



Government of **Western Australia**
Department of **Health**

WA Health patient fees and charges manual 2025/26

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Abbreviations

Abbreviation	Meaning
ACS	Australian Coding Standards
AMA	Australian Medical Association
CAEP	Community Aids and Equipment Program
CAHS	Child and Adolescent Health Service
CFO	Chief Finance Officer
CMBS	Commonwealth Medicare Benefits Schedule
CTG	Closing the Gap
Home Affairs	Department of Home Affairs
DOH	Department of Health
DVA	Department of Veterans' Affairs
EAF	Elective Admission Form
EMHS	East Metropolitan Health Service
ENT	Ear, Nose and Throat
EP	Entitled Persons
FMA	Financial Management Act 2006
FMM	Financial Management Manual
FMR	Financial Management Regulations 2007
HACC	Home and Community Care
HMDS	Hospital Morbidity Data System
HSD	Highly Specialised Drugs
HSA	Health Services Act 2016
HSS	Health Support Services
ICWA	Insurance Commission of Western Australia
ICU	Intensive Care Unit
IVF	In-Vitro Fertilisation
KEMH	King Edward Memorial Hospital
MOU	Memorandum of Understanding
MBS	Medicare Benefits Schedule
MRI	Magnetic Resonance Imaging
MVA	Motor Vehicle Accident
MVTPI	Motor Vehicle Third Party Insurance
NHDD	National Hospital Data Directory
NHRA	National Health Reform Agreement
NHTP	Nursing Home Type Patient
NMHS	North Metropolitan Health Service
OHCWA	Oral Health Centre of Western Australia

Abbreviation	Meaning
OSHC	Overseas Student Health Cover
PBS	Pharmaceutical Benefits Scheme
PCH	Perth Children's Hospital
POW	Ex-Prisoner of War
PPLO	Private Patient Liaison Officer
PRNI	Privately Referred Non-Inpatient
RHCA	Reciprocal Health Care Agreement
RSS	Revenue Strategy and Support
SHQ	State Headquarters
SIP	Surgically Implanted Prostheses
SMHS	South Metropolitan Health Service
TB	Tuberculosis
VC	Victoria Cross
WA	Western Australia
WACHS	WA Country Health Service

Introduction

The WA Health Fees and Charges Manual sets out the rules in relation to fees and charges that Health Service Providers may apply for 'health services' and 'other goods and services'.

For the purposes of this Manual:

- a **'health service'** is a service provided for maintaining, restoring, or managing a person's physical and mental health and wellbeing (including goods and facilities related thereto)
- **'other goods and services'** are services provided that are not 'health services' (including goods and facilities related thereto). These services are sometimes called 'commercial activity'.

The Manual includes much of the information that was previously in the WA Health Patient Fees and Charges Manual, with appropriate changes and additional information that reflect the new fees and charges regime applicable to Health Service Providers from 1 July 2016, as a result of the introduction of the Health Services Act 2016 (HSA).

Fees and charges regime under the Health Services Act 2016 (WA)

The HSA offers Health Service Providers greater clarity and flexibility on what services they can apply fees and charges to, than under the previous Hospitals and Health Services Act 1927.

The new fees and charges regime under the HSA is as follows:

- Certain health services are to be provided free of charge.

Health Service Providers are not permitted to apply fees or charges for non-chargeable health services (see s55(5) HSA); these are health services that are to be provided free of charge under the National Health Reform Agreement (NHRA) or that the Minister for Health has specified are to be provided free of charge by Ministerial Order.

- The Minister for Health can fix any applicable fees and charges.

The Minister for Health may fix the fees or charges to be applied for health services by Ministerial Order, either absolutely or by reference to a scale of fees or charges that are determined by a Commonwealth body, such as Medicare. Where the Minister for Health has fixed the fees or charges to be applied, Health Service Providers are not permitted to apply fees or charges in excess of that amount (see s27(1) HSA).

- The Director General can set restrictions on any applicable fees and charges.

The Director General may issue policy frameworks, to ensure consistent approaches to the provision of services by Health Service Providers; this includes setting limits on the fees or charges to be applied for both health services and other goods and services or specifying fixed rates to be applied in all cases. Restrictions set by the Director General will be documented in this Manual, which is mandatory under the [Financial Management Policy Framework](#), and binding on all Health Service Providers ([see s27\(1\) HSA](#)).

If a fee or charge is not prohibited, or otherwise regulated by the Minister for Health or Director General, the Health Service Provider may determine the fee or charge to be applied.

To enable a decision to be made by the Minister for Health or Director General on whether a fee or charge for health services needs to be regulated, Health Service Providers are to submit a request for approval to the Department of Health *prior* to applying any proposed new fee or charges that relates to a health service.

For fees and charges relating to 'other goods and services' or 'commercial activity' approval is not required by DoH or the Minister for Health. If an HSP would like to implement a new charge that falls into this category, then it is recommended that the HSP checks with DoH to agree the suggested fee does indeed fall into this category. If it does, the HSP is not required to seek approval for the new fee or charge. Health Service Providers should note that all fees and charges determined by them are subject to annual review in accordance with Treasurer's Instruction 6.3 Tariffs, Fees and Charges.

HSPs need to maintain their own database of fees and charges not located within this Manual along with costing methodology and justification of any increases.

If there are any difficulties interpreting or understanding a particular section of the Manual, users may contact Financial Policy and Reform, Department of Health, in the first instance, at: finance.policy@health.wa.gov.au

Using the patient fees and charges manual

Overall content and structure of the manual

The Manual sets out the rules in relation to fees and charges that Health Service Providers may apply when providing 'health services' and 'other goods and services'.

The Manual is divided into several sections, providing guidance on discrete subjects that are relevant in the context of fees and charges, particularly those applicable to patients:

- [Chapter 1: Medicare eligibility](#)
- [Chapter 2: Reciprocal health care agreements](#)
- [Chapter 3: Patient fees and charges](#)
- [Chapter 4: Non-Chargeable patients](#)
- [Chapter 5: Chargeable patients](#)
- [Chapter 6: Medication supply arrangements](#)
- [Chapter 7: Other fees and charges](#)
- [Chapter 8: Charging liability](#)
- [Chapter 9: Fees and charges guidelines](#)
- [Overview of public hospital fees and charges](#)
- [Schedule A1: Fees and charges regulated by the Minister for Health](#)
- [Schedule A2: Fees and charges regulated by the Director General](#)
- [Schedule A4: Specialised orthoses for adults](#)
- [Schedule A5: Specialised orthoses for children](#)
- [Schedule B: Summary of patient fees and charges](#)
- [Schedule C: Application form for new fee or charge](#)
- [Schedule D: Standing exemptions](#)
- [Schedule E: Appendices](#)

Distinguishing fees, charges and deposits

For the purposes of this Manual, it should be noted that there is a significant difference between a fee, a charge and a deposit:

- a fee is a price set at cost recovery level; this is generally applied in the context of health services, which are not discretionary from the consumer's perspective
- a **charge** is a price set above cost recovery level; this is generally applied in the context of other goods and services, which are discretionary from the consumer's perspective
- a deposit is a sum of money collected from a person, with an expectation that the money will be returned to that person after certain conditions are met; these are not considered to be a fee or a charge within the context of this Manual.

Note: Prices should not be set at a level below cost recovery, unless otherwise approved by the State Government (see [Costing and Pricing Government Services](#), published by the Department of Treasury and Finance). Deposits, on the other hand, are almost invariably set at a level below cost recovery.

Applying a fee or charge for a service

When deciding whether a fee or charge may be applied for a service, and determining at which rate the fee or charge may be applied, users should follow these steps (in sequence):

1. Determine whether the service is a non-chargeable health service.
 - No fees or charges are to be applied in relation to health services:
 - that are to be provided free of charge under the NHRA
 - that the Minister for Health has specified are to be provided free of charge.
 - The principles for determining Medicare eligibility, which dictate whether a health service is provided free of charge under the NHRA, are set out in Chapter 1.
 - The fees and charges regulated by the Minister for Health are set out in Schedule A1.
2. Determine whether the fees and charges are regulated by the Minister for Health.

Where the Minister for Health has fixed the fees or charges by Ministerial Order, a fee or charge cannot be applied in excess of that amount.

The fees and charges regulated by the Minister for Health are set out in Schedule A1.

3. Determine whether the fees and charges are regulated by the Director General.
 - Where the Director General has set limits on the fees or charges, or specified a fixed rate to be applied, a fee or charge cannot be applied contrary to those restrictions.
 - The fees and charges regulated by the Director General are set out in Schedule A2.
4. Determine if a fee or charge has been approved by the Department of Health.
 - If fees or charges are not prohibited, or otherwise regulated by the Minister for Health or Director General, the Health Service Provider may determine the fee or charge to be applied, provided that approval has been obtained from the Department of Health.
 - If approval has not been obtained, a request is to be submitted to the Department of Health, in accordance with the process described further below.
 - If approval has been obtained, the fee or charge may be applied in accordance with any restrictions specified by the Accountable Authority of the Health Service Provider.

5. Determine if a fee or charge is for a 'health service' or 'other goods and services'.
 - If fees or charges are for a 'health service', then an application to DoH for approval is required.
 - If the proposed fee or charge is for 'other goods and services', then the HSP is not required to seek approval but it is recommended that they discuss the fee or charge with the Department prior to implementation.
 - If the fee or charge is determined to be for 'other goods and services', then the HSP is able to determine the charge themselves.
 - HSPs are required to keep a record of all fees and charges applicable to their hospital, including all fees and charges for 'other goods and services'.

For the convenient reference of hospital admission staff, a summary of all the patient fees and charges regulated by the Minister for Health and the Director General are set out in [Schedule B](#); this will assist them in quickly completing Steps 1 to 3 above.

Health Service Providers should develop their own summary schedule of local fees and charges that they are approved to determine on their own, to assist staff in completing Step 4 above. The summary schedule is not to contain anything inconsistent with, or contrary to, this Manual.

Requesting approval to determine a new fee or charge for a service

Where a Health Service Provider may determine the fee or charge to be applied, approval is to be obtained from the Department of Health prior to applying the fee or charge, if the fee or charge is for a health service.

To this effect, an Application Form is to be submitted to Financial Policy. The Application Form is referred to as [Schedule C](#), and requires the following information:

- a description of the services to be provided
- a statement of whether those services are health services, or other goods and services.
Note: this will be determined at the review/approval process.
- an explanation of the motivation for applying a fee or charge to those services
- the proposed fee or charge to be applied for those services, and a statement of whether the fee or charge has been set at cost recovery level
- an explanation of the method for determining the estimated cost of those services.

The Schedule C application form is to be endorsed by the Health Service Provider's Chief Finance Officer, Chief Executive Officer, Chair of Finance Sub-Committee and Chair of Health Service Board prior to submission to the Department of Health.

A response from the Department of Health will generally take one of the following forms:

- notice that the fee or charge is to be regulated by the Minister for Health
Note: This is likely in situations where the application of a fee or charge has potential to adversely affect WA Health as a whole or is considered controversial in nature.
- notice that the fee or charge is to be regulated by the Director General
Note: This is likely in situations where there is a strategic advantage in standardising the fee or charge, such as minimising potential inequity between Health Service Providers.
- notice that the Health Service Provider may set the fee or charge, either subject to the conditions specified in the notice, or unconditionally.
Note: This is for situations where the fee or charge will only be relevant to that Health Service Provider.

Financial Policy will maintain a register of fees and charges approved to be determined by Health Service Providers (either conditionally or unconditionally); this will be updated regularly and made available online for staff to review before submitting requests to the Department of Health for approval to apply a new fee or charge.

Standing exemptions

Where it is deemed, as a matter of policy, that all Health Service Providers should be approved to determine the fees or charges to be applied for provision of a particular service, a standing exemption will be added to this Manual, in [Schedule D](#).

Health Service Providers are not required to submit an application for approval to apply a new fee or charge, if the service is included as a standing exemption in [Schedule D](#). If there is any doubt as to whether a service falls within the ambit of the standing exemption, advice should be sought from Financial Policy, in the first instance.

Annual review process of fees and charges

All fees and charges determined by the Department of Health or Health Service Providers are subject to annual review in accordance with Treasurer's Instruction 6.3 Tariffs, Fees and Charges.

Accountable areas in the Department of Health and Health Service Providers are responsible for reviewing their fees and charges, and as part of the annual review, they are:

- to provide sufficient detail of the cost of the services provided, and
- to ensure their costing method is sufficiently robust to provide a reasonable estimate of the percentage level of cost recovery.

Amendments to the fees and charges manual

Financial Policy is responsible for maintaining this Manual and is to ensure that it is a living document which is regularly updated and made available online.

A summary of all amendments to the Manual will be listed at the end of this document.

Further information

Any requests for further information can be directed to Financial Policy and Reform at:
finance.policy@health.wa.gov.au

Enquiries relating to patient billing can be directed to the relevant Health Service Provider.

Chapter 1: Medicare eligibility

1.1 Overview of access to Medicare

Australia's public health care funding system is called Medicare. It is a system that provides eligible people with access to free treatment as a public patient, as well as free or subsidised treatment on a private basis by doctors (both general practitioners and specialists), participating optometrists, and in certain circumstances dental practitioners. Eligibility for Medicare provides access to the Pharmaceutical Benefits Scheme (PBS), which covers many prescription medications provided by pharmacies.

- Medicare eligibility is generally restricted to people living permanently in Australia who are:
- Australian citizens (whom have residence in Australia)
- Permanent Australian residents (who have permanent visas)
- New Zealand citizens, **or**
- Certain persons with applications for permanent visas under consideration. This excludes applicants for some parent visas or applicants for protection visas who have also applied for a parent visa.

While overseas visitors and temporary residents do not have access to Medicare, there are exceptions:

- Australian citizens who go overseas retain their access to Medicare for any return visits to Australia for up to five years from when they were last residing in Australia; and
- Visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA). They have restricted access to Medicare. Foreign students studying in Australia are generally not covered by RHCA's.

Note: Refer to [Schedule E, Appendix E](#) (Flow Chart on Medicare Eligibility), to assess patient access to Medicare.

1.2 Obtaining patient consent to complete a Medicare eligibility check

Health Service Providers completing patient Medicare eligibility checks are first required to obtain express consent from the patient, this express consent can be verbal or in writing. There is no legal requirement that the consent be in writing however, best practice would be to obtain written consent from the patient.

1.3 Medicare exemptions

Under Medicare eligibility, some categories of patients are exempt:

Prisoners

Under the [Health Insurance Act 1973](#), prisoners are ineligible to access Medicare whilst incarcerated.

The Act precludes benefits for medical services provided under the control of a government authority, which prevents a service being funded twice from public resources. Sub-section 19(2) prohibits State governments from transferring costs to the Commonwealth. The States are responsible for ensuring prisoners have access to appropriate health care including associated treatment and medications.

Non-charging arrangements to Department of Justice for prisoners attending public hospitals

A Memorandum of Understanding (MOU) is in place between the Department of Justice and Health, which provides the governance framework to allow for the health care needs of people serving custodial terms in prison.

Clause 7(3)(a) states; “The Department of Health provides secondary and tertiary health services for offenders in WA, including inpatient and outpatient public hospital services, psychiatric services and dental services. These costs are not recouped from the Department of Corrective Services.”

Exemptions to charge pathology services and highly specialised drugs supplied to prisoners

Ministerial arrangements allow for the charging of pathology services. PathWest charges the Department of Justice for prisoners’ pathology services on a ‘fee for service’ basis.

S100 Highly Specialised Drugs (HSD) are able to be claimed on the Pharmaceutical Benefits Scheme for Prisoners. See [6.9. Inter-Agency Patient Supply Arrangements](#).

Immigration detainees

The Department of Home Affairs is responsible for the full cost of medical treatment and are to be directly billed by hospitals for reimbursement.

On admission to a public hospital, detainees’ financial classification is to be assigned in Patient Administration Systems as ‘Overseas’ and are to be charged at full cost recovery; where systems allow.

Asylum seekers and Displaced Persons

The State Government has determined the following persons are eligible to receive health services from Health Service Providers (HSPs), at no charge:

- **Asylum Seekers:** persons who have left their home country and are seeking international protection in Australia, but whose claim for refugee status has not yet been determined.
- **Displaced Persons:** persons who are unable to return to their home country due to some significant event (e.g. a natural disaster or war).

The above does not extend to health services provided by entities other than HSPs (e.g. ambulance services, general practitioner services, etc.).

Asylum Seekers

Eligibility for Treatment at No Charge

An asylum seeker is eligible for treatment by a HSP at no charge if they:

- are ineligible for Medicare benefits
- are in the process of applying for, or are awaiting a decision on an application for, refugee status or a humanitarian visa.

The source of an asylum seeker's referral to a HSP is irrelevant to their eligibility for free treatment e.g. public diagnostic services.

Evidence to be presented to Health Service Provider staff

A person receiving a health service from a HSP – such as a public hospital service, child and adolescent mental health service, or diagnostic service is to be treated as an asylum seeker if they present any of the following documentation:

- a copy of a letter from the Department of Home Affairs confirming they have applied for, or are awaiting a decision on an application for, refugee status or a humanitarian visa
- any other document from an Australian government agency, such as the Immigration Assessment Authority, the Administrative Appeals Tribunal or a Court (such as the Federal Circuit Court) evidencing that they have applied for, or are awaiting a decision on an application for a temporary or permanent protection visa, or a Safe Haven Enterprise visa
- any document confirming their status as a refugee, such as a visa, ImmiCard, etc.
- any document from one of the following organisations, which supports their claim that they are in the process of applying for refugee status or a humanitarian visa:
 - Association for Services to Torture and Trauma Survivors (ASeTTS)
 - Centre for Asylum Seekers, Refugees and Detainees (CARAD)
 - Circle Green Community Legal
 - Mercy care
 - Riverview Community Services
 - Southern Communities Advocacy Legal Education Service (SCALES)
 - Australian Red Cross (ARC)

Note: If a person presents with a supporting document from an organisation not listed above, hospital staff may contact CARAD at office@carad.org.au to confirm whether the organisation is suitable to endorse the person's claim to be an asylum seeker.

Where an asylum seeker is unable to provide any of the above documentation, they are to be classified as an 'Overseas' patient and informed financial consent is to be obtained.

HSPs may exercise their discretion to accept other forms of documentation as evidence of a person's status as an asylum seeker.

Displaced persons

From time to time, Australia is host to people who are unable to return to their home country due to some event (e.g. natural disaster, war, etc.), and the State Government may decide that such persons can receive health services from HSPs at no charge.

Eligibility for treatment at no charge

A displaced person is eligible for treatment by a HSP at no charge if they:

- have arrived in Australia on a temporary visa
- are ineligible for Medicare benefits
- are unable to return to their home country:
 - after 24 February 2022, due to the war in Ukraine
 - after 7 October 2023, due to the Israeli-Palestine conflict.

The source of a displaced person's referral to a HSP is irrelevant to their eligibility for free treatment e.g. public diagnostic services.

Evidence to be presented to Health Service Provider staff

A person receiving a health service from a HSP – such as a public hospital service, child and adolescent mental health service, or diagnostic service, is to be treated as a displaced person if they present:

- a letter from a community organisation listed under 'Asylum Seekers' above, that supports their claim that they are unable to return to their home country in the specified nation/region after the date listed (e.g. a letter of support from the Australian Red Cross, the Ukrainian Society of Western Australia, etc.)
- evidence of their nationality (e.g. passport or visa)
- other evidence of departure from the specified nation/region after the date listed above, such as a valid passport with date stamps, or any other relevant travel documents confirming their status as a displaced person

Where a displaced person is unable to provide any of the above documentation, they are to be classified as an 'Overseas' patient and informed financial consent is to be obtained.

HSPs may exercise their discretion to accept other forms of documentation as evidence of a person's status as a displaced person.

Specified persons or class of persons declared as being Medicare eligible

Under subsection 6(1) of the Health Insurance Act 1973, the Commonwealth Minister may, by order, declare that a specified person, or specified class of persons, as being Medicare eligible:

- A person visiting Australia financed via the Australian – American Educational Foundation;
- A person released into the community on a visa from a detention facility, such as a Temporary (Humanitarian Concern) visa (Subclass 786). To enrol for Medicare, a Temporary visa holder has to attend Medicare with identity documents that validate their residence in Australia; and
- Certain visas:
 - Witness Protection (Trafficking) – Subclass 787 (no longer issued)
 - Contributory Parent (Temporary) – Subclass 173
 - Contributory Aged Parent (Temporary) – Subclass 884

Chapter 2: Reciprocal health care agreements

2.1. Overview of reciprocal health care agreements

Overseas visitors holding a valid visa and being a resident of a Reciprocal Health Care Agreement (RHCA) country are eligible for 'medically necessary' treatment. 'Medically necessary' treatment covers ill-health or injury that occurs while visiting Australia and requires treatment before their return home.

The general principle underpinning the access to services under RHCA's is that visitors receive treatment within Australia's public health system on the same terms as an Australian resident.

Note: All agreements exclude medical coverage for residents of one partner country who enters the territory of the other partner country for the specific purpose of seeking medical treatment.

RHCA's only provide for public treatment, in a public hospital or in a publicly contracted bed in a private hospital (i.e. Joondalup Health Campus, Peel Health Campus and St John of God Midland Public Hospital). If an overseas visitor elects to be private, they are ineligible under a RHCA and will be charged as an ineligible patient.

RHCA's, apart from those with New Zealand and Norway, provide diplomats, staff of diplomatic missions and their families with Medicare cover for their length of stay. The Agreement entitles diplomats from the Republic of Ireland, Consular Officers and their families to a broader range of treatment that covers private medical treatment and is not restricted to being 'medically necessary'. Diplomatic visitors will be issued Medicare cards endorsed 'Visitor RHCA'.

The Commonwealth Government has signed RHCA's with the Governments of the following countries. RHCA's are valid from the dates specified in the right-hand column of the listing below:

Country	Operational Date
Belgium	1 September 2009
Finland	1 September 1993
Italy	1 September 1988
Malta	6 July 1988
New Zealand (includes Tokelau and Niue islands)	1 September 1999 (amended)
Norway	1 March 2004
Republic of Ireland	25 May 1998
Slovenia	1 July 2011
Sweden	1 May 1989
The Netherlands	4 January 1992
United Kingdom (includes Northern Ireland)	1 July 1986

Medicare eligible visitors admitted as a public patient during their visit to Australia should inform hospital staff that they wish to be treated as a Medicare public patient under the relevant RHCA. Admission staff should request evidence of their Medicare eligibility. RHCA eligibility generally depends on a person being a resident of their home country (and not resident in Australia).

In most cases, the patient will have enrolled in Medicare and will have a reciprocal Medicare card. In other cases, a valid passport, visa and/or European Health Insurance Card for the relevant country will be required as evidence of eligibility.

The RHCA's with the Netherlands, Slovenia, Italy and Belgium, however, require that a person is eligible for health insurance under the national health insurance schemes of those countries to be eligible. In these cases, a passport alone is not sufficient evidence of eligibility – the person is also required to have a European Health Insurance Card or other documentation establishing their eligibility for their home country's national insurance scheme.

RHCA's provide access to affordable medicines under the Pharmaceutical Benefits Scheme (PBS). Eligible persons are requested to produce evidence of their eligibility when presenting prescriptions. Only medicines prescribed for treatment are covered.

Please refer to [Appendix L: Reciprocal Health Care Agreement Matrix](#) for eligibility criteria.

Difference between a citizen and a resident

A citizen is usually a person who is born in a country, or granted citizenship of that country through naturalisation, and who has not renounced or lost their citizenship - this may vary in some countries depending on the custom or law of that country.

A resident refers to a person's living status in a country of which they are not a citizen. Residency status can be separated into temporary and permanent residency.

Depending on whether a person is a citizen or resident of a country they may or may not be covered under a RHCA with Australia.

Differences in Medicare access under RHCA's

The RHCA's with Belgium, Finland, Italy, Malta, the Netherlands, Norway, Slovenia, Sweden and the United Kingdom provide for free treatment as a public patient in a public hospital, Medicare benefits for out-of-hospital medical treatment and subsidised medicines under the PBS.

The RHCA's with New Zealand and the Republic of Ireland provide for free treatment as a public patient in a public hospital and subsidised medicines under the PBS, but they do not cover out- of-hospital medical treatment (i.e. visiting a general practitioner).

Period of cover

A person's period of cover starts on the day of arrival to Australia and ends depending on the country's RHCA with Australia.

If the person is from Finland, Norway, the Republic of Ireland, Sweden or the United Kingdom, their period of cover ends on the day their visa expires.

If the person is from Belgium, the Netherlands or Slovenia their period of cover ends on the day their European Health Insurance Card expires or the day their visa expires if earlier.

Visitors from Malta and Italy are usually covered for 6 months from their initial date of arrival in Australia (proof of entry into Australia is required).

Visitors from New Zealand are covered up until the day they leave Australia.

For more information on RHCA and countries participating go to the [Department of Human Services website](#).

Medical services not covered by Medicare under a reciprocal agreement

- Medicare will not cover:
- Medicines not subsidised under the Pharmaceutical Benefits Scheme
- Accommodation and medical treatment in a private hospital, and
- Accommodation and medical treatment as a private patient in a public hospital
- Ancillary services not covered:
 - Private patient hospital costs (including accommodation and theatre fees)
 - Dental examinations and treatment
 - Ambulance services
 - Home nursing
 - Allied health services not listed on the Medicare Benefits Schedule (private Medicare Services)
- Acupuncture (unless part of doctor's consultation)
- Glasses and contact lenses
- Hearing aids and other appliances
- The cost of non-medically necessary prostheses
- Medical costs for which someone else is responsible (e.g. compensable insurer or employer)
- Medical services which are not 'medically necessary'
- Surgery solely for cosmetic reasons
- Examinations for life insurance, superannuation or membership of a friendly society
- Eye therapy (Eye drops listed on the PBS are covered)

Reciprocal eligibility for childbirth

RHCA's include medical coverage for the birth of a child. The only exclusion is where a person has come to Australia for the sole purpose of having their child delivered here. No exclusions apply if the necessary hospital treatment was required as a result of a medical emergency.

Reciprocal eligibility for inter-hospital transfer

Reciprocal Health Care Agreements provide for public hospital treatment for any ill-health or injury, which includes inter-hospital transfers within Australia. However, reciprocal agreements

do not cover repatriation of a patient to their home country, which is the patient’s financial responsibility.

2.2. Medication supply arrangements for reciprocal health care persons

Reciprocal Health Care Agreements (RHCA) allow for patients to access medications as a General Patient on the Pharmaceutical Benefits Scheme (PBS). Medications for the IVF/GIFT Program on the PBS are not accessible for persons on a RHCA. Queries about eligibility can be referred to Medicare 132 011.

A RHCA visitor attending public hospital as an admitted patient, on discharge, same day patient or outpatient is eligible to receive Highly Specialised Drugs (HSD) as a general patient. The supply of HSD is limited to the original prescription and no repeat prescriptions are permitted.

In order to be eligible, public hospitals need to request proof of a valid Medicare card with ‘Reciprocal Health Care’ (Irish, excluding students, and NZ visitors are eligible for PBS on presentation of their passport) or an ‘Interim Card’ for those who have applied for permanent residence. The supply of HSD must be ‘medically necessary’ and it cannot be for pre-existing conditions or pre-arranged treatment.

Most residents of RHCA countries will be limited to the supply of HSD in Australia by the length of their applicable visa. While for residents of NZ, they are able to apply for permanent residency in Australia without leaving the country and this enables them to seek continuity of HSD treatment. However, they are required to maintain their Australian residency status, which excludes living in a non-reciprocal country (e.g. Indonesia) and travelling to Australia for the specific purpose of seeking medical treatment.

Note: the limitation of the supply of highly specialised drugs to the original prescription does not stop reciprocal patients from attending another public clinician for a further original prescription.

Details	Fee per Day or perService	Most recent amendment and notes
Inpatient Medications	\$0.00 (No hosp. fee)	Only for admissions that are covered by the RHCA For non-covered treatment, billed as unsubsidised medication charge.
Discharge Medications <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items 	Up to \$25.00 Unsubsidised Medication Charge	See Chapter 6
Outpatient Medications <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items 	Up to \$25.00 Unsubsidised Medication Charge	See Chapter 6
Non-Chargeable Medication Supplies	\$0.00 (No hosp. fee)	See Chapter 6

2.3. Specific issues relating to Reciprocal health care agreements

Guidelines covering reciprocal agreements with Australia (excluding the Republic of Ireland and New Zealand)

Eligibility:

That the person/visitor:

- Holds a current passport, valid visa and/or EHIC from a reciprocal country;
- Requires 'medically necessary' treatment, which is necessary before the visitor returns home;
- Treatment commenced after the operational date of their country's reciprocal agreement; and
- They are treated as a public patient, which includes both inpatient and outpatient treatment.

Procedure for enrolling in Medicare

Reciprocal visitors can enrol in Medicare by attending a Department of Human Services – Medicare office and presenting their passport or proof of enrolment in their country's national health scheme (usually, a European Health Insurance Card). Once approved eligible reciprocal visitors receive an Australian reciprocal Medicare card, with the expiry date being the expiry date on their visa.

Enrolment may take place after services have been provided either to confirm eligibility for public hospital services or to obtain Medicare benefits for out-of-hospital medical treatment such as visiting a GP (excluding New Zealand and Republic of Ireland visitors) and subsidised medicines under the PBS.

Reciprocal agreement conditions for the Republic of Ireland and New Zealand

These RHCA's cover 'medically necessary' treatment as a public patient, including both inpatient and outpatient care and subsidised prescription drugs through the PBS. These RHCA's do not entitle visitors to Medicare benefits for out-of-hospital medical care and do not apply where a person enters Australia for the sole purpose of accessing medical treatment.

RHCA access to public hospital treatment in Australia for visitors from Ireland and New Zealand is restricted to a person who is ordinarily resident in those countries and is temporarily in Australia.

Because New Zealand and Irish visitors are not eligible for Medicare benefits for out-of-hospital services, Medicare does not enrol them or issue them with Medicare cards. A current Irish or New Zealand passport is sufficient proof of eligibility for visitors from these countries to receive public hospital treatment and PBS medicines.

Note: *The Irish RHCA excludes students, who need to enter in a special private health insurance scheme.*

Reciprocal health care agreement conditions for dialysis services

The priority of the Department of Health is to provide public renal dialysis services to eligible patients based on their clinical need. However, the ability of the health system to fund eligible overseas patients is not to interfere with the physical, clinical and/or financial capacity of health services to meet the clinical priorities of Australian residents.

Currently, there are reciprocal dialysis arrangements with the United Kingdom, New Zealand and the Netherlands, which provide access to renal dialysis to eligible residents visiting either country.

However, there are no dialysis agreements with other RHCA countries. RHCA eligible visitors are entitled to use renal dialysis services free of charge as public patients. However, the number of dialysis treatments that a person receives depends on the availability of resources of the treating hospital and Health Service Providers may impose limits on the number of free treatments.

Renal service limits

The Department has imposed limits on the provision of dialysis treatment to the residents of reciprocal countries. It has been agreed to provide RHCA visitors free dialysis services for the lesser, of either a maximum period of four weeks (covering all service sites) or a maximum of 12 sessions within a 12-month period commencing from the date of first treatment.

Capacity guidelines

Dialysis is limited to one patient at each service site and is subject to availability of staffing / other resources and that no eligible public patient is disadvantaged due to this decision.

Clinical referral requirements

Prior to arrival in Australia, RHCA eligible dialysis patients need to request their treating physician contacts one of the tertiary hospitals seeking formal approval to receive dialysis treatment. If the tertiary hospital has capacity to meet their specific needs, the accepting hospital then assumes clinical governance for the patient during their stay and a clinical nurse manager will then organise treatment at a privately contracted satellite dialysis unit.

Satellite renal units

Private satellite dialysis units are located throughout the metropolitan area, with contracted sites at Cannington, Joondalup, Midland, Rockingham, Stirling and Spearwood.

Reciprocal agreement conditions for Magnetic Resonance Imaging (MRI)

Under RHCA's no treatment is excluded. However, RHCA's are structured on the basis that an eligible visitor may access inpatient and outpatient services, as a public patient, for 'medically necessary' treatment. Services such as MRI should be provided only where it is 'medically necessary'.

Clinical referral requirements

Medicare will only cover MRI services when a physician provides a letter of referral, which indicates that MRI is required as a matter of urgency.

Reciprocal agreements and certain visa classes

If a RHCA visitor holding a temporary visa, has applied for permanent residency and has either a spouse, parent or child who is an Australian citizen or permanent resident, or has legal authority from department of home affairs, they are classified as an 'Australian resident' for the purposes of the health insurance act 1973 and are fully Medicare eligible. They do not need to rely on a RHCA for Medicare access.

Temporary business (long stay) – standard business sponsorship (subclass 457)

On 18 April 2017, it was announced that the visa (subclass 457 visa) would be abolished and replaced with the completely new temporary skill shortage (TSS) visa (subclass 482 visa) which will support businesses in addressing genuine skill shortages.

Eligibility of RHCA overseas patients treated as a public patient in a privately managed hospital (Joondalup Health Campus, Peel Health Campus and St John of God Midland Public Hospital)

An overseas visitor, who is entitled to be treated as an eligible person under the national health reform agreement (NHRA) by virtue of a reciprocal agreement is entitled to receive free care as a public patient, where treatment is 'medically necessary'. Under the NHRA definition of a public patient, this applies irrespective of whether hospital services are owned or managed by the state.

Retirement visa (subclass 410 – temporary or subclass 405 - temporary)

If a visitor applied for their Retirement (Subclass 410) visa prior to 1 December 1998, they may choose to enrol in the Medicare program under the RHCA of their home country.

However, if they applied for their 410 visa, on or after 1 December 1998, they are not eligible for enrolment in the Medicare program and are not eligible under the RHCA. Holders of the Retirement Investor (Subclass 405) visa, which replaced the 410 visa in 2005, are also not eligible for Medicare. Retirement visa holders (if applied after 1 December 1998) can only be admitted to a public hospital as Medicare ineligible and are liable to meet 100% of the gazetted hospital fees.

Note: Refer to [Schedule E, Appendix F](#) (Medicare Eligibility Matrix for Commonwealth Visas) in the WA Fees Manual, to assess patient eligibility to Medicare for visa sub classes issued by the Commonwealth.

Medicare eligibility of foreign organ donors limited to kidney and stem cell transplants

Where an Australian resident requires a foreign donor who is clinically compatible, the foreign donor is Medicare eligible only if it is a kidney or stem cell transplant. All medical costs associated with the transplant, incurred by both the donor and recipient can then be attributed to the Australian resident free of charge.

Medicare eligibility of diplomats

A small number of members of the Diplomatic and Consular Corps (those belonging to missions or posts of New Zealand, the United Kingdom, the Netherlands, Sweden, Finland, Italy, Malta, the Republic of Ireland, Belgium and Slovenia) are considered eligible for treatment as public patients. This arises from reciprocal health care arrangements between Australia and these countries. Diplomats and consular representatives from Norway are not eligible for Medicare, refer to Appendix L: Reciprocal Health Care Agreement Matrix.

Further information on these arrangements is available from the Department of Human Services or Department of Foreign Affairs and Trade.

All other diplomatic and consular representatives are liable to pay the full rate for medical treatment received in Australia, including ambulance transport charges.

2.4. Overseas student health cover (OSHC)

Visitors to Australia on Student visas from the following countries are covered by the reciprocal health care agreements: New Zealand, United Kingdom including Northern Ireland, the Netherlands, Belgium, Sweden, Slovenia and Italy (for the first six months after entry into Australia).

All other foreign students who are studying in Australia plus those from Italy, are required to take out [Overseas Student Health Cover \(OSHC\)](#). Students should buy OSHC before they come to Australia to cover them from when they arrive. Students are required to maintain OSHC throughout their stay in Australia as part of their visa requirements.

OSHC assists students with the payment of medical and hospital expenses while studying in Australia and will contribute towards the cost of most prescription pharmaceuticals and emergency ambulance transport.

Swedish Students are not required to purchase OSHC as they have their own insurance, which is provided through the Swedish Government. However, Swedish students may choose not to purchase these products and instead, take out an OSHC policy in Australia.

Swedish students who are covered by CSN and Kammarkollegiet can demonstrate their health insurance status by showing their issued health policy card.

All Norwegian students are provided with adequate health insurance by the Norwegian government and are waived the compulsory OSHC visa requirement.

Belgian students are explicitly included by the Belgian reciprocal agreement and are not required to purchase OSHC.

New Zealand students are not issued with visas and so are not required to purchase OSHC.

Students who are covered by OSHC are issued with a certificate of purchase and a health membership card, which details whether they have current OSHC cover. Where a student does

not have a card, or the card has expired, eligibility should be confirmed with the relevant health fund.

Medications for students with Overseas Student Health Cover, for Non-PBS items, will be charged as per the rates for Unsubsidised Medication Charges, see Chapter 6.

Please refer to [Appendix L: Reciprocal Health Care Agreement Matrix](#) for eligibility criteria.

2.5. Provision of treatment to Medicare ineligible patients

Western Australian public Health Service Providers are frequently requested to provide medical care for Medicare Ineligible patients including:

- Overseas travellers
- International students
- Non-permanent residents of Australia including holders of business, retirement and family visas.
- Medical tourists who deliberately enter Australia to access treatment.
- Emergency care and urgent treatment should be provided, irrespective of Medicare eligibility as a duty of care.
- Medicare eligibility is to be determined at the time of accepting a patient for care or at the point of admission.
- Where a patient is not eligible for Medicare, cost recovery options are to be examined. This may include recourse to private health insurance funds, provision of an upfront payment, credit card or other personal payment details to enable cost recovery.

2.6. Medicare ineligible involuntary psychiatric inpatients

- Medicare ineligible patients defined as an involuntary patient (pursuant to Section 21 of the Mental Health Act 2014).
- Under an involuntary treatment order- i.e. an Inpatient Treatment Order (ITO) or Community Treatment Order (CTO) – are to have treatment provided free of charge (i.e. non-chargeable).
- Services provided under a temporary detention order, whether made by a psychiatrist or other medical practitioner, are also to be provided free of charge.

Chapter 3: Patient fees and charges

3.1. Chargeable patient categories

Category 1 – Compensable patients

- Motor Vehicle
- Eastern States Motor Vehicle
- Workers compensation
- Shipping
- Australian Defence Force
- Department of Veterans Affairs
- Compensable Other

Category 2 – Other chargeable patients

- Medicare Ineligible Overseas Patient
- Overseas Student
- Private
- Foreign Defence Force

3.2. Non-Chargeable patient categories

- Public
- Unaccompanied / unknown

3.3. Procedure for admitted patients

In accordance with clause G24 of the Schedule G – Business Rules for the National Health Reform Agreement national standards for public hospital patient admissions have been developed. Refer to [Schedule E, Appendix A](#) (National Patient Election Standards for Public Hospital Admitted Patients)

These standards cover the necessary information that should be provided to patients on the patient election form to assist patients in understanding the consequences of choosing to be treated as a public inpatient or private inpatient.

Health Service Providers should ensure that all patients who are admitted sign a patient election form regardless of their election status.

All WA hospitals should apply a standardised patient election admission form for all patients admitted.

Chapter 4: Non-chargeable patients

4.1. Public inpatients (Medicare eligible Australian residents)

Definition of a public patient

A public inpatient:

- is an eligible person (not being a compensable inpatient, nursing home type patient or private nursing home type private patient, or an inpatient who elects to be treated as a private inpatient); and
- who elects to be treated as a public inpatient; and
- in respect of whom the hospital concerned provides, in a hospital bed, accommodation, maintenance, nursing care and appropriate professional services and such other necessary services as are available.

Reference: [Part 3 Section 12 \(2\) Health Services \(Fees and Charges\) Order 2016](#)

Public patient election

At the time of admission to a hospital, or as soon as practicable after admission, an eligible person (not being a compensable inpatient or a veteran) is to elect whether they wish to be classified as:

- a) a public inpatient; or
- b) a private inpatient.

Reference: [Part 3 Section 12 \(4\) Health Services \(Fees and Charges\) Order 2016](#)

Treatment free of charge

An eligible person, who on admission to a hospital, or as soon as possible thereafter, elects to be treated as a public patient, is entitled to receive treatment free of charge including allied health, diagnostic, medical and nursing services. Accommodation charges may only be levied on public admitted patients if they are classified as a long stay Nursing Home Type Patient (NHTP).

Hospital nominated doctor

A public patient admitted as overnight stay or same day cannot choose a specific doctor. All medical treatment will be provided by a hospital nominated medical practitioner.

Public inpatient fees

Details	Fee per Day or per Service	Most recent amendment and notes
Overnight Admission	\$0.00 (No hosp. fee)	No charge to public patients
Same Day	\$0.00 (No hosp. fee)	No charge to public patients
Medical Services	\$0.00 (No hosp. fee)	No charge to public patients
Surgically Implanted Prostheses	\$0.00 (No hosp. fee)	Refer to Section 7.7
Radiology – for each item of service	\$0.00 (No hosp. fee)	No charge to public patients
Pathology – for each request	\$0.00 (No hosp. fee)	No charge to public patients however, PathWest charge hospitals on ‘fee for service’ basis at 90% of the MBS
Specialised Orthoses	\$0.00 (No hosp. fee)	No charge to public patients
Medications for each supply: <ul style="list-style-type: none"> ▪ Inpatient and Same-Day admitted medications 	\$0.00 (No hosp. fee)	Refer to Chapter 6 Clause G1 of the NHRA – where an eligible person receives public hospital services as a public patient no charges will be raised
Discharge medications <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ Safety Net Concession Card Holders ▪ Safety Net- Entitlement Card Holders 	\$7.70 (No hosp. fee) \$7.70 (No hosp. fee) \$0.00 (No hosp. fee)	
General Patients <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items 	Up to a max of \$25.00 \$25.00	
Non-chargeable medication supply	\$0.00 (No hosp. fee)	

4.2. Public non-admitted patients (Medicare eligible Australian residents)

Definition of public non-admitted patient

An eligible person, who elects to be treated as a public outpatient, who attends at a hospital and receives treatment under an outpatient service provided by the hospital, or in respect of whom a hospital provides a service elsewhere than at the hospital.

Reference: [Part 3 Section 14\(c\) Health Services \(Fees and Charges\) Order 2016](#)

NHRA principles on public non-admitted patient services

Sections G1 and G19 state:

An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

- a) There is a third-party arrangement with the hospital or the State to pay for such services; or
- b) The patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

Where an eligible person receives public hospital services as a public patient no charges will be raised, except for the following services provided to non-admitted patients and, in relation to (f) only, to admitted patients upon separation:

- a) Dental services;
- b) Spectacles and hearing aids;
- c) Surgical supplies;
- d) Prostheses – however, this does not include the following classes of prostheses, which is to be included free of charge:
 - (i) Artificial limbs; and
 - (ii) Prostheses, which either are surgically implanted, permanently or temporarily or are directly related to a clinically necessary surgical procedure;
- e) External breast prostheses funded by the National External Breast Prostheses Reimbursement Program;
- f) Pharmaceuticals consistent with the arrangements outlined in Chapter 6;
- g) Aids, appliances and home modifications; and
- h) Other services as agreed between the Commonwealth and Western Australia.

Reference: [Clauses G1 and G19 of the National Health Reform Agreement](#)

Public non-admitted fees

Details	Fee per Day or per Service	Most recent amendment and notes
Outpatient Services (other than pathology and radiology) – for each individual occasion of service	\$0.00 (No hosp. fee)	No charges apply to public patients
Radiology Services – for each item of service	\$0.00 (No hosp. fee)	No charges apply to public patients
Pathology Services – for each request	\$0.00 (No hosp. fee)	No charge to public patients. PathWest charge hospitals on a 'fee for service' basis at 90% MBS
Home Modifications service and supply or loan <ul style="list-style-type: none"> ▪ All occasions except Surgically Implanted Prostheses and Specialised Orthoses ▪ Surgically Implanted Prostheses ▪ Specialised Orthoses 	\$0.00 (No hosp. fee) Not applicable Various	For orthoses refer to Part 2, Section 9 Health Services (Fees and Charges) Order 2016 For prostheses refer to Part 2, Section 10 Health Services (Fees and Charges) Order 2016
Allied Health and Nursing Treatment – per occasion (chiropractic, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)	\$0.00 (No hosp. fee)	No charges apply to public patients.
Medication for each supply: Outpatient or Same-Day patient <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ Safety Net Concession Card Holders ▪ Safety Net-Entitlement Card Holders General patients <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items 	\$7.70 \$7.70 \$0.00 (No hosp. fee) Up to a max \$25.00 \$25.00	Clause G1 of the NHRA– where an eligible person receives public hospital services as a public patient no charges will be raised Clause G5 of the NHRA– States which have signed to Pharmaceutical Reform may charge the PBS for drugs supplied upon discharge Refer to Chapter 6

4.3. Guidelines to changing a patient election status post-admission

A change in patient election status after admission can only be changed from private to public in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:

- Patients who are admitted for a procedure but are found to have complications requiring additional procedures;
- Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
- Patients whose social circumstances change whilst in hospital (e.g. loss of job)

It is acceptable for a patient to change from public to private at any point during their admission if they have Private Health Insurance and wish to utilise it as it is the patient's right to be admitted as either a private or public patient.

In situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards and should not be retrospectively backdated to the date of admission.

Reference: [Clause G24 \(g-h\) of Appendix C of the National Health Reform Agreement](#).

Note: Refer to [Schedule E, Appendix A](#) (National Patient Election Standards for Public Hospital Admitted Patients)

Chapter 5: Chargeable patients

Chargeable patients have been split into two categories; compensable patients and other chargeable patients.

5.1. Compensable patients

Overview

On admission, the classification of a patient as a compensable patient is established either by the patient advising they are eligible for or likely to receive compensation, or where an officer within the hospital believes that a 'prima-facie' case for compensation is likely to exist.

A compensable patient does not have an election choice at admission to be a public or private patient and they are to be admitted as a compensable patient.

It is the responsibility of compensable insurers to conduct a liability assessment and determine the entitlements of a compensable patient.

Hospital employees are not to be coerced into changing the classification of a compensable patient at admission to a public patient, by either the patient or any other third party.

Reclassification of a compensable patient

From the 1st July 2023, the Chief Executive of a Health Service Provider (HSP) may make a determination that a patient who has received compensation or established a right to receive compensation (as defined within the Health Services Act 2016 and its regulations) in respect of an injury, illness, or disease for which the patient has received past health services, or is receiving ongoing health services from the HSP, is no longer deemed to be a compensable patient.

A decision to reclassify a compensable patient will result in the patient no longer being deemed a compensable patient in respect of future health services provided by the HSP.

The reclassification of a patient does not extinguish debts owing for services rendered prior to the date that the decision is made by the Chief Executive of a HSP, nor does it result in the legal reclassification of the patient for past services rendered.

This discretionary power is intended to allow HSPs to reclassify a compensable patient in limited circumstances, to ensure that health services continue to be funded through alternative sources in the event that full recovery from compensation payers and compensable patients is not feasible.

A determination made in respect of a patient's status as a compensable patient is to be documented in writing, including the reason for the determination, or captured using an appropriate form developed by the HSP for this purpose.

The Chief Executive may delegate the power to make this determination. Any delegation of this power by the Chief Executive is to be recorded in the respective HSP's authorisations and delegation schedule.

In making the determination, the Chief Executive (or delegate) is to be satisfied that one of the following criteria is met:

- The compensation received in relation to the injury, illness or disease treated by the HSP has been spent, and the person is not entitled to further compensation in relation to the injury illness or disease, such as:
 - Where the patient has exhausted the compensation received under the terms of a settlement of a claim or a court judgement.
- The patient no longer has a right to compensation in relation to the injury, illness, or disease for which it was received (including, for example, that a statutory limit to compensation has been reached).
 - In making such a determination, the Chief Executive should give consideration as to whether the patient may be entitled to make an application for a standard or special increase to statutory medical and health expense limits; or whether a patient may be entitled to pursue a common law claim in respect of their injury, illness, or disease.
- It would be unfairly disadvantageous to the patient to classify them as a compensable patient in the circumstances, such as:
 - Where the patient has fully exhausted a statutory compensation entitlement for medical and health expenses, including any standard and special increases; and
 - Has no prospect of a successful award for damages beyond statutorily prescribed amounts e.g. where there is no entitlement to common law damages.
- It would not be in the interest of the HSP to pursue a debt against the compensable patient, such as:
 - Where the patient is entitled to compensation but suffered a hospital-acquired complication during the treatment of their compensable injury which resulted in a need for extended treatment; or
 - Where a patient receives such a small amount of compensation that it is not in the financial interests of the HSP to pursue recovery; or
 - Where on the balance of legal advice it is considered that the HSP will be unlikely to recover incurred treatment costs through legal action against the patient.

The examples provided in respect of each of the above criteria are general in nature, and are not intended to be exhaustive or prescribed circumstances in which a Chief Executive must exercise the discretionary power to reclassify a compensable patient.

5.2. Motor vehicle third party Insurance fees

Overview

Effective 01 July 2024, the WA Department of Health (DoH) and the Insurance Commission of Western Australia (ICWA) have entered into an arrangement covering Motor Vehicle Third Party Insurance Patients where the liability for the patient is covered by the ICWA. This includes all patients who have a right to claim under the *Motor Vehicle (Third Party Insurance) Act 1943* or the *Motor Vehicle (Catastrophic Injuries) Act 2016*.

Under the funding agreement, the DoH will determine funding with the ICWA annually based on prior year activity with a reconciliation for previous year's over or under payments. This funding will be allocated in full to the Health Service Provider based on their share of the underlying

activity. Payments by the ICWA to the DoH will be for complete episodes, covering Emergency Department attendances, Inpatient admissions, Sub-Acute admissions, and Outpatient occasions of service. Funding for individual services, for example diagnostic imaging services or pathology tests, is included within the patient's funding, and should not be billed separately.

Under the Agreement, patients identified to have been motor vehicle accident victims will be initially classified in the patient administration system as the most appropriate alternative claim type. In many cases this will be public; however may be private, overseas visitor, overseas student or some other class of compensable patient. The patients will also be identified as having been in a motor vehicle accident in the patient administration system. The list of patients involved in a motor vehicle accident will be provided to ICWA, which will advise whether each of these patients meets their eligibility criteria.

5.3. Accidents involving other State motor vehicles / overseas visitors

Other States and Territories motor vehicles

In the event of a MVA involving only vehicles registered in other States, then the relevant interstate third party insurance authority should be charged the applicable compensable patient rate. Otherwise, in the event of an MVA involving vehicles registered interstate and in Western Australia, then ICWA will advise acceptance of liability for the relevant patients, to be processed under the new agreement. Patients whose claims are not covered by ICWA due to the liable vehicle being registered in another State or Territory should be charged to the interstate insurer, at the relevant compensable rate.

Overseas visitors

ICWA will cover MVA medical costs for overseas visitors who are Medicare ineligible, due to third party motor vehicle insurance being based on vehicle licensing, not the driver's Medicare eligibility.

5.4. Eligible war service veteran inpatients

Overview

The Hospital Services Arrangement (the Arrangement) between the WA Department of Health and the Department of Veterans' Affairs ensures Entitled Persons can access a range of admitted and non-admitted hospital services in WA publicly funded hospitals. Relevant details of the Arrangement are accessible at: [Department of Veteran Affairs \(DVA\) arrangements \(health.wa.gov.au\)](http://health.wa.gov.au). and supporting information to assist HSPs with operational procedures for the Arrangement can be found within the [DVA Supporting Guide](#).

Note: The Arrangement does NOT cover dental treatment or Australian Defence Force (ADF) patients.

Definition

Eligible war service veterans are collectively referred to as Entitled Persons (EP).

Entitled Person means a person who has elected to be treated under DVA arrangements and:

1. has been issued with:
 - a Gold Card, or
 - a White Card, or
 - an Orange Card (pharmaceuticals only), or
 - a written authorisation on behalf of the Repatriation Commission, or
2. is a Vietnam Veteran or his / her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

Important – Gold and White Cards are the only Health Treatment cards under the Arrangement. Orange, Blue or Green coloured cards have no health treatment entitlements under the Arrangement for recovery purposes.

- Gold Card gives access to treatment for all medical conditions.
- White Card gives access to treatment for accepted service-related conditions and may give access to mental health treatment.

EPs who choose to access WA publicly funded hospital services and be treated as Repatriation private patients under the Arrangement are entitled to a choice of:

- public hospital with a minimum shared ward accommodation; and
- doctor provided the doctor has admitting rights for private patients to the hospital.

Note: Repatriation Private Patient status is not equivalent to having private health insurance.

Entitled Persons may elect to be treated as public patients under the National Health Reform Agreement; however, they will not be entitled to their choice of hospital or doctor.

Identification of DVA entitled persons

All health providers should use best endeavours to ask patients if they have DVA treatment entitlements for the episode of care or attendance.

Identification of EP requires collection and electronic recording (in the relevant data collection systems) of three mandatory data items, on admission or in the case of non-admitted patients at attendance:

- Financial election - the value for EP should be 'VET' within webPAS, 'DVA' or its equivalent in other processing systems
- DVA card or file number; and
- DVA card colour- Gold or White

Gold cardholders

The Arrangement suggests best endeavours are made by hospital staff to obtain DVA financial authorisation prior to treatment, under the following circumstances, where possible to ensure that the patient will be financially covered by DVA:

- Respite care
- The treatment required is a non-MBS item; treatments occasionally nominated in writing by DVA such as cosmetic surgery or in vitro fertilisation; or a non-listed prosthesis item.
- The veteran is being admitted to a
 - non-contracted private hospital or
 - non-contracted day procedure centre.

White cardholders

Hospital staff are to obtain DVA financial authorisation as detailed for Gold Card holders above.

All other episodes of care/ occasions of service provided to DVA White Card holders will be submitted by the DoH to the Commonwealth DVA for retrospective confirmation of treatment eligibility.

To obtain DVA financial authorisation call the DVA Health Provider line for metro and non-metro areas: **1800 550 457**.

Provider invoicing & billing enquiries should be directed to Services Australia, DVA access on 1300 550 017.

Exclusions

In cases where a patient with DVA status presents for admission with a condition covered by workers' compensation, or another compensable claim, the patient is to be classified as compensable and charged at the compensable rate. The DVA Gold or White card treatment entitlements do not apply under these circumstances.

The Department of Veterans' Affairs will not accept financial responsibility for treatment that is covered by compensation or damages claims.

Nursing home type patient (NHTP) contribution for ex-prisoner of war (POW) patients and Victoria cross (VC) recipients.

Hospitals will not be able to raise accounts to DVA for the hospital accommodation fee, except for a patient contribution charge for NHTP. Entitled Persons who are admitted as, or re-classified to, NHTP will be charged a patient contribution in line with the provisions of the Health Insurance Act 1973. If the patient is an ex-POW or a VC recipient, the DVA should be invoiced for the patient contribution. The POW status is usually printed on the Gold Card, however if there is doubt, ring the DVA Health Provider line for metro and non-metro areas: **1800 550 457**. NHTP contributions for non-ex-POWs or non-VC recipients should be billed directly to the patient and they cannot recover any costs from the DVA.

Services subject to direct billing arrangements

There are services and items that are subject to direct billing arrangements between the hospitals and the DVA. These are detailed in:

- [Section 9.4](#) (Arrangements for the Provision and Charging of Aids or Equipment, Home Assessment and Home Modification for the Department of Veterans’ Affairs Entitled Persons)
- [Section 9.5](#) (Inter-Hospital Transport Arrangements for DVA Entitled Persons)
- [Section 9.7](#) (Loan Equipment – Arrangements for the Provision and Charging for the Department of Veterans’ Affairs (DVA) Entitled Persons)
- [Section 9.8](#) (Billing Arrangements for Selected Services Provided to DVA Entitled Persons)

It is essential that hospitals follow the procedures in place for the identification of all EP as detailed above or as amended from time to time.

Eligible war service veteran inpatient fees

Details	Fee per Day or per Service	Most recent amendment and notes
Overnight Admission	No charge to Eligible Patient	Centrally managed in DoH by Revenue Strategy and Support, System Finance.
Same Day	No charge to Eligible Patient	Centrally managed in DoH by Revenue Strategy and Support, System Finance.
Medical Services Note: Charges are levied to DVA and not the patient. The Health Insurance Commission (Medicare Australia) processes DVA claims	Various	Refer to the Local Medical Officer Fee Schedule: https://www.dva.gov.au/provide rs/notes-fee-schedules-and-guidelines/fee-schedules
Surgically Implanted Prostheses (SIP)	No charge to Eligible Patient	Centrally managed in DoH by Revenue Strategy and Support, System Finance.

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<p>Radiology – for each item of service Note: Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims</p>	<p>No charge to Eligible Patient</p>	<p>Refer to the Local Medical Officer Fee Schedule: https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/fee-schedules</p>
<p>Pathology – for each request Note: Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims</p>	<p>No charge to Eligible Patient</p>	<p>PathWest raise charges to DVA on a ‘fee for service’ basis at 100% of the MBS</p>
<p>Specialised Orthoses</p>	<p>No charge to Eligible Patient</p>	<p>Eligible veterans may be able to access through the Rehabilitation Appliances Program. (RAP). Further information is available at: RAP overview Department of Veterans' Affairs (dva.gov.au)</p>
<p>Medications for each supply: Medication supplied as an Inpatient, or Same-Day-Admitted Patient:</p> <p>Medication Supplied on Discharge, Outpatient or Same-day Patient:</p> <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ DVA Card Holders (where the supply is authorised for the card type) ▪ Safety Net Entitlement Card Holders <p>Non-Chargeable Medication Supplies</p>	<p>\$0.00 (No Hosp. fee)</p> <p>\$7.70 (No Hosp. fee)</p> <p>\$7.70 (No Hosp. fee)</p> <p>\$0.00 (No Hosp. fee)</p> <p>\$0.00 (No Hosp. fee)</p>	<p>Refer to Chapter 6</p>

5.5. Eligible war service veteran non-admitted patients

Overview

For an overview of the Hospital Services Arrangement (the Arrangement) between the WA Department of Health and the Department of Veterans' Affairs, and information on identifying Entitled Persons please see [section 5.4](#).

Eligible war service veteran non-admitted fees

Details	Fee per Day or per Service	Most recent amendment and notes
Outpatient Services (other than pathology and radiology) – for each individual occasion of service	No Charge to Eligible Patient	Centrally managed in DoH by Revenue Strategy and Support, System Finance.
Radiology Services – for each item of service. <i>Note: Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims.</i>	No Charge to Eligible Patient Hospitals charge DVA on a 'fee for service' basis at 100% of the MBS	Refer to the Local Medical Officer Fee Schedule: https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/fee-schedules
Pathology Services – for each request. <i>Note: Fees are levied to DVA, not the patient. Medicare Australia processes DVA claims</i>	No Charge to Eligible Patient	PathWest charge DVA on a 'fee for service' basis at 100% of the MBS
Home Modifications service and supply or loan <ul style="list-style-type: none"> ▪ All occasions except Surgically Implanted Protheses and Specialised Orthoses and Protheses ▪ Surgically Implanted Protheses ▪ Specialised Orthoses 	No Charge to Eligible Patient Not applicable No Charge to Eligible Patient	For orthoses refer to Part 2, Section 9 Health Services (Fees and Charges) Order 2016 For protheses refer to Part 2, Section 10 Health Services (Fees and Charges) Order 2016
Allied Health and Nursing Treatment – per occasion (chiroprody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)	Various	Centrally managed in the DoH by Revenue Strategy and Support, System Finance.

Details	Fee per Day or per Service	Most recent amendment and notes
Medications for each supply: Outpatient or Same-Day patient	\$0.00 (No Hosp. fee)	Refer to chapter 6
Medication supplied on Discharge, Outpatient, or Same-Day patient		
<ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ DVA Card Holders (where the supply is authorised for the card type) ▪ Safety Net Entitlement Card Holders 	\$7.70 (No Hosp. fee) \$7.70 (No Hosp. fee) \$0.00 (No Hosp. fee)	
Non-Chargeable Medication Supply	\$0.00 (No Hosp. fee)	

5.6. Nursing home type patients

Definition of a nursing home type patient

A Nursing Home Type Patient (NHTP), in relation to a hospital, means a patient in the hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days (Health Insurance Act 1973 and Private Health Insurance Act 2007).

Under the terms of the NHRA any patient who has been in hospital for more than 35 continuous days and no longer requires acute care, may be deemed a Nursing Home Type Patient. The designation of care type (acute, rehabilitative, palliative, maintenance care) is the responsibility of the clinician responsible for care.

Qualifying period

The 35-day qualifying period may accrue in a single hospital or two or more hospitals, but not in nursing homes. Hospitals in which the qualifying period is accrued may be public or private. Transferring between hospitals has no effect on the qualifying period.

The qualifying period is broken only if the patient leaves a hospital and does not enter another hospital for at least seven days. In this case, the patient will commence a new 35-day qualifying period from day one of the next admission to a hospital. Periods of 7 days or less do not break the continuity of the qualifying admission.

Long stay patients

Patients who remain in hospital for more than 35 days, in order to receive ongoing acute or other specified care (e.g. sub-acute care: rehabilitative and palliative), remain classified as 'other admitted patients' (not Nursing Home Type Patients). They are not deemed Nursing Home Type Patients until such time as the clinician authorises a change in care type to maintenance (non- acute) care.

Nursing Home Type Patients can be re-classified to acute/sub-acute care if there is a revision of the doctor’s opinion regarding the acuity of care required, such as may occur where the patient develops a secondary condition requiring medical attention.

It is expected that Nursing Home Type Patients will not actually remain in hospital but will be transferred to a nursing home or allocated a nursing home type bed for their ongoing care.

Legislative basis to raise charges for nursing home type patients

Under sub-section 6(2) of the Health Insurance Act 1973 Nursing Home Type Patients are declared as not being eligible persons. The effect of this declaration and provisions in the NHRA is that public hospitals are permitted to raise charges for Nursing Home Type Patients. Where a State provides services to NHTP in public hospitals, it is permitted to charge these patients fees in accordance with those determined by the Commonwealth Minister for Senior Australians and Aged Care. In this scenario, fees may be charged after the 35th day of continuous admission.

Current fees applicable to nursing home type patients in public hospitals

Under the definition of a ‘patient contribution’ in sub-section 3(1) of the Health Insurance Act 1973, the Commonwealth Minister for Health and Ageing may determine the maximum daily rate charged to Nursing Home Type Patients by a public hospital. In practice, NHTP rates are linked to the combined rate of the basic pension and rent assistance and are determined in consultation with each jurisdiction.

Admitted nursing home type patient fees

Details	Fee per Day or per Service	Most recent amendment and notes
Public Inpatient - Nursing Home Type	\$80.95	23 December 2025
Private Nursing Home Type – Patient Contribution	\$80.95	23 December 2025
Private Inpatient - Nursing Home Type <i>Note: The patient contribution forms part of the private NHTP fee. The Health Fund pays the difference (\$236.10 - \$80.95 = \$155.15)</i>	\$236.10	23 December 2025
Eligible Veteran Beneficiary Nursing Home Type – Patient Contribution	\$80.95	23 December 2025
Eligible Veteran Beneficiary Nursing Home Type – Patient Contribution for ex-Prisoner of War (POW) or Victoria Cross (VC) recipient <i>Note: POW’s status is printed on the Gold Card.</i>	\$80.95	23 December 2025 To be billed directly to DVA
Compensable Nursing Home Type – Inpatient	Not applicable	Cannot be classified as a nursing home type patient

Details	Fee per Day or per Service	Most recent amendment and notes
Motor Vehicle Third Party Insurance Nursing Home Type – Inpatient	Not applicable	Cannot be classified as a nursing home type patient
Medicare Ineligible Nursing Home Type – Inpatient	Not applicable	Cannot be classified as a nursing home type patient

- a) The increase in patient contribution relates to Commonwealth pension increase 20 September 2025.
- b) See 5.4 for DVA NHTP Contribution for ex-POWs and VC recipients

Note: *The nursing home type patient arrangement does not apply to either Medicare ineligible or compensable inpatients*

Derivation of the nursing home type patient contribution

The chargeable daily rate for the Nursing Home Type – Patient Contribution is calculated as follows: NHTP – Patient Contribution = 87.5% x (adult single pension rate + ‘single/no child’ rent assistance)

The Commonwealth pension rates are adjusted in accordance with the movements in the Australian Consumer Price Index (refer to Catalogue no. 6401.0) and are set by the Commonwealth Minister for Social Services in March and September every year.

5.7. Residential aged care (RAC) and respite care in a public nursing home or multi-purpose service (MPS)

Residential aged care is for senior Australians who can no longer live independently at home.

With the commencement of the *Aged Care Act 1997 (Cth)*, the Regulations made under the *Hospitals and Health Services Act 1927 (WA)* (replaced by the *Health Services Act 2016 (WA)* on 1 July 2016) were amended to remove their coverage of fees for residential aged care (RAC) and respite care provided by Health Service Providers (HSPs). Additionally the *National Health Reform Agreement* distinguishes the roles and responsibilities between Health, Disability and Aged Care systems.

The Aged Care Act 2024 (Cth) (ACA), which replaced the *Aged Care Act 1997 (Cth)* and commenced on 1 November 2025, regulates what fees and contributions may be charged to persons receiving aged care services. To avoid inconsistency with Commonwealth aged care legislation, the fees chargeable by HSPs providing these services, in both stand-alone public nursing homes or in a Multi-Purpose Service (MPS) setting, are applied by WA Health in accordance with the contribution rates determined by the Commonwealth under the ACA and associated Rules.

Note: *For fees applicable to Nursing Home Type Patients (NHTP) occupying an acute care bed in a public hospital, please refer to **Section 5.6**.*

RAC and Respite fees

Details	Fee per Day	Most recent amendment and notes
Long-Term Residential Aged Care, which includes: <ul style="list-style-type: none"> Nursing Home (only applies to care recipients who first enter care from 1 July 2014) Multi-Purpose Service (MPS) 	\$66.80 \$66.80	1 April 2026 20 March 2026
Short Term Residential Respite Care – In a home or community setting	\$13.75	20 March 2026
Short Term Residential Respite Care – In a Nursing Home or hospital setting	\$66.80	1 April 2026
Compensable Inpatients – Nursing Homes	\$368.00	1 July 2025

5.8. Boarders

Definition of a boarder

A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Types of boarders

There are many circumstances under which a health service is required to provide accommodation and meals to individuals who do not require formal admission to a hospital. The more frequent circumstances are listed below:

In some circumstances the need to have a boarder in hospital with a patient is necessary for the wellbeing of the patient. In these cases, the treating medical officer documents, that the sick person (patient) is accompanied by a boarder. Examples of these types of boarders would be:

- A breast or bottle fed infant of a sick mother or the breast or bottle-feeding mother of a sick infant.
- In remote parts of the State, there may be the need for a patient to be accompanied by a family member who may not be able to obtain accommodation elsewhere. This is more likely in areas where the patient lives a considerable distance from the hospital.
- There are circumstances when clients may be able to attend visiting medical officers' appointments or follow up treatments or appointments more easily if accommodated at the hospital as a boarder. These include appointments early in the day when the home may be a great distance from the hospital.

- Limited air flight and public road / train schedules to some remote areas may mean that patients travelling to, or returning from, a regional or city hospital may need to be accommodated at a hospital before or after receiving treatment. If accommodation but no treatment is provided these patients are classified as boarders.
- In some cases, the presence of a family member staying at the hospital as a boarder may assist both the care of the patient during the hospital stay and ensure that the patient is able to be discharged at the appropriate time. The hospital stay may be better managed by the presence of a boarder during the hospital stay to ensure there is no delay before discharge from the hospital.
- In cases of extremely ill patients or terminal illness, members of the family may wish to be present at the hospital during the critical period. The treating medical officer may decide that the presence of some family members as boarders will be of benefit to the patient.
- Patients who stay overnight for dialysis or similar treatment who are discharged the following day are to be classified according to the Australian Coding Standards (ACS), 2005. This standard states that for same-day and overnight episodes of care, where the patient is discharged on the same date as the admission, or on the next day after admission, code as principal diagnosis either the admission for chemotherapy, or dialysis or for other similar type case scenarios.

Guidelines for registration of boarders

Documenting the presence of boarders should follow these guidelines:

- Boarders are registered in the patient administration system against the relevant patient.
- People accompanying a sick person can only be classified as boarders if they stay overnight. Hotel services such as meals and a bed are to be provided.
- Where applicable, the clinician should record that it is necessary for the hospital to accommodate the person as a boarder. For example, there should be documentation in the patient medical record of a breast or bottle-feeding mother of a sick baby, or the breast or bottle-fed baby of a sick adult.
- In transit patients who may be accommodated at the hospital while awaiting transportation to either another health care facility, or to their home, may be admitted as boarders if they do not meet the admission criteria to be an admitted patient.
- If a patient who is in transit does not meet the admission criteria, and while admitted as a boarder requires minor treatment or investigation, which would normally be performed as a non-admitted patient service, this treatment should be recorded as an occasion of service and does not alter the patient's status as a boarder.
- In most circumstances there should be only one carer accompanying a patient as a boarder. The exceptional circumstances may include a mother breast or bottle feeding two infants.
- Family members may be accommodated as boarders in the case of terminal illness or extremely sick patients if the treating medical officer considers that it will assist the care of the patient.
- Babies aged 10 days and over, accompanying their mothers will be admitted as boarders unless they are receiving clinical care in their own right.
- Boarders accompanying a sick person admitted in the middle of the night with a subsequent discharge that day. The expectation is that the boarder will also be admitted. For example, a

sick baby being breast or bottle fed, and the mother accompanies the child for the wellbeing of the child.

- Patients admitted during the day and who are same-day patients. Family members accompanying the patient are not to be admitted as boarders.

Charges for boarders

The following rules regarding fees for boarders in hospitals or health services shall apply:

- The gazetted boarder's fee per night is charged for properly accommodated boarders determined by hospital staff to be fee paying boarders on the basis of receiving dedicated accommodation facilities (either in a hospital bed and / or in dedicated areas / rooms) and other services (food).
- Boarders occupying comfortable chairs without facilities or food are exempt. Boarders who need to remain with the patient for support are exempt from charges and do not incur accommodation and food costs.
- Medications:
 - Boarders requiring medication supply will be charged as a non-admitted patient, where they are an eligible 6.7.
 - Boarders who are not an eligible person requiring medication will be charged the WA Health unsubsidised medication charges, see 6.8.
 - Boarders who are an infant of whom the mother is an admitted patient are not charged for any medication supplies.
- No charges shall be raised for:
 - A mother accompanying a sick child for breast or bottle-feeding; or
 - A breast or bottle fed baby accompanying its sick mother; or
 - Person accompanying a sick child for the child's medical wellbeing, as determined by the doctor.

Boarder's fees

Details	Fee per Day or per Service	Most recent amendment and notes
Accommodation for boarders accompanying patients (excluding maternity boarders) who receive dedicated room facilities and food services, including eligible war service veteran patients	\$45.00 (inclusive GST)	1 July 2025
Non-accommodated boarders / distressed relatives whom are accompanying patients in comfortable chairs but do not receive any specific room facilities or food	\$0.00	Determined by hospital staff
Accommodation for a mother accompanying a sick child for breast or bottle-feeding, or a breast- or bottle-fed baby accompanying its sick mother, or persons accompanying a sick child for the medical well-being of the child (as determined by the doctor)	\$0.00	Ongoing
<p>Medications for non-infant boarders, for each supply:</p> <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ Safety Net Concession Card Holders ▪ Safety Net Entitlement Care Holders <p>Non-Chargeable Medication Supplies</p> <p>For all other eligible persons:</p> <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items <p>For ineligible persons</p> <p>Medication for Infant Boarders</p>	<p>\$7.70</p> <p>\$7.70</p> <p>\$0.00 (No Hosp. fee)</p> <p>\$0.00 (No Hosp. fee)</p> <p>Up to \$25.00</p> <p>Up to \$25.00</p> <p>Unsubsidised Medication Charge</p> <p>\$0.00 (No Hosp. fee)</p>	<p>Refer to Chapter 6</p>

5.9. Other compensable patients

Compensable Inpatients (excludes Motor Vehicle Third Party Insurance)

Definition of compensable inpatient

A compensable inpatient, namely, an inpatient who

- has received or established the patient's right to receive in respect of any injury, illness or disease for which the patient is receiving health services payment by way of compensation or damages (including payment in settlement of a claim for compensation or damages) under the law that is, or was, in force in a State or internal Territory; or
- on attendance at a hospital appears prima facie to have the right to receive any such payment in respect of an injury, illness or disease for which the patient is receiving health services

Reference: [Part 3 Section 12 \(2\) \(c\) Health Services \(Fees and Charges\) Order 2016](#)

Compensable patient election

It is mandatory that compensable admitted patients complete a Patient Election Form issued by the Department of Health. There are provisions for the patient to elect an alternative classification, if the 'third party insurer' rejects liability of a specific compensable claim.

Admission classification procedure for compensable patients

Patients not eligible for Medicare can be classified as a compensable patient. Compensable status takes precedence over other types of treatment status including Medicare ineligible status. The hospital must not amend charges to compensable patients because the patient voluntarily waives any rights to compensation, as this does not constitute the failure of a claim. Under these circumstances, normal debt recovery procedures should apply.

Multiple chargeable services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 7.1 Charging Arrangements for Multiple Services on Same Day.

Setting compensable inpatient charges

As part of the annual review of hospital fees and charges, fees for compensable inpatients admitted to a health service are set to achieve full cost recovery.

Compensable inpatient fees (excludes motor vehicle)

Details	Fee per Day or per Service	Most recent amendment and notes
Overnight Admission	\$3,187.00	1 July 2025
Same Day	\$4,173.00	1 July 2025
Medical Services	\$0.00 (No Hosp. fee)	Fee may be raised by: <ul style="list-style-type: none"> • A salaried medical officer exercising a right to private practice. • Private medical practitioners direct; or • A hospital on behalf of medical practitioners
Ventilator Dependent (with tracheostomy, requiring 24 hours individual care)	\$7,026.00	1 July 2025
Airway Management (with or without Tracheostomy, requiring 24 Hours Care)	\$4,200.00	1 July 2025
Surgically Implanted Prostheses	Relevant benefit amount for each listed item in Commonwealth Prostheses List	Refer to Section 7.7
Radiology – for each item of service	Up to 100% of the Private Practitioner rate	Patient charged directly by radiologist, or by hospital on the radiologist's behalf
Pathology – for each request	Various	PathWest raise charges to compensable insurers on a 'fee for service' basis at 100% of the MBS item
Specialised Orthoses	Various	For orthoses refer to Part 2, Section 9 Health Services (Fees and Charges) Order 2016
<p>Medications for each supply:</p> <p>All medications as an inpatient</p> <p>For medications supplied upon discharge:</p> <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ Safety Net Concession Card Holders ▪ Safety Net Entitlement Card Holders 	<p>\$0.00 (No Hosp. fee)</p> <p>\$7.70</p> <p>\$7.70</p> <p>\$0.00 (No Hosp. fee)</p>	<p>The Health Services (Fees and Charges) Order 2016 does not authorise the charging of pharmaceuticals to compensable inpatients</p> <p>Clause G5 of the NHRA – States which have signed to Pharmaceutical Reform may charge the PBS for drugs supplied upon discharge</p>

Details	Fee per Day or per Service	Most recent amendment and notes
<p>Non-Chargeable Medication Supplies</p> <p>For all other medication supplies</p> <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items (eligible persons) ▪ Non-PBS items (ineligible persons) 	<p>\$0.00 (No Hosp. fee)</p> <p>Up to \$25.00</p> <p>Up to \$25.00</p> <p>WA Health Unsubsidised Medication Charges</p>	

5.10. Compensable non-admitted patients

Definition of compensable non-admitted patient

A compensable outpatient, namely, an outpatient who:

- has received or established the patient’s right to receive in respect of any injury, illness or disease for which the patient is receiving health services payment by way of compensation or damages (including payment in settlement of a claim for compensation or damages) under the law that is, or was, in force in a State or internal Territory; or
- who on attendance at a hospital appears prima facie to have the right to receive any such payment in respect of an injury, illness or disease for which the patient is receiving health services.

Reference: [Part 3 Section 14\(2\)\(a\) Health Services \(Fees and Charges\) Order 2016](#)

Multiple chargeable services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to [Section 7.1](#) Charging Arrangements for Multiple Services on Same Day.

Applicable classes of compensable outpatients

Due to different charging arrangements with the Insurance Commission of Western Australia (ICWA) and the Commonwealth Department of Veterans’ Affairs (DVA), this section only applies to workers’ compensation and merchant shipping patients. Please refer to Sections 5.6 and 5.7 for charges applying to defence force personnel and Section 5.1 for motor vehicle accident patients.

The table below details outpatient charges applying to workers' compensation and merchant shipping patients.

Compensable non-admitted fees (excludes motor vehicle)

Details	Fee per Day or per Service	Most recent amendment and notes
Outpatient Services (other than pathology and radiology) – for each individual occasion of service	\$391.00	1 July 2025 Drugs supplied at the time of the initial service being treated as included in that service
Radiology Services (other than MRI and PET) – for each item of service	\$391.00	1 July 2025 Patient charged directly by radiologist, or by hospital on the radiologist's behalf
MRI and PET services – for each item of service	Up to 100% of the Private Practitioner rate	
Pathology Services – for each request	Various	PathWest charges the compensable insurer on a 'fee for service' basis at 100% of the MBS
Home Modifications service and supply or loan <ul style="list-style-type: none"> ▪ All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses ▪ Surgically Implanted Prostheses ▪ Specialised Orthoses 	\$0.00 (No hosp. fee) Not applicable Various	For orthoses refer to Part 2, Section 9 WA Health (Fees and Charges) Order 2016 For prostheses refer to Part 2, Section 10 WA Health (Fees and Charges) Order 2016
Allied Health and Nursing Treatment – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)	\$391.00	1 July 2025

Details	Fee per Day or per Service	Most recent amendment and notes
<p>Medication for each supply:</p> <p>For non-admitted patient supplies s:</p> <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ Safety Net Concession Card Holders ▪ Safety Net Entitlement Card Holders <p>Non-Chargeable Medication Supplies</p> <p>For all other non-admitted patients</p> <ul style="list-style-type: none"> ▪ PBS Items ▪ Non-PBS Items (eligible persons) ▪ Non-PBS Items (ineligible persons) 	<p>\$7.70</p> <p>\$7.70</p> <p>\$0.00 (No hosp. fee)</p> <p>\$0.00 (No hosp. fee)</p> <p>Up to \$25.00</p> <p>Up to \$25.00</p> <p>WA Health Unsubsidised Medication Charges</p>	<p>Refer to Chapter 6</p>

Category 2 – Other Chargeable Patients

5.11. Private inpatients (Medicare eligible Australian residents)

Definition of private inpatient

A private inpatient, namely, an inpatient:

- who is an eligible person (not being a compensable inpatient, nursing home type patient or private nursing home type patient); and
- who elects to be treated as a private inpatient, and
- in respect of whom the hospital concerned provides, in a hospital bed, accommodation, maintenance, nursing care and such other necessary services as are available, other than professional and dental services provided by a practitioner acting in a private capacity or midwifery services provided by a midwife acting in a private capacity.

Reference: [Part 3 Section 12\(2\)\(b\) Health Services \(Fees and Charges\) Order 2016](#)

Private patient election

At the time of admission to a hospital, or as soon as practicable after admission, an eligible person (not being a compensable inpatient or a war service veteran) are to elect whether they wish to be classified as:

- a) a public inpatient, or
- b) a private inpatient.

Reference: [Part 3 Section 12\(4\) Health Services \(Fees and Charges\) Order 2016](#)

Multiple chargeable services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to [Section 7.1](#) Charging Arrangements for Multiple Services on Same Day.

Allocation of single room accommodation

The allocation of single room accommodation is based primarily on clinical need, determined by the treating medical practitioner and subsequently on the availability of single rooms. As a rule, there is limited single room capacity in most WA public hospitals.

Setting private inpatient charges

Fees for private inpatients admitted to a hospital or health service are set as part of the annual review of hospital fees and charges.

The shared room fee is set according to the Commonwealth Minimum Benefit tables in the Private Health Insurance (Benefit Requirements) Rules 2011 and is the minimum level that health funds provide benefits for shared ward accommodation. The Department's practice is for

the Minister for Health to set the private shared room fee at the Minimum Benefit to avoid ‘out-of-pocket’ costs;

The single room fee is not regulated by the Commonwealth. The private single room fee is set through benchmarking other jurisdictions and escalation based on hospital cost growth modelling.

The same day fee is set according to the Commonwealth Minimum Benefit tables in the Private Health Insurance (Benefit Requirements) Rules 2011 and is the minimum level that health funds provide benefits for same day accommodation. The Department’s practice is for the Minister for Health to set the private same day fee at the Minimum Benefit to avoid ‘out-of-pocket’ expenses.

Private inpatient fees

Details	Fee per Day or per Service	Most recent amendment and notes
Overnight Admission – Shared Room	\$446.00	1 July 2025
Overnight Admission – Single Room (occupied at the patient’s request)	\$755.00	1 July 2025
Nursing Home Type – Patient Contribution	\$80.95	23 December 2025
Nursing Home Type – Private Inpatient <i>Note: The patient contribution forms part of the private NHTP fee. The Health Fund pays the difference (\$236.10 - \$80.95 = \$155.15)</i>	\$236.10	23 December 2025
Same Day	\$368.00	1 July 2025
Medical Services	\$0.00 (No Hosp. fee)	Fee may be raised by: <ul style="list-style-type: none"> ▪ A salaried medical officer exercising a right to private practice ▪ Private medical practitioners direct or ▪ A hospital on behalf of medical practitioners
Surgically Implanted Prostheses	Relevant benefit amount for each listed item in Commonwealth Prostheses List	For orthoses refer to Part 2, Section Health Services (Fees and Charge Order 2016)

Details	Fee per Day or per Service	Most recent amendment and notes
Radiology – for each item of service	Up to 100% of the MBS rate	Patient charged directly by radiologist, or by hospital on the radiologist's behalf
Pathology – for each request	Various	PathWest raise charges to private patients on a 'fee for service' basis at 100% MBS
Specialised Orthoses	Various	For orthoses refer to Part 2, Section 9 WA Health Services (Fees and Charges) Order 2016
<p>Medications, for each supply:</p> <p>All medication as an Inpatient.</p> <p>For medications supplied upon Discharge</p> <ul style="list-style-type: none"> ▪ Benefit Entitlement card holders ▪ Safety Net Concession Card Holders ▪ Safety Net Entitlement Card Holders <p>Non-Chargeable Medication Supplies</p>	<p>\$0.00 (No Hosp. fee)</p> <p>\$7.70</p> <p>\$7.70</p> <p>\$0.00 (No Hosp. fee)</p> <p>\$0.00 (No Hosp. fee)</p>	<p>Clause G4 of the NHRA – pharmaceutical services to private patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the PBS</p> <p>Clause G5 of the NHRA – States that have signed up to the Pharmaceutical Reform may charge the PBS for medications supplied upon discharge.</p>
<p>For all other medication supplies</p> <ul style="list-style-type: none"> ▪ PBS items ▪ Non-PBS items (eligible persons) ▪ Non-PBS items (ineligible persons) 	<p>Up to \$25.00</p> <p>Up to \$25.00</p> <p>WA Health Unsubsidised Medication Charges</p>	

Inter-Hospital transfer costs for privately insured patients in public hospitals

All privately insured patients requiring an ambulance transfer between public hospitals will have the cost met by the 'sending' public hospital.

Inter-hospital transport includes transfers of hospital admitted or registered emergency department patients from:

- A public hospital to another public hospital
- A public hospital to the airport where the patient is to be transported by air to another public hospital
- The airport to a public hospital where the patient is to be transported by air to another public hospital.

Exclusions

The following groups of patients are excluded from these arrangements:

- Workers Compensation
- Motor Vehicle Insurance Trust
- Other compensation
- Department of Veterans' Affairs – see [section 9.5](#)
- Department of Defence and
- Medicare Ineligible Overseas visitors

The patient is responsible for meeting the cost of ambulance transfers from a public to a private hospital. (except DVA).

5.12. Private non-admitted patients (Medicare eligible Australian residents)

Definition of private non-admitted patient

An eligible person, who elects to be treated as a private outpatient, who attends at a hospital and receives treatment under an outpatient service provided by the hospital, or in respect of whom a hospital provides a service elsewhere than at the hospital.

Reference: Part 3 Section 14(c) Health Services (Fees and Charges) Order 2016.

Multiple chargeable services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 7.1 Charging Arrangements for Multiple Services on Same Day.

Private non-admitted fees

Details	Fee per Day or per Service	Most recent amendment and notes
<p>Outpatient Services (other than pathology and radiology) – for each individual occasion of service</p>	<p>\$0.00 (No hosp. fee)</p>	<ul style="list-style-type: none"> ▪ Patient charged directly by the private medical practitioner, or ▪ by hospital on the doctor's behalf
<p>Radiology Services – for each item of service</p>	<p>Various</p>	<ul style="list-style-type: none"> ▪ Patient charged directly by the radiologist, or ▪ by hospital on the radiologist's behalf.
<p>Pathology Services – for each request. <i>Note: Private patients are chargeable, provided that the requesting doctor or medical consultant has exercised their 'rights of private practice'</i></p>	<p>Various</p>	<p>PathWest charge private patients on a 'fee for service' basis at 85% MBS</p>
<p>Home Modifications service and supply or loan</p> <ul style="list-style-type: none"> ▪ All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses ▪ Surgically Implanted Prostheses ▪ Specialised Orthoses 	<p>\$0.00 (No hosp. fee)</p> <p>Not applicable</p> <p>Various</p>	<p>For prostheses refer to Part 2, Section 10 WA Health (Fees and Charges) Order 2016</p> <p>For a list of orthoses products and fees, refer to Schedule A4 Specialised Orthoses for Adults OR A5 Specialised Orthoses for Children</p>
<p>Allied Health and Nursing Treatment – per occasion (chiropractic, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)</p>	<p>\$0.00 (No hosp. fee)</p>	<p>There are no private outpatient charges prescribed in the HealthServices (Fees and Charges) Order 2016</p>

Details	Fee per Day or per Service	Most recent amendment and notes
<p>Medication, for each supply: For all non-admitted patient supplies:</p> <ul style="list-style-type: none"> ▪ Benefit Entitlement Card Holders ▪ Safety Net Concession Care Holders <p>Non-Chargeable Medication Supplies</p> <p>For All Other Medication Supplies</p> <ul style="list-style-type: none"> ▪ PBS items ▪ Non-PBS items (eligible persons) ▪ Non-PBS items (ineligible persons) 	<p>\$7.70</p> <p>\$7.70</p> <p>\$0.00 (No hosp. fee)</p> <p>Up to \$25.00</p> <p>Up to \$25.00</p> <p>WA Health Unsubsidised Medication Charges</p>	<p>Refer to Chapter 6</p>

5.13. Medicare ineligible overseas inpatients

Definition of Medicare ineligible inpatient

An ineligible inpatient, namely, an inpatient

- who is not an eligible person (other than a person or a member of a class of persons to whom or which a declaration made under the Health Insurance Act 1973 (Commonwealth) section 6(2) applies in the relevant circumstances); and
- who is not a compensable inpatient; and
- in respect of whom the hospital concerned provides, in a hospital bed, accommodation, nursing care and such other necessary services as are available, other than professional and dental services provided by a practitioner acting in a private capacity.

Reference: [Part 3 Section 12\(2\)\(g\) Health Services \(Fees and Charges\) Order 2016](#)

Multiple chargeable services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to [Section 7.1](#) Charging Arrangements for Multiple Services on Same Day.

Setting Medicare ineligible inpatient charges

As part of the annual review of hospital fees and charges, fees for Medicare ineligible inpatients admitted to a hospital or health service are set to achieve full cost recovery.

Medicare ineligible inpatient fees

Details	Fee per Day or per Service	Most recent amendment and notes
Overnight Admission	\$3,118.00	1 July 2025
Same Day (excluding dialysis)	\$3,087.00	1 July 2025
Dialysis	\$948.00	1 July 2025
Medical Services	\$0.00 (No Hosp.fee)	Fee may be raised by: <ul style="list-style-type: none"> • A salaried medical officer exercising a right to private practice; • Private medical practitioners direct; or • A hospital on behalf of medical practitioners
Surgically Implanted Prostheses	Relevant benefit amount for each listed item in Commonwealth Prostheses List	Refer to Part 2, WA Health Services (Fees and Charges) Order 2016
Radiology – for each item of service potential	Up to 100% of the Private Practitioner rate	Patient charged directly by radiologist, or by hospital on the radiologist's behalf
Pathology – for each request	Various	PathWest raise charges to ineligibles on 'fee for service' basis at 100% of the MBS

Details	Fee per Day or per Service	Most recent amendment and notes
Specialised Orthoses	Various	For orthoses refer to Part 2, Section 9 WA Health (Fees and Charges) Order 2016 For a list of orthoses products and fees, refer to Schedule A4 Specialised Orthoses for Adults OR A5 Specialised Orthoses for Children
<p>Medications, for each supply:</p> <ul style="list-style-type: none"> ▪ Non-chargeable medication supply ▪ Medication as an inpatient where the medication is not a material part of/and or exceeds the daily bed charge fee ▪ Medication that is a material part and/or exceeds the daily bed charge fee ▪ Medication supplied upon discharge <p><i>Note: Medicare Ineligible persons (overseas residents) by definition are not Medicare eligible so they cannot access the PBS</i></p>	<p>\$0.00 (No Hosp. fee) \$0.00 (No Hosp. fee)</p> <p>WA Health Unsubsidised Medication Charges</p> <p>WA Health Unsubsidised Medication Charges</p>	<p>Refer to Chapter 6</p>

5.14. Medicare ineligible overseas non-admitted patients

Definition of a Medicare ineligible outpatient

A Medicare ineligible outpatient is an outpatient, who is not a Medicare eligible person, who is receiving services from a hospital or health service, is not admitted to the hospital or health service as an inpatient, and who is not a compensable non-admitted patient.

Reference: [Part 3 Section 14\(2\)\(d\) Health Services \(Fees and Charges\) Order 2016](#)

Multiple chargeable services

There are limitations on the amount a patient may be charged when more than one service occurs for chargeable overnight stay patients, outpatients and same day procedures. Please refer to Section 7.1 Charging Arrangements for Multiple Services on Same Day.

Overseas residents

A Medicare ineligible overseas student with compulsory Overseas Student Health Cover or a Medicare ineligible overseas visitor attending an outpatient department will be charged the outpatient fee.

Medicare ineligible non-admitted fees

Details	Fee per Day or per Service	Most recent amendment and notes
Outpatient Services (other than pathology and radiology) – for each individual occasion of service	\$391.00	1 July 2025
Radiology Services (other than MRI and PET) – for each item of service MRI and PET services – for each item of service	\$391.00 Up to 100% of the Private Practitioner rate	1 July 2025 Patient charged directly by the radiologist, or by the hospital on the radiologist's behalf
Pathology Services – for each request	Various	PathWest raises charges to Medicare ineligible patients on a 'fee for service' basis at 100% of the MBS
Emergency Department Services* <ul style="list-style-type: none"> • Triage Level 1 • Triage Level 2 • Triage Level 3 • Triage Level 4 • Triage Level 5 	\$2,470.00 \$1,510.00 \$1,110.00 \$745.00 \$519.00	1 July 2025 *The patient will be charged pathology and radiology in addition to the ED fees. The ED fees are also in addition to subsequent accommodation and professional fees if the patient is admitted. ED fees cover the cost of the patient being triaged so there may be costs for professional fees by VMPs in addition to this fee.
Home Modifications service and supply or loan <ul style="list-style-type: none"> ▪ All occasions except Surgically Implanted Prostheses and Specialised Orthoses and Prostheses ▪ Surgically Implanted Prostheses 	\$0.00 (No hosp. fee) Not applicable	For prostheses refer to Part 2, Section 10 WA Health (Fees and Charges) Order 2016

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<ul style="list-style-type: none"> ▪ Specialised Orthoses 	\$0.00 (No hosp. fee)	<p>For orthoses refer to Part 2, Section 9</p> <p>WA Health (Fees and Charges) Order 2016</p> <p>For a list of orthoses products and fees, refer to Schedule A4 Specialised Orthoses for Adults OR A5 Specialised Orthoses for Children</p>
<p>Allied Health and Nursing Treatment – per occasion (chiropody, clinical psychology, occupational therapy, physiotherapy, podiatry and speech therapy services)</p>	\$391.00	1 July 2025
<p>Medication, for each supply: Non-chargeable medication supply</p> <p>All other supplies</p>	<p>\$0.00 (No hosp. fee)</p> <p>WA Health Unsubsidised Medication Charges</p>	

Chapter 6: Medication supply arrangements

6.1. Pharmaceutical Benefits Scheme

Pharmaceutical Benefits Scheme fees

The Pharmaceutical Benefits Scheme (PBS) was established in 1948 and is a program of the Federal Government that provides access to medicines for eligible persons for approved conditions at an affordable price. The current provisions governing PBS are embodied in part VII of the National Health Act 1953 together with the National Health (Pharmaceutical Benefits) Regulations 1960 made under the Act. Eligibility to the PBS is restricted to Australian residents and RHCA visitors. Clause G5 of the NHRA states private inpatients cannot be charged for pharmaceuticals, nor claimed against PBS.

The PBS comprises of various sections for which a medication is able to be dispensed.

PBS Section	Benefit Scheme Description
Section 85	Section 85 provides a list of benefits able to be supplied by an authorised pharmacist.
Section 100	<p>Section 100 benefits are series of programs for medications able to be supplied as a PBS benefit under alternative supply arrangements (often for hospital use, or complexities in approval and/or patient management). Because pricing is negotiated at ex-manufacturer level, wholesale mark-up is not applied to the prices of medications in this schedule section.</p> <p>These programs available includes the:</p> <ul style="list-style-type: none"> • Highly Specialised Drugs Program • Highly Specialised Drugs (Public Hospital) Program • Complex Authority Required (CAR) medications • Highly Specialised Drugs (Community Access) Program • Efficient Funding of Chemotherapy • Botulinum Toxin Program • Human Growth Hormone Program • In-vitro Fertilisation Program • Opiate Dependence Treatment Program • Remote Area Aboriginal Health Services (RAAHS) Program

Pharmaceutical Benefits Scheme reform – implications for public hospitals

The Commonwealth Department of Health and Ageing offered the DOH a pharmaceutical reform proposal under the NHRA. The proposal has two fundamental parts:

- The ability for public hospitals to charge against the Pharmaceutical Benefits Scheme for drugs and medications supplied to non-admitted patients and inpatients on discharge; and
- The addition of PBS listings of cytotoxic medications into the Highly Specialised Drugs program.

Hospitals are permitted to charge for medications supplied to Outpatients, Same-Day patients and medication supplied to admitted patients as part of their discharge. This includes items on the PBS Section 85 and 100 listings. The State and Commonwealth PBS public hospital reform agreement allows for the levy of a patient co-payment for the supply of medicines at discharge, outpatients (including emergency department visits) and for Same-Day admitted patients upon discharge.

All public hospitals in WA are participating in the PBS Reform agreement.

PBS patient classifications

The PBS will determine fees based on the patient classification at the time a PBS benefit is dispensed. Patients who are not eligible for a Concession or an Entitlement are referred to as General Patients. A Patient is able to receive the concessional benefit and a reduction in the co-payment towards a medication supply if they are the valid recipient of an approved concession card.

Approved PBS Concession Benefit Cards:

- Pensioner Concession Card;
- Commonwealth Seniors Health Card;
- Health Care Card; or
- Department of Veterans Affairs White, Gold, or Orange Card

PBS safety net

The Commonwealth has established safety net arrangements to protect individuals and families from large overall medication expenses when a person or their family reaches a defined Safety Net Threshold. The scheme is for all eligible medication co-payment contributions during from the 1st of January until the 31st of December that same year.

A family can consist of:

- A spouse or de facto spouse
- Children under the age of 16
- Full-time dependent students under 25 years

Medications co-payments eligible for inclusion under joint safety net arrangements are:

- Community pharmacy – PBS listed medications only
- Private Hospitals – PBS listed medications only
- Public hospital – PBS listed medications and Non-PBS medications

The amount able to be claimed for a PBS supply towards the patient's safety net is determined by Medicare. This may be less than the co-payment paid depending on the Medicare calculated PBS Safety Net contribution. Refer to the Pharmaceutical Benefits Scheme to determine PBS Safety Net patient contributions.

Regulation 84BA of the National Health Act 1953 allows the amount paid for any outpatient supply to be counted towards the PBS Safety Net total. Where the patient has not contributed to and/or the co-payment has been waived, it cannot be claimed towards the patients Safety Net total.

Note that in order for a patient to access Safety Net arrangements, patients need to maintain records of PBS expenditure on a Prescription Record Form and have this submitted to Medicare in order to be issued with a Safety Net benefit.

Safety Net Benefit	Threshold	Description
Safety Net - General	\$1,748.20	A General Patient who does not hold a valid Concession who reaches the threshold during the calendar year.
Safety Net - Concessional	\$277.20	A Patient who holds a valid Concession Card that reaches the threshold during the calendar year.

All medications dispensed by a public authority contribute towards the Safety Net total, irrespective if the interval of supply is less than 20 days. Refer to the [Pharmaceutical Benefits Scheme](#) for additional information.

Overview of Charges for Medication Supply Arrangements

	PBS/RPBS Item				Non-PBS				Other	
	Inpatient ⁴ Same-Day Admitted	Discharge	Outpatient	Same-Day Patient	Inpatient ⁴ Same-Day Admitted	Discharge	Outpatient	Same-Day Patient	Clinical Trial	Medicine Access Program
General	NA	Up to \$25.00 ¹	Up to \$25.00	Up to \$25.00	-	Up to \$25.00 ¹	Up to \$25.00	Up to \$25.00	\$0.00	Up to \$25.00
Entitlement Card Holder	NA	\$7.70 ¹	\$7.70	\$7.70	-	\$7.70 ¹	\$7.70	\$7.70	\$0.00	\$7.70
DVA Card Holder	NA	\$7.70 ¹	\$7.70	\$7.70	-	\$7.70 ¹	\$7.70	\$7.70	\$0.00	\$7.70
Safety Net - Concession	NA	\$7.70 ¹	\$7.70	\$7.70	-	\$7.70 ¹	\$7.70	\$7.70	\$0.00	\$7.70
Safety Net - Entitlement	NA	\$0.00	\$0.00	\$0.00	-	\$0.00 ¹	\$0.00	\$0.00	\$0.00	\$0.00
Reciprocal Healthcare Agreement	NA ⁵	Up to \$25.00 ¹	Up to \$25.00	Up to \$25.00	NA ⁵	Chargeable amount ^{1,3}	Chargeable amount ³	Chargeable amount ³	\$0.00	Up to \$25.00
Prisoners	-	-	-	-	-	-	-	-	\$0.00	\$0.00
Non-Eligible (no Medicare)	Chargeable amount ^{2,3}	Chargeable amount ³	Chargeable amount ³	Chargeable amount ³	Chargeable amount ^{2,3}	Chargeable amount ^{1,3}	Chargeable amount ³	Chargeable amount ³	\$0.00	Up to \$25.00

¹ Not charged at some sites as the service may not facilitate an informed consent billing process and/or service capacity does not allow for billing.

² Medication not captured as part of the Daily Bed Charge Fee.

³ WA Health Unsubsidised Medication Charge.

⁴ Includes, Day Admitted, Leave and HITH Supply arrangements.

⁵ For treatment covered by the RHCA, for other supply arrangements treated as Non-Eligible.

NB: Boarders are treated as a non-admitted patient (Outpatient) should medication supply be required upon presentation of a valid prescription.

Where a medication supply is non-chargeable, no charge is raised. This is irrespective of Medicare eligibility and admission type.

6.2. Repatriation Pharmaceutical Benefits Scheme (RPBS)

The Repatriation Pharmaceutical Benefits Scheme (RPBS) is administered by the Department of Veterans' Affairs (DVA) through the Veterans' Entitlements Act 1986 for subsidised medications and dressings supplied under approved arrangements in the benefits schedule for veterans and their dependants.

Entitlement cards and eligibility for RPBS

Persons issued with an entitlement card from the DVA are eligible for some benefits on the RPBS depending on the level of entitlement.

Entitlement Card Type	Fee per Day or per Service
Gold Card – all conditions within Australia	Issued to veterans of Australia's defence force, their widows/widowers and dependants entitled to treatment for all medical conditions
White Card – for specific conditions	Issued to Australian veterans or mariners under the Veterans' Entitlements Act 1986 with: <ul style="list-style-type: none"> • an accepted war or service-caused injury or disease; • malignant cancer (neoplasia) whether war-caused or not; • pulmonary tuberculosis whether war-caused or not; • post-traumatic stress disorder whether war-caused or not; or • anxiety and/or depression whether war-caused or not.
Orange Card	Issued to Commonwealth and allied veterans and mariners who: <ul style="list-style-type: none"> • have qualifying service from World War I or II and • are aged 70 or over and • have been resident in Australia for 10 years or more.

6.3. Reciprocal health care agreements

See [Chapter 2 Reciprocal Health Care Arrangements](#).

Chargeable medication supply arrangements

In line with Commonwealth subsidised supply arrangements as part of the Pharmaceutical Benefits Scheme and the Health Services ([Fees and Charges Order](#)) 2016, certain supplies of medications to eligible patients are supplied under an arrangement where there is no patient charge, or a maximum co-payment in accordance with legislation. To ensure consistent and equitable charging across WA Health, these charges are specified.

Reference: [Part 2 Section 10\(A\)\(1\) Health Services \(Fees and Charges\) Order 2016](#)

6.4. Medication supplies generally

Quantities of medication supply

All supplies are required to be in accordance with the prescription, the Medicines and Poisons Regulations 2016 (WA), and the National Health (Pharmaceutical Benefits) Regulations 2017 where applicable.

Reference: [Part 4 Division 2 National Health \(Pharmaceutical Benefits\) Regulations 2017](#)

Patients will be supplied with a clinically appropriate quantity, this being generally:

Treatment for an acute condition: a full course of treatment or sufficient treatment until the next hospital appointment or one month's supply, as clinically appropriate.

Treatment for a chronic condition: up to one month's supply, or a supply consistent with a manufacturer's proprietary pack(s), as clinically appropriate.

Medication supplied will be consistent with:

- [MP0077/18 State-wide Medicines Formulary Policy](#)
- Individual Patient Approval, consistent with institutional policies
- Approved Clinical Trial, consistent with institutional policies
- Approved Medicines Access Programs, consistent with institutional policies
- [Schedule 8 Medicines Prescribing Code](#)

6.5. Pharmaceutical Benefits Scheme (PBS) charges

Where a benefit can be raised in accordance with the PBS supply criteria, pricing is determined by the [Department of Health Disability and Ageing](#).

General Patients: up to \$25.00

Concessional Patients: \$7.70 per supply

Safety Net Concessional Patients: \$7.70 per supply

Safety Net Entitlement Patients: \$0.00 per supply

6.6. Repatriation Pharmaceutical Benefits Scheme (RPBS) charges

Charging only applies to eligible benefits for eligible patients

DVA Gold, White or Orange Card Holders: \$7.70 per supply

6.7. WA Health subsidised (non-PBS) medication charges

WA Health charges and subsidises, a number of medications to patients. This is to ensure equitable access of medications from public authorities as a well as a mechanism to subsidise medications for patients.

These medicines will generally be:

- Not listed in the Pharmaceutical Benefits Scheme schedule
- Listed in the Pharmaceutical Benefits Scheme schedule but prescribed for an indication, patient group, dose, quantity or number of repeats not approved in the Pharmaceutical Benefits Scheme Schedule.
- The Supply Arrangement is not eligible to be a PBS benefit

The charges are applicable to:

- Medicare eligible patients
- Compensable patients (excluding WA Motor Vehicle Insurance Claims)
- Private admitted and non-admitted medication supplies

Entitlement (Concession) Card Holders: \$7.70 per supply

General Patients: = [[Medication Cost¹] + [10%] + [Dispensing Fee²]] + [Compounding Fee³] ≤ Non-PBS General Patient Co-Payment⁴

Medication Cost¹ = [Quantity of Medication] x [Average Weighted Price]

Dispensing Fee² = As defined the ready prepared item dispensing fee listed on the [Pharmaceutical Benefits Scheme](#): \$8.88 from 01/07/2025

Compounding Fee³ = A compounding fee is applied where the medication is prepared by:

- Compounding medicaments and excipients into formulation for a specific patient
- Manipulation of a medication for a specific patient or prescriber to customise therapy
- Preparation of the medication according to manufacturer's (excludes reconstitution of non-sterile dry powder suspensions)

Where any proportion of the compounding occurs under aseptic conditions, the compounding is considered to be sterile compounding, all other types of compounding are considered to be extemporaneous.

Compounding Type	Fee
Extemporaneous Compounding	\$10.92
Sterile Compounding	\$40

References: [Pharmaceutical Benefits Scheme \(Compounding Payment Scheme\)](#)

[Pharmaceutical Benefits Scheme \(Ready Prepared dispensing Fee\)](#)

Non-PBS General Patient Co-Payment⁴ = As defined in the Health Services (Fees and Charges) Order 2016 Sch 1, Div 1, (5)(C)(ii)

Note: Medication Cost is exclusive of GST

6.8. WA Health unsubsidised medication charges

The charges are applicable to:

- All ineligible persons where:
 - The medication supplied is not during an admission,
 - The medication supplied during admission is a material proportion of and/or exceeds the Daily Bed Charge Fee
 - The medication is supplied upon Discharge
- Persons from a Reciprocal Health Care Arrangement Country where:
 - The medication or Supply Arrangement is not a PBS benefit
 - The medication supplied is not during an admission

Patient Price = [Medication Cost¹] + [Dispensing, Administration and Handling Fee²] + [Compounding Fee³]

Medication Cost¹ = [Quantity of Medication] x [Average Weighted Price]

Dispensing, Administration, and Handling Fee² = Tier of Fee applied dependent on the cost of the medication

Tier	Medication Cost	Dispensing, Administration and Handling Fee
Tier 1	<\$180	\$7.49 +18% of medication cost, per supply
Tier 2	\$180-\$2,089.71	\$25.48 + 6% of medication cost, per supply
Tier 3	>\$2,089.71	\$182.38

Compounding Fee³ = A compounding fee is applied where the medication is prepared by:

- Compounding medications and excipients into formulation for a specific patient
- Manipulation of a medication for a specific patient or prescriber to customise therapy
- Preparation of the medication according to manufacturer’s instructions (excludes reconstitution non-sterile dry powder suspensions)

Where any proportion of the compounding occurs under aseptic conditions, the compounding is considered to be sterile compounding, all other types of compounding are extemporaneous.

Compounding Type	Fee
Extemporaneous Compounding	\$9.43
Sterile Compounding	\$40

References: [Pharmaceutical Benefits Scheme \(Compounding Payment Scheme\)](#)

[Pharmaceutical Benefits Scheme \(Ready Prepared dispensing Fee\)](#)

6.9. Medicines access programs (MAP)

Medicines Access Programs are a series of arrangements where a Pharmaceutical Company (Sponsor) may make available a medication to a patient via a Health Service for compassionate, commercial or other reasons, of which the medication may not meet the criteria to be subsidised to the patient other arrangements. The types of programs include:

- Compassionate Use
- Expanded Access Programs
- Product Familiarisation Programs
- Cost-Share Programs

There is additional documentation and reporting requirements that may be required as part of the administration of a Medicines Access Program.

The WA Therapeutic Advisory Group has [Guidelines](#) and [Guiding Principles](#) that should be adhered to when such an arrangement should take place.

Additional doses of the same medication within the same month are non-chargeable.

All medicines access programs

Safety Net Entitlement: \$0.00

Concessional Patients: \$7.70

Other Patients: \$25.00

6.10. Differential pricing

Where the calculated charge for a WA Health Subsidised (Non-PBS) Medication is materially different relative to a comparable medication from within the community or private sector, for a charge below the maximum WA Health Subsidised (Non-PBS) charge, the charge may be modified to be consistent with the comparable charge.

Non-Chargeable medication supply arrangements

Medication charges that would normally be raised due to a provision in the Health Service (Fees and Charges Order) 2016 may be classified as a non-chargeable medication supply due to:

- A legislative instrument, WA Health Policy or Memorandum that instructs the supply to be non-chargeable.
- Requirements under a specific funding arrangement for the occasion of service, as the medication supply costs have been captured under Activity Based Funding remuneration and cannot be claimed again from the patient.
- The identified cohort is at risk of harm should a fee be raised or deemed to be a vulnerable cohort.
- It is uneconomical for the Health Service Provider to raise a charge in a specific instance and/or cohort.
- The Supply Arrangement will result in the patient not being admitted and/or discharged in a timely manner.
- The occasion of service does not lend itself to be able to obtain informed financial consent from the patient for a charge to be raised.
- The arrangement is part of a clinical trial or research activity.

Where a supply of medication meets any of these criteria a charge may not be raised.

Non-chargeable supplies do not require management as a waiver, write-off or write-back, as the charge cannot be raised in order to be treated as a liability.

6.11. Non–Chargeable patient classifications

Inpatient

See [Section 4.1. Public Inpatients \(Medicare Eligible Australian Residents\)](#)

For Public Inpatients no charge is to be raised for any medications supplied during the admission. Medications supplied for discharge may be chargeable in accordance with the National Health Reform Agreement.

Reference: [Clauses G1 and G5 of the National Health Reform Agreement \(NHRA\)](#)

See [Section 4.1. Public Inpatients \(Medicare Eligible Australian Residents\)](#)

A service of acute, sub-acute and post-acute care, which would otherwise be provided as an inpatient service. Admission criteria includes that the requirement for care is for a period of up to seven days. Medication related to the admission provided to patients is non-chargeable and includes:

- All non-oral medications for which admission is directly related. (excluding insulin, iron infusions and infliximab)
- All chemotherapy-related medication, including supportive medications for oncology patients admitted to HITH

Any medications that are required pre-procedure, during procedure and supportive medications post procedure may be non-chargeable. This is due to the medication's component being reimbursed as part of the episode of care via Activity Based Funding where this is indicated and/or the inability to be able to obtain informed financial consent.

All medication supplies required as part of the reason for admission are non-chargeable.

Reference: Clause G1 of the National Health Reform Agreement (NHRA)

Leave

See [Section 4.1. Public Inpatients \(Medicare Eligible Australian Residents\)](#)

Leave is where the patient remains an admitted patient; however, leaves the hospital for a defined period prior to returning and/or discharge. All medication supplies during the period of leave are non-chargeable.

Same-Day admitted patients

See [Section 4.1. Public Inpatients \(Medicare Eligible Australian Residents\)](#)

A patient admitted for same-day surgery, a non-medication related procedure or chemotherapy administration, but not for the sole reason of non-oral related medication administration will receive Medications supplied for treatment during the admission are non-chargeable.

Medications supplied upon discharge may be chargeable.

Any medications that are required pre-procedure, during procedure and supportive medications post-procedure may be non-chargeable. This is due to the medication's component being reimbursed as part of the episode of care via Activity Based Funding where this is indicated and/or the inability to be able to obtain informed financial consent.

Where the funding for the episode does not include medications costs and the Health Service is able to obtain informed financial consent, the Supply Arrangement is chargeable.

Determination for each type of activity and consenting process is to be undertaken, and where appropriate the Supply Arrangement become chargeable.

Outpatients requiring non-oral medication administration

Patients attending the hospital for the sole purpose of administration of a medication that cannot be self-administered at home.

The medication is generally administered in an outpatient infusion clinic but may be administered in another area, such as an outpatient clinic or day stay unit.

Medications include, but are not limited to:

- Parenteral infusions (including ocular injections)
- Implants
- Depot injections
- Intrauterine devices
- Paralyzing agents
- Erythrocyte Stimulating Agents
- Bladder Installations

- Allergen testing

Medications supplied to patients for administration at the hospital may be non-chargeable. Medications supplied to be taken following the administration at the hospital are chargeable.

Boarders

Medication supplies to an infant boarder of whom the mother is an admitted patient, all medication supplies are non-chargeable. See Section 5.7

6.12. Public health supply arrangements

Notifiable diseases

Treatment of a Notifiable Infectious Disease in any patient classification and any patient eligibility are non-chargeable under the Public Health Act 2016 (WA), when it is provided by a public official and the treatment is still required to prevent transmission of the disease to another person. A list of all Notifiable Diseases that require treatment with medication to prevent transmission are found in [Appendix K](#).

See [Section 8.2 Treatment of Patients with Notifiable Infectious Diseases](#)

Reference: [Part 9, Division 1, Section 88, subsection \(5\)\(d\)\(ii\) of the Public Health Act 2016](#)

Post exposure prophylaxis

Where a person irrespective of election or Medicare eligibility, has been exposed and is at risk of contracting a notifiable infectious disease, treatment with medication provided by a public official until either the confirmation of presence or absence of the disease is non-chargeable.

Reference: [Part 9, Division 1, Section 88, subsection \(5\)\(d\)\(ii\) of the Public Health Act 2016](#)

WA immunisation schedule

Immunisations listed in the [WA Immunisation Schedule](#) and where the patient meets the eligibility criteria are non-chargeable. This also includes “Catch Up” schedules for patients who have not been administered the vaccine during the required time frame.

Vaccines meeting the eligibility criteria are able to be supplied irrespective of patient’s residency or Medicare eligibility.

Healthcare worker immunisation programs

Vaccinations supplied to healthcare employees and volunteers as part of the Department of Health or Commonwealth programs are non-chargeable.

Healthcare worker nicotine replacement therapy programs

Nicotine Replacement Therapy provided to staff in accordance with [Smoke Free WA Health System Policy OD0414/13](#) and applicable local policy is non-chargeable.

Patient nicotine replacement therapy programs

Nicotine Replacement Therapy prescribed and or supplied to patients prior to an admitted procedure as part of a Nicotine Replacement Therapy Program is non-chargeable.

Healthcare worker infection prevention & management

Medications supplied to healthcare workers in accordance with local policy, for the treatment and/or prevention of conditions that require management by the Health Service Provider, so the employee does not transmit the infection to other staff or patients, are non-chargeable. This will generally be infections that the staff member may have been exposed to in the workplace but are not classified as a notifiable disease.

6.13. Inter-Agency patient supply arrangements

Prisoners

See [Section 1.3. Medicare Exemptions](#)

Prisoners are ineligible for Medicare and all costs are born by the state.

Medication fees and charges for Prisoners are unable to be raised against the Department of Justice for any medication costs incurred in any occasion of service type.

The Commonwealth extended funding of the Section 100 Highly Specialised Drugs (HSD) program to prisoners incarcerated in prisons. While such exemption allows claiming on the Pharmacy Benefit Schedule, all program rules apply. All co-payments are unable to be raised against the patient or billed to the Department of Justice.

Reference: Memorandum of Understanding between Department of Corrective Service and the Department of Health 2014.

Children under the guardianship of the Minister

Medication fees and charges for children under the guardianship of the Minister are unable to be raised against the Department for any medication costs incurred in any occasion of service type.

6.14. Equity in health outcome supply arrangements

Closing the gap

Closing the Gap is a Council of Australian Governments (COAG) initiative to improve outcomes for Aboriginal and Torres Strait Islanders. A component of the initiative is the Medicare measure to ensure low cost or free access to medications for Aboriginal and Torres Strait Islanders.

Patients are eligible if they:

- would experience setbacks in preventing or managing chronic disease if they didn't take the prescribed medicine and/or;

- are unlikely to keep up their treatment without assistance through the measure.

To ensure delivery of the COAG commitment to improve indigenous outcomes and continuity of care between hospital and community settings, Closing The Gap medication supply arrangements when a patient would otherwise meet the Federal eligibility criteria, apply to State subsidised Supply Arrangements.

All medication supplies where a prescriber determines, and a patient declares eligibility under the Closing The Gap program by a public health authority, are non-chargeable.

Section 100 remote area Aboriginal health services (RAAHS) program

Medication supplies for patients who are eligible for the Section 100 RAAHS program are non-chargeable.

Outpatients experiencing financial hardship

Supply of medications to persons experiencing financial hardship may be non-chargeable consistent with a local process approved by the relevant Chief Pharmacist and the delegated authority.

6.15. Capacity to obtain informed financial consent

Informed financial consent is where the patient is advised and agrees to any charges that are to be raised prior to them being processed. Not obtaining consent for a charge may be an unsolicited good/service and is a breach of the [Competition and Consumer Act 2010 \(Cth\)](#)

Certain patient admission presentations may result in the inability to obtain informed financial consent for medications from the patient/guardian and those medication Supply Arrangements may be non-chargeable.

Reference: [Competition and Consumer Act 2010 \(Cth\)](#)

Reference: [ACSQHS AS18/10: Informed financial consent](#)

Emergency supply

Where a patient presents to a non-admitted care setting and is supplied with medication in accordance the [Medicines and Poisons Regulations 2016 \(WA\)](#), the supply of the medication may be non-chargeable, if informed consent cannot be obtained.

Structured administration supply arrangements (SASA)

Medication that has been supplied to a patient as part of Structured Administration Supply Arrangement in accordance with the [Medicines and Poisons Regulations 2016 \(WA\)](#) is non-chargeable, if informed consent cannot be obtained.

Miscarriage or termination of pregnancy

Medications related to miscarriage or the termination of pregnancy where treated by a public official are non-chargeable, if informed financial consent cannot be obtained.

Sexual and/or domestic assault

Medication supplies for patients whom are treated for sexual and/or domestic assault, all medication supplies related to the treatment of the episode of care are non-chargeable.

Assaulted paediatric patients

Medication supplies for children whom are treated for assault or abuse (including suspected), all medication supplies related to the treatment of the episode of care are non-chargeable.

6.16. Specific patient groups supply arrangements

Paediatric haematology and oncology

Paediatric patients receiving chemotherapy, all medication supplies relating to the management of paediatric cancer are non-chargeable.

Paediatric palliative care

Paediatric patients receiving palliative care, all medication supplies relating to their management are non-chargeable.

Adult haematology and oncology

Medications supplied under the Section 100 Efficient Funding of Chemotherapy (EFC) may be non-chargeable.

Parenteral chemotherapy, medications supplied prior to parenteral chemotherapy and for short term symptom management following chemotherapy may be non-chargeable.

Bone marrow donors

All medications supplied to Bone Marrow Donors as part of the procedure for making a donation are non-chargeable.

Obstetric patients under drug and alcohol dependence services

Medications and supplements associated with routine antenatal care for antenatal patients, receiving care under a specialist drug and alcohol dependence service, are non-chargeable.

Obstetric patients under adolescent services

Medications and supplements associated with routine antenatal care for antenatal patients, receiving care under an adolescent obstetric service, are non-chargeable.

Voluntary assisted dying

Medications supplied in accordance with the procedures of the [Voluntary Assisted Dying Act 2019](#) by the Statewide Pharmacy Service are non-chargeable.

6.17. Mental health medication supply arrangements

Treatment under the mental health legislation

Medication supplies for patients receiving treatment under the [Mental Health Act \(WA\) 2014](#) or the [Criminal Law \(Mentally Impaired Accused\) Act 1996](#) are non-chargeable. This is inclusive of Community Treatment Orders and Inpatient Treatment Orders.

Medicare ineligible involuntary psychiatric inpatients

Medication supplies associated with the admission and discharge process for ineligible involuntary inpatients are non-chargeable.

See [2.7 Medicare Ineligible Involuntary Psychiatric Inpatients](#)

Clozapine titration

The first occasion a patient is prescribed clozapine and it is supplied by a public health authority, medication supplies for clozapine up to 18 weeks are non-chargeable until the patient has established therapy. For all other instances of clozapine titration, the patient is to be charged on for the first supply of each calendar month.

Staged supply

Patients that on the requirement of a prescriber, may be required to have medication supplied by a public authority in more frequent intervals as to ensure the appropriate review and does not lead to intentional overdose.

Staged Supply Arrangements should be consistent with the Pharmacy Board of Australia: [Guidelines on dose administration aids and staged supply of dispensed medicines](#).

The first medication supply for each month is chargeable, all other medications supplied during the same month as part of the staged supply arrangement are non-chargeable.

6.18. Clinical trials

Clinical trials are research investigations, in which people volunteer to test new treatments, interventions or tests as a means to prevent, detect, treat or manage various diseases or medical conditions.

All clinical trials are approved by a Human Research and Ethics Committee.

Fees for medication supply to patients as part of clinical trials will be non-chargeable and be recovered via the trial sponsor, unless otherwise agreed upon with the trial participants.

6.19. Facilitation of early discharge

Small quantities

In order to facilitate patient flow and access, a Health Service may supply a small quantity of medications which the patient would have received as an inpatient or a pre-admission medication, without charge. This may include discharge medications or medications supplied in preparation for an admission.

For Schedule 2, Schedule 3 or unscheduled supplies, a Small Quantity must be:

- Medications the patient would have received in hospital if still admitted or
- Medication required to be taken prior to an admission, and
 - less than 48 hours supply or,
 - less than or equal to 1/3 of a manufacturers proprietary pack

For Schedule 4 or Schedule 8 supplies, a Small Quantity must be:

- Medications the patient would have received in hospital if still admitted or
- Medication required to be taken prior to admission, and
 - less than 48 hours supply and,
 - less than or equal to 1/3 of a manufacturers proprietary pack

Other Medication Supply Arrangements Related Charges

6.20. Elective delivery of medications

Where a patient elects to receive a medication other than by attending the hospital nominated location for collection, a fee equal to the cost of delivery may apply.

This fee type is applicable to all patient election types.

Generally, delivery charges will be described below, but may vary depending on specific delivery requirements.

Registered Post: \$10

Courier: \$20

Reference: [National Health \(Pharmaceutical Benefits\) Regulations 2017, Regulation 56](#)

Reference: [Department of Home Affairs Designated Regional Postcodes](#)

6.21. Dosage administration aids

A Dosage Administration Aid (DAA) is a device that assists patients with their medication management by dividing their medicines according to the dose schedule as prescribed by the patient's doctor.

There is no charge for the preparation and supply of dosage administration aids.

6.22. Devices and equipment for medication administration

Where a device or equipment for medication administration is supplied as a loan arrangement with the Health Service Provider, the terms of the loan arrangement will apply.

Where there is no loan arrangement in place, there is no charge for the supply of a device that's purpose is to assist with the administration of medications supplied.

6.23. Medication samples

Where a Medication Sample is provided to hospitals at nil cost, the supply for the medication is non-chargeable.

Chapter 7: Other fees and charges

7.1. Multiple services on same day

Overview

A person may attend, or be admitted to, and discharged from, a health service more than once in the same day. Similarly, a patient of one health service may receive services at another health service when such services are part of the total treatment. The following rules are to apply to these situations.

Chargeable overnight patients

Where a chargeable overnight stay patient is transferred to another hospital or health service, and subsequently returns to the original hospital or health service, (or to a third hospital or health service) the total charges raised by the hospital or health service should not exceed the charges which would have been raised had the patient remained an overnight stay patient of the original hospital for the full period from original admission to final discharge.

Where a chargeable overnight stay patient of a hospital or health service obtains treatment not arranged by the hospital or health service in which the patient is being treated, the normal fees may be charged by the private medical practitioners, or other hospital providing the service.

Chargeable same day patients

Where a chargeable same day patient is admitted and discharged, and then subsequently re-admitted and discharged within the period of one day (midnight-to-midnight) at the same hospital, only one same day patient account is to be issued.

Where a same day patient is for medical reasons retained (or if discharged, re-admitted on that same day) beyond midnight on the day of admission, they are to be reclassified as an overnight stay patient.

Chargeable outpatients

In line with activity counting rules for public patients, chargeable outpatients should not attract a charge for duplicated services.

Where a chargeable outpatient is recorded as attending a single clinic multiple times on a given calendar day, or where Patient Administration System (PAS) limitations require a patient event to be recorded twice due to a particular event extending past midnight, only one charge should be raised for attendance at the clinic.

Multiple ED Charges

On occasion, a patient may be triaged through an Emergency Department (ED) more than once on any given day, for example where a patient attends ED and is discharged into the community, only to present at the same ED again later in the day. Patients may also present at separate ED departments as a result of inter-hospital transfer.

Health Service Providers may choose to charge for each attendance in these circumstances, provided that the patient was provided a complete service at each presentation. However, there may be circumstances where it may be unclear as to whether it is equitable for a hospital to charge a fee. Guidelines to assist hospitals with decision-making in these situations are provided below.

Multiple presentations within same day

In practice, hospitals may choose not to charge a patient for two distinct occasions of service in circumstances such as the below:

- The patient left against medical advice due to long wait times in the ED and presented again later in the day.
- The patient could not be provided a particular service in the ED and was advised by hospital staff to reattend later in the day (e.g. patient required ultrasound but no qualified physician available at time of initial presentation).
- On clinical review, the patient did not receive appropriate health care during the initial presentation, symptoms worsened, and they re-presented.
- The patient did not receive a medical certificate and is triaged for a second time on presenting for supply of a certificate.

Transfer between Hospital Emergency Departments

Patients may also be transferred from one hospital to another and triaged in two separate EDs as a result of hospital admission pathways, or where further stabilisation of the patient is required at the point of arrival at a second hospital and this care is most appropriately provided in an emergency setting.

While each hospital is entitled to charge for services rendered as a result of an emergency triage, consideration should be given to the following when deciding whether to apply a charge:

- Whether the service provided within a particular ED was a comprehensive emergency triage and assessment of a patient's acute condition, stabilisation of the patient, or appropriate medical treatment in the emergency setting which might justify a charge; or
- Whether the service was provided in place of a direct admission to a hospital bed, such as where an ED triage primarily occurs for assessment of the most appropriate admission pathway after transfer from a hospital where triage and stabilisation occurred, or where a patient is held in ED pending bed availability on a suitable ward; and
- Whether fees are justified for the service provided, particularly in cases where a patient is provided minimal care or assessment in the ED either prior to or after transfer.

Examples:

1. Patient admitted into hospital A with life threatening injuries which requires a full triage, resuscitation, and stabilisation. Patient then transferred to hospital B but while in transit, patient's condition deteriorates further. Patient is triaged on arrival and admitted to hospital B's ED for stabilisation before surgery. In this scenario both hospitals may make an assessment that charges are warranted and invoice the patient.
2. Patient admitted to hospital A and receives a full triage. The diagnosis indicates the patient requires health care that cannot be provided in hospital A. The medical team approaches hospital B and a specialist consultant accepts the patient for direct admission into his/her care. The patient is transferred to hospital B via ED because there are no beds available. In this case, hospital B may decline to charge.
3. Parents bring their sick child into hospital A's ED. Hospital A is not a paediatric hospital so as a duty of care the child receives preliminary and/or basic healthcare to ensure she/he is fit for transfer and the family transfers to paediatric hospital B. In this case hospital A may decline to invoice for the presentation as a full triage was provided at hospital B.
4. At point of injury paramedics determine the patient will need to go to hospital B, however patient must transit through hospital A first. Patient transfers from hospital A after being registered as an ED patient. Hospital B receives patient into their ED and provides a full triage and follow-on health care. In this instance, hospital A may choose not to invoice for this presentation.
5. A pregnant woman presents to a non-maternity hospital A. After preliminary assessment it's decided care would be more appropriate in a specialist facility and is transferred to maternity hospital B. As hospital B provides the majority of care including a full triage and assessment, hospital A may decline to charge.
6. Patient presents to hospital A and receives a full triage and then hospitalisation. Patient's condition does not improve so after consultation with hospital B's medical team, the patient transfers as a direct admit to hospital B. However, patient is diverted to hospital B's ED because the specialist medical team want to assess the patient before admitting to the ward. In this scenario hospital B may decline to charge as the patient had already been triaged at hospital A, both hospitals' medical teams had discussed the patient's condition and transfer, and the patient could have been reassessed on the ward.

7.2. Chargeable outpatient services

Definition

An outpatient service is any assessment, examination, consultation, treatment, education, or other service provided to a patient who has not undergone the formal admission process, where that service has not been provided within an Emergency Department setting.

Charging

An outpatient charge may be raised each time a chargeable non-admitted patient receives a service recorded, or eligible to be recorded, as an outpatient service event within a Patient Administration System.

An outpatient service event must satisfy all of the following criteria in order to be charged:

- One or more health care providers, providing care to a patient at the same time; and
- attendance of one non-admitted patient (e.g. each patient receiving care is recorded as an individual event regardless of whether they receive care as an individual or as part of a group); and
- must contain clinical or therapeutic content (i.e. any preparation, travel, report writing, liaison with other health care providers etc. does not meet the definition of a non-admitted patient service event); and
- must result in a dated entry to the patient's permanent medical record; whether this is paper or electronic.

Outpatient services are not restricted to face-to-face consultations, and charges may be raised where a chargeable non-admitted patient receives a service delivered via information and communications technology (ICT), including but not limited to telephone calls or teleconferencing, so long as the following criteria are met:

- The service involves an interaction between at least one healthcare provider and the patient; and
- the interaction is the equivalent of a face-to-face consultation; and
- the interaction contains therapeutic/clinical content and is equivalent in content in the sense that if the consultation could not be provided via ICT, a face-to-face consultation would have occurred; and
- must result in a dated entry to the patient's permanent medical record; whether this is paper or electronic.

Exclusions

Certain outpatient services will not meet the required standard for a charge to be raised:

- Diagnostic outpatient services which are assigned a 30 series Tier 2 Code by the Independent Hospital Pricing Authority, and which would not typically be expected to be recorded within a Patient Administration System as an outpatient event (e.g. radiology services performed by an imaging technician or sonographer).
- Diagnostic services may be charged by a specialist exercising a right of private practice, this exclusion only prevents a hospital outpatient fee being charged to the patient in respect of these services.
- 'Chart Only' or 'Non-Client' events where clinical staff review patient records, discuss care plans as part of a Multidisciplinary Case conference, liaise with the patient GP or other clinical staff, or other administrative functions that occur without the attendance of the patient.
- Repeat events for a single clinic falling into a single calendar day, or where a service event crosses midnight and is required to be recorded twice due to system limitations. See 7.1. Multiple Services on Same Day.
- Outpatient events that fall within an episode of admitted care, where that outpatient event is provided at the same physical hospital location as the episode of admitted care (outpatient service events provided by a different hospital during an episode of admitted care may be charged at the discretion of the hospital).
- Administrative communication via ICT is not considered an outpatient service event and must not attract a charge. For example:
 - Booking or rescheduling an appointment.
 - Enquiring as to whether to present to the emergency department.
 - Enquiring as to when to come into the hospital for maternity delivery.
 - Receiving blood test results where no further consultation is required.
 - Other non-scheduled patient telephone contact where the interaction contains no therapeutic or clinical content.

7.3. MBS billed non-admitted services

A separate Manual has been developed for MBS Billed Non-Admitted Services. The Manual can be found using the following link:

<https://ww2.health.wa.gov.au/Reports-and-publications/WA-Health-Fees-and-Charges-Manual>

7.4. Dental health services

Overview

Eligible public patients can receive subsidised dental treatment from government funded dental clinics, private practitioners who participate in the metropolitan or country Dental Subsidy schemes, or the Oral Health Centre of Western Australia (OHCWA), depending on the patient's circumstances and location of residence.

Eligibility criteria

To receive public dental care, patients will need to meet eligibility criteria, which are dependent on their concession status:

Health care card and pensioner concession card holders

A person, who is in receipt of a health care card or pension concession card, or a dependent listed on the card, may be eligible for emergency and general dental care at the basic rate of subsidy, which is 50% of the treatment fee.

Pensions and allowances

A person who is in receipt of a full or near full pension or an allowance issued by Centrelink or the Department of Veteran's Affairs, may upon production of a Statement of Benefit letter, be eligible for a higher rate of subsidy up to a maximum of 75% of the cost of the treatment.

Notes:

- Wards of the State, Department of Justice patients, patients registered with the Disability Services Commission and eligible for treatment at the Dental Health Services Special Needs Dental Clinic and public inpatients of teaching and non-teaching hospitals (for emergency care) will not be charged.
- Children aged 5-16 years, who attend an educational facility recognised by the Department of Education, are eligible for free general dental care via the School Dental Service.
- Inpatients of Graylands Hospital and psychiatric residents of hostels who attend the Graylands Dental Clinic are not charged.

Eligible persons

Eligible patients who receive public subsidised dental care will be charged a co-payment. Dental fees are based on the Department of Veteran's Affairs schedule of dental fees and the co-payment will relate to the patient's subsidy level entitlement. Patients entitled to a 50% or 75% subsidy will be charged 50% or 25% respectively for the dental fees incurred.

Note: Please contact the Manager Central Clinical and Support Services, Dental Health Services on telephone (08) 9313 0502 for information about the current Department of Health (DoH) scale of fees for general dental services.

Other sources of information

Contact OHCWA on (08) 6457 4400 for information about:

- Referral acceptance guidelines for specialist services
- Patient eligibility

Department of Veterans Affairs fee schedule of dental services

The Department of Veterans' Affairs maintains a 'Fee Schedule of Dental Services for Dentists and Dental Specialists' (Effective 1 January 2021), which is available from their web site:

<https://www.dva.gov.au/providers/dentists-dental-specialists-and-dental-prosthetists>

[Fee Schedule of Dental Services for Dentists and Dental Specialists \(dva.gov.au\)](https://www.dva.gov.au/providers/dentists-dental-specialists-and-dental-prosthetists)

Note: This is based on the Australian Schedule of Dental Services and Glossary, 12th edition.

7.5. Pathology services

Overview

Pathwest Laboratory Medicine WA, a Health Service Provider, is the provider of pathology services for all Western Australian public hospitals. In addition, it provides pathology services to private patients, general practitioners, private hospitals, the State Coroner, the WA Police and other commercial companies.

Legislative background

Charges for pathology services provided to patients in the public hospital system are set out in Div. 4 Health Services (Fees and Charges) Order 2016.

Charges applicable to payment classes receiving pathology services

The charge payable in respect of a pathology service specified in the Commonwealth Medicare Benefits Schedule (CMBS) is:

- 100% of the CMBS amount for the service for all patients, except;
- if the service is rendered to a private pathology outpatient – 85% of the CMBS amount for the service.

Public patients in public hospitals

Public patients of public hospitals together with patients of public emergency departments are treated free of charge. Pathwest raises an account for its services with the public hospital concerned. These fees are reviewed from time to time but are currently set at 90% of the CMBS.

Private inpatients

Billed directly to the patient at 100% of the CMBS rate. There are no 'out-of-pocket' expenses to the patient. Charges are covered by Medicare Australia and private Health Fund rebates. Identified Hospital Benefit Fund (HBF) members' pathology services are billed directly to HBF.

Compensable inpatients

Billed directly to the patient at 100% of the CMBS rate or to a third-party insurer, when identified.

Private nursing home type patients

For Medicare rebatable tests, if the patient signs a Medicare assignment of benefits forms, the account is bulk-billed to Medicare Australia, otherwise the patient is billed at 85% the CMBS rate.

Medicare ineligible inpatients

Billed directly to the patient at 100% of the CMBS rate.

Compensable day patients

Billed directly to the patient at 100% of the CMBS rate or to a third-party insurer, when identified.

Compensable outpatients

Billed directly to the patient at 100% of the CMBS rate or to a third-party insurer, when identified.

Medicare ineligible outpatients

Billed directly to the patient at 100% of the CMBS rate.

Private same day patients

Billed directly to the patient at 100% of the CMBS rate. There are no 'out-of-pocket' expenses to the patient. Charges are covered by Medicare Australia and private Health Fund rebates. Identified Hospital Benefit Fund (HBF) members' pathology services are billed directly to HBF.

Compensable same day patients

Billed directly to the patient at 100% of the CMBS rate or to a third-party insurer, when identified.

Medicare ineligible same day patients

Billed directly to the patient at 100% of the CMBS rate or at full cost recovery.

Private outpatients

For Medicare rebatable tests, if the patient signs a Medicare assignment of benefits forms, the account is bulk-billed to Medicare Australia, otherwise the patient is billed at 85% the CMBS rate.

Non-Hospital patients

For Medicare rebatable tests, if the patient signs a Medicare assignment of benefits forms, the account is bulk-billed to Medicare Australia, otherwise the patient is billed at 85% the CMBS rate. Non-Medicare rebatable tests are billed directly to the patient.

Eligible war service veterans

Charges for pathology services provided to Eligible War Service Veterans are billed directly to the Commonwealth Department of Veterans' Affairs (DVA) at 100% of the CMBS rate, to the following classes:

- Veteran Affairs inpatients;
- Veteran Affairs outpatients.

7.6. Magnetic Resonance Imaging and Positron Emission Tomography Services

This section applies to Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) services rendered by provider sites as defined in the Fees and Charges Order (2016). At the time of writing the list of provider sites comprised:

- Fiona Stanley Hospital
- Fremantle Hospital (MRI only)
- Perth Children's Hospital (MRI only)
- Royal Perth Hospital (MRI only)
- Sir Charles Gairdner Hospital
- Kalgoorlie Hospital (MRI only)

Charges based on Private Practitioner rates are only payable in respect of MRI and PET scan services rendered to:

- Compensable inpatients;
- Medicare Ineligible inpatients;
- Compensable outpatients;
- Medicare Ineligible outpatients;
- Compensable same day patients;
- Medicare Ineligible same day patients; or
- Any person for the purposes of research

Note: Private Patients are to be charged directly by the private medical practitioner or by the Hospital on the practitioner's behalf. A hospital is not authorised to levy any additional charges for MRI & PET scan services in their own right.

Charging against Medicare for MRI services to eligible patients

- A Medicare benefit is only payable if the MRI unit is licensed for the purpose of Medicare eligibility.
- A Medicare benefit is not payable if the service is provided by the hospital.

- A Medicare benefit is only payable if the contractual arrangement is between the medical practitioner and an eligible person who elects to be treated as a private patient, i.e. the doctor is providing the service to the patient in a private capacity – the hospital is not providing the service.
- A Medicare benefit is not payable for MRI services provided to public patients.

7.7 Surgically implanted prosthesis

Overview

The Commonwealth introduced legislative amendments on 10 March 2005 necessary for the implementation of new prostheses arrangements.

The amendments require registered health funds to offer a 'no-gap' and 'gap' permitted range of prostheses in relation to every admitted hospital procedure on the Medicare Benefits Schedule (MBS) for which they provide cover.

At least one clinically effective no-gap prosthesis will be available for each admitted hospital MBS procedure specified in the Prosthesis List.

Under the new legislation, if the product has only a Minimum Benefit Level then a gap payment is not required (no-gap prosthesis) and the health fund will cover the full cost. In these circumstances, the health fund member (if covered) will not incur any out-of-pocket costs for that prosthesis.

If a listed product has a Minimum Benefit Level and a Maximum Benefit Level, then a gap payment may be required (gap prosthesis). The health fund will cover the cost of the gap prosthesis to at least the minimum benefit level and the health fund member will be responsible for any outstanding amount up to, but not exceeding, the difference between the maximum and the minimum.

The new prostheses arrangements implemented on 31 October 2005 include the new Prostheses List, which itemises the benefits payable against all no-gap and gap products.

Prostheses fees to be charged by public hospitals

The Commonwealth does not regulate prostheses fees charged by WA public hospitals; these fees are set by the State. The State has adopted the Commonwealth's schedule of Benefit Levels for items in the Prostheses List, as the relevant fees and charges payable for the fitting of surgically implanted prostheses in WA public hospitals, as per [Div. 6 Health Services \(Fees and Charges\) Order 2016](#).

Commencement date

The Prostheses List is effective from 31 October 2005 when the new arrangements commenced and is applicable for prostheses and medical devices implanted on or after 31 October 2005.

However, to reflect arrangements negotiated between the States, Territories and Health Fund Insurers a discount will be applicable to the Prostheses List for any Cardio-thoracic or

Ophthalmic claim for reimbursement processed from that date, subject to the conditions outlined in Clause 4 below.

Prostheses with minimum benefit level only

For items with a minimum benefit only, other than Cardio-thoracic and Ophthalmic items (as described under Categories in the Prostheses List), the fee charged will be the minimum benefit. No invoices are required to be submitted to health funds.

For Cardio-thoracic items on the List a 7.5% discount applies and for Ophthalmic items on the List a 20% discount applies. No invoices are required to be submitted to health funds.

If a public hospital is unable to procure any Cardio-thoracic or Ophthalmic items on the Prostheses List at or below the agreed percentage discount from the Prostheses List minimum benefit, then that hospital may provide a supplier invoice to the relevant health fund for reimbursement. The health fund under the current legislation is able to pay a benefit for that prosthesis up to the minimum benefit level listed on the Prosthesis List. Given the additional administrative and financial cost of procuring and sending an invoice to a fund, it is expected that hospitals will only provide an invoice where the cost is significantly above the discount level.

Prostheses with maximum/minimum benefit level

Certain items on the Prostheses List have a maximum and minimum benefit. The maximum charge for these prostheses is the maximum benefit level. Reimbursement from health funds above the minimum benefit is at the discretion of health funds.

Any prostheses charge above the benefit level paid by the health fund will be the private patient's responsibility. Therefore, the hospital or health service will need to ascertain from the relevant health fund for each prosthesis that has a maximum benefit, what benefit level above the minimum, if any, the health fund will pay. Note that discounts still apply to the minimum benefit level for Cardio-thoracic and Ophthalmic items as outlined above.

***Note:** Hospitals and health services are to comply with this Operational Directive with respect to charging for Prostheses on the Prostheses List and are required to cease other charging practices with private health funds such as charging the supplier invoice price for prostheses on the Prostheses List except in exceptional circumstances as outlined above.*

Informed financial consent

Hospitals are to ensure that patients in billed categories provide informed financial consent prior to surgery, and in doing so, understand that they are liable for any charges not covered by their health insurer for any prostheses items.

There are a small number of prostheses which are either not on the Commonwealth's Prostheses List, or a benefit amount has not been determined.

In these circumstances hospitals will need to ensure procedures are in place whereby informed financial consent is obtained from the patient in advance of their procedure where a gap payment may result.

Categories of patient to be billed

- Private inpatients
- Compensable inpatients
- Medicare Ineligible inpatients
- Private same day patients
- Compensable same day patients
- Medicare Ineligible same day patients
- Overseas visitors treated under Reciprocal Healthcare Agreements (only if the surgically implanted prostheses is not medically necessary)

Web link for the latest prostheses list

The Australian Government's Department of Health maintains the Prostheses List. The most current Prostheses List is accessible via the following hyperlink:

<https://www.health.gov.au/resources/publications/prostheses-list>

Note: It remains the responsibility of WA public hospitals and health services to regularly access all relevant Commonwealth Private Health Insurance Circulars and monitor updates to the Commonwealth Prostheses List in order to obtain all determination benefit revisions.

7.8. Specialised orthoses

Charges payable in respect of specialised orthoses

The charges are payable in respect of the supply of specialised orthoses to:

- Private inpatients
- Compensable inpatients (excludes DVA and WA MVA)
- Medicare Ineligible inpatients
- Compensable outpatients
- Eligible outpatients
- Medicare Ineligible outpatients
- Private same day patients
- Compensable same day patients
- Medicare Ineligible same day patients

For a list of orthoses products and fees see

- [Schedule A4 Specialised Orthoses for Adults](#) or;
- [Schedule A5 Specialised Orthoses for Children](#)

7.9. Home modification services

Overview

Under the NHRA between the Commonwealth and Western Australia under Clause G1 (g), where an eligible person receives public hospital services as a public patient no charges will be raised, except for specific services provided to non-admitted patients. The effect of this

particular clause is that public health systems may prescribe charges for non-admitted patients, in relation to the provision of aids, appliances and home modifications.

The Minister for Health has determined that inpatients (public, private, compensable, nursing home type and ineligible) will be provided with home modifications at no charge in accordance with the NHRA. No determination has been made in respect to what charges may be levied on non-admitted patients. In effect, this silence means that hospitals should not charge non-admitted patients for this service.

Funding for home modifications in Western Australia

Whilst patients cannot be charged for home modification services there are currently two programs that provide funding to subsidise the cost of home modifications;

- National Disability Insurance Scheme (NDIS)
- Commonwealth Home Support Program (CHSP)
- Community Aids and Equipment Program (CAEP)

National Disability Insurance Scheme (NDIS)

The NDIS provides services to younger Western Australians with a disability, supporting them to maintain their independence at home. Home modifications is one of the services available and includes structural changes to the client's home, so they can continue to live and move safely about the house, including the fitting of rails and ramps, alarms and other safety and mobility aids. Further information about eligibility and services available through NDIS can be found at <https://www.ndis.gov.au>

Commonwealth Home Support Program (CHSP)

On 1 July 2018, WA Home and Community Care (HACC) services for older people transitioned to the CHSP. Older people who require home modification services now have a new entry point to access these services. This entry point is My Aged Care (<https://www.myagedcare.gov.au/> or 1800 200 422).

Community Aids and Equipment Program (CAEP)

CAEP is the State Government funded aids and equipment program administered through the Department of Health for people with long-term disability living in the community. CAEP provides basic and essential equipment for people who meet the CAEP eligibility criteria. Access to CAEP funded equipment is guided by the CAEP Manual, which outlines the policies and procedures as well as the basic and essential equipment that can be funded.

For more info on CAEP services and eligibility please refer to [Community Aids and Equipment Program \(CAEP\) | Western Australian Government \(www.wa.gov.au\)](#) or at CAEP@health.wa.gov.au

7.10. Newborn babies whose mother elects to be private

Qualified newborn

Any newly born baby, who is less than ten days old on admission and meets one or more of the following criteria:

- Is the second or subsequent live-born infant of a multiple birth, whose mother is currently an admitted patient; or
- Is accommodated in a special care nursery. This includes Level 3 Neonatal Intensive Care Unit and Level 2 Special Care Nursery. The baby needs to be receiving special clinical care. ('Well' babies located in the nursery because the mother can't give the baby complete care don't meet this criterion and should be unqualified); or
- Remains in hospital without the mother; or
- Is admitted to hospital without the mother.

Unqualified newborn

A baby under ten days old on admission, who does not meet the criteria of a qualified newborn. This includes the first born of a multiple birth or a singleton that stays in hospital with its mother for less than 10 days and is not accommodated in a special care nursery.

Accommodation definitions

Level 3 Neonatal Intensive Care Facility:

A Level 3 Neonatal Intensive Care Unit is a separate and self-contained facility in a hospital capable of providing complex, multi-system life support for an indefinite period. The unit must be capable of providing mechanical ventilation and cardiovascular monitoring.

Criteria to Qualify for Treatment in a Level 3 Neonatal Intensive Care Unit:

- One or more of the following criteria is to be present if a newborn is to receive care in a L3 Neonatal Intensive Care Unit:
- Need for sustained assisted ventilation, either mechanical or continuous positive airway pressure;
- Need for cardio-respiratory monitoring for recurrent apnoea or bradycardia if condition is unstable;
- Extreme illness, e.g. sepsis, recurrent seizures;
- Need for parenteral nutrition by central line;
- Post major surgery, especially the first 24-48 hours; and
- During the first 48 hours of life if less than 30 weeks gestational age

Criteria to Qualify for Treatment or Care in a Level 2 Special Care Nursery:

One or more of the following criteria is to be present if a newborn is to receive care in a L2 Special Care Nursery:

- There is a requirement for oxygen concentrations up to 40%;
- There is a need for continuous cardio-respiratory monitoring, but the condition is relatively stable;
- There is a need for parenteral fluid therapy including via an umbilical arterial catheter;
- The newborn requires short term assisted ventilation to maintain the infant until the transport team arrives;
- There is a need for convalescent care following acute problems;
- There is a need for post minor surgery care for at least the first 24 hours;
- The newborn requires monitoring of transient problems, for example, observation of babies of drug addicted mothers; and
- There is a requirement for the monitoring of dying babies if parents do not wish the baby to stay with the mother.

Clinical examples of qualified and unqualified newborns

Example 1: Single newborn

Baby is born at King Edward Memorial Hospital (KEMH) on 09/04/22. Then transferred from KEMH to a local health service on 14/04/22 and discharged on 25/04/22.

According to departmental policy a newly born baby remains unqualified for the first 9 days. However, on the 10th day (and thereafter), if baby remains in hospital the admission coding is changed to Acute.

So, for the newborn circumstances above the admission record would appear as follows:
09/04/22 to 19/04/22 – Unqualified Newborn

19/04/22 – A statistical discharge and re-admission should be processed changing care type to Acute for the remainder of the admission; and

19/04/22 to 25/04/22 – Acute Care, which means the newly born baby, is now a qualified newborn.

If the guardian of a qualified newborn elects the baby to be treated as a private inpatient, then they are chargeable at the private shared room rate, under this scenario from day ten.

Example 2: Twins – multiple births

The first twin is admitted as an unqualified newborn for the first 10 days and replicates the admission processes as described in Example 1.

The second twin is automatically admitted as a qualified newborn.

If the guardian of a qualified newborn elects the baby to be treated as a private inpatient, then they are chargeable at the private shared room rate, under this scenario from day one.

Chapter 8: Charging liability

8.1. Waiver, reduction or write-off of fees and charges

Waivers

The purpose of a waiver is to allow a debt to be removed from the Health Service Provider underlying systems, on the basis that it has decided to permanently forgive the debt. See [s372 of the Financial Management Manual](#).

Write-Offs

Write-offs generally arise where revenue is deemed to be irrecoverable, or if assets or inventory are stolen, lost or damaged. See [s371 of the Financial Management Manual](#).

Write-Backs

A write-back occurs if a debt is raised, but it is subsequently discovered that the debt is not legitimate; a reversal of the entry is required, instead of a write-off. See [s373 of the Financial Management Manual](#).

8.2. Medical services and treatment exempt from charges

Treatment of patients with a notifiable infectious disease

As per the *Public Health Act 2016* (the Act), examination and treatment of notifiable infectious diseases are to be provided free of charge (i.e. non-chargeable). This includes, but is not exclusive of, radiology, pathology, pharmacy, emergency, outpatient, and inpatient charges associated with management of the notifiable disease.

Treatment and investigation of a suspected or confirmed notifiable infectious disease is to be provided free of charge to all patients, regardless of Medicare eligibility or insurance status.

This policy only applies to the extent that the examination or treatment can be reasonably associated with the investigation of potential notifiable infectious diseases, or management of proven notifiable infectious diseases.

In circumstances where a patient attends hospital or a Public Health Unit (PHU) and is treated for two different conditions, one of which is notifiable and the other which is not, the hospital or PHU are able to charge for treatment of the condition which is not notifiable.

A list of all [notifiable infectious diseases](#) can be found on the WA Department of Health website.

Treatment of patients with tuberculosis or leprosy

WA Health is committed to the elimination of mycobacterial diseases within Australia. A key strategy in ensuring prompt and effective diagnosis and treatment for patients with tuberculosis (TB) and leprosy is the provision of free care.

Patients may not be charged for the investigation of suspected cases of TB or leprosy, or for the management and treatment of confirmed cases of TB or leprosy. This applies to the extent that the health services provided are reasonably associated with the investigation, treatment, or management of suspected or confirmed cases of TB or leprosy.

In the event of differing medical opinions as to whether a particular condition is related to a patient's TB or leprosy, and in the absence of any local policy or procedures establishing a decision-making pathway, the Director of Clinical Services (or equivalent) of the relevant site should determine whether the condition is to be treated as related to a tuberculosis or leprosy diagnosis for the purposes of this policy. The Director of Clinical Services (or equivalent) of the relevant site should seek the opinion of the Medical Director of Tuberculosis for Western Australia in making such a decision.

The WA Medical Director of TB can be contacted directly or through the Anita Clayton Centre (Mon – Fri, business hours, T: 92228500, E: ACCAdmin@health.wa.gov.au). If the Medical Director is not available advice can be sought from a TB expert physician in the Centre.

All efforts should be made by Health Service Providers to ensure that patients with suspected or confirmed TB or leprosy maintain contact with the public health system, including by removing financial barriers to care wherever necessary.

Patients may be referred to the Tuberculosis Control Program for free investigation, drug therapy and/or management for TB and leprosy. Enquiries can be directed on telephone (08) 9222 8500.

Further guidance can be found within [the Guidelines for Tuberculosis Control in Western Australia](#).

Non-charging arrangement for specified group of Medicare Ineligible patients receiving abortion services

A person is eligible for abortion services by a HSP at no charge if they are ineligible for Medicare and meet any of the following criteria:

- under 18 years of age,
- homeless,
- victims of sexual assault,
- victims of family or domestic violence including reproductive coercion.

Persons meeting any of the above criteria are to be granted access to free admitted and non-admitted services for the termination of pregnancy, as well as related pharmacy prescriptions and any pathology services.

HSPs should ensure that local policies and procedures comply with this policy, and should establish mechanisms to evidence that a person meets the above criteria. This may include advice received from the treating medical team (including clinicians, social workers or welfare officers), referrals to applicable support services, and supporting evidence provided from applicable support services. HSPs may exercise their discretion to accept other forms of documentation and utilise alternate methods to confirm eligibility.

Non-charging arrangement for all services relating to sexual assault and/or family and domestic violence provided to Medicare ineligible patients

Any Medicare ineligible patient who seeks treatment as a result of sexual assault and/or family and domestic violence (FDV), is to receive public health services from Health Service Providers (HSP) at no charge.

Services to be provided at no charge under this policy include (but are not limited to): emergency department services, inpatient services, outpatient services, allied health services (including counselling), treatment (including medication), procedures, as well as any diagnostics services required (including radiological and pathological).

HSPs should ensure that local policies and procedures comply with this policy, and should establish sensitive and discrete mechanisms to evidence that a service has been provided in relation to a sexual assault and/or FDV for the purposes of this policy. This may include advice received from the treating medical team at the HSP (including clinicians, social workers, or welfare officers), and evidence of referrals to or from applicable support services e.g. the Sexual Assault Resource Centre (SARC). Documentation that may compromise patient confidentiality should not be retained for the purposes of this policy.

Charging arrangements for hospital accommodation while an admitted overnight or multi-day inpatient is on patient leave

If an admitted overnight or multi-day inpatient is statistically counted to be on a 'Leave Day' and they are not occupying a bed at midnight, no accommodation charges are to be raised.

Chapter 9: Fees and charges guidelines

9.1. Private patients in WACHS hospitals

In those hospitals that rely on general practitioners for the provision of medical services (normally small rural hospitals), eligible persons may obtain non-admitted patient services as private patients where they request treatment by their own general practitioner, either as part of continuing care or by prior arrangement with the doctor.

In most country hospitals, local general practitioners provide medical services, supported by resident and/or visiting specialists, as private practitioners. This situation has been in place prior to the existence of either the Australian Health Care Agreement or the NHRA. Local general practitioners are able to charge the patient a fee for the service provided, as a private patient. Under that arrangement, the patient can seek reimbursement from Medicare at the basic rate.

9.2. Provision of medical treatment on compassionate grounds

The following guidelines are intended to offer clarity for the process of obtaining approvals for clinicians seeking to provide medical care to overseas patients sponsored by charitable organisations on compassionate grounds while also allowing Health Services and WA Health to anticipate the costs incurred by provision of such treatments. WA specialists seeking to accept overseas patients for medical treatments in WA on compassionate grounds are expected to have obtained prospective approvals from the relevant hospital executive director, Health Service Chief Executive and the Director-General for Health.

This guidance applies to both patients from countries with whom Australia shares and does not share reciprocal health care agreements.

- Patients from countries with which Australia does not share reciprocal health care agreements are not eligible for Medicare; the sponsoring charitable organisation is liable for all health care costs for the patient.
- Patients from countries which have reciprocal health care arrangements with Australia are not covered if the treatment was arranged prior to arrival in Australia or if the purpose of the travel is to receive medical treatment therefore the sponsoring charitable organisation is liable for all health care costs for the patient.

Eligibility requirements for patients

Proposed patients must have been granted or be eligible for a visa from the Department of Home Affairs permitting stays up to 3 months (Medical Treatment Visa – short stay subclass 675) or permitting stays between 3 to 12 months (Medical Treatment Visa – Long stay subclass 685) to enter Australia to obtain medical treatment. To obtain one of these visa patients would need to demonstrate that they have the financial means to cover the cost of treatment in Australia, which may be in the form of sponsorship by a charitable organisation.

Eligibility requirements for procedures

Provision of medical care should not be at the expense of Australian residents.

The following criteria needs to be satisfied if the planned procedure is to be performed within Western Australia's public health system:

- Intervention must be established, and recommended treatments supported by a strong evidence base.
- The intervention proposed must offer a real prospect of success in this patient.
- Intervention is unavailable in patient's home country.

In obtaining approval from the Hospital Executive Director, Health Service Chief Executive and Director-General; the WA specialist must provide:

- An indication of the duration and estimated cost of treatment proposed.
- An indication regarding the nature of pre-intervention assessment.
- The follow-up required.
- The full cost of treatment including pre-intervention and follow-up phases.
- Whether these costs will be met in full or partially by the referring charitable agency.

Health Service Providers are to ensure that the estimated costs quoted in submission to Director General are correct and the provision of treatment is not at the expense of Australian residents. The health service Provider is to ensure that adequate services are available in the hospital to carry out the procedure and follow-up, and if the treatment requires a multidisciplinary approach then all the involved parties are in agreement.

The admitting specialist must advise the referring charitable organisation about estimated cost of treatment. The referring charitable organisation must provide their support in writing detailing the estimated cost they have agreed to sponsor.

9.3. Provision of treatment to Medicare ineligible patients

At any given point of time, there are approximately one million overseas visitors in Australia (excluding New Zealand citizens). Some will require medical attention at a public hospital. Not all are eligible for Medicare coverage. The Health Services Act 2016, the Health Services (Fees and Charges) Order 2016 and the National Healthcare Agreement oblige Medicare ineligible patients to pay for their care.

Emergency and urgent treatment is to be provided to all patients regardless of Medicare eligibility as a duty of care. In addition, as it may not always be reasonable for long-term visitors/temporary residents to travel to their home country for treatments, some Medicare ineligible patients may seek elective or non-urgent treatment. This operational guideline acknowledges the health service's duty of care and seeks to ensure that where care is provided, measures are taken to enable later efforts of cost recovery. Having proper processes to determine eligibility enables cost recovery and reduces the risk of unpaid debt.

Purpose of the guidelines

The purpose of this operational guideline is to ensure Health Services identify non-Medicare eligible (ineligible) patients at the point of admission and assess the ability of non-Medicare patients to pay for the full costs of care.

Background

Western Australian public Health Service Providers are frequently requested to provide medical care for Medicare ineligible patients including:

- Overseas travellers
- International students
- Non-permanent residents of Australia including holders of business, retirement and family visas and;
- Medical tourists who deliberately enter Australia to access treatment.

The insurance coverage and eligibility for Medicare for each of the above groups varies and many patients do not have any form of health cover. WA Health has identified several issues which hamper later efforts at cost recovery. These issues include:

- Failure of Health Services to identify Medicare status of patients on presentation or admission
- Failure of Health Services to assess the ability of a Medicare ineligible patient to pay (in full or part) for treatment and
- Failure of Health Services to collect appropriate information to ensure successful debt collection.

Therefore, Health Services are unable to commence debt recovery procedures for treatment costs when a Medicare ineligible patient does not pay for treatment. In other instances, Health Services have been obliged to consider waiving costs part-way through treatment to permit continuing care. Both issues frequently result in WA Health off-setting the cost of treatment provided to Medicare ineligible patients.

Medicare eligibility

Medicare Eligibility must be determined at the time of admission. Medicare entitlement is not automatic, and a person needs to apply for enrolment. A Medicare number may be issued on the day of application. Patients, who are eligible for Medicare but have not yet applied for a Medicare number, should be encouraged to apply as soon as possible.

Generally, Medicare eligibility is restricted to people living permanently in Australia who are:

- Australian citizens (who are resident in Australia)
- Permanent Australian residents (who have permanent visas)
- New Zealand citizens
- Persons with applications for permanent visas under consideration (excluding applicants for aged parent visas -Medicare eligible subclass 804), who also have:

- authority from Department of Immigration and Border Protection (DIBP) to work, or are
- an Australian citizen or permanent resident spouse, parent or child.

While overseas visitors and temporary residents generally do not have access to Medicare, there are exceptions. The WA Health Services Fees and Charges Manual and the Reciprocal Health Care Agreements (RHCA), describe these exceptions and provide guidance on how to determine Medicare eligibility. These exceptions include:

- Visitors from countries with which Australia has a RHCA. These visitors have restricted access to Medicare
- A person or classes of person declared by the Commonwealth Minister of Health to be Medicare eligible and
- Some asylum seekers.

Provision of care

Emergency care and urgent treatment should be provided, irrespective of Medicare eligibility as a duty of care.

Emergency treatment

Patients requiring emergency or urgent treatments will be treated in a comparable manner to Medicare eligible WA patients. This applies regardless of their Medicare eligibility, other health or travel insurance coverage or whether the patient (or proxy) agrees to pay treatment costs.

The relevant HSP will attempt to recover the cost of providing emergency or urgent treatments to non-eligible Medicare patients retrospectively. Appropriate processes should be in place to receive payment from the patient or obtain approval for payment from the travel insurer, for the urgent treatment provided to the patient prior to discharge from the health care facility. To facilitate this, such patients should be clearly identified and appropriate documentation collected. If a patient continues to require further treatment after emergency care has been provided.

Urgent treatment

Where treatment, although not medically necessary, cannot be deferred until the patient returns home or where there is a risk that a pre-existing or new medical condition may deteriorate into a life-threatening condition without timely treatment, patients should receive medically necessary care. The hospital should ascertain the patient's Medicare eligible status. If the patient is Medicare ineligible, insurance coverage should be determined. Where appropriate, an upfront payment should be sought. Otherwise the provision of credit card or other personal payment details or approval from the travel insurer must be taken to cover the estimated treatment cost.

Provision of non-urgent or extended treatment

In the case of non-urgent or extended treatment, health services should adopt processes akin to that of private facilities in ensuring costs of treatment are met.

Where a patient requires ongoing or non-urgent care, clinical staff should work with appropriate Revenue staff to identify what level of financial risk is posed by treating the patient, and follow any local procedures and/or authorisation and delegation schedule to seek approval to provide care.

Where patients are Medicare ineligible and do not have sufficient health or travel insurance coverage, up-front payment of anticipated treatment costs should be obtained two weeks prior to admission as per the Financial Management Manual.

Process for accepting patients not eligible for Medicare

Please refer to [Schedule E, Appendix E](#) (Flowchart on Medicare Eligibility)

Clinician’s responsibilities

The admitting medical practitioner determines the urgency and necessity for treatment.

- To enable efficient and timely decision making, it is important that the medical practitioner works with the hospital executive team and provides information on the nature of treatments required, duration and cost estimates. This should include information on the nature of pre-intervention assessment, the follow-up required and the estimated total cost of treatment including pre-intervention and follow-up phases.
- It is the medical practitioner’s responsibility to ensure that approval for treatment (apart from the infectious diseases listed in section 8.2) is obtained from the appropriate approval authority, noting that medically necessary emergency care should be provided regardless of financial risk.
- A Health Service Provider may include authorisations within an authorisation and delegation schedule for approval of treatment based on estimated treatment costs for Medicare ineligible patients where there is a risk of non-payment.
- In the absence of a delegated authority listed within the authorisation and delegation schedule of the relevant HSP, approval to incur costs should be sought based on the estimated costs as per the following table:

Estimated Costs	Approval Authority
Up to \$10,000	Area Revenue/Operations Manager, or equivalent
\$10,000 and up to \$50,000	Co-Director/Director Medical Services
\$50,000 and up to \$100,000	Executive Director, Site Health Service
Greater than \$100,000	Chief Executive, Health Service

Once a Medicare ineligible patient is admitted, information must be submitted to the responsible department in the hospital.

Hospital responsibilities

- It is recommended that health services establish treatment cost thresholds to support clinicians in their decision making for admission.
- Hospitals need to ensure that the provision of treatment would not disadvantage Australian residents.

- Upon admission (and/or leading to acceptance for care), the hospital should confirm a patient's identity and eligibility status.
- Hospitals need to ensure that the written estimated costs are as correct as possible and that the patient has provided informed written financial consent.
- Hospitals need to ensure that either:
 - the payment is made two weeks in advance of admission, and / or
 - the patient is adequately covered by a private health insurance, and / or
 - sufficient identification information has been gathered to enable billing and debt recovery, and / or
 - pre-approval from the travel insurer has been sought and received.
- Hospitals should apply normal debt recovery and / or assurance of payment policies to facilitate the full payment of hospital fees. This may require one of the following methods:
 - taking credit card details and verification of available limits sufficient to cover estimated medical costs,
 - cash deposit or bank cheque to that amount, or
 - guarantee from a patient's health insurance fund or referring agency.
- All hospitals, health services and clinical departments need to ensure adequate systems are in place with staff appropriately trained to:
 - Ensure Medicare ineligible patients are identified.
 - Ensure patients are informed of their liability for the costs of treatment. This should be with written information and staff should have the knowledge and skills to convey such information and obtain informed financial consent.
 - Interview patients to establish whether they are exempt from charges or liable for charges.
 - issue invoices.

Role of delegated officers

Hospitals are expected to identify specific staff to familiarise themselves with the contents of this document. The delegated officer would:

- Counsel a patient about their entitlements and estimated costs of their treatment.
- Ensure that patient and clinician are aware of the patient's Medicare ineligibility.
- Advise the patient about the option of receiving treatment in a private facility.
- Complete necessary forms for record keeping, information and audit purposes.
- Collect specific identification information from admitted patients according to circumstances, i.e. temporary Medicare number, passport and visa, sponsor details, address in Australia and overseas, email, travel insurance details.
- Liaise with external agencies like the Department of Home Affairs and the Health Insurance Commission to determine eligibility and travel insurance agency to obtain pre- approval for treatment costs.

HSPs will process all such accounts relevant to the hospitals that fall under their Health Service. They may also be contacted for specific advice.

Treatment costs

Patients need to have written information on the estimated costs and eligibility of medical treatment.

It is the responsibility of the medical practitioner accepting a patient, to ensure that the patient is informed of all anticipated costs. The Medical practitioner should work with the delegated officer to ensure that this information is provided to the patient or referrer.

Clinicians and clinical departments need to refer to the current Health Services Fees and Charges Manual for detailed information on accommodation and associated medical services costs for prospective medical treatment.

Note: *The Fees and Charges Manual only details hospital fees. It excludes clinicians' fees, for which overseas visitors will be liable and which cannot be charged against the MBS. If a salaried doctor provides the service, it is recommended that medical practitioners use their Private Practitioner rates for Medical Services and Fees as a basis for charging for medical treatment.*

Additionally, patients need to be advised of other associated costs: pathology and imaging, surgically implanted prostheses, prostheses and orthoses, transport and medical escorts. Where pre-operative assessment and follow-up are required, these should be considered in the cost of medical care.

The published Diagnosis Related Groups codes may assist in estimating the cost of a procedure.

Billing and debt recovery

Invoices should be issued to all patients not eligible for Medicare or where Medicare eligibility cannot be determined. HSPs will process all such accounts.

Defaulters will be recorded and debt recovery measures will be undertaken as appropriate.

Appeal process

HSA enables the State Minister for Health, notwithstanding any other provision of the Act, where the Minister thinks it reasonable to do so, and having regard to the means of the person indebted and the circumstances of the case, to reduce or waive payment of any fees for hospital service that would otherwise be payable.

Doctors can choose to waive their private billings, but the hospital costs can only be waived by the Minister for Health.

Accountability and record keeping

Health services should make normal provisions for keeping updated records of treatment of Medicare ineligible patients. This information would be reported to the Director General annually. Special forms may need to be designed to collect data from Medicare ineligible patients.

9.4. Provision of aids, equipment, home assessment & home modification services for DVA entitled persons

Policy

The Hospital Services Arrangement (HSA) between the Department of Veterans' Affairs and Western Australia (WA) ensures that Entitled Persons receive a range of admitted and non-admitted hospital services in WA Funded Hospitals. Hospital staff can access the relevant details of the HSA here: [Department of Veteran Affairs \(DVA\) arrangements \(health.wa.gov.au\)](http://health.wa.gov.au)

This arrangement covers the requirements for aids or equipment on discharge for admitted patients and non-admitted patients, including any required home assessment and home modification. If an Entitled Person requires aids or equipment during their hospital stay, the items are part of the inpatient service and DVA should **NOT** be invoiced for the costs.

Where an Entitled Person is already in receipt of aids or equipment from the DVA prior to admission, the DVA will continue to provide the items upon discharge. Aids or equipment may be loaned to an Entitled Person on either a short-term or long-term arrangement. Items issued under RAP are generally designed specifically for people with an illness or disability.

Definitions

'Entitled Person' means a person who has elected to be treated under DVA arrangements and:

- a) has been issued with:
 - a Gold Card, or
 - a White Card, or
 - an Orange Card (pharmaceuticals only), or
 - a written authorisation on behalf of the Repatriation Commission, or
- b) is a Vietnam Veteran or his / her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

Overview

The Rehabilitation Application Program (RAP) is an Australian Government Program administered by the Department of Veterans' Affairs (DVA). It provides aids and appliances to eligible veterans in their homes to enable them to maintain their functional independence.

Products and services are supplied under six categories:

- Continence
- Mobility and Functional Support
- Home Medical Oxygen
- Diabetes
- Personal Response Systems

- Continuous Positive Airway Pressure

Furthermore, detailed DVA Rehabilitation Appliance Program information can be found here: [Aids, equipment and modifications through RAP | Department of Veterans' Affairs \(dva.gov.au\)](https://dva.gov.au/aids-equipment-modifications-through-rap)

Gold Card holders are eligible to receive aids and appliances subject to assessed clinical need.

White Card holders are eligible to receive aids and appliances subject to assessed clinical need in relation either to a disability accepted by DVA as service-related, and/or cancer, tuberculosis, anxiety, depression and post-traumatic stress disorder, whether these conditions are accepted by DVA as service-related.

Further DVA information can be found here: <https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap>

The RAP Schedule contains details on the most appropriate allied health professional to assess/prescribe specific items or services. However, in cases where an allied health professional is not available, a GP is able to assess the veteran.

Where a home assessment is required prior to undertaking the home modification, hospitals should record the service as a community service in webPAS, HCARE and the Allied Health System. The Revenue Strategy and Support, System Finance team at the Department of Health will manage the cost recovery on behalf of all WA Funded Hospitals for this item. This excludes assessments undertaken by the Aged Care Assessment Team.

The RAP National Schedule lists items available through RAP.

The RAP Schedule is arranged by aid/appliance type (beds, wheelchairs etc.) and provides detailed information on eligibility, clinical assessment, functional criteria, contraindications, and Residential Aged Care Facility (RACF) and Community Aged Care Package (CACP) recipients. The Entitled Person's responsibilities with regard to safe usage, care, maintenance and transport (if applicable) are also detailed.

There are items on the RAP Schedule that require prior approval by DVA. The RAP Schedule lists these items and any criteria that might need to be met in order for the item to be provided.

DVA has implemented national supply models for products in the Continence, Mobility and Functional Support, Home Medical Oxygen Therapy, and Personal Response System categories. This ensures that prices, service provision and reporting arrangements are consistent from State to State.

Several different suppliers are available within each group/class of equipment. For example, within the Mobility and Functional Support (MFS) category the suppliers contracted to provide products and services are Aidacare, Allianz Global Assistance, Country Care Group, and BrightSky.

Diabetes products are listed in the RAP Schedule.

Further information is available under the 'Schedule and Guidelines' link on the RAP website.

The 'Provider Factsheets and Forms' link on the RAP website contains order forms as well as contact details for contracted suppliers

You may need to complete an assessment / application form in addition to an order form-. Forms can be found here: [Forms | Department of Veterans' Affairs \(dva.gov.au\)](https://www.dva.gov.au/forms)

Guidelines for specific categories, if available, can be accessed by clicking on the category name on the left-hand menu of the RAP website: [Equipment and Modifications](#)

Home modifications and household adaptive appliances

The Home Modifications section of the website contains an OT Assessment form, Information for Prescribers and veterans on major modifications, a direct order form, and an Authority to Install form. Please also refer to the DVA website section on Rehabilitation Appliances Program for Providers:

[The Rehabilitation Appliances Program \(RAP\) | Department of Veterans' Affairs \(dva.gov.au\)](http://dva.gov.au)

Rehabilitation appliance program and residential aged care

Entitled Persons receiving high level care in an Australian Government funded residential aged care facility (RACF) are not generally provided with RAP aids and appliances. DVA does, however, routinely provide a range of items to Entitled Persons in low-level care. These may include custom made wheelchairs, continence products, low vision aids, compression stockings and medical grade footwear.

When an Entitled Person moves from low-level care to high-level care, RAP items previously issued may be taken with them subject to the approval of the RACF. DVA will maintain responsibility for the repair, maintenance and replacement of such items. Entitled Persons receiving Extended Aged Care at Home (EACH) services or Community Aged Care Packages (CACP) are able to access RAP items where the service provider is not legally required to supply them.

Further information is available by calling the My Aged Care Contact Centre on 1800 200 422. If your hospital does not have a contract with a RAP provider, please follow these steps.

The list of available items and equipment is derived from Schedule 3 of the GST Act. To access the Schedule, please click on the link below.

Schedule of aids and equipment

If the item's cost is \$500 or less, the hospital should supply the item and then invoice DVA. If the item's cost is greater than \$500 the hospital should then contact DVA for prior approval (contact details below). DVA will then advise whether they approve or arrange alternative provision of the item directly through their suppliers.

The list is not exhaustive therefore, if the patient requires an item that is not in the list, hospitals should provide the item and the approval process applies if the cost is more than \$500.

Should you have any additional queries or would like more information, please contact the DVA Provider Hotline: on 1800 550 457 for both metro and regional areas.

9.5. Inter-Hospital transport arrangements for DVA entitled persons

Background

The Hospital Services Arrangement (HSA) between the DVA and Western Australia (WA) covers inter-hospital transport across WA for treatment purposes relating to the Entitled Person's episode of care.

Policy

The WA-DVA Hospital Services Arrangement (HSA) ensures that DVA EP receive a comprehensive range of admitted and non-admitted patient services. Hospital staff can access the relevant details of the HSA here: [Department of Veteran Affairs \(DVA\) arrangements \(health.wa.gov.au\)](http://health.wa.gov.au)

The DVA contracts with Day Procedure Centres (DPCs), public hospitals, and private hospitals under a Tier 1 arrangement.

Tier 1 hospitals (including mental health facilities) and DPCs are facilities where admission of Entitled Persons does not require prior approval from DVA. All WA public hospitals are Tier 1 facilities. In addition, DVA has contracts with a number of private hospitals.

Tier 2 hospitals are private facilities where all admissions of Entitled Persons require prior financial authorisation from DVA. These hospitals are used when treatment cannot be provided within a reasonable time in the Tier 1 hospitals. Currently no private hospitals are contracted under these arrangements.

All other private facilities are categorised as **Tier 3** where admission requires prior financial authorisation from the DVA and would only be granted if the treatment is not available or cannot be provided in the Tier 1 facilities.

Definitions

'Entitled Person' means a person who has elected to be treated under DVA arrangements and:

a) has been issued with:

- a Gold Card, or
- a White Card, or
- an Orange Card (pharmaceuticals only), or
- a written authorisation on behalf of the Repatriation Commission, or

b) is a Vietnam Veteran or his/her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

Roles and responsibilities

Inter-hospital transport refers to transfers of admitted and emergency patients between hospitals using road ambulance, Royal Flying Doctors Service (RFDS), Emergency Rescue Helicopter Service (ERHS), commercial flights, taxi in the metropolitan area, and taxi or other forms of patient transport in regional/remote areas. It also includes emergency transfer from nursing posts to a WA Funded Hospital.

Eligible DVA patients are entitled to all modes of inter-hospital transport that are available to all other patients. The inter-hospital transport arrangements in this circular do not cover transport costs of next-of-kin travelling with the patient.

When arranging inter-hospital transport, hospitals are required to notify the DVA Transport Bookings line on 1800 550 455 (for both metro and regional areas).

Inter-hospital transport includes transfers of admitted and emergency patients from a:

- WA Funded Hospital to another WA Funded Hospital
- WA Funded Hospital to a Tier 1 private facility
- WA Funded Hospital to a Tier 3 private hospitals where DVA has approved the transfer
- Funded Hospital
- Airport to a WA Funded Hospital
- Nursing post to a WA Funded Hospital
- WA Funded Hospital to a Transition Care facility and
- Transition Care facility to a WA Funded Hospital (and return) for medical appointments and/or treatment relating to the patient's episode of care.

Responsibilities of hospitals

- a) Identify DVA treatment entitlements

All DVA patients must be asked whether they are treatment entitled according to the guidelines in 'Identification of DVA Entitled Persons'.

Where entitlement could not be established before arranging the transport due to the patient's clinical condition or if the event has occurred after hours (including weekends or public holidays), hospitals should verify the veteran's entitlements the next business day or no later than five (5) working days and advise accordingly the:

- Ambulance provider if the patient was transported by road ambulance; or
- DVA if the patient was transported by commercial flight.

- b) Determine the appropriate mode of transport based on the patient's clinical condition.

- c) Obtain financial approval from DVA, call on 1800 550 457 for both metro and regional areas prior to booking the transport from a WA Funded Hospital to a Tier 2 or 3 facility. If approval is granted, DVA will arrange all transports and process all associated costs.
- d) Notify the DVA Transport Bookings line by calling 1800 550 455 (for both metro and regional areas) for:
 - taxi within the metropolitan area
 - appointments unrelated to the current episode of care.

For commercial flights, call 1800 550 455.

Non-metropolitan areas:

Taxi may be used in some regional areas. Authorisation must be given by DVA before transport. Some remote regions may have other methods of transport. DVA should be contacted in these cases for review - call 1800 550 455.

Failure to check treatment entitlements and/or notify the DVA where required, could result in hospitals retrospectively paying for the cost of inter-hospital transport for Entitled Persons.

- e) Booking of required transport.

Road ambulance

The 'fee for service' for all admitted DVA patients requiring non-urgent road based inter-hospital patient transport will be met by the sending hospital. All hospitals will need to comply with relevant directives and policies around the use of providers.

St John Ambulance Australia (SJAA) is DVA's preferred provider and will be contacted in the first instance. If SJAA decline the pickup location, do not provide coverage in the required region or the requested location is Halls Creek, Fitzroy Crossing or Derby then under these circumstances the hospital should contact WACHS Ambulance service.

Exceptions to fees for services are for admitted patients requiring inter-hospital transport via road ambulance when community services are required. In this case, the DVA Transport Bookings line should be contacted (1800 550 455 for both metro and regional) for eligibility determination and approval as DVA is responsible for this transportation and costs incurred.

Non-admitted patients: DVA entitled patients requiring clinically deemed necessary non-urgent road ambulance transport between public hospitals, public mental health inpatient facilities, private health care facilities or community facilities will call the DVA Transport Bookings line for eligibility determination and approval, or alternative methods arranged. DVA is responsible for the costs of patient transport under these circumstances. Generally, DVA will arrange the transport via SJAA if approved.

Hospitals will provide the name and DVA file number of the Entitled Person to book an ambulance. If the DVA number is not recorded then the associated costs cannot be recovered.

Summary table of financial responsibility for ambulance transport for DVA eligible patients

Transport From	Transport To	Responsible for Payment
Public health facilities – admitted patients	Public hospital or public mental health facility	Sending hospital
	Diagnostic or public day procedure service	Sending hospital
	Private health facilities	Sending hospital
	Community	DVA
Public health facilities - non-admitted patients	Public hospital or public mental health facility	DVA
	Private health facilities	DVA
	Community	DVA
Community	Public healthcare facilities	DVA
	Private healthcare facilities	DVA
	Receive treatment at a medical facility, to receive diagnostic services, to attend appointments at non-admitted patient clinics or to return the patient to their point of origin following such transport and to be transported from one aged care residence to another providing the receiving aged care residence will provide a higher level of care.	DVA
Private health care facilities	Public hospital or public mental health facility	DVA
	Diagnostic or public day procedure service	Sending hospital
	Private health facilities	DVA
	Community	DVA

RFDS (where clinically required)

This arrangement covers RFDS transfers from remote and rural areas to the nearest hospital in the rural or metropolitan area, using the hospital booking process.

Note: Where a patient is transported by air and then taken to a hospital by road ambulance, the air transfer will be recorded as it takes priority over other modes of transport.

Emergency rescue helicopter service (ERHS) (where clinically required)

Hospitals should advise SJAA that the patient is DVA-entitled to ensure that bills are sent to the DVA and not to the hospital. Payment for this service will be administered between DVA and SJAA.

Commercial flight (where medically certified)

Notify the DVA Transport Bookings line on 1800 550 455 for both metro and regional (during normal business hours) of the need to use a commercial flight. The DVA will be responsible for booking the flight, not the hospital. However, if the transport is required after hours including weekends and public holidays, hospitals should arrange the flight using the approved hospital booking process. Then advise the DVA Transport Bookings line of the transaction on the next business day or no later than five (5) working days. All relevant information including patient details, DVA number, flight details, hospital details and any other information will need to be provided to the DVA. Please use the hospitals standard procedures for collecting and recording this information.

Depending on the local hospital's policy, this information will either be processed locally or will need to be forwarded to the section responsible for hospital billing and invoicing.

Some regional hospitals may need to contact WACHS Patient Assisted Travel Scheme (PATS) staff to assist in this process. Local hospital staff should check with their internal systems to confirm the correct method to use. This method may change with time or differ between hospitals and regions.

Hospitals or other sections should forward the tax invoice for the cost of the flight directly to the DVA Transport Unit. The tax invoice must be accompanied by the required information detailed in the attachment to this circular. The DVA will make payments directly to the requesting party against the tax invoice if the transport has been approved.

Taxi services (where clinically appropriate)

Metropolitan areas

Taxi service is covered if the doctor determines that it is clinically appropriate. Hospitals should notify the DVA Transport Bookings line on 1800 550 455 of the need to use a taxi and DVA will book the transport and pay for the cost.

Regional areas

For regional areas, DVA should be contacted on 1800 550 455 and advice will be given on the best mode of transport.

Appointments unrelated to the current episode of care

Inter-hospital transport to and from appointments unrelated to the current episode of care (e.g. eye or dental) is not usually covered under this arrangement. Therefore, unless there is a medical need or other compelling reason, the patient is expected to reschedule any appointments booked prior to admission. Where it is necessary for appointments to be kept or in cases of long stay patients where appointments may need to be made during the course of the admission, the patient should:

- Obtain a doctor's clearance to leave the hospital to attend an appointment; and
- arrange for their own transport or hospital staff should notify the DVA Transport Bookings line on 1800 550 455 of the appointment. If agreed, DVA will arrange and pay for the transport.

Reporting requirements

All hospitals should record all inter-hospital transfers in the Entitled Person's record in the relevant feeder system under 'Source of Referral-Transport' using the current values in the Hospital Morbidity Data System (HMDS) Manual. The Department of Health is using this information as part of its reporting requirement to the DVA under the terms of the HSA.

The HMDS values are as follows:

- 1 = Private / public transport
- 2 = Hospital transport
- 3 = Ambulance – emergency
- 4 = Royal Flying Doctor Service
- 5 = Helicopter (evacuation)
- 6 = Other (includes commercial flight)

Note: Where a patient is transported by air and then taken to a hospital by road ambulance, the air transfer should be recorded as it takes priority over other modes of transport.

9.6. Invoicing for inter-hospital transport using commercial flights for DVA entitled persons

All WA Funded Hospitals that utilise commercial flights for inter-hospital transport of DVA Entitled Persons after hours, weekend or public holidays should endeavour to collect the following information for their own internal reference and provide this to the DVA on the next business day (or no later than five (5) working days) when seeking approval.

Hospital details:

ABN:

Hospital Name:

Hospital Address:

Patient details:

Surname:

First Name:

Date of Birth:

Residential Address:

Suburb:

Post Code:

DVA Card Colour: Gold or White

DVA File Number:

Date of Admission:

Date of Separation:

Flight details:

Name of Commercial Airline:

Flight Date:

Flight Origin:

Flight Destination:

Authorisation:

DVA Authorisation No:

DVA Authorisation Date:

Invoice Total including GST:

9.7. Loan equipment for DVA entitled persons

Overview

This guideline outlines the arrangement for the provision of loan equipment for DVA Entitled Persons. This arrangement covers admitted patients on discharge and non-admitted patients.

Policy

The Hospital Services Arrangement (HSA) between the DVA and Western Australia (WA) ensures that Entitled Persons receive a range of admitted and non-admitted hospital services in WA Funded Hospitals. Hospital staff can access the relevant details of the HSA here:

[Department of Veteran Affairs \(DVA\) arrangements \(health.wa.gov.au\)](http://health.wa.gov.au)

This arrangement covers the requirements for aids or equipment on discharge for admitted patients and non-admitted patients. Hospitals should refer to related policy documents and authorization from the DVA Health Provider Hotline 1800 550 457.

If an Entitled Person requires aids or equipment during their hospital stay, the items are part of the inpatient service and DVA should NOT be invoiced for the costs.

Where an Entitled Person is already in receipt of aids or equipment from the DVA prior to admission, the DVA will continue to provide the items upon discharge. Aids or equipment may be loaned to an Entitled Person on either a short-term or long-term arrangement.

Where an Entitled Person is NOT in receipts of aids or equipment from the DVA prior to admission, the hospital will contact the DVA (DVA Health Provider line: 1800 550 457 (for both metro and regional areas), pre-discharge and seek approval to arrange appropriate equipment as per the patient's clinical need.

If the loan equipment is approved by the DVA, no further action will be required by the hospital staff. The DVA will arrange for delivery and address any costs relating to this equipment.

Should the loan equipment request be rejected by the DVA, the hospital staff will follow normal hospital policy and procedures for issuing loan equipment to patients.

Definitions

'Entitled Person' means a person who has elected to be treated under DVA arrangements and:

- a) has been issued with:
 - a Gold Card, or
 - a White Card, or
 - an Orange Card (pharmaceuticals only), or
 - a written authorisation on behalf of the Repatriation Commission, or
- b) is a Vietnam Veteran or his/her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

To determine whether the patient's condition is approved, please follow the steps below:

Financial authorisation – gold and white card holders

How to obtain DVA financial authorisation

- a) Make sure you have the patient's name, DVA card colour and file number, and information about the treatment or procedure required.
- b) Ring the DVA Health Provider line: 1800 550 457 (for both metropolitan and non-metropolitan areas).
- c) From the series of prompts, select Option 3 'Prior approval, eligibility checks and provider registration'.

- d) This will lead to three further options. Select Option 1: 'Prior approvals, eligibility checks, and all general medical and allied health queries. The information required by DVA will depend on the nature of the condition(s) for which the patient requires the loan equipment.
- e) If approved, the DVA will provide confirmation accordingly.
- f) If approval is not granted the loan equipment should be provided to the patient as per public patient procedures.

Loan equipment and residential aged care

Entitled Persons receiving high level care in an Australian Government funded residential aged care facility (RACF) are not generally provided with loan equipment. DVA does, however, routinely provide a range of items to Entitled Persons in low-level care. These may include custom made wheelchairs, continence products, low vision aids, compression stockings and medical grade footwear.

When an Entitled Person moves from low-level care to high-level care, Rehabilitation Appliances Program (RAP) items previously issued may be taken with them subject to the approval of the RACF. DVA will maintain responsibility for the repair, maintenance and replacement of such items. Entitled Persons receiving Extended Aged Care at Home (EACH) services or Community Aged Care Packages (CACP) are able to access loan equipment where the service provider is not legally required to supply them.

Further information is available by calling the My Aged Care Contact Centre on 1800 200 422.

Should you have any additional queries or would like more information, please contact the DVA Provider Hotline: 1800 550 457 (regional areas) and, Select Option 1 for RAP.

9.8. Billing for selected services provided to DVA entitled persons

Overview

This guideline outlines the billing arrangements between Western Australia (WA) and the Department of Veterans' Affairs (DVA) for pharmaceuticals, nursing home type patient (NHTP) contribution for ex-Prisoners of War (POW) and Victoria Cross (VC) recipients and post discharge services provided to Entitled Persons.

Policy

The Hospital Services Arrangement (HSA) between the DVA and WA ensures that Entitled Persons receive a range of admitted and non-admitted hospital services in WA Funded Hospitals. Hospital staff can access the relevant details of the HSA here: [Department of Veteran Affairs \(DVA\) arrangements \(health.wa.gov.au\)](https://www.health.wa.gov.au/department-of-veterans-affairs-dva-arrangements)

Definitions

'Entitled Person' means a person who has elected to be treated under DVA arrangements and:

- a) has been issued with:

- a Gold Card, or
 - a White Card, or
 - an Orange Card (pharmaceuticals only), or
 - a written authorisation on behalf of the Repatriation Commission, or
- b) is a Vietnam Veteran or his/her dependant who is not otherwise eligible for treatment and who is certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

Roles and responsibilities

Pharmaceuticals

Entitled Persons will have the same access to pharmaceuticals as other admitted and non-admitted patients. Where an Entitled Person requires access to:

- a) Highly Specialised Drugs (HSD)
- b) Pharmaceuticals under the Special Access Scheme (SAS)
- c) Pharmaceuticals not included in the hospital drug formulary

The hospital should first seek financial authorisation from the DVA by calling the Veterans' Affairs Pharmacy Advisory Centre (VAPAC) on 1800 552 580. If approval for supply of these pharmaceuticals is granted, DVA should be invoiced for the cost.

Under the Pharmaceutical Benefits Scheme Reform Program, hospitals may charge a patient co-payment for pharmaceuticals provided (to admitted patients) on discharge or as a non-admitted patient.

NHTP contribution for ex-POWs and VC recipients

Entitled Persons who are admitted as, or reclassified to, NHTP would be charged a patient contribution in line with the provisions of the Health Insurance Act 1973. If the patient is an ex-POW or a VC recipient, the DVA should be invoiced for the patient contribution.

The POW status is usually shown on the gold card, however, if there is some doubt contact DVA on 1800 550 457 (metro and regional callers) to confirm. NHTP contributions for non-ex-POWs should be billed directly to the Entitled Person and they cannot recover the cost from the DVA.

Post discharge services

Where an admitted Entitled Person requires post discharge care, hospitals are encouraged to refer them to DVA-contracted health service providers. A list of providers for the relevant area can be obtained by contacting DVA on 1800 550 457 (both metro and regional callers).

If the DVA advises that there are no DVA-contracted providers in the area, hospitals should seek approval by contacting 1800 550 457 (metro and regional callers) to provide the service themselves or arrange for the service to be provided by their subcontractors. Upon approval, the hospital should arrange the required service and the DVA should be invoiced for the cost.

The DVA Discharge Planning Resource Kit, which provides more information about post discharge services for Entitled Persons, can be accessed via the DVA website.

Entitled Persons may be eligible to access the Veterans' Home Care (VHC). More information about VHC is available by calling 1300 550 450 or the DVA website.

Overview fees and charges for admitted patients

Patient Payment Classification	Same Day (excluding dialysis)	Dialysis (Fee Chargeable as of 28 July 2021)	Overnight Fee per Day	Outpatient Fee per Service	Emergency Department Triage Fee	Ventilator Dependent	Airway Management	NHTP	NHTP Patient Contribution	Surgically Implanted Prostheses	Radiology	Pathology	Specialised Orthoses	Drugs and Medication	Medical Services	Notifiable Sexually Transmitted Disease Management	Home Modifications
Public Patients	No Charge	No Charge	No Charge	N/A	No Charge	No Charge	No Charge	Note 10	Note 10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Private Patients – Shared Room	\$368	N/A	\$446	N/A	N/A	No Charge	No Charge	Note 10	Note 10	Note 3	Note 5	Note 6	Note 8	No Charge	Note 2	No Charge	No Charge
Private Patients – Single Room	\$368	N/A	\$755	N/A	N/A	No Charge	No Charge	Note 10	Note 10	Note 3	Note 5	Note 6	Note 8	No Charge	Note 2	No Charge	No Charge
Nursing Home Type Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	\$80.95	N/A	N/A	N/A	N/A	No Charge	No Charge	No Charge	No Charge
Private Nursing Home Type Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	\$236.10	\$80.95	N/A	N/A	N/A	N/A	No Charge	Note 2	No Charge	No Charge
Eligible War Service Veterans	Note 11	Note 11	Note 11	N/A	N/A	Note 11	Note 11	N/A	\$80.95 or DVA pays if POW or VC. See s5.4 and s5.5	Note 11	Note 7	Note 7	Note 11	No Charge to Eligible Patient	No Charge. Fees levied by DVA unless Note 2.	No Charge	See s9.4
Compensable Patients (other than CWA-MVA and DVA)	\$4,173	N/A	\$3,187	N/A	N/A	\$7,026	\$4,200	N/A	N/A	Note 3	Note 5	Note 6	Note 8	Note 1	Note 2	No Charge	No Charge
Motor Vehicle Third Party Insurance (MVTPI) Patients	Note 9	Note 9	Note 9	N/A	N/A	Note 9	Note 9	N/A	N/A	Note 9	Note 9	Note 9	Note 9	No Charge	Note 2	No Charge	No Charge
Medicare Ineligible Patients	\$3,087	\$948	\$3,118	N/A	Note 12	No Charge	No Charge	N/A	N/A	Note 3	Note 5	Note 6	Note 8	Note 1	Note 2	No Charge	No Charge

Overview fees and charges for non-admitted patients

Patient Payment Classification	Same Day	Overnight Fee per Day	Outpatient Fee per Service	Ventilator Dependant	Airway Management	NHTP	NHTP Patient Contribution	Surgically Implanted Protheses	Radiology	Pathology	Specialised Orthoses	Drugs and Medication	Medical Services	Notifiable Sexually Transmitted Disease Management	Home Modifications
Public Patients	N/A	N/A	No Charge	N/A	N/A	N/A	N/A	N/A	No Charge	No Charge	No Charge	Note 1	No Charge	No Charge	No Charge
Private Patients	N/A	N/A	No Charge	N/A	N/A	N/A	N/A	N/A	Note 5	Note 6	Note 8	Note 1	Note 4	No Charge	No Charge
Eligible War Service Veterans	N/A	N/A	Note 11	N/A	N/A	N/A	N/A	N/A	Note 7	Note 7	Note 11	Note 1	Note 11	Note 11	See s9.4
Compensable Patients (other than ICWA-MVA and DVA)	N/A	N/A	\$391	N/A	N/A	N/A	N/A	N/A	\$391	Note 6	Note 8	Note 1	Note 2	No Charge	No Charge
Motor Vehicle Third Party Insurance (MVTPI) Patients	N/A	N/A	Note 9	N/A	N/A	N/A	N/A	N/A	Note 9	Note 9	Note 9	Note 9	Note 2	No Charge	No Charge
Medicare Ineligible Patients	N/A	N/A	\$391	N/A	N/A	N/A	N/A	N/A	\$391	Note 6	Note 8	Note 1	Note 2	No Charge	No Charge

Note 1: Refer to [Section 6.8 WA Health unsubsidised medication charges](#).

Note 2: Medical services fees may be raised by visiting medical practitioners, salaried medical officers exercising a right to private practice, private medical practitioners, or by the hospital on behalf of medical practitioners

Note 3: Refer to [Section 7.7](#).

Note 4: All medical services are charged directly to the patient either by the medical practitioner or by the hospital on their behalf.

Note 5: All radiology services are charged directly to the patient (or 'compensable insurer') either by the radiologist, or by the hospital on behalf of the radiologist.

Note 6: All pathology services are charged directly to the patient (or 'compensable insurer') by PathWest Laboratory Medicine WA.

Note 7: All radiology and pathology services to Eligible War Service Veterans are charged directly to DVA on a 'fee for service' basis.

Note 8: Refer to schedule A4 for adult orthoses and A5 for child orthoses.

Note 9: If the Motor Vehicle Accident (MVA) is a Western Australian (WA) case covered by the Insurance Commission of WA (ICWA) service are funded under the ICWA agreement (refer to [section 5.1](#)) and no invoices are to be raised. MVA cases from other States or where out of court settlements have been awarded use compensable rates for both admitted and non-admitted patients refer to [section 5.2](#).

Note 10: Refer to [Section 5.6](#).

Note 11: Centrally managed within the DOH by the DVA, no invoices to be raised.

Note 12: Refer to [Section 5.14](#).

Overview fees and charges for boarders

Patient Payment Classification	Same Day	Overnight Fee per Day	Outpatient Fee per Service	Ventilator Dependant	Airway Management	NHTP	NHTP Patient Contribution	Surgically Implanted Prostheses	Radiology	Pathology	Specialised Orthoses	Drugs and Medication	Medical Services	Notifiable Sexually Transmitted Disease Management	Home Modifications
Boarders	N/A	\$45.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Schedules

- Schedule A1: [Fees and Charges Regulated by the Minister for Health](#)
- Schedule A2: [Fees and Charges Regulated by the Director General](#)
- Schedule A4: [Specialised Orthoses for Adults](#)
- Schedule A5: [Specialised Orthoses for Children](#)
- Schedule B: [Summary of Patient Fees and Charges](#)
- Schedule C: [Application to Determine a New fee or Charge](#)
- Schedule D: [Standing Exemptions](#)
- Schedule E: [Appendices](#)

Schedule A1: Fees and charges regulated by the Minister for Health – July 2025/26

Division	Item	Maximum Fee Chargeable
Inpatients	Accommodation, Maintenance, Nursing Care and Other Services	
	Public Inpatients	No Charge
	Private Inpatients – in Single Bed Wards (if taken at patient’s request)	per day \$755.00
	Private Inpatients – in Other Wards	per day \$446.00
	Nursing Home Type Patients	per day \$80.95
	Nursing Home Type Private Patients	per day \$236.10
	Medicare Ineligible Inpatients	per day \$3,118.00
	Eligible Veteran Inpatients	No Charge
	Medicare Ineligible Inpatients Medicines	Fees chargeables of 28 July 2021 Refer to Chapter 6
Inpatients	Home Modifications Services	
	Home Modifications Service and Supply or Loan of such Aids and Appliances, Orthotics and Prostheses, Oxygen, Gas and Equipment, Wigs, Surgical Implants or Devices as approved by the Director General	No Charge
Day Patients	Accommodation, Maintenance and Other Services	
	Eligible Day Patients	No Charge
	Medicare Ineligible Day Patient Medicines	New fees chargeable as of 28 July 2021 Refer to Chapter 6
Outpatients	Outpatient Services, Except for Medicines	
	Eligible Outpatients	No Charge
	Eligible Veteran Outpatients	No Charge
	Medicare Ineligible Outpatient – for each individual service rendered	\$391.00
Outpatients	Medicines	
	Holders of an Entitlement Card	No Charge
	Veterans who hold a Gold Card or a White Card	for each item \$7.70
	Pensioners	for each item \$7.70
	Concessional Beneficiaries	for each item \$7.70
	All other people (excluding overseas Medicare Ineligible patients) at a participating hospital ¹ – for an item on the PBS list	PBS price up to a maximum of \$25.00
	All other people (excluding overseas Medicare ineligible patients) at a participating hospital ¹ – for an item not on the PBS list	\$25.00
	Medicare Ineligible Outpatients Note: Fees chargeable as of 28 July 2021	Refer to Section 6.8
Other	Hotel Quarantine Fees (including meals)	
	Persons not in shared accommodation	\$180.00 per day
	For the first person in shared accommodation	\$180.00 per day
	For each additional person in shared accommodation (over the age of 6 years)	\$60.00 per day

¹Participating hospitals are public hospitals participating in the Commonwealth Pharmaceutical Reform Agreements (PRAs), all public hospitals in WA are participating hospitals.

Schedule A2: Fees and charges regulated by the Director General – July 2025/26

Division	Item	Maximum Fee Chargeable
Emergency	Emergency Department Fees for Medicare Ineligible Patients	
	Triage Level 1	\$2,470.00
	Triage Level 2	\$1,510.00
	Triage Level 3	\$1,110.00
	Triage Level 4	\$745.00
	Triage Level 5	\$519.00
Same Day	Dialysis	
	Medicare Ineligible Patients	\$948.00
Other	Residential Aged Care (RAC) and Residential Respite Care	
	Residential Aged Care (in a Nursing Home or MPS) and Short-Term Residential Respite Care (in a home, community, Nursing Home or hospital setting)	Refer to section 5.7
Other	Medical and Related Reports¹	
	Base Medical Report - This fee includes assessment, obtaining documents, review of documents by a clinician and preparation of the report (up to 1 hour), copying (up to 10 pages) and sending the finalised report.	\$385.00
	Medical Report Copying per page - This is an additional charge to the base fee if copying of the report is required and the report is over 10 pages.	\$1.10
	Report preparation >1hr by Clinical Staff per hour - These fees are to be charged in addition to the Base Medical Report Fee if the preparation of the report involves more than 1 hour of clinical time.	
	Medical Staff	\$242.00
	Allied Health/Nursing Staff	\$110.00
	Medical Report Search Fee - This fee is for a basic search to determine if the HSP has relevant records about the patient. It is a standalone fee and should not be charged additionally to the Base Medical Report Fee.	\$110.00
	Follow-Up Report - Follow up reports are applicable where further information has been requested following provision of an initial report. This fee is to be charged in addition to the number of hours involved for clinical staff to prepare the follow up report.	\$110.00

¹The fees listed for medical reports are relating to those required for legal purposes. Most commonly these reports are requested by lawyers and insurance companies acting on behalf of patients. Reports are to be prepared from clinical notes and other information held regarding the patient. These fees are not for the provision of copies of discharge summaries or redacted clinical notes.

Medical reports requested by government agencies are not chargeable: Police, Coroner, Department of Communities, State Ombudsman, or Commonwealth Ombudsman.

Note: When a government organisation requests a report that does not relate to the services provided to a patient by the hospital (i.e. independent advice is being sought on a matter not relating to hospital care), by mutual agreement, these services may be chargeable.

Medical report fees include GST.

Schedule A4: Specialised orthoses for adults

CODE	Item	Maximum Fee Chargeable
	Chargeable as of 1st August 2023	
AFMD	Ankle Foot Orthosis, Metal, Double Bar Only	\$647.10
AFMDF	Ankle Foot Orthosis, Metal, Double Bar with Ferrule Only	\$779.07
AFMDFT	Ankle Foot Orthosis, Metal, Double Bar with Ferrule and T-Strap	\$881.65
AFMS	Ankle Foot Orthosis, Metal, Single Bar Only	\$419.62
AFMSFT	Ankle Foot Orthosis, Metal, Single Bar with Ferrule and T-strap	\$654.17
AFOA	Ankle Foot Orthosis, Articulated Plastic (Tamaracks)	\$1,029.92
AFOAT	Ankle Foot Orthosis, Articulated Plastic with Toe Plate	\$1,068.28
AFOCC	Custom AFO (CAD/CAM)	\$850.95
AFOCCF	Custom carbon Fibre AFO	\$1,673.33
AFOCF	Ankle Foot Orthosis, Carbon Fibre	\$740.24
AFOF	Ankle Foot Orthosis, Custom Plastic Fixed	\$701.13
AFOFL	Ankle Foot Orthosis, Custom Plastic Fixed with Liner	\$788.18
AFOFT	Ankle Foot Orthosis, Custom Plastic, Fixed with Toe plate	\$722.33
AFOGO	Otto Bock 'Go-On' AFO	\$265.39
AFOHR	Ankle Foot Orthosis, Heal Protection, Bed Resting	\$226.00
AFON	Ankle Foot Orthosis, Plastic Lined Night Use with Tread	\$187.84
AFOOS	Ankle Foot Orthosis, Oedema Compression Stocking	\$236.68
AFOPR	Ankle Foot Orthosis, Bed Resting	\$353.03
AFOPRL	Ankle Foot Orthosis, Bed Resting Spare Liners	\$197.00
AFOPTB	Custom Patella Tendon Bearing (PTB) Orthosis	\$2,027.87
AFOTFB	Custom Tibial Fracture Brace	\$1,053.93
AODE	Ankle Foot Orthosis, Strap to Shoe, Dorsi Assist	\$172.12
AODES	Ankle Foot Orthosis, Strap Shoeless, Dorsi Assist	\$173.22
AOS	Ankle Orthosis, Air-Cast Stirrup	\$181.17
CAMA	Ankle Foot Orthosis, CAM Walker Adjustable Ankle Joint	\$198.56
CAME	Ankle Foot Orthosis, CAM Walker	\$98.07
CC1	Neck Orthosis, Plastic & Liner, Adult Pad set only	\$96.80
COMJ	Neck Orthosis, Plastic & Liner	\$152.84
COS	Neck Orthosis, Soft	\$85.77
COVE	Neck Orthosis, Adjustable with Extra Pads	\$203.47
COVP	Neck Orthosis, Adjustable Replacement Pad Set Only	\$84.14
CPU	Crutches Permanent Users	\$339.63
CROWI	Ankle Foot Orthosis, Charcot Restraint Orthotic Walker	\$2,480.14
CROWICC	Crow walker with insert CadCam	\$2,122.14
CSCP	Customized Steel Crutches	\$639.84
CTC	Neck Orthosis, Plastic & Liner Extension Replacement Pad Only	\$234.64
CTLSO	Neck & Back Orthosis, Custom Plastic	\$3,097.49

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CODE	Item	Maximum Fee Chargeable
CTLSOCC	Cervical TLSO CadCam	\$2,961.13
CTLSOS	Neck & Back Orthosis, Prefabricated Bivalve	\$1,908.38
CTOAA	Neck Orthosis, Extended, Multi Adjustable	\$601.64
CTOAP	Neck Orthosis, Extended, Multi Adjustable, Replacement Pads Set Only	\$118.24
CTOE	Neck Orthosis, Plastic & Liner Extension Only with Extra Pad	\$432.58
CTOLM	Neck & Back Orthosis, Plastic body, Metal neck	\$790.29
CTOMJTE	Neck Orthosis, Extended Plastic & Liner with Extra Pads	\$460.83
CTONH	Neck Orthosis, Non-Invasive Halo	\$2,961.08
EOPF	Elbow Orthosis, Custom Fixed	\$497.72
EOPH	Elbow Orthosis, Custom Hinged	\$805.03
EOT	Elbow Orthosis, Telescoping, Adjustable	\$209.50
FER	Ankle Foot Orthosis, Ferrule fitting to shoe only	\$122.22
FO2P1	Foot Orthosis, 2 Pairs to Make 1 Pair	\$986.09
FOCS	Foot Orthosis, Custom Made Surgical Shoes	\$1,954.64
FOD	Foot Orthosis, Interim Shoe	\$88.08
FOGS	Gentle Steps	\$212.27
FOMIP	Foot Orthosis, Pair of Custom Moulded Insoles	\$343.05
FOMIPICC	Custom Moulded Foot Orthosis pair CadCam	\$527.11
FOMISCC	Custom Moulded Foot Orthosis single CadCam	\$427.07
FOMIU	Foot Orthosis, Single Custom Moulded Insoles	\$185.15
FOS1	Foot Orthosis, Insoles Pair 2/3 Length	\$68.74
FOS3	Foot Orthosis, Insoles Pair Full Length	\$101.87
FOXD	Foot Orthosis, Orthopaedic Extra Depth	\$554.61
HALOC	Neck Orthosis, Halo Complete System	\$5,934.38
HALORTP	Halo Ring and Titanium Pins Set	\$2,268.72
HALOV	HALO vest only	\$3,788.28
HAOP	Hip Orthosis, Abduction & Flexion Control	\$792.49
HFO	Humeral Orthosis, Fracture	\$542.51
HOD1	Hand Orthosis, Driving (Each)	\$324.95
HR1	Heel raise 1cm	\$90.38
HR2	Heel raise 2cm	\$141.29
HR3	Heel raise 3cm	\$176.24
KAFOM	Knee Ankle Foot Orthosis, Metal with Assembly Components	\$2,671.53
KAFOCF	Custom carbon-fibre KAFO	\$2,560.76
KAFOP	Knee Ankle Foot Orthosis, Plastic with Assembly Components	\$2,250.66
KOACL	Rigid Frame ACL Knee Brace	\$1,018.33
KOGL	Genu Lux Knee	\$175.40
KOGN	Genu Neurexa Knee	\$394.96
KOPCL	Rigid Frame PCL Knee Brace (Ossur Rebound)	\$1,744.00
KOROM	Knee Orthosis, Adjustable Range of Motion	\$148.81
KOS	Knee Orthosis, Metal Cage	\$343.17

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CODE	Item	Maximum Fee Chargeable
KOU	Knee Orthosis, Compartment Unloader	\$930.51
LSAB10	Back Orthosis, Abdominal Binder 10" width	\$117.78
LSAB8	Back Orthosis, Abdominal Binder 8" width	\$108.70
LSODP	Back Orthosis, Corset Elastic Lower Back Dual Pull	\$131.36
PB	Foot Orthosis, Patten Bottom Shoe Adaption	\$851.88
PHO	Head Orthosis, Protective Helmet	\$314.94
PHOC	Head Orthosis, Custom Protective Helmet	\$574.17
PHOM	Head Orthosis, Modified Protective Helmet Shell	\$392.62
PRWO	Back Orthosis, Pelvic Rib Wedge Orthosis	\$184.32
PRWS	Back Orthosis, Pelvic Rib Wedge Straps (pair) Only	\$60.49
RGO	Hip Knee Ankle Foot Orthosis, Reciprocating Gait	\$15,266.90
RMO1	Repair/Modification Orthosis 1 up to 30 mins	\$40.11
RMO2	Repair/Modification Orthosis 2 up to 60 mins	\$119.49
RMO3	Repair/Modification Orthosis 3 up to 90 mins	\$196.19
SFP	Foot Orthosis, Shoe Float (Pair)	\$134.47
SFS	Foot Orthosis, Single Shoe Float	\$81.53
SMFTP	Foot Orthosis, Shoe modification with Ferule & "T" Strap (Pair)	\$315.51
SMFTS	Foot Orthosis, Shoe modification with Ferule & "T" Strap (Single)	\$186.44
SOLE	Foot Orthosis, Sole Rebuild	\$103.39
SOME	Custom erkoflex supramalleolar Orthosis	\$996.55
SOMI	Neck Orthosis, Extended, Adjustable Lined Metal Frame	\$728.14
TLSOBV	Back Orthosis, Custom Bivalve	\$2,147.85
TLSOCF	Back Orthosis, Corset Front Lace	\$570.87
TLSOCS	Back Orthosis, Corset Side Lace	\$570.87
TLSOJ	Back Orthosis, Metal Frame, Hyperextension	\$289.44
TLSOS	Back Orthosis, Prefabricated, Bivalve, Plastic	\$1,202.18
TLSOSC	Back Orthosis, Scoliosis, Flexible	\$5,527.07
TLSOSCC	Spinal Poly Jacket cad cam	\$2,147.85
TS	Ankle Orthosis, T-Strap Only	\$110.86
UCBL	Foot Orthosis, Plastic Insole Cup (Each)	\$358.49
UCBLP	Foot Orthosis, Plastic Insole Cup (Pair)	\$459.61
WOP	Wrist Orthosis, Custom Plastic	\$408.92
WOS1	Wrist Orthosis Prefabricated	\$93.25
WPM	Hand Orthosis, Wheelchair Push Mitts	\$247.69
WPME	Hand Wrist Orthosis, Extended Wheelchair Push Mitts	\$331.40

Schedule A5: Specialised orthoses for children

CODE	Item	Maximum Fee Chargeable
2	Abdominal binder	\$92.85
3	Abduction wedge	\$664.98
4	Abduction orthosis plastic	\$537.47
5	Ankle foot orthosis - Bivalved	\$ 668.86
6	Ankle foot orthosis - Fixed	\$ 528.53
7	Ankle foot orthosis - Hinged	\$ 663.65
9	AFO carbon fibre - walk on reaction/junior	\$ 633.14
10	Bachelor hip orthosis	\$ 845.73
11	Boots and bar - Replace boots	\$ 473.36
12	Camboot	\$ 62.77
13	Collar - Aspen CTO child plus pads	\$ 514.67
14	Collar - Aspen CTO adult plus pads	\$514.67
16	Collar - Miami J	\$136.05
17	Collar - Miami J CTO	\$617.26
18	Collar Philadelphia	\$114.91
19	Ankle foot orthosis - Leaf spring (off the shelf)	\$96.97
20	Collar - Soft	\$61.95
21	Correctio harness	\$206.89
23	Edinboro brace	\$321.25
25	Foot orthosis - Off the shelf pair	\$66.43
26	Foot orthosis - EVA pair	\$304.99
27	Foot orthosis - UCBL each	\$443.33
28	Graphite insoles	\$296.47
29	Ankle foot orthosis - GRAFO	\$647.42
30	Helmet - cranio custom made	\$636.20
31	Hip knee ankle foot orthosis	\$1, 730.87
32	Jewett brace	\$206.89
33	Knee ankle foot orthosis - plastic and joints	\$1,331.33
34	Knee ankle foot orthosis - plastic fixed	\$760.33
35	Kidney guard	\$ 313.35
36	Knee immobiliser	\$ 61.55
37	Knee ROM brace	\$ 249.63
38	Patella brace	\$ 62.77
39	Pavlik harness	\$ 84.75
42	Rhino brace	\$ 198.88
43	Spinal orthosis (incl polyjacket)	\$ 998.99
44	Standing frame - flexistand	\$1307.49

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CODE	Item	Maximum Fee Chargeable
46	Reciprocal gait orthosis	\$14,085.88
47	Neoprene wraps	\$173.34
49	Wrist orthosis	\$62.77
50	Helmet - soft protective	\$ 92.85
51	Piedro boots	\$ 514.24
52	Shoe raise - internal	\$ 35.90
53	Shoe raise - external	\$ 267.95
54	Silicone heel cup	\$ 84.75
55	Ankle foot orthosis - SMFO/DAFO	\$ 408.51
56	Ankle foot orthosis - bed resting custom made	\$ 495.55
57	AFO carbon fibre - blue rocker plus liner	\$581.84
58	AFO carbon fibre - kiddie gait plus liner	\$557.41
59	AFO carbon fibre - custom manufactured (HTF)	\$2,441.95
60	Bebax	\$292.38
61	Boots and bar - Complete set	\$626.66
62	Boots and bar - ADM	\$632.79
63	Walk aide	\$5,273.61
64	Collar - Aspen child plus pads	\$139.10
65	Collar - Aspen adult plus pads	\$139.10
66	Halo	\$4,843.44
67	Viasaw	\$1,305.30
68	Spare pads for Aspen collar	\$67.65
69	Spare pads for Aspen CTO	\$94.52
70	Repair/Modification Orthosis 1 up to 30 mins	\$62.91
71	Repair/Modification Orthosis 2 up to 60 mins	\$118.21
72	Repair/Modification Orthosis 3 up to 90 mins	\$183.26
73	Ankle foot orthosis - bed resting (off the shelf)	\$109.18
74	AFO carbon fibre - walk on flex	\$581.29

Schedule B: Summary of patient fees and charges – July 2025/26

Item	Fee Chargeable FY 2024/25	Fee Chargeable FY 2025/26
Private Patients (Medicare Eligible Australian Residents)		
Shared Room	\$436.00	\$446.00
Single Room	\$737.00	\$755.00
Same Day	\$359.00	\$368.00
Compensable Patients		
Emergency	\$379.00	\$391.00
Inpatients – Hospitals	\$3,100.00	\$3,187.00
Inpatients – Nursing Homes	\$359.00	\$368.00
Same Day	\$3,834.00	\$4,173.00
Outpatients – per Occasion of Service	\$379.00	\$391.00
Ventilator Dependent (with Tracheostomy, requiring 24 Hours Care)	\$6,821.00	\$7,026.00
Airway Management (with or without Tracheostomy, requiring 24 Hours Care)	\$4,078.00	\$4,200.00
Medicare Ineligible Patients (Overseas Residents)		
Inpatients	\$2,884.00	\$3,118.00
Same Day (excluding dialysis)	\$2,894.00	\$3,087.00
Dialysis	\$850.00	\$948.00
Emergency Department Services		
• Triage Level 1	\$2,265.00	\$2,470.00
• Triage Level 2	\$1,345.00	\$1,510.00
• Triage Level 3	\$975.00	\$1,110.00
• Triage Level 4	\$640.00	\$745.00
• Triage Level 5	\$419.00	\$519.00
Outpatients – per Occasion of Service	\$379.00	\$391.00
Medicines Note: Fees chargeable as of 28 July 2021	Refer to Chapter 6	Refer to Chapter 6
Other Services		
Boarders Note: The rate per day is inclusive of GST	\$44.00	\$45.00
Hotel Quarantine Fees (including meals)		
Persons not in shared accommodation	\$180.00 per day	\$180.00 per day
For the first person in shared accommodation	\$180.00 per day	\$180.00 per day
For each additional person in shared accommodation (over the age of 6 years)	\$60.00 per day	\$60.00 per day
Nursing Home Type Patients		
	20 May 2025	23 December 2025
Nursing Home Type Patient Contribution Note: The increase in patient contribution on 23 December 2025, relates to the Commonwealth pension increase of 20 September 2025.	Per day \$78.95	Per day \$80.95
Private Nursing Home Type Patients	Per day \$232.10	Per day \$236.10

Schedule C: Application to determine a new fee or charge

Please refer to Schedule C Application Form to Determine a New Fee or Charge located in the Appendices and Schedules section of the main webpage:

[Fees and Charges Manual \(health.wa.gov.au\)](https://health.wa.gov.au)

Schedule D: Standing exemptions

None in place as at 1 July 2025

Schedule E: Appendices

[Appendix A: National Patient Election Standards for Public Hospital Admitted Patients](#)

[Appendix B: Administration Process for Private Inpatients](#)

[Appendix C: Public Hospitals and Health Services in Western Australia](#)

[Appendix D: List of Health-Related Contacts](#)

[Appendix E: Flow Chart on Medicare Eligibility and Access to Medicare](#)

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[Appendix J: Information on Governance of Medical Practitioner details within the Doctor's Provider and Arrangement Listing System Policy](#)

[Appendix K: A list of all notifiable diseases that require treatment with medication to prevent transmission](#)

[Appendix L: Reciprocal health care agreement matrix](#)

Appendix A: Patient election standards for public hospital admitted patients

In accordance with the National Health Reform Agreement (NHRA) between the Commonwealth of Australia and the States and Territories, public hospital admitted patient election processes for eligible persons should conform to the following national standards. Health Services should review existing processes to ensure they are consistent with these standards.

Admitted patient election forms:

Admitted patient election forms can be tailored to meet individual State/Territory or public hospital needs. However, as a minimum, forms should include:

- A statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in Clause 3 of Schedule G - Business Rules for the NHRA. This Clause states that “private patients, compensable patients and Medicare ineligible persons may be charged an amount for public hospital services as determined by the State.”
- A private patient may be treated by a doctor of his or her choice, and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient, who requests and receives single room accommodation, must be admitted as a private patient. (Note: eligible veterans are subject to a separate agreement refer to section 5.4.)
- A statement that a patient with private health insurance can elect to be treated as a public patient.
- A clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for Nursing Home Type Patients):
 - Will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services;
 - Are treated by the doctor(s) nominated by the hospital.
- A clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:
 - Will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;
 - May not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital, and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and
 - Are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital.

- Evidence that the form was completed by the patient or legally authorised representative before, at the time of, or as soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee.
- A statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:
 - Patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
 - Patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
 - Patients whose social circumstances change while in hospital (e.g. loss of job).
- In situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission.
- It will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in Clause 7 apply.
- A statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision.
- A statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement might result in the refusal of their Health Fund to provide benefits.
- Where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

Multiple and frequent admissions election forms:

A State / Territory or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specific period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.

Other written material provided to patients:

Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross-reference to the admitted patient election form in any such written material.

All parties agree that written material provided to patients by public hospitals or private health insurers on the choice to elect to be treated privately will:

- be appropriate, robust and best support the consumer to make an informed choice; and
- refrain from directing the patient to a particular choice.

Verbal advice provided to patients:

- Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.
- Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election.
- To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.
- Verbal advice provided to patients by public hospitals or private health insurers on the choice to elect to be treated privately will:
 - be appropriate, robust and best support the consumer to make an informed choice; and
 - refrain from directing the patient to a particular choice.
- Through the provision of translation / interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

Appendix B: Administration process for private inpatients

Health Service Providers need to ensure that the financial election process for private inpatients is consistent with Clause 24 of Schedule G - Business Rules for the NHRA, titled "Public Hospital Admitted Patient Election Forms".

The administrative processes outlined below are to be followed once an inpatient episode of care has been determined clinically necessary.

- Elective Patients will be given the opportunity to discuss financial election and provided additional information on the consequence of admission as a private patient. This will occur at either the Private Rooms or Outpatients Clinic following the clinical decision to be admitted as an inpatient.
- An Elective Admission form (EAF) is completed. This must include Medicare number, health fund type, health fund number and patient's signature confirming informed financial election. Admitted public patient election forms must be consistent with the national standards for public hospital admitted patient election as set out in the Schedule G - Business Rules for the NHRA. The national standards set out the minimum information to be included in patient election forms.
- Doctor's clerk or Outpatients will send the EAF to Area Health Service Waitlist Department. The waitlist clerks input financial election information onto the Patient Management System. If a financial election has not been made, the waitlist clerks input financial election as "Unknown".
- The Private Patient Liaison Officer (PPLO) or equivalent will review information, which indicates:
 - Booked inpatients with financial election unknown.
 - Booked inpatients with private insurance who have booked in as a public election.
 - Inpatients that have come in through ED who have elected as Private Inpatients.
 - In the event of financial election being unknown the PPLO will send the patient a letter, seeking financial election prior to booking into hospital, by completing the attached Financial Election form (660). A leaflet and a self-addressed and stamped envelope will be included in this package. Once the information is received the PPLO will make a record and forward to the Area Health Service Waitlist Department.
- When the Area Health Service Waitlist Department receives the form 660, the financial election information is logged and the form is forwarded to Booked Admissions.
- On the patient's admission to hospital, if the patient has elected as a Private Inpatient, the Booked Admissions clerk will confirm e.g., "I see you have opted to use your health fund and book in as a private patient". The clerk will then complete a register for the PPLO with patient labels and provide the Patient with their Incentive Pack including the voucher booklet.
- If at this stage there is still no financial election on the patient management system, staff proceed as usual, i.e. provide a form 660 and ask for their financial election. Staff could also provide a leaflet and inform patients of the PPLO and provide them his/her business card.

- Emergency Department patients to be provided with information leaflets to enable them to make an informed financial election.
- At the time of admission to ward Emergency Department patients will be consulted on their financial election. Should the patient elect as Private, the clerk will complete a register for the PPLO with patient labels and provide the Patient with their Incentive Pack including the voucher booklet and letter to patient.
- The PPLO will liaise with Private Inpatients to discuss their election and ensure that they have had the appropriate and adequate information to make their decision. In addition, the PPLO provides the patient with the following:
 - Completes any additional Health Fund requirements, which is sent to Patient Fees, and
 - Informs the patient that he/she can assist with any financial election queries and is the person to contact should their stay be longer than a week's duration, for additional vouchers.
 - Inpatient survey form.
- Upon receipt of all financial documentation from Booked Admissions (form 660 and HA92) and PPLO (Medibank claim form), Patient Fees collate these forms and claims from Private Health fund and upon receipt provide this information to PPLO for his/her records.
- Payments are usually received within 4-6 weeks of submission to the Private Health fund; however should there be an issue (e.g. pre-existing illness) the patient would then be contacted to request the patient to discuss the issue with the health fund. In the event of excess gap, Patient Fees will ensure that hospital policy on "Gap" is implemented.
- Key areas such as radiology and pathology will need to be consulted to ensure these accounts are combined with hospital accounts. The intention is to reduce the documentation to patients.

Appendix C: Public hospitals and health services in Western Australia

Metropolitan hospitals

North Metropolitan Health Service (NMHS)

Graylands Psychiatric Hospital
King Edward Memorial Hospital for Women Osborne Park Hospital
Sir Charles Gairdner Hospital

South Metropolitan Health Service (SMHS)

Fiona Stanley Hospital Fremantle Hospital
Murray District Hospital (Pinjarra)
Peel Health Campus
Rockingham General Hospital
Royal Perth Hospital (Non-Tertiary)
Woodside Maternity Hospital

East Metropolitan Health Services (EMHS)

Armadale Kelmscott Memorial Hospital (includes Specialist Centre)
Bentley Hospital
Kalamunda District Community Hospital
Royal Perth Hospital (Tertiary)
St John of God Midland Public Hospital

Child and Adolescent Health Service (CAHS)

Perth Children's Hospital
Reports to the Director General, administratively managed via NMHS.

Privately Managed Hospitals (Contracted to provide medical services to public inpatients)

Joondalup Health Campus (North Metropolitan Health Service)
St John of God Midland Public Hospital (East Metropolitan Health Service)

Western Australian Country Health Services (WACHS)

South West hospitals

Augusta District Hospital
Boyup Brook Hospital (Upper Blackwood)
Bridgetown District Hospital
Bunbury Regional Hospital
Busselton District Hospital
Collie District Hospital

Harvey District Hospital
Margaret River District Hospital
Nannup District Hospital
Pemberton District Hospital
Warren District Hospital (Manjimup)
Donnybrook District Hospital

Great Southern hospitals

Albany Regional Hospital
Denmark District Hospital
Gnowangerup District Hospital
Katanning District Hospital

Kojonup District Hospital
Plantagenet District Hospital (Mt Barker)
Ravensthorpe District Hospital

Wheatbelt hospitals

Beverley District Hospital
Boddington District Hospital
Bruce Rock Memorial Hospital
Corrigin District Hospital
Cunderdin District Hospital
Dalwallinu District Hospital

Goomalling District Hospital
Kellerberrin Memorial Hospital
Kondinin District Hospital
Kununoppin District Hospital
Lake Grace District Hospital

Merredin District Hospital
Moora District Hospital
Narembeen District Memorial Hospital
Narrogin Regional Hospital
Northam Regional Hospital
Dumbleyung District Memorial Hospital
Quairading District Hospital
Southern Cross District Hospital
Wagin District Hospital
Wongan District Hospital
Wyalkatchem-Koorda District Hospital
York District Hospital

Goldfields and South East Coastal hospitals

Esperance District Hospital
Kalgoorlie Regional Hospital
Laverton District Hospital

Leonora District Hospital
Norseman District Hospital

Midwest hospitals

Dongara Health Service
Carnarvon Regional Hospital
Northampton District Hospital
North Midlands District Hospital (Three Springs)
Meekatharra District Hospital

Mullewa District Hospital
Geraldton Regional Hospital
Kalbarri Health Service
Exmouth District Hospital
Morawa District Hospital

Pilbara hospitals

Onslow District Hospital
Hedland Health Campus
Newman District Hospital
Nickol Bay Hospital (Karratha)

Paraburdoo District Hospital
Roebourne District Hospital
Tom Price District Hospital

Kimberley hospitals

Broome District Hospital
Derby Regional Hospital
Fitzroy Crossing Hospital

Halls Creek Hospital
Kununurra District Hospital
Wyndham District Hospital

Appendix D: List of health-related contacts

WA Department of Health (DoH):

Revenue Strategy and Support, System Finance, DOH (08) 6373 1839

Motor Vehicle Third Party Insurance Cases:

Insurance Commission of WA Metro (S/w) (08) 9264 3333

Email: gi@icwa.wa.gov.au Country (S/w) 1800 643 338

Commonwealth Department of Health Central Office:

Email: enquiries@health.wa.gov.au

Switchboard: (02) 6289 1555

General Fax: (02) 6281 6946

Private Health Insurance (PHI) - Health Services Reform Section:

Email: phi@health.gov.au (02) 6289 9853

General Enquiries: (08) 9346 5111

General Fax: (08) 9346 5222

Commonwealth Department of Veterans' Affairs (DVA) 1800 550 457

Other Commonwealth Departments – National Information Lines:

Centrelink – General Enquiries 13 24 68

Medicare – General Enquiries 13 20 11

Centrelink (part of Services Australia) - Information on Concession and Health Care Cards: 13 23 00

Pharmaceutical Benefits Scheme (PBS Information Line) 1800 020 613

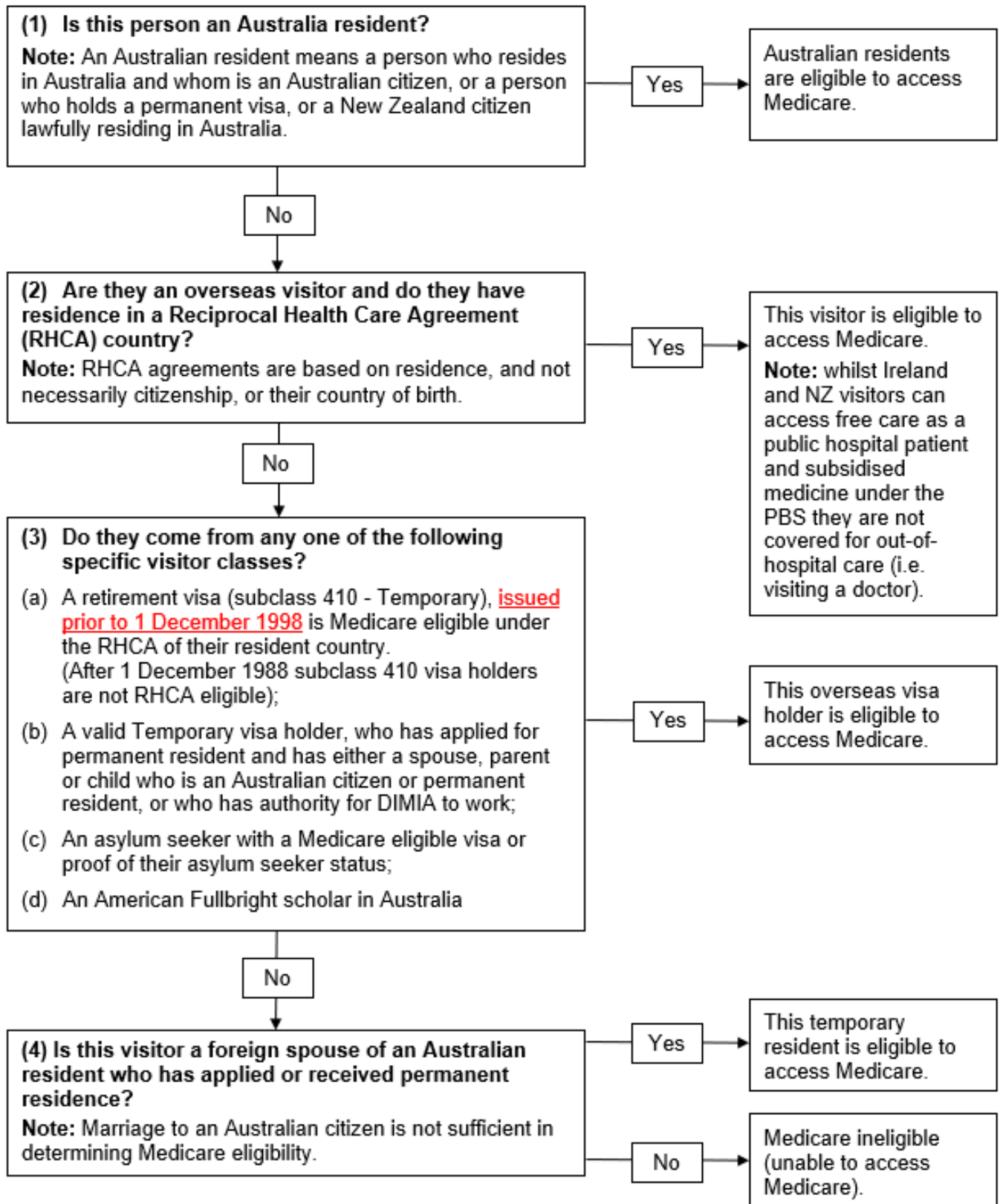
For information on pharmaceutical benefits, see the Department of Health and Ageing website:

(<http://www.health.gov.au/pbs/general/aboutus.htm>)

Overseas Student Health Cover (OSHC)

https://www.privatehealth.gov.au/health_insurance/overseas/overseas_student_health_cover.htm

Appendix E: Flow chart on Medicare eligibility and access to Medicare



Appendix F: Medicare eligibility matrix for Commonwealth visa sub classes

RHCA - VISA SUB CLASS ELIGIBILITY			
Visa Sub Class	Meaning	Eligibility	Action
010,020,030 040,050,051	Bridging Visa	YES Only entitled if they have applied for Permanent Residency	Take receipt, DIBP letter and related documents to Medicare office
100-299	Permanent Resident	YES	Permanent card
173	Aged Parent	YES 12 months at a time RHCA only	Take Passport to branch or certified copies by post.
300	Prospective Marriage (Fiancée)	YES 9 months from date of grant of visa	Requires DIBP receipt and letter. Take to branch or certified copies by post.
309, 310, 445	Provisional	YES If they have applied for Permanent Residency	Interim card
410	Retiree Visa	NO Unless applied before 01-Dec-98 RHCA only	If applicable RHCA only. Must have been approved by National Office.
417	Temporary Resident (Working holiday visa usually 12 months)	YES Only if from RHCA or they have applied for Permanent Residency.	Take Passport to branch or certified copies by post.
447, 451	Temp Protection Visa	YES If appears on Protection Schedule	Processed in Branch Office or SHQ
457, 482, 686 (subclass 457 visa has been replaced by subclass 482 visa)	Temporary Resident business visa usually 4 years	YES Only if from RHCA or they have applied for Permanent Residency.	Take Passport to branch or certified copies by post.
560, 570, 571 572, 573, 574, 575, 576 485	Student Visa Temporary Graduate Visa	NO Overseas Student Health Cover (OSHC) only, unless they have applied for Permanent Residency	Requires DIBP receipt and letter. Take to branch or certified copies by post.

RHCA - VISA SUB CLASS ELIGIBILITY			
Visa Sub Class	Meaning	Eligibility	Action
685	Medical Visa	YES RHCA only	For items only not related to the reason for the visa. Reason for Medical Grant from Doctor
686	Visitor Visa	YES Only if from RHCA	RHCA card only. Passport and National Health Card. Take to branch or certified copies by post.
785	Temporary Protection Visa	YES	Interim card only.
801, 845	Permanent Residency Visa	YES	Existing Interim card. Requires DIBP receipt and letter. Take to branch or certified copies by post.
820, 826	Provisional Spouse Visa	YES Applicants for Residence.	Interim card. Requires DIBP receipt, letter and visas. Take to branch or certified copies by post.
880	Permanent Residency	YES	DIBP receipt and letter. Take to branch or certified copies by post.

Appendix H: Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the Health Services Act 2016 (WA).

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients' fees and charges for:

Nursing home type patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or Medicare ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient 'contribution' based on March and September pension increases. To achieve consistency with the Commonwealth Private Health Insurance Act 2007, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients; instead medical charges are fully recouped from the Department of Veterans' Affairs.

The following fees and charges also apply:

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.

The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists.

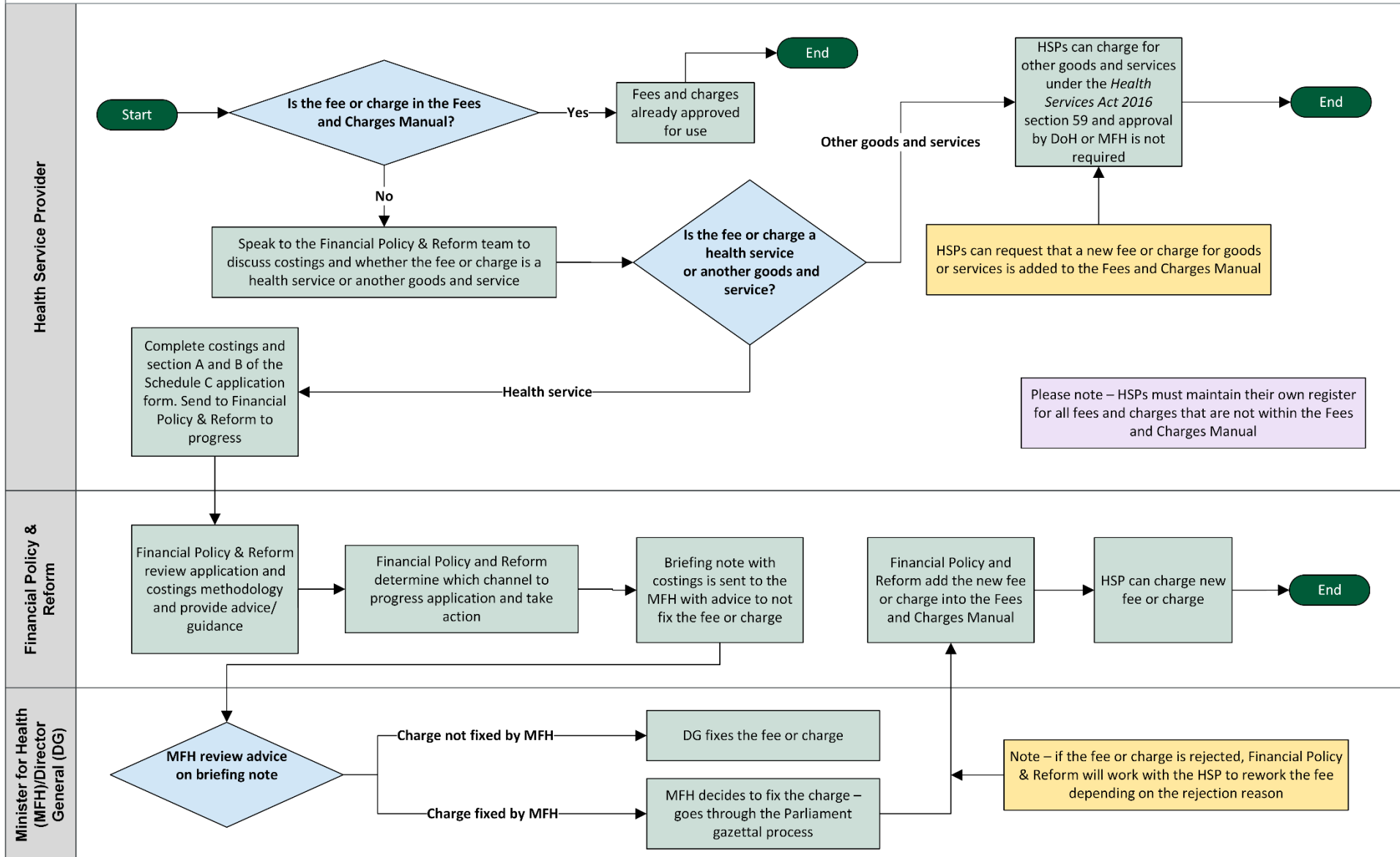
Eligible patients are charged the following co-payment rates:

- 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, Magnetic Resonance Imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Appendix I: Process for applying for a new fee or charge

Process for applying a new fee or charge



Appendix J: Information on governance of medical practitioner details within the doctor's provider and arrangement listing system policy

1. Purpose

WA Health collects, stores and uses a vast amount of data, including patient health information and medical practitioner details. The accuracy of medical practitioner details recorded within WA Health's information systems is paramount in ensuring optimal patient treatment, appropriate patient billing and correct payment of health service staff.

WA Health is responsible for maintaining medical practitioner details and ensuring this information is accurate, current and appropriately managed. There are a myriad of information systems within WA Health that are used to collect medical practitioner details. Of these systems, WebPAS is the primary source used for information and reporting of medical practitioner details. Information systems such as the Radiology Information Systems, e-referrals, Ultra and Cardiobase rely on WebPAS to source or match medical practitioner information.

Although WebPAS is the primary source for patient billing, the system is not able to collect and store all relevant billing information required from the doctors to allow accurate and timely patient billing. In this regard, the 'Doctor Provider and Arrangement Listing' (DPAL) system is established to be viewed as the initial primary source of truth which means that subsequent systems must be reconciled back to the DPAL system including payroll and WebPAS.

The DPAL (then known as the Doctor Register) was established in 2015 as a whole of health solution to capture information on doctors billing arrangements, restrictions and exemptions. Prior to the development of this module there had been no uniform process employed at hospital sites to record and maintain doctor's information that has the ability to bill or not bill on behalf of a particular doctor. Currently, a number of database systems are being utilised and often Health Service/Hospital revenue department staff have to access and interrogate more than one database system to confirm whether billing can be processed for a particular doctor.

The DPAL module is a subset of the CredWA module. CredWA is a WA Health system which operates as an administrative portal to Mercury eCredential. Mercury eCredential is a centralised secure portal for Australian health practitioners to create and manage their own online career profile. With a single interface for maintaining a complete clinical profile, practitioner's details are available in a central, accessible location, enabling the practitioner to quickly and easily submit their details for the credentialing review process. It confirms these practitioners are appropriately qualified, registered and comply with their professional development obligations. It also maintains information essential to creating and validating clinical scope of practice. In addition, CredWA generates standardised credentialing letters and Medical Service Agreements contracts.

2. Applicability

This Policy is applicable to the following Health Service Providers (HSPs):

- Department of Health
- North Metropolitan Health Service
- South Metropolitan Health Service
- East Metropolitan Health Service
- Child and Adolescent Health Service
- WA Country Health Service
- PathWest

3. Policy requirements

3.1 Roles and Responsibilities

The Medical Executive Director at each HSP is to ensure that this policy and its procedures are complied with, and are accountable for the monitoring of any non-compliance.

It is the responsibility of the revenue or relevant department within HSPs to ensure that all doctors billing information is uploaded and maintained within the DPAL system.

The following processes are to be adhered to by the relevant departments:

- The Workforce / Medical Administration invite a doctor to create a profile under the relevant speciality on the CredWA system. Once the application has been processed and approved, the relevant department will advise Revenue staff that there is a new doctor in the system.
- Revenue staff are to ensure that the doctors' details, including provider numbers, specialties, Private Practice Arrangement, contract dates and S19AB details, are uploaded into the CredWA and DPAL.
- Revenue staff are to ensure all relevant billing information is collected from doctors and uploaded into the DPAL system.
- Revenue staff should ensure that all related systems have correct billing information.

Each Health Entity must designate an accountable person to ensure all information is correctly collected, stored and maintained within each relevant system. The Health Entities' accountable person is responsible for cross-checking all relevant systems on a regular on- going basis at least every three months.

3.2 Further Information

This policy and its procedures are maintained by the Financial Policy and Reform team. Any requests for further information can be directed to: finance.policy@health.wa.gov.au

3.3 Process for Maintenance of the DPAL System

A Doctor must create their personal profile within the CredWA module and complete all mandatory information. Once the doctor has completed their profile, HSPs' Medical Workforce or Medical Administration must upload all pertinent contract and credentialing information into the credentialing component of CredWA.

The designated authority within Workforce or Medical Administration must then inform the following groups that a doctor has been entered into CredWA:

- Payroll
- Revenue staff
- WebPAS coordinator
- Any other relevant system within each Health Entity as deemed necessary to capture doctors' information

Workforce or Medical Administration need to also inform revenue staff which arrangement the consultant has chosen (either A or B). If the doctor has not selected an arrangement, then they are to be defaulted to Arrangement A. Workforce needs to upload a copy of the signed Arrangement Agreement to allow revenue staff to process the correct paperwork.

Once revenue staff have been informed in writing that a doctor is active within the CredWA system it is their responsibility to ensure that the doctors billing information is entered into the Doctor Register module. If the doctor is new to the hospital, they must be given all relevant forms to sign. It is the revenue staff's responsibility to monitor and follow-up in a timely manner all relevant forms that have not been returned, to ensure billing can be undertaken as soon as possible.

If a doctor is already established at a hospital revenue staff need to ensure that all relevant billing forms and information are uploaded as soon as they are made aware that the doctor has been added to CredWA. Revenue staff are to ensure that all information received is entered into the DPAL system correctly. Revenue staff need to check all provider numbers that the Doctor has provided or upload the correct Provider number.

Revenue staff need to ascertain whether a new consultant is an Overseas Trained Doctor and whether they have a 19AB exemption. If they do have an exemption a copy of the exemption letter needs to be uploaded into the DPAL system along with all other relevant information. All Health Fund forms need to be sent out to the consultants for them to sign and be returned and uploaded individually.

Unless otherwise specified, Medical Administration / Revenue staff are to ensure that all records relating to doctors' employment and billing information are retained on an official file, in accordance with a relevant Recordkeeping Plan.

(Note: Where a document has been signed, the signed document is to be retained on file.)

4. Compliance monitoring

4.1 Subject to Audit

All revenue documentation is subject to review by Internal Audit, Medicare and/or the Office of the Auditor General, to ascertain compliance with this policy, and any other applicable policies or legislation.

4.2 Relevant Legislation and Policy

- Health Services Act 2016
- Health Services (Fees and Charges) Order 2016
- Australian Medical Association Awards 2016

4.3 Record Keeping

5. Definitions

The following definition(s) are relevant to this Policy.

Term	Definition
Health Service Provider(HSP)	A legal Health Service Provider in WA Health: <ul style="list-style-type: none"> • Department of Health • Board Governed Health Service Providers • Chief Executive Governed Health Service Providers. • Queen Elizabeth II Medical Centre Trust

6. Policy contact

Enquiries relating to this policy may be directed to:

Title: Financial Policy and Reform
 Directorate: System Finance
 Email: finance.policy@health.wa.gov.au

Appendix K: A list of all notifiable diseases that require treatment with medication to prevent transmission

The below list is all notifiable disease under the Public Health Act (2016) that require treatment with a medication in order to prevent transmission. More information can be obtained under [Chapter 8.2](#) and [Chapter 6](#).

- Chancroid
- Chlamydia trachomatis infection (sexually acquired)
- Cholera
- Cryptosporidiosis – for immunocompromised patients
- Diphtheria
- Donovanosis
- Gonococcal infection
- Group A streptococcal infection (invasive) (iGAS)
- Haemophilus influenzae type b (Hib) infection (invasive)
- Hepatitis B (chronic) in pregnant women only
- Human Coronavirus with Pandemic potential (including COVID-19)
- Human immunodeficiency virus (HIV) infection
- Influenza
- Leprosy (Includes pyridoxine with Isoniazid)
- Lymphogranuloma venereum (LGV)
- Meningococcal infection (invasive)
- Paratyphoid fever
- Pertussis (whooping cough)
- Pneumococcal infection (invasive)
- Salmonella infection
- Shigellosis – for immunocompromised patients
- Syphilis (all stages and congenital)
- Tuberculosis (Includes pyridoxine with Isoniazid) (Excludes Mycobacterium Avium Complex [MAC])
- Typhoid fever
- Yersinia infection

Appendix L: Reciprocal health care agreement matrix

Country	Operational Start Date	Eligibility Criteria	What is Covered	Students	Diplomats	Documentation Required		Period of Cover	
						Citizen	Resident	Start	End
Belgium	1/9/2009	Must be both: <ul style="list-style-type: none"> living in Belgium before arriving in Australia, and insured in the Belgian health system 	Medically necessary care out of hospital. Medically necessary care as a public patient in a public hospital. Some PBS prescription medicines at the general rate.	Eligible – exempt from OSHC requirements	Diplomat and family are eligible to enrol in Medicare while posted in Australia.	Belgian Passport, current visa and either: <ul style="list-style-type: none"> valid Belgian Health Insurance Card, or valid EHIC - initials BE 	Non-Belgian passport, current visa and either: <ul style="list-style-type: none"> valid Belgian Insurance Card valid EHIC - initials BE 	The day of arrival into Australia	On expiry of Belgian Health Insurance Card, EHIC or visa.
Finland	1/09/1993	Must have been living in Finland before arriving in Australia	As above	Not eligible	As above	Finnish Passport and evidence of current visa. May also be required to show at least two documents as proof of residency in Finland.	Non-Finnish passport, current visa and either: <ul style="list-style-type: none"> valid Sickness Insurance Card from the Finnish Social Insurance Institution, or valid EHIC - initials FI, or Two documents as proof of residency in Finland. 	As above	On the expiry of Finnish Health Insurance or visa.
Italy	1/9/1988	Must be both: <ul style="list-style-type: none"> a citizen of Italy, and eligible to use Italy's national health insurance Italian citizens can live outside of Italy before arriving in Australia as long as they are covered under an insurance agreement with Italy.	As above	Eligible but only for six months - required to take out OSHC insurance	As above	Italian Passport and evidence of current visa and either: <ul style="list-style-type: none"> valid EHIC with the initials IT, or valid Italian Health Insurance Card (Tessera Sanitaria), or a statutory declaration that says recipient can get medical and hospital care under Italy's national health law. 	Must be a citizen to be eligible	The day of arrival into Australia - proof of entry must be provided to determine start date of RHCA	Six months from entry into Australia <u>OR</u> Upon expiry of EHIC, Italian health insurance cover or visa.
Country	Operational	Eligibility Criteria	What is Covered	Students	Diplomats	Documentation Required		Period of Cover	

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	Start Date					Citizen	Resident	Start	End
Malta	6/7/1988	<p>Must be both:</p> <ul style="list-style-type: none"> a citizen of Malta, and living in Malta before arriving in Australia. <p>This includes all the Maltese Islands</p>	As above	Not eligible	As above	<p>Evidence of current visa and either:</p> <ul style="list-style-type: none"> Maltese passport, or Maltese identity card, or included as a dependent on someone else's Maltese passport or identity card. 	Must be a citizen to be eligible	The day of arrival into Australia - proof of entry must be provided to determine start date of RHCA	Six months from entry to Australia, unless visa expires earlier.
The Netherlands	4/1/1992	<p>Must have been both:</p> <ul style="list-style-type: none"> Living in the Netherlands before arriving in Australia, and enrolled in the Netherlands Health Insurance Scheme 	As above	Eligible	Diplomat and family are eligible to enrol in Medicare while posted in Australia.	<p>Dutch passport, current visa and either:</p> <ul style="list-style-type: none"> valid insurance in the Netherlands Health Insurance Scheme (ZorgPas), or valid EHIC with initials NL 	<p>Non-Dutch passport, current visa and either:</p> <ul style="list-style-type: none"> valid insurance in the Netherlands Health Insurance Scheme (ZorgPas), or valid EHIC with initials NL, or Two documents as proof of residency in the Netherlands 	The day of arrival into Australia	On expiry of the Netherlands Health Insurance Card, EHIC or visa.
New Zealand (includes Tokelau and Niue Islands)	1/9/1999 (amended)	<p>Must have been both:</p> <ul style="list-style-type: none"> a New Zealand citizen or resident before arriving in Australia, and temporarily visiting Australia 	<p>Medically necessary care as a public patient including public hospital inpatient and outpatient services.</p> <p>Not eligible to receive cover for out of hospital services (i.e. GP).</p> <p>Some PBS prescription medicines at the general rate.</p>	Eligible – cover not limited. Entitled to full Medicare benefits inc. GP visits	<p>Diplomat and family are eligible for Medicare (full entitlements) while posted in Australia.</p> <p>Do not need to enrol in Medicare.</p>	<p>New Zealand passport must be shown to prove New Zealand citizenship.</p>	<p>Non-New Zealand passport, visa and proof of New Zealand residency, i.e:</p> <ul style="list-style-type: none"> At least two documents as proof of residency in the New Zealand 	As above	The day of departure from Australia
Norway	1/3/2004	<p>Must have been both:</p> <ul style="list-style-type: none"> Living in Norway before arriving in Australia, and 	Medically necessary care out of hospital.	Not Eligible	Not eligible to enrol in Medicare	<p>Norwegian passport, current visa and either:</p> <ul style="list-style-type: none"> valid insurance in the Norwegian 	Non-Norwegian passport, current visa and either:	As above	On expiry of Norwegian health

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Country	Operational Start Date	Eligibility Criteria	What is Covered	Students	Diplomats	Documentation Required		Period of Cover	
						Citizen	Resident	Start	End
Norway (continued)		<ul style="list-style-type: none"> A member of the Norwegian National Insurance Scheme 	<p>Medically necessary care as a public patient in a public hospital.</p> <p>Some PBS prescription medicines at the general rate.</p>	(Health insurance provided by the Norwegian government so compulsory OSHC requirement waived)	while posted in Australia.	<ul style="list-style-type: none"> National Insurance Scheme, or valid EHC with initials NO 	<ul style="list-style-type: none"> valid insurance in the Norwegian National Insurance Scheme, or valid EHC with initials NO 		insurance, EHC or visa.
Republic of Ireland	25/5/1998	<p>Must have been both:</p> <ul style="list-style-type: none"> a resident of Ireland, and living in Ireland for at least 6 months prior to coming to Australia 	<p>Medically necessary care as a public patient including public hospital inpatient and outpatient services.</p> <p>Not eligible to receive cover for out of hospital services (i.e. GP).</p> <p>Some PBS prescription medicines at the general rate.</p>	Not eligible	<p>Diplomat and family are eligible for Medicare (full entitlements) while posted in Australia.</p> <p>Do not need to enrol in Medicare.</p>	<p>Valid visa and either:</p> <ul style="list-style-type: none"> Irish passport, or EHC with initials IE 	<p>Valid visa and either:</p> <ul style="list-style-type: none"> Irish passport, or EHC with initials IE <p>May also need to show at least two documents proving Irish residency.</p>	As above	On visa expiry
Slovenia	1/7/2011	<p>Must have been both:</p> <ul style="list-style-type: none"> Living in Slovenia before arriving in Australia, and Insured in the Slovenian health system 	<p>Medically necessary care out of hospital.</p> <p>Medically necessary care as a public patient in a public hospital.</p> <p>Some PBS prescription medicines at the general rate.</p>	Eligible	<p>Diplomat and family are eligible to enrol in Medicare while posted in Australia.</p>	<p>Slovenian passport, current visa and either:</p> <ul style="list-style-type: none"> valid Slovenian Health Insurance Card, or valid EHC with initials SI 	<p>Non-Slovenian passport, current visa and either:</p> <ul style="list-style-type: none"> valid Slovenian Health Insurance Card, or valid EHC with initials SI 	As above	On expiry of either the Slovenian Health Insurance Card, EHC or visa
Sweden	1/5/1989	<p>Must have been living in Sweden before arriving in Australia</p>	<p>Medically necessary care out of hospital.</p> <p>Medically necessary care as a public patient in a public hospital.</p> <p>Some PBS prescription medicines at the general rate.</p>	Eligible	<p>Diplomat and family are eligible to enrol in Medicare while posted in Australia.</p>	<p>Swedish passport and current visa.</p> <p>May also need to show at least two documents proving Swedish residency.</p>	<p>Non-Swedish passport, current visa and either:</p> <ul style="list-style-type: none"> valid Health Insurance Certificate from a Swedish Social Insurance Office, or valid EHC with initials SE, or two documents proving Swedish residency. 	The day of arrival into Australia	On expiry of either the Swedish Health Insurance or visa

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Country	Operational Start Date	Eligibility Criteria	What is Covered	Students	Diplomats	Documentation Required		Period of Cover	
						Citizen	Resident	Start	End
United Kingdom (including Northern Ireland)	1/7/1986	Must have been living in the UK before arriving in Australia	As above	Eligible	As above	Current visa, and either: <ul style="list-style-type: none"> • British passport • evidence you are a resident of the UK, Jersey, Guernsey or the Isle of Man May also need to show at least two documents as proof of British citizenship	Non-British passport, current visa, and either: <ul style="list-style-type: none"> • EHIC with initials UK, or • National Health Insurance card if from Great Britain or the Isle of Man, or • Health Service card if from Northern Ireland, or • a Health card from the Health and Social Services department of the States of Jersey, or • proof of insurance from the Guernsey States Insurance Authority, or • other proof of Guernsey residency, or • two documents proving UK residency. 	As above	On expiry of either the British health insurance or visa

Abbreviations:

RHCA: Reciprocal Health Care Agreement

EHIC: European Health Insurance Card

GP: General Practitioner

For further information or how to enrol in Medicare, please visit the [Services Australia](#) website

Documents proving residency of a country may include:

- a work contract
- a rental or lease agreement or bond receipt
- a bank statement
- evidence of child enrolled in childcare or school
- property or contents insurance
- gas, electricity, water or rates account

Documents must be date marked