The Role of Private Hospitals in Australia's Universal Health Care System

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Executive Summary

In the wake of the COVID-19 pandemic, provincial governments across Canada relied on private clinics in order to deliver a limited number of publicly funded surgeries in a bid to clear unprecedented surgical backlogs. Subsequently, surveys indicated that 78% of Canadians support allowing more surgeries and tests performed in private clinics while 40% only support this policy to clear the surgical backlog. While a majority of Canadians are either supportive (or at the very least curious) about these arrangements, the use of private clinics continues to be controversial and raise questions around their compatibility with the provision of universal care.

The reality is that private hospitals play a key role in delivering care to patients in other countries with universal health care. Canada is only one of 30 high-income countries with universal care and many of these countries involve the private-sector in their health-care systems to a wide extent while performing better than Canada. Australia is one of these countries and routinely outperforms Canada on key indicators of health-care performance while spending at a similar or lower level. Like Canada, Australia ranked in the top ten for health-care spending (as a percentage of GDP and per capita) in 2020. However, after adjusting for the age of the population, it outperforms Canada on 33 (of 36) measures of performance. Importantly, Australia outperformed Canada on a number of key measures such as the availability of physicians, nurses, hospital beds, CT scanners, and MRI machines. Australia also outperformed Canada on every indicator of timely access to care, including ease of access to after-hours care, same-day primary care appointments, and, crucially, timely access to elective surgical care and specialist appointments.

Australia's universal system is also characterized by a deep integration between the public and private sectors in the financing and delivery of care. Universal health-insurance coverage is provided through its public system known as Medicare. However, Australia also has a large private health-care sector that also finances and delivers medical services. Around half of the Australian population (55.2% in 2021/22) benefit from private health-insurance coverage provided by 33 registered not-for-profit and for-profit private insurance companies.

Private hospitals (for profit and not for profit) made up nearly half (48.5%) of all Australian hospitals in 2016 and contain a third of all care beds. These hospitals are a major partner in the delivery of care in Australia. For example, in 2021/22 41% of all recorded episodes of hospital care occurred in private hospitals. While delivering a small minority of emergency care (8.2%), private hospitals delivered the majority of recorded elective care (58.6%) and 70.3% of elective admissions involving surgery.

Private hospitals primarily deliver care to fully funded public patients in two ways. The first is contracted care, either through *ad hoc* inter-hospital contracts or formal programs. Fully publicly funded episodes of care occurring in private hospitals made up 6.4% of all care in private hospitals, while representing 2.6% of all recorded care. The second way is privately delivered care paid for through the Department of Veterans' Affairs. A full 73.5% of care paid for by the Department of Veterans' Affairs occurred in private hospitals.

It would be easy, however, to underestimate the significance of this public-private partnership by examining only the delivery of care that is fully publicly funded. Privately insured care is also partially subsidized by the government, at a rate of 75% of the public fee. Therefore, in order to understand the full extent of publicly funded or subsidized care in private hospitals, it is helpful to examine private hospital expenditures by the source of funds. In 2019/20, 32.8% of private hospital expenditures came from government sources, 18.2% of which came from private health-insurance rebates. This means that a full third of private hospital expenditure comes from a range of public sources, including the federal government.

Overall, private hospitals are important partners in the delivery of care within the Australian universal health-care system. The Australian system outranks Canada's on a range of performance indicators, while spending less as a percentage of GDP. Further, the integration of private hospitals into the delivery of care, including public care, occurs while maintaining universal access for residents.

Introduction

Following the pandemic, and in the face of ballooning backlogs, several provinces contracted with private clinics to deliver publicly funded surgeries. This strategy was instrumental in reducing wait times in Saskatchewan in the first half of the 2010s, and is a well-documented feature of universal health-care systems around the world. However, the reality is that provincial governments have typically eschewed the use of private clinics to deliver publicly funded surgeries. And, despite the fact that a majority of Canadians (61%) now either support or are curious about the private delivery of publicly funded care, decisions to contract with private providers are nearly always controversial and frequently evoke concern about their compatibility with the existing publicly funded universal system (Angus Reid, 2023).

Canada is one among 30 high-income countries with a universal health-care system. Each of these countries have achieved universal health-care coverage by different means and, naturally, all have different approaches to their workforce, hospitals, and the involvement of the private sector. Many of these countries, including those with greater private-sector involvement, also maintain universal systems that outperform Canada's on a number of key performance metrics, including availability of resources and timely access to care (Moir and Barua, 2022).

One country that routinely outperforms Canada on key indicators of health-care performance with similar (or lower) expenditure is Australia. Australia's approach to universal health care relies on a deep integration of its public and private health-care sectors. Indeed, this functioning partnership of Australia's public and private sectors serves as an example of the compatibility between this arrangement and the goal of universal health care.

This study summarizes the role of private hospitals in Australia's health-care system with particular emphasis on the delivery of publicly funded care within Australia's universal system. The first section summarizes the performance of Australia's health-care system in comparison to its international peers. Section 2 provides a brief overview of the organization, financing, and structure of Australia's insurance system. Section 3 documents the number of public and private hospitals in Australia, as well as their defining characteristics. Section 4 describes how publicly funded care is delivered in private hospitals in Australia. A conclusion follows.

1 The Performance of Australia's Health Care System

Before outlining the structural features that differentiate the Australian health-care system, it is helpful to examine its performance. Moir and Barua (2022) compared 30 high-income countries with universal health care on several indicators measuring their overall performance. In addition to health-care spending, these performance indicators fell into four groups: [1] availability of resources; [2] use of resources; [3] access to resources; and [4] clinical performance. These countries were also compared with one another based on indicators measuring overall health status (for example, life expectancy at birth, infant mortality, and treatable mortality).

After adjusting for age, Moir and Barua (2022) found that Australia spent 11.5% of its GDP on health care, ranking 7th highest out of 30. For comparison, Canada spent 13.3% of its GDP on health care, ranking highest out of 30. [1] When per-capita spending was examined, Australia spent US$6,089 PPP per person and ranked 6th out of 30 countries. Canada ranked just behind Australia at 8th out of 30, spending $5,988 per capita. Both countries ranked above the OECD average on both spending as a percentage of GDP (10%) and spending per capita ($4,627).

For overall performance, Australia reported on 36 relevant indicators. Of these 36 indicators, after adjusting for age, Australia outperformed Canada on 33 of 36 indicators. Importantly, Australia outperformed Canada on a number of key measures such as the availability of physicians, nurses, hospital beds, CT scanners, and MRI machines. [2]. When timely access to resources was examined, Australia outperformed Canada on every indicator. These included measures of ease of access to after hours care, same day primary care appointments and, crucially, timely access to elective surgical care and specialist appointments. [3] Australia also outperformed the OECD average on 24 of 36 indicators (Moir and Barua, 2022).

[1] Data are for 2020 or most recent year available in (Moir and Barua, 2022).

[2] The availability of resources measures the number of medical personnel, equipment, and technology relative to the population.

[3] The OECD collects publishes several measures on wait times for a range of select procedures (e.g., cataract surgery, coronary bypass, knee replacements). These data are not included in here, or in Moir & Barua, 2022 because there are concerns about comparability, as both Australia and Canada (in addition to Denmark and Norway) are flagged by the OECD for having methodological and definitional differences from the rest of the cohort that affect how data for these variables are reported. Importantly, these are considered priority procedures in Canada and receive targeted funding that may biase results, and do not represent wait times for the system as a whole.

2 Organization, Financing, and Insurance in Australia's Universal Health Care System

In 2020/21, Australia spent AUD220.9 billion on health care. Of this, approximately 42.7% was spent by the federal government, 27.9% came from state and territorial governments, and 29.4% from non-government sources. Non-government sources spent AUD64.9 billion on health, with 51.1% coming from individuals, 27.8% from private insurance providers, and 21.1% from other non-governmental sources (Australian Institute of Health and Welfare, 2022c).

Australia's universal health-care system can be characterized as a primarily tax-funded public system. Universal health-insurance coverage is provided through its public system known as Medicare. Australia also has a large private health-care sector that also finances and delivers medical services.

The federal government in Australia plays a leadership role in formulating health policy and is primarily responsible for the funding of inpatient and outpatient care through the Medical Benefits Scheme (MBS); and outpatient medicines through the Pharmaceutical Benefits Scheme (PBS). The federal government is also responsible for supporting and regulating the private health-insurance industry (Glover, 2020).

Responsibility for the delivery of health care, and some financing, is decentralized. State governments are responsible for the management and delivery of hospital services at public hospitals, community care, public dental and mental health care, and the regulation of private hospitals. They also fund public hospitals using their own tax revenue in addition to federal transfers (Glover, 2020).

Financing for Australia's health-care system primarily comes through general taxation at both the federal and state levels. [4] [5] In addition to using general taxation to finance health care, the federal government also imposes Medicare-specific

[4] The federal government provides a general transfer to the states for health care, education, and other programs that is financed from a 10% goods and services tax (GST) (Australian Government, 2022).

[5] Hospitals are funded by both the federal and state governments. Until 2011, the federal government provided states with health care-specific funding through the National Healthcare Agreements, a block grant negotiated every 5 years (Biggs, 2018; Healy, Sharman, and Lokuge, 2006: 46). Since then, the annual growth in federal funding for hospitals is limited to "45% of the efficient growth in hospital services (based on an efficient price)" over a pre-determined base. For more details, see Biggs, 2018.

"levies" based on income. These include [1] the Medicare Levy: a 2% contribution on taxable income; and [2] the Medicare levy surcharge: an additional 1%–1.5% on taxable income for those above a specific income threshold who do not purchase private insurance (Australian Taxation Office, 2023b, 2023c).

The public scheme provides benefits for care (through the MBS) and pharmaceuticals (through the PBS). Benefits on the MBS are extensive, but generally cover items such as consultation fees for physicians (GPs and specialists), hospital care, maternity care, mental health care, prescribed diagnostic testing, surgeries and therapeutic procedures performed by a physician, some dental care and surgeries, and some optometry care (eye tests). The PBS is the benefit schedule for outpatient prescription medicine. Patients are frequently expected to pay for a portion of the cost of medicines on the PBS through a co-payment (Glover 2017, 2020; Healy, Sharman, and Lokuge, 2006).

In addition to the public scheme, Australia also has an extensive private healthcare insurance sector that provides duplicate, supplementary, and complementary coverage (Ellis, Chen, and Luscombe, 2014). Currently, there are 33 registered not-for-profit and for-profit private insurance companies in Australia (Australian Competition & Consumer Commission, 2022). In 2021/22, approximately 55.2% of the Australian population had a private health-insurance policy (Private Healthcare Australia, 2023).

Among other insurance products, [6] [7] these firms also offer hospital coverage, which provides coverage for patients who wish to be treated as a private patient in a public or private hospital. These patients receive a public subsidy of 75% of the MBS fee, and can use private insurance to cover the remainder (further details below).

The Australian government actively encourages the uptake of private insurance. In addition to the Medical Levy Surcharge mentioned above (which applies an additional tax to high income earners without private insurance), it also provides a means-tested rebate to individuals and families who purchase a private health-insurance plan that covers general care, hospital treatment, and ambulance services [8] to reduce the effective after-tax cost of purchasing private health insurance. Through the "Life

[6] Other products include [1] general treatment coverage, [2] ambulance coverage, [3] broader health coverage. For more information, see (Australian Government n.d.-b).

[7] Private insurers cannot cover gap payments for ambulatory GP or specialist care.

[8] The basis of this rebate has evolved over the years; today it is based on age and means testing, and what is referred to as the "Rebate Adjustment Factor", the difference between the Consumer Price Index (CPI) and the industry-weighted average increase in premiums. The rebate is approximately "25% now for most members" (Australian Government n.d.-a; Department of Health and Aged Care, Australia, 2023b); Private Healthcare Australia 2020: 13). For more information on income thresholds and age bands for rebate, see Australian Government, n.d.-a.

Time Health Cover" the Australian Government also requires that those over the age of 30 without private insurance must pay an increased amount on their premiums in the event they decide to purchase coverage. [9]

Australians are also expected to share in the cost of some of the health-care services they receive. This expectation depends on where a patient decides to receive care. For example, while the MBS fee is covered at 100% by the public plan for a visit to a general practitioner, general practitioners may set their fees above this MBS rate. When this occurs, it is the patient who is responsible for making up the "gap payment", which is the difference between the fee set by the physician and the reimbursement rate. [10] Patients are also commonly expected to pay a co-insurance fee for specialist consultations, as only 85% of the MBS fee is reimbursed, leaving the patient responsible for, at least, the remaining 15%. Specialists may also charge above the MBS fee. [11]

For hospital care, Australian's may choose to be treated as either a public or private patient in a public hospital, may receive care as a public patient in a private hospital through contracting arrangements (discussed below), or may choose to be treated as a private patient in a private hospital. Public patients are covered at 100% of the MBS, whereas those who choose to be treated as a private patient (be it in a public or private hospital) receive coverage at only 75% of the federally determined medical services fee. Private patients are expected to make up the difference out of pocket or through their private insurance.

[9] This amount increases by 2% for every year after 31 without coverage. Once applied, individuals must pay for this increase in insurance premiums for 10 consecutive years of coverage. The maximum increase that can be applied is capped at 70% (Australian Taxation Office, 2023a).

[10] Physicians who do not set their fees above the federal schedule retain their ability to directly bill the government (known as bulk billing).

[11] For a more detailed explanation of cost-sharing in Australia, see Barua and Moir, 2022.

3 Ownership of Hospitals and Delivery of Care

In Australia, hospital care is provided by both public and private hospitals. In 2016, 698 (51.5%) of Australia's hospitals were public, 543 (40.1%) were private for-profit, and the remaining 114 (8.4%) were private not-for-profit (table 1). Despite a near even split between the number of public and private hospitals, out of the available 92,826 hospital beds in 2016, 61,797 (66.6%) were in public hospitals. The remaining beds were split between private for-profit hospitals with 17,477 beds (18.8%) and the private not-for-profit hospitals with 13,552 (14.6%). [12] [13]

Table 1: Breakdown of hospitals by ownership, 2016

Type of hospital	Number of hospitals (percentage)	Number of beds (percentage)
Public hospitals	698 (51.5)	61,797 (66.6%)
Private for-profit	543 (40.1%)	17,477 (18.8%)
Private not-for-profit	114 (8.4%)	13,552 (14.6%)
Total	1,355 (100%)	92,826 (100%)

Source: OECD, 2023; calculations by authors.

[12] 2016 data are used here as they are the latest available that is able to provide both a comparison between the number of hospitals broken down by ownership status and the capacity of those hospitals (as measured by bed count) based on the same ownership breakdown.

[13] In 2020/21, data reporting on public hospitals tend to classify them as either acute (674 hospitals) or psychiatric (23 hospitals) (Australian Institute of Health and Welfare, 2022b). Private hospitals, on the other hand, tend to be classified as day facilities (303 hospitals) or as "other" (280 hospitals) (Department of Health and Aged Care, Australia, 2022a). According to the Department of Health and Aged Care (2022a), the "number of hospitals reporting to PHDB refers to a count of distinct hospital provider numbers reporting to PHDB during a financial year and is not necessarily a measure of the number of physical hospital buildings". According to the list of declared hospitals published in Department of Health and Aged Care, Australia, 2023a, there were 644 declared private hospitals in 2023.

Public hospitals

Public hospitals are funded by both federal and state/territorial governments, but the delivery of services remains the responsibility of states (Productivity Commission, 2009). They are "operated by, or on behalf of, the government of the state or territory in which it is established" and treat public patients free of charge. They also provide care to a "significant number of fee-paying patients" who choose to be treated as a private patient in the public facility (Productivity Commission 1999: 5, 2009: 18). One major advantage of being treated as a private patient in a public hospital is that one has a choice of doctor. Some private insurance plans may also cover the cost of a single room (Australian Government, n.d.-b). [14]

The explicit role of public hospitals is to "provide acute medical care, including emergency services and complex specialist procedures, as well as to undertake the clinical research and training needed to sustain the hospital sector" (Productivity Commission 2009: 23). These facilities also provide advanced treatments such as intensive care, major surgery, and organ transplants. Further, hospitals that are associated with university medical schools, and large tertiary care centres, have a "teaching function" within the system (Esmail 2013: 20).

Private hospitals

The key characteristics of a private hospital in Australia are: [1] private ownership; [2] private operation; [3] the charging of patient fees; and [4] providing patients a choice of doctor [15] (Boxall, Tobin, and Gillespie, 2014; Productivity Commission, 1999, 2009). These hospitals have traditionally been "involved [primarily] in the provision of services to fee-paying private patients" (Productivity Commission 1999: 5).

While hospitals may be privately owned, they are still licensed and regulated by government (Australian Institute of Health and Welfare, 2016). [16] Private not-for-profit hospitals tend to be operated by religious and charitable entities (for example, the Catholic Church) or other not-for-profit entities. For-profit facilities can be sub-divided into group/chain hospitals and independent facilities (Productivity Commission, 1999).

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[14] However, public waiting lists still apply in this care (Australian Government n.d.-b).

[15] According to the Productivity Commission (2009), many medical specialists have "rights of private practice" in addition to having an "established relationship with one or more private and/or public hospitals". It is common that those working in both sectors will be "a salaried or sessional medical officer in the public sector" and "an independent practitioner in the private sector" (2009: 62).

[16] Institutions must be "declared to be a hospital by the Minister for Health and Aged Care under section 121-5 of the Private Health Insurance Act 2007 to receive private health insurer benefits" (Department of Health and Aged Care, 2022b).

Private hospitals tend to be smaller institutions that have historically dealt with a more limited range of cases. Private hospitals have "traditionally provide[d] less complex non-emergency care for private patients" while being "focused on providing an alternative to elective surgery in public hospitals" (Esmail 2013: 20). Private hospitals are, at times, contracted by the public health-care system to provide care to public patients. In 2016/17, there were at least 11 hospitals that were privately owned that predominantly provided public care (Australian Institute of Health and Welfare, 2019). [17] [18] [19]

Figure 1 shows the split between public and private hospitals for "separations" by urgency of admission, which hereafter are simply referred to as "care episodes". [20] In figure 1, these care episodes are classified as emergency, elective, or not aassigned. [21] The overall total for 2021/22 (the latest data available) is also included. In total, 59% of care episodes occurred in public hospitals while private hospitals accounted for the remaining 41%. [22] However, the split by classification reveals the differing nature of public and private hospitals: while only 8.2% of emergency care episodes occurred in private hospitals, they accounted for a majority (58.6%) of recorded elective care

[17] For discussion on different Public Private Partnerships (PPPs) in the Australian hospital industry, see Productivity Commission, 1999.

[18] Private hospitals may also "co-locate" with a public facility, forming a "joint medical facility or precinct". Co-located facilities operate at "arms length", with the private hospital not "usually involved in the delivery of any public hospital services", despite the potential for a "sharing of facilities" (Productivity Commission, 1999: 9). There were 47 private hospitals co-located with a public hospital in 2013/14 (Australia Bureau of Statistics, 2016).

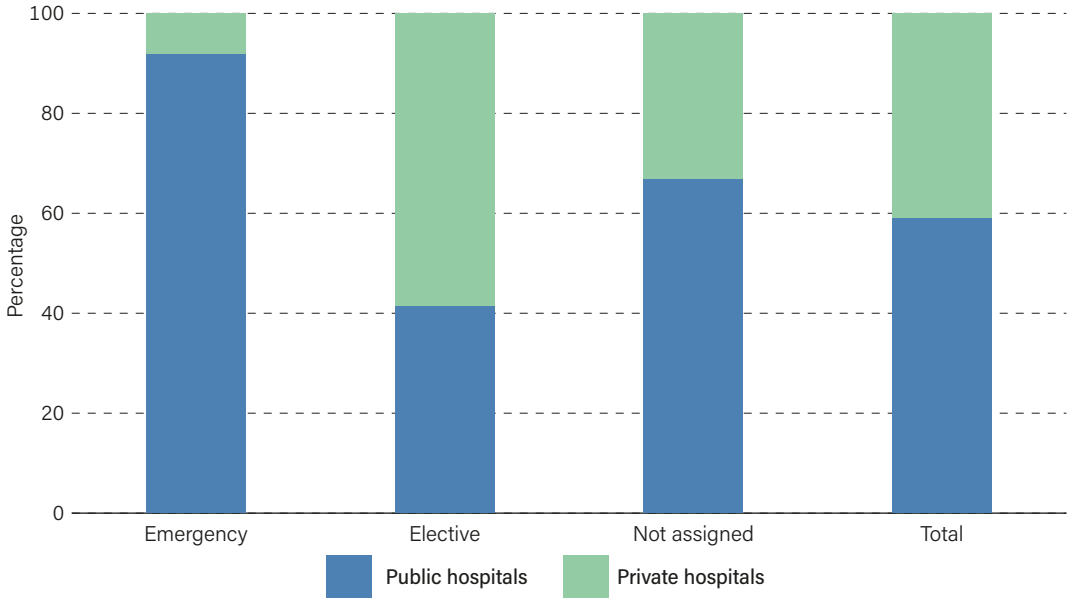
[19] In Australia, it has been recognized that the lines between the public and private hospitals, and health care at large, are often "blurred" (Boxall, Tobin, and Gillespie, 2014: 4; Healy, Sharman, and Lokuge, 2006: 34; Productivity Commission, 1999: 2). A part of this may be attributed to the fact that the role and features of the public hospital sector have been "changing over time" in concordance with population needs and characteristics "as private hospitals adopt some of the functions traditionally reserved for the public sector". The result is a settlement where public hospitals "do not typify" their traditional model, and where private hospitals increasingly "resemble public hospital establishments" (Productivity Commission, 2009: 23).

[20] "Separations" refer to "[a]n episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital, or changing type of care" (Australian Institute of Health and Welfare, 2023b).

[21] Emergency admissions occur "if a patient requires admission within 24 hours"; elective admissions are defined as "one that could be delayed by at least 24 hours" (Australian Institute of Health and Welfare, 2023b).

[22] Figure for total separations (care episodes) includes the following admission urgencies: emergency, elective, not assigned, and not reported. See Australian Institute of Health and Welfare, 2023d: table 4.3 for additional information.

Figure 1: Episodes of care (separations) for patients admitted to public and private hospitals in Australia, by urgency of admission, 2021/22



Note: The figure for total separations in this data set also includes those "for which the urgency of admission was not reported".
Source: Australian Institute of Health and Welfare, 2023d: table 4.3.

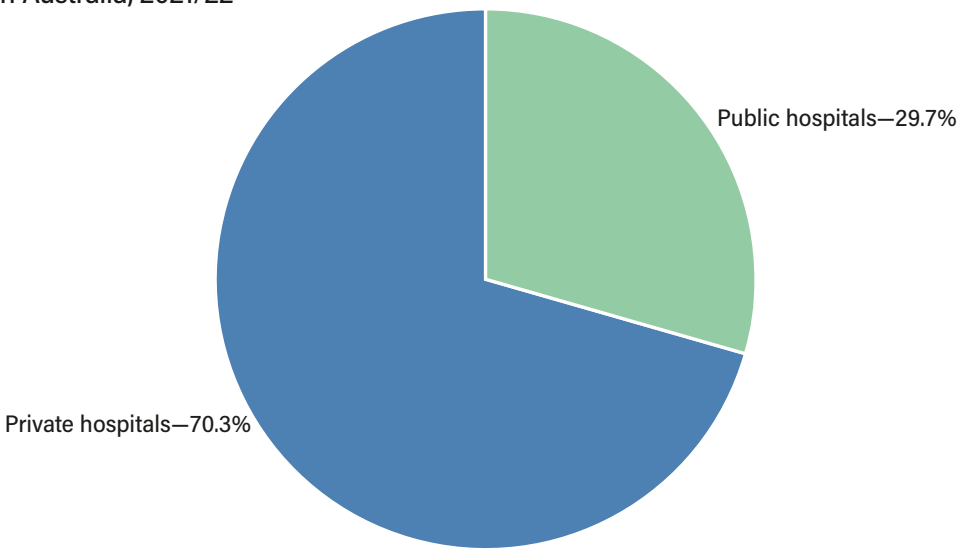
episodes. Put simply, in general, public hospitals in Australia fulfil a role within the overall health-care system different from that of private hospitals, which focus on providing elective care.

The role of private hospitals within Australia's universal health-care framework in providing elective admissions involving surgery [23] is even greater. As shown in figure 2, 70.3% of elective admissions involving surgery were performed in a private facility in 2021/22. While private hospitals clearly deliver the majority of elective care in Australia, they also provide a number of other types of medically necessary care. For example, in 2020/21, more Chemotherapy, Interventional cardiology, ENT, Gynaecology and Ophthalmic care episodes were reported in private hospitals compared to public hospitals (Australian Institute of Health and Welfare 2022b).

A broad overview of the characteristics of the care provided to admitted patients in public and private hospitals is shown in table 2.

[23] Here elective admission is one "that could be delayed by at least 24 hours" and, as long as it meets this definition, is categorized as "elective, regardless of when the admission occurred" (Australian Institute of Health and Welfare, 2023b).

Figure 2: Elective admissions involving surgery to public and private hospitals in Australia, 2021/22



Source: Australian Institute of Health and Welfare, 2023d: table 6.24.

Table 2: Characteristics of the care provided to patients admitted to public and private hospitals in Australia, 2021/22

	Public hospitals	Private hospitals	All Hospitals
Hospitalizations	6.8 million	4.8 million	11.6 million
Medical	4.8 million	1.6 million	6.4 million
General intervention (Surgical)	999,000	1.6 million	2.6 million
Specific Intervention	443,000	933,000	1.4 million
Childbirth	232,000	69,000	301,000
Mental health care	134,000	218,000	352,000
Sub-acute and non-acute care	211,000	332,000	543,000
Overnight versus same day	55% same-day stays	73% same-day stays	64% same-day stays
Number of days of patient care	21.7 million (average annual increase of 1.9% since 2017/18)	10.0 million (average annual increase of 0.2% since 2017/18)	31.8 million (average annual increase of 1.3% since 2017/18)
Average length of stay (for overnight stays)	5.9 days	5.2 days	5.7 days

Source: Australian Institute of Health and Welfare, 2023a.

4 Publicly Funded Care in Private Hospitals

The previous section clearly documents a significant role for private hospitals in Australia's overall health-care system, accounting for 48.5% of facilities and 33.4% of beds. Further, 41% of care episodes took place in private hospitals. However, this data should not be taken to mean that these facilities operate exclusively outside the purview of the universal health-care system. While they perform an important supplementary and complementary role, they also serve as an important partner for the delivery of publicly funded care. This is primarily done in three ways.

1 Contracting

The most direct way in which private hospitals deliver publicly funded care is by being contracted for the provision of medical and surgical services, a practice that has been ongoing since, at least, the early 1990s (Productivity Commission, 1999). According Boxall, Tobin, and Gillespie (2014), there are two main ways in which this type of contracting occurs in Australia. Contracting is, often, short term and used *ad hoc* to manage lengthening wait lists that deal with "particular specialties in a local area". They can also, occasionally, take the form of "a more general state-wide program". [24]

Programs have, in the past, ranged from using off-hand arrangements, where local heath districts have been able to determine if they want to use contracting, assuming they must abide by a set of "procurement principles", to more formalized and structured approaches (Boxall, Tobin, and Gillespie, 2014: 6). One example of a more formalized and structured approach is the Queensland Surgery Connect program. The program allows patients who have waited longer than what is recommended [25] for an elective surgery to be offered an opportunity to be treated at a private hospital under the public plan (Queensland Health, n.d.). [26] In Quarter 2 of 2022, there were 4,100 patients who used this program (Queensland Health, 2023).

[24] An example of the latter occurred in New South Whales in 2006, where 1,020 public surgical patients were treated privately.

[25] An urgency category is assigned by the assessing specialist before a patient is placed on the elective wait list, each of which has qualifying criteria and a recommended surgical wait time attached to it. Category 1 patients are recommended to have surgery within 30 days; Category 2, 90 days; and Category 3, 365 days. For qualifying criteria, please see Queensland Health, n.d.

[26] In this program, patient care is either coordinated by the private hospital, also responsible for paying for "all aspects" of a patient's care, or by a treating practitioner, who does not pay for care but who coordinates the hospital accommodations and other services (Boxall, Tobin, and Gillespie 2014: 6).

In the past, the Victorian Department of Health has also administered a competitive tendering process, open to both public and private hospitals, in which resources ($165m) could be allocated for contracts for public patients between 2013/14 to 2016/17. In 2013/14, this mechanism allocated $15 million between 17 "public and public and private partnerships" to undertake 2,235 operations, which was "around 200 more than would have been undertaken under standard Victorian government funding arrangements" (Boxall, Tobin, and Gillespie, 2014: 7).

On March 31, 2020, a major partnership between the Commonwealth and the private sector was announced, billed as a part of "national efforts to address the COVID-19 pandemic". More specifically, this agreement required that private hospitals agree to support the response to the COVID-19 pandemic by offering services that included:[1] hospital services for public patients that were positive and negative for COVID-19; [2] Category 1 (urgent) elective surgeries; [3] use of wards and theaters to provide expanded intensive care unit capacity; and [4] accommodation for quarantine and isolation cases when required. With an initial estimated cost of AUD1.3 billion, separate agreements were made between state and territorial governments to fulfil these objectives (Biggs, 2020).

While several varied formalized contracting programs between states and private hospitals have existed over the years, much of this interaction has also occurred under the category of less formal "*ad hoc*" arrangements; *ad hoc* in this context means the decision to contract out treatment of specific public patients, often on a short-term basis, made by a purchaser (usually either a state bureaucrat or public hospital executive) (Boxall, Tobin, and Gillespie, 2014). In 2021/22, there were at least 148,848 inter-hospital contracted patients [27] from public-sector hospitals reported by contracted private hospitals (that is, interhospital contracted care) representing approximately 1.3% of total care episodes that year (Australian Institute for Health and Welfare, 2023d: table 7.7). However, this likely undercounts the number of patients contracted by public hospitals for a number of reasons.

First, it does not include the number of inter-hospital patients contracted to private-sector hospitals reported by contracting public hospitals. Although this data is available (127,122), adding the two may result in some double-counting. Second, "it is not possible to identify whether separations had multiple episodes of contracted care" because "patient status is assigned only once by the contracting hospital". And finally and more importantly, this data "does not include separations under contract between private hospitals and the jurisdictional health department or between private hospitals and Local hospital networks" (Australian Institute of Health and Welfare, 2018: 245).

[27] According to the Australian Institute for Health and Welfare (AIHW) (2023b), interhospital contracted care is "[a]n episode of care for an admitted patient whose treatment and/or care is provided under an arrangement (either written or verbal) between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital) and for which the activity is recorded by both hospitals."

By examining data for the total number of care episodes in private hospitals classified as "public patients" we can get a better understanding of the number of patients who receive care in private hospitals who are paid for in full by Medicare. In 2021/22, there were 303,844 care episodes for public patients in private hospitals, accounting for 6.4% of the total in private hospitals, and 2.6% of all care episodes that year (Australian Institute of Health and Welfare, 2023d: table 7.5).

2 Department of Veterans' Affairs (DVA)

The Australian Government also "funds [the] DVA by making payments through DVA for health services and programs to eligible veterans and their families and their carers", which includes the funding of "hospital care for eligible ex-serving ADF [Australian Defence Force] members and eligible dependants" (Australian Institute of Health and Welfare, 2023c). This hospital care for veterans occurs in both the public and private hospitals in Australia.

In 2021/22, 131,678 care episodes in private hospitals were classified as paid for by the Department of Veterans' Affairs. While this is only 1.1% of all care episodes and 2.8% of those episodes occurring in private hospitals, they accounted for 73.5% of all episodes paid for by the Department of Veterans' Affairs. In other words, nearly three fourths of all care episodes paid for by the Department of Veterans' Affairs occurred in private hospitals (Australian Institute of Health and Welfare, 2023d: table 7.5).

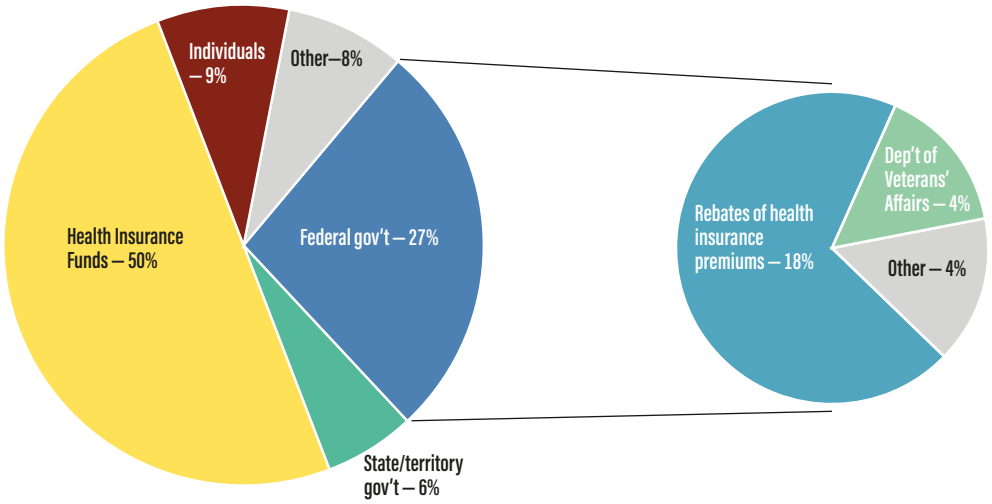
3 Private health insurance and rebates

Although the data presented above illustrate a fairly limited role for fully publicly funded care in private hospitals, data classified as care episodes for public patients treated in private facilities miss the true magnitude of publicly funded care in private hospitals. This is because Medicare pays for 75% of the MBS fee schedule for patients receiving treatment in private hospitals, with patients responsible for the remainder either using private insurance and/or paying out of pocket, which is not reflected in the data above. One way to better understand the magnitude of publicly funded care provided by private hospitals in Australia is to examine, instead, private hospital expenditures by source of funds.

In 2019/20, governments in Australia (including federal and state/territorial) accounted for 32.8% of private hospital spending (Australian Institute of Health and Welfare, 2022e). [28] 18.2% of total private hospital expenditure was spent on rebates for private health-insurance premiums (figure 3). While public dollars are the source

[28] In 2020/21, the Australian Federal Government and state and local governments together accounted for 31.8% of private hospital expenditures (Australian Institute of Health and Welfare, 2022d). Data from 2019/20 used as detailed data according to source of funds was not available for 2020/21 at the time of writing.

Figure 3: Expenditure on private hospitals in Australia, by source of funds, 2019/20



Note: Totals may not equal the sum of subtotals as a result of rounding.
Source: Australian Institute of Health and Welfare, 2022e: table 2.2.

of 32.8% of private hospitals' expenditures, it is not precisely clear how hospitals are funded by the full array of public sources (including the flow of these dollars). For example, rebates can be paid directly to insurance providers or through the tax system. For the purpose of Australian expenditure accounts, the rebate is considered

> an indirect subsidy of all types of health services through PHI [Private Health Insurance] ... the estimate of health spending reported in HEA [Health Expenditure Australia] is an estimate of the rebate paid out as benefits. It is therefore smaller than the total rebate paid to individuals to reduce premiums ... [in 2018/19] 94.3% of total PHI provider revenue was spent on health (including paid out as health benefits to members and spent on administration). As the rebate is treated as a revenue source for PHI providers, only 94.3% of the total rebate is counted as health expenditure in the same year. (Australian Institute of Health and Welfare, 2022a)

5 Conclusion

Private hospitals play a significant role in Australia's universal health-care framework. They provided care in 59% of elective episodes and 70.3% of elective admissions that involved elective surgery in 2021/22. While they perform an important supplementary and complementary role, they also serve as an important partner for the delivery of publicly funded care. This is done for fully funded patients in two ways:

1. Contracting—fully publicly funded episodes of care occurring in private hospitals, in 2021/22 made up 6.4% of total care episodes that occurred in private hospitals. This represents 2.6% of all recorded care.

2. The Department of Veterans' Affairs—private hospitals also provided care in 73.5% of care episodes paid for by the Department of Veterans' Affairs.

However, examining the role of private hospitals in the delivery of publicly funded care only through hospital activity (as measured by episodes of care) understates the true extent of this public-private partnership. This is because public subsidization also occurs through partial public coverage of some fees (75% of the MBS), alongside premium rebates for private patients in both public and private facilities. Taken together, public sources make up a full a third (32.8% in 2019/20) of the expenditures of private hospitals.

A core component of the Australian health-care system is its integration of private hospitals into a public universal framework. It is important to keep in mind that this is also a system that out-ranks Canada on 33 of 36 indicators of health-system performance while spending less as a percentage of GDP. Further, this close integration with private hospitals is maintained while ensuring universal access to more timely care than is provided to Canadians. The Australian system is a demonstrative case of an arrangement in which the noble goals of universal coverage are balanced with a pragmatic approach towards involving the private sector as a partner.

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