



Independent Hospital Pricing Authority

Submission to the Senate Community Affairs References Committee inquiry into the value and affordability of private health insurance and out-of-pocket medical costs

IHPA is an independent agency established under Commonwealth legislation as part of the National Health Reform Act 2011.

IHPA was established under the National Health Reform Agreement to contribute to significant reforms to improve Australian public hospitals. The Agreement aimed to improve patient access to public hospital services and public hospital efficiency. A major component of this was a new way of funding public hospitals to ensure increased efficiency and more transparency with the implementation of national activity based funding (ABF) for Australian public hospitals.

Since 2011 IHPA has overseen the implementation of national ABF and has published an annual National Efficient Price Determination for Australian public hospital services. The National Efficient Price provides a price signal or benchmark for the efficient cost of providing public hospital services and has increased the transparency in costs of delivering public hospital services.

Setting the NEP for private patients in public hospitals

The terms of the National Health Reform agreement dictate that IHPA must determine a price for private patients treated in public hospitals, taking into account the other revenue streams available for these services, such as Commonwealth Medical Benefits Schedule (MBS) payments and payments made by private health insurers on behalf of patients, including for prostheses and accommodation charges.

IHPA does this using data on actual benefits paid to patients, sourced from the Hospital Casemix Protocol, collected by the Commonwealth Department of Health, as well as cost data submitted to IHPA by states and territories.

IHPA's methodology for setting the NEP for private patients in public hospitals seeks to ensure that the price paid for a public or private patient are equivalent once other revenue sources are taken into account.

There is some evidence that funding policies in some jurisdictions provide significant incentive to both hospitals and patients. This is detailed to some extent in the report *Private Patient Public Hospital Service Utilisation*, commissioned by IHPA in late 2016 (Attachment A).

National Hospital Cost Data Collection

The system of ABF is predicated on a large, robust set of national activity and cost data that accurately captures the types and costs of services provided at hospitals across Australia. Cost data is collected through the National Hospital Cost Data Collection (NHCDC) from both public and private hospitals in two separate collections.

The public sector NHCDC, collected through the states and territories, is the primary data collection used to determine the National Efficient Price. The public NHCDC is collected across all service streams and captures more than 90 per cent of acute admitted hospital activity. To ensure consistency in the costing process, IHPA works with stakeholders to develop and implement a national set of costing standards, the Australian Hospital Patient Costing Standards. Costs are collected at the patient or 'product' level providing detail of costs facing the Australian public hospital system. This data undergoes validation and quality assurance checks prior to use in calculating the National Efficient Price including an annual independent financial review, to ensure the data is fit for use.

The private sector NHCDC is a voluntary collection that produces a range of hospital cost and activity information on overnight acute admitted care episodes at private hospitals. The Round 18 2013-14 private sector NHCDC contains data on 60 per cent of in-scope separations. The high level of participation by private hospitals in the NHCDC ensures that the resulting data set is robust and reliable. IHPA has confidentiality arrangements with participating private hospitals to formally recognise that this data is treated as confidential. As with the public sector NHCDC, the detailed nature of the collection provides significant insight into the costs facing private hospitals in Australia.

IHPA would be pleased to provide further assistance to the Committee as appropriate.

Private Patient Public Hospital Service Utilisation

Independent Hospital Pricing
Authority

Final Report
2 March 2017

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The results of Ernst & Young's work, including the assumptions and qualifications made in preparing the report, are set out in the enclosed Report ("Report"). You should read the Report in its entirety including the applicable scope of our work and any limitations. A reference to the Report includes any part of the Report. No further work has been undertaken by Ernst & Young since the date of the Report to update it.

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2 March 2017

Dear James

We are pleased to present our report on the private patient utilisation of public hospital services.

During the period 16 September 2016 to 2 March 2017, Ernst & Young was engaged by the Independent Hospital Pricing Authority ("IHPA") to examine trends in the number of privately insured patients being treated in public hospitals and to examine factors contributing to observed trends in accordance with our engagement agreement dated 16 September 2016.

This report outlines the key findings and recommendations arising from this assessment, as well the work performed and approach. Consistent with our engagement agreement, our report has been completed solely for the benefit of the IHPA and Ernst & Young has not been engaged to act, and has not acted, as advisor to any other party. Accordingly, Ernst & Young makes no representations as to the appropriateness, accuracy or completeness of the report for any other party's purposes.

If you have any questions in regards to the content of this report, please do not hesitate to contact Tim Goodhew on 02 9248 4894 or myself on 02 8295 6103.

Yours sincerely

A handwritten signature in black ink, appearing to read 'C. Francis'.

Caitlin Francis
Partner
Health Advisory

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Glossary of Terms

Abbreviation	Description
ABF	Activity Based Funding
ACT	Australian Capital Territory
DHHS	Department of Health and Human Services (Victoria)
DRG	Diagnosis Related Group
ED	Emergency Department
HHSs	Hospital and Health Services
HSAP	Health Service Allocation Price
IHPA	Independent Hospital Pricing Authority
LHD	Local Health District
LHN	Local Health Network
MBS	Medicare Benefits Schedule
NEC	National Efficient Cost
NEP	National Efficient Price
NHRA	National Health Reform Agreement
NSW	New South Wales
NT	Northern Territory
NWAU	National Weighted Activity Unit
OSR	Own Sourced Revenue
PAC	Projected Average Cost
PBS	Pharmaceutical Benefits Scheme
PHIs	Private Health Insurers
PPAA	Private Patient Accommodation Adjustment
PPSA	Private Patient Service Adjustment
QLD	Queensland
QWAU	Queensland Weighted Activity Unit
SA	South Australia
SHN	Specialty Health Network
SLA	Service Level Agreement
TAS	Tasmania
THOs	Tasmanian Health Service Organisations
TWAU	Tasmanian Weighted Activity Units
VIC	Victoria
WA	Western Australia
WIES	Weighted Inlier Equivalent Separation

1. Executive summary

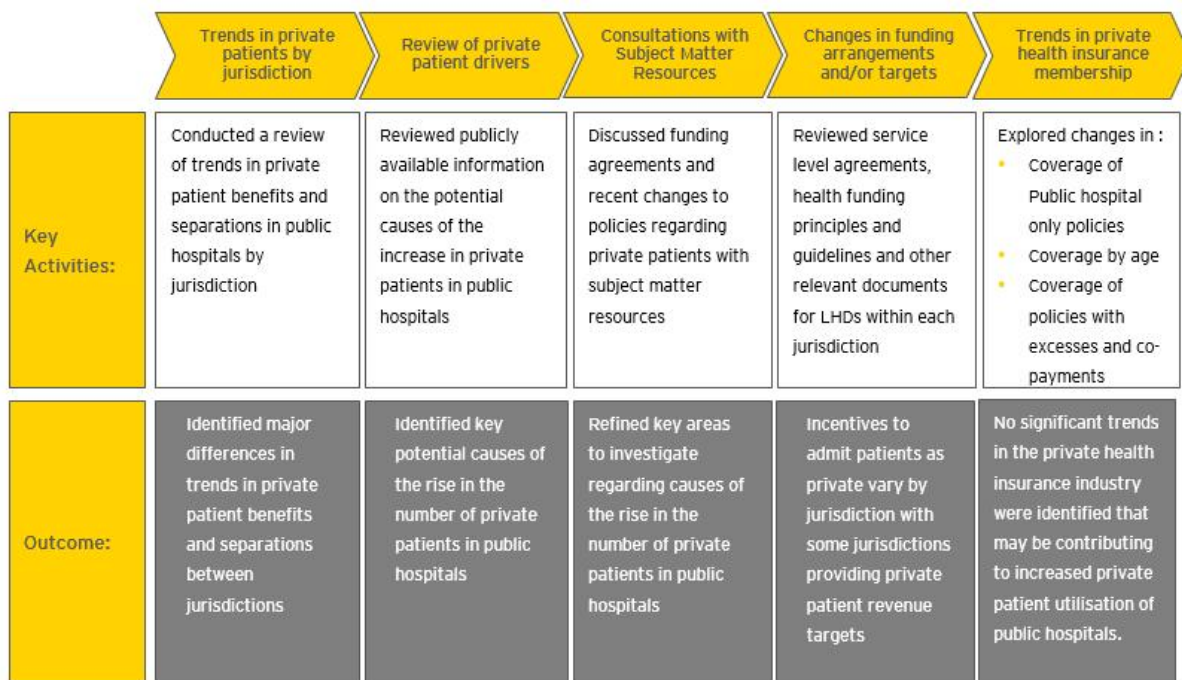
1.1 Background and scope

The Independent Hospital Pricing Authority (IHPA) engaged Ernst & Young (EY) to examine trends in the number of privately insured patients being treated in public hospitals and to identify factors contributing to observed trends to assess what impact, if any, the national ABF model has had in the utilisation of private health insurance by patients in public hospitals.

1.2 Approach

The findings outlined in this report are the result of an approach that combined a desktop review, qualitative analysis from consultations with EY’s State and Territory health leaders, and quantitative analysis of relevant private health insurance and public hospital data across each jurisdiction. An overview of the key activities and outputs for each phase are outlined in the figure below. For a detailed understanding of our approach, refer to Section 3 of this report.

Approach overview



The analysis and key findings set out in this report are reliant on the accuracy of the data sources utilised and limited in relation to the time and scope of EY’s engagement with IHPA. This report should be read within the context of the reliance and limitations detailed in Section 6.

1.3 Key findings

1. IHPA Pricing Framework 2015–16

- ▶ The Pricing Guidelines in the IHPA Pricing Framework 2015–16 outline the rationale behind the determination for a Private Patient Accommodation Adjustment and Private Patient Service Adjustment in the IHPA 2016–17 NEP Determination. At a national level, Commonwealth funding for ABF services for eligible private patients in public hospitals is discounted by these two adjustments in accordance with Clause A41 of the National Health Reform Agreement (NHRA).

2. State and Territory ABF Implementations

- ▶ New South Wales (NSW), Queensland (QLD), Western Australia (WA) and Tasmania (TAS) have implemented state-specific versions of the National ABF Model. They have localised or modified either the design of the funding model or the application of the model to the budget build up process and development of service level agreements (SLAs) between State and Territory governments and Local Health Networks (LHNs).¹ The SLAs do not include reductions to the funding provided to LHNs for private patients, creating an incentive for LHNs to target private patients.
- ▶ Victoria (VIC) has a unique state-specific implementation of ABF, with a different price set for public and private patients per WIES. This does provide some reduction for private patients to provide public-private neutrality in funding to LHNs. However, it cannot be determined if the differences in the state public and private price generate residual incentives or other unintended incentives, as they represent a less specific adjustment than those outlined within the IHPA National ABF framework (e.g. Private Patient Service Adjustment by DRG).
- ▶ South Australia (SA) applies the acute admitted model, including private patient adjustments as determined by the IHPA. However, there may be residual incentives or unintended outcomes for private patients receiving subacute or non-admitted care.
- ▶ The Australian Capital Territory (ACT) applies a full implementation of the IHPA National ABF Model. Therefore, on the assumption that IHPA National Private Patient Adjustments are fit for purpose to achieve price neutrality, the ACT implementation of ABF would also achieve public-private neutrality within the ACT.
- ▶ There was insufficient publicly available information on the ABF framework for the Northern Territory (NT) Department of Health to be able to conclude whether or not the use of private patient adjustments or funding mechanisms used promote public-private neutrality.
- ▶ Overall, analysis of State and Territory funding frameworks and service level agreements with LHNs identified evidence of private patient revenue targets in NSW, VIC, QLD, WA and TAS which may create incentives for public hospitals to increase the number of private patients. This may be contributing to recent increases in privately funded public hospital separations, as illustrated in the following table.

Proportion of public hospital separations funded by private health insurance by State and Territory, 2008-09 to 2014-15²

Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National
2008-09	15.8%	8.9%	4.0%	6.9%	8.4%	13.2%	6.5%	0.7%	9.7%
2009-10	17.1%	9.7%	4.5%	6.6%	8.2%	15.0%	6.6%	0.5%	10.4%
2010-11	17.2%	9.8%	5.7%	5.9%	7.4%	15.1%	6.8%	0.6%	10.5%
2011-12	17.2%	10.5%	8.3%	5.6%	7.2%	16.7%	7.4%	0.6%	11.1%
2012-13	19.0%	12.9%	10.6%	6.1%	7.6%	17.7%	9.2%	0.7%	13.0%
2013-14	20.0%	13.3%	11.7%	7.5%	8.2%	18.4%	10.3%	0.8%	13.9%
2014-15	20.7%	13.3%	12.1%	7.7%	8.1%	18.3%	10.8%	1.4%	14.1%
Growth from 2008-09 to 2014-15	4.9 percentage points	4.4 percentage points	8.1 percentage points	0.8 percentage points	-0.3 percentage points	5.1 percentage points	4.3 percentage points	0.7 percentage points	4.4 percentage points

¹ Local Health Networks are referred to as Local Health Districts in New South Wales and Health and Hospital Services in Queensland.

² Figures calculated from Australian Institute of Health and Welfare's *Admitted patient care: Australian hospital statistics*, from 2008-09 to 2014-15

3. Trends in private patients' utilisation of public hospitals by jurisdiction

- ▶ The number of separations in public hospitals funded by private health insurance has increased from 451,591 in 2008–09 to 814,702 in 2014–15 (i.e. an average increase of 10.3% per annum). This represents an increase of 4.4% in the proportion of public hospital separations funded by private health insurance over the same period (excluding self-funded, DVA, workers compensation, third party motor vehicle and other funding sources).
- ▶ There is considerable variation in the proportion of public hospital separations funded by private health insurance between jurisdictions from 2007–08 to 2014–15 with QLD (an 8.1% increase) and TAS (a 5.1% increase) experiencing larger growth.

4. Promotion of benefits to patients of private patient election

- ▶ A number of practices encouraging patients in public hospitals to elect to use their private health insurance have been identified, for example, job descriptions in advertisements for private patient liaison officer positions, and appeals to patients from hospitals on their websites about the savings provided to the hospital from patients electing to be treated as private patients.

For further details on the key findings and supporting research and analysis, refer to Section 4 of this report.

In summary, the desktop review of publicly available information on State and Territory ABF frameworks and service level agreements with LHNs has found sufficient evidence to conclude that the national ABF framework has not been a significant driver in the upward trend in privately funded public hospital separations. Meanwhile, it has been identified that certain features of the implementation of ABF by a number of jurisdictions indicate that the Private Patient Service Adjustment and/or Private Patient Service Adjustment as determined by IHPA has not been implemented. This creates residual system incentives for LHNs, and consequently public hospitals, to target privately insured patients, as LHNs and public hospitals can retain Own Sourced Revenue (including revenue from Private Health Insurers) without corresponding reductions to NHRA ABF funding. Additionally, evidence of private patient targets in selected jurisdictions and a focus on promoting the benefits of private patient election to patients in public hospitals suggests that State and Territory health funding policy parameters are contributing to the recent trend of increased privately funded public hospital separations.

2. Background and scope

2.1 Background

The Independent Hospital Pricing Authority (IHPA) is an independent government agency established by the Commonwealth Government in 2011 to contribute to reforms to improve Australia's public hospitals. IHPA provides advice in relation to funding for public hospitals, specifically the development of pricing frameworks and determining the National Efficient Price (NEP) and National Efficient Cost (NEC) for health care services provided by public hospitals.

In its 2016–17 Pricing Framework, the IHPA outlines a series of Pricing Guidelines that provide the justification for decisions made in relation to the National Activity Based Funding and Block Funding Cost Models (see Section 4.1 for further analysis of the Pricing Guidelines). This includes the rationale for specific adjustments determined that impact National Health Reform Agreement (NHRA) funding provided by the Commonwealth to jurisdictions for private patients in public hospitals through the national ABF framework.

In addition, the IHPA publishes technical specifications outlining the details of the ABF and Block Funding cost models and determination of Private Patient Adjustments set out in the NEP Determination. In the technical specifications, IHPA currently outlines two specific Private Patient Adjustments: the Private Patient Accommodation Adjustment which is a per diem amount by state; and the Private Patient Service Adjustment which varies by Diagnosis Related Group (DRG). The Private Patient Accommodation Adjustment accounts for the revenue generated for public hospitals through charges to private health insurers for same or multi-day admissions. Additionally, the Private Patient Service Adjustment accounts for additional MBS billings, prosthetic charges and private health insurance payments for medical services provided as part of an episode of care. Collectively, these adjustments are intended to neutralise funding differences between public and private patients and to mitigate any potential risk that public hospitals may be incentivised to prioritise private patients in public hospitals to obtain additional sources of revenue.

Notwithstanding these adjustments, IHPA has observed a recent increasing trend in privately funded public hospital separations and commissioned this report to identify what, if any, impact the national ABF framework has had on the increase in private patient utilisation of public hospital services.

To understand the extent to which the number of private patients in public hospitals is increasing, it is important to compare the number of private patients to the number of public patients in public hospitals. Table 1 outlines the growth in public hospital separations funded by private health insurance from 2008–09 to 2014–15.

Table 1: Proportion of public hospital separations funded by private health insurers (excluding self-funded, workers compensation, DVA, motor vehicle third party and other sources), Australia, 2008–2015³

Funding Source	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15
Private health insurance (000's)	452	501	527	584	686	756	815
Public (000's)	4,189	4,316	4,492	4,659	4,608	4,702	4,949
Proportion	9.7%	10.4%	10.5%	11.1%	13.0%	13.9%	14.1%

³ Figures calculated from the Australian Institute of Health and Welfare, *Admitted patient care 2014–15: Australian hospital statistics, Chapter 7 – Costliness and funding*. Proportions exclude public hospital funding sources other than private health insurance and public patients (e.g. self-funded, workers compensation, DVA, motor vehicle third party and other sources)

As illustrated in Table 1, hospital separations funded by private health insurance have increased from 451,591 in 2008–09 to 814,702 in 2014–15, which is an average increase of 10.3% per annum. This represents a steady increase in the proportion of public hospital separations funded by private health insurance in Australia of 4.4 percentage points over this period. Further investigation of the trends driving the increase in private patients in public hospitals, including differences by jurisdiction, can be found in Section 4.1 of this report.

2.2 Scope

IHPA engaged Ernst and Young (EY) to prepare a report, which examines trends in the number of privately, insured patients being treated in public hospitals and to examine factors contributing to observed trends.

The specific key deliverables of this project are:

- 1) A report which considers:
 - ▶ A comparison of State and Territory approaches to the pricing of private patients in public hospitals, including any incentives or changes in the policy or methodology in recent years
 - ▶ A comparison of State and Territory approaches to IHPA's Private Patient Adjustments for Activity Based Funding (ABF)
 - ▶ Analysis of the trends in the number of private patients treated in public hospitals in recent years at State and Territory and national levels over the past 10 years (subject to available data), and an assessment of any financial or policy impacts of national ABF implementation
 - ▶ A review of any significant changes in the private health insurance market (e.g. increased take-up, introduction of public hospital-only policies)
- 2) Subject matter resource consultation
 - ▶ Consultations with EY State and Territory health leaders to understand the current funding requirements within jurisdictions

The purpose of this project is to produce a report outlining findings suitable for consideration by IHPA. The analysis, key findings and conclusions set out in this report are reliant on the accuracy of the data sources utilised and limited in relation to the time and scope of EY's engagement with IHPA. This report should be read within the context of the reliance and limitations detailed in Section 5.

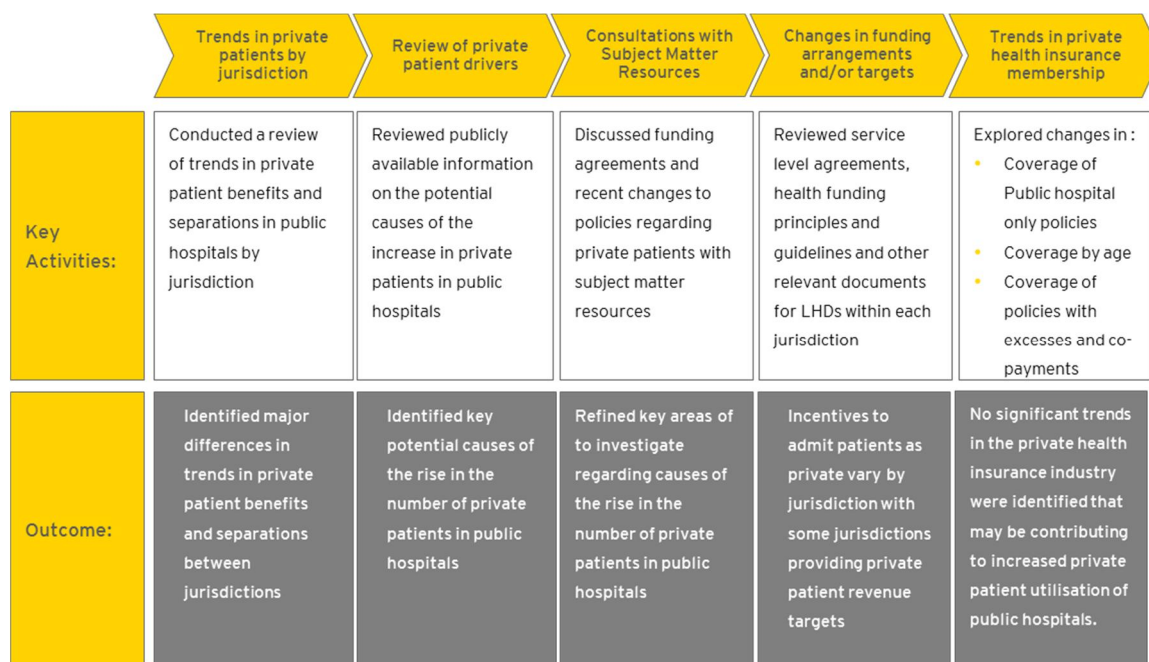
3. Approach

Our approach to assessing the increase in the number of private patients in public hospitals was as follows:

- ▶ Review of trends in private patients in public hospitals by State and Territory
- ▶ Review of publicly available information on the potential causes of the increase in private patients in public hospitals
- ▶ Consultation with a selection of State and Territory-based subject matter resources to understand the funding arrangements and other potential causes of the increase in private patients in public hospitals within each State and Territory
- ▶ Further analysis focusing on the key potential causes of the increase in private patients in public hospitals after our initial review of publicly available information and consultations with subject matter resources. Key areas of focus included:
 - ▶ Trends in private health insurance membership, in particular public hospital-only private health insurance policies
 - ▶ Changes in ABF arrangements and/or targets for the Local Health Networks

This approach is illustrated in Figure 1 below.

Figure 1: Approach overview



4. Key findings

4.1 IHPA Pricing Framework 2015–16

In order to promote transparent policy-making, IHPA developed a set of Pricing Guidelines, as outlined in the IHPA Pricing Framework 2015–16. These Pricing Guidelines are used to explain the key decisions made by IHPA in the Pricing Framework. They may also be used by governments and other stakeholders to evaluate whether IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

These Pricing Guidelines outline the rationale behind the determination for a Private Patient Accommodation Adjustment and Private Patient Service Adjustment in the IHPA NEP Determination 2016–17. At a national level, the Commonwealth provides funding for ABF for both public and private patients in hospitals in accordance with the NHRA. However, the funding provided to State and Territory governments per National Weighted Activity Unit (NWAU) is discounted for private patients through the implementation of a Private Patient Adjustment to account for additional revenue for private patients from Private Health Insurers (PHIs) and other Commonwealth sources.

Without making allowances for additional funding for private patients through private patient adjustments, there would be financial incentives for State and Territory governments, LHNs and public hospitals to increase the number of patients admitted as private patients to public hospitals to generate additional funding.

Accommodation costs for privately insured patients treated in public hospitals are generally fully covered by private health insurers and this represents approximately 70%⁴ of the total benefits paid to public hospitals for privately insured patients. However, as the IHPA commissions an annual, independent, external validation of the ABF and Block Funded Cost Models, an assessment of the fit-for-purpose nature of the Private Patient Accommodation and Private Patient Service Adjustment determined by the IHPA is outside the scope of this report. For the purposes of this report, it is assumed that these adjustments are fit for purpose on the basis that they have been independently validated.

⁴ APRA Statistics, 2015, *Trends in Hospital Accommodation, Medical Services and Prostheses*
<http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Trends-in-hospital-accommodation-medical-services-and-prostheses_June-2015.pdf>

4.2 Trends in private patient numbers by jurisdiction

The recent trends in public hospital separations funded by private health insurance within each State and Territory and nationally are outlined in Table 2 below. QLD (27.2% per annum), NT (18.7% per annum) and the ACT (11.3% per annum) have experienced growth rates over the past six years that are higher than the national average, while SA has had a relatively modest growth of 1.7% per annum.

Table 2: Number of public hospital separations (000's) funded by private health insurance by State and Territory: 2008-09 to 2014-15⁵

Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National
2008-09	223	116	33	31	30	12	5	1	452
2009-10	248	132	39	32	30	14	6	1	501
2010-11	254	140	53	31	28	14	6	1	527
2011-12	266	155	79	32	28	16	7	1	584
2012-13	309	178	106	36	30	18	8	1	686
2013-14	336	190	123	43	33	20	9	1	756
2014-15	358	204	141	45	33	21	10	2	815
Average annual growth	8.2%	9.9%	27.2%	6.3%	1.7%	9.9%	11.3%	18.7%	10.3%

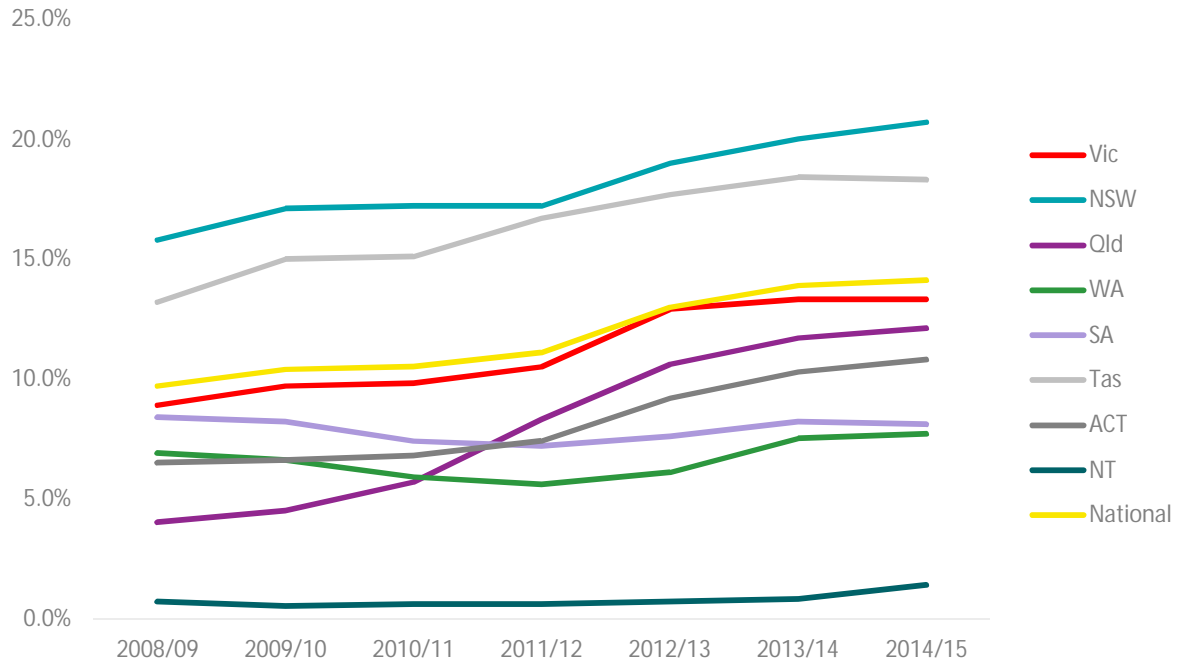
Table 3 and Figure 3 below illustrate the corresponding trends in the proportion of public hospital separations funded by private health insurance for each State and Territory from 2008 to 2015 (excluding self-funded, DVA, Workers compensation, third party vehicle and other funding sources).

⁵ Figures calculated from Australian Institute of Health and Welfare's *Admitted patient care: Australian hospital statistics*, from 2008-09 to 2014-15

Table 3: Proportion of public hospital separations funded by private health insurance by State and Territory, 2008-09 to 2014-15⁶

Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National
2008-09	15.8%	8.9%	4.0%	6.9%	8.4%	13.2%	6.5%	0.7%	9.7%
2009-10	17.1%	9.7%	4.5%	6.6%	8.2%	15.0%	6.6%	0.5%	10.4%
2010-11	17.2%	9.8%	5.7%	5.9%	7.4%	15.1%	6.8%	0.6%	10.5%
2011-12	17.2%	10.5%	8.3%	5.6%	7.2%	16.7%	7.4%	0.6%	11.1%
2012-13	19.0%	12.9%	10.6%	6.1%	7.6%	17.7%	9.2%	0.7%	13.0%
2013-14	20.0%	13.3%	11.7%	7.5%	8.2%	18.4%	10.3%	0.8%	13.9%
2014-15	20.7%	13.3%	12.1%	7.7%	8.1%	18.3%	10.8%	1.4%	14.1%
Growth in proportion between 2008-09 and 2014-15	4.9 percentage points	4.4 percentage points	8.1 percentage points	0.8 percentage points	-0.3 percentage points	5.1 percentage points	4.3 percentage points	0.7 percentage points	4.4 percentage points

Figure 2: Proportion of public hospital separations funded by private health insurance by State and Territory, 2008-09 to 2014-15



As can be seen from Table 3 and Figure 2 above, New South Wales and Tasmania in particular have recorded higher proportions of separations funded by private health insurance compared to the

⁶ Figures calculated from Australian Institute of Health and Welfare's *Admitted patient care: Australian hospital statistics*, from 2008-09 to 2014-15

other States and Territories. Conversely, the Northern Territory clearly has a much lower proportion of separations funded by private health insurance than other States and Territories.

The other notable trend is the growth in these proportions over time. As can be seen clearly in the last row from Table 3 above, the growth in the proportion of public separations funded by private health insurance has increased for all states from 2008 to 2015 other than South Australia. The increases between all states over this period is also quite variable with Queensland (an increase of 8.1 percentage points) and Tasmania (an increase of 5.1) rising faster in recent years than compared to the other States and Territories (National average increase of 4.4 percentage points%).

4.3 State and Territory ABF Implementations

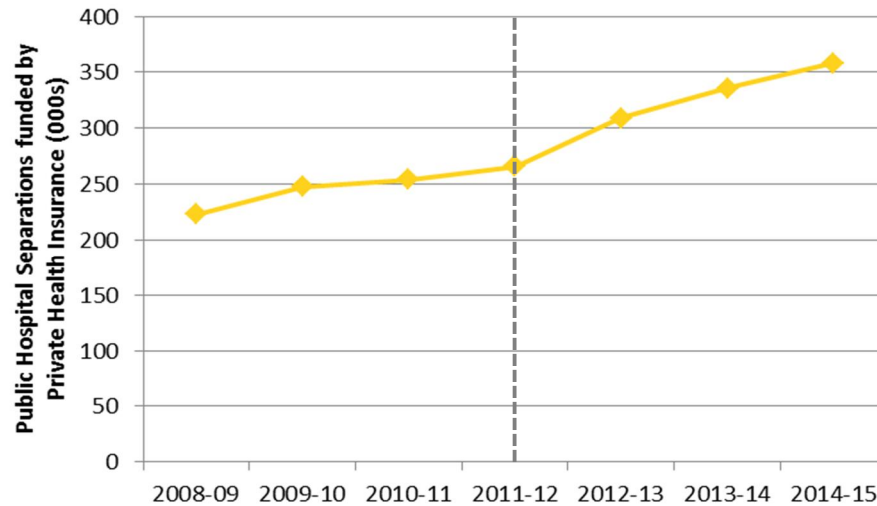
Summarised below, for each jurisdiction, are the private patient trends, ABF framework, private patient adjustments and the price received by Local Health Networks for private patients in public hospitals. The State and Territory ABF implementations are shown in descending order by the number of public hospital separations funded by private health insurance in each jurisdiction.

4.3.1 New South Wales

Private Patients in Public Hospitals

New South Wales has experienced an annualised growth of 8.2% per annum in the number of public hospital separations funded by private health insurance from 2008-09 to 2014-15. Since the introduction of ABF through the National Health Reform Agreement signed by the Commonwealth and States and Territories in 2011, New South Wales has experienced an increased annualised growth of 10.4% per annum. Figure 3 illustrates the increased rate of public hospital separations funded by private health insurance before 2011-12 and after.

Figure 3 – NSW public hospital separations funded by private health insurance (000's)



<p>Activity Based Funding Framework</p>	<p>The NSW State Government approach to funding for public hospital services within New South Wales is outlined in the 2013-14 NSW Health Funding Guidelines. The NSW Ministry of Health, as system manager, considers the total pool of funds that are available, the volume and the mix of services in New South Wales to determine the state funding contribution and therefore the total funding provided to each Local Health District or Specialty Health Network in New South Wales.</p> <p>NSW Health determines a State Price for each National Weighted Activity Unit (NWAU) and calculates NWAU without exclusion of any adjustments set by IHPA in the National Efficient Price (NEP) Determination. The State Price differs from the Nationally Efficient Price (NEP) due to the use of more recent data in the state model, the application of NSW Treasury indexation figures, and analysis of NSW-specific data in place of national data. The State Price for 2016-17 is \$4,605 compared to the NEP of \$4,883.</p> <p>Activity targets are used to set the ABF budget by service stream. The budget allocated to LHDs or SHNs is set according to the lower of either the State Price or the Projected Average Cost (PAC) for the LHD/SHN. Growth funding is provided at the State Price for all LHDs/SHNs. For efficient LHDs/SHNs, the budget is determined as forecast activity multiplied by the PAC and additional growth activity (i.e. target activity less forecast activity) multiplied by the State Price. Therefore, incentive funding is provided for additional negotiated activity.</p>									
<p>Private Patient Adjustments</p>	<p>In 2013-14, NSW Health applied a private patient accommodation adjustment as well as private patient service adjustments by DRG for acute admitted and mental health and by care type for subacute and non-acute admitted services. The specific 2013-14 private patient service adjustments by DRG and care type are not publicly available. However, a comparison of NSW private patient accommodation adjustments to the 2013-14 NEP Determination is outlined in Table 4 below.</p> <p>Table 4 - Comparison of 2013-14 NSW Private Patient Accommodation Adjustment to IHPA National Efficient Price Determination</p> <table border="1" data-bbox="395 1245 1386 1458"> <thead> <tr> <th></th> <th>Same day</th> <th>Overnight</th> </tr> </thead> <tbody> <tr> <td>NSW private patient accommodation adjustment⁷</td> <td>0.0455 NWAU</td> <td>0.0650 NWAU</td> </tr> <tr> <td>IHPA NEP Determination 2013-14</td> <td>0.0475 NWAU</td> <td>0.0657 NWAU</td> </tr> </tbody> </table> <p>Table 4 indicates that in 2013-14, the private patient accommodation adjustment applied by NSW Health may have been inconsistent with the IHPA NEP Determination 2013-14. The private patient accommodation and service adjustments used by NSW in subsequent years are not publicly available, however IHPA has received advice from NSW Health that the same day and overnight NWAU adjustments set by the IHPA are applied within NSW.</p>		Same day	Overnight	NSW private patient accommodation adjustment ⁷	0.0455 NWAU	0.0650 NWAU	IHPA NEP Determination 2013-14	0.0475 NWAU	0.0657 NWAU
	Same day	Overnight								
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⁷ ABF Taskforce, *NSW Health: 2013-14 NSW Health Funding Guidelines*, 2013.

<p>Price for Private Patients in Public Hospitals</p>	<p>NSW Health determines the expense budget for each LHD/SHN with consideration of forecast activity, agreed activity targets, the State Price and the PAC for the LHD/SHN by each ABF service stream (i.e. acute, subacute and non-acute, ED and non-admitted). Activity is expressed in NWAU in accordance with IHPA's Pricing Framework and incorporates private patient accommodation and private patient service utilisation adjustments. To determine hospital expense budgets for treatment of all patients (i.e. Schedule C Part 1), NSW Health includes a private patient gross up adjustment⁸ which adds back in the reductions in NWAU for private patient accommodation and service adjustments set out by IHPA in the NEP Determination for the purpose of outlining the total expense for the NWAU ABF activity.</p> <p>The revenue budget (i.e. Schedule C Part 2) itemises the sources of revenue hospitals will use, including Own Source Revenue, to cover the private patient related expense. IHPA NWAU adjustments for private patients are not itemised within the revenue budget and consequently it cannot be determined from publically available data if reductions to OSR determined by NSW Health align with the IHPA National Pricing Model. The revenue budget is based on normal price and volume increases as well as a performance factor and other adjustments. One component of the performance factor is based on private patient performance and requires each LHD/SHN to achieve a designated target in relation to revenue generation performance discussed during service agreement negotiations.⁹ The specific private patient targets set out for each LHD/SHN do not appear to be publicly available.</p> <p>Cash payments processed within the National Health Funding Pool (NHFP) Payments System for LHDs/SHNs are based on the accrued budget for both ABF and in-scope block funding derived from the LHD/SHN Service Agreements after deducting an allowance to recognise own-sourced revenue earned and retained by the LHD/SHNs and liabilities for superannuation and long service leave which are accepted by the Crown.¹⁰ This means that where private patient targets are exceeded, LHDs/SHNs can retain the associated own-sourced revenue with no commensurate reduction in funding from other sources. However, if private patient targets are not being met, LHDs/SHNs will experience a reduction in funding provided without a commensurate increase in funding from other sources. This provides an incentive for LHDs/SHNs to seek an increase in the proportion of private patients admitted.</p>
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⁸ This can be found in the service agreements between NSW Health and the Local Health Districts, for example, for the Murrumbidgee Local Health District for 2016-17 <<http://www.mlhd.health.nsw.gov.au/MLHD201617SA30June2016.pdf>>

⁹ Service Agreement 2017-17, An agreement between: Secretary, NSW Health and Murrumbidgee Local Health District, <<http://www.mlhd.health.nsw.gov.au/MLHD201617SA30June2016.pdf>>

¹⁰ Administrator National Health Funding Pool, *NSW Report June 2016*. Basis for National Health Reform payments – New South Wales.

4.3.2 Victoria

<p>Private Patients in Public Hospitals</p>	<p>Victoria has experienced an annualised growth of 9.9% per annum in the number of public hospital separations funded by private health insurance from 2008-09 to 2014-15. Since the introduction of Activity Based Funding through the National Health Reform Agreement signed by the Commonwealth and States and Territories in 2011, Victoria has experienced a reduced annualised growth of 9.6% per annum. Figure 4 illustrates the trend of public hospital separations funded by private health insurance before 2011-12 and after.</p> <p>Figure 4 - VIC public hospital separations funded by private health insurance (000's)</p> <table border="1"> <caption>Data for Figure 4 - VIC public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>115</td> </tr> <tr> <td>2009-10</td> <td>130</td> </tr> <tr> <td>2010-11</td> <td>140</td> </tr> <tr> <td>2011-12</td> <td>155</td> </tr> <tr> <td>2012-13</td> <td>175</td> </tr> <tr> <td>2013-14</td> <td>190</td> </tr> <tr> <td>2014-15</td> <td>205</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	115	2009-10	130	2010-11	140	2011-12	155	2012-13	175	2013-14	190	2014-15	205
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<p>Activity Based Funding Framework</p>	<p>The Victorian Government’s approach to funding activity in public hospitals is outlined in the Department of Health and Human Services policy and funding guidelines.¹¹ Victoria uses the Weighted Inlier Equivalent Separation (WIES) funding model which accounts for approximately 60% of health services funding within the state; the remainder is funded through a mixture of block funding and specified grants.</p> <p>The Department of Health and Human Services (DHHS) determines the total funding for health services based on activity volumes and prices according to the VIC cost models (e.g. WIES). Commonwealth contributions to Victoria are based on a projected equivalent NWAU and passed through to health services at a specific NWAU rate.</p> <p>DHHS allocates funding according to expected activity levels; however, where acute, subacute or non-admitted activity falls below the target by up to 3%, DHHS recalls 50% of the weighted relevant rate and if activity falls below target by more than 3%, DHHS recalls 100% of the weighted relevant rate.</p>																

¹¹ Department of Health and Human Services, *Policy and Funding Guidelines 2016*, <<https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>>

<p>Private Patient Adjustments</p>	<p>The DHHS VIC funding models specify different prices for public and private patients; therefore, no further adjustment for private patients are incorporated into the calculation of WIES. The ratio of the private to public WIES price (outlined in Table 5 below) is a 24% discount applied for eligible private patients. This compares to the IHPA private patient service adjustment that applies a discount of 2% to 75% based on the NEP Determination 2016-17, depending on the DRG for acute admitted separations. Additionally, a further discount calculated on the basis of a per diem of 0.0655 NWAU per day for overnight separations and a discount of 0.0498 NWAU for same-day separations is applied in the national ABF model. Therefore, for a range of DRGs, the 24% discount applied by Victoria may not be appropriate when compared to those indicated by the IHPA national cost models.</p> <p>This approach is inconsistent with the application of a private patient accommodation adjustment and private patient service adjustments based on DRG as specified in the IHPA NEP Determination. The discounted private WIES price may adequately adjust for the additional revenue from private health insurers for accommodation charges in a similar manner to the fixed adjustment set by States and Territories in IHPA's NEP Determination. However, there is evidence that prosthesis and other additional revenue sources for private patients vary between DRGs, which formed the basis of DRG-specific private patient service adjustments. Consequently, the VIC funding model may provide a residual incentive for health services to target private patients for particular conditions where additional revenue has not fully been incorporated into the discounted private WIES price for specific DRGs.</p>																		
<p>Price for Private Patients in Public Hospitals</p>	<p>The DHHS funding model for Victoria specifies a WIES price for public and private acute admitted patients based on health service peer groups outlined in Table 5 below. The private WIES price represents a 24% discount (i.e. $\\$3,527/\\$4,640 - 1 = 24\%$) to the public WIES price for all health service peer groups.</p> <p>Table 5 - 2016-17 public and private WIES by health service peer group⁹</p> <table border="1" data-bbox="392 1205 1383 1384"> <thead> <tr> <th></th> <th>Metropolitan and regional</th> <th>Sub-regional and local</th> <th>Small rural</th> </tr> </thead> <tbody> <tr> <td>Public WIES</td> <td>\$4,640</td> <td>\$4,857</td> <td>\$4,724</td> </tr> <tr> <td>Private WIES</td> <td>\$3,527</td> <td>\$3,690</td> <td>\$3,590</td> </tr> </tbody> </table> <p>Additionally, the 2016-17 subacute WIES prices for public and private patients set by DHHS for VIC health services are outlined in Table 6 below. The private WIES subacute price is approximately a 7% discount to the public WIES subacute price</p> <p>Table 6 - 2016-17 public and private subacute admitted WIES prices⁹</p> <table border="1" data-bbox="392 1608 1197 1709"> <thead> <tr> <th></th> <th>Public</th> <th>Private</th> </tr> </thead> <tbody> <tr> <td>All health services</td> <td>\$10,247</td> <td>\$9,530</td> </tr> </tbody> </table> <p>The Nationally Efficient Price was \$4,883 per NWAU in 2016-17; however, WIES and NWAU are not equivalent measures of activity. Consequently, a direct comparison cannot be drawn between the DHHS prices and the NEP.</p>		Metropolitan and regional	Sub-regional and local	Small rural	Public WIES	\$4,640	\$4,857	\$4,724	Private WIES	\$3,527	\$3,690	\$3,590		Public	Private	All health services	\$10,247	\$9,530
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4.3.3 Queensland

<p>Private Patients in Public Hospitals</p>	<p>Queensland has experienced the highest annualised growth of 27.2% per annum in the number of public hospital separations funded by private health insurance from 2008-09 to 2014-15. Since the introduction of Activity Based Funding through the National Health Reform Agreement signed by the Commonwealth and states and territories in 2011, Queensland has maintained annualised growth of 21.3% per annum. Figure 5 illustrates the trend of public hospital separations funded by private health insurance in the lead up to 2011-12 and thereafter.</p> <p>Figure 5 - QLD public hospital separations funded by private health insurance (000's)</p> <table border="1"> <caption>Data for Figure 5: QLD public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>35</td> </tr> <tr> <td>2009-10</td> <td>40</td> </tr> <tr> <td>2010-11</td> <td>55</td> </tr> <tr> <td>2011-12</td> <td>80</td> </tr> <tr> <td>2012-13</td> <td>105</td> </tr> <tr> <td>2013-14</td> <td>125</td> </tr> <tr> <td>2014-15</td> <td>140</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	35	2009-10	40	2010-11	55	2011-12	80	2012-13	105	2013-14	125	2014-15	140
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2014-15	140																
<p>Activity Based Funding Framework</p>	<p>The Queensland Government establishes service agreements with each Hospital and Health Service (HHS) based on the Department of Health's funding and purchasing models. The funding model determines the price at which the department purchases services from HHSs and the purchasing model determines the volume of services that are purchased.</p> <p>In 2016-17, 36 public hospitals are funded through the Queensland ABF model. The model is largely based on the national ABF model but includes a number of modifications to reflect Queensland priorities or pricing models that are more suitable. At the same time, 87 public hospitals are block funded and most non-hospital services (e.g. mental health, alcohol and other drug, preventative health) are funded on a price per unit of output.</p> <p>Overall funding is determined according to QLD Weighted Activity Units (QWAU) and the State Price. Some of the key differences of the QLD funding model are the way that Own Sourced Revenue (OSR) is treated, the inclusion of Pharmaceutical Benefits Scheme costs that are excluded from the IHPA National models, and additional localisations and incentives.¹²</p>																

¹² State of Queensland (Queensland Health), July 2016. *Health funding principles and guidelines 2016-17 financial year.*

<p>Private Patient Adjustments</p>	<p>The QLD ABF model varies from the national ABF model for acute admitted patients, as there are no QWAU private patient adjustments due to the recognition of the contribution of HHS Own Sourced Revenue in the funding and purchasing model. In the Commonwealth funding model, private admitted services attract NWAUs but at a discounted rate compared to public admitted services. Where an HHS is above its OSR target in respect of private patients, it will be able to retain the additional OSR with no compensating adjustments to funding from other sources. Conversely, where a HHS is below its OSR target in respect of private patients, it will experience a reduction in revenue with no compensating adjustments to funding from other sources. Budget adjustments for changes in OSR from private patients will be actioned through the process set out in Schedule 5 of the Service Agreement. This provides an incentive for HHSs to increase the volume of private patients treated to maximise their OSR and total revenue.</p> <p>IHPA has received advice from QLD Health that any OSR generated from private patients is included within the HHS total funding envelope to mitigate the financial impact of unrecovered revenue.</p>
<p>Price for Private Patients in Public Hospitals</p>	<p>There are no private patient adjustments within the QLD ABF model. Consequently, HHSs will receive the same amount of funding for private and public patients receiving similar services (e.g. for the same acute admitted DRGs or subacute admitted AN-SNAP separations).</p> <p>The QLD ABF model State Price is set at \$4,755.66 per QWAU for 2016-17.</p>

4.3.4 Western Australia

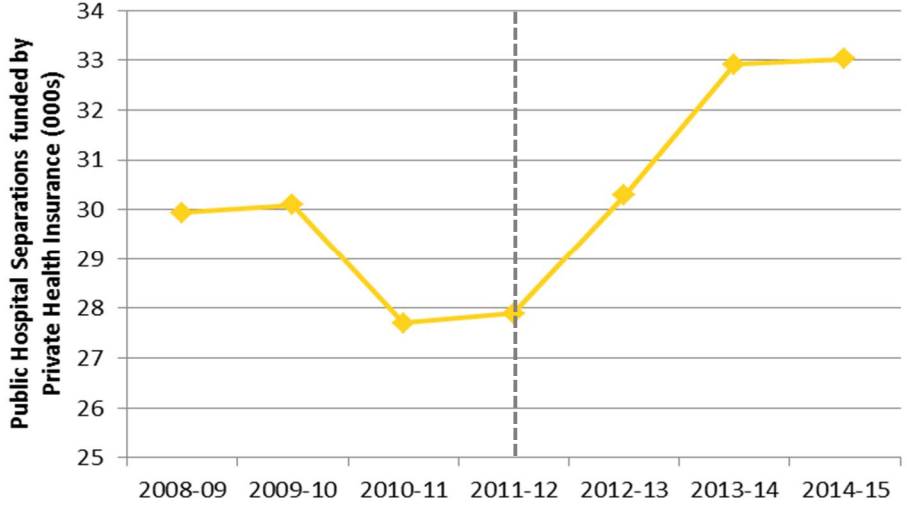
<p>Private Patients in Public Hospitals</p>	<p>Western Australia has experienced an annualised growth of 6.3% per annum in the number of public hospital separations funded by private health insurance from 2008-09 to 2014-15. Since the introduction of Activity Based Funding through the National Health Reform Agreement signed by the Commonwealth and states and territories in 2011, Western Australia has experienced an increased annualised growth of 12% per annum. Figure 6 illustrates the trend of public hospital separations funded by private health insurance before 2011-12 and after.</p> <p>Figure 6 - WA public hospital separations funded by private health insurance (000's)</p> <table border="1"> <caption>Data for Figure 6 - WA public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>31</td> </tr> <tr> <td>2009-10</td> <td>32</td> </tr> <tr> <td>2010-11</td> <td>31</td> </tr> <tr> <td>2011-12</td> <td>32</td> </tr> <tr> <td>2012-13</td> <td>36</td> </tr> <tr> <td>2013-14</td> <td>43</td> </tr> <tr> <td>2014-15</td> <td>45</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	31	2009-10	32	2010-11	31	2011-12	32	2012-13	36	2013-14	43	2014-15	45
Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)																
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<p>Activity Based Funding Framework</p>	<p>The Western Australian Government approach to funding public hospitals is outlined in the WA Health Funding and Purchasing Guidelines 2016-17.¹³ WA State Government budget settings for health activity, delivered by WA Health, are set using the National ABF Framework and are informed by the annual Pricing Framework published by the IHPA. WA Treasury determines activity settings on the basis of demand projections on age-weighted population growth and historical hospital activity information.</p> <p>Historically, Western Australia has set the State Price with reference to the Projected Average Cost (PAC) determined by the IHPA and the National Efficient Price (NEP) that removes funding from other Commonwealth services (e.g. Highly Specialised Drugs, Blood Program expenditures, etc.). In 2016-17, due to a number of challenges in achieving convergence with the PAC, Western Australia has decoupled the State Price setting from the PAC and sets cost growth in line with public sector wage inflation (i.e. 1.5% per annum) and requires a 1% efficiency dividend from 2017-18 onward.</p> <p>In 2016-17, the NEP is \$4,883 and the Projected Average Cost for Western Australia including the costs excluded in the NEP is \$5,015. The final approved State Price for Western Australia was set at \$5,767.</p>																

¹³ Department of Health, State of Western Australia. *WA Health Funding and Purchasing Guidelines 2016-17*. <http://ww2.health.wa.gov.au/About-us/Service-agreements> >

<p>Private Patient Adjustments</p>	<p>The Service Agreements between the Department and Health Service providers are developed using a total expenditure profile which includes weighted activity related to private patients in public hospitals. The IHPA model applies a discount for these private patients to offset revenue that States and Territories receive from alternative funding sources. The WA ABF model currently does not utilise the DRG discount for private patient service adjustments or the bed day private patient accommodation adjustments applied to the IHPA model.</p> <p>Western Australia also provides private patient revenue targets as can be seen from this excerpt from the WA Health Funding and Purchasing Policy Guidelines 2015-16:</p> <p>“The Department will set targets for Total OSR for 2015-16. Specifically, Private Patient Revenue targets will be set with the requirement that Health Service Providers achieve their revenue targets by improving the efficiency and capability of internal revenue generation systems”.¹⁴</p>
<p>Price for Private Patients in Public Hospitals</p>	<p>The WA ABF Model does not make any adjustments for private patients and therefore the same Health Service Allocation Price is paid for both public and private patients.</p> <p>This means that there may be a residual incentive for Health Service Providers to actively target private patients where additional revenue is received from Private Health Insurers and the Commonwealth, as they will receive the same amount of state-based funding in relation to those patients with no adjustment.</p>

¹⁴ Western Australia Department of Health, 2015, *WA Health Funding and Purchasing Policy Guidelines 2015-16*, <<http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Service%20Agreements/PDF/201516/2015-16-FPP-Guidelines-FINAL-17JUL3.ashx>>

4.3.5 South Australia

<p>Private Patients in Public Hospitals</p>	<p>South Australia has experienced an annualised growth of 1.7% per annum in the number of public hospital separations funded by private health insurance from 2008-09 to 2014-15. Since the introduction of Activity Based Funding through the National Health Reform Agreement signed by the Commonwealth and States and Territories in 2011, South Australia has experienced an increased annualised growth of 5.8% per annum. Figure 7 illustrates the trend of public hospital separations funded by private health insurance before 2011-12 and after.</p> <p>Figure 7 – SA public hospital separations funded by private health insurance (000's)</p>  <table border="1"> <caption>Data for Figure 7: SA public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>30</td> </tr> <tr> <td>2009-10</td> <td>30</td> </tr> <tr> <td>2010-11</td> <td>27.5</td> </tr> <tr> <td>2011-12</td> <td>28</td> </tr> <tr> <td>2012-13</td> <td>30.5</td> </tr> <tr> <td>2013-14</td> <td>33</td> </tr> <tr> <td>2014-15</td> <td>33</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	30	2009-10	30	2010-11	27.5	2011-12	28	2012-13	30.5	2013-14	33	2014-15	33
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<p>Activity Based Funding Framework</p>	<p>The mechanism for allocation of public hospital funding within South Australia is set out by the South Australian Government in <i>Casemix Funding for South Australian Public Hospitals 2015-16</i>.¹⁵ The SA Casemix Funding model has operated since 1994 and represents a significant proportion of budget funding provided to Local Health Networks. SA Health reviews and appraised the ABF models from other States and Territories to assess their applicability for South Australia. As the models become sufficiently refined, if they are deemed superior to SA Health's model, SA Health will update it.</p> <p>In 2014-15, the acute component of the National ABF model has been adopted and other streams (e.g. subacute and non-acute admitted, emergency care and non-admitted) will be reviewed on an annual basis and may be implemented at a later point in time by SA Health. For 2015-16, SA Health will use classification standards and price weights specified by IHPA for acute admitted activity. SA Health determines a State Price which is set as a discount to the Nationally Efficient Price in recognition of costs relating to centralised services provided by SA Health (e.g. ICT, workforce and finance-related services) that are incorporated in the NEP.</p> <p>Rehabilitation episodes are funded according to a per diem that differs by patient type (e.g. spinal, stroke/acquired brain injury/neurological/amputee, orthopaedic or psychiatric) and varies for paediatric and for episodes in country regional and sub-regional hospitals. Maintenance care is funded at a set bed day per diem that is set for metropolitan or country hospitals. Non-admitted patients are funded at a rate that differs by activity type (e.g. emergency, outpatients and outreach) for metropolitan and country hospitals and by metropolitan and country hospitals.</p>																

¹⁵ South Australia, Department of Health and Ageing, *Casemix Funding for South Australian Public Hospitals 2015-16*.

<p>Private Patient Adjustments</p>	<p>Since 2014–15, SA Health has applied the private patient accommodation and private patient service adjustment to acute admitted activity. However, adjustments for private patients are passed on to LHNs through a block amount to provide full funding of cost for service delivery, regardless of the revenue offset.</p> <p>Additionally, the private patient adjustments are not applied to subacute and non-acute admitted activity where private and public patients receive the same per diem rates for the activity.</p> <p>A review of the current SA Service Level Agreements (SLA) and service agreement performance frameworks did not identify any evidence of current private patient targets.</p>
<p>Price for Private Patients in Public Hospitals</p>	<p>SA Health has set a price of \$4,799 per NWAU in 2015–16 for acute admitted separations and takes into account the private patient accommodation adjustment and DRG-specific private patient service adjustments. However, for rehabilitation and maintenance care, SA Health does not incorporate private patient adjustments and therefore provides the same price for public and private patients.</p> <p>Reductions in funding to LHNs as a result of private patient adjustments are provided separately through a block amount to LHNs. This means that there may be a residual incentive for LHNs to actively target private patients where additional revenue is received from Private Health Insurers and the Commonwealth, as taking the additional block payments into account they will receive the same amount of state-based funding in relation to those patients with no adjustment.</p>

4.3.6 Tasmania

<p>Private Patients in Public Hospitals</p>	<p>Tasmania has experienced an annualised growth of 9.9% per annum in the number of public hospital separations funded by private health insurance since 2008-09 to 2014-15. Since the introduction of Activity Based Funding through the National Health Reform Agreement signed by the Commonwealth and States and Territories in 2011, Tasmania has experienced a reduced annualised growth of 9.6% per annum. Figure 8 illustrates the trend of public hospital separations funded by private health insurance before 2011-12 and after.</p> <p>Figure 8 – TAS public hospital separations funded by private health insurance (000's)</p> <table border="1"> <caption>Data for Figure 8: TAS public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>12</td> </tr> <tr> <td>2009-10</td> <td>14.5</td> </tr> <tr> <td>2010-11</td> <td>14.5</td> </tr> <tr> <td>2011-12</td> <td>16</td> </tr> <tr> <td>2012-13</td> <td>18</td> </tr> <tr> <td>2013-14</td> <td>20</td> </tr> <tr> <td>2014-15</td> <td>21</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	12	2009-10	14.5	2010-11	14.5	2011-12	16	2012-13	18	2013-14	20	2014-15	21
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<p>Activity Based Funding Framework</p>	<p>The Tasmania Department of Health and Human Services (TAS DHHS) outlined details of its implementation of ABF in its 2013 presentation, 'Activity Based Funding - Purchasing Health Services in Tasmania'.¹⁶ Tasmania operates under a Funder-Purchaser-Provider structure with SLAs established with the Tasmania Health Organisations (THOs) responsible for delivering contracted services at the negotiated price and appropriate level of safety and quality.</p> <p>The TAS DHHS, as system manager, is required to fund all activity undertaken by hospitals, including services that the Commonwealth deems out of scope in the Nationally Efficient Price and NWAU. The TAS model funds on a gross basis with revenue targets as opposed to the NWAU determined by the IHPA.</p> <p>The Tasmanian model provides funding on the basis of agreed volumes of TAS Weighted Activity Units (TWAU). Acute admitted services by DRG were funded in 2013-14 at the TAS State Price of \$4,502 per TWAU with differences by overnight admitted, same-day admitted, outlier LOS days, ICU hours and hours of mechanical ventilation. Other admitted patients were funded on a per diem basis by bed days and category (e.g. rehabilitation, palliative care, geriatric evaluation and management, maintenance care, organ donor and boarder). Non-admitted occasions of service were funded at a per service rate for public non-admitted patients.</p> <p>No further information appeared to be publicly available on modifications or changes to the TAS ABF Model since 2013.</p>																

¹⁶ Tasmanian Government, Department of Health and Human Services. [Activity Based Funding - Purchasing Health Services in Tasmania](https://www.dhhs.tas.gov.au/data/assets/pdf_file/0003/138306/ABF_-_Version_PUBLIC_RELEASE_-_9_August_2013.pdf), <[https://www.dhhs.tas.gov.au/data/assets/pdf_file/0003/138306/ABF - Version_PUBLIC_RELEASE - 9_August_2013.pdf](https://www.dhhs.tas.gov.au/data/assets/pdf_file/0003/138306/ABF_-_Version_PUBLIC_RELEASE_-_9_August_2013.pdf)>

<p>Private Patient Adjustments</p>	<p>The TAS DHHS advises that additional private patient revenue does not necessarily flow directly to the hospitals and the amounts vary by private practice schemes in operation and region. So, a uniform discounting of the price is not appropriate.¹⁷</p> <p>Consequently, Tasmania does not make any private patient accommodation or private patient service adjustments in determination of TWAUs or the TAS State Price. The TAS ABF model funds on a gross basis with revenue targets. This means that THOs will receive the same amount of funding from the Tasmanian Government for public and private patients. As such, this provides incentives to THOs to target private patients to increase the total revenue received as there are no compensating adjustments to state funding for additional private health insurance or Commonwealth funding provided.</p> <p>Additionally, a review of SLAs for 2016–17 identified private patient revenue targets as follows: “The funding model provides a target for private patient revenue for RHH, LGH and NWRH which is higher than the budget papers. The target for private patient revenue is based on the 2014-15 actual revenue received with 2 years CPI added at 2.5% per year”.¹⁸</p>
<p>Price for Private Patients in Public Hospitals</p>	<p>The 2013–14 price per acute admitted TWAU was \$4,502 and as there are no private patient adjustments specified, the same level of funding is provided for public and private patients.</p>

¹⁷ Tasmanian Department of Health and Human Services, 2013, Activity based funding: Purchasing Health Services in Tasmania, <https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/138306/ABF_-_Version_PUBLIC_RELEASE_-_9_August_2013.pdf>

¹⁸ Tasmanian Department of Health and Human Services, 2016, *2016-17 Service Agreement between the Minister for Health and the Tasmanian Health Service*, <http://www.dhhs.tas.gov.au/tho/service_agreements>

4.3.7 Australian Capital Territory

<p>Private Patients in Public Hospitals</p>	<p>The Australian Capital Territory has experienced an annualised growth of 11.3% per annum in the number of public hospital separations funded by private health insurance since 2008-09 to 2014-15. Since the introduction of Activity Based Funding through the National Health Reform Agreement (NHRA) signed by the Commonwealth and states and territories in 2011 ACT has experienced an increased annualised growth of 15.2% per annum. Figure 9 illustrates the trend of public hospital separations funded by private health insurance before 2011-12 and after.</p> <p>Figure 9 – ACT public hospital separations funded by private health insurance (000's)</p> <table border="1"> <caption>Data for Figure 9: ACT public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>5.5</td> </tr> <tr> <td>2009-10</td> <td>5.6</td> </tr> <tr> <td>2010-11</td> <td>6.0</td> </tr> <tr> <td>2011-12</td> <td>6.8</td> </tr> <tr> <td>2012-13</td> <td>8.2</td> </tr> <tr> <td>2013-14</td> <td>9.5</td> </tr> <tr> <td>2014-15</td> <td>10.5</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	5.5	2009-10	5.6	2010-11	6.0	2011-12	6.8	2012-13	8.2	2013-14	9.5	2014-15	10.5
Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)																
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2013-14	9.5																
2014-15	10.5																
<p>Activity Based Funding Framework</p>	<p>The Australian Capital Territory consists of one Local Hospital Network (LHN) the ACT LHN. The ACT Health Directorate has advised that the method for determining funding to the ACT LHN in 2016-17 is based on budget-neutral modelling.</p> <p>Modelling is predicated on the historical cost of providing hospital services plus wages and non-wages indexation. The activity for activity-based funded services is derived using historical activity levels plus an allowance for reasonable growth in public hospital services for the current year. The weighted activity is measured and funded based on the full Independent Hospital Pricing Authority pricing model and framework parameters¹⁹.</p>																
<p>Private Patient Adjustments</p>	<p>ACT Health has implemented the full national ABF model and consequently it incorporates private patient accommodation adjustments and DRG specific private patient service adjustments. After a review of the current SLAs our research also did not identify any evidence of private patient targets.</p>																
<p>Price for Private Patients in Public Hospitals</p>	<p>In 2015-16, the ACT price per NWAU was \$6,815.82²⁰ compared to the NEP determined by IHPA of \$4,971. The price paid for private patients will vary by DRG in alignment with the Private Patient Adjustments specified in the 2015-16 NEP Determination by the IHPA.</p>																

¹⁹ Administrator, National Health Funding Pool. *Australian Capital Territory report, June 2016*.
<http://www.publichospitalfunding.gov.au/reports/state?state=act&month=jun2016>

²⁰ Derived from 2015-16 Service Level Agreement, Agreement between the ACT Minister for Health and the Director General, ACT Local Hospital Network Directorate. http://www.health.act.gov.au/sites/default/files/Policy_and_Plan/2015-16%20Service%20Level%20Agreement%20-%20Final.pdf

4.3.8 Northern Territory

<p>Private Patients in Public Hospitals</p>	<p>The Northern Territory has experienced an annualised growth of 18.7% per annum in the number of public hospital separations funded by private health insurance from 2008-09 to 2014-15. However, this figure is derived from a very small base of 653 private-funded hospital separations in 2008-09. Since the introduction of Activity Based Funding through the National Health Reform Agreement signed by the Commonwealth and States and Territories in 2011, the Northern Territory has experienced an increased annualised growth of 39.4% per annum with 1,830 private funded hospital separations in 2014-15. Figure 10 illustrates the trend of public hospital separations funded by private health insurance before 2011-12 and after.</p> <p>Figure 10 – NT public hospital separations funded by private health insurance (000's)</p> <table border="1"> <caption>Data for Figure 10: NT public hospital separations funded by private health insurance (000's)</caption> <thead> <tr> <th>Financial Year</th> <th>Public Hospital Separations funded by Private Health Insurance (000's)</th> </tr> </thead> <tbody> <tr> <td>2008-09</td> <td>0.65</td> </tr> <tr> <td>2009-10</td> <td>0.55</td> </tr> <tr> <td>2010-11</td> <td>0.60</td> </tr> <tr> <td>2011-12</td> <td>0.65</td> </tr> <tr> <td>2012-13</td> <td>0.85</td> </tr> <tr> <td>2013-14</td> <td>0.95</td> </tr> <tr> <td>2014-15</td> <td>1.85</td> </tr> </tbody> </table>	Financial Year	Public Hospital Separations funded by Private Health Insurance (000's)	2008-09	0.65	2009-10	0.55	2010-11	0.60	2011-12	0.65	2012-13	0.85	2013-14	0.95	2014-15	1.85
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<p>Activity Based Funding Framework</p>	<p>The NT Department of Health plays the role of System Manager by undertaking jurisdiction-level responsibilities and functions and acting as the purchaser in a purchaser-provider arrangement. In the Northern Territory, SLAs are reached with the Top End Health Service (comprising Royal Darwin Hospital, Katherine Hospital and Gove District Hospital, together with associated community health services in the northern region) and Central Australia Health Service (comprising Alice Springs Hospital and Tennant Creek Hospital along with associated community health services in the Central Australia region).</p> <p>No further details appeared to be publicly available from the Administrator, National Health Funding Body or the NT Department of Health in relation to the NT implementation of Activity Based Funding and its technical specifications.</p>																

<p>Private Patient Adjustments</p>	<p>The technical specifications of the NT Department of Health territory funding model do not appear to be publicly available. Consequently, no conclusion can be made in relation to whether or not private patient adjustments are applied. In our review of the current service delivery agreements and service delivery agreement performance charters and strategic plans of Local Health Networks, no private patient targets set by the NT Government were identified.</p> <p>However, in the Central Australia Health Service Strategic Plan 2014-2017, there is a reference to “explore and implement new strategies to maximise revenue generation, such as improved identification of private patients” which may have an impact on private funded public hospital separations if there are no adjustments applied in the funding provided for private patients by the NT Department of Health.</p>
<p>Price for Private Patients in Public Hospitals</p>	<p>In 2016-17, the NT Department of Health price per Weighted Activity Unit is set in alignment with the NEP of \$4,883 determined by the IHPA.²¹ It is not clear from the publicly available information on the NT Department of Health funding model whether or not private patient adjustments are implemented in line with the national ABF framework. Consequently, no conclusion can be made on the price differences between public and private patients in the Northern Territory.</p>

²¹ Northern Territory Government, 2016, [Central Australia Health – Service Delivery Agreement 2016/17](http://digitallibrary.health.nt.gov.au/prodjspu/bitstream/10137/658/13/CAHS%20Service%20Delivery%20Agreement%202016-17%20full.pdf).
<<http://digitallibrary.health.nt.gov.au/prodjspu/bitstream/10137/658/13/CAHS%20Service%20Delivery%20Agreement%202016-17%20full.pdf>>

4.3.9 Promotion of benefits to patients of private patient election

The private patient targets set by the States and Territories provides clear evidence that there are incentives for Local Health Networks to increase their number of private patients. However, these targets by themselves are not evidence that LHNs are employing practices to increase their number of private patients. However, there is additional evidence which suggests LHNs are employing techniques to increase the number of private patients and this can be seen in Section 4.3.9.1 below.

4.3.9.1 Examples of job advertisements and open endorsements

Various examples are shown in Table 7.1 and Table 7.2 below which outline the active role that various health providers and even in some cases health ministers, across various jurisdictions, have been playing to increase the number of private patients in public hospitals.

Table 7: Job advertisements encouraging private patient targeting

Job Advertisements		
Hospital	State/Territory	Job description
South Western Sydney Local Health District	New South Wales	The role of the Private Patient Officer is pivotal to the Local Health District's strategy to raise additional revenue from patients electing to use their private health insurance. This is an extremely important initiative and contributes to purchase of clinical equipment and employment of front line clinical staff. ²²
Department of Health and Human Services (TAS)	Tasmania	Provide and coordinate a wide range of administrative services associated with the hospital's Private Patient Plan (PPP) providing an efficient and effective patient billing service for members of the PPP and maximise hospital revenue. ²³
Sydney Local Health District - Private Patient Services Officer	New South Wales	The Private Patient Services Officer (PPSO) plays a pivotal role in encouraging the use of private health insurance by providing accurate and timely information about using private health insurance in a public hospital. This position is primarily a customer service focused role responsible for driving exceptional performance to achieve revenue targets in a challenging environment. The PPOS develops effective relationships with patients, relatives, multidisciplinary staff and key stakeholders in an effort to maximise hospital revenue through eligible admitted patients utilising their private health cover. ²⁴
Prince of Wales Hospital - Patient Liaison Officer	New South Wales	This position contributes significantly to increasing revenue for the organisation from patients electing to use their private health insurance in a public hospital setting. It plays a key role in promoting the use of private health insurance by patients. ²⁵

²² NSW Health, 2016, Position advertisement, <<https://nswhealth.erecruit.com.au/ViewPosition.aspx?id=328059>>

²³ LG Assist, 2014, *Private patient officer*, <<http://www.lgassist.com.au/career/40978/Private-Patient-Officer-Tasmania-Tas-Launceston>>

²⁴ NSW Health, 2016, Position advertisement, <<https://nswhealth.erecruit.com.au/ViewPosition.aspx?id=251590>>

²⁵ Jora, 2016, *Private Liaison Officer* <https://au.jora.com/job/Patient-Liaison-Officer-e8adfd9bc5ff609335779090785ba78e?from_url=https%3A%2F%2Fau.jora.com%2FPrivate-Patient-Officer-jobs-in-Bankstown-NSW&sl=Bankstown+NSW&sp=serp&sponsored=false&sq=Private+Patient+Officer&sr=4&tk=9c139901-70f8-429a-9de0-17dbfaefff21>

Table 8: Appeals from LHNs or jurisdiction governments

Appeals		
Hospital	State/Territory	Appeal
The Queen Elizabeth Hospital	South Australia	"As a private patient in a public hospital you will enjoy a number of benefits and help your hospital. The Queen Elizabeth Hospital provides all patients with the highest possible quality and standard of care. The income we receive from your health fund helps to improve hospital facilities, update equipment and provide staff education and training." ²⁶
South Western Sydney Local Health District	New South Wales	"Money received from private health funds is given directly to the hospital to assist in providing services to all patients. For more information in regards to using Private Health Insurance at Bankstown-Lidcombe Hospital, please contact the Private Patient Officer on 02 9722 8256." ²⁷
Royal Hobart Hospital	Tasmania	"By using your private health insurance, the money received assists the hospital to buy additional equipment, maintain facilities and provide improved services to the Tasmanian community." ²⁸

²⁶ SA Health, *Private patients at The Queen Elizabeth Hospital*,

<<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/hospitals+and+health+services+metropolitan+adelaide/the+queen+elizabeth+hospital/private+patients+at+the+queen+elizabeth+hospital>>

²⁷ NSW South Western Sydney Local Health District, *Hospital fees and insurance*,

<<https://www.swsld.nsw.gov.au/bankstown/fees.html>>

²⁸ Royal Hobart Hospital, 2015, *Patient Information Guide, 2015*

<https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/34654/Royal_Hobart_Hospital_2015_final.pdf>

5. Conclusion

On the basis of a desktop analysis of recent trends in privately funded public hospital separations in the context of State and Territory policies for public hospital funding, there is overall sufficient evidence to conclude that the national Activity Based Funding model has not been a significant driver in the upward trend in privately funded public hospital separations.

Specifically, this report has considered State and Territory policies that relate to: health budget allocation processes; implementations and localisations of the national ABF 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. These policy settings, 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 ABF.

Analysis of State and Territory ABF implementations indicates that within selected jurisdictions, ABF payments made for eligible private patients of a similar classification to public patients may not contain exclusions or reductions (as appropriate) for services covered by other Commonwealth funding sources other than ABF and patient charges (e.g. prosthesis, accommodation, etc.) as required by clause A41 of the National Health Reform Agreement. Therefore, State and Territory policy parameters and localisations of the IHPA National ABF model, including the explicit determination of selected states to not incorporate private patient adjustments, is likely contributing to the recent increase in privately funded public hospital separations.

6. Reliance and Limitations

This report has been prepared solely for the purpose outlined in the Background and Scope and only considers issues pertaining to the scope outlined in Section 2 of the report. No further analysis or consideration of additional issues outside the scope of this report or subsequent to the date of this report has been completed.

Consistent with our engagement agreement, this report is intended solely for the information and use of the management of IHPA and is not intended to be and should not be used by anyone other than these specified parties. This engagement has been limited in time and scope and it is stressed that more detailed procedures may reveal issues that this engagement has not. The procedures summarised in this report do not constitute an audit, a review or other form of assurance in accordance with any generally accepted auditing, review or other assurance standards, and accordingly EY does not express any form of assurance.

This report provides an overview of the trends in private patients in public hospitals by State and Territory as well as potential drivers of these trends. Consequently, the findings and recommendations outlined in this report rely on the information sources referenced throughout.

The statements and opinions provided in this report are given in good faith and in the belief that such statements and opinions are not false or misleading. The conclusions are based on the assumptions stated and on information extracted through our desktop review.

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