ISSUES PAPER: Private Admitted Patients in Public Hospitals

Introduction

During private health insurance consultation in late 2015 numerous participants raised the matter of private patients in public hospitals. While states and territories support the current arrangements, many insurers and private hospital groups suggested that there should be some sort of limit or restriction on the ability of public hospitals to charge privately insured patients for admissions. Some suggested a total ban.

The way forward

Any reform to the current regulatory arrangements for private patients in public hospitals would need to be considered by Council of Australian Governments (COAG) as part of its broader consideration of public hospital funding arrangements.

On 1 April 2016, COAG signed the *Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding* (the Head Agreement). Under the Head Agreement, the Commonwealth's contribution to hospital services from 1 July 2017 until 30 June 2020 will continue to include funding related to eligible private patients in public hospitals and a range of settings with funding provided on the basis of activity based funding. The Head Agreement was negotiated with no anticipated change to current private hospital patient arrangements.

The Commonwealth and states anticipate the development of a longer-term public hospital funding agreement to commence on 1 July 2020. This longer-term agreement will be developed by the Commonwealth and all jurisdictions and be considered by COAG before September 2018.

The Private Health Ministerial Advisory Committee (the Committee) should also note that the Independent Hospital Pricing Authority (IHPA) has advised in its *Consultation Paper on the Pricing Framework for Australian Public Hospitals Services 2017-18* that:

> *In late 2016 IHPA has commissioned an independent review of historical activity data and jurisdictional approaches to pricing private patients to empirically assess what impact, if any, the national activity based funding model has had on the utilisation of private health insurance by patients in public hospitals.*

The Committee may wish to consider issues related to private patients in public hospitals, with the view to providing the Minister for Health with a record of the Committee's views. The Minister would then be fully informed should private patients in public hospitals be considered in the COAG process. The Committee could also consider non-regulatory changes which industry could lead outside the COAG process.

This paper sets out the history and background to the issue, identifies some options and explores their implications.

Background

History

Privately insured patients in public hospitals have been a feature of the current health financing regime since 1984. The original conception of Medicare, including free public hospital treatment for public patients envisaged some restrictions on the charges visiting medical officers (VMO) in public hospitals could raise for private patients. However, attempts to implement these restrictions were the principal cause of the 1984 NSW doctors' dispute.

By the end of 1984 rights of private practice for doctors in public hospitals were firmly established, and they have not been challenged since. Rights of private practice remain fundamentally linked to the funding of private patients in public hospitals. Successive public hospital funding agreements between the Commonwealth and the states have recognised the right of patients to elect to be treated privately in a public hospital by a doctor of their choice, and that all patients will make the election based on informed financial consent.

Payment structure for private patients in public hospitals

By 1986 the basis of the current medical remuneration structure was in place: Medicare Benefits Schedule (MBS) benefits were payable at 75% of the schedule fee for in-hospital services, and private health insurers were required to pay the 25% gap. In 1994 insurers were allowed to pay benefits above the schedule fee for doctors who entered into "no-gap" or "known-gap" arrangements.

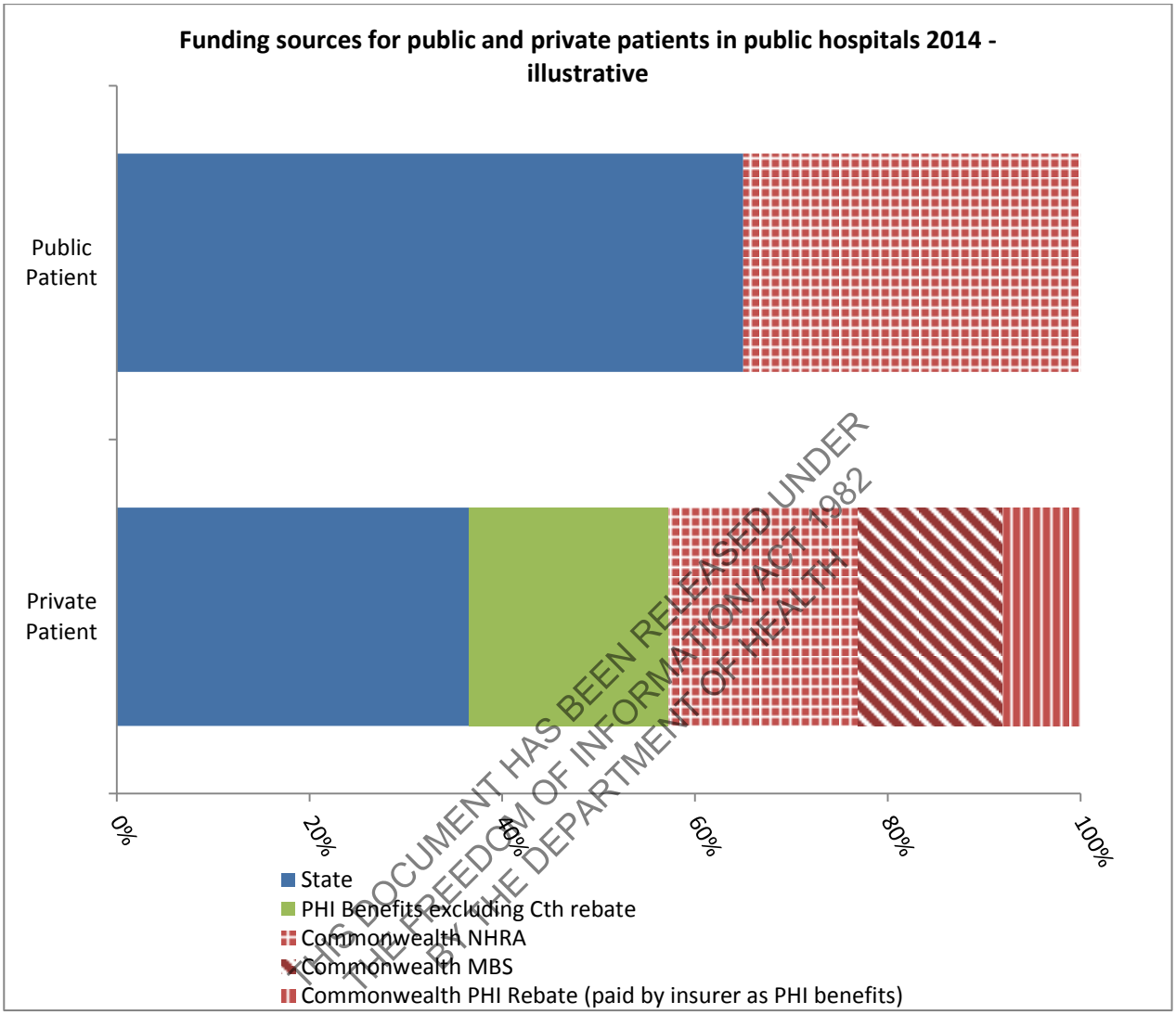
The general framework for private health insurance remuneration for public hospitals (as distinct from medical remuneration) has not changed since 1984. At that time private health insurers offered two kinds of hospital insurance: basic insurance that covered the costs of treatment in a shared ward, and supplementary insurance that covered the costs of single room accommodation and other charges made by private hospitals. Insurers were required to pay a minimum level of per diem benefits under the basic table. Those amounts, indexed by CPI since 1990, are now the Commonwealth-determined minimum benefits payable by insurers in any hospital where policy holders are treated for any illness or condition covered by their policy, and the insurer does not have a contract.

The minimum benefits are not intended to reflect the cost of delivering hospital services; instead they ensure that privately insured patients are guaranteed some level of reimbursement regardless of whether a patient's hospital has a negotiated agreement with the patient's health insurer. However, because health price inflation is generally higher than CPI, the minimum benefits have reduced from around half of the cost of providing hospital services to around a third of the cost.

Under the National Health Reform Agreement (NHRA), the IHPA sets the price for admitted private patients in public hospitals accounting for payments made by other parties, including private health insurers and the MBS, which make up about half the cost of treatment. The Commonwealth then pays about 40% of the remaining cost and the states the other 60%.

Current payments for private patients

The graph below provides an illustrative comparison of funding flows for public patients and private patients in public hospitals.



Note: The amounts included in this figure are illustrative of the typical composition of funding for public and private patients treated in a public hospital. The exact composition of funding for a given service will vary according to a range of factors including the jurisdiction and the procedure delivered. As a general rule, private patients in public hospitals face low or no out-of-pocket costs (including excesses) because public hospitals tend to not charge out-of-pocket costs and/or to waive excesses. PBS costs excluded.

Who are private patients in public hospitals?

There are three broad kinds of privately insured patients in public hospitals.

The first are elective surgery patients who are admitted on a scheduled day to be treated by a clinician with rights of private practice who they have seen for a consultation before admission. These patients may choose to be treated in the public sector for reasons such as:

- the services they require are only available there;

- their risk profile is such that their specialist wants to have access to the back-up services that only a major public hospital can provide in case of complications; or
- their specialist works in both the public and private sector but they prefer to attend the public hospital, for example to avoid or reduce out-of-pocket costs.

The second are privately insured patients who enter the hospital through the emergency (or other) department, are subsequently admitted, and agree to elect to be treated as a private patient. These patients' "choice of doctor" is limited to whoever is on duty.

Finally, there is a (probably very small) subset of patients who are admitted through the emergency (or other) department and genuinely choose their doctor. For example, a patient requiring an orthopaedic surgeon may have a pre-existing relationship with a surgeon who practises at the hospital, and may be able to choose to be treated by that surgeon.

Recent trends

In 2014-15, the private health insurance benefits paid to public hospitals for treatment of private patients was approximately $1.0 billion dollars.

Over the eight years to 2014-15 the number of privately insured patients in public hospitals increased by an annual average of 10.1%, compared with a rate of 2.8% for public patients. Over the same period, total public hospital admissions grew by an annual average of 3.4% and private hospitals by 4.8%.

Overall privately insured admissions almost doubled from 416,000 to 815,000, and from 9% of total public hospital admissions to 14%. Within this overall growth there was a marked shift in the pattern of utilisation of privately insured patients as shown in the table below.

Basis of Admission	2007-08		2014-15	
	Private Patient in public	Public Patient	Private Patient in public	Public Patient
Elective	44%	41%	38%	41%
Emergency	42%	41%	49%	40%
Other[1]	14%	18%	14%	19%

Source: Unpublished Admitted Patient Care dataset, Department of Health

Another way to look at the trends is to consider how the privately insured patient growth rates vary across each setting. The table below shows that from 2007-08 to 2014-15 cumulative growth in private patients in public hospitals outstrips the growth in private settings.

1 Other includes planned activity such as obstetrics, dialysis and chemotherapy.

	Cumulative growth privately insured episodes 2007/08 to 2014/15			
	Episodes	**Episodes per insured person**	**Benefits per episode**	**Proportion of total privately insured episodes in each setting 2014/15**
Private patients in public hospitals	81%	51%	9%	18%
Day hospitals	54%	28%	22%	15%
Private overnight hospitals	36%	13%	29%	67%
Total	45%	21%	18%	100%

Source: APRA Private Health Insurance Benefits Trends – June 2016

These patterns of growth strongly suggest that efforts to encourage patients to use their insurance in public hospitals upon admission for an emergency are being successful.

If the number of private patients in public hospitals had grown at the rate of public patient hospital admissions over the eight years to 2014-15 insurers would have saved about $424 million in that year (and the Commonwealth would have saved about $165 million in MBS payments).

Stakeholder Views

Is the glass half full or half empty?

There are several ways of viewing the current arrangements.

One view is that all privately insured patients have a right to elect to be treated as a public patient and pay nothing to the hospital, and should not be pressured by public hospitals to use their private health insurance. In common with other members of the community they pay taxes to support public hospitals, and by charging them as private patients the states are double-dipping.

The opposite view is that private insurers have taken premiums to indemnify their policy holders against the costs of hospitalisation, and to provide them with choice about their treatment, and that they should thus pay the full cost of public hospital treatment for those patients just as they would meet the costs of private hospital treatment.

States, Territories and public hospitals

The public hospital sector strongly supports current arrangements for private patients in public hospitals, including public hospital only policies. States and territories and public hospitals are likely to be highly concerned about any policy reform to private patient arrangements should it impact on public hospital revenue.

States and territories argue that a patient's ability to choose to use their private health insurance in a public hospital improves the value of private health insurance, particularly for highly specialised services or in rural and regional areas.

They also argue the arrangement supports doctors' right to private practice and this increases hospitals' capacity to recruit specialist workforce.

States and territories have also been concerned about the level of Commonwealth-determined minimum benefits for shared ward accommodation and health insurers reducing the benefits they pay for members accessing single rooms at public hospitals over recent years.

Private Health Insurers

Health insurers claim public hospitals are cost-shifting by pressuring privately insured patients to elect to be treated privately. They also claim that many private patients in public hospitals do not choose their own doctor and effectively receive hospital treatment that is no different to what they would receive as a public patient.

Health insurers argue that the growth in private patients in public hospitals conflicts with the intent of private health insurance to reduce the burden on the public hospital system, and that the ongoing revenue stream from private health insurers to public hospitals is driving up premiums.

Health insurers are also concerned about the impact of medical expenses on premiums with one submission to the consultation stating:

> *Once a patient has elected to be treated as a private patient the doctor has the right to charge the patient fees as he/she deems appropriate. Medical specialists welcome the private election of patients in public hospital settings as a way to effectively supplement their normal public hospital income.*

Another submission to the consultation process claimed that "restriction of billing by public hospitals to private insurers … will result in projected $510 million to $1,030 million in cost savings, potentially lowering premiums by up to 5.3 percent". This position seems to assume that, if the option to be a private patient in a public hospital was not available, these patients would instead choose treatment as public patients rather than attend private hospitals.

Private Hospitals

Private hospitals argue that existing arrangements go against the principles of competitive neutrality because private patients in public hospitals are significantly subsidised by the Commonwealth and State governments, and undermine the private health insurance policy objectives of alleviating pressure on public hospitals.

They also claim that the public hospital practice of actively encouraging patients to be treated as private patients creates cost shifting from the states and 'fast track' opportunities for patients with private health insurance. However, this is unlikely to be an issue for patients who have presented in an emergency situation, are subsequently admitted and elect to be treated privately.

Private hospitals claim that private patients in public hospitals could be more efficiently treated in the private sector and this would free up thousands of public hospital beds and reduce public hospital waiting lists. This position seems to assume that, if the option to be a private patient in a public hospital was not available, these patients would instead choose treatment in a private hospital rather than remaining in the public system.

Doctors

Doctors will be very concerned about any proposed changes to private patients in public hospital arrangements and the impact on doctors' rights to private practice at public hospitals.

Consumers

Consumers would be concerned about any proposed changes that lessen their right to make a genuine election to receive treatment in a public hospital as a private patient. This may be of particular concern where the treatment is only offered at the public hospital, for example in rural and regional areas, and electing to be treated privately allows a choice of doctor.

Any change that limits a consumer's choice about how they use their private health insurance is likely to reduce the perceived value of private health insurance.

On the other hand, it has been argued that public hospital only policies are a type of 'junk' policy. If this argument is accepted, then some consumers may benefit from reducing or eliminating coverage for public hospital services. However, this argument ignores any flow-through impact on premiums.

Issues for consideration

The Committee may wish to advise the Minister of its preferred options for private patients in public hospitals. The options presented below are intended to guide and encourage discussion, and are not exhaustive. In considering the following options, the Committee should be mindful that it is likely COAG will ultimately consider any reform to admitted private patients in public hospitals.

The Committee should also recognise that neither states and territories, nor their public hospitals, are represented on the Committee although they are the groups that will be most affected by any proposed changes to private patients in public hospitals. It is likely they will be highly critical of any proposed change that will impact on revenue received from private patients.

Are private health/private hospital sectors able to use non-regulatory measures to influence the number of privately insured consumers electing to be treated in public hospitals?

The Committee may wish to consider whether there are non-regulatory options available to health insurers or the private hospital sector to influence a consumer's choice to receive public hospital services as a private patient.

For example, could insurers do more to educate their members that if they attend a public hospital expecting to receive free public hospital services, and they subsequently agree to be treated privately, the benefits the insurer must pay the public hospital flows through to increase health insurance premiums for all members?

Insurers contracting with public hospitals would place boundaries around private patients in public and allow insurers more influence around who goes private for which services. It may be difficult for insurers and public hospitals to reach a win-win position whenever minimum benefit requirements are in place.

Are there further options open to the private hospital sector to improve its value proposition to encourage consumers to choose treatment in a private hospital, for example promotion or partially waiving excesses?

Exclude privately insured patients using their health insurance in the public sector

This option may establish a clearer distinction between public and private hospital care, and would make 'public hospital only' policies redundant.

Under this option patients could still elect to be treated as private patients in public hospitals, and be charged by the hospital for the treatment, but would not able to claim any reimbursement from their health insurer. This would limit consumer choice, of particular concern in rural and regional areas where the public hospital may be the only facility available, and likely reduce the perceived value of private health insurance.

It is likely this option would limit public hospitals from encouraging patients who would otherwise be public to elect private treatment. However, it would also disadvantage patients making an informed genuine private patient election, for example elective surgery agreed at a private consultation with a specialist who has rights of private practice at the public hospital. Doctors would also likely be critical of any impact on their rights of private practice.

Some patients may choose to be treated in a private hospital rather than remain in the public system. The proportion of patients that move to the private sector will influence whether there is an increase or decrease in the costs to private health insurers and premiums. This could also change the level of patient MBS gap payments.

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.

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. Whether or not the hospital would still be able to charge private patients for hospital treatment would need to be considered.

Remove the requirement for private health insurers to pay benefits to public hospitals for private patients

Under this option insurers would no longer be required to pay the Commonwealth regulated minimum benefits, but would still pay benefits toward the doctor's charges (the 25% MBS gap, and doctors 'no-gap' or 'known-gap' payment). This would encourage contracting between public hospitals and insurers. Depending on how insurers respond under contracting arrangements, this option may limit consumer choice through reduced access to services, for example in rural and regional areas, which may reduce perceived value of private health insurance.

This option may also establish a clearer distinction between public and private hospital care as benefits would primarily be paid for private hospital treatment and may discourage the purchase of low-cover 'public hospital only' policies.

Remove 'public hospital only' policies' eligibility for government incentives

Some submissions to the private health insurance consultations suggested removing government incentives from policies which only cover services in public hospitals.

While removing government incentives from 'public hospital only' products may encourage consumers to purchase polices with more extensive coverage, it may not reduce the number of private patients in public hospitals because consumers could still choose to receive private treatment at a public hospital.

The Committee's consideration of product design includes possible minimum product standards. The changes being considered, if implemented, would impact on 'public hospital only' products. However, in instances where an insurer does not have a contract with a private hospital, even a 'Gold' product would provide no guarantee that patients would be fully covered for their treatment. In this instance, the patient would likely face out-of-pocket costs for treatment at the private hospital which may encourage them to seek private treatment at the public hospital.

Change the private patient election processes

Under Schedule G of the NHRA an election by an eligible patient 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 practicable after admission, and must be made in accordance with minimum private patient election standards set out in the NHRA. In particular, private patients have a choice of doctor and all patients will make an election based on informed financial consent. The minimum private patient election standards are at Attachment A.

Through the minimum standards for election states and territories have agreed that all admitted patient election forms will include 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 a hospital employee to a particular decision. The NHRA is silent on whether a hospital can 'encourage' patients in their election decisions.

Suggestions for changing the admitted patient election processes in order to reduce the number of private patient elections have been put forward. These include:

- remove the requirement that "on admission, the patient will be given the choice whether to elect to be a public or private patient…" and instead ask patients "are you prepared to be treated by a doctor chosen by the hospital, and if not which doctor would you like to be treated by?"
- ensure that a patient's election to be treated as a private patient happens within 24 hours of admission to limit the hospital's ability to 'chase' private patient elections.
- remove the ability for public hospitals to offer inducements to private patients that are not also available to public patients (for example, free TV or newspapers).
- remove the requirement that "any patient who requests and receives single room accommodation must be treated as a private patient" with the view that public patients should equally have the right to request a private room if one is available.

Stop the public hospitals from waiving any excess payable under the patients 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.

There may be legislative constraints on the ability to implement this option.

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 that present expecting to be public patients from electing to be private, it may also reduce the consumer's perceived value of their health insurance.

This option would also disadvantage those patients 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.

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 involved in the patient's treatment.

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

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.

Change the basis of the private health insurance minimum benefit from a per diem payment to an activity based payment

The Commonwealth-determined minimum benefits are currently set as a benefit payable per night (or per day for day only accommodation). This option moves away from a per diem benefit and would align the Commonwealth-determined minimum benefits with the patient classification and payment structure used for the Commonwealth payments to public hospitals through the NHRA. These payments are calculated using the IHPA's National Efficient Price (NEP) which is based on the Australian Refined Diagnosis Related Groups (AR-DRG).

The IHPA has described the importance of classification systems such as the AR-DRG in its *Consultation Paper on the Pricing Framework for Australian Public Hospitals Services 2017-18:*

> *Classification systems provide the hospital sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs in order to better manage, measure and fund high quality and efficient health care services.*
>
> *The use of these systems is a critical element of activity based funding as they group patients who have similar conditions and cost similar amounts per episode together (i.e. the groups are clinically relevant and resource homogenous).*

Under this option the IHPA could be tasked with setting minimum health insurance benefits for shared ward accommodation that are consistent with the processes used to set the public sector NEP. Using a standardised payment methodology for private patients in public hospitals would provide a more definitive and transparent funding split between the Commonwealth, states, insurers and patients.

Basing the minimum benefits for private patients in public hospitals on the AR-DRG, rather than a per diem rate, would also mean insurers have better information on what treatments they are purchasing for their members. This information would allow for improved contract management and could also feed into insurer initiatives such as Chronic Disease Management Programs.

Attachment A

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 a 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.