Australian
Private Hospitals
Association

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

Dear James

Re: Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22 – Private Patients in Public Hospitals

Thank you for the opportunity to comment on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22. In principle APHA supports the proposed change to the IHPA Guidelines to reflect the requirements of the Addendum to the 2020-25 National Health Reform Agreement signed by The Prime Minister and Premiers/Chief Ministers:

> '*ABF pricing should ensure that there is funding neutrality for the service provider for treating a person who elects to be treated as a private or a public patient in a public hospital*'.

We note however the Agreement refers not only to 'funding neutrality' but 'payment parity' which we take to mean that the actual payments received from both State and Commonwealth sources should not result in a higher level of income when a patient is treated on a private basis. This point is significant in light of the findings in the report done by EY and Associates for IHPA which found that some States did not adjust their funding to take account of the income derived from the treatment of private patients.

The consultation paper notes that Clause A44 of the Addendum specifies that in determining the cost weight for private patients, IHPA will adjust the price to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction. This takes into account all hospital private patient revenues. The consultation paper notes that where adjustments are estimated before activity has taken place, the Commonwealth contribution will need to be reconciled based on actual revenue as data becomes available.

APHA is of the view that it is imperative that IHPA's adjustment process take account of all private patient revenues including:

- Payments from the MBS
- Payments from the PBS
- Payments from private health insurers for medical, prostheses, nursing/accommodation and ex gratia benefits
- Payment of any patient out of pocket changes including medical out-of-pocket charges, charges for services not covered by private health insurance and excess charges associated with the patient's private health insurance policy.
- Revenues received from the State.

It is also important to take account of charges made for the treatment of private patients even when these charges have not been paid. It has been common for public hospitals to offer to waive excess charges and other out-of-pocket charges in order to induce patients to elect to be treated as

a private patient. Sometimes public hospitals carry bad debts if patients do not pay their excess charges or out of pocket costs. APHA does not regard it as being in the spirit of the agreement, for such waived charges or bad debts to be excluded from the calculation of private patient revenue. To do so would mean that the Commonwealth was subsidizing private patients even though liability for excess charges is a choice made by consumers when they purchase private health insurance.

Failure to take excess and out-of-pocket charges into account would also excuse public hospitals from their obligation to fully obtain informed financial consent. It is important to note that the Addendum places added emphasis on the importance of ensuring that patients are fully aware of their options, including the option to be treated as a public patient, and fully aware of their financial liabilities when electing to be treated as a private patient.

APHA welcomes the decision to require an additional data collection to be established to ensure all hospital revenues are captured and to reconcile this information with a complete Hospital Casemix Protocol (HCP) data set. It is important that all revenues are captured including benefits paid to and retained by treating clinicians, revenues paid into trust accounts, revenues retained at hospital/health district level and revenues accrued by the State.

APHA notes that any adjustments will be back-cast. This means that States/Territories which increase the quantum of private patient services during 2020-21 will not be penalised for maintaining that level of activity in future years. They will only lose the incentive for further growth after 30 June 2021. At the very least the evaluation of the Agreement should include analysis of trends from 1 July 2020 to establish whether States/Territories have deliberately sought to put themselves in an advantageous position ahead of the removal of incentives.

Yours sincerely

Michael Roff
CHIEF EXECUTIVE OFFICER
16 October 2020