AUSTRALASIAN COLLEGE
FOR EMERGENCY MEDICINE

STATEMENT

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STATEMENT ON THE ROLE OF PRIVATE HOSPITAL EMERGENCY DEPARTMENTS

1. PURPOSE

This statement outlines the position of the Australasian College for Emergency Medicine (ACEM) on the role of private hospital emergency departments (EDs), referred to as private EDs.

2. SCOPE

This statement applies to all private EDs that operate in Australia and New Zealand.[1]

New Zealand urgent care clinics are out of scope of this statement.

3. DEFINITIONS

All EDs in Australia and New Zealand must meet and abide by the definitions and requirements set out within ACEM's Policy on Standard Terminology (P02). (1)

3.1 Private hospital terminology

There are multiple terms relating to the type of private hospital. These include:

- Not-for-profit entities
- Religious organisations
- For profit private hospitals
- Small private companies.

4. EXPECTATION OF A PRIVATE ED

All EDs in Australia and New Zealand, including private EDs, are expected to meet the standards[2] set out in ACEM's Statement on the Delineation of Emergency Departments (S12). (2)

5. BACKGROUND

An ED is a key component of a hospital's infrastructure. Private hospitals and private EDs employ a number of ACEM Fellows (FACEMs) and emergency medicine trainees.

Private EDs commenced operating in Australia in 1987. In 2006/07 it was estimated that 24 private EDs were providing emergency care in Australia. (3) In 2015/16, there were 630 private hospitals and 30 private EDs[3] in

[1] As of April 2018, there are no private emergency departments in New Zealand that meet ACEM's definition of an ED.
[2] Outlines the minimum standards required to be called an emergency department, including physical location, staffing, dedicated facilities and service access (for example, blood, laboratory/radiology, specialty care services).
[3] As of July 2017

Australian hospitals. (4) In 2017, there were 76 private hospitals in New Zealand but none with dedicated ED facilities. (5)

The increase of private hospitals and private hospitals with EDs in Australia is in response to an increase in patient demand. In 2015/16, approximately 538,000 presentations were managed by dedicated EDs in Australian acute and psychiatric private hospitals. (6)

Concurrent to the rising demand for services is the proportion of Australians with private health insurance (PHI), which in 2017 was 46.5%. (7) Private health insurance is a component of Australian government health policy that provides greater choice to patients when choosing which doctor or hospital from whom to receive treatment. (8) However, PHI policies taken up by individuals and families do not cover treatment in private EDs.

6. POSITION

ACEM recognises that private EDs are important components of acute health care systems. Emergency departments provide patients with access to specialised, quality care from staff that are undertaking, or have undertaken, significant specialist training.

ACEM supports patient choice and advocates for patients to make informed decisions about their care. ACEM considers that government and private health insurers can do more to facilitate and communicate options available to patients about their care choices and ACEM supports efforts to achieve this.

ACEM considers that private EDs are an additional resource. Private EDs are well placed to take a consistent and growing number of patients to assist public EDs in their local area to cope with increasing demand pressures. Private EDs are also well positioned to help jurisdictional capacity in times of major incident and disaster response. ACEM considers that a more even distribution of patient demand may result in benefits to patients' ED experiences, and across the broader hospital system.

6.1 An additional resource

The percentage of patients holding PHI and the number of presentations to private EDs demonstrates policy and system inefficiencies. This is primarily due to private health insurers defining private ED presentations as outpatient services. It is also influenced by government policy that encourages individuals and families to hold PHI.

Options to address these inefficiencies are outlined below.

Public awareness – greater patient choice

ACEM considers that all patients, including patients with PHI, should be supported and encouraged to make informed choices about their health care. This includes the ability to decide whether or not to hold PHI.

If a patient decides to hold PHI, patients must be provided with information that clearly articulates what service of care is and is not covered under their policy. ACEM supports the use of public awareness campaigns as a useful approach to inform the public of their options, including their right to request treatment in a private ED where appropriate.

Patient choice – PHI and private EDs

ACEM acknowledges that during a medical emergency it is not always possible for a patient to choose which hospital ED to receive their care. The main focus of emergency response systems is to align the patient with the closest available service to meet their needs.

With this in mind, ACEM advocates that all privately insured patients should be afforded every reasonable opportunity to attend a private ED and be admitted at that facility (if required). To assist patients to make an

informed choice, private health insurers are encouraged to provide materials to their customers that clearly articulate the services that are covered under their PHI, both in public and private hospital settings, and the cost of these.[4]

ACEM also advocates for insurance companies to review the determination of private EDs as outpatient services, and for government to allow for funding of the emergency care component for an insured patient with an acute illness. This would give patients security that they can utilise their PHI in a private ED without incurring additional out-of-pocket expenses.[5]

Emergency management – planning and response

ACEM supports the inclusion of private EDs into jurisdictional emergency planning and response plans. ACEM considers that private EDs can be utilised as an additional resource by jurisdictional health services as part of the response to emergency events and surges, e.g. as occurred with the 2016 Thunderstorm Asthma incident in Melbourne. Such events place significant demand on emergency services and health services, including hospital and ED resources. (9)

6.2 Training opportunities

ACEM supports the inclusion of private EDs within specialty medical training programs/initiatives.[6] Private EDs are a resource for trainees to gain valuable emergency medicine experience, which provides an avenue for developing a greater understanding of the private hospital system.

6.3 Professional equity

Private EDs are staffed by FACEMs and provide an alternative employment option to the public system. The systems, referral patterns and processes within private EDs, and across the private hospital where the private ED operates, allow FACEMs to experience different hospital environments, cultures and imperatives.

These differences can provide a workplace and professional skill set variety that is valuable for FACEM work and career opportunities. Private EDs offer FACEMs the opportunity to complement their public ED experience. Private EDs can provide an enriching and engaging pathway for FACEMs to develop their educational, clinical knowledge and skills as specialist medical staff.

[4] An example to draw on is the response telecommunications services and energy providers have taken to provide their customers with easier to understand billing charges.

[5] Note that some private health insurers already do this, e.g. Department of Veteran Affairs, Workcover and the Transport Accident Commission.

[6] The Australian Government's Specialist Training Program (STP) is an example of linking private EDs with educational opportunities and outcomes that compliments traditional public hospital approaches. Trainees and specialists with experiences in different settings is in the best interests of patients presenting to an ED (either public or private).

7. REFERENCES

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8. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

8.1 Responsibilities

Authoring body:	Private Practice Committee
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8.2 Revision History

Version	Date of Version	Pages Revised / Brief Explanation of Revision
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