which among other things states that “hospital employees will not direct patients towards a particular choice”. Clearly asking which fund a patient is with is not a pertinent question until after the patient has elected to be private.

- Some of the comments included: “the hospital only asked for my health insurance card” or “if you use your health insurance you are assisting in providing better facilities for the hospital”. Other comments stated - that they thought if they elected to go private they would be given better care and faster attention however with one survey revealed that a member discovered this was not the case.

- The survey showed that almost 1 out of 2 members who are being admitted to these public hospitals are being deliberately influenced to choose to be a private patient. The results also indicated that the patients were not being provided the necessary information to make informed choices.

Another survey was conducted some time ago by a South Australian private health fund and feedback from this review included:

- Hospitals offering to waive excess, co-payment and access gap payments if members went private
- Members being informed that hospitals ‘need the money’ as they are ‘underfunded’
- Members being told that ‘it won’t cost you anything.

**Admission Procedures for Private Patients**

Patient admission to a public hospital falls into two streams: planned (elective) and unplanned (emergency). This section outlines the typical public hospital admittance procedures involved and the point at which the hospital asks if the person has private health insurance.

In the case of a planned admission the GP may refer the patient to outpatients where a salaried specialist at the public hospital will examine the patient and if appropriate put the patient on the hospital waiting list for treatment. The patient then waits for advice on when he/she can attend the hospital for treatment. The hospital will normally telephone the patient to advise them of the date and time and at this point ask for details including whether they have private health insurance, and encourage them to declare their intention to use it, explaining that this will help the hospital. On admittance someone from the public hospital’s Private Patient Liaison Team will meet the patient and ask them to confirm their intention to use their private health insurance and ask them to sign the election form.
In the case of an unplanned admission where the patient has perhaps arrived at the hospital in an ambulance, the triage nurse attends the patient and an assessment is made. If the patient is to be admitted, then as soon as possible after that a clerical person will ask the patient if they have private health insurance and if so encourage them to use it, pointing out the benefits to them and the hospital if they do.

There are two other cases where a privately insured person will intentionally go to a public hospital either as a planned or unplanned admission. One is where he/she has an exclusionary product which excludes treatment for the treatment that they need. In this case they will remain a public patient as the public hospitals when enquiring whether they have private health insurance also take great care to ensure that the person has insurance cover for the required treatment before assisting them to complete the private election form. The other is where there is a special relationship between the specialist and the patient and the specialist would prefer to treat the patient at a public hospital where he/she has admitting rights. In this case the patient could be a public or private patient depending on their insurance status.

The great majority of private patients in a public hospital have come through the unplanned admission rather than the planned admission stream.

The reason for this is simply that there is always a waiting list for planned admissions at a public hospital and there is normally no incentive for a person with private health insurance to wait on a waiting list when they can get treatment earlier at a private hospital. The only exception to this is where the Surgeon is given priority for his private patients over the public patients and it is know that this does occur.

Specific Examples of Recruitment Practices in Public Hospitals

In 2005 a major NSW hospital recognising that they were not realising the potential that patients with private health insurance offered prepared a comprehensive and specific business plan to target private patients which were subsequently implemented. The business plan required that there be specific private patient revenue targets.

Recognising that staff were distracted with non-private patient tasks the business plan required that duties be separated and that additional staff be recruited and tasked with the job of reviewing every hospital admission and visiting every overnight patient within 24 hours of their admission. The business plan also required that the admission process be automated to assist the process of converting patients from public to private. The business plan also required that the conversion of initially undecided patients with PHI be monitored. The increase in conversions as a result of implementing the recommendations in the business plan was considerable.

In 2009 Australian Private Hospitals Association executive director Michael Roff was reported as saying that public hospitals taking responsibility for patients' FEDs, or their gap fees, was becoming increasingly common and was of serious concern. Mr Roff
cited a brochure from the Ballarat Health Services, where pregnant women with private health insurance were offered up to $600 to use a public maternity ward and bill their private health fund. The brochure states that the money was not only available to pay the FED, a single room co-payment or payment to a private obstetrician, but could also be traded for a trip to Melbourne to see a show, have the patient’s house cleaned or a day spa visit, among a range of benefits.

The following specific examples are taken from letters from patients addressed to their private health funds, and reports by the private health funds themselves based on direct patient feedback following hospitalisation in a public hospital.

• In some hospitals there are posters/signs located on walls/corridors of the waiting areas and treatment areas/rooms of accident and emergency departments encouraging patients to utilise their private health insurance.

• A letter from a patient that has been discharged states the following: - “I have already informed the hospital in writing that I did not want to cost shift our expenses to our private health insurance. Despite this notification we have received the enclosed follow up request. I do not feel it is appropriate for the hospital to pursue patients to change their decision. We sacrifice a lot to maintain our insurance and I have made this decision to help ensure that premiums do not increase unnecessarily.’

• Another letter from a patient states the following: - “I arrived at the hospital in an ambulance and was asked if I had private health insurance. I answered yes and was given all the documentation to sign. I don’t believe that I was really given a choice to be a public or private patient, and I don’t believe I received better or different treatment because I was a private patient.”

• A patient who received an anaesthetist bill and was questioning why she received it when she had been in a public hospital, discovered that three days after her admission for a broken leg the hospital had asked her husband to sign a form so that she would not be charged for the TV. As far as he was concerned it was the TV he was signing for not the private admission!!! However the hospital insisted on charging the patient as a private patient.

• Similarly, when a fund questioned a delayed election with another public hospital the hospital produced a statement to show that he had in fact received his newspaper, and that therefore he was a private patient.

• Patients have highlighted public hospitals requesting they elect to be a private patient with a guarantee that the hospital will cover any excess and also ensure there are no out of pockets for medical for the patient or the health fund or cover the medical costs.

• A patient reported being visited by the private patient liaison officer 2 days after admission with a sealed envelope with information encouraging the patient to use their private health insurance, what the benefits would be to the hospital, etc. The liaison officer then visited every day following to see if the patient had made a decision.
• A patient reported that as an encouragement to elect to go private they were told that the money provided by the health fund will go into research for the condition that he was admitted for.

• Patients have advised that at one hospital the intake clerk/nurse asks the patient if they have PHI and takes further details at the point of presentation to triage in the emergency department.

• There have been several examples in South Australia where the patient has signed both private and public election areas and both signature areas have been marked with “X”, presumably by the hospital staff. In addition there have been frequent cases where the witness signature is not identifiable, just a squiggle with no name printed with the position. There have been cases where the witness signature is not dated or dated differently to the signature by the patient.

• It is far from clear in many cases whether the patients that have agreed to sign an election form to be a private patient are treated any differently to a public patient. Post discharge dated election forms have been received which have in some cases have been posted to the member to complete after discharge

• There are several cases where patients have reported being coerced to be treated as private patients:

**Public hospital pressure on doctors to admit private patients**

In the above sections the emphasis was on the recruitment of private patients from public patients that have already arrived at the hospital expecting to be admitted as a public patient.

There is another important source of private patients and that is from the surgeons themselves, particularly the Visiting Medical Officers (VMOs), but also Salaried Medical Officers (SMOs).

If the surgeons can be enticed to admit their patients to a public hospital then this increases the revenue to the public hospital. In some States the public hospitals therefore put considerable pressure on the surgeons to bring in private patients rather than treat them at a private hospital.

At some hospitals, particularly in NSW the hospital administration staff will tell the surgeon that the hospital only has budget cover for a fixed number of public patient hip replacements and that the surgeon must fill the rest of his list with private patients or risk losing the surgical time allocated to him/her.

The surgeons naturally respond to this pressure as:-

a) The surgeon does not want to have their list cut back, and
b) The no gap fees from the insurer/Medicare are better than the fees the surgeon will receive at the public hospital hourly rate.
Once a VMO decides to admit their patient to a public hospital their private patient is given priority over those public patients already in the waiting list.

The private patients are informed that they will have no out of pocket payment and go on the surgical list immediately.

At some NSW hospitals the surgeon is required to treat as many private patients as public patients. Whether this practice exists in other States to the same extent was not able to be ascertained.

**Revenue from Private Patients in Public Hospitals**

Private patient brings five additional revenue streams to the hospitals which are non-existent with public patients. The revenue streams are:

- Accommodation fee charged to the private health fund
- Diagnostic imaging charged to Medicare (75%) and the private health fund (25%)
- Pathology charged to Medicare (75%) and the private health fund (25%)
- Prostheses charged to the private health fund at a price typically 45% greater than cost
- Procedural fee (up to 100% of fee in the case of salaried specialist)

**Accommodation Fee**

The accommodation fee is set by the Commonwealth and State governments for shared and private rooms respectively. The Commonwealth fee for a shared room is referred to as the Default Rate. As private health funds are legislatively required to pay the shared room Default there is no out of pocket risk for the patient if the public hospitals charge this amount.

As a result public hospitals invariably charge the Default shared room rates set by the Commonwealth when the patient is in a shared room.

The shared room Default rate is $313 per day in the ACT, NSW, NT, SA and WA and $320 in Queensland. Victoria and Tasmania have a range of shared room Default rates from $378 to $262 per day depending on the category of care (Advanced Surgery, Surgical/Obstetrics, Psychiatric and Other), as well as a step down payment rate which reduces with length of stay.

The private room rates are set by the State Government and these vary from $538 to $729, the highest rate being in Victoria for the first 14 days of advanced surgery.
Over recent years the public hospitals have been charging progressively more for private rooms consistent with the rates defined by their State governments and private health funds have generally been reimbursing the patient the full amount. However there is no requirement for the private health funds to pay more than the shared room Default. As a result the two largest private health funds have recently decided reduce their reimbursement for private rooms to a little more than the shared room Default rate.

What has effectively happened is that the State governments have pushed the private room rate up to a point which the market can no longer bare and so private health funds are electing not to pay it.

Private health funds have always paid a private room add-on for their members when the private hospitals have provided their members with a private room rather than a shared room. Market rates have determined the size of this private room add-on which is typically $60 to $70. As there is no reason why the additional cost of a private room over a public room in a public hospital should be more than the additional cost of a private room at a private hospital these private health funds have set the add-on rate that they will pay for a private room at these levels.

Prior to these changes being introduced the total accommodation fee paid by private health funds was $864 million (2012 figure).

**Diagnostic Imaging and Pathology**

Public hospitals must cover the cost for diagnostic imaging and pathology from their State provided expenditure budgets for all public patients. However if a patient agrees to elect to be a private patient the public hospital can invoice Medicare for 75% of the schedule fee for these services. In addition the public hospital can bill the health fund for the remaining 25% of the schedule fee.

For public patients on the other hand the only revenue source is from the discharge medication at the hospital pharmacy if the patient chooses to purchase his ongoing medicines there rather than down the road.

This source of private patient revenue can be very lucrative for the hospital as some services such as PET scans and nuclear medicine are very expensive.

**Prostheses**

Private patients requiring prostheses provide public hospitals with a very attractive and highly profitable revenue source.

The reason for this is that public hospitals obtain their prostheses at prices the State governments have negotiated with the prostheses providers including any handling
charges if any. As a result of the buying power of the State governments and the competition within the prostheses industry the prices are reasonable.

However for private patients, despite the fact that the prostheses come from the same store as those for public patients the prostheses are charged, not at the cost to the hospital, but at the amount determined by the Current Private Health Insurance (Prostheses) Rules. This amount (the so called minimum benefit amount) is considerably higher than the cost to purchase the prostheses. In some cases the mark up is 200%. The private health funds are legislatively compelled to pay this higher price despite the fact that it is well above the cost of the prostheses to the public hospital.

This is thus another reason public hospitals find it attractive to convert patients to private status. Whilst there is no profit at all in treating a public patient from the prostheses item there is a very large profit to be obtained from a private patient.

The private patient is of course not advised of this profit taken by the public hospital. It costs the private patient nothing and the private health fund is compelled under legislation to pay the amount charged by the public hospital.

PHIAC data on Prostheses in public hospitals indicates that $123 million was paid by private health funds for prostheses at public hospitals in 2012.

The fact that public hospitals are able to purchase prostheses at prices well below those on charged to the private health funds is covered in detail in the Productivity Commission’s 2009 report “Public and Private Hospitals” xiv. Of the 20 DRGs with the greatest average cost per separation the public prostheses cost is around 55 per cent of that charged to the private health insurance funds. Using this percentage the profit to public hospitals from the on charging of prostheses to the private health funds in 2012 is estimated to be $55.4 million.

As things currently stand with the Independent Hospital Pricing Authority this situation will be unchanged post July 2014, despite representation made by the health insurance industry. As a result public hospitals will continue to target those patients due for a prostheses implant and try to convince them to elect to be treated as a private patient.

Revenue from Medical Practitioners

The ability to charge Medicare for services provided by medical practitioners is another compelling reason for public hospitals to prefer patients to be private rather than public.

Once a patient has nominated a doctor and elected to be treated as a private patient then bills can be raised against Medicare Australia transferring costs from the State to the Commonwealth. It is not necessary for the patient to be admitted by a medical practitioner for this transfer of costs to occur.
In addition to the payments made by Medicare, there are also payments made to the doctors by the private health funds themselves.

Once a patient has elected to be treated as a private patient the doctor has the right to charge the patient fees as he/she deems appropriate. A Salaried Medical Officer (SMO) may as part of his/her Right of Private Practice Agreement be required to charge as per the MBS schedule – however this is not always the case. But in most cases no such restriction applies to a Visiting Medical Officer (VMO).

Where medical practitioners charge in accordance with the Medical Benefits Schedule (MBS) for private patients, 75% of the schedule rate is paid for by Medicare and 25% is paid for by the private health insurance fund. This revenue is then shared with the public hospitals based on the Right of Private Practice Agreement in place between the doctor and the hospital. With some agreements 100% of the MBS fees is retained by the hospital as hospital revenue. This revenue is received from all doctors involved on the case which includes the principal surgeon, assistant surgeon, and the anaesthetist.

In the case of SMOs the hospital normally raises the charges on behalf of the medical practitioner. Whilst this fee is raised against the doctors provider number and made payable to the doctor, the actual bank account into which the fees are paid belongs to the public hospital.

A Visiting Medical Officer (VMO) on the other hand has his MBS fees paid into his own account and instead pays a facility fee to the hospital.

Private patients are a particularly important revenue source in those States where it is common for employed doctors to give 100% of all receipts for private patients to the hospital. This then allows the hospital to pay the doctors salary, indemnity insurance, special equipment and other benefits such as support for conferences that the doctors may wish to attend.

Whilst in Victoria and WA much of the MBS revenue is retained by the public hospital this is not the case in Queensland. The Queensland government’s submission to the Independent Hospital Pricing Authority (IHPA) states that “Much of the MBS revenue is retained by the specialist rather that received by the public hospital. Generally, the hospital receives a facility fee with the balance of the income forming part of the specialist’s remuneration. Different specialists and services have different facility fees. These arrangements assist in the employment of specialists. If a hospital negotiated not to pay a doctor any MBS income as part of their remuneration, the cost of employing the specialist for their public work would be higher (and the relevant cost buckets for public patients in the NHCDC would be higher).”

A further factor that is often cited is that public hospitals need to allow their senior medical staff to take in private patients if they are to attract and retain high quality medical specialists within the public hospital system. Allowing medical specialists to treat private patients in public hospitals enables them to supplement their public
hospital income. Without such a scheme operating, it is argued that the public hospital system would miss out on the services of clinicians who would otherwise no work in the public system.

The alternative argument, expressed by the private hospitals, is that there is no impediment whatsoever to staff specialists employed by public hospitals admitting and treating their privately insured patients in private hospitals, particularly where the private hospital is co-located with the public hospital, e.g. Prince of Wales Private Hospital (Sydney) and Melbourne Private Hospital. In fact the basic principle behind public/private hospital co-locations is predicated on exactly this occurring.

It is difficult to ascertain the total medical benefits revenue received by public hospitals.

Based on an extrapolation of the Medicare and medical benefits paid by nearly 50% of the private health funds it is estimated that in 2012, Medicare paid $256 million and the private health funds paid $128 million. The proportion of the total $384 million retained by the public hospitals however depends on the contractual arrangements between the public hospitals and the SMOs and VMOs. This varies significantly between the States.

**Total Revenue Growth**

The Australian Institute of Health and Welfare provides information on the revenue growth from private patients and other sources in their report, Australian Hospital Statistics – 2011-2012.

*Between 2006–07 and 2010–11, public hospital recurrent expenditure increased by an average of 5.9% per year in constant price terms (adjusted for inflation). Over the same period, public hospital revenue increased by an average of 9.8% per year (adjusted for inflation). Public hospital revenue comes from private patients, the use of hospital facilities by salaried medical officers or private practitioners exercising their rights of private practice, and other recoveries, plus investment income, income from charities, bequests and accommodation provided to visitors.*

Revenue growth from private patients and other non government sources exceeded expenditure growth over the period 2006-07 to 2010-11 by 3.9% on average per year.

**Public Hospital Waiting Lists versus Referral to a Private Hospital**

One would think that public concern in regard to public hospital waiting lists would drive public hospitals to scan their waiting lists for privately insured patients (remembering this is data that is usually collected at the time of putting the patient on the waiting list) and offer to assist them to be referred to a private hospital.
The reason this is not done is due to the loss in potential revenue that the public hospital will incur, revenue which is on top of what they would receive for a public patient. Private patient revenue can typically represent 10% of a hospital’s revenue.

There are however situations that arise from time to time where the public hospital waiting list becomes of political concern. In these situations the State Health Departments have provided additional financing to the public hospitals to enable them to pay private hospitals to take patients off their waiting list. Given that the patients are normally only on the waiting list if they are either without private health insurance or with private health insurance with an exclusion which does not cover the treatment they need the patients are and will remain public patients. In this situation the patients are therefore treated as public patients in the private hospital. This can be of considerable concern to private paying patients when they find themselves in the same ward as a non-paying public patient.

If reducing the public hospital waiting list was deemed an ongoing higher priority by the State governments then they would direct the public hospitals to offer assistance to privately insured patients to be referred across to a private hospital for their treatment and meet the cost of the lost private patient revenue the public hospital would have otherwise received. The cost to the State government of doing this would be considerably less than the cost of additional funding to pay for the patient to be treated at a private hospital.

The reason this is not done, is that over a full year, State government expenditure in referring and paying for patients at private hospital on the odd occasion that politics demands it, is significantly less than the annual revenue that the public hospitals receive as a result of treating private patients.

With the current financing arrangements there is therefore little incentive to refer patients to a private hospital other than when the waiting lists become a political issue.

If public sector financing was arranged differently then things could be done differently. For example once a patient has indicated they have private health insurance they could be given the choice to be referred in a timely way to a private specialist and a private hospital and actively assisted by the public hospital in arranging this referral if this is the patient's choice and the referral is clinically safe and appropriate. Of course, having been given this choice, if the patient preferred to receive treatment at the public hospital, then this choice was respected and implemented. This system operated with great effect as a demand management strategy 24/7 at The Alfred Hospital in Melbourne in the late 90's.

To offer the choice of a private hospital is in fact providing additional choice to private patients attending public hospitals that those patients do not enjoy at present. Put another way it could be presented as “helping people access what they pay for – you pay private health insurance and we will help you access private hospital care if that is your choice”.

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Private Patients in Public Hospitals
In practice it is extremely rare for a public hospital to direct their admittance staff to offer to assist patients with private health insurance to get into a private hospital despite the long waiting lists at the public hospitals.

Public Hospital Funding Post July 2014

Very significant public hospital funding changes are planned to be introduced from July 2014. These will markedly change the arrangements between the Commonwealth and State governments and as a consequence are expected to also change the funding provided by State governments to their public hospitals. It is also expected to change the incentives for treating private patients in public hospitals. The extent of this change in incentives will however depend on the policies and procedures adopted by each State.

Commonwealth funding will continue at its current levels adjusted for inflation for the volume of activity in 2013/2014, however for all growth in activity beyond this the funding will be based on Activity Based Pricing at a price determined by the Commonwealth.

National Efficient Price

The National Health Reform Agreement specified that an Independent Hospital Pricing Authority (IHPA) would be set up and that this would set the price for both public patients and private patients in public hospitals. In discharging this responsibility the IHPA has defined a National Efficient Price (NEP). The IHPA has also defined a National Weighted Activity Unit as the pricing unit. The NEP is the price set by the Commonwealth for each National Weighted Activity Unit (NWAU).

The price is not expected to be the price paid to public hospitals as this is a matter for the individual States to determine. The price will be used however to calculate how much funding is contributed by the Commonwealth as a result of case growth above the previous year’s volume of cases in each State.

In 2012-2013 and 2013-2014, the Commonwealth funding to the States is guaranteed under the National Health Reform Agreement and is relative to the former National Healthcare Specific Purpose Payment. Therefore the Commonwealth Contribution to the States is not impacted by the introduction of the National Efficient Price (NEP) in these years.

From 2014-2015 to 2016/2017 the Commonwealth will pay 45% of the NEP for growth in the volume of services relative to the previous year adjusted for the proportion of
private patients treated in public hospitals, and 50% from 2017/2018. Importantly Commonwealth funding from July 2014 will be uncapped.

The States are required to meet the balance of payments made to public hospitals; however there is no requirement that the states pay 55% of the NEP for the growth in services. The amount each State decides to spend on public hospital services is at the discretion of each State government. Furthermore Local Hospital Networks and public hospitals will not necessarily be paid at the NEP currency. They could be paid more or less depending on the current efficiency levels within each State.

The IHPA paper “The Pricing Framework for Australian Public Hospital Services”\(^{xvi}\) dated 30 May 2012, outlines IHPA thinking behind the National Efficient Price which at that time was $4,808.

The paper states that:-

“the national implementation of ABF is expected to change the incentives faced by local hospital Networks, particularly from 2014/15 when Commonwealth funding is uncapped. It is important to note that the national implementation of ABF applies equally to public and private patients in public hospitals. This means that States and Territories and Local Hospital Networks will jointly make decisions through service agreements about the ranges and volume of public hospital services to be provided including the share of public and private patients.

States and Territories have autonomy under the Agreement to determine the level of the payment they make towards the costs of public hospital services for public and private patients. This means that States and Territories remain free to use funding initiatives to either encourage or discourage the provision of services to private patients in public hospitals.”

A key pricing guideline adopted by the IHPA referred to as public private neutrality states.

“The Public Private Neutrality guideline states: Activity based pricing should not disrupt current incentives for a person to elect to be treated as a private or public patient in a public hospital.”

What this means is that Activity based pricing need not disrupt current incentives. Whether it does or not is entirely a matter for the States.

**Commonwealth Contribution for Private Patients in Public Hospitals**

The Commonwealth Contribution/Price for private patients in public hospitals will be the NEP discounted by the additional revenue received as a result of the patient being a private rather than public patient. The discount at the State level will be aggregated up from the DRG level where for each DRG there is a percentage private patient adjustment to the price weight. The State discount thus depends on the volume and case mix of the private sector cases.

The adjustments are quite significant. For example the payment discount for private patients varies between 63% for an AICD implantation with complication to 7% for
peritoneal dialysis. The higher percentage in the first case reflects the high price private health funds pay for a defibrillator.

The effect of this is that the total revenue received for private patients after inclusion of MBS payments, private health fund payments plus the Commonwealth payment will be the same as for public patients.

It should be noted however that the deduction does not take into the profit public hospitals make by the provision of prostheses to the private health funds at a cost much lower than the price paid by the private health funds.

These new arrangements between the Commonwealth and the States will commence in July 2014. If a State governments decides to pay their public hospitals based on the NEP for public patients and the discounted NEP for private patients then the total payment received by the hospital will be the same for both public and private patients. This would be a desirable outcome as it would remove the incentive to convert public patients to private patients.

Post July 2014 the Commonwealth will pay the State governments 45% of the discounted NEP for each private patient in a public hospital, the same percentage that it pays for public patients.

As is currently the case every additional private patient in a public hospital who would otherwise have been a public patient increases the cost to the private health insurance sector. Approximately 30% of this cost is ultimately born by the Commonwealth through the PHI rebate arrangements.

On the other hand when a patient is treated as a private rather than public patient in a public hospital the Commonwealth pays the State government a reduced amount: 45% of the discounted NEP rather than 45% of the NEP.

The additional cost to the Commonwealth of an increased percentage of private patients in public hospitals is ultimately therefore the increase in the PHI rebate less 45% of the discount in the NEP.

In a NSW Technical Paper “The Next Step – Funding Reform”, it is stated that the amount of activity based funds allocated to States and Territories by the Commonwealth in 2012/13 is based on the National Efficient Price (NEP) of $4,808 per NWAU, whereas funding to LHDs/SHNs from the state for ABF is largely based on the state price of $4,471 per NWAU.

It is expected that if Victoria maintains the same funding levels to its hospitals that it too will also have a State Efficient Price below the NEP, reflecting the price efficiency in that State.

For 2012-13 Western Australia has developed a State Efficient Price along the lines of the National Efficient Price to be introduced from July 2014. The 2012-13 price is
$5,315. The State Efficient Price is slightly higher than the $4963 NEP excluding private patient adjustments for revenue.

The variation in price per NWAU at the state level reflects to a significant degree cost difference outlined in the 2009 Productivity Commission Report on Public and Private Hospitals. There are at least two significant implications. The first is that there will be major efficiency drives in the high cost states. The second is that the marginal rate for additional work will be higher than 45% of the state price in those States that set a State Efficient Price below the NEP. If the full Commonwealth payment is passed on to the hospitals it will assist in making marginal activity profitable for hospitals leading to increased throughput.

Public Hospital Incentives to Treat Private Patients Post July 2014

The public hospital incentive within each State to treat private patients post July 2014 will depend, as is does currently, on the price set by the State for private patients relative to the price for public patients, the extent to which the public hospitals can retain private patient revenue and the difference between these two numbers.

Whilst the fees payable by private health funds for private patients will be the same regardless of whether the public hospital has exceeded its throughput target or not, this is not the same for public patients as the States are expected to retain capped funding. This means that the incentive to treat private patients increases once the State government caps are reached.

The following extract from the IHPA paper “The Pricing Framework for Australian Public Hospital Services” is consistent with the view that it will be the States that determine whether there will be a change in private patient incentives.

“The IHPA commissioned a study to assess the potential impact on private patient utilisation of public hospitals under the national implementation of ABF. This study was not able to definitively rule in or out changes to the utilisation of public hospital by private patients. The outcome will depend upon the behaviour of the many different agents – State Governments, Local Hospital Networks, doctors, and patients – who will be involved in or impacted by the national implementation of activity based funding.”

Various submissions to the IHPA on the other hand, including a submission by AHSA, suggest that there could be significant effects on private patient uptake.

Several papers point out that whilst the private health fund payment for private patients is a per diem arrangement and hospitals are paid on a DRG basis there will inevitably be greater incentives for the public hospitals to convert patients to private status on selective DRGs.

As the default benefit paid by private health funds is a per diem arrangement and the PPNEP varies with each DRG there will be some cases where if the hospital were to
receive the PPNEP then the hospitals will receive significantly greater revenue from a private patient than a public patient. This is particularly the case where the care involves prostheses, as in this case there is a further incentive for public hospitals to treat private patients as the private health funds are legislatively compelled to pay a price for prostheses which is well above the cost to the public hospital. In some cases the revenue thus obtained by the public hospital is twice the prostheses cost.

The IHPA is clearly aware of this issue as in their request for comments on their proposals they have asked the question “Is there support for future work on harmonising default benefits to achieve consistency across classification systems used for public and private patients in public hospitals?”

_The Queensland government stated in their response to IHPA that_ it would be appropriate to transition from the existing per diem default benefits to an approach using the same ABF classification as applies to public patients. This would appear to be an excellent suggestion.

In regard to a further question posed by the IHPA

“Are there any distorted incentives in the approach used by the IHPA such that public hospitals are either encouraged or discouraged from treating public patients and private patients equally?”,

the Government of South Australia in their submission to the IHPAxx, comment that

_“the method of calculating the private patient discount will encourage jurisdictions to game their private/public patient mix as the results differ markedly from the cost realities at the hospital level.”_

The SA submission goes on to say that the removal of the inpatient accommodation fee paid by private health funds will disrupt existing incentives which at present encourage private patient admissions.

The Victorian government in their submission to the IHPAxxi state that the private patient adjustments may reduce the incentives to treat private patients in public hospitals. The reasons stated are a) that MBS and patient co-payments do not cover the costs of pathology and imaging, b) without prior DRG-level adjustments to more accurately reflect prostheses costs in the NHCDC (DH&A’s National Hospital Cost Data Collection) the method will over or under discount private patient costs and c) the removal of the 75% of MBS fees paid by Medicare does not allow for those cases where the doctor is not eligible for MBS billing.

The Victorian government submission goes on to state that the IHPA discount for private patients will be significantly larger than the current 24% discount that currently operates in Victoria, thereby reducing the incentive for public hospitals to treat private patients.
The State government submissions with respect to private patients in public hospitals are clearly directed at trying to reduce the discount as any discount leads to less payment from the Commonwealth.

Some States have calculated the proposed Commonwealth discount for private patients to be equivalent to just over 40%, significantly greater than the 27% discount currently operating in Victoria. On this basis the States lose 40% of the 45% Commonwealth contribution when they convert a public patient to a private patient, ie: 18% (40% x 45%) of the NEP.

On the same basis the States will enjoy a net gain of 22% (40% - 18%) from treating private patients over public patients. As a result the States and public hospitals will still have a financial incentive to treat private patients rather than public patients.

Thus despite the reduction in the Commonwealth payment for private patients in public hospitals the State governments will still have an incentive to convert public patients to private patients as it will still represent additional net revenue.

**Issues**

There are a number of issues surrounding private patients in public hospitals.

1) Loop holes in the National Health Reform Agreement which permit public hospitals to proactively recruit private patients contrary to the intent of the agreement
2) The lack of public hospital adherence to the Patient Election Standards
3) The financial incentives for public hospitals to treat private patients in lieu of public patients.
4) The ability for a hospital to entice a patient to choose to be private after their admission (G14) to the hospital, when the patient is already captive to the hospital and in a vulnerable state.
5) The requirement that a patient must have a choice of doctor in order to be treated as a private patient (G15) is not really being met when the patient has already been admitted without having nominating a doctor and is restricted to doctors with rights to practice at the hospital he/she is already at. In practice a patient that has already been admitted to the public hospital will accept whatever doctor the hospital recommends.
6) The requirement not to direct patients towards a particular choice (G18) leaves the hospitals free to influence a patient’s choice by both offering patient incentives and appealing to their altruistic sense of helping the community by contributing to public hospital costs.
7) The increased costs to private health funds due to the growth in the number of privately insured patients being recruited by public hospitals.

8) The fact that the States remain free to use funding initiatives as they please to either encourage or discourage the provision of services to private patients in public hospitals thereby varying the cost implications for private health funds.

9) Despite the Commonwealth setting the Default payment that private health funds must pay to public hospitals and the introduction in July 2014 of a standard National Efficient Price, the autonomy States still have under the Health Reform Agreement to determine the level of the payment they make towards the costs of public hospital services for private patients.

10) The expected increase in the financial incentives for public hospitals to treat private patients in select DRGs resulting from the adoption of the National Efficient Price from July 2014.

**Recommendations**

1) That the Business Rules for the National Health Reform Agreement (Schedule G18 b.) be amended to include the words “neither seek to influence nor” so that the wording becomes “that hospital employees will neither seek to influence nor direct patients or their legal guardians towards a particular choice”.

2) That the phrase in the Business Rules “On admission, the patient will be given the choice to elect to be a public or private patient” be changed to “On admission, the patient has the choice to elect to be a public or private patient”. This puts the initiative to request to be a private patient with the patient instead of the public hospital admittance staff.

3) That the Business Rules for the National Health Reform Agreement (Schedule G4) be amended to remove the requirement that any patient who requests and receives single room accommodation must be admitted as a private patient.

4) That there be either one nationally agreed patient election form or specific clauses with predetermined wording which are required to be adopted by all States and public hospitals.

5) That consideration be given to requiring that for all elective cases the election to be treated as a private patient in a public hospital must be made in the doctor’s rooms prior to the day of hospital admission.

6) That the patient be required to state on the election form that he has elected to be a private patient in order to be treated by a named doctor who might not otherwise be available to him/her as a public patient, and not simply to obtain other benefits offered by the hospital.

7) That the patient be required to acknowledge in writing prior to electing to be a private patient that if his illness was caused by an accident his/her private health fund is not required to reimburse the patient for any hospital or medical costs.
until the patient has completed the appropriate paper work to enable the private 
health fund to make a determination as to whether they or another insurer 
(general accident insurer, Worker’s compensation, Transport Accident) is 
responsible for payment.

8) That the patient election should be between public and private/third party 
insurer rather than public or private as the patient cannot know until a 
determination is made by the private health fund as to whether the private 
health fund will be responsible for payment.

9) That the minimum election standards defined by the Commonwealth be 
adhered to by all public hospitals with penalty clauses introduced for non-
compliance.

10) That the public hospital practice of trying to influence patients to use their 
private health insurance through various incentive arrangements cease.

11) That the public hospital practice of asking patients whether they have private 
health insurance cease as no patient is required to answer this question. 
Whether the patient has private health insurance or not should be regarded as 
a private matter unless the patient has initiated a request to be treated as a 
private patient or asked to be treated by a specific doctor of their choosing.

12) That the rate paid for private rooms in a public hospital should be the shared 
room rate plus an excess equivalent to the excess paid for private rooms in a 
private hospital.

13) That post July 2014 State governments be required to pay public hospitals for 
private patients based on the private patient percentage discount as determined 
by the Independent Hospital Pricing Authority.

Conclusion

There are currently very strong financial reasons for the growth in private patients in 
public hospitals which benefit both the State governments the public hospitals and 
medical practitioners at the expense of the Commonwealth and the privately insured.

It is not surprising therefore that every effort is made by State governments and public 
hospitals to maximise the number of private patients through specific private patient 
recruitment programs. The action of public hospitals to recruit private patients will 
continue to drive up private health fund premiums unless the business rules are 
changed.

Public hospitals find that the most effective mechanism for increasing the number of 
private patients is to ask patients that have already been admitted to the public hospital 
if they have private health insurance and then focus on these patients with the specific 
intention of persuading them to use their insurance.

Public hospital actions to encourage patients to use their private health insurance are 
likely to continue unless the National Health Reform Agreement is amended to arrest 
such practices. This could simply be achieved by amending the rules to state that
public hospitals must not seek to influence patients to elect to be private after they have been admitted.

The issue of public hospitals encouraging visiting medical officers to admit their patients to public hospitals rather than private hospitals, and giving these private patients priority over public patients is unlikely to cease unless State hospital budget move from being capped to unlimited. As this is not likely given current State budgets this undesirable situation is expected to continue.

The optimum solution is to adjust the public hospital payment arrangements such that the hospital receives the same revenue for public and private patients. Once true hospital revenue neutrality exists between public and private patients, public patients will then be given the same priority as private patients. The opportunity for the States to do this occurs in July 2014.

Attachments

1) Victorian Public Hospital – Information for Patients
2) Victorian Government - Patient Election Form
3) St Vincent’s Hospital – Private Patient Services
4) Select Private Patient - Wimmera Health Care Group
5) Royal Perth Hospital – Inpatient Incentive Program

References

i Department of Health and Ageing - National Health Reform Agreement Schedule G, “Business Rules for National Health Agreement”
iii Infrastructure NSW, State Infrastructure Strategy, Section 13 – Health Infrastructure
vi Victorian Policy and Health Funding Guidelines, 2012–2013, Part Two, Health Operations
ix Queensland Government letter to IHPA dated 3 May 2012
xi Hospital Budget Performance and Remediation Review, Summary of Recommendations.
xiii Australian Health Review Paper Volume 25 No 3, 2002
Queensland Government letter to IHPA dated 3 May 2012
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