



CATHOLIC HEALTH
Australia

UPSETTING THE BALANCE

How the Growth of Private Patients in Public Hospitals
is Impacting Australia's Health System



JUNE 2017

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This report

Over 77 hospitals, more than 550 aged care facilities and numerous community care services are operated by different bodies of the Catholic Church within Australia.

CHA promotes the ministry of health care as an integral element of the mission of the Catholic Church. It works to fully provide health care in accordance with Christ's ministry to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

CHA is the peak member organisation of these health and aged care services. Further detail on CHA may be obtained at www.cha.org.au

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Executive Summary

Australia's health system is characterised by a mixed model of public and private provision which is intended to ensure that the private system takes pressure off public hospitals. Over recent years the balance between public and private provision of healthcare has been changing with the rapid growth of private patients being treated in public hospitals. This report examines how the growth of privately insured patients in public hospitals is impacting Australia's health system and finds that the growth is having a deleterious effect on patients and other stakeholders within the system. If current growth trends continue, the sustainability of Australia's mixed model of healthcare provision will be undermined, to the detriment of all patients.

Key findings

The number of privately insured patients in public hospitals has increased by an average of 10 per cent per annum since 2008–09, almost doubling over this period from 451,591 to 871,902 in 2015–16. The cost of treating private patients in public hospitals has more than doubled over the period from \$2 billion in 2008–09 to \$4.6 billion in 2015–16. Growth of private patients in public hospitals is outstripping rates of growth of public patients in public hospitals and private patients in private hospitals.

There is growing inequity between public and private patients, with private patients receiving a number of inducements in some public hospitals that are not available to public patients. There is also evidence that, on average, public patients are waiting more than twice as long as private patients for elective surgeries in public hospitals.

Activity growth in private hospitals is relatively stagnant and likely to further decline if current trends continue. Although the evidence suggests that the growth of private patients in public hospitals is, in significant part, substituting activity that would otherwise be public, at least a proportion of private patient activity in public hospitals is being attracted away from private hospitals. For example, in obstetrics there has been a substantial shift of activity from private to public hospitals in recent years.

There are differences in how capital expenditure is funded between private and government operated public hospitals. Whereas government operated public hospitals receive separate state funding for capital expenditure, private hospitals fund capital expenditure from within their own budget. These differences in funding affect private hospitals' ability to compete to attract private patients, with each state recently undertaking significant hospital redevelopments. New facilities with single rooms, together with other noted advantages are creating competitive tension. Catholic Health Australia (CHA) members' public hospitals are not government operated and do not have access to the same government capital funding arrangements.

The growth of private patients in public hospitals is also cost shifting from the states to private health insurers, with flow on impacts to consumers. Private health insurers spent \$1.1 billion on benefits for private patients in public hospitals in 2014–15, which is putting upward pressure on premiums.

The key driver of the growth of private patients in public hospitals may be attributed to the practices of some public hospitals in encouraging patients to declare and use their private health insurance product. It is important to note that there is wide variation in the behaviour and practices of hospitals, which differs by state and by individual hospital. In some cases, local health districts and/or states establish revenue targets for what is considered 'own source' revenue, with private patient throughput providing additional revenue.

During the course of this project, the following examples of practices undertaken by some hospitals were compiled from hospital brochures and websites, and interviews with hospital and other private health executives:

- patients being given inducements to be private patients such as waiving of policy related excesses, coffee club and other vouchers, newspapers, toiletries, bath robes, nappy-washing services, meals for visitors, a la carte menu and beverage selection, free phone calls, television hire, internet and Foxtel use, free parking, preferential access to private rooms, contribution to excesses which can be traded for a trip, house cleaning or day spa visit;
- patients being asked, in some cases repeatedly, to use their private health insurance as this will buy equipment for the hospital;
- private patients being told that it would not cost them anything or that a nearby private hospital was full.

At least some of the above examples appear to directly violate the terms of the National Health Reform Agreement and potentially contravene privacy law and the *Competition and Consumer Act 2010*. Examples of such behaviour are concerning, and some of them are in conflict with the fundamental universal health care principles of Medicare (equity and access based on clinical need and not insured status). The practices also appear to conflict with competitive neutrality principles, particularly because of the way capital infrastructure is funded. Whilst CHA members are aware of unethical practices within the system, CHA's member hospitals are governed by a code of ethical standards that would preclude such misleading or coercive conduct.

Where found, these practices are driven by systemic incentives to maximise private patient activity, including:

- public hospital funding arrangements whereby states set private patient or own source revenue targets for hospitals, and incentives in state funding models;
- fluctuations in the amount of Commonwealth funding for public hospitals;
- private practice entitlements in employment arrangements between public hospitals and doctors;
- regulated insurer funding arrangements.

Another key driver of the growth of private patients in public hospitals is the proliferation of private health insurance policies with exclusions and restrictions. A number of policies do not adequately cover patients for treatment in a private hospital (not 'fit for purpose'), and only cover public hospital treatment. In effect there is duplication of funding for the Commonwealth – funding of these products via the private health insurance rebate and direct funding of the states for the care of all patients in public hospitals.

Insured patients are also choosing to attend public hospitals because of their improved amenity, in terms of standard of care improvements, patient experience and access to new and refurbished public hospitals. It has been found that the desire to help the public health system is a key factor for some patients in electing to use their private health insurance. Other reasons include lack of provision of some service types in the private sector (less the case now than in the distant past) and/or lack of private services in a particular geographical location, high acuity or doctor preference. There is no doubt that over the course of the last two years there has been a growing consumer awareness of out-of-pocket costs associated with medical expenses including costs associated with inpatient radiology and pathology. High or unknown out-of-pocket medical expenses in the private sector can encourage private patients to choose public hospital services where medical professionals often charge no or low out-of-pocket fees.

Recommendations

CHA believes that it is imperative to maintain the balance of Australia's dual and interdependent hospital system to ensure equity of access to health services and the stewardship of appropriate distribution of health care resources.

CHA supports the right of privately insured patients to use public hospital services as a fundamental feature of Australia's health system. There is a cohort of privately insured patients who will legitimately need to, or choose to, attend a public hospital for reasons such as access, location or the nature of their complex clinical condition. For example, there may be services (such as multi-trauma or heart-lung transplants) which are usually provided in a public hospital setting, or in rural and remote areas, where fewer or no private hospital services are available. The Australian health system gives patients a choice of where to receive treatment, and it is vital that patients' choice to make a genuine election is retained. CHA seeks to ensure that all patients are given the right to make a fully informed choice about their treatment, and that funding mechanisms do not create incentives to discriminate between patients in public hospitals based upon private health insurance utilisation.

Further, CHA rejects any practices that disadvantage public patients or undermine the public hospital system on which low income and vulnerable Australians are fully reliant.

CHA recommends the following reforms to current arrangements concerning private patients in public hospitals:

- enforce compliance with the Medicare principles so that private patients in public hospitals do not receive preferential access to services in a public hospital setting, and that the only driver for prioritising treatment is the nature of a person's clinical condition;
- restrict hospitals' ability to offer inducements or unduly pressure consumers to declare their private health insurance status and encourage greater data sharing between the Commonwealth and states to monitor adverse behaviours;
- provide greater transparency around contracting of public patient care to the private sector;
- provide greater transparency of real time data showing the status of waiting lists by specialty in public and private hospitals;
- clearly identify private health insurance products for consumers (restricted cover products) that are not fit for purpose in a private hospital without attracting significant consumer out-of-pocket costs;
- enhance the provision of information to consumers to assist with pre-admission choice of doctor and improved understanding of charges that may be incurred, in both public and private hospitals;
- ensure that private patient election forms are submitted to the relevant health fund and that public hospitals provide equivalent information as submitted to insurers by private hospitals (Hospital Casemix Protocol data) where private health insurance is claimed. CHA understands that this is occurring in some, but not all, cases;
- include provisions in public hospital funding agreements between the Commonwealth and states to ensure neutrality of funding for public and private patients and to address the current funding incentives for public hospitals to maximise private patient activity, such as own source revenue targets. Funding mechanisms also need to incentivise prevention and deter avoidable hospital admissions;
- use available capacity within private hospitals more effectively to free up public hospital beds so that public hospitals can provide timely, high quality care to those who need it. Optimise the split of public and private hospital activity so that services are delivered in the most cost effective setting;
- achieve greater neutrality between public and private hospitals in relation to the manner in which capital expenditure is funded.

It is important to consider the overall funding implications of any proposed changes to current arrangements concerning private patients in public hospitals, as own source revenue currently represents a material proportion of public hospital funding. Many public hospitals are reliant on this revenue to support their services to public patients. Any reduction in private patient revenue that is not replaced with supplementary funding from Government sources could have a significant financial impact on public hospital service capacity, patient care and medical staff recruitment.

To conclude, the Australian mixed public-private healthcare system has evolved to improve individual wellbeing by offering a greater choice of provider and care options, and faster access for elective treatments. This model seeks to maintain a sustainable public health sector, by reducing cost pressures on public hospitals. However, the rising growth of private patients in public hospitals impacts on those policy intentions; current evidence shows that public patients have longer waiting times than private patients in public hospitals and that a growing number of public hospitals are contracting with private hospitals to treat public patients because of demand pressures. This seems to CHA to be incongruous with the intended balanced public-private system in Australia. If these trends remain unchecked, the sustainability of Australia's mixed model will be undermined, to the detriment of all patients.

Introduction

- 1 The number of privately insured patients being treated in public hospitals is increasing rapidly. Growth of private patients in public hospitals is outstripping rates of growth of public patients in public hospitals and private patients in private hospitals.
- 2 In 2014–15, private health insurers paid \$1.1 billion in benefits for private patients in public hospitals. Private health insurance participation rates are also declining for the first time in 15 years.
- 3 If current trends continue, this will undermine the viability and competitiveness of Australia's private hospital system, erode the value of private health insurance, and put further pressure on public hospitals.
- 4 The purpose of this project was to examine the effect of the growth of private patients in public hospitals on patients and other stakeholders within the system. The project approach combined:
 - a. interviews with members of Catholic Health Australia (CHA), other industry associations (representing public hospitals, private hospitals, and insurers), individual health funds, individual private hospitals, the Independent Hospital Pricing Authority (IHPA), and academics;
 - b. analysis of data supplied by CHA members; and
 - c. review of publicly available data and information.
- 5 This report sets out the key findings of the project, the case for change to current arrangements concerning private patients in public hospitals, and recommends possible options for reform.

About CHA

- 6 CHA represents Australia's largest non-government grouping of hospitals, aged and community care services, providing approximately 10 per cent of hospital and aged care services in Australia. CHA represents more than 77 hospitals which account for more than 25 per cent of Australia's private hospital beds and around 5 per cent of Australia's public hospital beds.
- 7 CHA members subscribe to a code of ethical standards for health and aged care services in Australia that includes principles of justice and collaboration in healthcare. CHA supports reform which is patient centered and reflects the just and effective stewardship of resources.
- 8 This report reflects the majority position of CHA members but does not necessarily reflect the position of all individual members.

Outline of report

- 9 The report includes the following six sections:
 - a. policy intent for the Australian Government's support of private health insurance;
 - b. current framework, which sets out private patient rights in public hospitals and funding arrangements;
 - c. growth trends of private patients in public hospitals, which are examined by state and territory and contrasted to growth trends for other patient groups (private patients in private hospitals, public patients in public hospitals and public patients in private hospitals). The breakdown of emergency and elective admissions of private patients in public hospitals is also examined;
 - d. possible causes of the growth of private patients in public hospitals;
 - e. the impact of the growth on patients and other stakeholders;
 - f. recommendations as to possible options for reform.
- 10 Except where otherwise expressed, in this report, 'private patient' refers to a patient funded by private health insurance, and excludes compensable patients and other patients funded by third parties.

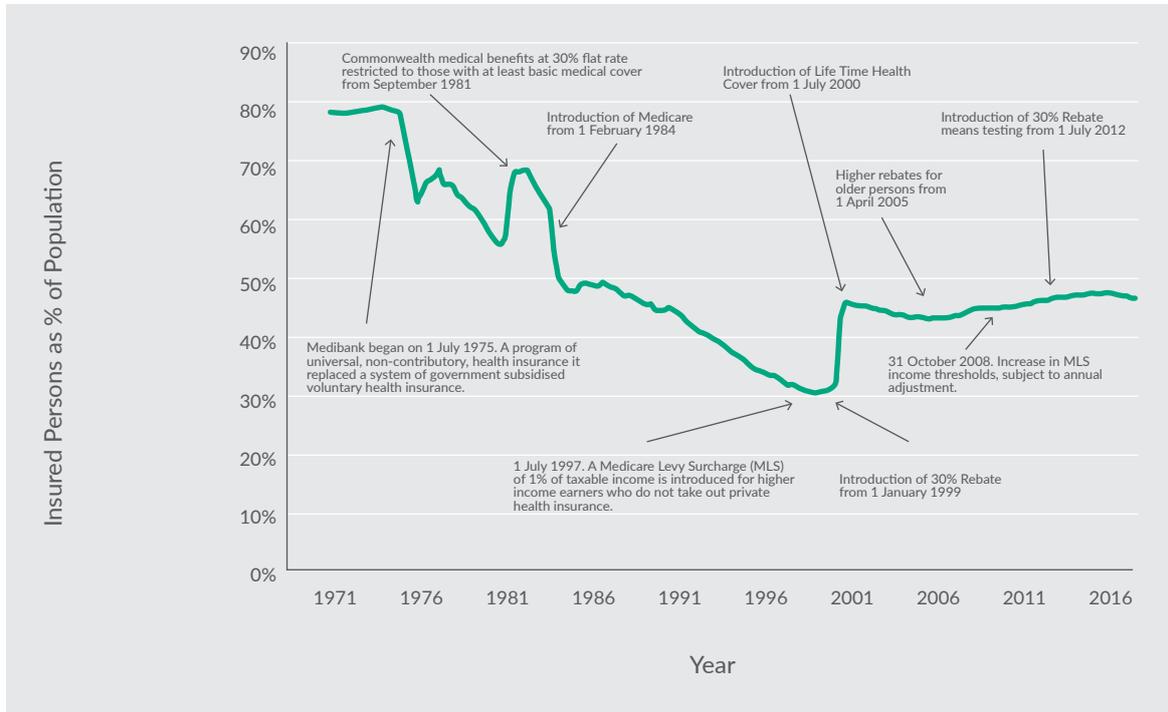
Policy intent for Australian Government support of private health insurance

- 11 Australia's health system is characterised by a mixed model of public and private provision which is supported by policy levers that encourage people to take up private health insurance. These policy levers were introduced to maintain and increase private health insurance participation, because the Australian Government believed that a strong private health system would give consumers choice and take pressure off public hospitals.¹
- 12 The levers by which the Australian Government encourages people to take up private health insurance are:
 - a. Medicare Levy Surcharge;
 - b. Private Health Insurance Rebate;
 - c. Lifetime Health Cover
- 13 The **Medicare Levy Surcharge** was introduced in 1997. It is a tax surcharge imposed on high income earners who do not have private hospital cover. The surcharge is an additional 1 to 1.5 per cent of income which applies in addition to the Medicare Levy of 2 per cent.ⁱ The surcharge 'aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce demand on the public Medicare system.'²
- 14 The **Private Health Insurance Rebate** was introduced in 1999. It began as a 30 per cent rebate on the cost of premiums for all persons with private hospital cover. Changes to the rebate in recent years mean that it is no longer available to all persons with private hospital cover, and its value as a proportion of premiums is diminishing. In 2012, the rebate was means tested. In 2013, the rebate was removed from the Lifetime Health Cover loading on premiums. In 2014, the rebate was indexed to the Consumer Price Index.ⁱⁱ The current Medicare Levy Surcharge and rebate tiers that apply are set out in Appendix 1.
- 15 **Lifetime Health Cover** was introduced in 2000. It is 2 per cent loading on premiums that applies for each year that a person is aged over 30 when he or she takes out cover. Lifetime Health Cover, which is payable for ten continuous years, is 'designed to encourage people to take out hospital insurance earlier in life and to maintain their cover.'³
- 16 As Figure 1 demonstrates, these policy levers (particularly Lifetime Health Cover) led to significant take-up of private health insurance by Australians.
- 17 Currently, 46.5 per cent of the Australian population has private hospital cover. This includes many low to middle income earners: almost half of all people with private health insurance have an annual income of less than \$50,000.⁴ Australia's rate of private health insurance coverage is high compared to most other OECD countries.
- 18 Recently, however, private health insurance participation has declined for the first time in fifteen years.⁵ This is accompanied by growing concern about the affordability of private health insurance, flattening growth of private patient volumes in private hospitals and rapid growth of private patients in public hospitals.
- 19 CHA believes that it is imperative to maintain the balance of Australia's dual and interdependent hospital system to ensure equity of access to health services and the just allocation of health resources. CHA is concerned that if current trends continue, the sustainability of Australia's mixed model health system will be undermined, to the detriment of all patients.

i In the 2017 Budget, the Australian Government announced that the Medicare Levy will increase to 2.5 per cent from 2019.

ii The mechanism for this is a Rebate Adjustment Factor by which the rebate is indexed annually on 1 April. The Rebate Adjustment Factor represents the difference between the Consumer Price Index and the industry weighted average increase in premiums.

Figure 1: Hospital treatment coverage (insured persons as % of population)



Source: Australian Prudential Regulation Authority (APRA), *Private health insurance membership trends*, March 2017.

Current framework

- 20 It is a fundamental principle of Medicare that all eligible persons have the right to receive public hospital services free of charge. The National Health Reform Agreement underpins the right of privately insured patients to elect to be treated as a public or private patient in a public hospital, and it sets out the funding principles that apply. The current framework purports to provide protections for patients around the election process and to ensure neutrality of funding for public and private patients.
- 21 CHA supports the right of private patients to use public hospital services as a fundamental feature of Australia's healthcare system. However, CHA believes there is scope to improve the current framework by enhancing monitoring and enforcement of rules that are designed to protect patients, and ensuring that funding mechanisms achieve neutrality between public and private patients in practice.

Patients' right to elect to be treated as a public or private patient in a public hospital

National Health Reform Agreement

- 22 In the National Health Reform Agreement signed in 2011, the Commonwealth, states and territories set out their commitment to the Medicare principles:
 - a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;
 - b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
 - c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.ⁱⁱⁱ
- 23 The Commonwealth agreed to provide activity based funding for hospital services provided to eligible private patients in public hospitals. The states and territories agreed to provide public patients with access to all services provided to private patients in public hospitals,⁶ and to ensure that eligible persons who elect to be treated as private patients have done so on the basis of informed financial consent.⁷
- 24 The Business Rules in Schedule G to the National Health Reform Agreement set out the procedural requirements to which public hospitals must adhere in relation to patient election. See Appendix 2 for an extract of relevant provisions from Schedule G.

Informed financial consent is the provision of cost information to patients, including notification of likely out-of-pocket expenses (gaps), by all relevant service providers, preferably in writing, prior to admission to hospital or treatment.

Source: Department of Health, Out-of-pocket expenses for private medical treatment (*Informed Financial Consent*) <http://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-outofpocket-expenses> at 7 May 2017.

- 25 Clause 9 of the National Health Reform Agreement requires states and territories to adhere to the Business Rules in Schedule G in providing public hospital services. However, the Agreement does not specify how compliance with the Business Rules will be monitored and enforced. There are no penalty provisions within the Agreement for failure to comply with the Business Rules.

ⁱⁱⁱ These principles were reaffirmed in the *Heads of Agreement on Public Hospital Funding* signed by the Commonwealth, states and territories on 1 April 2016. The Heads of Agreement will form the basis of negotiations leading towards an addendum to the National Health Reform Agreement that will apply from 1 July 2017 to 30 June 2020.

- 26 In practice, complaints about the provision of public hospital services can be made to independent complaints bodies in each state and territory. The National Health Reform Agreement requires states and territories to maintain these independent complaints bodies.⁸ There are also general dispute resolution provisions within the Agreement whereby a dispute between parties to the Agreement may be referred to the Council of Australian Governments (COAG) if it cannot be resolved by the relevant Ministers.⁹
- 27 The provisions of the National Health Reform Agreement concerning the rights and election process for private patients in public hospitals reflect provisions from previous public hospital funding agreements going back to 2003.^{iv}

Patient charters

- 28 The Australian Government has published a Private Patients' Hospital Charter^v which explains the rights and responsibilities that private patients have in both public and private hospitals. These include the right to:
 - a. choose their doctor, and decide whether to go to a public or private hospital that the doctor attends;
 - b. choose to be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital;
 - c. receive information prior to treatment except in an emergency where this is not possible, and to agree to the likely costs in writing before proceeding with treatment.
- 29 The National Health Reform Agreement requires states and territories to adhere to a Public Patients' Hospital Charter.¹⁰ Some states appear to have adopted the Australian Charter of Healthcare Rights^{vi} for this purpose, while others have published their own charter.^{vii} All of the charters codify patients' rights to access, safety, respect, communication, participation, privacy, and consent. The charters provide that complaints about public hospital services can be made to independent complaints bodies in each state and territory.

Funding for services provided to private patients in public hospitals

- 30 Responsibility for funding services to private patients in public hospitals is shared between the Australian Government, state and territory governments, and private health insurers.
- 31 The **Australian Government** provides:
 - a. public hospital funding to states and territories which is adjusted for private patients;
 - b. 75 per cent of the Medicare Benefits Schedule (MBS) fee for private patients whether they choose to be treated in a public or private hospital;
 - c. the Private Health Insurance Rebate.
- 32 **State and territory governments** provide funding for public hospital services.
- 33 **Private health insurers** are required to fund:
 - a. the remaining 25 per cent of MBS fees for private patients whether they choose to be treated in a public or private hospital;^{viii}

iv The funding mechanism has changed over this time, with the introduction of activity based funding in 2011.

v The Private Patients' Hospital Charter was a legislative instrument made under the *National Health Act 1953* but it was repealed by sunseting on 1 October 2016.

vi The Australian Charter of Healthcare Rights was developed by the Australian Commission on Safety and Quality in Healthcare and endorsed by Australian Health Ministers for national use in July 2008.

vii All states except Queensland and the Australian Capital Territory have developed their own charters.

viii Insurers are required to pay at least 25 per cent of the MBS fee if the fee charged is greater than the MBS fee, or equal to the difference between the fee charged and 75 per cent of the MBS fee if the fee charged is less than the MBS fee (*Private Health Insurance Act 2007*, s72-1(2)).

- b. the minimum benefit for a hospital admission (sometimes called the 'default' benefit). This is equivalent to the amount a public hospital would charge a private patient for a shared room, usually as an all-inclusive daily rate of approximately \$250-\$300 depending on the state in which the hospital is located;^{ix}
 - c. benefits for surgically implanted medical devices specified in the Prostheses List.^x
- 34 Additional hospital and medical costs (such as any amount the doctors charge above the MBS fee) may be funded by the insurer (depending on the policy) or the consumer.

Public hospital funding arrangements

- 35 The National Efficient Price paid by the Commonwealth to the states and territories under the National Health Reform Agreement is reduced for private patients in public hospitals to account for MBS payments and payments from insurers.¹¹ This approach is applied to prevent 'double dipping', that is, the hospital being paid once by the revenue source and the second time by the Commonwealth.¹² Public-private neutrality is one of IHPA's pricing guidelines. IHPA states that 'Activity based funding pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.'¹³
- 36 IHPA discounts the National Weighted Activity Unit (**NWAWU**) for private patients by a 'Private Patient Accommodation Adjustment' and a 'Private Patient Service Adjustment'. The Private Patient Accommodation Adjustment is a per diem amount that accounts for public hospital revenue from accommodation charges to private health insurers.¹⁴ IHPA applies a discount of 0.0674 to 0.0726 NWAWU per day for overnight separations depending on the state or territory and 0.0499 to 0.0584 NWAWU for same-day separations.¹⁵ The Private Patient Service Adjustment applies a discount of 1 to 94 per cent depending on the Diagnosis Related Group (**DRG**) for acute admitted separations.¹⁶ It accounts for MBS billings, prostheses charges and insurer payments for medical services provided as part of an episode of care.¹⁷
- 37 IHPA states that 'Collectively these adjustments are intended to neutralise funding differences between public and private patients and to mitigate any potential risk that public hospitals may be incentivised to prioritise private patients in public hospitals to obtain additional sources of revenue.'¹⁸
- 38 The 2016 *Heads of Agreement on Public Hospital Funding* allows states and territories to determine the amount they pay for public hospital services, provided that they at least maintain their current levels of funding and meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.¹⁹ The Commonwealth funds 45 per cent of the efficient growth of services, subject to a cap in the growth of overall Commonwealth funding of 6.5 per cent a year.²⁰
- 39 Some states and territories adjust public hospital funding for private patients and others do not. There is also inconsistency between states and territories with respect to the setting of private patient or own source revenue targets.

ix Minimum benefit rates are specified in the *Private Health Insurance (Benefit Requirements) Rules 2011*.

x The Prostheses List is a Schedule to the *Private Health Insurance (Prostheses) Rules 2016 (No.4)*.

Private patient funding arrangements in states and territories

In **Queensland, Western Australia and Tasmania**, service level agreements between state and territory governments and Local Health Networks (LHNs) do not reduce the funding provided to LHNs for private patients. Victoria applies different prices for public and private patients: the ratio of the private to public Weighted Inlier Equivalent Separation (WIES) price is a 24 per cent discount applied for eligible private patients. All of these states apply private patient revenue targets.

In **New South Wales**, there are examples of service level agreements which do not reduce funding for private patients and others which do.

South Australia and the **Australian Capital Territory** apply the private patient adjustments as determined by IHPA. However, South Australia passes on the adjustments to LHNs through a block amount regardless of the revenue offset, and it does not apply private patient adjustments for rehabilitation and maintenance care. IHPA did not identify any evidence of private patient targets in these states.

IHPA was not able to determine whether the **Northern Territory** applies private patient adjustments.

Source: IHPA, *Private patient public hospital service utilisation final report*.

Evolution of public hospital funding agreements

- 40 Public hospital funding agreements prior to 2003 more explicitly recognised the relationship between private health insurance and demand for public hospital services, and provided mechanisms to adjust Commonwealth funding based on private health insurance coverage or private patient activity.
- 41 Under the **1984–1988 Medicare Agreements** the Commonwealth gave the states a Medicare Compensation Grant to compensate states for the loss of private patient revenue following the introduction of Medicare. The compensation grant included a per diem amount for each bed-day which shifted from private status to public status, and a contribution of \$50 per bed-day for increased utilisation as a result of public hospital services being free.^{xi} In addition, the Grant provided for compensation in relation to the elimination of charges for outpatient services, the additional cost of providing medical services to public patients, and new arrangements for nursing home type patients.²¹
- 42 The **1988–1993 Medicare Agreements** adjusted the Commonwealth base grant if states' proportion of private bed-days exceeded the national average or if the state's per capita level of in-hospital Medicare benefit payments exceeded the national average by more than 5 per cent.²²
- 43 The **1993–1998 Medicare Agreements** provided that the amount of Commonwealth funding would be reviewed if the proportion of the population covered by hospital insurance fell by at least 2 percentage points from the 1993 level. However, when the reviews did take place as a result of the decline in private health insurance coverage, the Commonwealth, states and territories could not reach agreement about the financial impact or level of compensation which was appropriate.²³
- 44 The **1998–2003 Australian Healthcare Agreements** allowed for variations to the base health care grant on the basis of changes in private health insurance coverage. It was estimated at the time that a drop of 1 per cent in private health insurance coverage would impose an extra cost to the states and territories of \$83 million.²⁴
- 45 The **2003–2008 Australian Healthcare Agreements** provided that, in order to qualify for the full level of funding, the Commonwealth Minister had to be satisfied that the state or territory had met specified compliance requirements, including compliance with the Medicare principles.

xi However, the impact of the utilisation factor was not as anticipated because of issues such as declining length of stay and industrial action by doctors. In later agreements and negotiations separations rather than bed-days were used as a measure of utilisation.

The growth of private patients in public hospitals

- 46 Between 2008–09 and 2015–16, the number of separations in public hospitals with a funding source of private health insurance increased by an average of 10 per cent each year. As a proportion of all public hospital separations, private patients increased from 9.2 per cent in 2008–09 to 13.9 per cent in 2015–16. The number of public hospital separations funded by private health insurance almost doubled from 451,591 in 2008–09 to 871,902 in 2015–16.²⁵
- 47 The number of private patients in public hospitals is growing more rapidly in some states than others. It appears that growth in public hospital activity has centred on emergency admissions (of private patients), same-day admissions, and medical rather than surgical separations.
- 48 The growth of private patients in public hospitals has largely substituted activity that would otherwise be public. However, it is having a knock-on effect on private hospitals, which are experiencing relatively flat growth in private patient activity in all states and, in some states, an increase in public patient activity. This pattern is distorting the health system, and undermining the policy intent of private health insurance, which is to encourage patients to use private hospitals in order to relieve pressure on public hospitals.

Which states and territories have experienced the highest growth?

- 49 From 2008–09 to 2015–16, Northern Territory experienced the highest average annual growth of private patients in public hospitals (34.1 per cent), followed by Queensland (25.6 per cent) and the Australian Capital Territory (12.0 per cent).
- 50 Although the Northern Territory experienced the highest average annual growth over the period, its private patient activity in public hospitals remains much lower than other states (both in terms of the total number of private patients treated, and as a proportion of all public hospital separations).^{xii}
- 51 New South Wales (19.9 per cent) and Tasmania (17.6 per cent) had the highest proportion of private patients in public hospitals in 2015–16, both above the national average (13.9 per cent).

Table 1: Growth of public hospital separations funded by private health insurance by state and territory

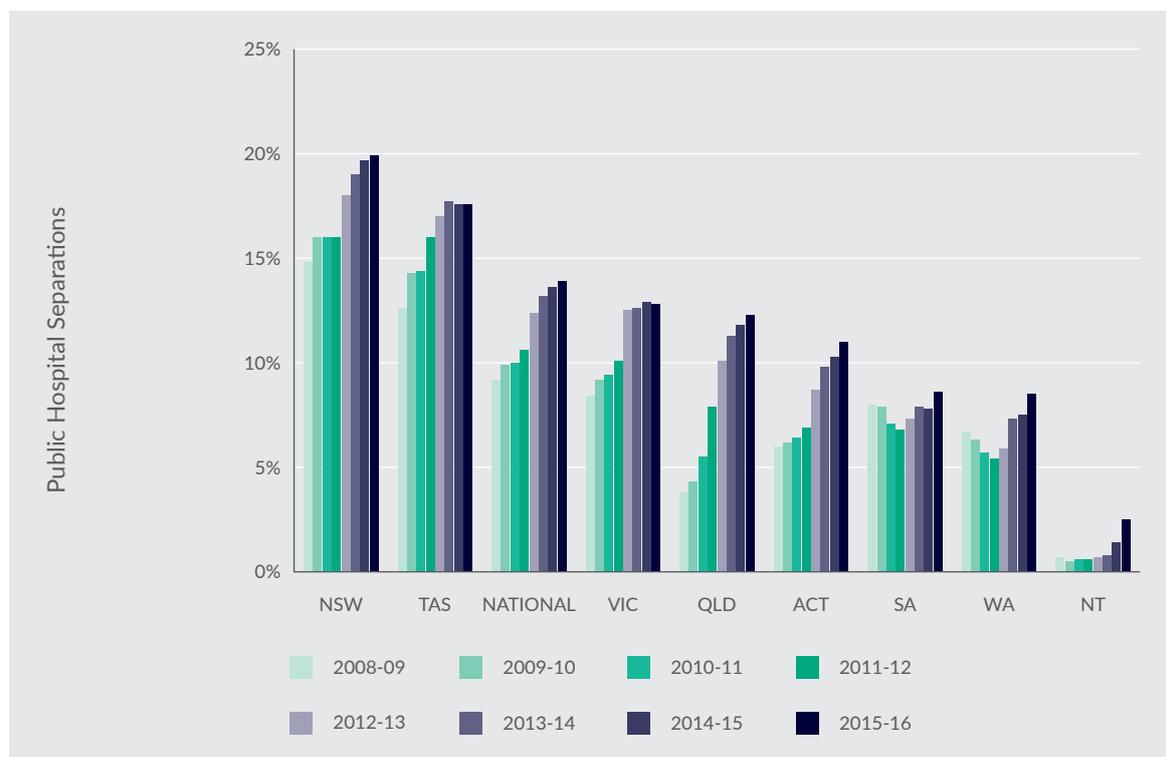
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	NATIONAL
Average annual growth in public hospital separation funded by private health insurance 2008–09 to 2015–16.	7.6%	9.2%	25.6%	8.4%	3.7%	9.0%	12.0%	34.1%	9.9%
Growth in proportion of public hospital separations funded by private health insurance between 2008–09 and 2015–16.	5.1 % points	4.4 % points	8.5 % points	1.8 % points	0.6 % points	50 % points	4.9 % points	1.8 % points	4.7 % points
Proportion of public hospital separations funded by private health insurance 2016–16	19.9%	12.8%	12.3%	8.5%	8.6%	17.6%	11.0%	2.5%	13.9%

Source: Australian Institute of Health and Welfare (AIHW), *Admitted patient care 2015–16, 2014–15 and 2013–14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2008–09, 2009–10, 2010–11, 2011–12, 2012–13*.

xii In 2015–16, Northern Territory had the lowest number of private patient separations in public hospitals (3,704 compared to the highest which was 370,369 in New South Wales) and the lowest proportion of private patients in public hospitals (2.5 per cent compared to the highest of 19.9 per cent in New South Wales).

52 The growth in the proportion of private patients in public hospitals since 2008–09 in each state and territory is depicted in Figure 2 below.

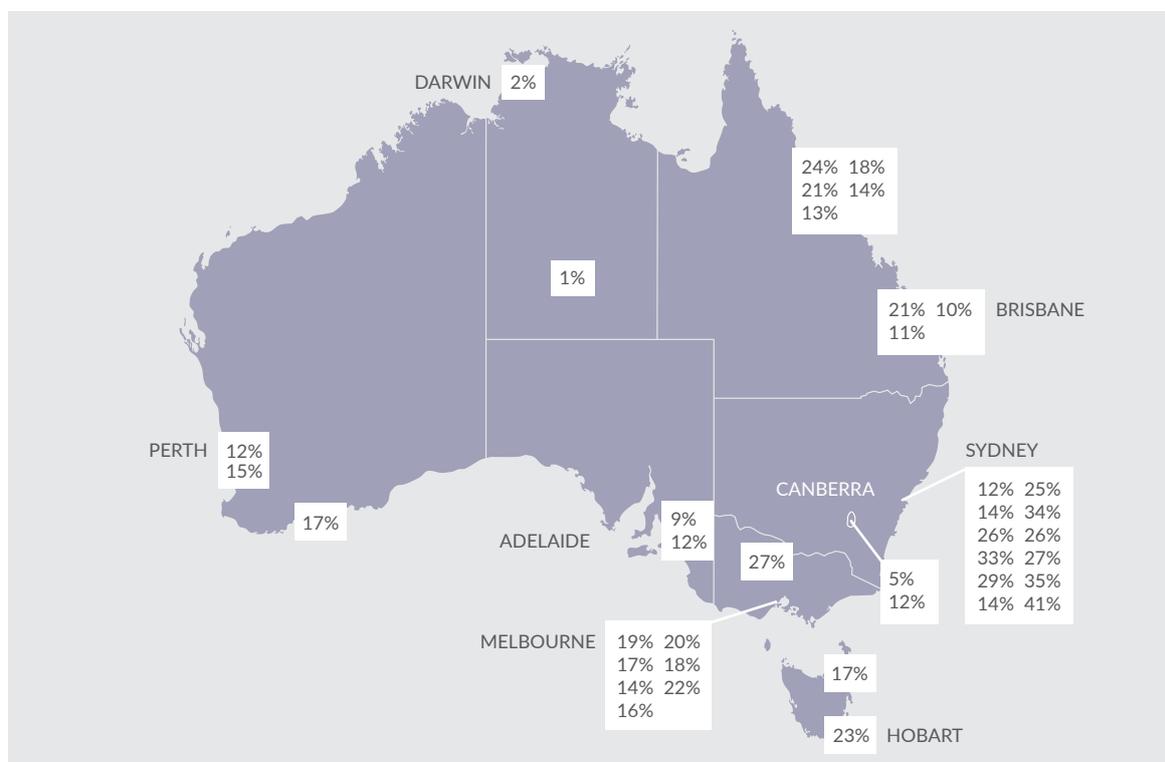
Figure 2: Proportion of public hospital separations funded by private health insurance by state and territory, 2008–09 to 2015–16



Source: AIHW, *Admitted Patient Care 2015–16, 2014–15 and 2013–14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2008–09, 2009–10, 2010–11, 2011–12, 2012–13*.

- 53 South Australia experienced the lowest growth of private patients in public hospitals from 2008–09 to 2015–16. The proportion of private patients in public hospitals in Western Australia and the Northern Territory also remained relatively low over this period.
- 54 Queensland escalated rapidly from a low base of 3.8 per cent in 2008–09, with the proportion of private patients in public hospitals more than tripling to 2015–16. The most rapid growth occurred in 2011–12. There were marked increases in the Australian Capital Territory and Victoria from 2011–12 to 2012–13. Victoria’s growth has most closely aligned with the national trend. New South Wales and Tasmania maintained the highest proportion of private patients in public hospitals throughout the period.
- 55 As Figure 3 below demonstrates, the proportion of private patients in individual public hospitals is variable, and can be much higher (up to two times more) or lower than the state average. There may be a number of reasons for the variation between hospitals including differences in funding arrangements, the extent of private health insurance coverage of the local population, and hospital practices to encourage patients to use their private health insurance. There are examples of both metropolitan and regional public hospitals having a high proportion of private patients.

Figure 3: Proportion of private patients in selected public hospitals by state and territory, 2013–14^{xiii}



Source: National Health Performance Authority, *Cost of acute admitted patients per NWAU 2013–14*, <http://www.myhospitals.gov.au/about-the-data/download-data>, at 11 May 2017.

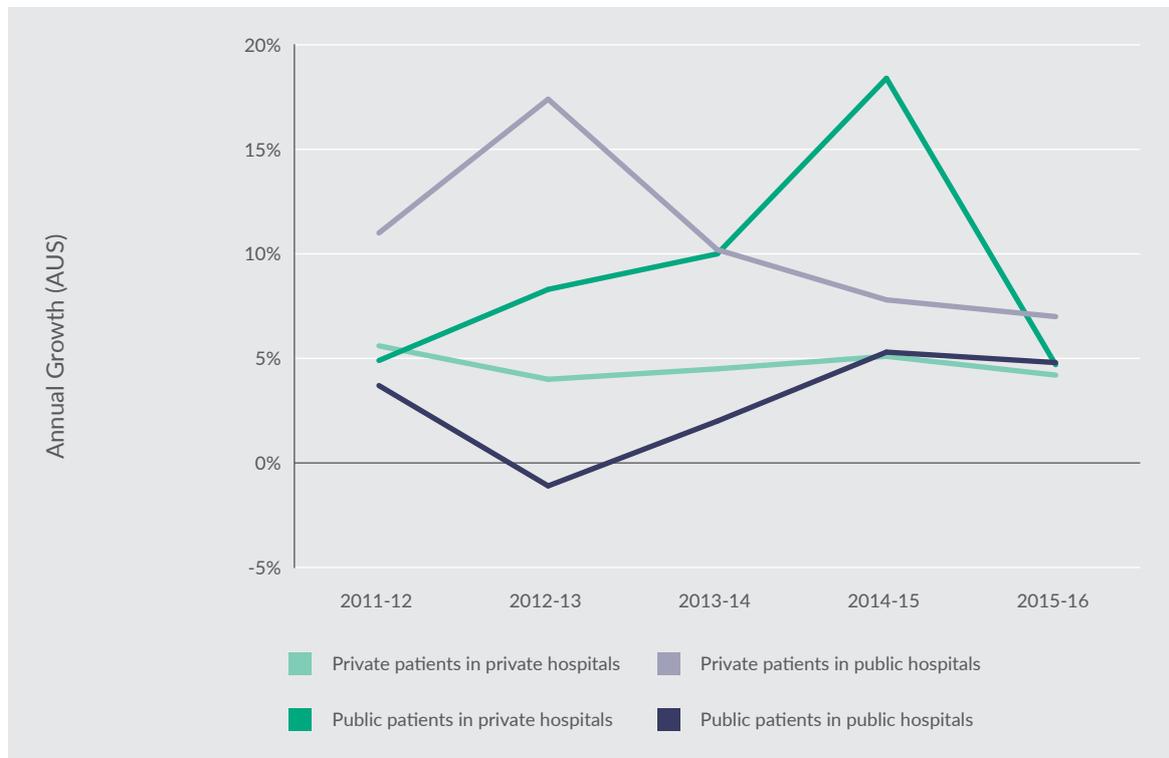
How does the growth of private patients in public hospitals compare to the growth of other patient groups?

- 56 The number of public hospital separations funded by private health insurance grew by 93 per cent from 2008–09 to 2015–16, compared to growth of 24 per cent over the same period in public patient separations in public hospitals and 40 per cent growth in private patients in private hospitals. There was 30 per cent growth in all hospital separations over the period. The cost of treating private patients in public hospitals has more than doubled over the period from \$2 billion in 2008–09 to \$4.6 billion in 2015–16.^{xiv}
- 57 Figure 4 below compares the growth of private patients in public hospitals to the growth of:
- public patients in public hospitals;
 - private patients in private hospitals; and
 - public patients in private hospitals.

^{xiii} These figures represent the proportion of public hospital separations in 2013–14 for which private patients (including privately insured and self-funded patients) accounted for.

^{xiv} Based on the average cost of a public hospital separation for a privately insured patient reported by the AIHW in *Admitted patient care 2015–16: Australian hospital statistics and Australian hospital statistics 2008–09*.

Figure 4: Annual growth in separations by principal source of funding 2011-12 to 2015-16, Australia



Source: AIHW, *Admitted patient care 2015-16: Australian hospital statistics*.

- 58 Figure 4 demonstrates that the annual growth of private patients in public hospitals had an inverse relationship to the growth of public patients in public hospitals over this period; for example, a sharp increase in the growth of private patients in public hospitals in 2012-13 corresponded to a decline in public patients in public hospitals. The correlation between the growth of private patients in public hospitals and private patients in private hospitals is less pronounced, although there was a small dip in the latter in 2012-13.
- 59 This suggests that over the period, the growth of private patients in public hospitals has largely substituted activity that would otherwise be public. However, the relatively flat growth of private patient volumes in private hospitals over the period suggests that at least a proportion of private patient activity in public hospitals is being attracted away from private hospitals. For example, a recent AIHW report shows that the number of childbirth separations in private hospitals has declined by 1.6 per cent on average each year since 2011-12, with a corresponding average annual increase (of 1.7 per cent) in childbirths in public hospitals over this time.²⁶
- 60 There was a decline in the annual growth of private patients in private hospitals over the period from 5.6 per cent in 2011-12 to 4.2 per cent in 2015-16. Annual growth of private patients in private hospitals was the lowest of the four patient groups in the last two years.
- 61 There was a slight increase in annual growth of public patients in public hospitals over the period (from 3.7 per cent in 2011-12 to 4.8 per cent in 2015-16). After rising to a peak of 18.4 per cent in 2014-15, annual growth of public patients in private hospitals reduced to 4.7 per cent in 2015-16.
- 62 One reason for the growth of public patients in private hospitals prior to 2015-16 could be an increase in the contracting of public activity to private hospitals. During interviews, some CHA private hospital members observed that they were receiving more public contracted activity from the state. CHA members noted that some regional areas try to avoid duplication of services, for example, they will provide all palliative care and dialysis for public and private patients in one facility only. It was also

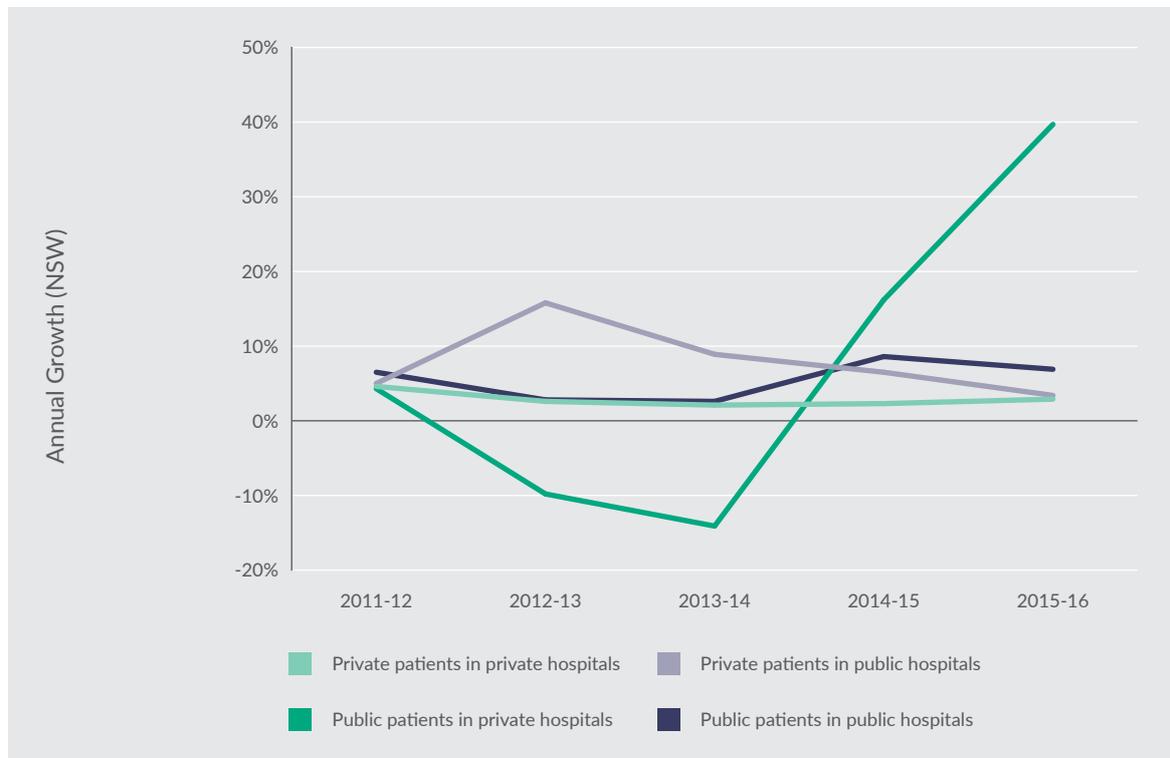
observed that public activity is offered to private hospitals generally between March and June if waiting list targets are unable to be met. For example, Ballarat Health Services in Victoria (whose proportion of private patients in its base campus hospital is 22 per cent^{xv}) is currently tendering out public activity to avoid missing waiting list targets.

- 63 According to AIHW, there were around 80,000 separations contracted to private hospitals from public hospitals in 2015–16.²⁷ However, this only accounted for around half of all separations of public patients in private hospitals. The information published by AIHW accounts for separations under contract between hospitals but does not include activity contracted to private hospitals by state health departments or LHNs.
- 64 Notwithstanding the high annual growth of public patients in private hospitals prior to 2015–16, they still account for a small proportion of total separations in private hospitals (4 per cent in 2015–16).²⁸
- 65 The charts below compare the growth of private patients in public hospitals to the growth of other patient groups in each state (except Tasmania, the Australian Capital Territory and the Northern Territory because AIHW did not publish data on private hospital separations in these states).
- 66 In most states, growth of private patients in private hospitals remained relatively flat over the period (at around 5 per cent or less per annum). In New South Wales, Victoria and South Australia, annual growth of private patients in private hospitals declined in 2015–16.
- 67 In New South Wales, annual growth of private patients in private hospitals went from 2.6 per cent in 2013–14 to 8.5 per cent in 2014–15 and 6.9 per cent in 2015–16. The growth in New South Wales may be attributable to the 7.1 per cent increase in the number of licensed private hospital beds from 2013–14 to 2014–15, which far exceeded that of other states^{xvi} and national growth in private hospital beds, which was 2.6 per cent from 2013–14 to 2014–15.²⁹
- 68 Annual growth of private patients in public hospitals was generally higher than for other patient groups. Growth peaked in New South Wales and Victoria in 2012–13 (at 15.8 per cent and 14.7 per cent respectively), in Queensland in 2011–12 (at 50.7 per cent), and Western Australia in 2013–14 (at 20.1 per cent). Annual growth in South Australia remained under 10 per cent until 2015–16, when growth peaked at 14.7 per cent.
- 69 Growth of public patients in private hospitals has been volatile. New South Wales and Victoria had negative or low annual growth in earlier years, but both peaked in 2015–16 at around 40 per cent. In Queensland, growth peaked at 63.9 per cent in 2014–15 then dropped to 1.6 per cent in 2015–16. Growth remained relatively flat in Western Australia and mostly declined in South Australia, contracting from 11.3 per cent in 2011–12 to -84.1 per cent in 2015–16.
- 70 Growth of public patients in public hospitals remained relatively low throughout the period, with negative growth in Victoria in 2012–13 and Western Australia in 2013–14.

xv Based on 2013–14 figures, see National Health Performance Authority, *Cost of acute admitted patients per NWAU 2013–14*, <http://www.myhospitals.gov.au/about-the-data/download-data>, at 11 May 2017.

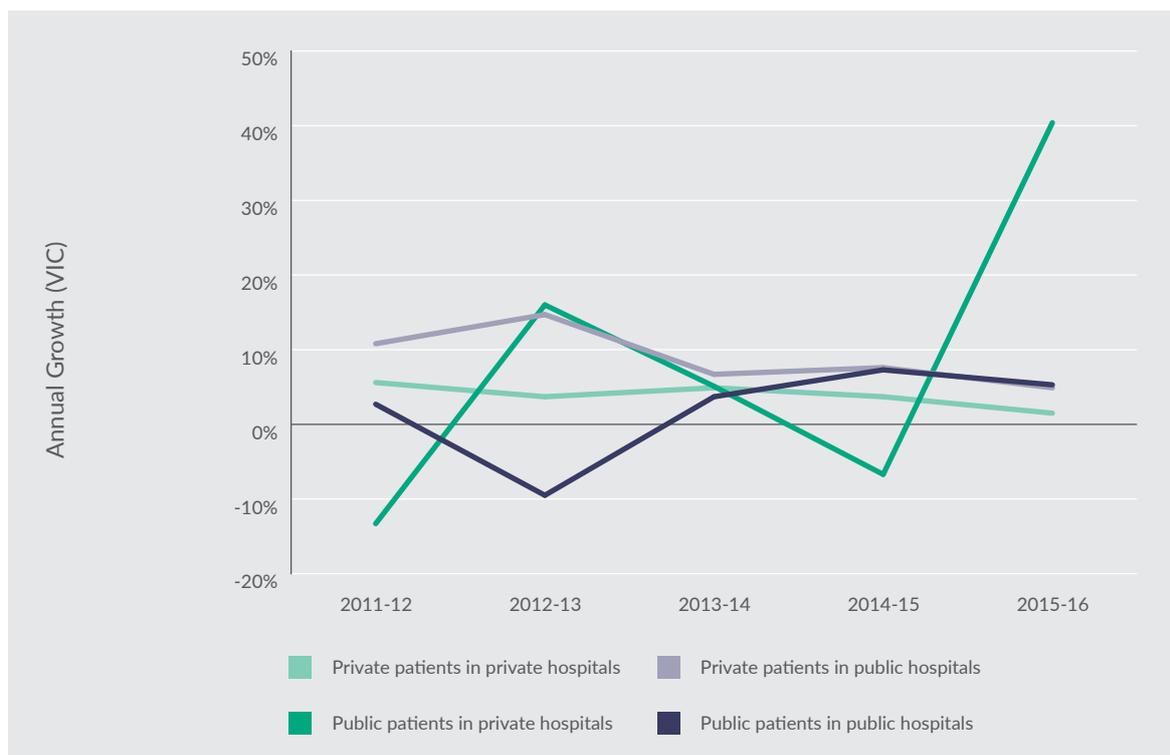
xvi From 2013–14 to 2014–15, the number of licensed beds in private hospitals reduced in Victoria and grew by less than 1 per cent in South Australia and Queensland. AIHW did not report data for other states over this period.

Figure 5: Annual growth in separations by principal source of funding 2011-12 to 2015-16, New South Wales



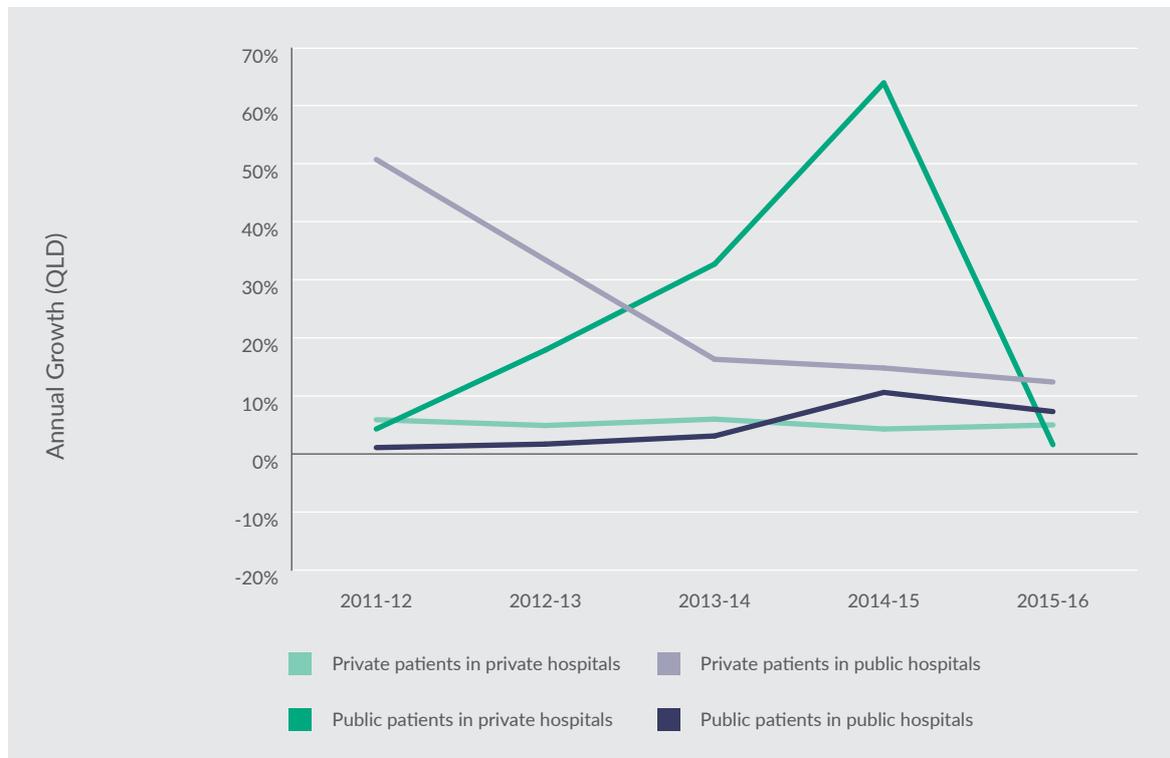
Source: AIHW, *Admitted patient care 2015-16, 2014-15 and 2013-14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2010-11, 2011-12, 2012-13*.

Figure 6: Annual growth in separations by principal source of funding 2011-12 to 2015-16, Victoria



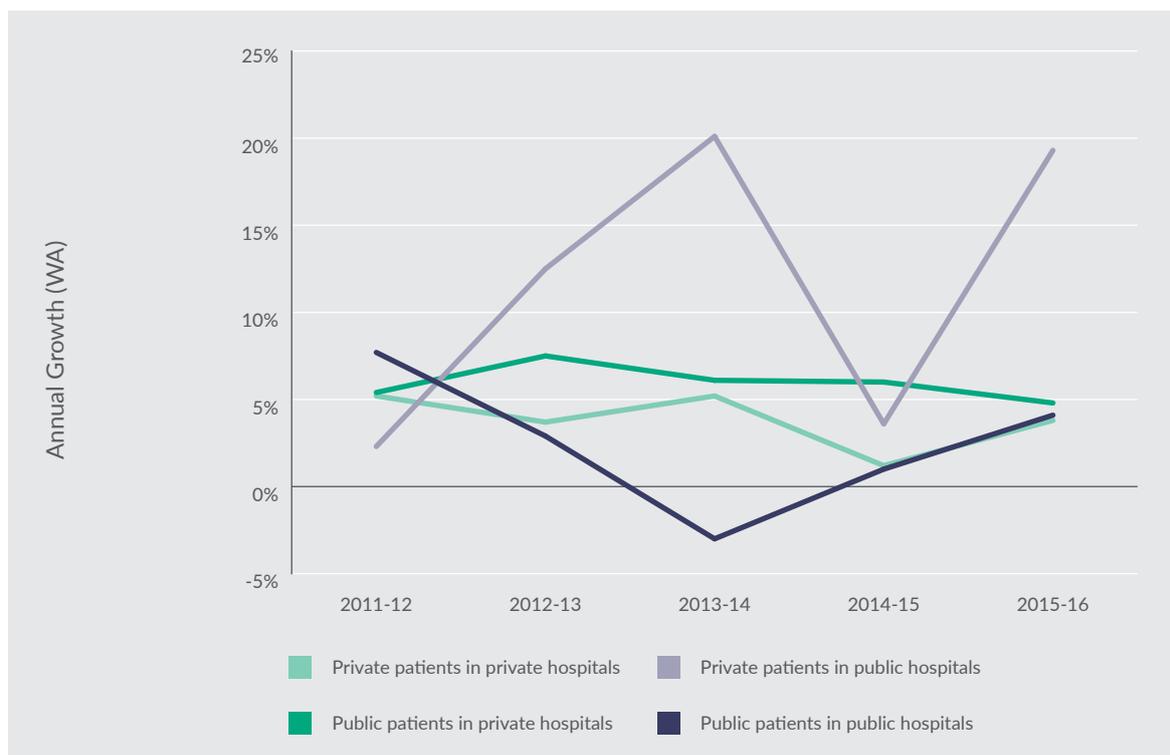
Source: AIHW, *Admitted patient care 2015-16, 2014-15 and 2013-14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2010-11, 2011-12, 2012-13*.

Figure 7: Annual growth in separations by principal source of funding 2011-12 to 2015-16, Queensland



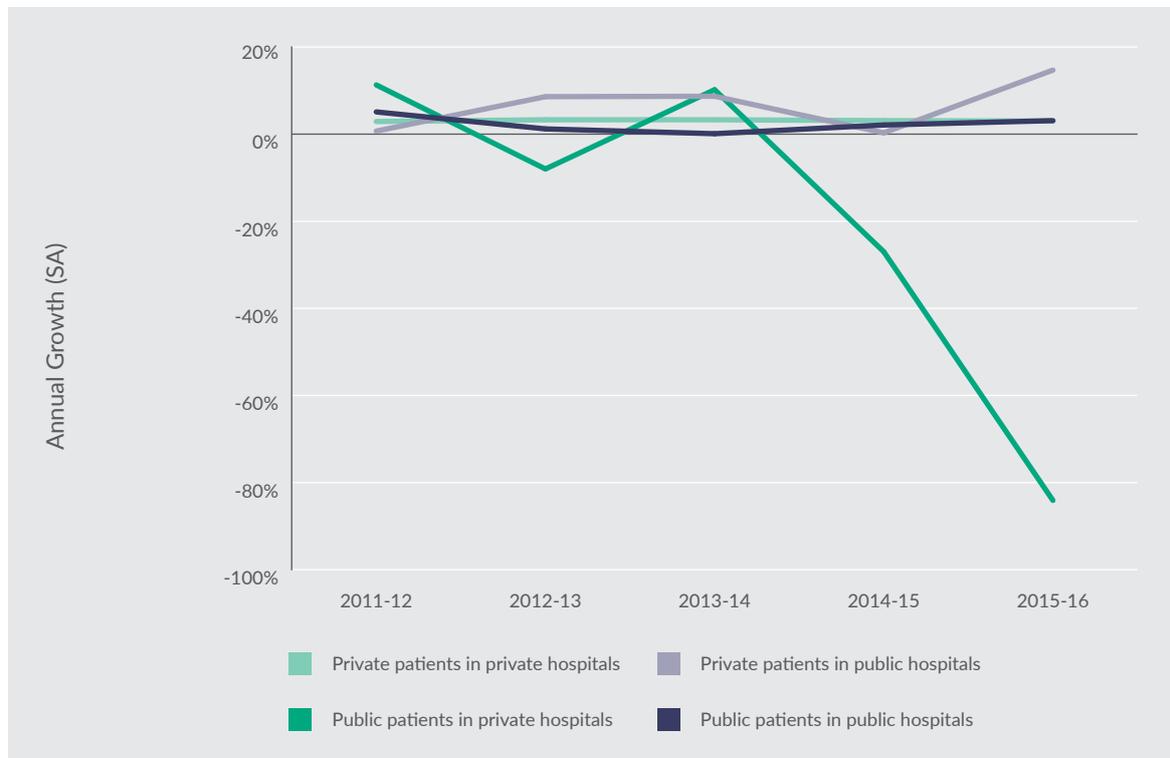
Source: AIHW, *Admitted patient care 2015-16, 2014-15 and 2013-14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2010-11, 2011-12, 2012-13*.

Figure 8: Annual growth in separations by principal source of funding 2011-12 to 2015-16, Western Australia



Source: AIHW, *Admitted patient care 2015-16, 2014-15 and 2013-14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2010-11, 2011-12, 2012-13*.

Figure 9: Annual growth in separations by principal source of funding 2011-12 to 2015-16, South Australia



Source: AIHW, *Admitted patient care 2015-16, 2014-15 and 2013-14: Australian hospital statistics* and AIHW, *Australian hospital statistics 2010-11, 2011-12, 2012-13*.

Are private patient admissions to public hospitals primarily for elective or emergency care?

- 71 Over time, the mix of admissions of private patients to public hospitals has changed, with an increase in the proportion of emergency admissions and a corresponding reduction in the proportion of elective admissions. It is notable that there has not been a corresponding increase in the proportion of public patient emergency admissions, which have remained relatively static.
- 72 One would expect alignment between the proportion of private and public emergency admissions, as it is clinically unlikely that proportionally more private patients require urgent treatment than public patients. Possible reasons for the disparity are that private health insurance coverage increased over the period, or that private patients are being admitted through emergency as a way to avoid waiting lists, and may be being advised to present in this manner.
- 73 In 2015-16, private patients accounted for 16 per cent of all emergency admissions and 13 per cent of all elective admissions to public hospitals.³⁰

Table 2: Basis of admissions to public hospitals 2015-16

	2015-16	
	Private patient in public	Public patient
Elective	38%	39%
Emergency	49%	41%
Not assigned	14%	20%
Total	101% ^{xvii}	100%

Source: AIHW, *Admitted patient care 2015-16: Australian hospital statistics* (2015-16 data).

74 Over the period 2011-12 to 2015-16, private patients increased as a proportion of total emergency admissions involving surgery to public hospitals, however, as a proportion of elective admissions involving surgery, remained relatively static (see Table 3 below).

Table 3: Emergency and elective admissions to public hospitals by funding source

	Emergency admissions involving surgery		Elective admissions involving surgery	
	Private patient	Public patient	Private patient	Public patient
2011-12	14%	77%	7%	88%
2012-13	16%	76%	7%	88%
2013-14	18%	75%	7%	87%
2014-15	18%	75%	8%	89%
2015-16	18%	75%	8%	88%

Source: AIHW, *Admitted patient care 2015-16, 2014-15 and 2013-14: Australian hospital statistics*. AIHW, *Australian hospital statistics 2012-13, 2011-12*.

75 State-wide data submitted by CHA members demonstrates that the breakdown of emergency and elective admissions of private patients in public hospitals can vary considerably by state. Whereas in New South Wales, a greater proportion of private patients in public hospitals are emergency admissions, in Victoria, elective admissions account for the vast majority. This could be attributable to differences between public hospital practices to attract and convert private patients in each state, or differences in private practice arrangements with doctors which may affect referral patterns.

76 There are also differences between New South Wales and Victoria in terms of the proportion of all admissions which private patients represent in each category. For example, private patients account for a larger proportion of elective admissions in Victoria than New South Wales. For emergency care, private patients represent a greater proportion of all public hospital admissions in New South Wales than in Victoria.

77 Data supplied by CHA members shows that there has been substantial growth in same-day elective admissions of private patients in public hospitals in Queensland and New South Wales in recent years.

xvii Due to rounding.

Other trends in public hospital admissions

- 78 Since 2011–12, medical separations have grown more rapidly in public hospitals than in private hospitals.
- average annual growth of same-day medical separations was 4.3 per cent for public hospitals, compared to 2.5 per cent for private hospitals;³¹
 - average annual growth of overnight medical separations was 1.1 per cent for public hospitals and -0.6 per cent for private hospitals.³²
- 79 Public hospitals account for the majority of all medical separations (73 per cent), compared to 27 per cent for private hospitals. Private hospitals continue to perform the majority of surgical separations (60 per cent), with 40 per cent performed in public hospitals.³³
- 80 Since 2011–12, public hospitals have accounted for a greater proportion of all private patient acute activity, increasing from 12 to 16 per cent of all private patient activity for same-day separations, and from 24 to 30 per cent for overnight separations.³⁴
- 81 Private patients are more likely to be admitted to public hospitals for overnight treatment than public patients, with 48 per cent of private patients in public hospitals admitted overnight, compared to 42 per cent of public patients. The proportion of public patients admitted for same-day treatment in public hospitals (53 per cent) is greater than private patients (46 per cent).³⁵ Given the range of personal, social, economic, and environmental factors that influence health status, it would seem these percentages should be reversed. One assumption for this ratio may be that privately insured patients are seeking additional recovery time or that some other factor is at play, for example, a funding model based upon a per diem payment may contribute to a differential in length of stay.
- 82 From 2014–15 to 2015–16, there was a decline in acute separations in private hospitals (by 1 per cent for same-day separations and 0.9 per cent for overnight separations). Public hospital acute activity continued to grow, particularly for same-day admissions (4.9 per cent), compared to 0.2 per cent growth for overnight admissions.³⁶

Possible causes of the growth of private patients in public hospitals

- 83 The key cause of the growth of private patients in public hospitals is the practices of some public hospitals to encourage patients to use their private health insurance. These practices have been driven by systemic incentives to maximise private patient activity. This section highlights examples of the practices used by some public hospitals and examines the incentives for public hospitals to do so. It also identifies factors that may influence private patients' choice to attend a public hospital.
- 84 CHA seeks to ensure that all patients are given the right to make a fully informed choice about their treatment, and that funding mechanisms do not create incentives to discriminate between patients based on ability to pay.

Public hospital practices to attract and convert private patients

- 85 The National Health Reform Agreement prohibits public hospital employees from directing patients or their legal guardians towards a particular choice³⁷ when patients are making their election. However, this has not precluded some public hospitals from engaging in practices to encourage patients to use their private health insurance.
- 86 It is important to note that there is wide differentiation in the behaviour of public hospitals, which varies by state and by individual hospital.
- 87 The following examples have been compiled from public hospital brochures and websites, and interviews with hospital and other private health executives during the course of this project:
- a. public hospital staff telling private patients that a nearby private hospital was full or that the private hospital did not know how to look after the patient's condition;
 - b. private patients being given inducements such as coffee club and other vouchers, newspapers, toiletries, bath robes, nappy-washing services, meals for visitors, a la carte menu and beverage selection, free phone calls, television hire, internet and Foxtel use, free parking, preferential access to private rooms, contribution to excesses which can be traded for a trip, house cleaning or day spa visit;
 - c. signs in the public hospital asking patients to support the hospital by using their private health insurance, patients being told that using their private health insurance assists the hospital to buy equipment, maintain facilities and services, deliver education and training, invest in research, or increase resources and beds;
 - d. patients being told that using their private health insurance will not cost them anything and then receiving bills;
 - e. patients being asked, in some cases repeatedly, to declare their private health insurance after they have said they do not wish to be treated as a private patient;
 - f. public hospital staff searching patients' medical records to identify whether they have private health insurance;
 - g. private patients being told they will be treated more quickly;
 - h. patients being told that they will need to be transferred to another hospital if they do not elect to use their private health insurance.
- 88 There are also examples of patients receiving such inducements from private hospitals, for example, to encourage early discharge.

- 89 At least some of the above examples appear to directly violate the terms of the National Health Reform Agreement and potentially contravene privacy law and the *Competition and Consumer Act 2010*. They are also inconsistent with patient charters and relevant codes of conduct. Examples of such behaviour are concerning, and some of them are in conflict with the fundamental principles of Medicare.
- 90 Arguably, providing inducements is contrary to the current terms of the National Health Reform Agreement which provide that public patients must receive access to all services provided to private patients in public hospitals.³⁸ The only difference in service which is expressly permitted by the Agreement is that private patients have the right to choose their own doctor.
- 91 Whilst CHA members are aware of unethical practices within the system, CHA's member hospitals are governed by a code of ethical standards that would preclude such misleading or coercive conduct.
- 92 Public hospitals typically employ private patient liaison officers whose job descriptions can include maximising hospital revenue through admitted patients using their private health cover, and promoting the use of private health insurance.
- 93 The National Health Reform Agreement allows states and territories to determine the charges they apply to private patients. In practice, public hospitals commonly cover the excesses and, in some cases, other out-of-pocket expenses of private patients.

Public hospital funding arrangements

- 94 Although public hospital funding arrangements purport to achieve neutrality between public and private patients, in practice they are creating incentives for public hospitals to maximise private patient activity.
- 95 State funding arrangements (particularly the setting of own source revenue targets) appear to have been more influential than Commonwealth funding arrangements in driving public hospital practices. However, issues with IHPA's collection of private patient cost data make it difficult to assess whether its private patient adjustments are operating as intended. Fluctuations in Commonwealth funding appear to have had some impact on public hospitals' behaviour, as does the delinking of Commonwealth funding from private health insurance coverage or private patient activity since 2003.

State funding arrangements

- 96 The marked differences between states and territories in the level of growth of private patients in public hospitals suggest that state and territory funding policies have had more of an impact on public hospitals' behaviour than Commonwealth activity based funding arrangements.
- 97 In its report, *Private patient public hospital service utilisation*, IHPA found that state and territory health funding policy settings were contributing to the trend of increased private patients in public hospitals. These policy settings included states not adjusting payments for private patients and setting private patient targets for own source revenue.
- 98 Own source revenue is vital for public hospital viability in the context of current state funding approaches. States do not fund the full cost of public hospital activity, and require that public hospitals raise their own revenue from other sources (such as private patients and commercial activities). State price growth (and consolidated budget growth) is well below health cost growth including wages, technology and other costs growth, and activity levels for public patients are capped.
- 99 Private patient or own source revenue targets create an incentive for public hospitals to attract and convert private patients because where targets are exceeded, they retain own source revenue with no corresponding reduction in activity based funding. If targets are not met, activity based funding is reduced without any increase in funding from other sources.³⁹

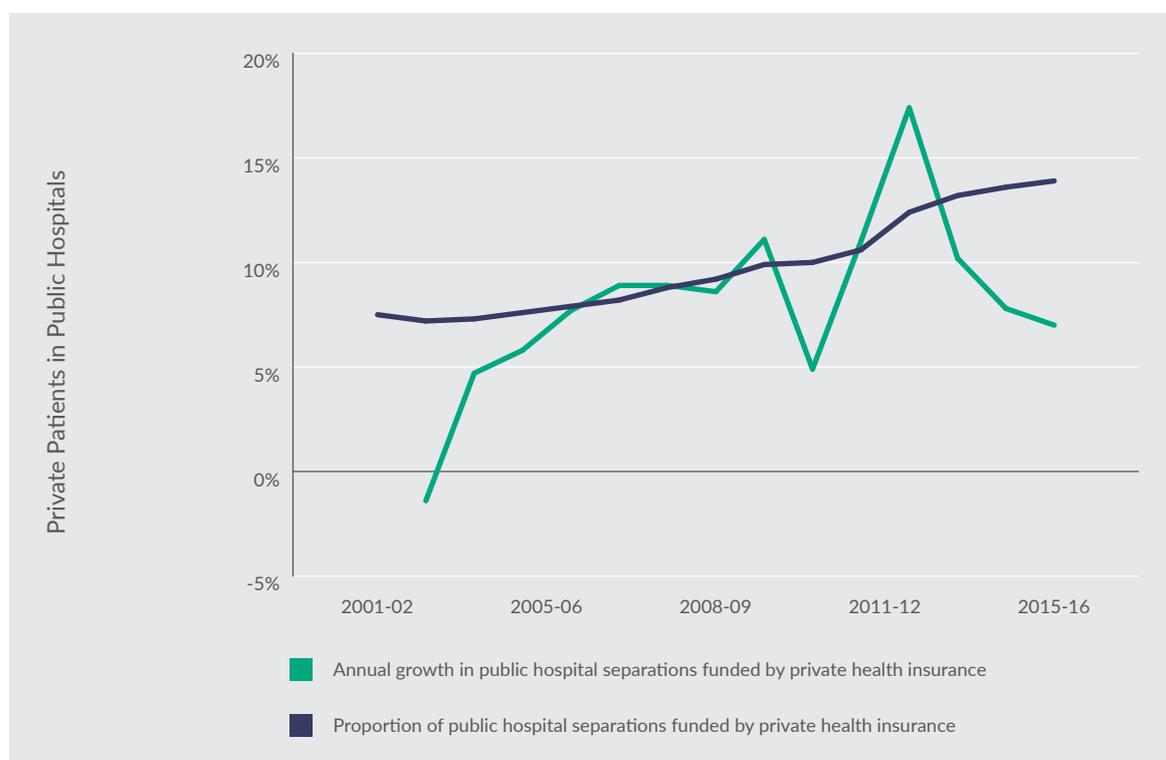
- 100 Converting private patients enables public hospitals to shift costs to private health insurers. For private patients, the Commonwealth pays MBS fees and insurers pay MBS and other fees (including for accommodation and prostheses), whereas for public patients, public hospitals must cover input costs including staff, accommodation, prostheses, diagnostic imaging and pathology costs.
- 101 South Australia and the Australian Capital Territory are the only states which do not set private patient/own source revenue targets, and which apply the private patient adjustments determined by IHPA. South Australia experienced the lowest growth of private patients in public hospitals from 2008–09 to 2015–16. The Australian Capital Territory's total proportion of public hospital separations funded by private health insurance in 2015–16 was still one of the lowest compared to other states and territories (at 11 per cent), however, unlike South Australia, this has grown rapidly since 2008–09. These figures suggest that the policy settings in the Australian Capital Territory and South Australia may have helped to limit the conversion of private patients in public hospitals. Western Australia, which only recently applied private patient revenue targets, has experienced relatively low growth of private patients as a proportion of public hospital separations, compared to other states.

Commonwealth funding arrangements

- 102 In its report, *Private patient public hospital service utilisation*, IHPA found that the national activity based funding framework had not been a significant driver in the upward trend of private patients in public hospitals, because Commonwealth payments were adjusted for private patients. However, in reaching this conclusion, it assumed that IHPA's private patient adjustments were fit for purpose.
- 103 The effectiveness of IHPA's private patient adjustments in neutralising Commonwealth funding differences between public and private patients depends on whether the adjustments accurately reflect private patient income that public hospitals receive from the Commonwealth and insurers.
- 104 IHPA notes that the collection of private patient medical expenses is problematic because special purpose funds (which are used to collect private practice revenue in some states) do not always appear in hospital accounts used for costing in the National Hospital Cost Data Collection. Since 2015, IHPA has applied a 'private patient correction factor' as an interim solution to correct the issue. IHPA intends to phase out this correction factor in 2018 if it is feasible to do so, as the collection of private patient cost data is improved.⁴⁰
- 105 IHPA sought to improve the collection of private patient cost data in version 3.1 of the Australian Hospital Patient Costing Standards, which were released in late 2014. IHPA notes that 2018 reflects two years after the implementation of version 3.1 of the Standards and should provide enough lead time for states and territories to fully comply with the requirement to report private patient medical costs in the cost data collection.⁴¹ CHA believes that the phase-out process should be delayed if full compliance with the standards is not achieved by 2018.
- 106 There may be some correlation between the growth of private patients and reductions in the growth of Commonwealth public hospital funding over time. Figure 10 below depicts the growth of private patients in public hospitals since 2001–02. The proportion of private patients in public hospitals has grown more rapidly since 2011–12, with a spike in the annual growth of private patients in public hospitals in 2012–13 (17.4 per cent). It is possible that changes in Commonwealth public hospital funding contributed to this, and to the rising proportion of private patients in public hospitals since 2011–12.
- 107 Figure 11 below shows that annual growth in Commonwealth health expenditure dropped sharply in 2011–12 to 2012–13, and Figure 12 shows that the gap between Commonwealth and state/territory hospital expenditure increased from 2008–09 to the largest it has been (\$4.5 billion) in 2013–14.

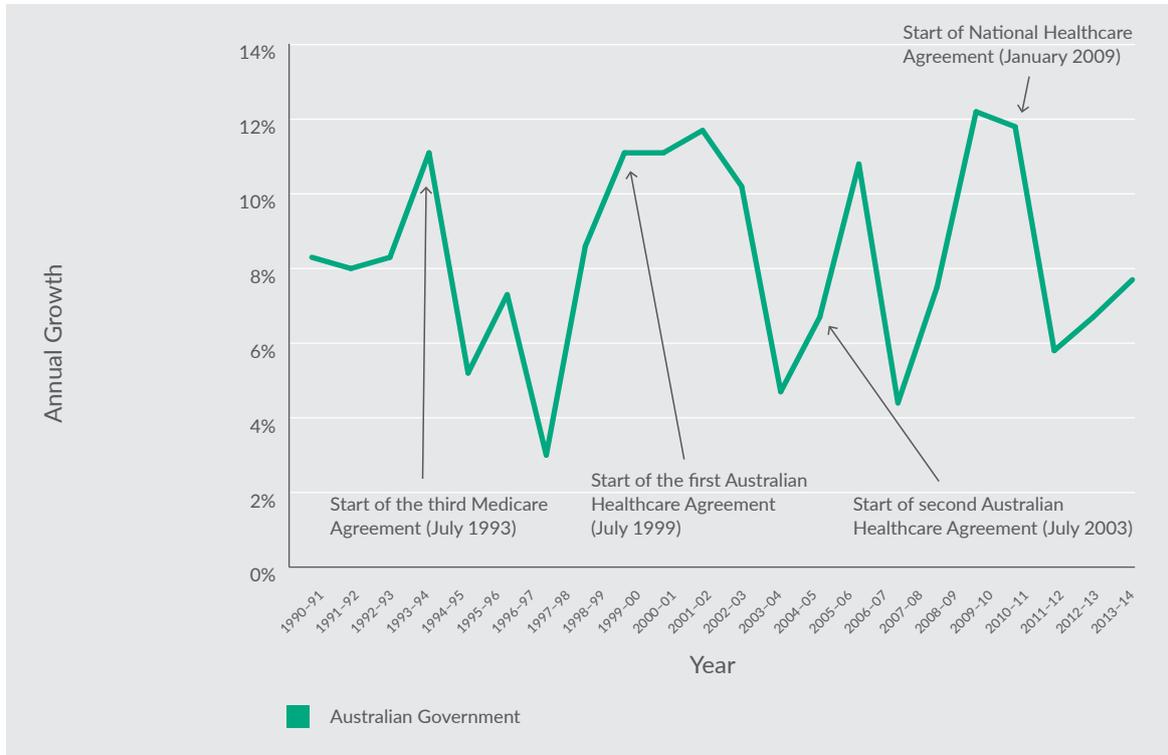
- 108 Since 2013–14, Commonwealth public hospital funding has increased (by more than \$3 billion over 2014–15 and 2015–16), and will continue to increase (by a further \$5.5 billion) to 2020–21.⁴² It remains to be seen whether this increase in Commonwealth public hospital funding will curb the growth of private patients in public hospitals.
- 109 Data on private patients in public hospitals prior to 2003 (when Commonwealth funding was adjusted based on private health insurance coverage or private patient activity) is limited. In 1998, Dr Michael Wooldridge noted that 'public hospitals, mostly consciously, have treated fewer people who are privately insured.'⁴³ Prior to 2001, the AIHW did not publish data on which patients used private health insurance in a public hospital, but the earliest annual growth figures published by AIHW show negative growth of private patients in public hospitals in 2002–03. This suggests that tying Commonwealth public hospital funding to private health insurance coverage or private patient activity may have discouraged states from increasing private patient volumes.

Figure 10: Growth of private patients in public hospitals 2001–02 to 2015–16



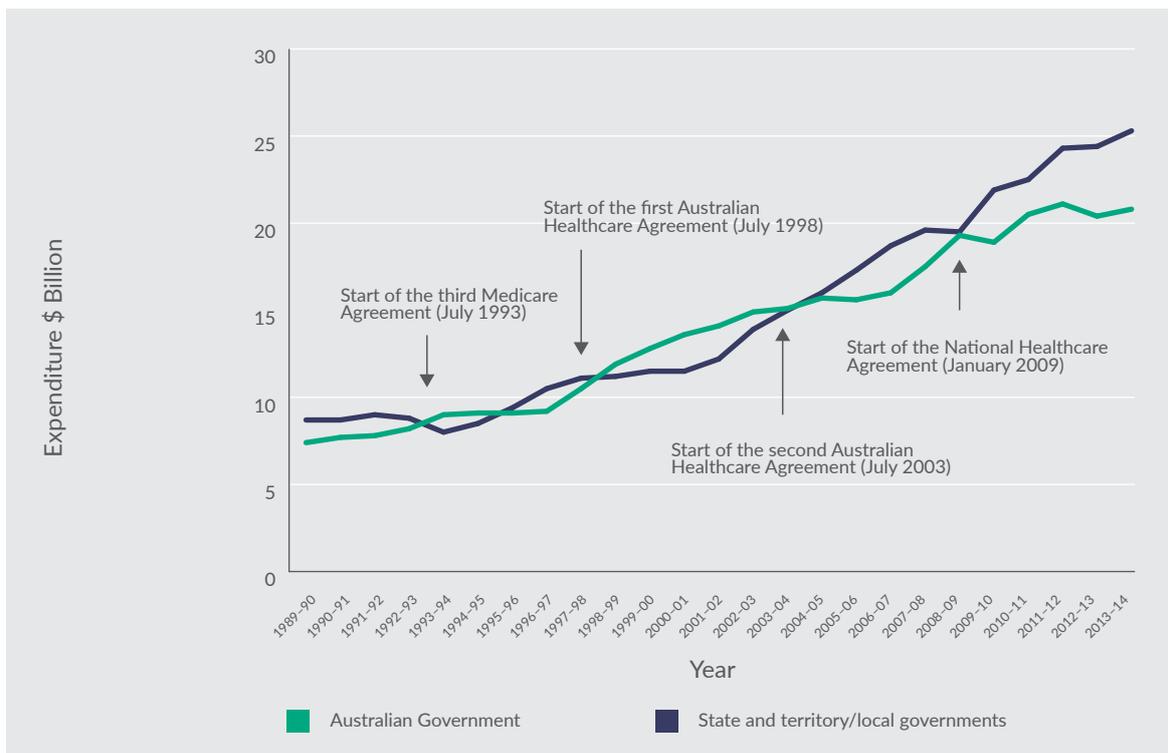
Source: AIHW, *Admitted patient care 2015–16, 2014–15 and 2013–14: Australian hospital statistics*; AIHW, *Australian hospital statistics 2012–13, 2011–12, 2010–11, 2009–10, 2008–09, 2007–08, 2006–07, 2005–06, 2004–05, 2003–04, 2002–03, 2001–02*.

Figure 11: Annual growth in Australian Government health expenditure, 1989-90 to 2013-14



Source: AIHW, 25 years of health expenditure in Australia 1989-90 to 2013-14.

Figure 12: Hospitals expenditure, constant prices, by Australian Government and state and territory/local governments, 1989-90 to 2013-14



Source: AIHW, 25 years of health expenditure in Australia 1989-90 to 2013-14.

Private practice arrangements with doctors

- 110 Public hospitals may benefit from MBS fees paid by the Commonwealth and insurers for private patients through the hospital's private practice arrangements with doctors. The lack of transparency around these arrangements makes it difficult to assess the extent to which they incentivise public hospitals to attract and convert private patients.
- 111 Private practice arrangements enable specialists to supplement their public hospital income, and are an important way for public hospitals to recruit and retain senior medical specialists. It has been estimated that a Visiting Medical Officer would typically receive a minimum of 25 per cent more for operating on a private patient than what they would earn from public hospital hourly rates.⁴⁴ Private practice arrangements are agreed on a state-wide basis, except in Victoria.⁴⁵ Appendix 3 sets out the private practice arrangements that apply in each state and territory.
- 112 Visiting Medical Officers in some instances are full time employees of public hospitals, and therefore may be conducting private work in publicly paid time. In these cases, individual hospital private practice arrangements may be enabling 'double dipping', thereby inflating the cost of healthcare and demonstrating poor stewardship of the Australian healthcare dollar.
- 113 There are three basic models of private practice arrangements:
- a. **Donation model:** all private practice revenue is assigned to the hospital and, in exchange, an allowance is paid to the medical specialist. The hospital pays the specialist's medical indemnity insurance. The hospital can use this private practice revenue according to the terms of the special purpose fund agreements. These usually give the hospital a wide discretion, for example, the hospital may pay for training and research, equipment and staff;
 - b. **Retention model:** the hospital retains all private practice revenue and the specialist pays a facility and administration fee to the hospital;
 - c. **Revenue sharing model:** the specialist pays a percentage of private practice revenue to the hospital.
- 114 Under private practice arrangements, hospitals may direct specialists not to charge gap fees.
- 115 One of the objectives of private practice arrangements is to generate additional revenue for the hospital. The extent to which private practice arrangements create an incentive for public hospitals to maximise private patient activity depends on whether, under the particular arrangement, private patient revenue received by the hospital outweighs the costs it incurs in treating these patients.
- 116 A report by the Queensland Audit Office in 2013 on the *Right of private practice in Queensland public hospitals* found that the private practice scheme had cost the public health system \$804.24 million over the decade, and that the donation model was the largest contributor to the shortfall. It found that the scheme increased private practice revenue but this was outweighed by the cost of payments to medical specialists. The Audit Office noted that the retention and revenue sharing models were more closely aligned to the original intent of the scheme.⁴⁶
- 117 Although a similar examination of the cost effectiveness of private practice schemes has not been undertaken in other states, if they were found to be similarly inefficient to Queensland's scheme, this could have cost Australia's public health system \$9 billion over the decade.^{xviii} Queensland introduced new private practice arrangements in 2014 following the Queensland Audit Office report.
- 118 In a 2008 report on *Private practice arrangements in health services*, the Victorian Auditor-General found that there was no evidence that the facility fee paid by specialists reflected the real value of public resources being used, and it may not cover actual costs.⁴⁷

xviii 2003–04 to 2011–12. This estimate assumes that \$804.24 million is 9.2 per cent of the potential national cost, on the basis that private patient separations in Queensland public hospitals over the period represented 9.2 per cent of private patient separations in public hospitals nationally. This estimate does not account for variations in private practice schemes between states.

119 It is also unclear to what extent private practice arrangements may influence a doctor to choose to treat a patient in a public rather than a private hospital. At some public hospitals in New South Wales, for example, the surgeon is required to treat as many private patients as public patients.⁴⁸

Insurer funding arrangements

120 Prostheses benefits for private patients are a source of additional revenue for some public hospitals which may incentivise them to attract and convert private patients. As minimum default benefits are often less than the actual cost of providing accommodation, they do not appear to create incentives to maximise private patient activity. However, as per diem payments, they may affect incentives around length of stay between private and public patients.

Prostheses benefits

121 The difference between the price of prostheses for public and private patients has been well publicised. The issue has been the subject of a recent Senate Inquiry, and prostheses prices have been targeted for further reform.

122 Purchasing of prostheses for use in public hospitals typically occurs through competitive tender. Prostheses costs for public patients are included in the National Efficient Price determined by IHPA. For private patients, whether treated in a private or public hospital, insurers are required to pay the specified Prostheses List benefit to the hospital. This benefit is often greater than the prostheses cost for public patients.

123 State competitive tendering for prostheses narrows choices for doctors in the public sector; typically states contract with fewer suppliers over longer periods (2, 3 and 5 year contracts) to acquire the best price. Profits for public hospitals under this purchasing model are substantial. However, not all public hospitals use this purchasing model, for example, some of CHA's members do not make any profit from prostheses.

124 IHPA's submissions to the Senate Inquiry included data on the difference between the prostheses benefits for private patients in a public hospital and the average prostheses costs for public hospital patients (see Table 4 below).

Table 4: IHPA data on prostheses costs and benefits, 2014–15

Description	Average prosthesis cost (public hospital patients)	Average prosthesis benefit (private patients in public hospitals)
Lens Procedures	\$282	\$491
Implantation and Replacement of Implantable Cardioverter-Defibrillator, Total System	\$18,923	\$50,224
Implantation and Replacement of Pacemaker, Total System	\$4,776	\$11,568
Insertion and Replacement of Pacemaker Generator	\$4,324	\$11,288
Hip Replacement	\$6,299	\$6,979
Knee Replacement	\$6,788	\$7,643
Other Hip and Femur Procedures	\$1,604	\$1,989
Spinal Fusion	\$10,963	\$10,804

Source: IHPA, Submission to the Senate Community Affairs References Committee inquiry into price regulation associated with the Prostheses List framework, and response to questions on notice, 3 April 2017.

- 125 In 2012, public hospitals' profit from prostheses benefits for private patients was estimated to be \$55 million out of \$123 million in total benefits.⁴⁹ This estimate was based on a 2009 report on *Public and private hospitals*, in which the Productivity Commission found that for the 20 DRGs with the greatest average cost per separation the public prostheses cost was around 55 per cent of that charged to the private health insurance funds.⁵⁰
- 126 Hospital Casemix Protocol data for 2014–15 indicates that prostheses benefits for private patients in public hospitals were \$96,823,810 (9.18 per cent of total benefits paid by insurers for private patients in public hospitals). Applying the above estimate to this figure, public hospital profit on prostheses for private patients would be \$44 million.

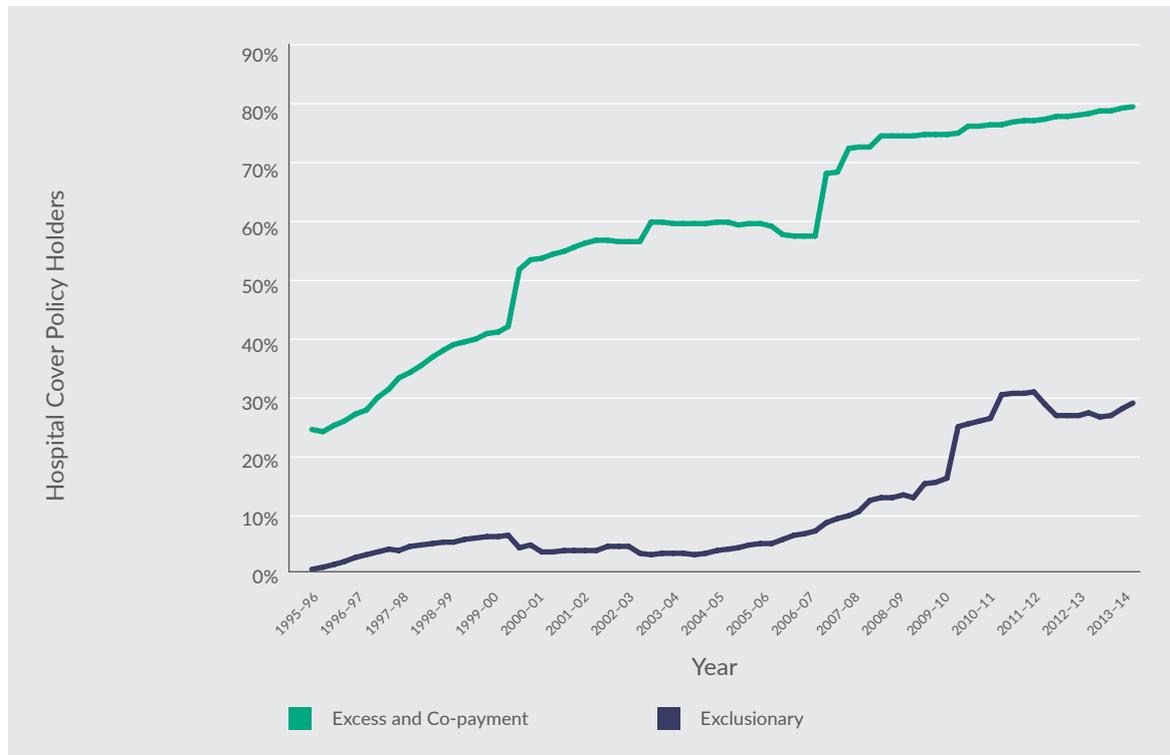
Minimum default benefits

- 127 There is considerable variation across states in payment arrangements for accommodation services for private patients in public hospitals, with most of this variation arising from historical circumstances.
- 128 It is unlikely that minimum default benefits create an incentive for public hospitals to attract and convert private patients because they are often less than the actual cost of providing accommodation. For example, the average cost of a public hospital separation for a private patient was \$5304 in 2015–16,⁵¹ and the minimum default benefit is only \$200–\$300 per day. The Victorian Department of Health has published data on its website showing the disparity between the minimum default benefit and the actual cost of providing accommodation (for example, the average cost of providing accommodation for advanced surgery is \$823, and the minimum default benefit is \$415).⁵²
- 129 It has been observed that because minimum default benefits are paid per diem, this is not consistent with the National Health Reform Agreement which requires that payments for private patients should use the same activity based funding classification as for public patients. In 2011, it was recommended that minimum default benefits transition from per diem to DRG payments,⁵³ however, this has not occurred.
- 130 As payments by DRG would drive greater efficiencies in length of stay than a per diem payment, it is possible that the continuation of per diem minimum default benefits has contributed to differences in the relative length of stay between private and public patients in public hospitals. In 2015–16, private patients in public hospitals had a marginally longer relative length of stay (1.00) than public patients (0.95).⁵⁴ It is also possible that per diem payments have contributed to the trend of proportionally more private patients being admitted to public hospitals for overnight treatment than public patients (see paragraph 81 above).

Growth of out-of-pocket costs and exclusionary policies

- 131 The growth of out-of-pocket costs in the private sector, for treatment both in and out of hospital, and exclusionary policies are likely to influence private patients' choice to attend a public hospital rather than a private hospital, noting that public hospitals typically waive excesses and, in some cases, other out-of-pocket expenses for private patients.
- 132 The number of private health insurance policies with exclusionary features or excesses and co-payments has increased over time (see Figure 13). In March 2017, 82.6 per cent of hospital cover policies had excesses and co-payments, and 39.3 per cent of hospital cover policies were exclusionary.⁵⁵

Figure 13: Percentage of hospital cover policy holders with excess and co-payment or exclusionary features^{xix}



Source: Private Health Insurance Administration Council, *Competition in the Australian Private Health Insurance Market*, June 2015.

- 133 The Commonwealth Ombudsman noted that in 2015–16, the largest area of complaint (1359 complaints) was private health insurance benefits, including key issues such as hospital exclusions and restrictions and medical gaps.⁵⁶
- 134 The rise of private health insurance products with restrictions, exclusions and increasing excesses has been described as a ‘race to the bottom’. Complaints by consumers have included ‘fit for purpose’ concerns about aggregators (such as ISelect and Compare the Market) selling policies based on price rather than clinical need.
- 135 The growth of out-of-pocket costs and exclusionary policies, which has led to churn, and consumers devaluing private health insurance as a product, is likely to have contributed to the growth of private patients in public hospitals. This has been exacerbated by the increasing number of policies which do not cover patients for treatment in a private hospital at all, and only cover public hospital treatment.
- 136 Patients may face significant out-of-pocket costs in a private hospital. The average out-of-pocket cost per episode for hospital treatment is \$318.⁵⁷ Although the average gap payment has declined over time (see Table 5 below), there is still considerable variability in out-of-pocket expenses. For example, in a recent report, the average out-of-pocket fee for a hip replacement (from a sample of 299 surgeons) ranged from \$0 to \$4,057.⁵⁸

xix The increase in exclusionary products in June 2010 is partly due to a re-classification of policies between exclusions and restrictions by some insurers. Further, there is a break in the excess and co-payment data in June 2007 due to a change in the definition used. While the data on exclusionary products pre and post June 2010 and the data on excess and payments pre and post June 2007 is not strictly comparable, the data over the entire period can be taken as a proxy of the overall trend.

Table 5: Average gap payments (\$) per hospital episode

	2008	2009	2010	2011	2012	2013	2014
Hospital gap – Accommodation	126	123	120	112	113	119	125
Medical gap	175	177	185	178	173	167	163
Prosthesis gap	3	5	7	1	1	1	1
Total hospital gap	304	304	310	297	287	287	288

Source: PHIAC, *Competition in the Australian Private Health Insurance Market*, June 2015.

137 Over time, there has been a substantial increase in the proportion of medical providers charging 125 to 200 per cent more than the MBS fee (see Table 6 below).

Table 6: Medical services – fees charged relative to the MBS fee

	2003	2008	2014
MBS fee or less	22.1%	22.3%	25.3%
MBS fee to 125% of MBS fee	31.1%	28.1%	16.0%
125% of MBS fee to 150% of MBS fee	23.6%	20.3%	27.7%
150% of MBS fee to 200% of MBS fee	18.1%	22.8%	24.5%
More than 200% of MBS fee	5.1%	6.5%	6.4%

Source: PHIAC, *Trends in hospital accommodation, medical services and prostheses: statistical bulletin*, June 2015.

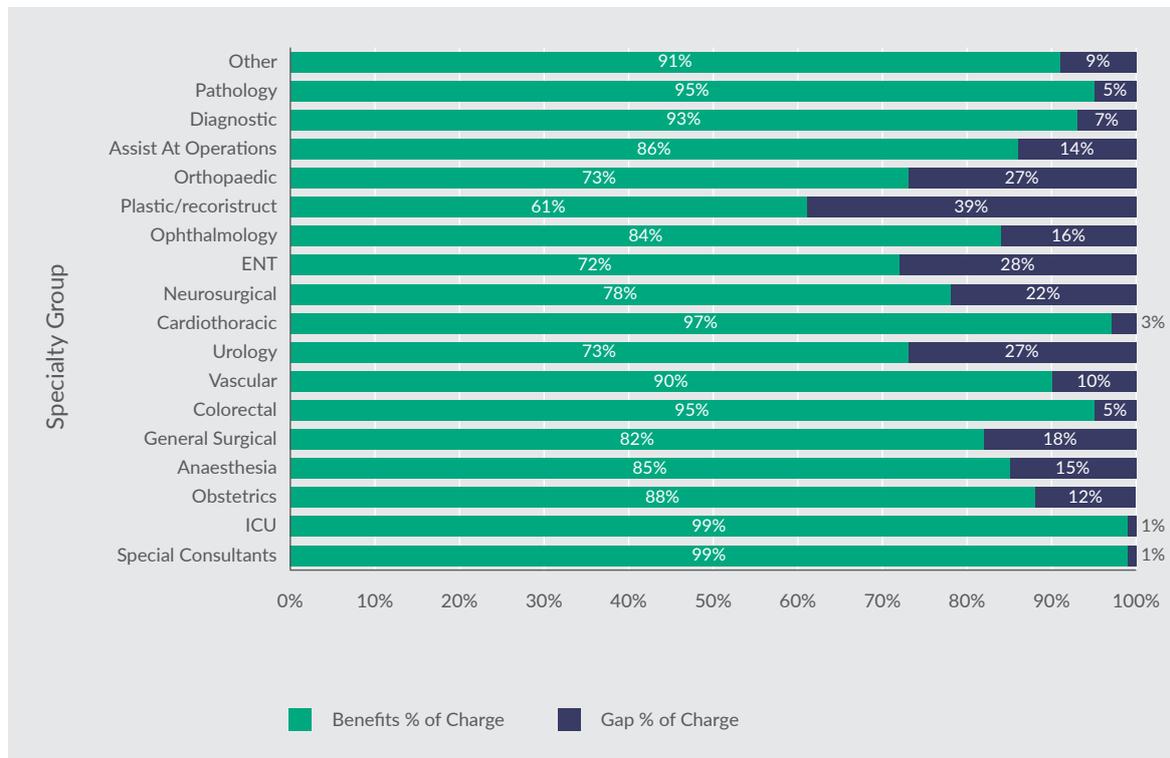
138 A report released by the Royal Australasian College of Surgeons utilising 2015–16 data provided by Medibank revealed that some surgeons are charging upwards of \$10,000 more than other surgeons for the same private procedure. Gastric banding procedures topped the list with the greatest variance between lowest and highest price (48,878 to \$33,602). Gastric sleeve procedures varied from \$9,360 to \$20,848, while colonoscopies (\$6,308 to \$11,583) and hernia procedures (\$2,430 to \$9,933) filled out the top four price variances. Medibank raised concerns about the fact that approximately 80 per cent of hernia procedures are being admitted for overnight treatment, highlighting that a hernia procedure would not normally require an overnight stay in hospital. Medibank estimates that 70 to 80 per cent of hernia repairs could be same-day treatments, saving approximately 5000 nights in hospital each year.⁵⁹

139 Medibank is preparing to publish a list of surgeons who charge little or no out-of-pocket expenses for private surgeries to assist members in shopping around. NIB also plans to publish data related to the performance of individual surgeons to better enable patients to make informed decisions. Both reports are due to be published in the coming months.⁶⁰

140 There is no doubt that over the course of the last two years there has been a growing consumer awareness of out-of-pocket costs associated with medical expenses including costs associated with inpatient radiology and pathology. The Australian Competition and Consumer Commission has instituted proceedings against Medibank for failing to notify members of its decision to limit benefits for inpatient radiology and pathology services.

141 Figure 14 below shows the latest data on medical gaps by specialty group. However, reported out-of-pocket charges may not reflect the reality of actual out-of-pocket costs to consumers. For example, accounts may be stamped 'not rebatable by your private health insurer' and therefore not presented or reported. This is particularly evident in a number of specialties including plastic surgery, orthopaedics, urology and obstetrics. Such practices make it difficult to assess the true impact to the consumer of out-of-pocket fees.

Figure 14: Medical benefits and out-of-pocket by specialty group

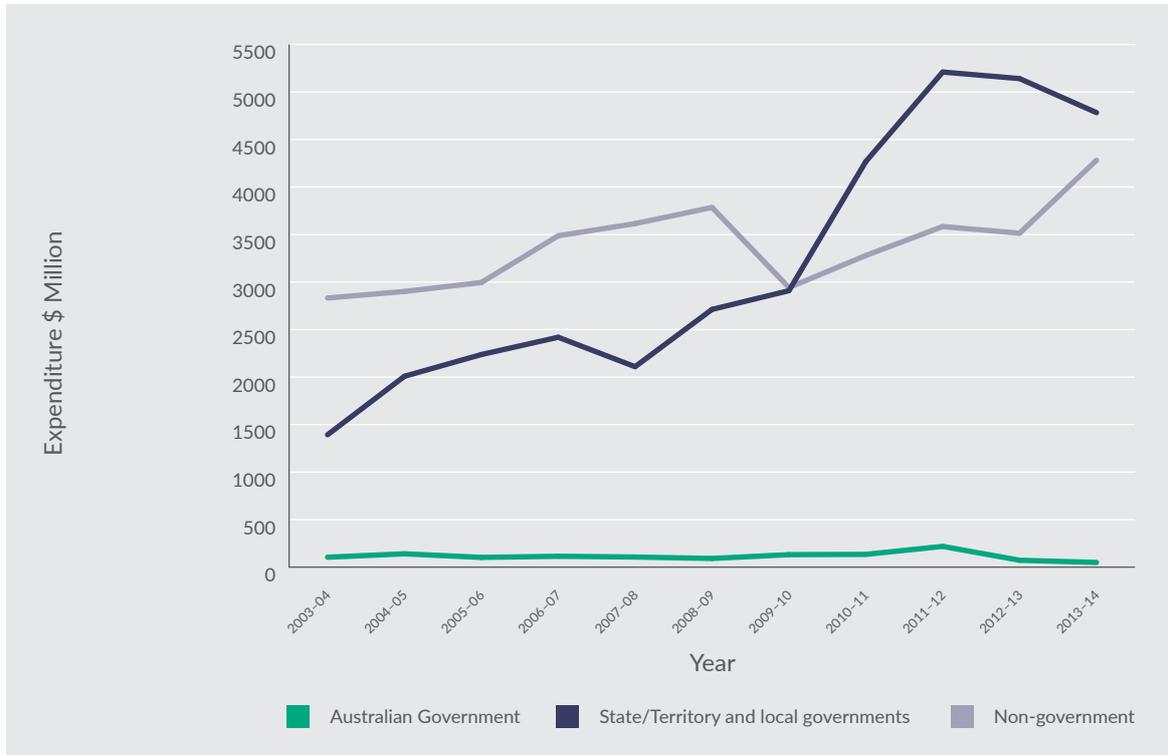


Source: APRA, *Private health insurance quarterly statistics*, March 2017.

Improved amenity of public hospitals

- 142 Other reasons why private patients may choose to attend a public hospital include access, location and clinical profile. For example, in rural and remote areas, there may be no private hospitals accessible to patients. In addition, large scale capital investment in public hospitals by state and territory governments has seen the amenity of public hospitals improve. New hospitals such as the Sunshine Coast University Hospital and the new Royal Adelaide Hospital include more private rooms for patients and state-of-the-art facilities.
- 143 Since 2009–10, state government health capital expenditure has outstripped that of the non-government sector (see Figure 15 below). There was a relatively rapid increase in capital expenditure by state and territory and local governments between 2009–10 and 2011–12, which was supported by the \$5 billion Health and Hospitals Fund established by the Australian Government in 2009.

Figure 15: Capital expenditure, by owner of asset, constant prices, 2003-04 to 2013-14 (\$ million)



Source: AIHW, *Health expenditure Australia 2013-14: analysis by sector*.

Impact of the growth of private patients in public hospitals

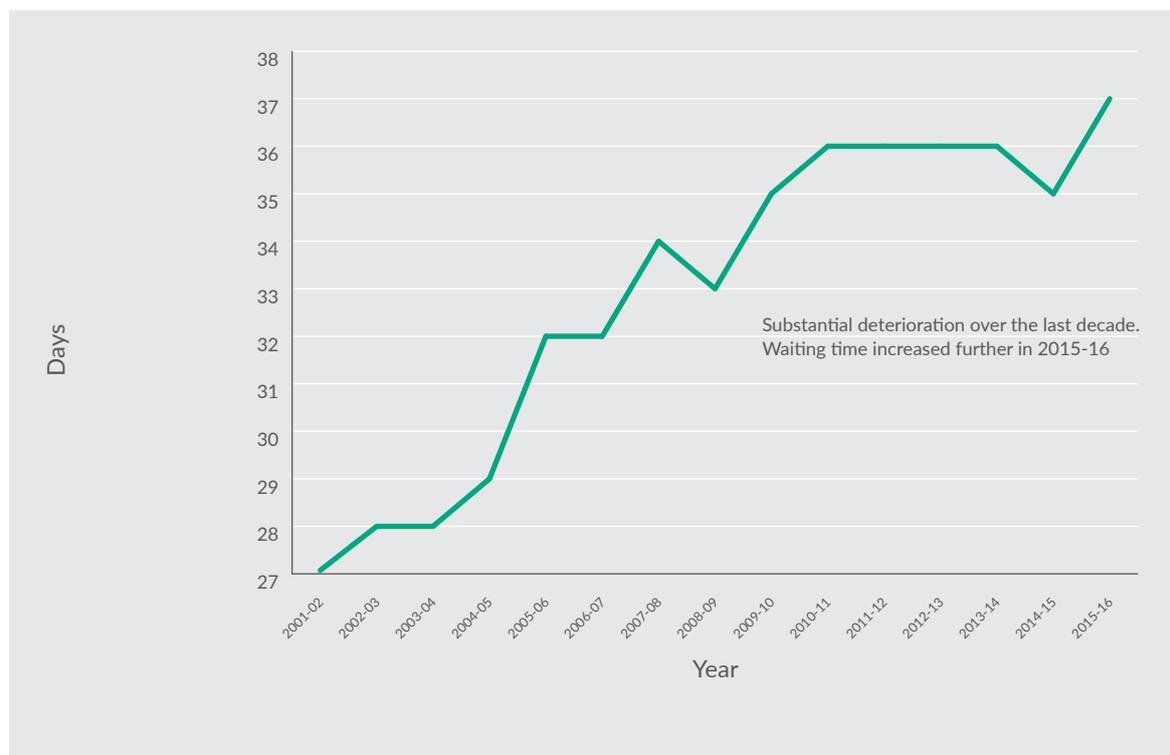
144 The growth of private patients in public hospitals is undermining Australia's mixed model of healthcare provision, and is having a deleterious impact on various stakeholders within the system. CHA is concerned that current trends may be leading to inequity between private and public patients, and adding costs to the system.

Patients

Are patients waiting longer for treatment?

145 In its *Public Hospital Report Card 2017*, the Australian Medical Association (AMA) found that the performance of public hospitals was essentially frozen at the unsatisfactory levels of previous years. The AMA noted that both emergency department waiting times and elective surgery waiting times in public hospitals had worsened, and that all states and territories were failing to meet targets. The national median elective surgery waiting time was the longest reported since 2001-02 (see Figure 16 below).^{xx}

Figure 16: Median waiting time for elective surgery (days)



Source: AMA, *Public hospital report card 2017*.

xx The AMA states that the data understates the real picture because it does not include waiting times from GP referral to specialist consultations. The waiting times data was not volume-adjusted.

- 146 There is not a strong correlation between increased waiting times and the growth of private patients in public hospitals, noting that even states and territories with lower growth are failing to meet waiting time targets. However, in an environment where public hospitals are already under strain, attracting or retaining patients who could otherwise be treated in private hospitals may be exacerbating the burden.
- 147 As demonstrated earlier in the paper, despite the fact that public hospitals are generally converting more emergency than elective patients, there remains a substantial proportion of private patients in public hospitals (38 per cent) admitted for elective care.
- 148 Whilst there may be legitimate reasons for private elective patients choosing to be treated in a public hospital such as clinical concerns, access or amenity, the inducements offered by public hospitals to private patients may also be influencing this choice. In particular, in circumstances where a private patient could be treated more quickly in a private hospital, rather than being placed on a public waiting list, further examination of why such patients are choosing to be treated in public hospitals is warranted.
- 149 The way in which waiting lists are managed, and who exercises discretion about when patients are admitted, varies by state. For example, waiting lists may be centrally managed by the hospital or by the individual doctor.
- 150 During the course of this project, anecdotal reports and some evidence was received to indicate that private patients were being treated more quickly than public patients in public hospitals. Until the publication of the AIHW's report *Admitted patient care 2015-16: Australian hospital statistics* on 17 May 2017, the difference in waiting times between private and public patients in public hospitals was not routinely reported.
- 151 The AIHW's report shows that there is a significant and consistent difference between waiting times for public and private patients in public hospitals, with public patients waiting more than twice as long as private patients for treatment (see Table 7 below).

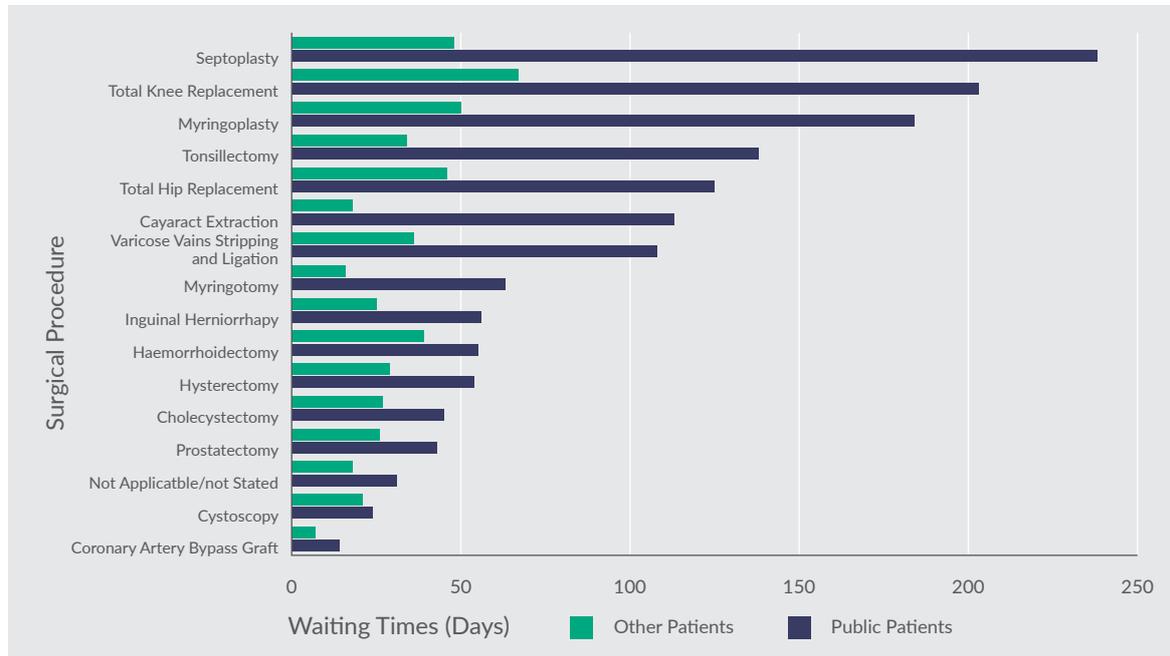
Table 7: Median waiting time (days) for patients admitted from public hospital waiting lists for elective surgery

Principal source of funding	Days waited at 50 th percentile	Days waited at 90 th percentile	Percent waited greater than 365 days
Public patients	42	273	2.0
Private health insurance	20	107	0.8

Source: AIHW, *Admitted patient care 2015-16: Australian hospital statistics*.

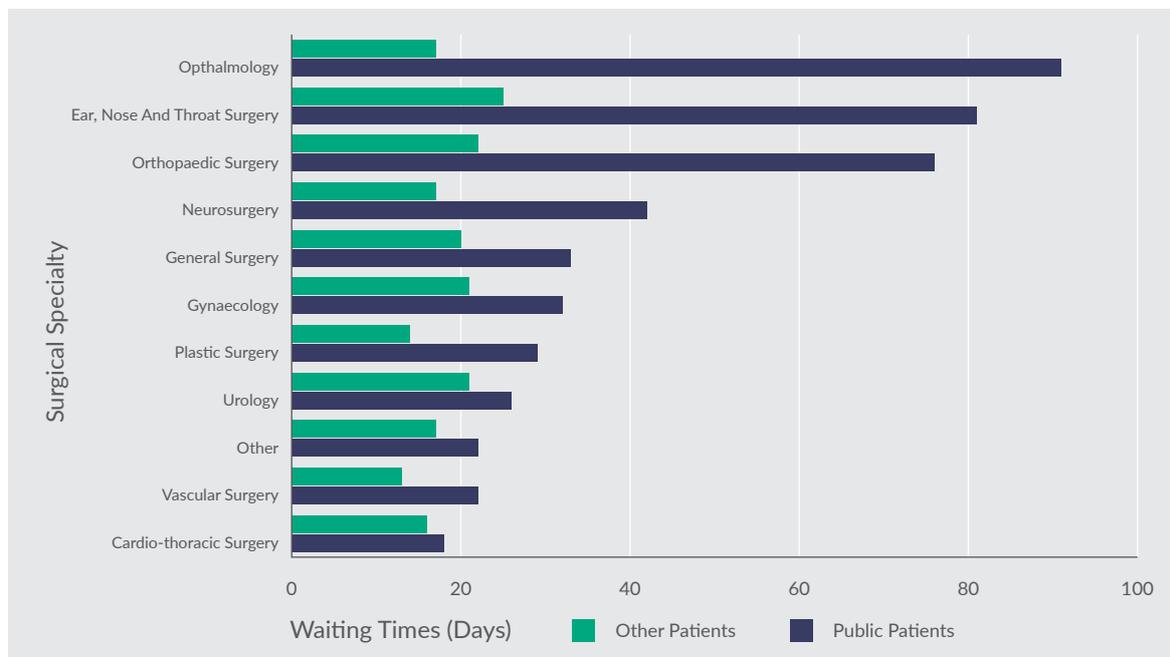
- 152 For all of the surgical procedures and surgical specialties reported, public patients had higher median waiting times than private patients (see Figures 17 and 18 below).
- 153 For surgical procedures, the greatest difference in median waiting time was for septoplasty (238 days for public patients and 48 days for other patients), followed by total knee replacement (203 days for public patients and 67 days for other patients).
- 154 For surgical specialties, the greatest difference in median waiting time was for ophthalmology (91 days for public patients and 17 days for other patients), followed by ear, nose and throat surgery (81 days and 25 days, respectively) and orthopaedic surgery (76 days and 22 days, respectively)

Figure 17: Median waiting time (days) for public and other patients admitted from public hospital waiting lists for elective surgery, by surgical procedure, 2015–16^{xxi}



Source: AIHW, *Admitted patient care 2015–16: Australian hospital statistics*.

Figure 18: Median waiting time (days) for public and other patients admitted from public hospital waiting lists for elective surgery, by surgical speciality, 2015–16



Source: AIHW, *Admitted patient care 2015–16: Australian hospital statistics*.

^{xxi} The 'other patients' category in these charts includes patients funded by any source other than public patients (eg. compensable patients, Department of Defence). 80 per cent of these patients are funded by private health insurance.

- 155 CHA has submitted Freedom of Information requests to state health departments to obtain state-level data on waiting times for public and private patients in public hospitals, but responses have not been received at the time of this report.
- 156 In its 2013 report on *Right of private practice in Queensland public hospitals*, the Queensland Audit Office found that the private practice scheme in that state had led to private patients in public hospitals receiving priority access compared to public patients. In particular, category 2 elective surgery private patients were seen more consistently within the clinically recommended timeframes than public patients (97 per cent of private patients were seen within the 90 day timeframe compared to 69 per cent of public patients).^{xxii} The Queensland Audit Office noted that tying the remuneration of specialists and public hospital revenues to patient election created a conflict of interest and a risk that private patients would be given preferential treatment to public patients.
- 157 The Queensland Audit Office further found that several hospitals were also failing to meet the in-turn^{xxiii} target set by Queensland Health of 60 per cent. The Audit Office observed that there was an intermediate waiting list, whereby private patients of a Visiting Medical Officer receiving elective surgery in a public hospital were captured as waiting only when surgery was scheduled, not when they were first identified as requiring surgery: “Queensland Health was unable to demonstrate that these patients were not receiving a benefit over public patients – in terms of being treated sooner or effectively out of turn.”⁶¹ The Audit Office further noted that “dedicating resources to VMO intermediate patients reduces the availability of theatres for public patients and gives priority access to surgery for these intermediate patients.”⁶²
- 158 CHA members that operate public hospitals confirm that private patients are not prioritised over public patients in their hospitals. In New South Wales and Victoria, there are regular audits and oversight from Health Departments to ensure compliance with policies that require patients on elective surgery waiting lists to be prioritised according to clinical need.
- 159 It is a fundamental principle of Australia’s healthcare system that access to care is based on clinical need, and ability to pay should not be a factor in waiting times for treatment. Private patients being treated more quickly violates this principle and the terms of the National Health Reform Agreement.

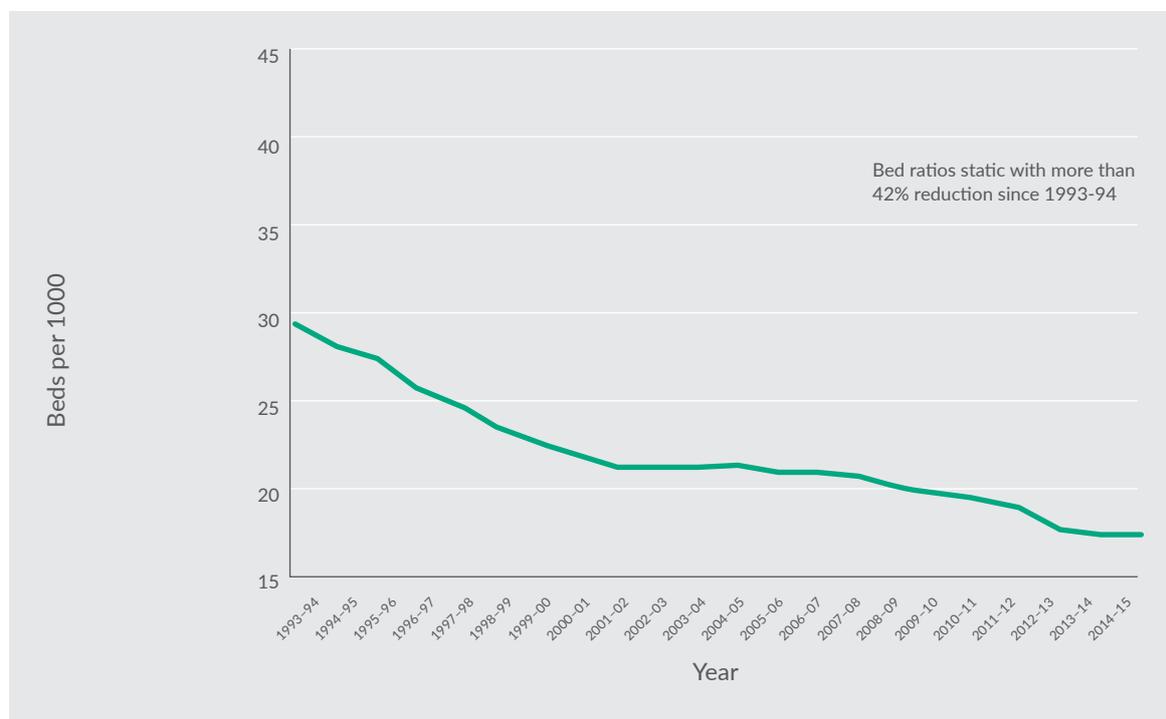
Is bed blocking occurring?

- 160 If public hospitals are attracting and converting patients who would otherwise go to a private hospital, the growth of private patients in public hospitals could add extra pressure to the public system which, according to data published in the AMA’s *Public hospital report card 2017*, is already capacity constrained. Public hospital capacity is not keeping pace with population growth and is currently at its lowest level in the past 21 years (see Figure 19 below).

xxii In 2010–11 and 2011–12.

xxiii ‘In-turn’ means that patients are treated in the order they are placed on the elective surgery waiting list.

Figure 19: Number of approved/available public hospital beds per 1000 population aged 65 and over



Source: AMA, *Public hospital report card 2017*.

- 161 Some CHA members suggested that bed blocking by private patients may be occurring in public hospitals. However, it is difficult to ascertain whether bed blocking by private patients is occurring on the basis of publicly available data. Data indicates that private patients in public hospitals had a marginally longer relative length of stay (1.00) than public patients (0.95) in 2015–16, and that proportionally more private patients are admitted to public hospitals overnight.⁶³
- 162 In a 2008 report it was observed that some specialists operating in public hospitals had a tacit understanding with the hospital, which included having a continuing ‘entitlement’ to a number of beds for that doctor’s patients. It was noted that, if not managed by a hospital’s administration, this practice could reduce the availability of beds and the flexibility of their allocation to other doctors’ patients.⁶⁴
- 163 When asked about bed blocking by private patients in 2013, the Victorian Health Minister at the time denied that private patients were taking beds that could be used by the 55,000 people on Victoria’s waiting list. He said that hospitals asked about patients’ insurance status only after they had been admitted, making it impossible to give priority to those who pay.⁶⁵ CHA’s public hospital members confirm that this reflects the practice in their hospitals.

Are private patients paying more?

- 164 Although public hospitals commonly cover excesses and, in some cases, other out-of-pocket expenses for private patients, the increasing number of patients using their private health insurance in public hospitals could be contributing to premium growth. Private health insurers spent \$1.1 billion on benefits for private patients in public hospitals in 2014–15, which accounts for about 6 per cent of premiums.⁶⁶ This adds more to premium costs than the average year’s premium increase.
- 165 Some CHA members note that conversely, private health insurers typically pay less for patients admitted to a public hospital than a private hospital which would reduce pressure on premiums.

Are private patients getting what they pay for?

- 166 Insured patients may choose a public hospital over a private hospital due to: restricted private health insurance products (public hospital only cover); lack of provision of some service types in the private sector and/or lack of private services in a particular location; high acuity; doctor gap payments and patient or doctor preference. The standard of care improvements, patient experience and access to new and refurbished public hospitals are other reasons privately insured patients may elect to have their care in a public hospital.
- 167 A 2002 survey conducted by the Austin Medical Centre found that the key reasons patients elected to use their private health insurance in a public hospital were that there were no out-of-pocket expenses and to help the public health system. Fewer survey participants said that being able to choose their doctor influenced their choice. Patients indicated that they considered material items such as free television/telephone, better food, and a single room as worthwhile benefits.⁶⁷
- 168 The benefits for patients if they elect to use their insurance in a public hospital (rather than remain as a public patient) include the ability to choose their doctor (although this may be practically limited in an unplanned / emergency admission) and continuity of care for follow up care or regular treatments.
- 169 However, there is evidence to suggest that private patients often do not receive their choice of doctor, to which they are entitled under the National Health Reform Agreement. A *Hospital Patient Experience Survey* conducted by HCF found that 60 per cent of HCF members did not receive their choice of doctor in a public hospital and only 20 per cent received a single room, despite being admitted as a private patient.⁶⁸ The survey of more than 12,000 HCF members was conducted in 2015.
- 170 It does not appear that many patients are complaining to independent complaints bodies about private patient election processes. In 2015–16, the New South Wales Health Care Complaints Commission received five complaints about private/public patient election out of a total of 11,842 complaints. It is not clear whether the low number of complaints is attributable to the fact that patients are not concerned by current practices, or are simply not aware of their rights in relation to election. Not all independent complaints bodies in states and territories specifically report on the number of complaints about patient election.

Private hospitals

- 171 The growth of private patients in public hospitals is one factor that is contributing to the relatively stagnant growth of private patient activity in private hospitals.
- 172 APRA data for the March 2017 quarter shows a decline in benefits and episodes for private hospitals. Private hospital utilisation (measured in episodes) decreased by 5.7 per cent over the quarter, with a corresponding decline in benefits. On the other hand, public hospital utilisation increased 3.8 per cent over the quarter, and benefits to public hospitals also increased.⁶⁹
- 173 CHA's private hospital members say that the growth of private patients in public hospitals is affecting their profitability and investment decisions. Declining revenue growth and reduced margins are affecting their capacity to invest in improving and expanding facilities. Some members gave examples of planned expansion of facilities being put on hold, or services being closed, because of increasing private activity by public hospitals.
- 174 Other private hospitals are also being affected, for example, Healthscope saw slower than expected revenue growth in the first quarter of 2016-17 due to reduced patient visits, which it attributed in part to the growth of private patients in public hospitals.⁷⁰
- 175 The Queensland Audit Office found in 2013 that the state's private practice scheme was not attracting significant patient activity away from the private sector. However, the Queensland Audit Office did not consider the impact on private hospital activity by specialty, for example, in obstetrics there has been an observable shift of activity from private to public hospitals in recent years.

- 176 Although the majority of private activity in public hospitals appears to be substituting activity that would otherwise be public, in light of the continuing low growth of private patients in private hospitals compared to other patient groups, it is likely that at least a proportion of private patients in public hospitals is substituting activity that would otherwise be undertaken by a private hospital.
- 177 There is a lack of publicly available information on why patients are choosing to be treated as private patients in public hospitals, and whether, in the absence of public hospital practices to encourage them to use their private health insurance, they would otherwise attend a private hospital.
- 178 In order to quantify the true cost to the system of the growth of private patients in public hospitals, further information about this cohort is required (in particular, information about location and DRGs). This will assist in ascertaining what proportion of private patients in public hospitals could otherwise be treated in a private hospital.
- 179 In addition to flattening growth of private patients in private hospitals, there has been an increase in the number of public patients in private hospitals, which is more pronounced in some states than others. This circularity undermines the intent of the system which is for private hospitals to relieve pressure on public hospitals. A previous report for CHA found that contracting is often done on an ad hoc or short-term basis and at short notice.⁷¹
- 180 Differences in how capital expenditure is funded give government operated public hospitals a competitive advantage in competing with private hospitals to attract private patients. Whereas government operated public hospitals receive separate state funding for capital expenditure, private hospitals fund capital expenditure from within their own budget. CHA members' public hospitals are not government operated and do not have access to the same government capital funding arrangements.
- 181 As Figure 15 shows, historically, capital expenditure on hospitals by the non-government sector was greater than that of state and territory governments. This pattern changed in 2009–10, with a \$5 billion capital injection through the Health and Hospitals Fund, and state and territory capital expenditure has continued to outstrip that of the non-government sector since. An example of the significant capital investment in public hospitals is the new Royal Adelaide Hospital, which is the most expensive building in Australia, and the third most costly in the world.⁷²
- 182 Maintaining a balance between public and private hospitals is critical to the integrity of Australia's health system. Private hospitals have an important role within the system by giving patients choice, taking pressure off public hospitals and delivering services more efficiently where possible. If the growth trend of private patients in public hospitals continues, it is likely that private hospital growth will continue to decline. This will undermine the viability and competitiveness of private hospitals and the sustainability of Australia's mixed model health system.

State governments and public hospitals

- 183 Although public hospitals are seeking to maximise private patient activity to increase revenue, there are associated costs.
- 184 The cost of treating private patients in public hospitals has more than doubled over the period from \$2 billion in 2008–09 to \$4.6 billion in 2015–16.^{xxiv} It is more costly to treat private patients than public patients in a public hospital: the average cost weight of separations for public patients (0.92) is less than that for private patients in public hospitals (1.04).⁷³ This difference in cost weight equates to a \$612 difference in the national average cost for a public hospital separation (where \$5,100 represents a cost weight of 1.00).^{xxv} Applying these figures, it cost public hospitals \$534 million more^{xxvi} to treat 871,902 private patients than if they had been treated as public patients.^{xxvii}

xxiv Based on the average cost of a public hospital separation for a privately insured patient reported by the AIHW in *Admitted patient care 2015–16: Australian hospital statistics and Australian hospital statistics 2008–09*.

xxv \$5100 is the 2013–14 national average cost for a public hospital separation. Average cost weight information provides a guide to the expected resource use for separations, with a value of 1.00 representing the theoretical average for all separations.

xxvi Based on the average cost of a public hospital separation for a private patient.

xxvii If a proportion of these patients had been treated in private hospitals this would have saved public hospitals further costs.

- 185 The difference in cost weight between public and private patients may reflect complexity or higher costs, both equating to additional resource requirements. The above difference in cost weight does not account for excesses, which public hospitals also typically pay for private patients. If one assumes that 80 per cent of private patients are liable for an excess, and that the lowest excess is \$250 per admission, this means that public hospitals could be paying \$174 million more each year in addition to the \$534 million stated above.
- 186 As noted earlier in the paper, private practice arrangements could also represent a cost to public hospitals rather than an additional source of revenue.
- 187 As states increasingly contract with private hospitals to treat public patients, state expenditure on private hospitals is growing. AIHW statistics show that this expenditure grew by 19.4 per cent to \$621 million in 2014–15.⁷⁴
- 188 The proportionate increase in emergency admissions of private patients in public hospitals also adds costs, as acute separations through the emergency department cost twice as much as planned admissions. In 2014–15, the average cost of a patient admitted via the emergency department was \$6964 and a planned admission was \$3590.⁷⁵ Increased emergency theatre utilisation over weekend periods may also add to public hospital costs, particularly staff costs arising from penalty rates. However, more information about this cohort is required to determine whether these costs are avoidable, for example, if patients could present to a private hospital instead.
- 189 While states are receiving additional revenue if they are converting patients who would otherwise be public, if they are converting patients who would otherwise be private they are incurring treatment and capital costs which they would not otherwise incur, and adding to the strain on waiting lists and beds. Infrastructure NSW has previously expressed concern that the proactive practices of hospitals to recruit private patients as a means of generating additional operating revenue were causing an unnecessary increase in the demand for investment in public hospitals. Infrastructure NSW concluded that less use of public hospital beds by private patients would provide additional hospital beds for public care, reduce waiting times and reduce the need for new capital expenditure.⁷⁶
- 190 The current distortion caused by the growth of private patients in public hospitals is generating inefficiencies. For example, available capacity within private hospitals could be used more effectively to free up public hospital beds so that public hospitals can provide timely, high quality care to those who need it. Optimising the split of public and private hospital activity so that services are delivered in the most cost effective setting could also deliver benefits (both financial and non-financial) to the overall system. For example, a 2009 Productivity Commission report on *Public and private hospitals* found that private hospitals performed the majority of surgical DRGs at a lower cost than public hospitals,^{xxviii} whereas public hospitals were more cost effective for some medical DRGs.^{xxix}
- 191 It is important to consider the impact of any proposed changes to current arrangements concerning private patients in public hospitals on public hospital budgets, as own source revenue currently represents a material proportion of public hospital funding. In Queensland it accounts for 7 per cent of total funds for health and hospital services.⁷⁷ It has elsewhere been estimated that private patient revenue can account for 10 per cent of public hospital revenue.⁷⁸

Cost shifting to private health insurers

- 192 The growth of private patients in public hospitals is enabling states and territories to shift a proportion of public hospital costs to private health insurers.

xxviii The cost per separation of almost three-fifths of surgical DRGs was at least 10 per cent lower in private hospitals than public hospitals.

xxix The cost per separation of almost a quarter of medical DRGs was at least 10 per cent lower in public hospitals than private hospitals.

- 193 Insurers spent \$1,060m on public hospital services in 2014–15, which was 7.6 per cent of their total health expenditure. This grew by 9.6 per cent from 2013–14 to 2014–15. The average annual growth rate of non-government^{xxx} funding of public hospitals over the decade (2004–05 to 2014–15) was 7.5 per cent. It is growing at least 1.5 times faster than government funding of public hospitals.⁷⁹ The fastest growth in expenditure on referred medical services over the decade was by private health insurers (6.1 per cent), who spent \$1.5 billion on this in 2014–15.⁸⁰
- 194 The Commonwealth spent \$18.2 billion on public hospital funding in 2014–15. The Commonwealth's share of public hospital funding, relative to that of states and territories, has fluctuated over time. However, in 2014–15, growth in expenditure by the Commonwealth government and non-government sector significantly outweighed that of state and territory governments. State and territory recurrent funding of public hospitals grew by only 0.4 per cent, compared to annual growth of 5.4 per cent for the Commonwealth government and 5.7 per cent for non-government sources. State and territory expenditure declined in real terms for the first time in the decade by 0.4 per cent compared with average annual growth of 4.8 per cent per year.⁸¹
- 195 In 2014–15, the ratio of health expenditure to tax revenue for state and territory governments fell by 1.4 percentage points (from 24 per cent in 2013–14 to 22 per cent in 2014–15). This is the third consecutive year this ratio has declined, and it occurred in all states and territories, although the amount varied.⁸²
- 196 Private Healthcare Australia has noted that public hospital cost shifting adds more to premiums than the average year's premium increase. If every state and territory achieved cost shifting at the same level as New South Wales, which is 3.2 per cent of public hospital costs, it would cost an additional \$500 million in outlays annually and potentially drive up premiums by a further 2.8 per cent.⁸³ This means that private patients in public hospitals could account for 8.8 per cent of premiums.
- 197 The waiving of excesses and co-payments by public hospitals undermines the private health insurance product structure. If the consumer chooses to accept front-end deductibles in exchange for a lower premium, the impact upon all insured persons is significant.
- 198 Private health insurance participation, until recently, has remained fairly consistent despite premium increases. Maintaining high participation gives patients choice, and helps to relieve pressure on public waiting lists which may creep up if more patients drop cover. The growth of private patients in public hospitals may be contributing to the decline in private health insurance participation because of its effect on premiums, and on consumers' perception of the value of private health insurance.
- 199 By undermining the value proposition of private health insurance, the growth of private patients in public hospitals may lead to further declines in participation and private hospital volumes. It is possible that in the last 18 months, negative press about private health insurance has contributed to a decline in participation, particularly by younger people. For example, Choice has launched a website called 'Do I need health insurance?', which requires users to take a quiz before they receive a yes, no, or maybe answer.
- 200 CHA believes that it is important to maintain Australia's high level of private health insurance participation, which underpins community rating. The private health sector provides choice, competition and helps to drive efficiency. If, long term, the viability of private health and the sustainability of Australia's mixed model is undermined, all stakeholders in the system will be adversely affected.

xxx This includes individuals, private health insurance and other non-government sources.

Recommendations

- 201 CHA believes that it is imperative to maintain the balance of Australia's dual and interdependent hospital system to ensure equity of access to health services and the stewardship of appropriate distribution of health care resources.
- 202 CHA supports the right of privately insured patients to use public hospital services as a fundamental feature of Australia's health system. There is a cohort of privately insured patients who will legitimately need to, or choose to, attend a public hospital for reasons such as access, location or the nature of their complex clinical condition. For example, there may be services (such as organ transplantation) which are usually provided in a public hospital setting, or in rural and remote areas, where fewer or no private hospital services are available. The Australian health system gives patients a choice of where to receive treatment, and it is vital that patients' choice to make a genuine election is retained. CHA seeks to ensure that all patients are given the right to make a fully informed choice about their treatment, and that funding mechanisms do not create incentives to discriminate between patients in public hospitals based upon private health insurance utilisation.
- 203 Further, CHA rejects any practices that disadvantage public patients or undermine the public hospital system on which low income and vulnerable Australians are fully reliant.
- 204 CHA recommends the following reforms to current arrangements concerning private patients in public hospitals:

Short term

- enforce compliance with the Medicare principles so that private patients do not receive preferential access to services in a public hospital setting, and that the only driver for prioritising treatment is the nature of a person's clinical condition;
- restrict hospitals' ability to offer inducements or unduly pressure consumers to declare their private health insurance status and encourage greater data sharing between the Commonwealth and states to monitor adverse behaviours.

Medium term

- provide greater transparency around contracting of public patient care to the private sector;
- provide greater transparency of real time data showing the status of waiting lists by specialty in public and private hospitals;
- clearly identify private health insurance products for consumers (restricted cover products) that are not fit for purpose in a private hospital without attracting significant consumer out-of-pocket costs;
- enhance the provision of information to consumers to assist with pre-admission choice of doctor and improved understanding of charges that may be incurred, in both public and private hospitals;
- ensure that private patient election forms are submitted to the relevant health fund and that public hospitals provide equivalent information as submitted to insurers by private hospitals (Hospital Casemix Protocol data) where private health insurance is claimed. CHA understands that this is occurring in some, but not all, cases;
- include provisions in public hospital funding agreements between the Commonwealth and states to ensure neutrality of funding for public and private patients and to address the current funding incentives for public hospitals to maximise private patient activity, such as own source revenue targets. Funding mechanisms also need to incentivise prevention and deter avoidable hospital admissions;

- use available capacity within private hospitals more effectively to free up public hospital beds so that public hospitals can provide timely, high quality care to those who need it. Optimise the split of public and private hospital activity so that services are delivered in the most cost effective setting.

Long term

- achieve greater neutrality between public and private hospitals in relation to the manner in which capital expenditure is funded.

205 It is important to consider the overall funding implications of any proposed changes to current arrangements concerning private patients in public hospitals, as own source revenue currently represents a material proportion (around 10 per cent nationally) of public hospital funding. Many public hospitals are reliant on this revenue to support their services to public patients. Any reduction in private patient revenue that is not replaced with supplementary funding from Government sources could have a significant financial impact on public hospital service capacity, patient care and medical staff recruitment.

206 CHA considers that these reform options are consistent with the Australian Government's private health reform agenda and CHA's foundation principles, which include ensuring equity of access to healthcare for all. The reforms preserve the universality of Medicare and the right of Australians to free treatment in a public hospital as a public patient. The reforms do not curtail private patients' right to elect to be treated as a private or public patient in a public hospital.

207 To conclude, the Australian mixed public-private healthcare system has evolved to improve individual wellbeing by offering a greater choice of provider and care options, and faster access for elective treatments. This model seeks to maintain a sustainable public health sector, by reducing cost pressures on public hospitals. However, the rising growth of private patients in public hospitals impacts on those policy intentions; current evidence shows that public patients have longer waiting times than private patients in public hospitals and that a growing number of public hospitals are contracting with private hospitals to treat public patients because of demand pressures. This seems to CHA to be incongruous with the intended balanced public-private system in Australia. If these trends remain unchecked, the sustainability of Australia's mixed model will be undermined, to the detriment of all patients.

Appendix 1: Medicare Levy Surcharge and Private Health Insurance Rebate tiers

The table below sets out the rebate and surcharge levels applicable from 1 April 2017 to 31 March 2018.

SINGLES FAMILIES	≤\$90,000 ≤\$180,000	\$90,001-105,000 \$180,001-210,000	\$105,001-140,000 \$210,001-280,000	≥\$140,001 ≥\$280,001
REBATE				
	BASE TIER	TIER 1	TIER 2	TIER 3
< age 65	25.934%	17.289%	8.644%	0%
Age 65-69	30.256%	21.612%	12.966%	0%
Age 70+	34.579%	25.934%	17.289%	0%
MEDICARE LEVY SURCHARGE				
All ages	0.0%	1.0%	1.25%	1.5%

Source: Private Health Insurance Ombudsman, *Medicare Levy Surcharge* <http://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/mls.htm> at 2 May 2017.

Appendix 2: Relevant provisions of Schedule G to the National Health Reform Agreement

Patient Arrangements

G14. 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 and must be made in accordance with the minimum standards set out in this Agreement.

G15. In particular, private patients have a choice of doctor and all patients will make an election based on informed financial consent.

G16. Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms.

G17. Services provided to public patients should not generate charges against the Commonwealth MBS:

- a. except where there is a third party payment arrangement with the hospital or the State, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;
- b. referral pathways must not be controlled so as to deny access to free public hospital services; and
- c. referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.

G18. 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 (unless a third party has entered into an arrangement with the hospital or the State to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient. However:

- a. a choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice; and
- b. hospital employees will not direct patients or their legal guardians towards a particular choice.

G19. An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

- a. there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or
- b. the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

G20. Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as a part of the patient's treatment and will be provided free of charge.

G21. In those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own GP, either as part of continuing care or by prior arrangement with the doctor.

G22. States which have signed a Memorandum of Understanding with the Commonwealth for the COAG initiative “Improving Access to Primary Care Services in Rural Areas” may bulk bill the MBS for eligible persons requiring primary health care services who present to approved facilities.

G23. In accordance with this Agreement, public hospital admitted patient election processes for eligible persons should conform to the national standards set out in this schedule.

Public Hospital Admitted Patient Election Forms

G24. 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:

- a. a statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in clause G1 of this Agreement;
- 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. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation must be admitted as a private patient (note: eligible veterans are subject to a separate agreement);
- c. a statement that a patient with private health insurance can elect to be treated as a public patient;
- d. a clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for care and accommodation type patients as referred to in clause G2):
 - i. will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and
 - ii. are treated by the doctor(s) nominated by the hospital;
- e. a clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:
 - i. will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;
 - ii. 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; and
 - iii. are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital;
- f. evidence that the form was completed by the patient or legally authorised representative before, at the time of, or as soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee;
- g. a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:
 - i. patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
 - ii. patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
 - iii. patients whose social circumstances change while in hospital (for example, loss of job);

- h. in situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission;
- i. it will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in this Schedule apply;
- j. a statement signed by the admitted patient or their legally authorised representative 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 admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement may result in the refusal of their health fund to provide benefits; and
- l. where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

Multiple and Frequent Admissions Election Forms

G25. A State or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specified period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.

Other Written Material Provided to Patients

G26. Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross reference to the admitted patient election form in any such written material.

Verbal Advice Provided to Patients

G27. Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.

G28. Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election.

G29. To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.

G30. Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

Appendix 3: Private practice arrangements in each state and territory

State	Basis of private practice arrangement
Victoria	No prescribed state-wide arrangement, although Department of Health strongly prefers a 100% donation model, which is the prevailing model in Victoria. Health Services agree private practice arrangements with individual medical specialists.
New South Wales	<p>Five-tiered structure, with each increasing tier producing a higher salary to the staff specialist:</p> <ul style="list-style-type: none"> Level 1: 100% of salary + 20% allowance Level 2: 100% of salary + 14% allowance + 24% drawing rights (guaranteed supplementation if insufficient billing – up to 11%) Level 3: 100% of salary + 8 % allowance + 36% drawing rights (guaranteed supplementation if insufficient billing – up to 17%) Level 4: 100% of salary + 50% drawing rights (guaranteed supplementation if insufficient billing – up to 25%) Level 5: 75% of salary + 100% drawing rights <p>Allowance – paid as salary and not specifically set aside from income raised from private practice</p> <p>Drawing rights – specifically set aside for medical specialist from income raised from private practice</p>
South Australia	<p>There are three choices for employed medical specialists under SA Health’s Health Private Practice Arrangement 2008 together with the SA Health Salaried Medical Officer Enterprise Agreement. In addition to base salary:</p> <ul style="list-style-type: none"> Scheme 1: Capped private practice ceiling of 65% of base salary after paying 9% admin/indemnity fee, together with a 30% attraction and retention allowance Scheme 2, Option A – minimum 30% allowance in lieu of private practice Scheme 2, Option B – 100% of all billings up to 65% of base salary, one third of billings from 65-100% of salary and 15% of billings thereafter after paying a 9% admin/indemnity fee. <p>VMOs bill patients and pay hospitals a 5% fee to manage billings and a 4% fee for medical indemnity insurance.</p> <p>Pathologists are entitled to a private practice allowance of 65% of base salary in lieu of the 65% capped private practice amount.</p>
Queensland	<p>Private practice arrangements are based on a state-wide policy with staff specialists having two broad options with specific variations for pathologists and radiologists:</p> <ul style="list-style-type: none"> Option A (most common type) – SMO receives a supplementary allowance equivalent to a percentage of base salary and Queensland Health retains all billings generated from private patients. (Note that pathologists have access to a variation on this arrangement: Option P, which is the same as Option A, except that a small percentage of billings is set aside in a pool to be shared by SMOs). Option B – SMO earns income in addition to base salary, up to a ceiling and then receives one third of additional net billings with the remainder lodged into a private practice study, education and research trust account. (Note that radiologists have access to a variation of this arrangement (Option R), which has reduced administration and facility fees). <p>Queensland Health is the billing agent.</p>

State	Basis of private practice arrangement
Western Australia	<p>There are two options available for employed medical specialists under the state-wide awards (there are separate awards for metropolitan and country employed medical specialists). In addition to base salary:</p> <ul style="list-style-type: none"> • Rights assigned to health service to bill and specialist receives an allowance (increasing from 3.25% to 4.5% of base salary over three years). Hospitals bill on behalf of the medical practitioner. • Specialist bills private patients and pays facility fee to hospitals. Medical practitioners are responsible for their own billings. Specialists are able to retain earnings up to a nominated percentage, which varies by type of medical practitioner <p>Facility fees are charged at 50% of net earnings from private practice for:</p> <ul style="list-style-type: none"> • EMG • Radiation oncology • Pathology • Nuclear medicine • Ultrasound (outside of a radiology department) • Pulmonary physiology • Audiology • EEG.
Northern Territory	<p>Limited application of private practice in the Northern Territory with there being no state-wide arrangement.</p>
Australian Capital Territory	<p>Whole of territory agreement for staff specialists to have rights of private practice which sets out three schemes:</p> <ul style="list-style-type: none"> • Scheme A: Specialist receives an allowance of 20% of base salary in lieu of private practice • Scheme B: Specialist receives a bonus on earnings from private practice billings of up to 50% of base salary • Scheme C: Specialist receives 75% of base salary, plus a bonus of up to 133.33% of base salary from private practice billings. <p>Pathologists and radiologists have handed over their rights of private practice to ACT Health in return for increased remuneration.</p> <p>Private patients seen by VMOs are billed by the VMO in a separate business capacity, with no billing being performed by ACT Health and no facility fee being received.</p>
Tasmania	<p>State-wide arrangements for salaried doctors with two options:</p> <ul style="list-style-type: none"> • Option A. Pays participating specialists an allowance of up to 35% of projected base salary and then pays amounts to staff development and equipment accounts • Option B. Pays as per option A with differing amounts being paid to staff development and equipment accounts. <p>State-wide arrangements also provide for hospitals to charge facility fees to VMOs where VMOs see patients in their own rooms at public hospitals.</p>

Source: Department of Health and Ageing, *MBS use by public hospitals*, June 2011.

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