Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2012-2013, 30 & 31 May and 1 June 2012

Question: E12-337

OUTCOME 13: Acute Care

Topic: South Australian cost shifting to Medicare

Type of Question: Written Question on Notice

Number of pages: 2

Senator: Senator Fierravanti-Wells

Question:

a) Have you considered or investigated any allegations, as reported publicly, of the South Australian Health Department requiring doctors in public hospitals to bill under Medicare and to sign over their rights to the money?
b) If so, what was the outcome?
c) If not, why not?
d) With respect to the SA Health directive, that if patients elect, there may be "MBS-billed pathology, diagnostic imaging and procedural services", would this possibly lead to a variation in the Commonwealth's contribution under Clause B63 of the Agreement?
e) Under Clause B63 is there a formula for varying the Commonwealth's contribution?
f) What consultation or negotiation would occur with respect to a variation to the Commonwealth's contribution?
g) The SA Health Minister has stated that

   "to the extent we can get Medicare to pay for services, we will, legally that is, we will do that".

   Is it possible to be compliant with the Health Insurance Act for the purposes of Medicare, but still be in breach of the Agreement?

   That is, is it possible that the cost-shifting practices being alleged in South Australia are not prohibited under the Act and therefore not 'illegal' in the view of the Minister, but still result in action under the Agreement?
h) Has any consideration been given to amending the Health Insurance Act to address some of the issue of billing Medicare for services provided to public hospital patients?

Answer:

a) Yes.

b) The Department of Health and Ageing is aware of longstanding arrangements in rural South Australian hospitals which involve general practitioners working in a private capacity and charging patients for services they provide on a non-admitted basis. These

arrangements have been in place for many years. The Department has provided advice to SA Health that the Commonwealth considers that these arrangements continue to be appropriate under the National Health Reform Agreement (NHRA).

c) See answer to b).

d) Should an admitted patient in a public hospital elect to be a private patient, Clause A41 of the NHRA sets out how the National Efficient Price for that service will be calculated.

For non-admitted services, if a patient elects to be treated as a private patient, that service is ineligible for funding under the NHRA (Clause A6 refers).

The extent to which a variation of the Commonwealth's contribution may be required depends upon whether this service was forecast to be provided as a public (admitted or non-admitted) or private (admitted only) service in the Local Hospital Network Service Agreement.

e) There is not a specific formula for varying Commonwealth contributions. Under the NHRA, adjustments will be based on calculating the Commonwealth contribution for actual services provided, compared with the funding provided in advance based on estimates of service volume.

f) Consultation or negotiation is not expected to be required. The Commonwealth contribution is based on estimated service volume data provided by states, adjusted as required by reconciliation against actual service data. In providing data to the National Health Funding Pool Administrator, states and territories will be able to calculate the impact of Commonwealth funding for their state or territory.

g) The NHRA does not prohibit patients electing to be treated as private patients in public hospitals (see answer to d)).

h) See answer to d).