

Know your rights and responsibilities as a private patient in hospital

Private Patients' Hospital Charter



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Private Patients' Hospital Charter

Know your rights and responsibilities as a private patient in hospital

The Private Patients' Hospital Charter is issued by the Minister for Health and Ageing pursuant to section 73F of the *National Health Act 1953*.

Publications approval number 2913/JN7504

I, TONY ABBOTT, Minister for Health and Ageing, issue the following statement, called the Private Patients' Hospital Charter, under section 73F of the *National Health Act 1953*.

This statement revokes all previous statements issued under section 73F of the *National Health Act 1953*.

A handwritten signature in black ink, appearing to read 'Tony Abbott', with a long horizontal line above it.

Minister for Health and Ageing

Dated: 7 June 2004

Private Patients' Hospital Charter



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Private Patients' Hospital Charter

Purpose of the Charter

The Private Patients' Hospital Charter is a guide to what it means to be a private patient in a public hospital, a private hospital or a day hospital facility. It also sets out what you can expect from:

- the doctor(s) providing your treatment;
- the hospital in which you receive your treatment; and
- your health insurance fund.

The Charter also provides information on what to do if you have a problem with your care or your private health insurance.

If you would like more copies of the Charter or have any comments in relation to the Charter, please email the Australian Government Department of Health and Ageing at **privatehealth@health.gov.au** or telephone **(02) 6289 9853**.

The Charter is also available on the internet at **www.health.gov.au/privatehealth/consumers/charter/index.htm**

If English is not your first language, [information on](#) the Private Patients' Hospital Charter is available in other languages on the Department of Health and Ageing web-site at:

www.health.gov.au/privatehealth/consumers/charter/index.htm.

Planning your health care

Private patient or public patient?

One of the first steps in planning for your health care is to decide whether you wish to be treated as a private patient or a public patient.

What does it mean to be a public patient in a public hospital?

Under Medicare, Australian residents and “eligible persons” from countries with reciprocal health care agreements who elect to be admitted as a public patient are entitled to free treatment in a public hospital, including free accommodation, doctor services, diagnostic tests and medications (but excluding personal expenses such as TV hire or telephone calls). A public patient is treated by a doctor (or doctors) appointed by the hospital.

What does it mean to be a private patient?

A private patient can either be self-insured (ie. you must meet all the costs yourself except those medical costs covered by Medicare. See glossary for more detail) or have private health insurance.

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A private patient in a public hospital

Being a private patient in a public hospital gives you a choice of doctor. Depending on your illness or condition and your needs, this may or may not be the same doctor who would have been allocated to you by the hospital as a public patient.

A private patient in a private hospital

Depending on the circumstances, being a private patient in a private hospital or a private day hospital facility allows you to choose the doctor who treats you at a time that suits you.

What are the costs involved in being a private patient?

As a private patient in either a private or public hospital, you may be charged for a range of services which could include:

- hospital accommodation;
- care in intensive/critical care units;
- doctors' services (including diagnostic tests);
- operating theatre fees;
- allied health services (eg. physiotherapy);

- dressings, medications/drugs, other consumables and surgically implanted prostheses (eg. artificial hips); and
- personal expenses such as TV hire and telephone calls.

The hospital and the treating doctor(s) should, where possible, advise you on the services for which you will be billed.

Private Health Insurance

You may purchase private health insurance to cover all or some of the costs of health care as a private patient in either a public or private hospital or a private day hospital facility.

There are two types of private health insurance cover available: hospital cover and ancillary (or extras) cover.

Hospital cover helps with the cost of treatment such as hospital accommodation and your doctors' charges for admitted hospital services. This applies when you are a private patient in a public or private hospital or a private day hospital facility.

Ancillary cover helps with the cost of services that occur out of hospital and which are not covered by Medicare such as physiotherapy, dental treatment and optical appliances. Some funds offer packaged products that cover both hospital and ancillary services.

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Generally, the more extensive the health insurance cover, the higher the price (premium). When choosing your private health insurance, it is important to make sure it suits your particular needs, as well as your budget. Health funds should provide you with the information to make an informed choice about the private health insurance cover that is appropriate for you.

You should regularly check your cover to make sure it meets your needs.

What does your private health insurance cover?

As a private patient with private health insurance, all your hospital and medical bills may be covered by your insurance, or you may have to pay an amount out of your own pocket. The amount you will have to pay, if anything, depends on your type of cover. It also depends on whether your health fund, doctor and/or hospital have a gap agreement or gap cover scheme in place.

Medical costs

When you receive medical treatment in hospital as a private patient, Medicare pays 75 per cent of the Medicare Benefits Schedule (MBS) fee for the service of the doctors who treat you in hospital and your health fund pays the remaining 25 per cent of the MBS fee, provided you have hospital cover.

If your doctor charges above the MBS fee, your health fund may be able to cover this 'gap' if:

- **there is a gap agreement between your fund, hospital and/or doctor(s); or**
- **the fund has a gap cover scheme.**

When there is a gap agreement or gap cover scheme, you will either have no out-of-pocket expenses or you will be provided with details of your out-of-pocket expenses. You are always entitled to ask your doctor(s) for, and be given, an estimate of the costs in advance of your treatment, whether or not a gap agreement or gap cover scheme applies.

Most funds now offer gap benefits under agreements or schemes. In most cases these benefits have been added to existing policies - so you may already be covered for all or part of the gap. You should contact your fund to find out if it offers gap benefits under your policy - if it does not, you might consider transferring to another policy or health fund which does provide such benefits.

To ensure you know all the expected costs involved before agreeing to admitted hospital treatment you should speak to your doctor about his or her fees and those for associated specialists. You should also ask your doctor whether he or she participates in your fund's gap agreement or scheme. You can also talk to your fund about whether your doctor participates in the fund's agreement or scheme. This will help to ensure you don't receive any unexpected bills after your treatment.

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In certain circumstances, you may be referred by your General Practitioner (GP) to a specialist who has a private practice in rooms at a public or private hospital. If this happens, you are not an admitted patient of the hospital and will only receive 85 per cent of the MBS fee from Medicare. Currently the law does not permit health funds to provide any benefits for medical treatment provided outside hospital (ie. not admitted to hospital) for which there is a Medicare benefit payable.

Accident and Emergency

If you go to an emergency department of a private hospital, you will find that this part of the hospital does not admit patients. This means that if you require admission to the hospital, you may be transferred to a ward and then admitted.

Health fund hospital tables do not cover the medical fees and charges for services provided in private hospital emergency departments. This means that these fees are reimbursed as services to 'not admitted patients' by Medicare at 85% of the MBS fee, as they are for a visit to your GP. If tests are required in the emergency department (eg blood tests or x-rays), the gap between the MBS fee and the amount charged is not covered by any gap agreement or gap cover scheme your health fund may have for hospital treatment.

Many private hospitals charge a 'facility fee' for attendance at their emergency department to help off-set the cost of establishing and running this high cost facility. Your health fund may provide benefits covering a facility fee through ancillary tables. However, as the emergency department does not admit patients, a facility fee is not covered by hospital tables of your health insurance fund.

Having a baby in hospital

When you have a baby as a private patient in hospital you are an admitted patient of the hospital but generally your newborn baby is not an admitted patient. The newborn (who is nine days old or less) will only be an admitted patient if the baby:

- is admitted to an Australian Government approved neonatal intensive care unit; or
- is the second or subsequent baby born in a multiple birth; or
- is in hospital without his/her mother.

If your baby is not an admitted patient of the hospital and you, for example, elect to have your baby seen by a paediatric specialist, Medicare pays the first 85% of the schedule fee and you must meet all costs not covered by Medicare.

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You should check with your hospital and health fund to determine the health insurance status of your baby. The hospital and treating doctor should advise you on the services for which you will be billed.

Outreach Services

Some hospitals and day hospital facilities are able to provide treatment outside hospital (such as in the patient's home) where the hospital or day hospital facility has an approved outreach service. Treatment provided through an outreach service is a direct substitute for the treatment that would have been provided to the patient in the hospital or day hospital facility.

If you receive treatment through an outreach service, you are an admitted patient of the hospital or day hospital facility, even though your treatment is being provided elsewhere. You will be under the care of the hospital or day hospital facility and your treatment will be provided by the same doctors and nursing staff who would have treated you if you had been in the hospital or day hospital facility.

If you have hospital cover, your private health insurance will provide benefits for treatment provided through an outreach service.

Your hospital or day hospital facility will be able to advise whether it has an approved outreach service.

Hospital costs

The amount of benefit you receive from your health fund for hospital services will depend on the type of cover you purchase. It will also depend on whether your fund has a gap agreement or gap cover scheme in place with the hospital in which you choose to be treated. When there is an agreement or scheme you will have either no out-of-pocket expenses or you will be provided with details of your out-of-pocket expenses.

You are always entitled to ask for and be given an estimate of the costs in advance of your treatment. Ask your hospital or fund.

Confirm your level of cover

As soon as you know that you will need hospital treatment, where practicable, you should:

- contact your health fund to find out:
 - your level of hospital cover. Make sure your private health insurance does not exclude the procedure you need; and
 - whether waiting periods will apply. If you purchased your hospital cover in the past 12 months, be aware that there is a 12 month waiting period on hospital benefits for any pre-existing ailments. Where possible you should allow a few days for health funds to make an assessment;

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- ask your doctor(s) whether they are participating in your health fund's gap agreement or scheme;
- ask your hospital, doctor(s) or fund for an estimate of your admitted hospital medical costs not covered by Medicare or your private health insurance; and
- ask your doctor(s) or fund whether there is any additional payment required from you for any surgically implanted prostheses you need.

Check your level of cover with your health fund before you are admitted to hospital - your fund may need a few days to reply.

Long-stay patients

If your hospital stay is longer than 35 days and your doctor considers that you no longer need acute care, you will need to pay a contribution to your living costs in much the same way as nursing home residents contribute to the cost of their care. The patient contribution is payable by both public and private hospital patients and cannot be reimbursed by your health fund.

However, if your doctor considers that you still need acute care, you will not be required to pay a contribution to your living costs.

If you would like more information about the arrangements for long-stay patients, please talk to your hospital or health fund.

Waiting periods

When you take out private health insurance or upgrade your existing hospital cover, you may have to wait before you can claim for some services. The maximum waiting periods allowed under legislation are:

- 12 months for pre-existing ailments, and ailments, illnesses or conditions relating to an obstetric condition; and
- 2 months for all other ailments, illnesses or conditions.

Health funds can waive or reduce these waiting periods but they cannot increase them. Check with your health fund before you are admitted to hospital.

Waiting periods for ancillary services may vary between products and health funds. You should check the waiting periods on ancillary services carefully when choosing your health insurance fund and product.

Pre-existing conditions

When you decide to take out or upgrade your hospital cover you may already be ill or suffering from a medical condition. You have a pre-existing ailment or condition.

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A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time during the six months before the day on which you joined or upgraded to a higher level of hospital cover. Whether an ailment is "pre-existing" is determined by a medical practitioner appointed by the health fund. It is unnecessary for you or your doctor to have diagnosed the ailment, simply that signs and symptoms were in existence. In making this judgement, however, the fund-appointed practitioner must take into account the medical evidence presented by your own treating doctor(s).

This means that if you have less than 12 months membership of your current hospital cover and you need hospital treatment, you should confirm with your fund whether or not the pre-existing ailment waiting period applies to you.

It is important you do this before you are admitted if possible. Funds will need a few days to make this assessment, so contact your fund as soon as you know you have to go to hospital.

What you can expect from your doctor and hospital

The choice of being treated as a public or private patient in a public hospital

- You can expect to be asked before or on admission to a public hospital whether you wish to be treated as a private patient or a public patient, irrespective of whether you have private health insurance.
- You will be asked to sign a 'Patient Election Form', which will record your choice. This form should provide a clear and unambiguous explanation of the consequences of election. If you are unable to make an election at the time of admission, you will be asked to make a selection as soon as you or your legal guardian is able to do so. You will be treated as a public patient until this election is made.
- If you choose to be a private patient, you may not be able to change to be a public patient unless there are unforeseen circumstances such as complications requiring additional procedures or an extension of your length of stay.

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An explanation of any treatment(s) and associated risks before giving your consent to the treatment(s)

- Your doctor should give you a clear explanation of your diagnosis, your treatment and other treatment options available.
- You should be told that you are able to withdraw from treatment at any stage (with some exceptions).
- In an emergency, where it is not possible to obtain your consent, you will receive treatment.
- If you do not understand English, you should ask for an interpreter.

Advice about seeking other medical opinions

You can ask for referrals for other medical opinions, although there will almost certainly be additional costs associated with doing this (ie. any costs not covered by Medicare or your private health insurance).

Visiting Rights

You should approach your hospital about visiting rights, for example: facilities for visitors; rights of family access (and who is considered family); and the arrangements for the parents if the patient is a child.

Your choice of doctor and access to treatment in a public hospital, a private hospital or a private day hospital facility

- Depending on the circumstances, being a private patient in a private hospital or a private day hospital facility allows you to choose the doctor who treats you at a time that suits you. This is provided your doctor has an arrangement with that hospital to treat private patients and that the hospital you have chosen has beds and/or the services available.

Advice about the likely costs

- If your health fund has a gap agreement or a gap cover scheme with your doctor and/or hospital, the law requires that you are provided with the following information before you are admitted:
 - the doctors' fees relating to your treatment (for a gap cover scheme this advice must be in the form of a written estimate and you must acknowledge receipt of this advice);
 - the amount of any likely out-of-pocket expenses for the services provided by the hospital; and

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- (in the case of a gap cover scheme) any financial interest the doctor(s) involved in your treatment may have in recommending any products or services.
- Your doctor should outline any payment required from you for any surgically implanted prostheses you need.
- You always have a right to ask your doctor and/or hospital of expected treatment costs, even where no agreement or scheme exists.
- In an emergency, it is very unlikely there will be enough time to provide you with an estimate of out-of-pocket expenses prior to your admission. It is, however, your entitlement to be advised of these costs as soon as you are well enough.

You should ask your doctor(s), hospital or health fund for details.

Confidentiality and access to your medical records

- Your personal details will be kept strictly confidential. However, there may be times when information about you needs to be provided to another health worker to assist in your care, or if this is required or authorised by law.
- Your health fund needs access to certain information to allow payments to be made; you will need to sign a form to agree to this.

- Under Freedom of Information (FOI) legislation, you are entitled to see and obtain a copy of your medical records (with some exceptions or limitations) kept in a public hospital. You can also request that information be corrected.
- You can also approach private hospitals and your doctors to access the medical records they keep about you. The *Privacy Act 1988* provides you with a general right under the National Privacy Principles to access personal information collected about you by the private sector.

Treatment with respect and dignity

- You can expect to be treated with courtesy and to have your ethnic, cultural and religious practices and beliefs respected.
- You can legally discharge yourself at any time, even against the advice of your doctor or hospital staff. However, you must accept the associated risks and sign a form taking responsibility.
- Staff who attend you should always identify themselves.
- You should treat your health care workers and other patients with respect and courtesy.

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Care and support from nurses and allied health professionals

Nurses and allied health professionals (eg. physiotherapists) are a very important part of your treatment in hospital. Nurses provide vital care and support for patients, while allied health professionals provide a range of services.

- You should feel confident to discuss any issues in relation to your treatment or hospital experience with your nurse(s) or allied health professional(s).

You can help your doctor(s) and hospital staff provide you with better care by:

- letting your doctor(s) and hospital know about any physical or psychological conditions affecting you, eg. allergies;
- providing your doctor(s) with information such as your medical and family history, as required; and
- informing your doctor(s) and hospital about any other treatment you are receiving or medication or complementary medicines you are taking (whether prescribed by a doctor or bought over the counter), and taking your medicines with you when you go to hospital.

Advice about care after discharge

- You can expect to be consulted, before you leave hospital, as part of planning for your continuing health care. This includes being given information on the need for, and costs of, further medical care, medication, home nursing, or other community services. You should also be asked whether you need help with transport home. Some health funds can help patients arrange their care after discharge.
- You should actively participate in the planning of your after-discharge care.

Advice on how to make a compliment or a complaint about your health care or treatment

- You are entitled to comment on, or complain about, the services you received in hospital. You should approach the staff caring for you and raise your concerns at the time.
- If you would like to make a formal statement about the care you received, you should contact or write to the officer responsible for handling complaints at the hospital where you were treated. You should be advised who is the Complaints Officer within the hospital.

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- If you would like to make a complaint about your health care or treatment but you are incapacitated, you should be provided with assistance to make the complaint, including the writing down of details about the complaint.
- Your hospital would also appreciate hearing from you if you have a suggestion for improvements or a compliment.
- There are a number of complaints bodies listed at the end of this Charter, which you can approach if you are not satisfied with the manner in which your complaint has been dealt with by the hospital.

What you can expect from your health fund

Clear, timely and accurate advice about:

- the types of health insurance cover available, as well as the premiums and benefits of each type of cover (including advice about reviewing your health cover when your needs change);
- your level of cover and the likely out-of-pocket expenses, including any excess or co-payments that you may face while you are in hospital;

- your certified age at entry under the Lifetime Health Cover arrangement and any periods of absence accrued; and
- any conditions of the health insurance cover such as waiting periods before benefits are payable, inclusion of newborns, health fund rules regarding pre-existing ailments or illnesses, and treatment not covered by your health insurance.

Note: Funds can only provide advice about definite out-of-pocket costs when there is a gap agreement or scheme in place with the relevant doctor or hospital. Funds should, nevertheless, be able to provide information as to the likely benefit level even in the absence of an agreement or scheme.

Reassurance that you can:

- upgrade your cover with the same fund at any time and be advised of any waiting and benefit limitation periods that apply before you are eligible to claim higher benefits; and
- transfer from one fund to another without being faced with any additional waiting periods, provided that you are taking out a comparable or lower level of cover with your new fund.

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If you have hospital cover, you can transfer between funds at the same or a lower level cover, without serving additional waiting periods. This is sometimes called portability between health funds. The fund you transfer to must give you credit for any waiting periods already served. You may have to serve additional waiting periods if you upgrade your level of cover even if it is with your current fund.

Check your entitlements with your new health fund before transferring.

You can also ask for the brochure entitled: "The Right To Change" available from your health fund.

Advice on making a complaint

If you have concerns regarding your hospital care under your health insurance cover, your health fund would like to know. You should, however, advise the hospital about your concerns first.

You are entitled to have a complaint satisfactorily addressed by your health fund when you have concerns about any aspect of the service provided by your fund. If you have a complaint you should first formally approach your health fund and proceed through their complaints handling process. If you think your health fund has not dealt with your complaint in a satisfactory manner you can contact the Private Health Insurance Ombudsman (see page 26).

**You can help your health fund
provide you with a better service by:**

- obtaining confirmation of your entitlements in writing from your fund, before going ahead with any treatment or hospitalisation; and
- reviewing your health cover regularly so that it continues to meet your needs.

Contact for health insurance complaints

Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman is an independent national body established to deal with enquiries and complaints about private health insurance arrangements.

Level 7
362 Kent Street
SYDNEY NSW 2000

Telephone: **(02) 8235 8777**

Facsimile: **(02) 8235 8778**

Toll free: **1800 640 695**

www.phio.org.au

Email: info@phio.org.au

Complaints resolution bodies

State and territory complaints resolution bodies are all independent organisations dealing with complaints about health services (such as hospitals, medical centres and nursing homes) and individual health practitioners (such as doctors, nurses, dentists and counsellors).

NEW SOUTH WALES

Health Care Complaints Commission

Telephone: **(02) 9219 7444**

Toll free: **1800 043 159**

TTY for hearing impaired

(02) 9219 7555

www.hccc.nsw.gov.au

VICTORIA

Office of the Health Services
Commissioner

Telephone: **(03) 8601 5200**

Toll free: **1800 136 066**

TTY for hearing impaired

1300 550 275

www.health.vic.gov.au/hsc

QUEENSLAND

Health Rights Commission

Telephone: **(07) 3234 0272**

Toll free: **1800 077 308**

TTY for hearing impaired

(07) 3225 2559

www.hrc.qld.gov.au

AUSTRALIAN

CAPITAL TERRITORY

Community and Health Services
Complaints Commissioner

Telephone: **(02) 6205 2222**

TTY for hearing impaired

(02) 6205 1666

www.healthcomplaints.act.gov.au

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WESTERN AUSTRALIA

Office of Health Review

Telephone: **(08) 9323 0600**

Toll free: **1800 813 583**

www.healthreview.wa.gov.au

TASMANIA

Office of Health

Complaints Commissioner

Telephone: **(03) 6233 6348**

Toll free: **1800 001 170**

[www.justice.tas.gov.au/
health_complaints/home.html](http://www.justice.tas.gov.au/health_complaints/home.html)

NORTHERN TERRITORY

Health Complaints Commission

Telephone: **(08) 8999 1969**

Toll free: **1800 806 380**

[www.nt.gov.au/omb_hcsccl/
HCCSC/welcomelh.htm](http://www.nt.gov.au/omb_hcsccl/HCCSC/welcomelh.htm)

SOUTH AUSTRALIA

Complaints concerning
publicly funded hospitals
and mental health facilities.

South Australian

Ombudsman's Office

Telephone: **(08) 8226 8699**

Toll free: **1800 182 150**

www.ombudsman.sa.gov.au

Complaints concerning
medical practitioners:

Medical Board

of South Australia

Telephone: **(08) 8362 7811**

www.medicalboardsa.asn.au

The Office of the Federal Privacy Commissioner

The Office of the Federal Privacy Commissioner is an independent national office established to deal with enquiries and complaints about privacy and the handling of personal information. The Privacy Commissioner is able to deal with complaints on the handling of personal information held in the private sector. If you have a complaint you should raise the complaint with the relevant organisation or individual prior to raising it with the Privacy Commissioner.

Further information is available at the following website
www.privacy.gov.au

GPO Box 5218
Sydney NSW 2001

Telephone: **1300 363 992**
(for the cost of a local call anywhere in Australia)
TTY for hearing impaired: **1800 620 241**
Facsimile: **(02) 9284 9666**
Email: privacy@privacy.gov.au

Additional information on Private Health Insurance

Private Health Insurance Administration Council

The Private Health Insurance Administration Council (PHIAC) is an independent statutory authority that regulates the private health insurance industry. In addition, PHIAC collects and disseminates financial and statistical data regarding health funds; and collects and disseminates information about private health insurance to enable consumers to make informed choices.

Suites 1 & 2
31 Thesiger Court
Deakin ACT 2600

Phone: **(02) 6215 7900**

Fax: **(02) 6215 7977**

Email: phiac@phiac.gov.au

Website: www.phiact.gov.au

Glossary

Benefits: money or services you may receive from your health fund.

Charter: a formal document detailing rights and privileges.

Co-payments: A co-payment is an agreed amount paid towards the total cost of each day spent in hospital. For example, you might agree to pay the first \$50 for each day's hospital admission.

Eligible person: a visitor to Australia from a country that has an agreement with the Australian Government under which the visitor is entitled to immediately necessary medical treatment free of charge at an Australian public hospital.

Excess: An excess is an amount of money you pay towards the cost of hospital treatment, regardless of the number of days of hospitalisation. For example, you have membership with an excess of \$300. This means if you go to hospital you pay the first \$300 of hospital charges for your care.

Facility Fee: the fee charged by some private hospitals for attendance at their accident and emergency department, to offset the cost of establishing and running a high-cost facility.

Gap Agreement: a contractual agreement under which registered health benefits funds are permitted to pay benefits above the Medicare Benefits Schedule (MBS) fee for admitted patients.

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Gap Cover Scheme: a scheme that allows a registered health benefits fund to pay benefits above the MBS fee for admitted patients without the need for contracts.

Hospital costs: costs associated with your stay in hospital, such as nursing and accommodation.

Lifetime Health Cover: Lifetime Health Cover is a system of private health insurance that was introduced on 1 July 2000. Under Lifetime Health Cover, health funds are required to charge members different premiums based on the age they are when they first take out hospital cover. When you first take out hospital cover, for every year you are aged over the age of 30, you will pay an additional 2% loading on top of your hospital cover premium. For example, someone who first takes out hospital cover at age 40 will pay 20% more than someone who first took out hospital cover before the age of 31. People born on or before 1 July 1934 can join at any time and not have to pay the 2% increase.

Medical costs: costs associated with the provision of medical services.

Out-of-pocket expenses (the gap): the out-of-pocket costs you have to pay for in-hospital medical services and hospital services that are not covered by Medicare or your fund.

Prostheses: Prostheses are the manufactured items that are surgically implanted during an in-hospital medical procedure. These prostheses do not include items that are not permanently inserted into people, such as artificial limbs, external mammary prostheses or wigs.

Schedule fee: The Government sets a schedule of medical fees - called the Medicare Benefits Schedule - based on a fair price and how much Australia can afford to pay for the total health system. Whether you are a member of a health fund or a private patient paying for all your own costs, the Government provides a rebate on nearly all medical fees. This rebate is currently 75% of the MBS fee for admitted hospital medical services to private patients and 85% of the MBS fee for medical services incurred out of hospital. Your doctor can, however, choose to charge more than the scheduled fee.

Self-insured: In electing to be a private patient you are responsible for paying hospital and medical fees connected with your treatment. You can either be self-insured or have private health insurance. If you are self-insured you will be required to meet all costs not covered by Medicare. You will be eligible for a 75% rebate on services covered by Medicare. You will be responsible for paying all other costs.

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Contact the Australian Government Department of Health and Ageing on: **(02) 6289 9853**

- For more copies of the Private Patients' Hospital Charter; or
- To find out more about private health insurance issues; or
- To comment on this Charter.

