Australian
Private Hospitals
Association

Submission to the Consultation on Private Health Insurance Reforms – Second Wave Mental Health

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Introduction

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 which requires the effective collaboration of 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.

The Consultation Paper poses the question of whether chronic disease management programs (CDMPs) might be made more readily available for people living with a mental health condition. 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.

However, the Consultation Paper released by the Department of Health (the Department) presents an incomplete exploration of the issue. Consequently, the proposed reform as outlined in the Consultation Paper will not meet the Australian Government's stated objectives for private health insurance.

Furthermore, the proposals outlined in the Consultation Paper fail to address the challenge identified in the recent Productivity Commission report on Mental Health which identified 'the missing middle' – a lack of coordinated services to meet the requirements of people with moderate to high mental health needs[1]. This cohort includes those at high risk of admission to private psychiatric hospitals; a population at high risk of suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities and shortened life-expectancy.

In response to this need APHA provides an alternative reform proposal targeted directly at addressing the service gap identified by the Productivity Commission. APHA argues that CDMPs, while potentially underused, are also of limited utility in meeting the needs of people with moderate to high mental health service needs.

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

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. APHA outlines a proposal whereby this goal might be achieved, 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 is, 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 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

[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

- 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
- Support the efficient and effective deployment of highly skilled mental health professionals and accredited peer workers
- Enable service providers to achieve the scale necessary establish sustainable services and real alternatives for consumers and increase the over-all efficiency and cost effectiveness of private mental health services.

The Consultation Paper and the Australian Government's objectives for private health insurance

In responding to this consultation APHA believes the Department's Consultation Paper has not sufficiently considered the issues that would need to be addressed to meet the Australian Government's objectives for private health insurance.

Affordability and sustainability

The Department's proposal assumes that greater availability and utilisation of CDMP services in mental health would improve the affordability and sustainability of private health insurance.

While a well-designed and targeted reform could provide a valuable contribution to the continuum of care required by people living with a mental health condition, a poorly targeted reform could have serious unintended consequences including the creation of unsustainable consumer expectations, increased claims and increased pressure on premiums.

The Consultation Paper makes reference to risk equalisation arrangements. APHA notes the Australian Government has already announced its intention to commission a separate study of risk equalisation. It is important any reform proposal is informed by that study. The implications of the Department's proposal for risk equalisation should not be considered in isolation.

Quality

The quality of private health insurance depends on its ability to fulfil its function of supporting consumers to meet the costs of accessing private health care and protecting consumers from sudden and unaffordable health expenses.

Quality private health insurance also needs to provide cover for an acceptable range of health services necessary for consumers to have their health needs met to the level expected by the Australian community.

It is imperative any change to the way CDMPs are funded through hospital cover policies should not result in a reduction in the value of private health insurance cover. Specifically, it must not result in patients receiving services of a lesser quality or reduce the minimum level of cover provided in hospital insurance products by offering a restricted level of cover.

Consumers accessing mental health services through private health insurance, including CDMPs, whether funded through hospital policy cover or through general/ancillary cover must be assured their service providers meet all relevant regulatory standards including the

National Safety and Quality Health Service Standards which, in their second edition, incorporate the Australian Mental Health Standards[3].

APHA is of the view that, unlike CDMPs for other conditions it is neither practical nor clinically safe and appropriate for mental health CDMPs intended for a person with 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, and with the involvement of, the consumer's treating psychiatrist.

Choice

The proposal might facilitate choice for consumers to the extent that it might encourage insurers to fund access to a greater range of services for people with a mental health condition, but it will only achieve this objective if these services are relevant and quality assured.

Services must also be enabled to establish models of care that are economically sustainable and of a size, scale and sophistication necessary to provide the complex services required by people living with a mental health condition. Private hospitals are already well equipped to provide specialist clinically-led multidisciplinary mental health outreach/community care that would directly meet the needs of patients most at risk of hospital admission.

Finally, consumers need clarity and transparency regarding the coverage provided by health insurance products. The First Wave of private health insurance reforms improved certainty for consumers by introducing a standardised framework for the classification of hospital cover products. This proposal risks undermining the gains made by permitting insurers to determine their own criteria. This will create uncertainty for consumers about the coverage provide by hospital products and make products difficult to compare.

[3] The National Safety and Quality Health Service (NSQHS) Standards, ACHSQC, https://www.safetyandquality.gov.au/standards/nsqhs-standards, accesses 6February 2021

Response to the Consultation Paper proposals

Proposed policy part one: Benefits payable for preventative mental health treatments to all patients from hospital treatment products

The Department proposes private health insurers could fund 'preventative' mental health services from hospital treatment products. It is unclear from this proposal what the Department means by 'preventative' and how this would be different from the existing 'management' provision. It is APHA's understanding there is no regulatory requirement preventing a patient who has not been admitted to hospital from accessing a CDMP.

An expansion of scope for CDMPs funded from hospital insurance products could risk driving up premiums and this should not be contemplated without careful modelling of the actuarial implications. Furthermore, this reform should not be permitted to result in a reduction in the minimum level of cover provided by hospital policies where the coverage for mental health is restricted.

Preventative CDMPs are already funded through the general/ancillary category 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 providing low-level interventions on a clinically referred or self-referred basis. It is crucially important however, to differentiate between services suitable for people requiring low-level preventative support for mental health and wellbeing from services required by people in need of high level and complex supports and interventions to reduce the risk of hospital admission/readmission.

The distinction that needs to made in order to frame effective policy is that 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.

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 hospital admission/readmission require integrated services and supports delivered under the direction and involvement of their treating psychiatrist. The provision of services not delivered in this way poses direct clinical risks to vulnerable patients. APHA does not regard the way CDMPs are generally delivered (i.e. managed by health insurers or contracted third parties without the direct involvement of the consumers treating psychiatrist) to be an appropriate service for people with a mental health condition.

Whether private health insurance policies should take a greater role in funding such services is a complex policy question that should be addressed in the context of the best way to ensure the provision of preventative mental health programs overall. However, as

discussed above, a greater role for private health insurance in funding preventative mental health programs could be antithetical to the Australian Government's stated priorities for private health insurance. APHA is concerned that under the proposal insurers could decide their own rules for offering these products, specifically the suggestion insurers could determine the criteria for to whom such products would be offered. This proposal would appear to undermine community rating and impinge on the role of clinicians in determining and administering clinical criteria.

This proposal also needs to be assessed in light of the emergence of insurers with large service provision arms and the risk this proposal might lead to insurers using this reform to preferentially promote and expand their own services to the detriment of consumer choice and access to appropriate services.

For all of these reasons, APHA does not support the funding of 'preventative' CDMPs through hospital-cover policies.

APHA strongly believes the focus of any private health insurance reform to support mental health care through hospital cover should be to improve access to supports and services for people at risk suicide, self-harm, chronic and episodic psychiatric illness, medical complications and co-morbidities, shortened life-expectancy due to mental illness and hospital admission/readmission. The objective should be to improve access to specialist clinically-led multidisciplinary mental health outreach/community care. APHA's proposal for achieving this goal is outlined at pages nine and following.

Proposed policy Part two: CDMPs provided to a wider range of professional groups.

The Consultation Paper proposes private health insurers could be explicitly allowed to directly fund the mental health services of a wider range of allied health professionals as part of a CDMP: nurses, peer workers, and other mental health providers.

Current arrangements permit the funding of services provided by a range of professionals including 'mental health worker', which the Australian Prudential Regulatory Authority further interprets to mean psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers[4].

APHA considers benefits paid from hospital cover policies should only be used to support services with appropriate qualifications, accreditation and registration in place, i.e. services specified in the Guidelines for Determining Benefits for Private Health Insurance

[4] APRA, Data Dictionary, HRF 601.0 and HRF 601.1 https://www.apra.gov.au/sites/default/files/HRF%2520601%2520Data%2520Dictionary.pdf, accessed 8 February 2021

Purposes for Private Mental Health Care (the Guidelines)[5].

Proposed policy part three: Expanded payments for CDMP expenses to include indirect service delivery of low cost interventions

The Consultation Paper proposes private health insurers could be allowed to pay for a wider range of services including subscriptions to mental health "apps".

While APHA acknowledges technological advances have significantly expanded the way in which mental health supports and services can be provided, such expansion should only be permitted to the extent that it supports the intended purpose for CDMPs.

If such costs are to be paid from hospital cover products, they should only be covered in the delivery of services consistent with the Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care. Hospital policy cover should not be used to pay for "apps" or 'low cost' interventions for use outside the context of specialist clinically-led multidisciplinary mental health outreach/community care.

In addition, innovative technologies such as "apps" and virtual health services would have to meet relevant standards as determined by the Therapeutic Goods Administration and the Australian Commission on Safety and Quality in Health Care[6].

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

[6] The National Safety and Quality Digital Mental Health (NSQDMH) Standards https://www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards, Therapeutic Goods (Medical Devices) Regulations 2002 https://www.legislation.gov.au/Details/F2020C00822/Html/Text, Therapeutic Goods (Excluded Goods) Amendment (Software-based Products) Determination 2020; https://www.legislation.gov.au/Details/F2021L00047. Accessed 6 February 2021

APHA's alternative approach to reform

As is acknowledged in the Department's Consultation paper, the 2017 Improved Models of Care Working Group concluded were no regulatory barriers to provision of insurance benefits for alternative models of care in mental health[7]. That being the case an alternative approach to reform is needed that examines:

- 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.

As has already been argued, even though CDMPs can already be used to provide mental health services, further expansion of their role is antithetical to the Australian Government's stated priorities for private health insurance. It is 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 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

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. Similarly, there is no regulatory barrier to the use of private health insurance to fund the provision of specialist clinically-led multidisciplinary mental health outreach/community care. 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

[7] 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

- 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 may approach 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.

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 are 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 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.

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 CDMP programs 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.

Whether private health insurance should take a greater role in funding the provision of such services is a complex policy question that should be addressed in the context of considering the best way to ensure the provision of preventative mental health programs overall. However, as discussed previously, a greater role for private health insurance in the funding of preventative mental health programs could be antithetical to the Australian Government's stated priorities for private health insurance.

Funding "Management" CDMPs for people with a chronic conditions is already permitted through existing regulatory arrangements. As already identified above, the policy question that needs to be considered by Federal 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 Government needs to ensure emerging services provide high quality and appropriate levels of service to meet existing service gaps.

How to address the 'missing middle'?

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[8]. 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[9] are to be adequately addressed it will require the cooperation of all parts of the mental health sector. Consequently, the time is right for 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

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

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

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 whom they have as their insurer. 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.

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. 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. Only thus will the private health system be able to effectively play its part in addressing this national challenge.

One of the few examples where this goal has been demonstrated is Ramsay Health Care South Australia's Mental Health Services. Here, 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 A)[10]. 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.

[10] 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.

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, 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 overall 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.

Response to Consultation Paper questions

1. What additional mental health services funded by insurers under this proposal would be of value to consumers?

APHA believes any expansion of mental health services funded by insurers should be designed and targeted to meet the needs of consumers at risk of hospital admissions. For the reasons outlined in this proposal, APHA is not satisfied that the proposal as outlined would meet this objective.

2. Should an expanded list of allied health services available for direct private health insurance benefits as part of a CDMP be limited to only mental health conditions?

The Department needs to clarify its intentions regarding the distinction between hospital table and general services/ancillary table funding.

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)[11]. These Guidelines include specific recognition that it is essential that services have accreditation including the National Safety and Quality Health Service Standards, which, in their second edition, incorporate the Australian Mental Health Standards.

In regards to other CDMPs services allied health professionals should be appropriate trained and credentialled for the services they provide and health services should have all relevant accreditation.

3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

Any service funded through hospital-cover policies should be required to meet all relevant accreditation standards and registration requirements and meet the Guidelines for Determining Benefits for Private Health Insurance Purposes for

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

Private Mental Health Care (the Guidelines). APHA recommends nationally registered peer workers should also be eligible for coverage within the context of services meeting Guidelines requirements.

4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-Medicare Benefits Schedule related mental health services?

APHA considers it inappropriate for insurers, their employees or representatives to take a role in the coordination and planning of mental health CDMPs. 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

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.

5. Are there any mental health services insurers should not be permitted to fund?

Private health insurers should not be permitted to fund mental health services that are not consistent with the Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care (the Guidelines). No service should be funded from hospital policy cover and no service should be funded as hospital-substitute services[12] unless it meets the requirements of the Guidelines and holds accreditation against the National Safety and Quality Health Service Standards which, in their second edition, incorporate the Australian Mental Health Standards.

6. How should the relevant patient cohort be identified as eligible for services?

The response to this question assumes that APHA's wider concerns about the management, design and delivery of CDMPs for mental health are first addressed.

The identification of relevant patients/patient cohorts should be a decision for treating psychiatrists operating within the intent and purpose of the policy change.

[12] The term "Hospital-substitute services" refers to the definition outlined in Section 69-10, *Private Health Insurance Act 2007*

For example, if the intent is to minimise the risk of avoidable hospital admission, the policy should be directed at consumers receiving treatment for a mental health condition. This approach would also support the principle that such services should only be delivered under the direction and with the active involvement of the treating psychiatrist.

Community rating must not be undermined.

7. Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?

If criteria are set, they should be set in regulation and be universal. The purpose of such criteria would be to ensure the policy change is targeted appropriately with a view to attaining its intent and purpose. The identification of patients/patient cohorts should be a decision for treating psychiatrists.

Insurers should not set their own criteria. Their discretion should be to offer a type of cover or not. Allowing insurers to set their own criteria would directly undermine the intent of the First Wave of private health insurance reform to provide consumers with clarity about the cover provided by private health insurance products.

8. What are appropriate metrics for measuring the impact of this proposal?

Metrics need to include a focus on the response of health insurers – do they actually offer new/expanded types of cover that are appropriately designed to meet the needs of people with a mental health condition?

If the proposal were targeted at those at risk of readmission then monitoring should come within the ambit of Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS). This service is funded jointly by the Department and participating private hospitals. It is managed by APHA.

9. What is the regulatory burden associated with this proposal?

Providers of services funded from hospital cover insurance policies should in the interests of patient safety and quality of care be subject to credentialing/accreditation as defined in the Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care (the Guidelines).

The regulatory impact of this requirement on bona fide mental health service is negligible.

10. Service providers: what services would you deliver under this proposal?

Some private hospitals already provide specialist clinically-led multidisciplinary mental health outreach/community care and many want to do more. APHA is concerned this proposal will not address the barriers to the expansion of such services.

Appendix A: 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.