Private Healthcare Australia
Better Cover. Better Access. Better Care.

Private health reform options

January 2025

Contact:

Ben Harris – Director Policy and Research

0418 110 863

ben.harris@pha.org.au

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have more than 20 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 14.7 million Australians.

Introduction

Like many sectors in the Australian economy, some private hospitals have had a hard four years. COVID shutdowns badly affected the sector and costs are increasing.

The Government's Private Hospital Sector Financial Health Check estimated the sector's weighted average EBITDA margin was between 7% and 8% in 2022-23 – lower than the previous decade's large profits, but still significantly higher than most health funds' profits.

Between 2020 and 2024, health funds returned more than $4.5 billion to members as patients could not access some health services. This honoured the sector's commitment not to profit from lower claims during the pandemic. Over the same period, the Commonwealth Government provided more than $1 billion in additional subsidies to private hospitals due to the drop off in activity.

Demand for private hospital services is increasing after a pandemic slump that lasted longer than expected. In the year to September 2024, Australian Prudential Regulation Authority data shows health funds paid 7.5% more for hospital services compared to the previous year. The market is returning to expected levels of activity, but hospitals are grappling with inflation, and consumers are struggling with cost-of-living pressures.

The real challenge now is figuring out how to provide services in areas of undersupply where many specialist doctors don't want to work and introducing the right incentives to support more home-based care in response to improving technology and patient demand. This needs to be worked through carefully to maintain the sustainability and affordability of private health insurance and private healthcare into the future as our population continues to age with more chronic disease.

The Government has asked a CEO Forum to consider a range of targets for potential reform. PHA welcomes the opportunity to comment on the private health reform options presented in the discussion paper of 7 January 2025. In addition, we have highlighted additional initiatives, which should be considered in the short term to improve hospital viability.

PHA notes the short-term reform options outlined in the paper have been identified through recent engagement with the private health sector. The Department of Health and Aged Care claims the suggestions have been raised on the basis "they can contribute to alleviating financial pressures on private hospitals and improve the value of private health insurance without putting pressure on policyholders' premiums." However, no data or modelling has been supplied to demonstrate these proposals will not cause premiums to increase.

It is clear to health funds that many of the proposals will increase the cost of health insurance premiums. This response paper will outline why this is the case with supporting data. Many consumers are struggling with cost-of-living issues, so increasing premiums more than needed will put unnecessary pressure on household budgets.

However, there are options for several of these proposals that can, and should, be progressed with a sharper focus on consumer needs, efficiencies and cost-savings. These options are presented below.

PHA has already provided substantial feedback on three of the options presented, with policy papers attached on default benefits, out-of-hospital care, and risk equalisation. We are happy to work with the Australian Government by providing modelling, access to industry experts, actuaries and economists to ensure any decisions made are in the best interests of the community, rather than the vested interests of others.

Reforms must enhance competition and innovation and we cannot fall into the trap of guaranteeing the survival of every participant in the sector, particularly if they are unable or unwilling to adjust their business models to meet consumer needs in a changing world.

Our focus remains squarely on our 15 million members and their need for a strong, viable, high-quality and efficient hospital sector. Independent market research continues to identify premium affordability and medical out-of-pocket costs as the top concerns for consumers using the private health system. Addressing these issues is our priority. If the Government or other stakeholders want to use private health funding to address other issues, this should at the very least be done on the basis of properly conducted consumer research to ensure the public interest is being prioritised.

If the reform process leads to upward pressure on premiums this must be offset by claims savings elsewhere to protect consumers from increasing costs. PHA will hold the Government accountable for this.

2.1 Second-Tier Default Benefits

Private Healthcare Australia has published a policy paper outlining the problem with default benefits (attachment one).

Default benefits for hospitals are a policy failure. Designed in the 1990s as a political fix when vastly different market dynamics applied, the policy is no longer serving its intended purpose of safeguarding access and choice for consumers. Nor is it supporting smaller hospitals and those in under-serviced areas, including Australia's rural, remote and regional areas where more healthcare options are needed.

Instead, the default benefits policy has become a hospital subsidy program, particularly for small day hospitals in over-serviced, wealthy urban areas. For example, the current settings provide higher subsidies in affluent northern Sydney than in northern Tasmania, the northern fringe suburbs of Adelaide, and the Northern Territory.

Hospital default benefits are also linked to higher out-of-pocket costs for consumers, with a small number of hospitals eschewing health fund contracts, pocketing the second-tier benefit and charging very high out-of-pocket costs, double-dipping through default benefits and patient contributions.

The current default benefit policy also supports poor care in shoddy facilities. Some of the day hospitals attracting second-tier default benefits include cosmetic surgery clinics facing class actions over alleged medical negligence affecting hundreds of patients.

Volume weighting of contracted services to determine each insurer's second-tier default benefit schedules

Any changes to the calculation methodology that increases second-tier default benefits will increase costs to consumers without any additional benefit in terms of access or quality. It is a simple wealth transfer from consumers to private hospitals and should not be considered without corresponding changes that provide benefits to consumers.

PHA recommends that, should the government consider this revised approach, an appropriate trade off to benefit consumers would be:

- ensuring any hospital claiming second-tier default benefits is not able to charge consumers out-of-pocket costs above a prescribed rate, and
- default benefits to be standardised at a consistent dollar rate rather than according to a percentage that varies by location.

The existing second-tier default benefit is a floor price, but there is no ceiling. With most services now contracted between insurers and hospitals, services attracting second-tier default benefits have some of the largest out-of-pocket costs in the nation. It is unfair to consumers, health funds and contracting hospitals that non-contracting hospitals have a high floor price with no limits on what they can charge consumers

PHA recommends that to access second-tier default benefits, providers should be required to sign an undertaking that stipulates services receiving default benefits are prohibited from charging more than 100% of the reference price. There is a legislative precedent; prior to 2015,

Medicare only paid benefits for services provided by 'participating' optometrists who had signed a Common Form of Undertaking for Participating Optometrists with the Australian Government. The optometry Common Form of Undertaking required that optometrists charge no more than the Medicare Benefits Schedule standard fee. This model could easily be adopted for default benefits.

It is extraordinary that the floor price set by default benefits is higher in North Sydney than it is in northern Tasmania or the Northern Territory. It is untenable that default benefits can be higher in overserviced states than underserviced states. This is entirely unfair and based on hospital location rather than consumer need. The existing percentage-based default benefit varying by location should be removed, and a dollar figure based on the lowest quartile of existing second tier rates should replace it so it is set as a national rate (subject to a rural loading, see below). This national rate would be determined by the Department of Health and Aged Care based on every fund's contractual rates.

There is no case for a second-tier benefit based on other contracts, as this fuels health inflation. Once these new rates are set by the Department, they should automatically increase each year by the Consumer Price Index, or the average rate of health fund premium increases, whichever is the lower.

Increase the second-tier default benefits payable to established non-metropolitan hospitals

PHA recommends abolishing default benefits, as outlined in our policy paper (attachment one).

Simply increasing the default benefits payable to non-metropolitan hospitals will not help promote services in country areas. This policy change, if implemented, must be targeted to address market failures in thin markets. This will require both an increase in default rates for country areas and a decrease in oversaturated markets.

PHA recommends that, should the government consider this revised approach, an appropriate trade off that would provide a consumer benefit would be:

- increasing default benefits in underserviced country areas to the equivalent of 90-95% while reducing default benefits in overserviced urban areas to 75%, and
- not allowing new services to attract second-tier default benefits in over-serviced areas (grandparenting existing services).

The first consumer benefit proposal is to increase the default benefit rate in underserviced rural and remote areas with a corresponding decrease in overserviced urban areas. As outlined in the previous section, PHA recommends that the current floating rates based on other contracts be replaced by a national dollar rate. Once that rate is established, urban hospitals in MMA1 or MMA2 should have a second-tier default rate of 75% (or 80% if the DoHAC Secretary declares the location an area of undersupply), while rural and remote areas should have a second-tier default rate of 95% (or 90% if the Secretary nominates a location as having an adequate supply of private hospital services).

Simply increasing the default rate in the country, while leaving it the same in the city, will be inflationary and maintain the imbalance of supply as providers are still likely to prefer city

locations. Increasing the rate in the country and decreasing it in the city provides a significant incentive to establish new services in underservices country areas.

The data clearly shows that default benefit arrangements are used overwhelmingly in overserviced areas (see PHA policy paper, p5 and EY consultation paper, p14). Those most reliant on default benefits are those who have not chosen to, or been unable to come to, a contractual arrangement with a health fund. In many cases, these providers have not been able to demonstrate value to consumers and should not be subsidised.

PHA recommends the maximum rate for default benefits in rural and remote areas be set at 95%. Setting it at 100% provides no incentive for contracting, and the additional consumer benefits funds can secure for their members through contracting.

The second consumer benefit proposal is not allowing any new licensed hospital or service in an urban area (MMA1 or MMA2) access to default benefits unless the Secretary is satisfied the new hospital or service materially improves access for consumers to services that are currently not available in that location.

For example, a new hospital competing with another hospital for commonly available hospital treatments would not be eligible for second-tier benefits. A new hospital (or new service within an existing hospital) would not be eligible for second-tier benefits if those services were already available in the local area. Improving access can include more modernising models of care (for example, a short stay orthopaedic model) or a service that provides no-gap medical services. We need to continue to encourage the right types of service models, rather than protect incumbents (or those providing similar services) from competition.

PHA does not, however, recommend grandparenting in country locations. We need to do everything we can to encourage more service providers in the country, so adding legislative barriers would not be appropriate.

PHA's proposal would prevent the proliferation of hospitals in already crowded markets, which spreads the health fund dollar too thinly, while incentivising providers to offer services in currently underserved areas such as regional communities.

2.2 Payment terms and administrative costs

Health funds are deeply frustrated by administrative costs. While recognising that many in the industry run efficient operations, it is imperative that hospitals bill funds correctly the first time, so funds can pay them in the first instance. The overwhelming payment delays are caused by poor or inefficient billing practices. One fund reports that audits are uncovering coding error rates of up to 40%. This error rate is unacceptable.

Further, there is substantial commercial value captured for both parties in contractual terms, with variations a significant source of trade-offs in HPPA negotiations over multiple cycles. Any move toward more standardised terms would harm the value created by trading off contract terms. These can include administrative arrangements, quality incentives, transparency and simple payment terms.

Any interference with these commercial arrangements would need to be carefully managed with long transition timing, phased in line with contract renewal cycles.

Implementing a moratorium on private hospitals' benefit claims that remain unpaid by private health insurers, which have exceeded a reasonable payment period (e.g. 45 business days)

The onus needs to be on hospitals to bill correctly. Funds would appreciate if this was done within 45 days, but a one-sided approach is not acceptable. Funds will continue to insist on correct billing, record keeping and administrative efficiency.

As a principle, if hospitals had efficient billing processes and complied with a service level of providing the required information within a certain timeline, at a certain quality, payment would occur within a reasonable time. However, part of the challenge is that some hospitals drip-feed information to funds and expect immediate payment, even though it has taken an inordinate amount of time for the fund to receive the correct billing information.

In addition, member funds report some hospitals continue to use manual claiming processes that are highly inefficient and unnecessary when there are commercial electronic claiming solutions available that could assist hospitals and funds to build more efficient payment systems. One medium-sized fund reports that last financial year it processed more than 31,000 manual (or paper-based) claims from hospitals. Paper claims require many manual touchpoints, which adds significantly to administrative costs. Processing those claims took approximately 3,645 business hours of work across a single year.

It is also worth noting that payment issues are far from one-sided. In instances where overpayment is made by a health fund, it is not uncommon for hospitals to take months to return funds owed to insurers, which is hardly within a reasonable timeframe.

PHA recommends that health funds and hospitals continue to manage billing issues through contract terms, rather than asking the government to intervene. Funds and hospitals include a range of payment terms in their contracts, to help both businesses manage cash flow. While some of these arrangements include 45-day payment terms, others use different time periods.

Time limits on post payment audit processes initiated by the insurer

Health funds are custodians of consumers' money and would object to any waiving of fraud, overpayments or other results of post payment audit processes.

The Australian Government may be happy to waive any wrongdoing from hospital providers, but they should not impose that on health fund customers.

Should the government legislate a two-year time limit, recognising this may condone fraud, funds would also expect a reciprocal arrangement where hospitals or doctors could not claim monies from customers or health funds after a similar period.

Standardising administrative, reporting and compliance contract terms in Hospital Purchaser Provider Agreements

PHA has no objection to working towards a common language for contract terms. But we are unclear how this could be achieved within the Australian Competition Law. PHA would appreciate legal advice from the Commonwealth on progressing this initiative.

PHA would not agree to standard contract terms, which would limit the ability of health funds to promote quality, safety and reporting requirements through contracting. Many hospitals and health funds agree to a range of consumer benefits with quality and transparency mechanisms.

If standard contract terms promoted a lowest common denominator approach to quality, safety and transparency, this would be a step backwards for the industry.

One area where adjusting terms of payment would benefit both hospitals and consumers, however, would be reimbursement for medical devices. There are a significant number of disputes with medical device reimbursement, as some suppliers seek to maximise their revenue. Hospitals are caught in the middle, as device companies demand payment prior to the hospital receiving the rebates. Where there is a dispute, hospitals are generally out-of-pocket.

In one recent example, a device company started charging two components of a device that was listed in the Prescribed List as a "system" or "kit". Previously, that company charged one unit per procedure and all other suppliers charge one unit per procedure for similar devices. When the company decided to charge twice per procedure, health funds pointed out the error and refused to pay twice as much as previously. Unfortunately, hospitals had already paid for the devices and were, therefore, out-of-pocket.

PHA recommends that the *Health Insurance Rules* be amended to ensure that hospitals only need to pay device companies for items on the Prescribed List once they have received reimbursement from the patient or their health fund. The Rules should allow hospitals and device companies to come to alternate arrangements by agreement only.

2.3 Hospital in the Home

In 2023, PHA released a paper, *There's no place like home*, which highlighted the need for reform to promote out-of-hospital care (see attachment two). Following this, the Australian Medical Association also drew attention to the issue with the publication of *Out-of-hospital models of care in the private health system*, which noted: "For some patients, out-of-hospital care can deliver the same outcomes as in-hospital care while also providing patients with other benefits such as the ability to recover in the comfort of home."

Australia is falling behind global best practice because of the limited accessibility of out-of-hospital care. Australian patients are not receiving healthcare supported by the best available evidence. Doctors are unable to support the most effective and innovative models of care because our system does not support them to provide best practice.

Our health financing system was designed in the 20th Century, yet we are dealing with 21st Century health problems. Demand for Australia's healthcare system is growing at an unsustainable rate, driven by the dual burdens of a rapidly ageing population and the growing prevalence of chronic disease. This unsustainable growth is placing pressure on access to care and healthcare costs, especially for patients bearing out-of-pocket costs, and taxpayers more broadly.

We are not rising to the challenge. Australia's private healthcare system is leaving $1.3bn of potential efficiency on the table by lagging well behind other countries in the uptake of out-of-hospital care models. For many patients, out-of-hospital care is not just safe, high quality and clinically proven, it is the best possible care.

We have not developed these alternatives to cost-intensive inpatient care due to incentive structures and regulation that impede their growth. Increasing adoption of these models of care will provide better care with less burden of treatment, reduce the load upon 'bricks and mortar' hospitals, and reduce wait times and care bottlenecks. Adopting best practice care, including out-of-hospital options, will also reduce growth in private health insurance premiums and out-of-pocket costs, supporting overall access and affordability of care for patients.

We need to:

- address misalignment of incentives in existing funding models
- enable sufficient supply of out-of-hospital care providers to improve consumer access at scale
- enable increased uptake through better use of data and technology, and
- standardise quality and safety of out-of-hospital care models.

Minimum level of funding for mandated out-of-hospital care programs

The first issue with this proposal is that there is a dearth of well-established programs with clinical guidelines. The first task must be to develop guidelines for agreed clinical areas where out-of-hospital care is appropriate. This requires clinical leadership, with the medical profession providing advice on modern best practice. This should be informed by, but not led by, health funds, hospitals and other out-of-hospital care providers.

Clinical areas that would benefit from early work on guidelines include services which are predominantly provided out of hospital in other jurisdictions (such as rehabilitation and some cancer treatment) and services which are inadequately managed in hospital (such as palliative care). While provider preferences are important, improving access to care for consumers should be a high priority.

Minimum default benefits for out-of-hospital care are favoured by providers because they superficially provide certainty, but this is a bad option for consumers. Experience with second-tier default benefits for inpatient care has proven such approaches are cost inflationary, stifle innovation and promote low-value care. This approach will inflate premiums. In the out-of-hospital setting, application of blanket minimum default benefits would also reduce the scope for funds and other stakeholders to effectively monitor the quality of such services. The government need only look at the experience of minimum benefits in the National Disability Insurance Scheme, which has seen the proliferation of poor-quality care, fraud and mismanagement.

2.4 Mental health

PHA supports any efforts to improve access to mental health professionals across the community. We have been advocating for nurse practitioners, mental health nurses and primary care nurses to be able to provide services through Chronic Disease Management Programs, and we would welcome the Government's prompt action to change the Rules to allow greater access to out-of-hospital care for patients.

Increasing the supply of internationally educated psychiatrists able to admit patients to private mental health hospitals

All health professionals providing services in private mental health hospitals need to be well trained, and well supervised where necessary. PHA defers to the learned medical colleges on standards and training for medical practitioners. We support efforts to improve access to care through targeted migration of doctors, nurses and other mental health professionals.

International medical graduates and other migrating health professionals need to be well supported, not only for their clinical needs, but for guidance on the Australian health system, Medicare, private health insurance and other professional matters.

In addition, PHA recommends the Government allow Nurse Practitioners to admit and treat patients in private hospitals, as per our position paper in November 2024. This would also increase the number of practitioners available to work in private mental health facilities.

2.5 Maternity Care

The costs of having a baby in the private system are becoming prohibitive. Further, the decline in birth rates is putting pressure on providers with several maternity facilities struggling with lower demand. This leads to higher cost structures with higher out-of-pocket costs, and the potential for a spiral, which threatens private maternity care in several places across the nation.

The most common complaint of new parents in the private system is high and unknown out-of-pocket costs. Consumer research reveals 43% of families with private health insurance cite out-of-pocket costs as the reason for not choosing a private hospital for childbirth.[1] From initial and follow up consultations, scans, pathology, hospital birthing services, anaesthetists, paediatricians and midwives, there are many opportunities for consumers to be slugged with significant out-of-pocket costs. Many of these costs are not disclosed to the expectant parent/s at the beginning of the episode of care. Despite this, many people feel powerless to challenge these unexpected costs.

In a cost-of-living crisis with a declining birth rate, any attempt to unilaterally adjust private health insurance to promote maternity care without addressing the out-of-pocket costs for pregnancy management will be a complete failure.

New models of care can shift private maternity care to a more sustainable path with improved outcomes at lower costs. PHA supports the Scope of Practice Review: Unleashing the potential of our health workforce recommendation to introduce a bundled payment for maternity services (rec 11.1). The report "supports a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and private hospital settings".

Simply changing the product tiering for pregnancy and birth services will not address these core issues and will increase the costs of Silver and Bronze insurance products for millions of Australians.

Should the clinical category of 'Pregnancy and birth' be a mandatory inclusion in another product tier(s)?

Expanding existing maternity coverage from Gold to Silver and Bronze would create enormous upward pressure on premiums and wreck affordability and access for consumers to all forms of private health care.

Modelling undertaken on behalf of PHA suggests that adding in-hospital maternity care to other clinical categories would increase the cost of premiums for these tiers by 6.5% on average (attachment three). Silver policies would increase by 3.5% and Bronze by 13.3%.

In a community-rated system such as Australia's, these price increases would be catastrophic for the sector. Modelling shows an estimated 580,000 people would drop their private health insurance, which would further increase prices with a smaller pool of contributors, and place enormous pressure on public hospitals.

[1] IPSOS, Health Care and Insurance Australia (2023) Report 4, pp 83-88.

Should ‘Assisted reproductive services’ and ‘Miscarriage and termination of pregnancy’ be included in the same product tier(s) as ‘Pregnancy and birth’ or remain in the currently assigned product tier?

PHA does not recommend changing the product tiers for these clinical categories.

Services to assist with miscarriage and termination of pregnancy should continue to be widely available.

Assisted reproductive services are likely to be planned. Having these services available in lower priced categories will significantly increase the prices of Silver and Bronze insurance products for consumers.

2.6 Changes to Risk Equalisation arrangements

The Australian Government began work on changing risk equalisation arrangements in 2022, but this work has not progressed substantially since PHA published our submission in December 2022 (attachment four).

We made a range of recommendations to improve risk equalisation, recognising that tweaks to risk equalisation shift the cost burden among consumers rather than decrease that cost burden.

PHA outlined a range of principles for changes to risk equalisation arrangements, and government is yet to publish the results of further modelling.

Change the Risk Equalisation regime to equalise some or all of the benefits insurers pay for mental health and maternity care

PHA recommended in our 2022 submission that mental health and maternity care be included in the modelling for changes to risk equalisation arrangements, and our position has not changed.

However, we did ask that the government model the effects of such changes, and if implemented, put in place guard rails with limits on net claims changes over 3% per annum to ensure changes do not overly affect funds' operations.

PHA also recommended other changes, including a prospective model and allowing prevention initiatives to be included in the pool. These proposals will increase the incentives for health funds to promote better health care to their customers, with consumer benefits over time. PHA would be concerned if short term changes to maternity and obstetrics coverage came at the expense of more substantive changes with greater consumer benefit.

More details are available in the attachment.

3. Other areas to improve hospital viability

Real improvements for consumers' premiums and private hospital viability will only occur with real reductions in costs and/or improved efficiency. Four suggestions are highlighted below, which could be immediately implemented to improve hospital viability.

Nurse practitioners

PHA recommends the Government allow Nurse Practitioners to admit and treat patients in private hospitals, as per our position paper in November 2024. This would reduce costs for private hospitals as it would increase the available workforce. The Australian College of Nurse Practitioners and the Australian Private Hospitals Association have also backed this change.

The proposal is also consistent with other government policy directions, including Strengthening Medicare, and Scope of Practice changes.

Bed block

PHA recommends a roundtable of all Australian governments, private health insurers, private hospitals and aged care providers to help find solutions to aged care type patients remaining in hospital and causing 'bed block.' This would focus on out-of-hospital care, and affordable models and address an increasing problem for private and public hospitals. With an ageing population this is becoming a serious and intractable issue across the whole sector, not just for public hospitals. One single health insurance claim for an elderly patient awaiting discharge to an aged care facility came to a staggering $753,362 in 2024.

A strategic solution is required which involves engagement by all Australian governments with the private health and aged care sectors. PHA is prepared to commit resources to this.

Medical device costs

Medical device prices in the private system are regulated by the Australian Government and set at rates 7-100% higher than in public hospitals, 30% higher than in New Zealand, and more than double the prices in Germany. As recently highlighted in the report *Australia's surgical surcharge: How Australians are paying too much for medical devices through the prescribed list of medical devices*, health funds could reduce premiums for consumers if Australia had a more competitive pricing system for medical devices. PHA recommends the government immediately reduce the cost of medical devices to that of the public sector to make health insurance more affordable and to support private hospitals.

Where there is currently a 7-20% surcharge on private patients for medical devices (other than cardiac devices, where the surcharge is much higher), a short-term approach could be for this surcharge to be provided to hospitals rather than device companies. This would transfer around $84-120 million to private hospitals in 2025-26. Hospitals could then negotiate with suppliers to determine what additional services are required, rather than medical device companies pocketing the money with no requirement for additional services. Where these services are of value to the hospital, they will pay for them, and if they are not of value, hospitals can keep the funds to assist with their viability.

Adopting this measure immediately could be used to offset proposed reforms that will have an inflationary impact on premiums.

Private patients in public hospitals

Every Australian has the right to be treated as a private patient in a public hospital. Patients may opt to do this for choice of doctor or a single room if there's one available, but they should not be coerced into doing so.

Free public hospital care is a fundamental tenet of Medicare. However, there is a well-established practice in the public system to 'encourage' patients to use their insurance in public hospitals to boost government revenue.

Public hospitals make promises not to charge patients electing to be treated privately for "hospital generated accounts", nominating accommodation, devices, diagnostics and staff specialists. There is no guarantee that other charges won't be levied, and they often are.

There has been growing concern about the trend to increase private patient admissions in public hospitals. This practice was called out in the Mid-Term Review of the National Healthcare Reform Agreements conducted by Rosemary Huxtable last year. She said:

> *Some LHNs [local health networks] see private health insurance (PHI) income as an important source of own source revenue, potentially at the expense of public patient admissions. Instances were noted of patients feeling pressured to use their private insurance following an admission from the ED and/or public hospital stay, and then facing out-of-pocket costs. The extent of those costs was not always clear at the point of private patient election.*

PHA recommends the Australian Government require public hospitals to immediately update admission information provided to patients to ensure it is clear and accurate. Proper informed financial consent should give patients one of three options to consider when making their choice to become a private patient:

- They will not be charged any out-of-pocket costs,
- The hospital cannot guarantee they will not be charged out-of-pocket costs, or
- They will be charged out-of-pocket costs, and the full amount of those costs.

Should private patients in public hospitals feel they have not received the services promised, and/or have any additional charges they did not expect, these patients should be able to revoke their election and be treated as a public patient.