Submission No. 125
AUTHORISED: 24/5/06
KS

SUBMISSION OF EVIDENCE TO PARLIAMENTRY COMMITTEE.

INITIAL STATEMENT.

At this stage I wish to thank the Chairperson and the Committee Members for the invitation to present evidence to this committee about my experience with the current health system. The evidence which I present is **factual.**

SEQUENCE OF EVENTS.

On 27th September 2005 I was admitted Belmont Local Hospital after suffering a heart attack.
While in the emergency ward the Admission's Person asked me if I desired to be admitted as a **Public Patient or a Private Patient.** I asked the benefits of one against the other. I was advised if I was admitted as a **Public Patient,** all hospital and clinical costs would be covered under the Medicare agreement, however the Doctor giving me treatment would be whoever was on roster.
Alternatively, if I elected to be admitted as a **Private Patient,** I would have a choice of Doctor and I would not have to pay for a daily newspaper or television.
The admission person indicated to me it would preferable for me to be admitted as a private patient since the hospital would receive additional funding from the PHF which could be distributed for the benefit of all patients.
Although I was aware I would have to pay my Private Health Fund (PHF) an initial payment of $200.00 I elected to be a **Private Patient** because of the preference of choice of Doctor in view of my past heart complaints.

During my stay at the hospital I was treated daily by the Resident Cardiologist, and in my initial stay of 5 days I saw as I understood a Consultant Cardiologist.
Although the Consultant suggested a method of investigation I suggested to him that contact should be made to St. Vincent's Hospital in Sydney because of my case history.
I was discharged on 30th September 2005.
After 2 days at home I was re-admitted to Belmont District Hospital with unstable angina. Once again I was treated by the Resident Cardiologist, a different Consultant Cardiologist, stabilized and released for further assessment at St. Vincent's Hospital.

For this Committee's benefit I did have Cardiac Laser Surgery in 1998 at St. Vincent's and I was aware from past experience in Newcastle there were not many frontline doctors who had had experience in this technique.
Following some investigative tests recommended by St. Vincent's Hospital staff it was decided my need to have an angiogram.

On the 7th December 2005 I had an angiogram at St. Vincent's General Hospital when it was established my need for cardiac surgery?

My initial consultation with the surgeon was on 19th December 2005 the cost of this consultation was $300 and the only reimbursement was $62.95 from Medicare, no reimbursement was available from the PHF because I was not an impatient, (the consultation was in the doctor's private rooms).
During the consultation the surgeon enquired if I was in a PHF, he indicated to me there would be a **gap fee** over and above the reimbursements from Medicare and the PHF. The **estimated gap fee** for the anesthetist and the surgeon would be in the vicinity of $5000.00. This gap fee was because both professional's charges were in accordance with the scale of charges recommended by the Australian Medical Association. No other surgeon had experience in operating on a post laser surgical patient.

I wish to make it quite clear to this Committee I agreed to pay the gap fee.

It was arranged for my surgery to be done on 25th January 2006 and I would be admitted to St.Vincents Private Hospital on 24th January when I would have a CT scan.
On admission the Physiotherapist visited me and advised me of the scale of charges to which I would be liable, although there was specifically no mention of gap fees.
During the afternoon of 24th January the Anesthetist and Heart Lung Specialist visited me and explained the procedure to be done. The Anesthetist confirmed at this time his account would be structured on AMA rates of charges which meant there would be a **gap fee** for which I would be liable.

At this time no other doctor advised me of potential gap fees for their services.

During the next 11 days in hospital there were many hurdles to overcome and medical procedures to be completed.
I had several CT scans, X-Rays and a Cardiac Echo which in summation amounted to out of pocket expenses totaling $1678.60.

On returning home on 4th February the accounts for medical services were received.

An account received on 9th February from the Anesthetist was $6420.00 with an offer if the account was paid within 30days a reduction of 33% could be received. I then went to the local Medicare office to ascertain if it was possible for a Medicare Cheque be processed within the 30 days offered. I was advised no guarantee could be given that the cheque would be submitted to me within this time.
We (my wife and I) withdrew an amount of $6420.00 less 33% from our Retirement Fund. This meant a saving of $2120-00.
I submit to this Committee, a patient less fortunate than me who did not have the money to pre- pay this account prior to submission to Medicare would be severely disadvantaged.
As late as 28th April I have received another account for services at the hospital during my admission.
The care and attention I received was without question 1st class and I have no quarrel with the people who were involved in my return to normal health.

Attached is a schedule showing costs related to my surgery with amounts of reimbursements from Medicare, the Private Health Fund and our personal out of pocket expenses.

CONCLUSION

It is not for me to suggest to the Committee the policies to adopt in the improvement of health care in Australia; however it does seem we have a system which is unworkable.

My belief is if a person contributes to PHF and the Medicare levy they should equal the rates adopted by the AMA so no person like me is disadvantaged.
In my view everybody irrespective of their income should contribute to the Medicare levy and when visiting a health professional should be willing to pay something.

With experience I have endued, in the future I would give serious consideration to be admitted as a **public patient** which of course would add further strain to the present public system. If there was a database of private health insurance contributors the public health system may get some relief from the amount of financial strain on the system.

I thank this Committee for listening to the evidence I have presented.

Duncan Brown.
2nd May 2006.

Coronary Surgery Costs

Surgical	Charge $	Private Fund $	Medicare $	DB Cost $
Surgeon	7043.00	789.10	2430.30	3823.60
Anesthetist	4300.00	457.65	1373.75	2468.60
Clinical				
	506.15	125.25	375.90	5.00
	470.00	58.10	174.00	237.90
	1297.00	161.15	484.00	651.85
	1537.00	186.80	560.95	789.25
	271.00	37.00	111.25	122.75
Imaging				
	47.15	11.75	35.40	-------
	47.15	11.75	35.40	-------
	47.15	11.75	35.40	-------
	47.15	11.75	35.40	-------
	98.80	24.70	74.20	-------
	400.00	100.00	300.00	-------
	47.00	11.75	35.40	-------
	47.00	11.75	35.40	-------
	400.00	100.00	300.00	-------
Physiotherapy				
	690.00	524.60		165.40

Total out of pocket expenses = $ 8264.35

Note: There are no hospital accommodation charges in the above figures.