Private Hospitals

The fund will cover all or some of your accommodation costs while in hospital. If you are undergoing elective surgery, this has some distinct advantages. The accommodation tends to be more comfortable in a private hospital; you usually get a private room, for example, which is rare in a public hospital.

It also covers part – sometimes all – of the medical fees charged by your doctor(s). This means you can afford to get the doctor of your choice to treat you in hospital. In elective surgery this can be quite reassuring, because it means that you're able (theoretically anyway) to choose the doctor you think is most experienced, qualified and competent for the job. In practice, your GP usually makes this decision for you.

Of course, it's possible to undergo elective treatment in a public hospital. However you usually won't have the doctor of your choice, and the procedure might be undertaken by a senior trainee specialist rather than an accredited specialist. You may have to wait longer for treatment in a public hospital – months, in the case of some procedures.

However many conditions require surgery urgently, even if they're not immediately life-threatening. If you have private health cover there is little or no wait. Your doctor can operate on you as soon as he or she can book you in, which will be one to two weeks at the most.

So, for most people the choice is one of convenience and comfort. Private hospital cover will give you the doctor of your choice, in a comfy private hospital. But for this comfort factor, expect to pay more, and not just in monthly insurance premiums.

On top of this you will probably have to pay some expenses out of your own pocket. Many people who take out private hospital cover don't realise this until they are actually booking into hospital when the fees and charges and any expected out-of-pocket expenses are explained to them.

Hospital cover (including “top cover”) will only pay 100 per cent of accommodation costs if you stay in an 'approved' hospital. These are hospitals with which the fund has struck an agreement to keep its costs down, in order that its inpatients can be fully covered. Most hospitals have struck agreements with most funds. But there are no funds that have agreements with every hospital. If a hospital is not on your fund's list, the fund will only pay a percentage of the hospital's charges and leave you to cover the rest. Depending on how long you need to stay in hospital, this remaining cost could be considerable (sometimes thousands of dollars). So finding out whether the hospital is 'approved' is very important.

If you've purchased a hospital cover that has an excess you will also have to pay the excess (even if you go to an 'approved' hospital). Excess amounts are usually between $100 and $1000. With most policies you only have to pay the excess for your first hospital admission in any year but some funds offer policies that have an excess or 'copayment' for each admission. You may also be out of pocket when it comes to the fees charged by surgeons, assistant surgeons, anaesthetists and pathologists for medical services they provide for you during your admission.

Medicare will cover 75 per cent of what is known as the 'schedule fee'. This is the fee the Department of Health recommends a doctor should charge for a particular service. Your health fund will cover the remaining 25 per cent of the schedule fee. But in practice, most specialists charge much more than the schedule fee, and professional bodies such as the Australian Medical Association (AMA) openly recommend that they do so.

The difference between the schedule fee and what the doctor charges is known as the 'gap'. Gap cover is only available if your doctor has agreed to participate in this arrangement with the fund. Even if they have signed up to participate in your fund's gap scheme, it's up to the doctor in each case to decide whether to use the scheme for that patient. For example, some doctors may use the gap scheme for patients expressing particular financial distress and cannot wait for a public hospital surgery date.

Public Hospitals

Under Medicare, all Australian residents who decide to be admitted as public patients are entitled to free treatment in a public hospital. Even if you have private hospital insurance you can still be treated as a public patient (for free) if you want to.

When you book in or are admitted to a public hospital and you have private health insurance, you will be asked if you want to be treated as a public or private patient. You will be asked to sign a 'patient election form' to indicate this. It's your choice and the hospital is required to explain the implications of that choice for you.

As a public patient you will be treated by a doctor (or doctors) appointed by the hospital. You don't get your choice of doctor. This is normally an advanced surgical trainee performing the operation with the accredited specialist (Dr Mark Sywak) observing to ensure all is going well.

Regardless of whether you have private insurance, you'll be given the best treatment the public hospital system has to offer. If you elect to be treated as a public patient there will be no cost for your treatment. If you decide to be treated as a private patient, your health fund will pay the hospital cost but you might still be left with some bills to pay. Why?

Again, the 'gap'. If you're admitted as a private patient you'll be charged medical fees. Medicare will cover 75 per cent of the schedule fee and your health fund will cover the other 25 per cent, but neither will cover what the doctor(s) charge over and above this. Any hospital admission can involve several different types of medico's services – surgeons, anaesthetists etc – all of whom charge separately. You might also have extra paramedical costs like physiotherapy and speech therapy. When all these costs are added up it can run into thousands of dollars.

So the likelihood is that if you're admitted as a private patient, you'll end up with some costs to meet yourself. But if you decide to be treated as a public patient, the entire cost will be picked up by Medicare.

Avoiding unexpected costs (Informed financial consent)

Whether you're treated in a private hospital or as a private patient in a public hospital, it's your right to be provided with information about the costs you'll need to meet before you agree to the treatment, if at all possible.

In all cases, the information you're given in advance is an estimate. There can be extra charges if there are complications or unexpected developments and additional or different treatment is required.

Once you have been given an estimate of costs and know what your health fund will cover, you can decide whether to go ahead as planned or seek treatment as a public patient.