Australian
Private Hospitals
Association

Response to Productivity Commission Report Mental Health

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Australian Private Hospitals Association ABN 82 008 623 809

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Summary

The Australian Private Hospitals Association (APHA) strongly supports the importance of providing consumers with access to timely and comprehensive and coordinated mental health care. Provision of mental health services is an enormous challenge to the Australian health sector as a whole. It is one requiring effective collaboration across all sectors and stakeholders. In the face of this enormous challenge it is extremely important to ensure the role of private health insurance is well targeted to support access to safe and effective clinical care.

In December 2020, the Department of Health released a Consultation Paper to inform a 'Second Wave' for private health insurance including reforms regarding the coverage provided by private health insurance for mental health. On Monday 8 February 2021, APHA lodged a response to the Department of Health's consultation paper outlining the factors which limit access to timely, comprehensive and coordinated mental health care and specifically the provision of specialist clinically-led multidisciplinary mental health outreach/community care. The response explored:

- Factors which limit the use and utility of Chronic Disease Management Programs (CDMPs) in relation to mental health
- The barriers to the expansion of hospital managed specialist clinically-led multidisciplinary mental health outreach/community care.

Noting the relevance of these issues to the Australian Government's response to the Productivity Commission, APHA is pleased to provide a summary of APHA's reform proposal to this consultation.

APHA identifies 'the missing middle' – a lack of coordinated services to meet the requirements of people with moderate to high mental health needs[1] as the focus for further reform.

APHA argues that CDMPs, while potentially underused, are of limited utility in meeting the needs of people with moderate to high mental health service needs. APHA contends that private psychiatric hospitals are ideally equipped, and have proven their ability, to meet the challenge outlined by the Productivity Commission through the provision of specialist clinically-led multidisciplinary mental health outreach/community care.

Notwithstanding demand for services of this type, their potential remains unrealised and services have achieved sustainable scale in only very limited circumstances. APHA outlines a

[1] Productivity Commission, Mental Health, 16 November 2020 https://www.pc.gov.au/inquiries/completed/mental-health/report,accessed 6 February 2021

proposal whereby this problem can be addressed, while at the same time ensuring the sustainability and value proposition of private health insurance.

APHA 's proposal is directly targeted at addressing the confusion and frustrations experienced by consumers who find, no matter how high their level of private health insurance, integrated, specialist mental health services relevant to people with severe and complex mental health conditions are either unavailable or inaccessible because they are not covered by their insurer.

The 2017 Improved Models of Care Working Group concluded there were no regulatory barriers to provision of insurance benefits for alternative models of care in mental health[2] a conclusion that necessarily points to there being non-regularity barriers.

In Australia, there is a growing demand for mental health services across the board, and private health insurers have often been concerned at the growing demand for psychiatric hospital services. While well-designed coordinated specialist-led services provide direct benefits in reducing the risk of hospital admission at the individual level, such initiatives can only impact the capacity and efficiency of private hospital psychiatric services overall when they are implemented at scale.

APHA contends that in the current context, there are two challenges facing providers seeking to address the gap identified by Productivity Commission by providing specialist clinically-led multidisciplinary mental health outreach/community care at meaningful scale:

- Achieving critical mass without commitment across multiple insurers
- Competition from the emergence of vertically integrated business models where insurers are also health service providers who preferentially support their own services.

Without scale and critical mass, programs lack long-term viability and never reach the point where they deliver measurable change in the service profile. Only by facilitating the achievement of scale can the private health system play an effective part in addressing this national challenge.

APHA argues the introduction of a default benefit for the provision of hospital-managed specialist clinician-led multidisciplinary mental health out-reach/community care would:

- Increase the affordability of contemporary patient-centered care options
- Increase the value proposition of private health insurance

[2] Summary of the fifteenth meeting of the Private Health Ministerial Advisory Committee, 11 September 2018, https://webarchive.nla.gov.au/wayback/20191107100959/https://www1.health.gov.au/internet/main/publishing.nsf/Content/phmac-meeting-15

- Maintain the sustainability of private health insurance by enabling the emergence of new services without forcing all private health insurers to meet the full cost of such services
- Support the efficient and effective deployment of highly skilled mental health professionals and accredited peer workers.
- Enable service providers to achieve the scale necessary to establish sustainable services and real alternatives for consumers and increase the over-all efficiency and cost effectiveness of private mental health services.

How to address 'the missing middle'?

The private hospital sector is a crucial provider of overnight inpatient care and admitted day-programs for people requiring acute psychiatric care. The sector also provides outreach/community services but this role remains chronically under-developed relative to the need identified in the Productivity Commission's report. The services provided by the private hospital sector in mental health and the untapped potential are further described in Appendix A.

In 2017 the Improved Models of Care Working Group concluded were no regulatory barriers to provision of insurance benefits for alternative models of care in mental health[3]. Nevertheless provision of private health insurance benefits for specialist clinically-led multidisciplinary mental health outreach/community care has remained low. That being the case additional reforms need to be considered.

This paper discusses two avenues of reform:

- The factors restricting the use and utility of CDMPs in relation to mental health
- The factors that inhibit provision of specialist clinically-led multidisciplinary mental health outreach/community care.

Although CDMPs can already be used to provide mental health services, further expansion of their role could be seen as problematic in light of the Australian Government's stated priorities for private health insurance. While a well-designed and targeted reform of private health insurance regulations could provide a valuable contribution to the continuum of care required by people living with a mental health condition, a reform that was too loosely targeted could have serious unintended consequences including the creation of unsustainable consumer expectations, increased claims and increased pressure on premiums

APHA concludes that CDMPs are ultimately of limited utility in meeting the needs of the people most in need of additional services – those at high risk of suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities and shortened life-expectancy and admission to private psychiatric hospitals.

APHA argues a more direct and targeted approach to responding to the Productivity Commission's findings is to address the lack of consistent support from private health insurance companies for the provision of specialist clinically-led multidisciplinary mental

[3] Summary of the fifteenth meeting of the Private Health Ministerial Advisory Committee, 11 September 2018, https://webarchive.nla.gov.au/wayback/20191107100959/https://www1.health.gov.au/internet/main/publishing.nsf/Content/phmac-meeting-15

health outreach/community care by providing a default benefit for hospital-managed specialist clinician-led multidisciplinary mental health out-reach/community care.

Factors which restrict the use and utility of CDMPs in relation to mental health

Currently, private health insurance can cover CDMP's for two purposes and in two ways:

- CDMPs to prevent a chronic condition may be funded from general/ancillary cover
- CDMPs to manage a chronic condition may be funded from either general/ancillary or from hospital cover depending on how they are provided.

It is APHA's understanding there is no regulatory requirement to prevent a patient who has not been admitted to hospital from accessing a CDMP to support the management of a mental health condition. Rather the factors which have limited the use of CDMPs for mental health have been:

- The manner by which consumers and their treating psychiatrists become aware of their availability
- The manner in which CDMPs are managed
- The purpose of CDMPs
- The very limited number and range of CDMP mental health providers.

Awareness of CDMP availability

The availability of CDMPs is generally promoted to consumers by health insurers, but often it is a private health insurance claim, for example of claim for a hospital admission, which triggers the health insurer's awareness an individual member may benefit from such a service. Sometimes an insurer approaches the individual member whom they have identified through a transaction and sometimes the member may approach the insurer either with or without a clinical referral.

For people at risk of suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities, shortened life-expectancy due to mental illness and admission or readmission to a psychiatric hospital, who can be acutely vulnerable, this practice is highly problematic. An unsolicited approach from a health insurer could put the consumer at serious risk if services are provided without the direction and active involvement of their treating psychiatrist.

A more appropriate solution would be for insurers to more readily engage with private hospitals and mental health service providers to ensure:

- Greater awareness by mental health clinicians of the support available through CDMPs
- Easier access to information about CDMP providers, their credentials, accreditation status, clinical governance, management and coordination arrangements and the scope and nature of the services they provide.

This would allow consumers, in consultation with their treating clinicians to consider whether such a service would be appropriate and beneficial.

If a service provider is owned by a health insurer or a health insurer has a substantial financial interest in a service provider, it should operate at arms-length and the financial relationship should be disclosed to the consumer.

Management of CDMPs

Health insurers often take a direct role in managing CDMPs, recruiting nursing and allied health staff either directly through their own service provision arms or through third parties. Very few of these providers have any accreditation or credentialing as mental health service providers.

People living with a mental health condition, particularly those at risk of suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities, shortened life-expectancy due to mental illness and admission or readmission to hospital need a complex range of services and support which require specialised coordination and management:

- Their needs may be complex and subject to change requiring a high degree of personalised care
- They will generally already be under the care of a psychiatrist or at least have had some form of psychiatric assessment and have one or more existing clinical relationships with a mental health professional
- Interdisciplinary care in mental health requires close communications, trust and collaboration between all members of the care team, the consumer and carers
- People with a severe mental illness often require access to a range of supports and services. This access can be complex and time-consuming to navigate. Many of the supports and services they require are localised and the sector is highly fragmented.

For these reasons, it is of critical importance that the primacy of pre-existing clinical relationships is acknowledged and respected. Care needs to be coordinated at the direction and in consultation with the primary treating psychiatrist.

APHA is of the view that, unlike CDMPs for other conditions, it is neither practical nor clinically safe and appropriate for mental health CDMPs which are intended for a person with, or at risk of, a psychiatric condition to be managed by a health insurer. Rather services need to ensure continuity of care and appropriate clinical governance under the direction of, and with involvement by, the consumer's treating psychiatrist.

Coordination and planning must respect pre-existing therapeutic relationships. Services should not be delivered without the active direction and involvement of the treating psychiatrist and in accordance with the National Safety and Quality Health Service Standards which, in their second edition, incorporate the Australian Mental Health Standards.

The policy question that needs to be addressed is whether the costs of this type of complex and specialised management fall within the ambit of a CDMP or whether as is discussed below, an alternative approach is required that would support the provision of specialist clinically-led multidisciplinary mental health outreach/community care.

The purpose of CDMPs

Preventative CDMPs are already funded through general/ancillary policies for people deemed at risk of chronic conditions. These tend to target risk factors such as smoking, weight and lack of exercise. Some private health insurers already fund programs that might be deemed relevant to consumers at risk of poor mental health requiring low level interventions on a clinically referred or self-referred basis.

The distinction that needs to made in order to frame effective policy is the distinction between preventative mental health measures designed for the population as a whole and initiatives designed to meet the needs of a person with a mental health diagnosis or at risk of such a diagnosis.

Funding "Management" CDMPs for people with chronic conditions is already permitted through existing regulatory arrangements. As already identified above, the policy question that needs to be considered by government, is whether these arrangements provide access to the level of specialist support and coordination required by people with a psychiatric condition.

CDMP mental health care providers

At present, there are relatively few providers of "CDMPs" in mental health. Reported data does not differentiate between "Prevention CDMPs" and "Management CDMPs". Those that do exist are primarily phone-based support services primarily targeted at self-referred prevention programs. While these services are permitted under existing regulations they do not provide the level of support and clinical governance required in providing safe and adequate care for people at risk of suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities, shortened life-expectancy due to mental illness and admission or readmission to hospital.

Private sector health services evolve and grow when financial incentives align with effective models of clinical care. Unless appropriate and relevant services are available, consumers cannot access them.

Although there are a number of recent and fast growing entrants delivering health services in the home, the Federal Government needs to ensure emerging services provide high quality and appropriate levels of service to meet existing service gaps.

How to harness the private hospital sector to address the service gap

The Productivity Commission in its report on mental health has identified a critical gap in service provision – the missing middle – for people requiring moderate to high levels of

support[4]. This cohort includes people with the serious and high prevalence psychiatric conditions treated by private psychiatric hospitals who are at high risk of suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities, shortened life-expectancy due to mental illness and hospital admission/readmissions.

APHA contends there are two challenges facing providers seeking to address this gap by providing quality specialist multi-disciplinary mental health services targeted at people at risk of hospital admission:

- Achieving critical mass without commitment across multiple insurers
- Competition from the emergence of vertically integrated business models where insurers are also health service providers who preferentially support their own services.

APHA contends that if the urgent priorities identified by the Productivity Commission[5] are to be adequately addressed it will require the cooperation of all parts of the mental health sector. Consequently, the time is right for the introduction of a default benefit for the provision of hospital-managed specialist clinician-led multidisciplinary mental health out-reach/community care.

The lack of a default benefit for hospital managed specialist clinician-led multidisciplinary mental health out-reach/community care means insurers that do not specifically contract with a hospital to cover out-reach/community services, provide their members with no cover for that service:

- Consumers, even those with Gold level policies, find their cover has, in effect, a restriction on mental health cover. They may find there is no service in their location or the services that exist are full. They may find the services covered by their insurer are limited and inappropriate for their specific needs, as recommended by their treating psychiatrist.
- Consumers may find care options are available to some consumers but not others, purely on the basis of the insurer of which they are a member. While consumers have the right to switch to another insurer, this process can be cumbersome and stressful at a time when they need to be able to focus on their recovery. Switching to another insurer can be costly both financially and in terms of features lost from the old policy.

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[4] Productivity Commission, Mental Health, 16 November 2020 https://www.pc.gov.au/inquiries/completed/mental-health/report,accessed 6 February 2021

[5] Productivity Commission, Mental Health, 16 November 2020 https://www.pc.gov.au/inquiries/completed/mental-health/report,accessed 6 February 2021

Hospitals that have invested in developing hospital managed specialist clinician-led multidisciplinary mental health out-reach/community care with the support of one payer but not others inevitably struggle to establish such programs on a sustainable basis. Without scale such programs lack long term viability and never reach the point where they deliver measurable change in the service profile.

How would this proposal contribute to the sustainability of private health?

In Australia, there is a growing demand for mental health services across the board, and private health insurers have often been concerned at the growing demand for psychiatric hospital services.

Well-designed coordinated specialist-led services provide direct benefits in reducing the risk of hospital admission at the individual level, but such initiatives can only impact the capacity and efficiency of private hospital psychiatric services overall when they are implemented at scale. Only thus will the private health system be able to effectively play its part in addressing the challenges identified by the Productivity Commission.

One of the few examples where this goal has been demonstrated is Ramsay Health Care South Australia's Mental Health Services where a large, fully integrated and comprehensive psychiatric service spanning overnight in-patient services, day programs and out-reach services has proved able to provide high quality patient outcomes, high capacity and improved efficiency (See Appendix B)[6]. This achievement would not have been possible without multiple payers coming on board. The resistance of payers embracing this approach in other markets needs to be challenged.

In regards to mental health, any service funded through hospital cover policies should meet the Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care (the Guidelines)[7] Services receiving default benefits should also be required to comply with the Guidelines. These Guidelines include specific recognition that it is essential services have accreditation including the National Safety and Quality Health Service Standards which, in their second edition, incorporate the Australian Mental Health Standards.

A default benefit does not guarantee consumers protection from out-of-pocket costs and it is not at a level sufficient to dampen the interest of providers in contracting with insurers at a competitive price. It obliges health insurers to contribute part of the cost,

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[6] Laura J Fisher B.A (Hons) and Robert D Goldney M.D., *Evaluation of a New Model of Payment for Private Psychiatric Services - Report of the Stage One Evaluation*, AXA Australia Health Insurance and Ramsay Health Care. January 2002.

[7] Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care 2015 Edition https://nla.gov.au/nla.obj-299533756/view

but it also protects them from potentially much higher claims that would have been incurred by their members.

As such, a default benefit targeted at the provision of hospital-managed specialist clinician-led multidisciplinary mental health out-reach/community care would:

- Increase the affordability of contemporary patient-centered care options
- Increase the value proposition of private health insurance
- Maintain the sustainability of private health insurance by enabling the emergence of new services without forcing all private health insurers to meet the full cost of such services
- Increase the over-all efficiency and cost effectiveness of private mental health services
- Support the efficient and effective deployment of highly skilled mental health professionals and accredited peer workers.

Appendix A: Private hospital mental health services

Private hospital mental health services are accessed by more than 40,000 people every year[8]. They include people paying for services on a full-fee basis, people using private health insurance, compensable patients and clients of the Department of Veterans Affairs.

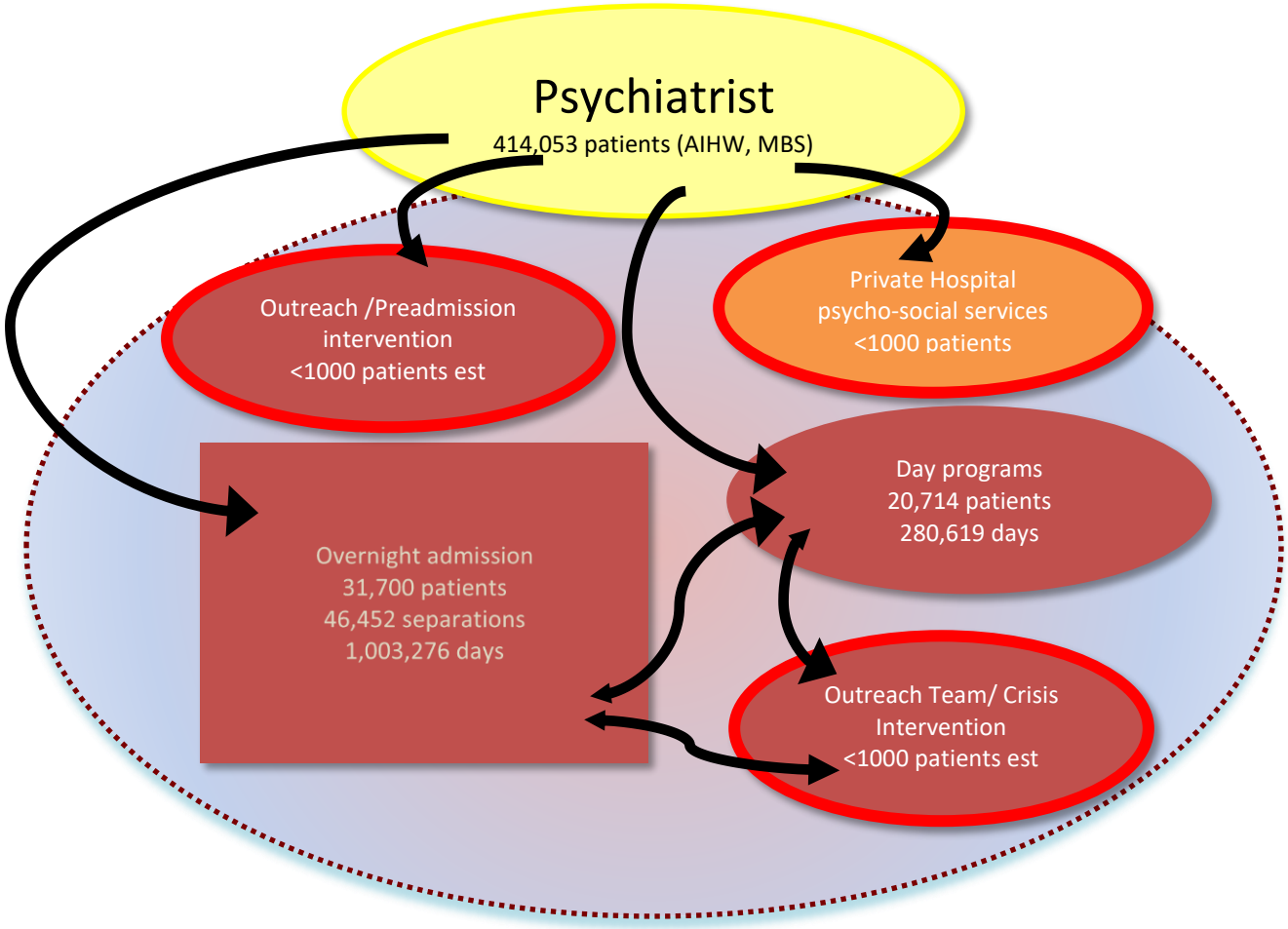
Private hospitals provide:

- Acute in-patient psychiatric care
- Psychiatrist referred intensive multi-disciplinary care delivered on either an overnight basis or, where clinically appropriate, to people living in the community and attending on a day-basis
- Psychiatrist referred community/out-reach programs targeting people at high risk of hospital readmission with multi-disciplinary care and linkages to social supports and other services.

The diagram on the next page provides an overview of these services[9]. The parts of the diagram circled in bright red highlight areas of specialist mental health care that could be expanded with appropriate reform.

[8] This figure includes multiplicities as a result of people attending more than one facility within the year ending 30 June 2019, the most recent period for which data have been published.
[9] PPHDRAS Annual Statistical Report for the 2018-19 Financial Year, March 2020
[9]Mental Health Services in Australia, Australian Institute of Health and Welfare, Australian Government, Canberra, last updated 3 May 2018 https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies Accessed 1 June 2018.

The estimated volume of services provided by the private hospital sector



Appendix B: Ramsay Health Care South Australia Mental Health Services

Ramsay Health Care South Australia Mental Health Services provides a full range of general, acute and specialised psychiatric services encompassing overnight, ambulatory and outreach services including an 84 bed acute psychiatric hospital, a stand-alone ambulatory care centre delivering over 28,800 patient days in total per year, and a mobile outreach service servicing the whole of metropolitan Adelaide.

The service treats patients with the full range of psychiatric disorders including mood disorders, anxiety disorders, schizophrenia, personality disorders and drug and alcohol detoxification. It includes electro-convulsive therapy and trans-cranial stimulation units and is also an active research centre and teaching hospital with links to the University of Adelaide.

Twenty-two years ago, as the only provider of private inpatient mental health services in South Australia, Ramsay recognised the opportunity to provide a suite of services concentrated on supporting patients with mental health disorders throughout their continuum of care, not only in an inpatient setting but also within the community. Partnering with Health Funds in a shared risk environment in 2000, it has shifted the psychiatric continuum of care to provide the right treatment, at the right time in the right environment.

The stand-alone day program centre focuses on programs to decrease dependency on inpatient services, develop self-awareness, responsibility, recovery and independence. Care is provided by a multidisciplinary team including psychiatrists, psychologists, medical consultants, clinical nurse specialists, registered nurses, physiotherapists, dieticians, occupational therapists and social workers.

Ramsay Health Care (SA) Mental Health Services provides a community service enabling registered nurses, enrolled nurses, social workers and occupational therapists to visit patients in the community both pre and post admission. The service covers the whole of the Adelaide metro area from Gawler through to Port Noarlunga.

The service consists of eight staff, has a fleet of five cars and safety systems to ensure the security of staff. There are about 200 patients being seen in the community by this service. Many of these people would have required inpatient treatment or, at the very least, longer admissions without this service.

The service provides early intervention services, admission avoidance, early discharge and community maintenance programs to prevent relapse. All these services have contributed to less inpatient care overall.