# ISSUES PAPER: OPTIONS FOR PRIVATE PATIENTS IN PUBLIC HOSPITALS

## Introduction

The issue of private patient admission in public hospitals has been an ongoing issue for numerous participants in the health insurance/hospital sectors. The Committee considered a range of issues about private patients in public hospitals at its 9 November 2016 meeting, and generally agreed that this was an important issue with significant cost implications for private health insurance. As the Committee is aware, the issue of private patients in public hospitals needs to be considered as part of the broader consideration of public hospital funding.

The Minister for Health, the Hon Greg Hunt MP, has asked that the Committee further consider the issue of private patients in public hospitals. In particular the Minister would like the Committee to consider five options related to private patient in public hospitals, with the view to confirming sector views on this issue before discussing the issue with state and territory health ministers.



## Options for reform

The Committee should consider whether the following options would reduce the pressure on private health insurance premiums arising from benefits paid for private patients in public hospitals, and deliver greater system stability.

The Committee has already seen the first four options as these were included in the Private Admitted Patients in Public Hospitals issue paper considered by the Committee at the 9 November 2016 meeting. The fifth option, which relates to the Independent Hospital Pricing Authority's (IHPA) determination of the National Efficient Price (NEP) and states' funding of private patients in public hospitals, has not previously been considered by the Committee.

***1: Limit private health insurance benefits to the medical costs of private treatment in public hospital with no benefits paid to the hospital***

Under this option patients could still elect to be treated as private patients in public hospitals but would only be able to claim benefits toward the doctor's charges (the 25% MBS gap and doctors 'no-gap' or 'known-gap' payment). There would be no benefit paid by the insurer to the hospital for accommodation or other charges, such as prostheses.

This option continues to support patients making genuine elections to be treated by a particular doctor in a public hospital, and explicitly recognises that this is the main component of their hospital treatment that differs to a public patient.

Hospitals could still choose to raise charges against private patients, but insurers would not be able to pay a benefit.

***2: Prevent public hospitals from waiving any excess payable under the patient's policy***
Public hospitals often waive the excess that would otherwise be payable under a patient's health insurance policy as an incentive to encourage private patient election. Under this option, hospitals would be required to collect any excess payable by patients should they elect to be treated privately.

This option is likely to reduce the number of patients who enter the public hospital through the emergency (or other) department intending to access free public hospital services, but are persuaded by hospital staff to elect private treatment.

Patients being admitted for elective surgery by a particular clinician with rights of private practice could still choose to be treated privately at the public hospital, albeit with an excess payable to the public hospital. This may also improve competition between the public and private systems because the excess payable by the consumer would be the same regardless of which hospital they choose.

***3: Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions***
Under this option, all patients admitted through the emergency department would be public patients. While this option would stop hospitals from encouraging patients who present expecting to be public patients from electing to be private, it may also reduce the perceived value of their health insurance for consumers.

This option would also disadvantage those people who present at the emergency department and want to make a genuine private patient election in order to choose a particular doctor for their treatment.



***4: Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement***
Under this option, health insurers would not be required to pay benefits for private patients in public hospitals for services where there is no meaningful choice of doctor, or limited doctor involvement in the patient's treatment. This would apply to both hospital and medical charges.

This option would require an assessment of the types of services which could be categorised as having no (or limited) choice of doctor, such as major trauma; or where the doctor has limited involvement in the patient's ongoing treatment, such as chemotherapy. These services would be defined in regulation.

This option has the benefit that a patient wanting to elect private treatment at a public hospital in circumstances where they can genuinely choose their own doctor could still claim private health insurance benefits.

***5: Make changes to the NHRA NEP determination and funding model***
This option would require working with the Independent Hospital Pricing Authority to ensure that the private patient adjustment to the NEP appropriately adjusts for all private patient income. For example, the private patient adjustment currently adjusts for accommodation at the minimum default bed day rate. This option would involve changing that adjustment to take account of revenue from single room charges and other accommodation payments above the default benefits. This would also

be an opportunity to ensure that the private patient adjustment for prostheses fully accounts for all revenue for prostheses.

In addition, there are a number of states which do not adjust their own funding to public hospitals to recognise private patient revenue. This creates an additional incentive for public hospitals to admit private patients. The option proposes engaging with states to encourage amendments to their service level agreements to ensure that reductions in the NEP for private patients are reflected in state funding levels.