Australian
Private Hospitals
Association

Private Patients in Public Hospitals

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Australian Private Hospitals Association ABN 82 008 623 809

Contents

Overview

Arrangements allowing consumers who wish to be treated privately in a public hospital are long-standing. Under these provisions, consumers holding private health insurance (PHI) are entitled to indicate their choice to be treated in the public hospital as either a private or a public patient, upon or as close as practicable to, their admission. In doing so, those who hold PHI are able to use that insurance to cover expenses charged by the public hospital. Choice is an important element of any good healthcare system but when one group of patients is advantaged over other patients in accessing publically funded health services, further investigation is required.

When a Medicare eligible consumer holding private health insurance elects to be treated as a private patient in a public hospital, the public hospital and treating clinicians in turn are able to charge both the Commonwealth Government and the consumer's health insurer. The public hospital and treating clinicians thereby access additional revenue-income to that paid through government funding for public hospitals.

Since 2000, there has been a rapid increase in the number and proportion of public hospital patients whose care is funded by PHI. These trends are driven by deliberate policy decisions by States/Territories. For example, in several jurisdictions, local hospitals and health districts are directed to achieve explicit targets for 'own source' revenue. Ernst & Young have recently shown that in all but one jurisdiction, hospitals achieve a financial benefit from attracting private patients even though Commonwealth-State funding arrangements were intended to neutralise these incentives.

By focusing attention on 'converting' admissions to private patients, public hospitals are diverting resources away from consumers who are dependent on the public hospital system, including patients on public elective surgery waiting lists. Privately insured patients accounted for 14% of public hospital bed days in 2015-16 (AIHW, 2017), up from 6.2% in 1999-2000 (see chart below). Private patients in public hospitals accounted for more than 2.9 million patient days in the year to March 2017 (APRA, 2017) – equivalent to more than 7,000 beds.

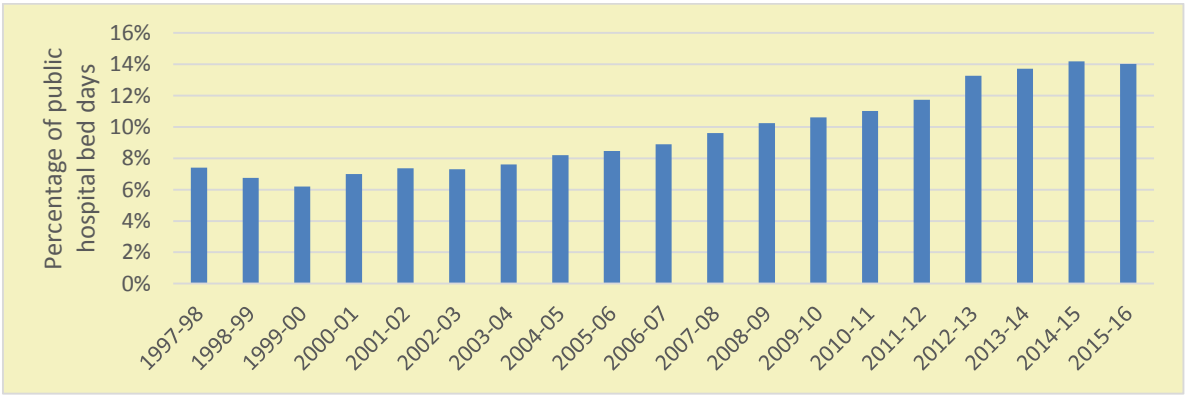


Figure 1: The percentage of public hospital bed days used to treat patients funded through private health insurance. Source: AIHW various years

According to data reported by the Australian Institute of Health and Welfare (AIHW), private health insurers pay out more than $1.5 billion in health insurance benefits each year to public hospitals. Public hospitals receive 13% of benefits paid by private health insurers for hospital care (AIHW, 2016c).

These trends are detrimental to consumers and the Australian health system by:

- Diverting funds allocated to public hospitals to subsidise privately insured patients and creating incentives for patients to elect to be treated as private patients
- Diverting public funds to incentivise doctors to treat private patients in public hospitals
- Exposing vulnerable patients to pressures to elect to be treated as private patients
- Privileging privately insured patients ahead of public patients in accessing elective surgery in public hospitals
- Using public hospital beds and resources to treat patients who could be more efficiently treated in the private sector
- Placing added pressure on PHI premium growth.

Why are public hospitals treating increasing numbers of private patients?

There are a number of factors contributing to the increase in privately insured patients in public hospitals, including:

- doctor remuneration agreements
- jurisdictional funding models incentivising hospitals and doctors to treat private patients and rewarding achievement of targets
- residual incentives in agreements between the States/Territories and the Commonwealth.

Historical context

Commonwealth funding of free access to public wards in public hospitals originated with the *Hospital Benefits Act 1945*. While there has always been some provision of services to private patients in public hospitals, the launch of Medicare and the New South Wales doctors' dispute in the mid1980s significantly changed the way doctors were remunerated. Medicare paid 85% of the scheduled fee for doctors' services provided in a hospital, through a schedule which would become the Medicare Benefits Schedule (MBS). At the same time the NSW government sought to impose restrictions on doctors practicing in public hospitals including restrictions on fees and private practice in public hospitals.

Doctors in NSW objected to these proposed restrictions and they were also concerned that their ability to practice privately substantially depended on access to public hospital beds. In New South Wales, 80% of hospital beds were public at the time. Specialist medical practice depended on access to public hospitals. In the final resolution of this dispute doctors gained the right to see private patients in public hospitals and to charge above the schedule fee (AMA, no date). Similar arrangements were adopted in other States/Territories.

Hospital statistics from 1985-6 indicate that nationally the private hospital sector accounted for just 23% of acute care beds, 21% of all acute care bed days and 26% of acute separations. In that same year 22% of public hospital bed days were used for the care of private patients, ie patients funded by private health insurance and/or self-funded (Mathers and Harvey, 1988).

Since the 1980s however, the hospital sector has changed significantly. The number of private hospital beds available has increased by almost 60% since in the mid-1980s and it is common for doctors to work across both sectors. In 2015-16 private hospitals accounted 28% of beds in NSW, 36% in Victoria, 38% in Queensland and 35% across Australia as a whole. Each year, the private sector treats 41% of separations (AIHW, 2017). Nevertheless the treatment of private patients in public hospitals is growing. In the past four years it has

risen dramatically in all jurisdictions. These more recent increases are directly related to the policies, incentives and targets set by States/Territories.

Trends at State/Territory and local level and the influence of funding models

In August 2011, all States and Territories and the Commonwealth Government signed the National Health Reform Agreement. This agreement made the jurisdictions and the Commonwealth Government jointly responsible for funding public hospital services. It committed the parties to activity-based funding[1] where practicable, and block funding[2] for hospitals not considered suitable for activity-based funding.

The implementation of the activity-based funding model in the financial year 2012-13 was not intended to incentivise for treatment of private patients in public hospitals. The nationally agreed model discounted private patients by two adjustments: the Private Patients Accommodation Adjustment and the Private Patient Service Adjustment (based on diagnosis related groupings, DRGs) (EY 2017:2). Despite this, annualised growth in the number of private patients treated in public hospitals was higher in the three years after the National Health Reform Agreement than in the three years leading up to it, in five States and Territories (New South Wales, Western Australia, South Australia, the Australian Capital Territory and the Northern Territory).

The following chart show privately insured patient separations as percentage of total public hospital separations and the change in that percentage over time in each State and Territory.

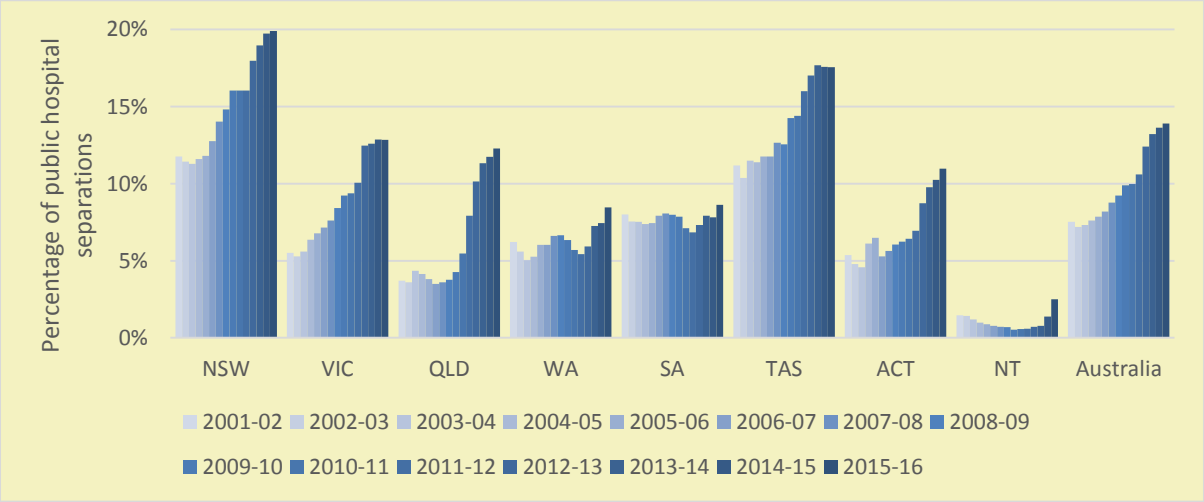


Figure 2: Privately insured separations in public hospitals by jurisdiction 2001-2 to 2015-16. Source: AIHW, *Admitted patient care: Hospital Statistics Report* various years

[1] Funds public hospitals based on the number of patients treated and the complexity of the treatment required for those patients.

[2] Funding model for hospitals that are unable to meet the technical requirements of activity-based funding reporting, a lack of economy of scale or remoteness

In 2015-16, the number of privately insured separations treated in public hospitals reached 871,902. The number in each State/Territory is provided in the table below.

State/Territory	Privately insured separations in public hospitals (2015-16)
New South Wales	370,369
Victoria	214,329
Queensland	158,815
Western Australia	53,420
South Australia	37,885
Tasmania	21,523
Australian Capital Territory	11,857
Northern Territory	3,704
Total	871,902

Source AIHW, *Admitted patient care: Hospital Statistics Report,* 2017

The growth in private patients in public hospitals since 2011-12 was partly because the funding model developed by the Independent Hospital Pricing Authority (IHPA) was implemented differently across the jurisdictions (See Appendix A). It sometimes created incentives for jurisdictions to chase private patient dollars, as the private patient adjustment factors were either not applied or not apparent. Additionally, many States and Territories also imposed private patient revenue targets on public hospitals.

> "Health budget allocation processes; implementations and localisations of the national [activity-based funding] framework specific to States and Territories; private patient targets for Own Sourced Revenue; service level agreements; and the promotion of the benefits for private patients of electing public hospital separations (…) in addition to residual system incentives within jurisdictions to target privately funded patients, correlate with increases in privately funded public hospital separations since the introduction of [activity-based funding]." (EY 2017:29)

It is worth noting the only jurisdiction that fully applied the national activity-based funding model was the Australian Capital Territory (ACT), yet this decision has not stopped the ACT experiencing a significant amount of growth in private patients in public hospitals during the three years since the funding model was agreed to.

Data published by the National Hospital Performance Authority (NHPA) is even more alarming because it suggests that at some public hospitals have a far higher percentage of private patient admissions. A table showing those hospitals with a proportion of private patients above the national average is provided on the following page. These figures do not represent the total percentage of private patients admitted to each hospital because some admissions were excluded from NHPA's analysis for methodological reasons. Even so, many of the percentages are sufficiently high to raise concern about the extent to which private patient election is being driven by jurisdictional policies rather than by patients freely exercising informed choice.

It is also notable that the majority of hospitals listed on the following page are in

metropolitan locations where private hospitals provide the full range of services, with the exception of complex trauma and organ transplant. Finally, the significant variation between States/Territories strongly suggests levels of private patient admissions are determined by deliberate marketing and incentivisation.

Public Hospitals with Percentages of Private Patients Higher than the National Average (by State/Territory)

Public hospital name	Location type	Private patients (%)
NEW SOUTH WALES		
Sutherland Hospital	Major metropolitan	41%
Manly Hospital	Large metropolitan	38%
St Vincents Hospital	Major metropolitan	35%
Mona Vale Hospital	Large metropolitan	35%
Royal North Shore Hospital	Major metropolitan	34%
Hornsby Ku-ring-gai Hospital	Major metropolitan	33%
John Hunter Hospital	Major metropolitan	29%
St George Hospital NSW	Major metropolitan	27%
Goulburn Hospital	Large regional	27%
Concord Hospital	Major metropolitan	26%
Royal Prince Alfred Hospital	Major metropolitan	26%
Prince of Wales Hospital	Major metropolitan	25%
Orange Health Service	Major regional	22%
Gosford Hospital	Major metropolitan	21%
Wollongong Hospital	Major metropolitan	21%
Ryde Hospital	Large metropolitan	21%
Tamworth Hospital	Major regional	20%
Coffs Harbour Hospital	Major regional	19%
Wagga Wagga Hospital	Major regional	19%
Shoalhaven Hospital	Major regional	18%
Westmead Hospital	Major metropolitan	16%
Wyong Hospital	Major metropolitan	16%
Canterbury Hospital	Large metropolitan	16%
Dubbo Hospital	Major regional	16%
Bathurst Hospital	Large regional	16%
Grafton Base Hospital	Large regional	15%
Campbelltown Hospital	Major metropolitan	14%
Liverpool Hospital	Major metropolitan	14%
Shellharbour Hospital	Large metropolitan	14%
Lismore Hospital	Major regional	14%
Port Macquarie Hospital	Major regional	14%
QUEENSLAND		
Mackay Base Hospital	Major regional	24%
The Prince Charles Hospital	Major metropolitan	21%
Rockhampton Hospital	Major regional	21%
Hervey Bay Hospital	Major regional	18%
Toowoomba Hospital	Major regional	16%
Bundaberg Base Hospital	Major regional	14%
VICTORIA		
Wimmera Base Hospital [Horsham]	Large regional	27%
Ballarat Health Services [Base Campus]	Major regional	22%
Maroondah Hospital [East Ringwood]	Major metropolitan	20%
Austin Hospital [Heidelberg]	Major metropolitan	19%
Royal Melbourne Hospital [Parkville]	Major metropolitan	18%
Box Hill Hospital	Major metropolitan	17%
Geelong Hospital	Major metropolitan	16%
Goulburn Valley Health [Shepparton]	Major regional	16%
Angliss Hospital	Large metropolitan	15%
The Bendigo Hospital	Major regional	15%
Frankston Hospital	Major metropolitan	14%
St Vincent's Hospital [Fitzroy]	Major metropolitan	14%
WESTERN AUSTRALIA		
Albany Hospital	Large regional	17%
Sir Charles Gairdner Hospital	Major metropolitan	15%
TASMANIA		
Royal Hobart Hospital	Major regional	23%
Launceston General Hospital	Major regional	17%

Source: NHPA: Costs of acute admitted patients in public hospitals 2013-14 supporting data http:--www.myhospitals.gov.au-about-the-data-download-data, April 2016

Jurisdictional policies and incentives

Growth in private patients in public hospitals has significantly exceeded the growth in PHI-funded admissions overall and despite the private hospital sector having expanded in capacity. It has occurred even in cities and regions where there are well established private hospitals offering a comprehensive range of services.

All of these trends point to the influence of deliberate jurisdictional policies, target setting and influence of incentives directed at patients and doctors.

Incentives offered to patients range from access to a private room (subject to availability), the opportunity to be treated more quickly (elective surgery), "free" parking, guest meals, entertainment packages, vouchers and waivers of out-of-pocket costs. The use of deliberate strategies to encourage patients to elect to be treated as privately insured patients is evidenced by:

- Brochures given to patients
- The use of 'nudge' techniques to increase the rate of election by patients
- Employment of staff whose specific role is to coerce patients to elect to be treated as private patients
- Routine collection of private health insurance membership data even when a patient is not electing to be treated as a private patient.

Waiving of out-of-pocket costs means excess payments, co-contributions and 'gap-payments' normally paid when a consumer uses private health insurance are met by the public hospital on the patient's behalf using taxpayer funds. These costs include those stipulated in the health insurance product purchased by the consumer.

Incentives offered to clinicians may include not only the opportunity to exercise a right of private practice, but also direct financial benefits such as payment of the gap between the relevant MBS rate (paid by Medicare and the private insurer) and the rate charged by the clinician (for example the Australian Medical Association (AMA) recommended rate).

These trends are not a response to lack of access to private hospitals

It is sometimes claimed that provisions for consumers to be treated as private patients in public hospitals provide people in regional areas access private treatment. Data released by the NHPA suggests that the vast majority (74%) of private patient in public hospital services are provided in metropolitan hospitals (NHPA, 2016).

This same dataset also shows there is no correlation between the percentage of services provided to private patients in public hospitals and the presence or absence of a private hospital in the same area. Even where regional hospitals do admit relatively high percentages of private patients, these percentages are significantly lower than those found in many metropolitan hospitals.

What treatments are provided to private patients in public hospitals?

Why are these patients admitted to hospital?

Private hospitals are requirement provide detailed information in relation to each insured patient they treat. By contrast there is very little published information on the treatments provided to private patients in public hospitals.

Data only recently published by the AIHW reveal a broad profile showing that:

- Almost half of all private patients in public hospitals are emergency separations, ie separations in which care was required within 24 hours
- Just over 12% of separations were surgical, of which about half (52%) were for patients from elective surgery waiting lists
- Just under a sixth of separations were classified as 'Urgency non-assigned or not reported', meaning their admission to hospital and treatment was likely part of a planned program, e.g. an admission to receive chemotherapy
- 6% of separations were for non-acute care, ie palliative care, rehabilitation care or other non-acute services (AIHW, 2017).

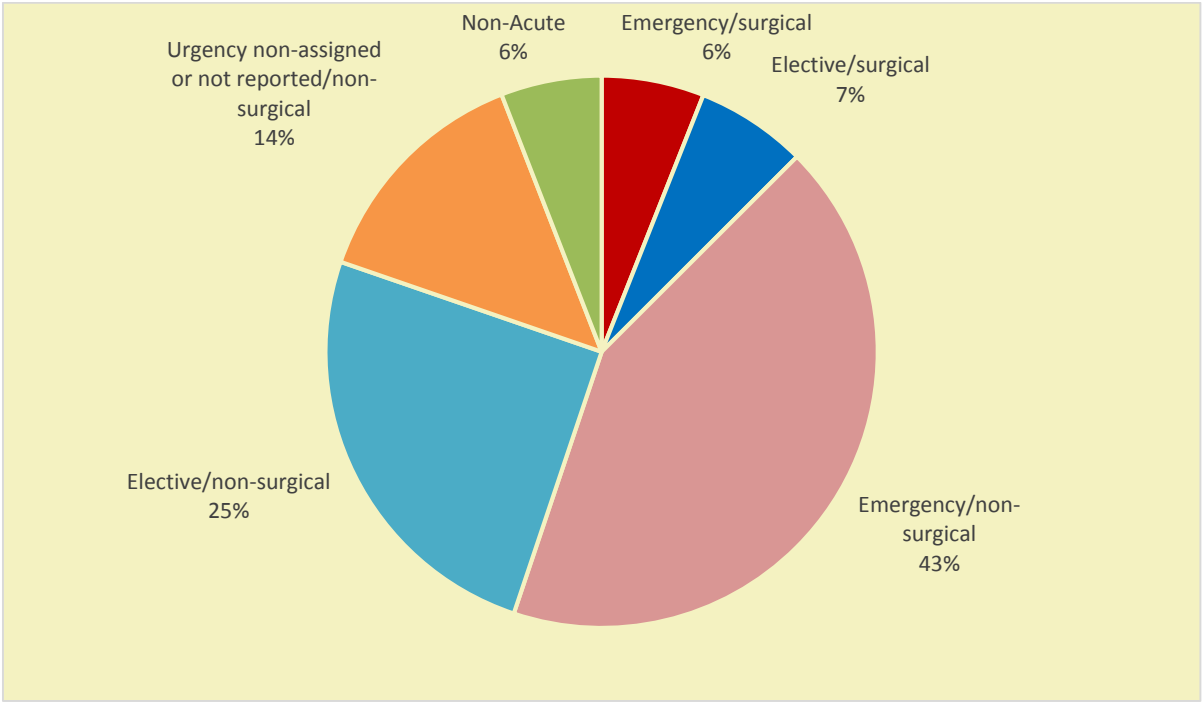


Figure 3: Private Patients in Public Hospitals 2015-16: Separations by Urgency and Type of Care. Source AIHW Admitted Patient Care: Hospital Statistics 2017

Almost half (46%) of all public hospital separations funded by private health insurance were same-day separations (AIHW, 2017).

These figures in themselves raise a number of causes for concerns. It is interesting to note that almost half of privately insured patients treated in public hospitals required urgent treatment; many of them patients presenting a public emergency departments.

Did election make a difference to the treatment provided?

Did election make any difference to the way these consumers were treated? For example:

- Did they have access to a private room?
- Did they choose their doctor? Did they have access to a doctor not otherwise available?
- Did they have access to care that would not otherwise have been provided?
- Were they able to access a different form of treatment or technology?
- Did they have a shorter wait time?

For the most part, AIHW does not answer these questions, except in the case of patients admitted from public elective surgery waiting lists. In this case, private patients have a distinct advantage in being able to access treatment more quickly.

Access to private rooms is almost always conditional on clinical need and room availability. This is not always understood by consumers and it is often a source of dissatisfaction when a private room is not provided.

With respect to choice of doctor, the evidence is equivocal. Market research conducted by the Australian Private Hospitals Association (APHA) shows that only 40% of private patients in public hospitals had a choice of doctor. The other 60% were treated by a doctor allocated to them in the same way as would have happened if they had elected to be treated as a public patient. Clearly patient experience of ‘election’ varies. The impact of doctor choice on subsequent treatment might also vary depending on the doctor’s role and level of active involvement during the admission.

Several question need to be asked: might these services have been more appropriately, effectively and efficiently provided in a private hospital? Might their treatment have been more appropriately provided at home, in the community or in an out-patient setting? Would these patients have ‘elected’ to be treated as a private patient in a public hospital if other options, together with the information necessary for full financial consent, had been presented to them?

What impact is this practice having on patients?

The opportunity to elect to be treated as a private patient in a public hospital is promoted by public hospitals as an attractive benefit. However, the drive by public hospitals to increase 'other source' revenue may be giving rise to practices compromising the rights of patients seeking treatment in public hospitals in two important respects:

- compromising patient choice in respect to the election process
- disadvantaging patients waiting on public elective surgery waiting lists.

Private patient election processes

Public hospital practices that might interfere with these patient rights include the following:

- Undue pressure applied to patients seeking admission as a public patient to use their PHI
- Undue pressure on patients presenting at an emergency department to use their PHI on admission to the hospital.

These concerns are all the more serious when the profile of private patients in public hospitals is considered. Many of them are highly vulnerable patients admitted through public hospital emergency departments.

Data published by the AIHW for 2015-16 show that of the 871,902 separations in public hospitals that were funded through private health insurance, almost half (48.6%) were emergency admissions (admission required within 24 hours) (AIHW 2017). A significant proportion of these emergency admissions are likely to have come through emergency departments. It is known that some jurisdictions and hospitals have implemented deliberate campaigns to persuade people to elect to be treated as private patients when they are referred for admission by the emergency department. These campaigns include such questionable tactics as:

- failure to provide informed financial consent, including patients not being aware that they are signing an election to be treated as a private patient
- 'conversion' of patients from public to private post-admission even though election is supposed to be exercised prior to, at, or as soon as possible after admission
- pursuit of patients post-discharge to retrospectively elect to use their PHI
- lack of, or insufficient provision of, information to enable a patient to consider care options and make an informed choice

- denial of a patient's request to transfer to a private facility.

APHA has received anecdotal accounts of public hospitals appearing to act contrary to the spirit of the National Healthcare Agreement:

- patients pressured to elect for private admission while family members have stepped away from the bedside for a short time
- patients emotionally blackmailed with threats that a facility will close if they do not elect to be admitted as a private patient
- public hospitals persuading a patient to retrospectively elect to be a private patient
- public hospitals writing to patients post-discharge inviting them to retrospectively elect to have the admission recorded as a private patient admission
- patients forced to wait for a transfer and/or being told that no private hospital bed is available when this is not the case
- patients told the private hospital doctor is on leave-not available when this is not the case
- patients being told the private hospital does not admit seriously ill patients when this is not the case
- patient preference for a transfer to a private hospital ignored
- patients forced to pay the cost of ambulance transfer from a public hospital to a private hospital even though they have PHI and ambulance cover
- patients persuaded to elect as a private patient and then directed down a public sector care plan without being advised of their alternatives including private sector options through which they could access the required treatment in a significantly shorter timeframe
- patients' requests to be taken to their private emergency department of choice refused by ambulance services, even though the hospital in question is formally recognised as able to take cardiac patients.

Specific accounts of pressure applied to patients have been obtained in a range of circumstances including psychiatric patients, patients admitted through emergency departments and cardiac patients. Of private insurance-funded separations in public hospitals, 13% involved surgery and the remainder were non-surgical (AIHW, 2017). Further information about the reasons for their admission has not been published. The proportion of these patients who could have been transferred for treatment in the private sector or who, with the removal of financial incentives, might not otherwise have been admitted is

also unknown. Arguably some, including patients with psychiatric conditions, may have been more appropriately cared for in the private hospital sector.

Informed financial consent and out-of-pocket costs

Although some public hospitals waive out-of-pocket costs in order to encourage patients to elect to be treated as a private patient, this practice is not universal and patients may still find that they have out-of-pocket costs for other reasons. For example, they may find their health insurer does not cover them for the services provided or they may find they are charged for incidental costs they did not expect.

Elective surgery waiting times

The growth of private patients in public hospitals is also having a negative effect on patients who have no choice other than to rely on the public health system. The growth in the treatment of private patients in public hospitals is putting public patients at a disadvantage. Data published by the AIHW show that patients on elective surgery waiting lists experienced considerably shorter waiting times when they elected to be treated as private patients.

In 2015-16, the 47,033 patients admitted from public hospital waiting lists for elective surgery and funded by private health insurance, experienced a median wait time of only 20 days, compared with 42 days for those treated as public patients (AIHW 2017). Private patients were treated more quickly than public patients, across the range of surgical procedures and surgical specialties for which waiting times are published by the AIHW. Questionable hospital practices in relation to waiting lists include ‘mixed lists’ and ‘intermediate lists’ whereby patients are induced to seek admission as a private patient in the public hospital.

Enabling consumers to access treatment in a timely fashion is one of the benefits of private health insurance. It is therefore entirely appropriate that consumers be able to exercise this choice. A minority of patients need to be treated in a public hospital because there is no suitable private hospital nearby or because their clinical condition requires facilities not available elsewhere. In most cases, however, the required surgery could just as easily have been done in the private sector.

During the past decade, the number of waiting list admissions per 1,000 population has increased by 0.7 hospitalisations, however, the average waiting times for public elective surgery increased from 32 days in 2005–06, to 38 days in 2015–16 (AIHW, 2016b, 2006). Demand is growing. During the past five years the number of admissions from public hospital waiting lists has increased annually by an average of just 2.4% (AIHW, 2016b). Private health insurance was used to fund treatment for 7% (47,033) of the 680,091 admissions from public hospital elective surgery waiting lists in 2015-16 (AIHW, 2017). Ostensibly all of these surgeries could have been performed in the private hospital sector, freeing up capacity to immediately increase elective surgeries for public patients by 8%.

Appendix A: State and Territories

The issue of private patients in public hospitals exists around Australia, but not to the same extent in each State and Territory. This could be due to incentives for public hospitals to attract private patients differing between States (Table 1).

Table 1: State/Territory incentives and data on attracting private patients to public hospitals

State/ Territory	Private patient revenue targets in place for public hospitals?	Annual growth in number of private patients since ABF implementation in 2011-12 to 2014-15 (%)	Annual growth higher or lower than in the 3 years before ABF implementation in 2011?	Are there explicit or residual financial incentives in place to attract private patients?	ABF as a proportion of total funding for 2015-16 (%)
NSW	✓	10.4	Higher	✓	87.7
VIC	✓	9.6	Lower	Possibly residual	86.6
QLD	✓	21.5	Lower	✓	86.1
WA	✓	12.1	Higher	✓	83.5
SA	×	5.9	Higher	Residual	87.8
TAS	✓	9.7	Lower	✓	58.8
ACT	×	15.3	Higher	×	90.3
NT	×	43.1	Higher	n.a	48.6

ABF: activity-based funding. Source: AIHW 2016a; EY 2017; ANHFP 2016.

This report also looks at the performance of the State and Territory public hospitals in terms of elective surgery wait times and the National Elective Surgery Target (NEST). Under NEST, 100 percent of all patients waiting for surgery are to be treated within the clinically recommended times (AMA, 2017). Details are provided in each section, and the overall summary is provided below in Table 2.

Table 2: Performance summary for selected indicators by State and Territory, 2015-16

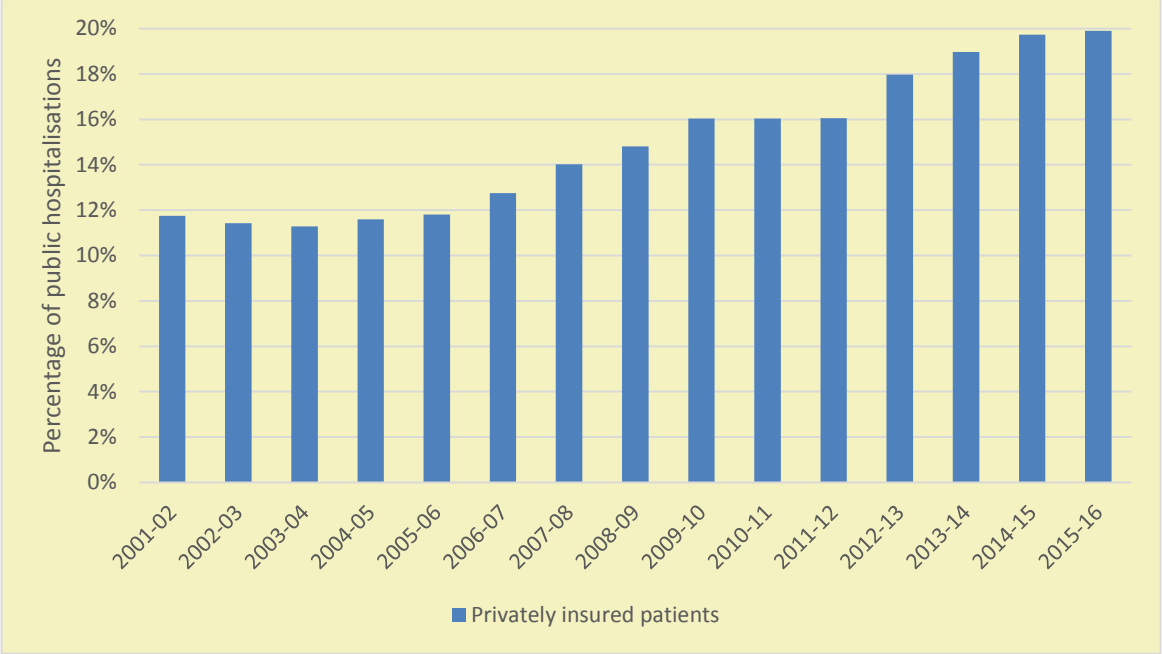
State/ Territory	Private patients as a proportion of total separations in public hospitals 2015-16 (%)	Average annual growth in number of PHI-funded separations in public 2006-07 to 2015-16 (%)	Improvement in median elective surgery waiting time 2014-15 to 2015-16?	Met National Elective Surgery Target – Category 2 2015?	Improvement in Elective Surgery Category 2 admission in 90 days?
NSW	19.9	8.3	×	×	×
VIC	12.8	9.6	×	×	✓
QLD	12.3	19.6	×	×	✓
WA	8.5	8.7	×	×	×
SA	8.6	3.2	×	×	×
TAS	17.6	7.1	×	×	×
ACT	11.0	10.2	n.a.	n.a.	n.a.
NT	2.5	22.7	✓	×	×

Clinical urgency Category 2 describes elective surgery procedures that are clinically indicated within 90 days.

Sources: AIHW 2007; AIHW 2017; AMA 2017

New South Wales

In New South Wales (NSW), there were 370,369 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 20% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations has been increasing over the past decade in New South Wales (Figure 6).



Note: data for ACT were included in NSW data prior to the Dec quarter 2009.
Source: AIHW 2003-2017.

Figure 4: Privately insured patients as a proportion of public hospitalisations in New South Wales, 2001-02 to 2015-16

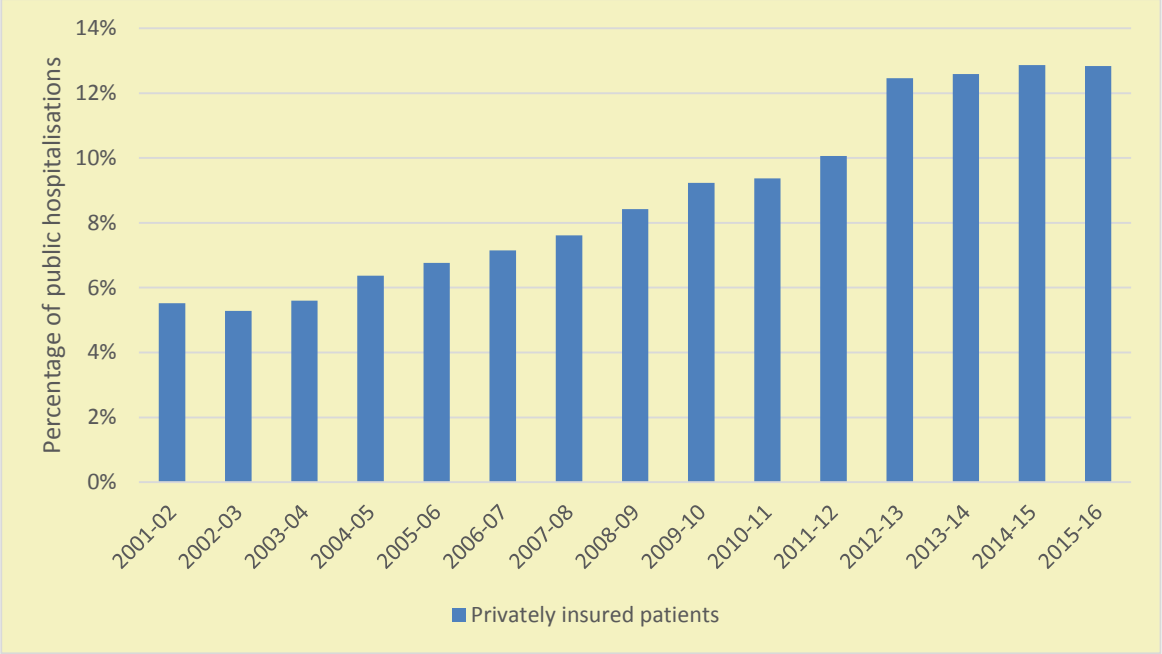
- In the three years after the implementation of activity-based funding in 2012-13, NSW experienced higher annualised growth in the number of public hospital separations funded by private health insurance (10.4%) than in the three years immediately preceding the agreement (6.2%).

- In 2013-14, NSW introduced a private patient accommodation adjustment as well as a private patient service adjustment by Diagnostic Related Group (DRG) for acute admitted and mental health and by care type for subacute and non-acute admitted services. The service adjustments are not publically available (EY 2017:12).

- There are specific private patient targets set out in health district and hospital service agreements, however, the specifics of these targets are not publically available. Where targets are exceeded, the LHD-SHN can retain the associated own-sources revenue with no commensurate reduction in funding from other sources (EY 2017:13). This effectively provides a very strong incentive for public hospitals to meet and exceed their private patient targets.

Victoria

In Victoria (VIC), there were 214,329 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 13% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations has been increasing over the past decade in Victoria (Figure 7).



Source: AIHW 2003-2017.

Figure 5: Privately insured patients as a proportion of public hospitalisations in Victoria, 2001-02 to 2015-16

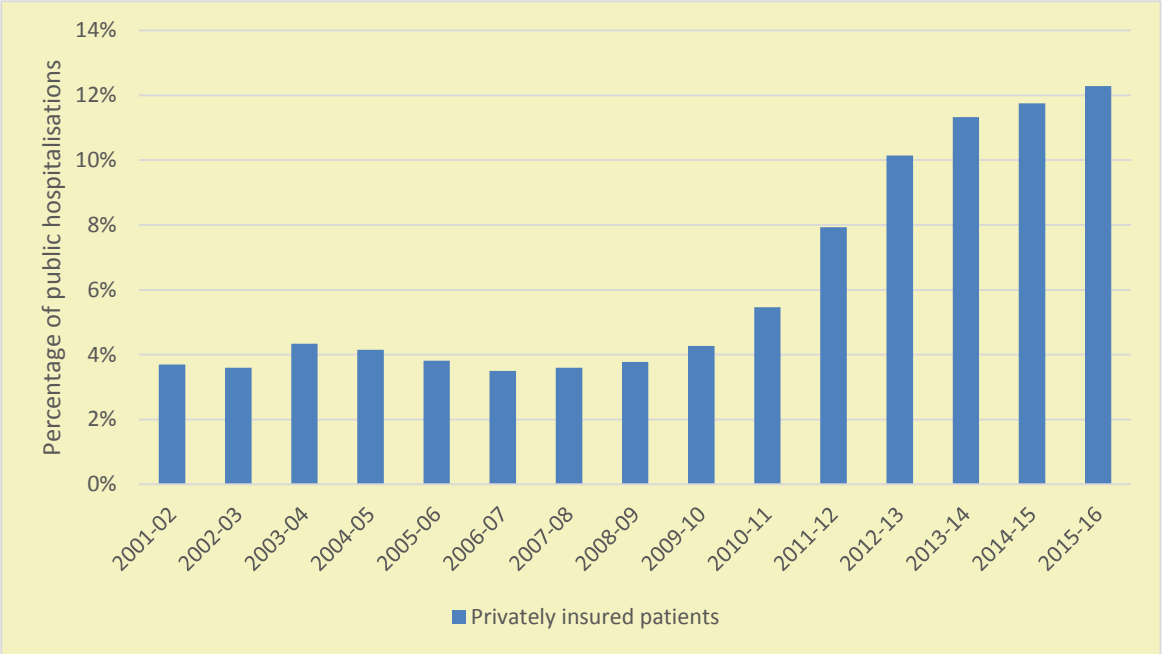
- Since the implementation of activity-based funding in 2012-13, Victoria has experienced a lower annualised growth in the number of public hospital separations funded by private health insurance (9.6%) than the three years immediately preceding the agreement (10.2%).

- The Victorian funding model specifies different prices for public and private patients, so there is no further private patient adjustment on top of this. There is a 24% discount applied to eligible private patients. There is also a further discount calculated on the basis of a per diem which differs for an overnight and a same-day separation. These discounts are different from the private patient adjustments originally devised by IHPA, and may not sufficiently take into account prosthesis and other revenue sources. This may mean there are residual incentives that remain for health services to target private patients with particular conditions (EY 2017:15).

- Due to differences in the calculations for price between a public and a private patient in the Department of Health and Human Services and the IHPA models, they cannot be directly compared (EY 2017:15).

Queensland

In Queensland (QLD), there were 158,815 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 12.3% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations have increased dramatically as a percentage of total public hospitalisations since 2009-10 in Queensland (Figure 8).



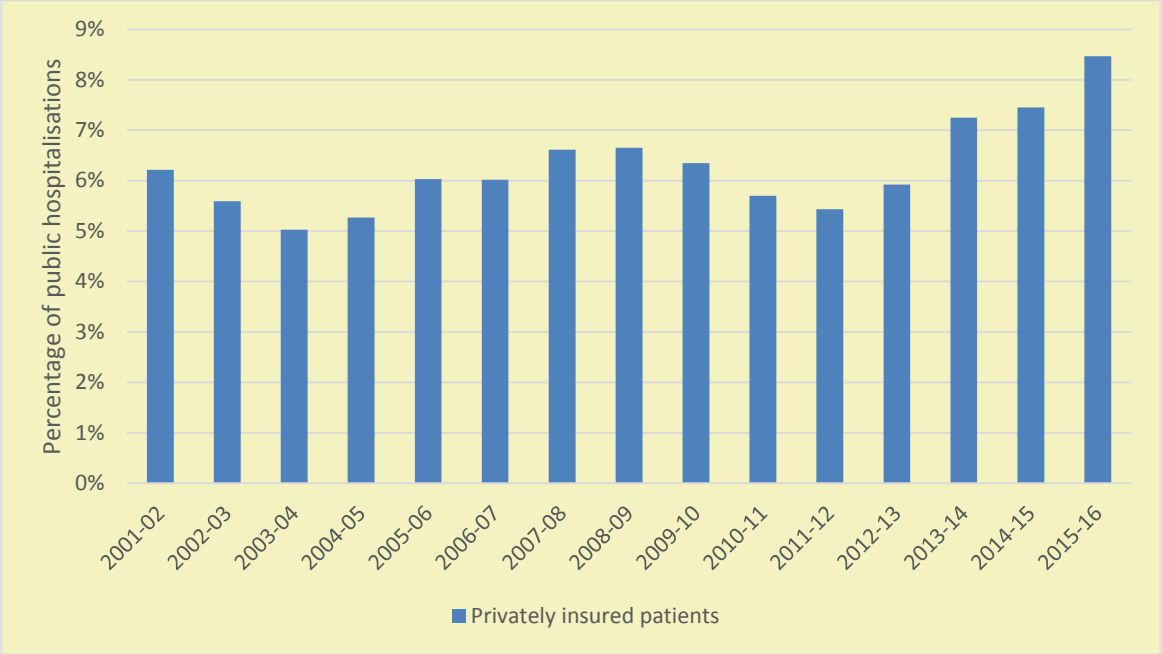
Source: AIHW 2003-2017.

Figure 6: Privately insured patients as a proportion of public hospitalisations in Queensland, 2001-02 to 2015-16

- Since the implementation of activity-based funding in 2012-13, Queensland has experienced a lower annualised growth in the number of public hospital separations funded by private health insurance (21.5%) than the three years immediately preceding the agreement (34.2%).
- The Queensland activity-based funding model does not have private patient adjustments, and each Hospital and Health Service (HHS) receives the same amount of funding for private and public patients receiving similar services.
- The Queensland activity-based funding model has an Own Sourced Revenue target, where any hospital and health service (HHS) that is above its target of private patients can retain the additional funding without a reduction in other funding. Conversely, if they do not meet their private patient target, services experience a reduction in funding without compensation from other funding sources. (EY 2017:17).

Western Australia

In Western Australia (WA), there were 53,420 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 8.5% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations have increased as a percentage of total public hospitalisations since 2011-12 in Western Australia (Figure 9).



Source: AIHW 2003-2017.

Figure 7: Privately insured patients as a proportion of public hospitalisations in Western Australia, 2001-02 to 2015-16

- Since the implementation of activity-based funding in 2012-13, WA has experienced a considerable increase in annualised growth in the number of public hospital separations funded by private health insurance (12.1%) compared to the three years immediately preceding the agreement (1.0%).

- The WA activity-based funding model uses an expenditure profile which includes weighted activity related to private patients in public hospitals. The WA model does not use the DRG discount for private patients service adjustments or the bed-day private patient accommodation adjustments applied in the IHPA model (EY 2017:19). Because there is no private patient adjustment, hospitals receive the same amount from the State for a private and public patient, creating incentives to chase private patients.

- WA also has private patient revenue targets.

South Australia

In South Australia (SA), there were 37,885 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 8.6% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations were relatively high in the period 2006-07 to 2009-10 and have increased dramatically as a percentage of total public hospitalisations since 2011-12 (Figure 10).

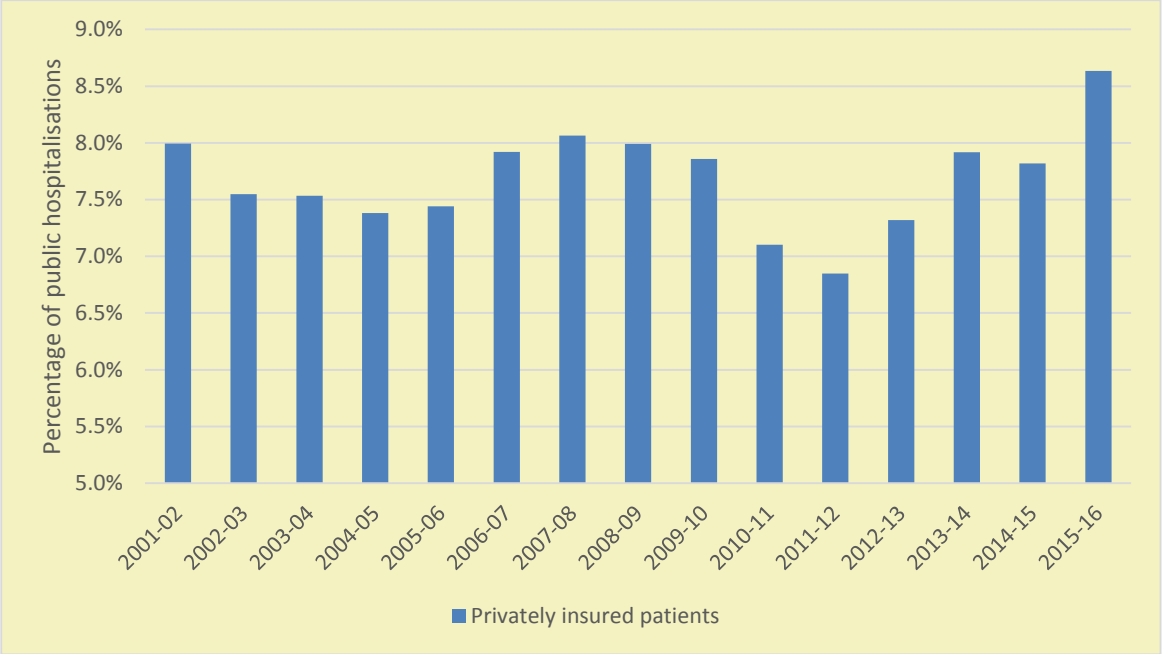


Figure 8: Privately insured patients as a proportion of public hospitalisations in South Australia, 2001-02 to 2015-16 Source: AIHW 2003-2017.

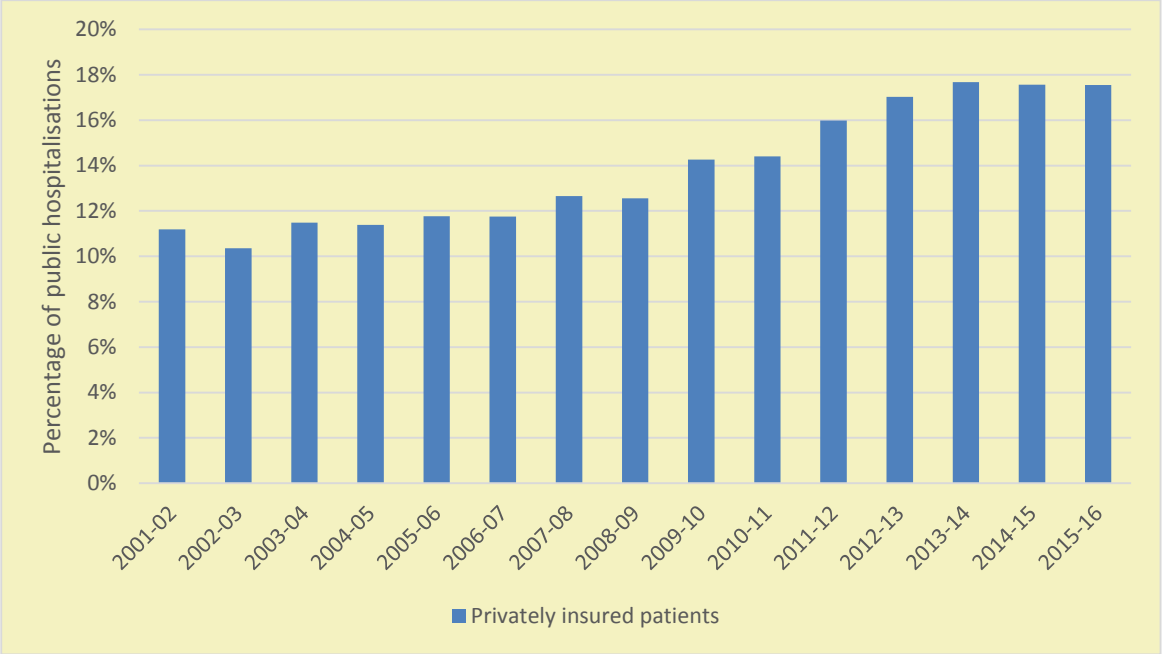
- Since the implementation of activity-based funding in 2012-13, SA has experienced a significant increase in annualised growth in the number of public hospital separations funded by private health insurance (5.9%) compared to the three years immediately preceding the agreement (-2.2%).

- Since 2014-15, SA has applied the private patient accommodation and private patient service adjustment to acute admitted activity (not subacute or non-acute). However, adjustments for private patients are passed on to Local Health Networks (LHNs) through a block amount to provide full funding of cost service delivery, regardless of the revenue offset. There may be some residual incentives to chasing private patients as additional revenue outside of the block funding might be received from Commonwealth and private health insurers (EY 2017:21).

- No private patient targets identified (EY 2017:21) although it is understood that clinicians are encouraged to admitted private patients and the benefits of electing to be a private patient are promoted to consumers.

Tasmania

In Tasmania, there were 21,523 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 17.6% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations have been steadily increasing since 2005-06 although this increase appears to have levelled off recently (Figure 11).



Source: AIHW 2003-2017.

Figure 9: Privately insured patients as a proportion of public hospitalisations in Tasmania, 2001-02 to 2015-16

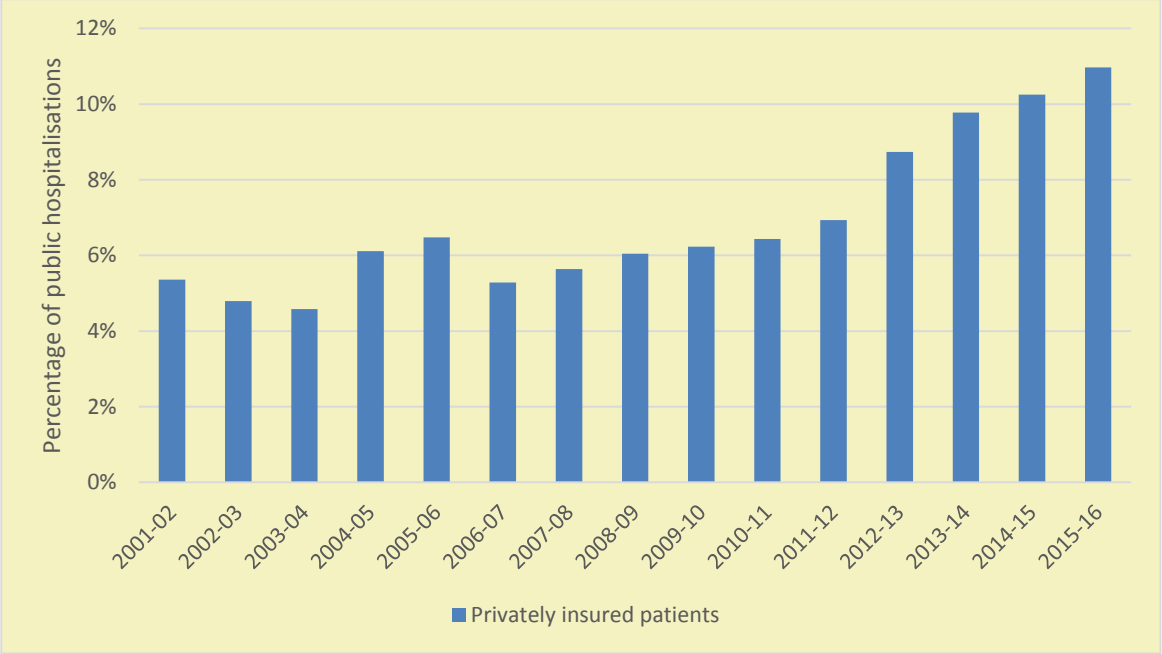
- Since the implementation of activity-based funding in 2012-13, Tasmania has experienced a lower annualised growth in the number of public hospital separations funded by private health insurance (9.7%) than the three years immediately preceding the agreement (10.6%).

- There is no uniform private patient adjustment in the Tasmanian activity based funding model – it funds on a gross basis with revenue targets. This means that Tasmania Health Organisations (THOs) receive the same amount of funding for a private and public patient, without compensating adjustments; a clear incentives for the THOs to target private patients (EY 2017:23).

- There are also stated private patient revenue targets (EY 2017:23).

Australian Capital Territory

In the Australian Capital Territory (ACT), there were 11,857 public hospitalisations where private health insurance was listed as the primary funding source in 2015-16. This was 11.0% of all public hospitalisations. Privately insured patients as a proportion of public hospitalisations have been steadily increasing since 2010-11 (Figure 12).



Note: data for ACT were included in NSW data prior to the Dec quarter 2009.
Source: AIHW 2003-2017.

Figure 10: Privately insured patients as a proportion of public hospitalisations in the Australian Capital Territory, 2001-02 to 2015-16

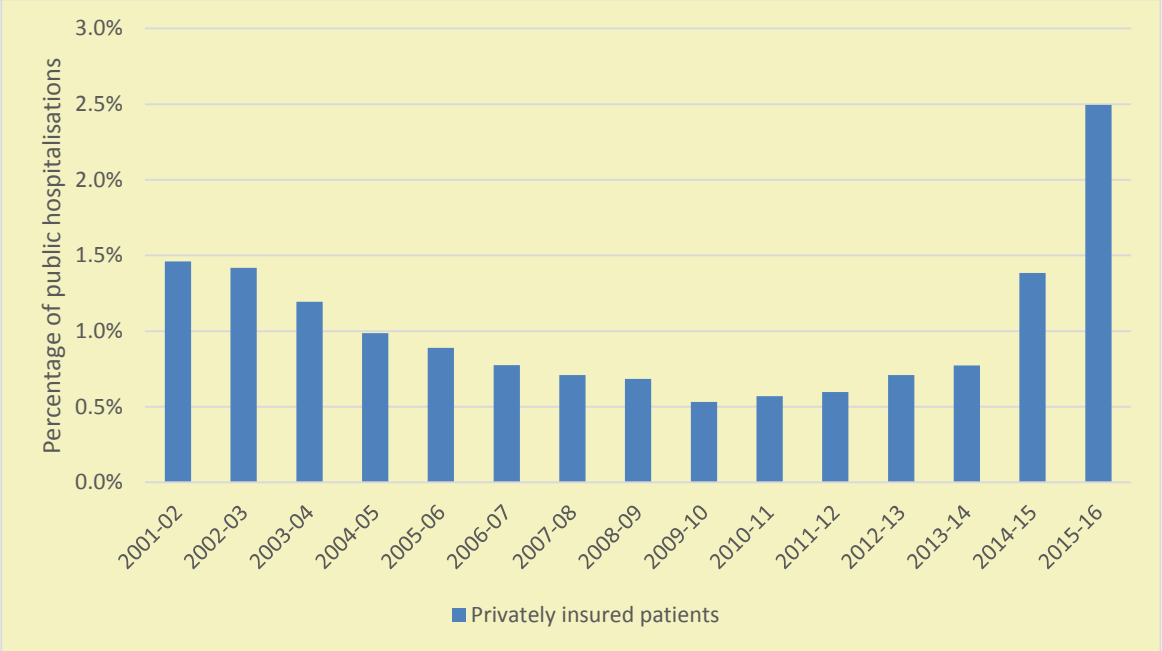
- Since the implementation of activity-based funding in 2012-13, the ACT has experienced a higher annualised growth in the number of public hospital separations funded by private health insurance (15.3%) than the three years immediately preceding the agreement (7.7%).

- The ACT activity-based funding model fully incorporates private patient accommodation adjustments and DRG specific private patient service adjustments (EY 2017:24). In theory, there should not be incentives to chase private patients.

- There was no evidence of private patient targets.

Northern Territory

There are very few private patients in public hospitals in the Northern Territory (NT): only 3,704 in 2015-16. This is due to lower uptake of private health insurance in the Northern Territory. The very large increase in private in public must be viewed from the very low base – so although numbers have almost quadrupled between 2013-14 and 2015-16, privately insured patients are still only 2.5% of all public hospitalisations in the Northern Territory (Figure 13).



Source: AIHW 2003-2017.

Figure 11: Privately insured patients as a proportion of public hospitalisations in the Northern Territory, 2001-02 to 2015-16

- Since the implementation of activity-based funding in 2012-13, the Northern Territory has experienced a considerably higher annualised growth in the number of public hospital separations funded by private insurance (43.1%) than the three years immediately preceding the agreement (2.3%).
- The technical specifications of the NT activity-based funding model are not available, so it is unknown if private patient adjustments are applied.
- No private patient targets are identified by the NT government.

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