Australian Government
Department of Health

Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals

This paper seeks public feedback on reducing pressure on private health insurance premiums by addressing the growth of private patients in public hospitals. Interested parties are invited to make a written submission by email to: phiconsultation@health.gov.au by 15 September 2017.

Australia, with its mixed public and private health model, spends slightly less than the OECD average on healthcare but achieves better than average health outcomes. The private healthcare system is underpinned by private health insurance which provides patients with choice and timely access to critical services, alleviating pressures on state public hospitals systems, while at the same time providing the basis for a significant industry and employment sector. A healthy and stable private health insurance system used by 13.5 million Australians is essential for the stability of Australia's overall health care system.

Recent growth in private health insurance premiums

Since 2011 private health insurance premiums per policy have increased annually by between 4.75 and 6.25 per cent, with a total increase of 46 per cent to April 2017. Average annual premiums for a family have increased from $3,670 to $4,590 between 2010-11 and 2015-16.

Premium growth is primarily driven by growth in hospital benefits. Growth in hospital benefits has been driven by a combination of increased use of services and increased prices, as shown in the following table.

Insured hospital episodes and benefits 2010-11 to 2015-16

	Private hospitals	Public hospitals	Total
Total privately insured episodes 2010-11 ('000)	2,811	498	3,309
Total privately insured episodes 2015-16 ('000)	3,641	773	4,414
Total insurance benefits 2010-11 ($m)	8,252	1,123	9,375
Total insurance benefits 2015-16 ($m)	12,114	1,791	13,905
Annual average percentage growth 2010-11 to 2015-16			
Growth in privately insured hospital episodes	5.3	9.2	5.9
Growth in hospital insurance benefits per episode	2.5	0.5	2.1
Growth in total hospital insurance benefits	8.0	9.8	8.2

As with the public hospital system, there are opportunities for addressing private health insurance premium growth. Given that private health insurance premiums are regulated by the Department of Health, and the Australian Prudential Regulation Authority (APRA), with health insurers returning around 90 cents in the premium dollar back to consumers as benefits, opportunities to identify savings through the internal operation of health insurers is limited. Opportunities do however exist to identify significant savings within the health service provider chain – for example prostheses pricing and second tier default benefits administration. The Government has established a Private Health Ministerial Advisory Committee to provide advice on reform of supply chain costs. This paper focuses on opportunities to improve efficiency in the shared Commonwealth-State policy.

Private patients in public hospitals

The rapid growth in privately insured episodes in public hospitals is a concern for private health insurance costs.

In an era when private hospitals are increasing both the volume of beds they offer and the complexity of their service offering there does not appear to be any clinical or demographic reason for the relatively rapid growth of private admissions in the public sector.

There is a wealth of public material suggesting that the growth in private patients is being driven by public hospitals making extensive efforts to persuade patients admitted through emergency departments, or those who had planned to be admitted as public patients, to elect to be treated privately.

The following table is drawn from a report to the Independent Hospital Pricing Authority (IHPA) and shows the proportion of private patients in public hospitals by state and growth over time.

Percentage of public hospital separations funded by private health insurance by state and territory									
Year	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**National**
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 percentage points	**3.5**	**3.5**	**6.4**	**1.8**	**0.7**	**3.2**	**4.0**	**0.8**	**3.6**
Growth in per cent	**20.3%**	**35.7%**	**114.0%**	**30.5%**	**9.5%**	**21.2%**	**58.8%**	**133.3%**	**34.2%**

IHPA data on the urgency status of patients in public hospitals shows that between 2012-13 and 2015-16:

- the number of private patients in public hospitals with an urgency of admission status of 'Emergency' increased by 37.9 per cent, compared with the number of public patients which increased by 17.3 per cent; and
- the number of private patients in public hospitals with an urgency of admission status of 'Elective' increased by 17.1 per cent, compared with the number of public patients which increased by 7.6 per cent.
- Overall the number of private patients in public hospitals increased by 28.6 per cent, compared with the number of public patients which increased by 13.7 per cent over the same period.

A detailed table prepared by the IHPA showing admitted patient public hospital separations by patient type (private or public), state, and urgency of admission status (emergency, elective or unknown) is provided at Attachment 1. This data reflects activity based funded hospitals only and as such the results differ to those published by the Australian Institute of Health and Welfare in their 2015-16 Admitted Patient Care report.

Australian Institute of Health and Welfare (AIHW) health expenditure data shows that private health insurance payments to public hospitals are an increasingly important revenue source. Compared with states' own funding of public hospital services, private health insurance benefits increased from 4.9 per cent of state and territory own source revenue contributions in 2010-11 to 5.8 per cent in 2014-15.

AIHW has published information showing the difference in admissions of private patients in public hospitals and wait times:

- In the five years to 2015–16, admissions for public patients rose by an average of 2.9% each year, compared with 5.5% for patients who used private health insurance to fund their admission;
- In public hospitals in 2015–16, 83% of admissions—or 5.2 million—were for public patients, with around 14% of patients—or 872,000—using their private health insurance to fund all or part of their admission;
- 'Public patients had a median waiting time of 42 days for elective surgery in a public hospital, while it was 20 days for patients who used private health insurance to fund all or part of their admission.'

Attachment 2 provides data on differences in wait times by surgical procedure and speciality.

Impact of private patients in public hospitals on private health insurance premiums

The proportion of hospital benefits paid for private patients in public hospitals as a share of total hospital benefits has increased from 12.0 per cent in 2010-11 to 12.9 per cent in 2015-16. However, at the consumer level, average benefits paid for private patients in public hospitals per family with insurance have increased from about $310 to $440 over the same period (42% over five years).

If the number of private patients in the public sector had grown at the same rate as private patients in private hospitals over the period since 2010-11, premiums in 2015-16 would have been about 2.5 per cent lower than they actually were.

Implications for the National Health Reform Agreement

Under the National Health Reform Agreement the IHPA is required to "determin[e]… the national efficient price that will apply to eligible private patients receiving public hospital services" with "the cost weights for private patients being calculated by excluding or reducing, as appropriate, the components of the service for that patient which are covered by: Commonwealth funding sources other than ABF; and patient charges including prostheses and accommodation and nursing related components/ charge equivalent to the private health insurance default bed day rate (or other equivalent payment)".

The Commonwealth and the states then pay the same proportion of this discounted NEP that they would have paid for a public patient at the full NEP, as shown in the diagram on the next page.

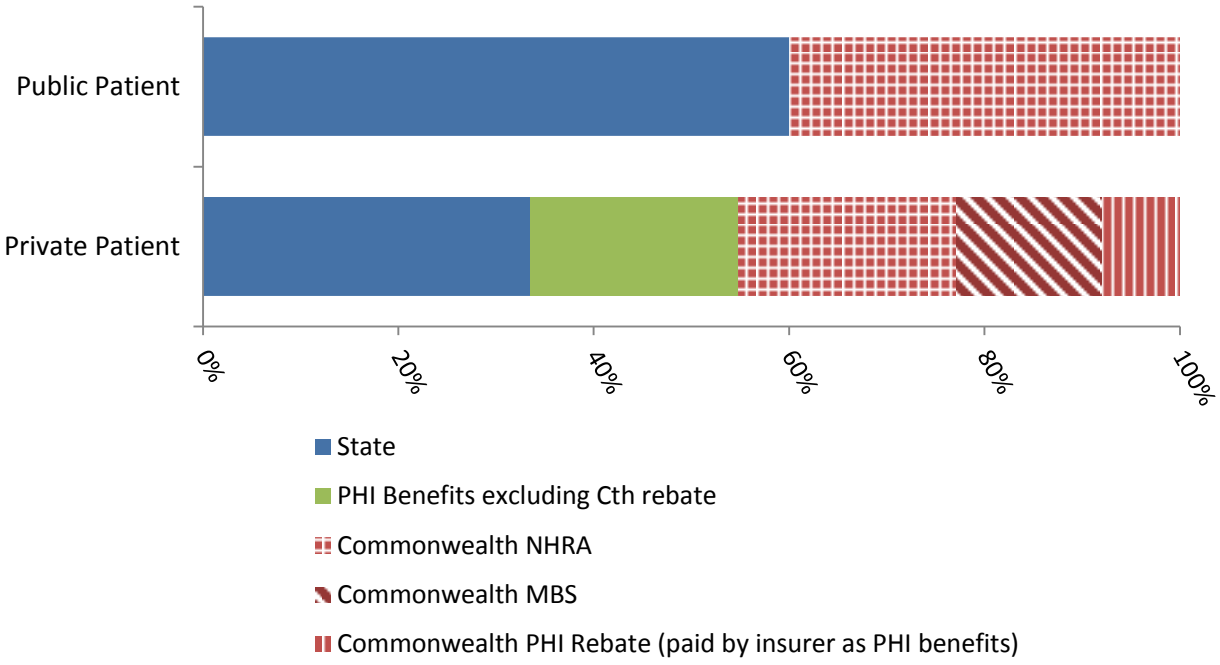
Even if the IHPA is making appropriate adjustments this arrangement still provides an incentive for states to increase the volume of private elections from patients who would otherwise have been admitted as public patients. If a state is paying (say) 55 per cent of the full NEP for a public patient, it will save 55 per cent of the private patient discount for every public patient who elects to be treated privately.

However, the adjustments made by the IHPA do not reflect the actual revenue derived from private patients. While the accommodation adjustment is based on the private health insurance default bed day rate, this ignores revenue derived from accommodation charges above the default benefit such as single room charges. The adjustment for prostheses is calculated by deducting the HCP prostheses component, however analysis which compares HCP, APRA and Medicare Benefits Schedule (MBS) payments indicates that the HCP data set under represents benefits paid to hospitals in the order of 20 per cent.

These disparities create a strong incentive at the hospital or Local Health Network level to encourage more private elections. The Ernst and Young report to the IHPA identified four

jurisdictions[1] that have implemented state-specific versions of the National ABF Model such that service level agreements between State and Territory governments and Local Health Networks do not include reductions to the funding provided to LHNs for private patients. EY concluded this also creates a strong incentive for LHNs to target private patients.

Funding sources for public and private patients in public hospitals 2014 – illustrative



Options for reform

Against this background there are a number of options that could reduce the pressure on private health insurance premiums arising from benefits paid for private patients in public hospitals, deliver greater system stability and address implications for the National Health Reform Agreement.

1: Limit private health insurance benefits to the medical costs of private treatment in public hospital with no benefits paid to the hospital

Under this option patients could still elect to be treated as private patients in public hospitals but would only be able to claim benefits toward the doctor's charges (the 25% MBS gap and doctors 'no-gap' or 'known-gap' payment). There would be no benefit paid by the insurer to the hospital for accommodation or other charges, such as prostheses.

This option continues to support patients making genuine elections to be treated by a particular doctor in a public hospital, and explicitly recognises that this is the main component of their hospital treatment that differs to a public patient.

[1] New South Wales, Queensland, Western Australia, and Tasmania.

This could be implemented by changes to subordinate legislation under the Commonwealth *Private Health Insurance Act 2007*. This would not require a change to the National Health Reform Agreement because hospitals could still choose to raise charges against private patients, but insurers would not be able to pay a benefit.

2: Prevent public hospitals from waiving any excess payable under the patient's policy

Public hospitals often waive the excess that would otherwise be payable under a patient's health insurance policy as an incentive to encourage private patient election. Under this option, hospitals would be required to collect any excess payable by patients should they elect to be treated privately.

This option is likely to reduce the number of patients who enter the public hospital through the emergency (or other) department intending to access free public hospital services, but are persuaded by hospital staff to elect private treatment.

This option would need to be implemented by states and territories. There is no legislative mechanism available to the Commonwealth to enforce implementation.

3: Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions

Under this option, all patients admitted through the emergency department would be public patients. While this option would stop hospitals from encouraging patients who present expecting to be public patients from electing to be private, it may also reduce the perceived value of their health insurance for consumers.

While it could be implemented by changes to subordinate legislation under the Commonwealth *Private Health Insurance Act 2007*, it would be desirable to amend the National Health Reform Agreement as well. A reduction in insured episodes would be contingent on accurate categorisation of patients by hospital staff.

4: Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement

Under this option, health insurers would not be required to pay benefits for private patients in public hospitals for services where there is no meaningful choice of doctor, or limited doctor involvement in the patient's treatment. This would apply to both hospital and medical charges.

This option would require an assessment of the types of services which could be categorised as having no (or limited) choice of doctor, such as major trauma; or where the doctor has limited involvement in the patient's ongoing treatment, such as chemotherapy. These services would be defined in regulation.

This option has the benefit that a patient wanting to elect private treatment at a public hospital in circumstances where they can genuinely choose their own doctor could still claim private health insurance benefits.

While this could be implemented by changes to subordinate legislation under the Commonwealth *Private Health Insurance Act 2007*, it would be desirable to amend the National Health Reform Agreement as well.

5: Make changes to the NHRA NEP determination and funding model

This option would require working with the Independent Hospital Pricing Authority to ensure that the private patient adjustment to the NEP appropriately adjusts for all private patient income. For example, the private patient adjustment currently adjusts for accommodation at the minimum default bed day rate. This option would involve changing that adjustment to take account of revenue from the bed day rate, single room charges and other accommodation payments above the default benefits. This would also be an opportunity to ensure that the private patient adjustment for prostheses fully accounts for all revenue from prostheses.

In addition, there are a number of states which do not adjust their own funding to public hospitals to recognise private patient revenue. This creates an additional incentive for public hospitals to admit private patients. The option proposes engaging with states to encourage amendments to their service level agreements to ensure that reductions in the NEP for private patients are reflected in state funding levels.

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Attachment 1

Private patient utilisation by urgency of admission

		Separations																	
		2012-13				2013-14				2014-15				2015-16				Change over 2012-13 to 2015-16	
State	Urgency of Admission	Public	Percentage	Private/ Self funded	Percentage	Public	Percentage	Private/ Self funded	Percentage	Public	Percentage	Private/ Self funded	Percentage	Public	Percentage	Private/ Self funded	Percentage	Public	Private/ Self funded
NSW	Emergency	423,686	74.7%	143,801	25.3%	452,190	73.1%	166,067	26.9%	465,305	72.4%	177,207	27.6%	486,172	72.6%	183,092	27.4%	14.7%	27.3%
	Elective	573,351	84.4%	105,723	15.6%	590,021	83.3%	117,961	16.7%	600,082	82.8%	124,701	17.2%	608,231	82.6%	127,947	17.4%	6.1%	21.0%
	Not assigned	137,256	86.8%	20,871	13.2%	136,815	84.4%	25,209	15.6%	135,912	83.2%	27,476	16.8%	139,800	82.6%	29,435	17.4%	1.9%	41.0%
	Not known/reported	13	100.0%	0	0.0%	11	100.0%	0	0.0%	41	65.1%	22	34.9%	7	77.8%	2	22.2%		
	Total	1,134,306	80.8%	270,395	19.2%	1,179,037	79.2%	309,237	20.8%	1,201,340	78.5%	329,406	21.5%	1,234,210	78.4%	340,476	21.6%	8.8%	25.9%
Vic	Emergency	356,111	86.0%	58,130	14.0%	388,934	86.1%	62,940	13.9%	437,313	86.2%	70,297	13.8%	477,298	86.8%	72,822	13.2%	34.0%	25.3%
	Elective	696,186	86.1%	112,148	13.9%	710,951	85.8%	117,363	14.2%	745,264	85.9%	121,965	14.1%	768,595	85.6%	129,000	14.4%	10.4%	15.0%
	Not assigned	74,519	95.1%	3,830	4.9%	74,655	95.2%	3,800	4.8%	77,548	95.4%	3,723	4.6%	80,762	95.7%	3,599	4.3%	8.4%	-6.0%
	Not known/reported	0		0		0		0		0		0		0		0			
	Total	1,126,816	86.6%	174,108	13.4%	1,174,540	86.4%	184,103	13.6%	1,260,125	86.5%	195,985	13.5%	1,326,655	86.6%	205,421	13.4%	17.7%	18.0%
Qld	Emergency	378,253	89.1%	46,504	10.9%	407,856	87.0%	60,705	13.0%	435,114	86.0%	70,596	14.0%	454,202	84.8%	81,317	15.2%	20.1%	74.9%
	Elective	183,223	87.9%	25,228	12.1%	188,327	88.6%	24,138	11.4%	209,495	89.4%	24,808	10.6%	222,139	90.0%	24,809	10.0%	21.2%	-1.7%
	Not assigned	229,555	87.5%	32,915	12.5%	228,954	87.0%	34,354	13.0%	274,138	87.1%	40,585	12.9%	315,919	87.6%	44,723	12.4%	37.6%	35.9%
	Not known/reported	0		0		0		0		0		0		0		0			
	Total	791,031	88.3%	104,647	11.7%	825,137	87.4%	119,197	12.6%	918,747	87.1%	135,989	12.9%	992,260	86.8%	150,849	13.2%	25.4%	44.2%
SA	Emergency	138,879	92.2%	11,807	7.8%	139,003	91.6%	12,802	8.4%	145,836	91.2%	14,118	8.8%	160,191	90.6%	16,669	9.4%	15.3%	41.2%
	Elective	98,658	91.5%	9,142	8.5%	99,366	90.7%	10,193	9.3%	98,780	91.3%	9,430	8.7%	93,407	91.1%	9,096	8.9%	-5.3%	-0.5%
	Not assigned	85,481	95.3%	4,201	4.7%	86,401	95.4%	4,159	4.6%	85,670	95.5%	4,059	4.5%	88,590	93.6%	6,069	6.4%	3.6%	44.5%
	Not known/reported	0		0		0		0		0		0		0		0			
	Total	323,018	92.8%	25,150	7.2%	324,770	92.3%	27,154	7.7%	330,286	92.3%	27,607	7.7%	342,188	91.5%	31,834	8.5%	5.9%	26.6%
WA	Emergency	204,661	91.8%	18,224	8.2%	185,555	89.1%	22,631	10.9%	187,280	88.7%	23,796	11.3%	180,391	86.3%	28,655	13.7%	-11.9%	57.2%
	Elective	146,647	93.4%	10,349	6.6%	149,321	92.3%	12,520	7.7%	142,965	91.8%	12,702	8.2%	147,754	90.6%	15,282	9.4%	0.8%	47.7%
	Not assigned	154,538	97.2%	4,492	2.8%	158,273	96.5%	5,715	3.5%	171,394	97.0%	5,357	3.0%	180,391	96.5%	6,465	3.5%	16.7%	43.9%
	Not known/reported	0		0		0		0		0		0		0		0			
	Total	505,846	93.9%	33,065	6.1%	493,149	92.3%	40,866	7.7%	501,639	92.3%	41,855	7.7%	508,536	91.0%	50,402	9.0%	0.5%	52.4%
Tas	Emergency	24,570	85.8%	4,059	14.2%	27,713	83.9%	5,328	16.1%	29,226	83.6%	5,753	16.4%	28,308	82.7%	5,910	17.3%	15.2%	45.6%
	Elective	38,558	78.3%	10,661	21.7%	39,359	78.5%	10,802	21.5%	41,057	78.7%	11,106	21.3%	40,416	76.3%	12,541	23.7%	4.8%	17.6%
	Not assigned	5,982	80.4%	1,456	19.6%	7,075	79.8%	1,791	20.2%	7,608	79.2%	1,997	20.8%	7,527	83.8%	1,456	16.2%	25.8%	0.0%
	Not known/reported	685	77.9%	194	22.1%	141	74.6%	48	25.4%	43	32.3%	90	67.7%	47	83.9%	9	16.1%		
	Total	69,795	81.0%	16,370	19.0%	74,288	80.5%	17,969	19.5%	77,934	80.4%	18,946	19.6%	76,298	79.3%	19,916	20.7%	9.3%	21.7%
NT	Emergency	34,537	98.4%	565	1.6%	35,731	98.2%	644	1.8%	38,300	96.5%	1,370	3.5%	44,024	94.8%	2,428	5.2%	27.5%	329.7%
	Elective	33,531	98.4%	543	1.6%	33,384	98.3%	566	1.7%	36,486	97.7%	840	2.3%	22,674	94.5%	1,318	5.5%	-32.4%	142.7%
	Not assigned	44,034	99.4%	273	0.6%	47,311	99.0%	471	1.0%	49,647	99.2%	415	0.8%	72,046	99.3%	499	0.7%	63.6%	82.8%
	Not known/reported	0		0		6	100.0%	0	0.0%	9	100.0%	0	0.0%	9	100.0%	0	0.0%		
	Total	112,102	98.8%	1,381	1.2%	116,432	98.6%	1,681	1.4%	124,442	97.9%	2,625	2.1%	138,753	97.0%	4,245	3.0%	23.8%	207.4%
ACT	Emergency	34,844	91.7%	3,174	8.3%	35,098	90.7%	3,585	9.3%	36,283	90.7%	3,714	9.3%	40,658	91.2%	3,906	8.8%	16.7%	23.1%
	Elective	20,081	92.3%	1,681	7.7%	20,912	90.3%	2,236	9.7%	22,154	90.3%	2,388	9.7%	23,517	90.1%	2,571	9.9%	17.1%	52.9%
	Not assigned	22,485	88.6%	2,903	11.4%	24,341	88.4%	3,193	11.6%	24,598	86.9%	3,696	13.1%	23,992	84.3%	4,458	15.7%	6.7%	53.6%
	Not known/reported	379	94.5%	22	5.5%	0		0		4	100.0%	0	0.0%	0		0			
	Total	77,789	90.9%	7,780	9.1%	80,351	89.9%	9,014	10.1%	83,039	89.4%	9,798	10.6%	88,167	89.0%	10,935	11.0%	13.3%	40.6%
National	Emergency	1,595,541	84.8%	286,264	15.2%	1,672,080	83.3%	334,702	16.7%	1,774,657	82.9%	366,851	17.1%	1,871,244	82.6%	394,799	17.4%	17.3%	37.9%
	Elective	1,790,235	86.7%	275,475	13.3%	1,831,641	86.1%	295,779	13.9%	1,896,283	86.0%	307,940	14.0%	1,926,733	85.7%	322,564	14.3%	7.6%	17.1%
	Not assigned	753,850	91.4%	70,941	8.6%	763,825	90.7%	78,692	9.3%	826,515	90.4%	87,308	9.6%	909,027	90.4%	96,704	9.6%	20.6%	36.3%
	Not known/reported	1,077	83.3%	216	16.7%	158	76.7%	48	23.3%	97	46.4%	112	53.6%	63	85.1%	11	14.9%		
	Total	4,140,703	86.7%	632,896	13.3%	4,267,704	85.7%	709,221	14.3%	4,497,552	85.5%	762,211	14.5%	4,707,067	85.3%	814,078	14.7%	13.7%	28.6%

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Attachment 2

Difference in wait times by surgical procedure and specialty

Table 6.48: Median waiting time (days) for public and other patients admitted from public hospital waiting lists for elective surgery[a], by surgical procedure, 2015–16

	Public patients[b]		Other patients[c]		Total	
Surgical procedure	Admissions	Median waiting time	Admissions	Median waiting time	Admissions	Median waiting time
Cataract extraction	56,765	113	6,997	18	63,762	95
Cholecystectomy	16,037	45	1,351	27	17,388	43
Coronary artery bypass graft	3,110	14	231	7	3,341	14
Cystoscopy	43,033	24	3,240	21	46,273	24
Haemorrhoidectomy	4,033	55	260	39	4,293	55
Hysterectomy	9,323	54	810	29	10,133	51
Inguinal herniorrhaphy	14,934	56	1,479	25	16,413	53
Myringoplasty	1,668	184	102	50	1,770	175
Myringotomy	4,177	63	504	16	4,681	57
Prostatectomy	6,859	43	515	26	7,374	42
Septoplasty	4,481	238	495	48	4,976	218
Tonsillectomy	15,874	138	1,580	34	17,454	122
Total hip replacement	9,510	125	887	46	10,397	117
Total knee replacement	14,432	203	980	67	15,412	193
Varicose veins stripping and ligation	3,445	108	366	36	3,811	99
Not applicable/not stated	402,318	31	50,295	18	452,613	29
Total	**609,999**	**42**	**70,092**	**20**	**680,091**	**38**

(a) Cluster data for the Australian Capital Territory were not included for this report, as the NESWTDC data were not available at the time of publication of *Elective surgery waiting times 2015-16: Australian hospital statistics* (AIHW 2016c).

(b) *Public patients* includes separations with a funding source of *Health service budget*, *Other hospital or public authority* (with a *Public* patient election status), *Health service budget (due to eligibility for Reciprocal health care agreements)* and *Health service budget—no charge raised due to hospital decision* (in public hospitals).

(c) *Other* includes separations with a funding source of *Private health insurance*, *Self-funded*, *Department of Veterans' Affairs*, *Workers compensation*, *Motor vehicle third party personal claim*, *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a *Public* patient election status), *Other*, *Health service budget—no charge raised due to hospital decision* (in private hospitals) and not reported.

Note: See boxes 1.1, 1.2 and appendixes A and B for notes on definitions and data limitations.

Table 6.49: Median waiting time (days) for public and other patients admitted from public hospital waiting lists for elective surgery[a], by surgical specialty, 2015–16

	Public patients[b]		Other patients[c]		Total	
Surgical specialty	Admissions	Median waiting time	Admissions	Median waiting time	Admissions	Median waiting time
Cardio-thoracic surgery	10,270	18	1,263	16	11,533	18
Ear, nose and throat surgery	51,582	81	5,849	25	57,431	75
General surgery	136,974	33	15,546	20	152,520	30
Gynaecology	78,801	32	6,723	21	85,524	31
Neurosurgery	9,510	42	1,853	17	11,363	35
Ophthalmology	74,499	91	10,176	17	84,675	77
Orthopaedic surgery	92,198	76	10,627	22	102,825	69
Plastic surgery	44,323	29	6,482	14	50,805	27
Urology	82,231	26	6,887	21	89,118	26
Vascular surgery	13,526	22	1,695	13	15,221	21
Other	16,085	22	2,991	17	19,076	21
Total	**609,999**	**42**	**70,092**	**20**	**680,091**	**38**

(a) Cluster data for the Australian Capital Territory were not included for this report, as the NESWTDC data were not available at the time of publication of *Elective surgery waiting times 2015-16: Australian hospital statistics* (AIHW 2016c).

(b) *Public patients* includes separations with a funding source of *Health service budget*, *Other hospital or public authority* (with a *Public* patient election status), *Health service budget (due to eligibility for Reciprocal health care agreements)* and *Health service budget—no charge raised due to hospital decision* (in public hospitals).

(c) *Other* includes separations with a funding source of *Private health insurance*, *Self-funded*, *Department of Veterans' Affairs*, *Workers compensation*, *Motor vehicle third party personal claim*, *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a *Public* patient election status), *Other*, *Health service budget—no charge raised due to hospital decision* (in private hospitals) and not reported.

Note: See boxes 1.1, 1.2 and appendixes A and B for notes on definitions and data limitations.

Source: AIHW Admitted Patient care 2015-16 : Australian Hospital Statistics