SUBMISSION NO. 14
AUTHORISED: 25-05-05

National Network of Private Psychiatric Sector Consumers and their Carers

SUBMISSION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

NATIONAL NETWORK SECRETARIAT
CANBERRA

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1 SUMMARY

The *National Network of Private Psychiatric Sector Consumers and their Carers* (hereafter National Network) represents Australians who contribute to Health Funds and who receive treatment and care, within the Australian private health sector, for their ***mental illnesses or disorders.***

The National Network would like to respond to the *House of Representatives Standing Committee on Health and Ageing, Inquiry into Health Funding.* As our title implies, the role of the National Network is to be the authoritative voice concerning the policy and practices of provider and funder organisations as they affect consumers and their carers using ***private sector mental health services.*** We shall therefore direct our responses within this Submission as they relates to mental health.

There is a common misconception that private sector consumers and their carers are financially secure. While that may be the case for some, many people make sacrifices to pay for private health insurance, so that they can be maintained in the private health sector. This affords them security in knowing that access to care is far more readily avaiable and timely. It must be remembered that young people can still be covered under their parents family health insurance cover until the age of 23, with most health funds.

Many people who are discharged from private psychiatric hospitals, after having been treated for an acute episode of their mental illness, re-enter the "public domain". They can, therefore, experience the same difficulties in respect of access to public housing, employment and social support services as those who do not have private health insurance. They usually rely upon these social supports being provided in the non-government sector. In particular, persons with chronic mental illness and little, or no immediate family support are very much affected.

If we look to the sustainability of the private sector into the future, then the current situation, whereby only 12 of the 46 private hospitals with psychiatric beds provide Australian Government Approved Outreach Services, must be addressed. These episodes of ambulatory care are paid for by private health insurance funds. Providing access to these Approved Outreach Services is an established way of limiting the number of inpatient admissions for chronic illnesses and disorders and reducing length of stay, if hospitalisation occurs. In effect, it is keeping people out of acute inpatient settings, while providing for their treatment and care in a much more suitable environment, usually their home.

The private sector is not well equipped to deal with complex and co-morbid conditions. These consumers, although privately insured, often find the care they require is better provided in the public mental health sector, because of their special and complex needs. This is not ideal, as it perpetuates the drain on scarce resources and results in a public sector that is overburdened, under resourced, and only able to focus on chronic and severe mental illnesses.

There is an urgent need to recognise that privately insured consumers and their carers have the right to access high quality health care, which promotes recovery. For this to occur, there must be an adequate mix of properly funded services.

The National Network would like to address, in particular, Term of Reference:

(d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government.

In doing so, we have outlined a number of pressing issues relating to the private mental health sector. These are included in the following Sections in greater detail and have been prioritised by the National Network as issues of concern for private sector mental health consumers and their carers.

Section 2 *Summary of Recommendations*

Section 4 *Some key issues*

Section 5 *The private mental health sector*

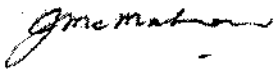
Section 6 *Private Health Insurance Funds*

Section 7 *Availability of Services Across the Continuum of Care – Implications*

Section 8 *Innovation including Integration to achieve Optimal Outcomes*

It has been demonstrated, particularly since the implementation of the Australian Government's National Mental Health Strategy in 1992, that the lived experiences of consumers and their carers provide a rich source of information about the quality, effectiveness, accessibility and appropriateness of mental health services. They know what does, and what does not, work for them.

It is the collective thoughts and lived experiences of private sector consumers and their carers, expressed through the National Network that have informed this Submission.



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2 RECOMMENDATIONS

RECOMMENDATION 1

That the necessary steps be undertaken to amend the section of the *National Health Act 1953*, which governs private health insurance, to ensure *portability* between private health insurance funds. The amendments must ensure that once a private health insurance fund member has served a waiting period with one private health insurance fund, they are not required to serve another waiting period, should they elect to change their health insurer on the same level of cover.

RECOMMENDATION 2

That the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-based Mental Health Care* (Guidelines) be strengthened to ensure that mental health services provided in private hospitals with psychiatric beds comply with the Guidelines. Compliance with the Guidelines should also be a requirement of approved accreditation authorities in Australia.

RECOMMENDATION 3

That a review of regulatory or legislative requirements is implemented, to support Health Funds appropriate funding models for the types of services required to provide a true continuum of care incorporating a number of different services that could be provided in a variety of settings.

3 INTRODUCTION

The National Network seeks to promote the interests of members of the community requiring private mental health services, and to promote effective advocacy as the driving force behind all changes in mental health services delivered in private sector settings. Since the beginning of 2002, the National Network has become an integral part of key policy and decision-making processes affecting many Australians.

The National Network welcomes this opportunity to make a submission to the H*ouse of Representatives Standing Committee on Health and Ageing, Inquiry into Health Funding.* It represents an opportunity to raise issues of concern for people directly involved in the receipt of mental health services, and those that care for them, in private health sector settings. These include treatment and care from psychiatrists in private practice, general practitioners (GP(s)) and private hospitals with psychiatric beds (or Hospital(s)).

The National Network would welcome the opportunity to discuss any of the issues raised in this Submission and would like to work together with the *House of Representatives Standing Committee* in a positive way to ensure that those who will be most affected by the findings of the Committee, that is consumers and their family carers, have direct input into it.

4 SOME KEY ISSUES

It is the belief of the Australian community that the public sector ***mental health*** system is in 'crisis'. While this may not yet apply to the mental health services provided in the ***private sector***, there are serious concerns emerging in relation to the practices of private health insurance funds (or Health Fund(s)) that we believe will, in time, impact on the **whole** mental health sector, if action is not taken.

In Australia, more people are treated privately than publicly for mental illnesses and disorders, and some issues are clearly common to both sectors. Adequate and appropriate standards of service provision, continuous quality improvement, and a comprehensive definition of consumer and carer participation, are needed for both sectors.

For the purposes of this Submission a ***consumer*** is a person using, or who has used, a private sector mental health service. A ***carer*** is a person, other than a service provider, whose life is affected by virtue of their close relationship with a private sector mental health consumer, or who has a chosen caring role with such a consumer. The carer may be a family member, partner, friend, neighbour, or paid helper, who is regularly caring for a person with a mental illness.

People who access mental health services within the private sector generally report better continuity of treatment and care. They do, however, have to contend with issues, which are different to public sector consumers. These issues include the following.

- The impact of changes to private health insurance legislation on the funding of private inpatient services.
- Variations in funding coverage of psychiatric services between Health Funds.
- Limitations in access to services as a result of tendering processes for psychiatric services.
- Substantial 'out-of-pocket' costs in a number of situations.

5 THE PRIVATE MENTAL HEALTH SECTOR

In Australia, the private sector treats over half (50-60%) of all people seen by the Australian specialist mental health sector. It employs 16% of the national mental health workforce and provides 16% (approximately 1500) of total psychiatric beds. The private sector provides a range of mental health care, which includes the services provided by psychiatrists in private practice, which are funded through the Medicare Benefits Schedule, and inpatient and day-only services provided currently by 46 private hospitals with psychiatric beds, for which Health Funds pay benefits.

Over 90% of people with a mental health problem or mental disorder seeking inpatient mental health services in the private sector are privately insured. The remainder are people covered by other third party payers including the Australian Government Department of Veterans Affairs, compensation insurers or people who fund their own care.

The following table provides an indication of the extent of the contribution to specialised mental health care in Australia made by private hospitals in 1999-2000.

Overnight separations with specialised psychiatric care (1999-2000)	Separations	Patient days
Public acute hospitals	63,635	927,332
Public psychiatric hospitals	15,568	1,153,859
Private hospitals	20,126	341,265
Total	99,329	2,422,456

By 2001-2002, the number of patient days spent in private psychiatric hospitals had increased by 23% and Separations were 28% more, relative to 1999-2000. The Australian Institute of Health and Welfare has also estimated that during 2002-2003, private hospitals provided 68% of all Same-day mental health services, and 91% of all Same-day Alcohol Use Disorder and Dependence services[1]. The same report showed that private hospitals also provided 43% of all hospital-based psychiatry services and treated almost 100,000 patients. Despite the limitations of this data, it is evident that there has been substantial growth in the private psychiatric hospital sector since the beginning of the National Mental Health Strategy[2].

In the private sector, 43 of the 46 (93%) Australian private hospitals with psychiatric beds have implemented the *Strategic Planning Group for Private Psychiatric Services (SPGPPS), National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services*[3]. Through participation in the National Model, Hospitals and Payers are able to clearly evaluate and monitor the quality and effectiveness of the care provided by those participating Hospitals.

6 PRIVATE HEALTH INSURANCE FUNDS

The National Network calls on the House of Representatives Standing Committee on Health and Ageing to address the steady attempt by private health insurers to restrict their coverage for services that are accessed by private consumers who have a chronic mental illness. The National Network understands the complex and difficult issues faced by the private health insurance industry in determining their products, and making decisions about the allocation of scarce funding resources in an environment of escalating health care costs. The National Network, however, holds serious concerns whenever *psychiatric* and *rehabilitation* services are targeted in an attempt to reduce the effect of rising costs. Mental illness is usually chronic, not episodic as many people think. The question that needs to be asked, for example, is whether people with renal failure requiring constant dialysis should be denied this treatment. Additionally, would

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1 Australian Institute of Health and Welfare (AIHW) (2004), *Australian hospital statistics 2002–03*. AIHW cat. no. HSE 32. Canberra: AIHW (Health Services Series no. 22).

2 Department of Health and Ageing (2003), *National Mental Health Report 2004. Eighth Report – Summary of changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002*, pp: 34-40, Commonwealth of Australia, Canberra.

3 Morris-Yates A and the Strategic Planning Group for private Psychiatric Services Data Collection and Analysis Working Group (2000) *A National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services*. Commonwealth of Australia, Canberra.

co-payments be applied to this treatment. The answer is obviously, no. Renal dialysis is chronic, why then single out psychiatry and rehabilitation.

Fundamentally, the key issues the National Network is concerned about include ***portability*** between health funds, ***exclusionary*** health insurance products, ***limitations*** on benefits paid for hospital-based care, ***co-payments*** for Day Programs, and ***disputes*** between Hospital providers and health funds.

Portability

The National Health Act 1953 governs Health Funds and provides for *portability* between Funds[4]. That is, once a Health Fund member has served a waiting period with one Health Fund, they are not required to serve another waiting period, should they elect to change insurers, with the proviso that the level of private health insurance cover remains the same. However, the wording concerning *portability* in the National Health Act is unclear and subject to differing legal interpretations.

The Private Health Insurance Ombudsman (PHIO) has acknowledged that it is probable that the wording of the legislation does not prohibit the imposition of waiting periods for Hospital Purchaser Provider Agreement Benefits in some transfer situations. The PHIO has also stated that:

> *It is my view, following appropriate research and discussions that the intent of the drafters and the legislators was to prohibit the imposition of waiting periods in such circumstances.*[5]

This uncertain legal situation has permitted several private health insurance funds to undermine the meaning of the portability legislation. In the most recent and concerning case, the Australian Government, Department of Health and Ageing (DoHA) approved an application from the Health Fund, Australian Unity, to impose a twelve-month limitation for benefits only for *psychiatric* and *rehabilitation* services. This meant that consumers of private psychiatric services transferring to Australian Unity would have their benefits paid at the default level, which would leave the consumer with significant out-of-pocket expenses, regardless of the level of their private health insurance cover.

While the PHIO is concerned about the current *portability* situation, they have been advised that they are powerless to act, as the DoHA is entitled to approve changes such as those sought by Australian Unity. The National Network has tried several times to have this issue addressed by DoHA. The Department has advised that the whole issue of *portability* is under review and that it is not currently in a position to make a decision. The review has been on-going for over a year.

Though concerns about the restrictions on *portability* have been raised by the National Network and the Mental Health Council of Australia, nothing has been done. This is despite public reassurances of the Minister for Health and Ageing, The Hon. Mr Tony Abbott MP, that this would be addressed. This matter must be resolved to protect Australians against discriminatory practices.

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[4] Portability is provided for in paragraphs (1a)-(1f) of schedule 1 to the National Health Act 1953. These paragraphs were introduced by the Community Services and Health Legislation Act 1988.

[5] Private Health Insurance Ombudsman (2000), *A Review of Portability Arrangements for Private Health Insurance*, Australian Government Department of Health and Ageing under Circular, HBF 688 PH 428.

Exclusionary health insurance products

Health Funds are allowed by law to offer a product that excludes benefits being paid for certain types of procedures. Common ones include products targeted towards the young, which exclude certain cardiac procedures or hip and knee replacements. The problem is that it is difficult, if not impossible, to accurately assess one's risk of contracting a particular condition or suffering a particular injury. Health Funds are prohibited, by law, from excluding payment of benefits for mental health services. They are, however, allowed to pay only a basic rate for some services. The default rate can be $150 to $200 per day below the actual service cost.

Health insurance products are complicated and consumers and their carers find it difficult to ascertain exactly what their private health insurance fund will or will not pay for, and whether or not their Health Fund will pay for the full range of services in a particular private hospital.

Limitations

A few Health Funds have also been applying *limitations* to the number of occasions of a service that they will fully fund in a calendar year.

Co-payments

The introduction of *co-payments* by some Health Funds, for persons attending Day Program activities has been done without any recognition of the patient's prior membership of that Health Fund. This places a large cost-burden upon the person with a chronic illness.

Disputes

Health Funds contract with Hospitals for the level of benefits paid for services and this contractual environment is generally highly commercially competitive, with constant breakdowns in negotiations. The d*isputes*, which arise between hospital service providers and Health Funds can cause great distress to consumers and their carers. In some cases, the consumer is forced to find a new treating psychiatrist, because they do not have visiting rights to the private hospital that is the subject of the dispute.

If Health Funds continue to be allowed to sidestep some of their prudential obligations, then over time consumers will terminate their private health insurance, putting even more pressure upon the public health system.

RECOMMENDATION 1

That the necessary steps be undertaken to amend the section of the *National Health Act 1953*, which governs private health insurance, to ensure *portability* between private health insurance funds. The amendments must ensure that once a private health insurance fund member has served a waiting period with one private health insurance fund, they are <u>not</u> required to serve another waiting period, should they elect to change their health insurer on the same level of cover.

7 AVAILABILITY OF SERVICES ACROSS THE CONTINUUM OF CARE – IMPLICATIONS

The Australian public mental health sector provides a range of services that include intensive case management, crisis teams, mobile community teams and after hours care. The National Network is not aware of respite care provision. The private mental health sector has some way to go in being able to provide similar services.

The National Network brings to the attention of the House of Representatives Standing Committee the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-based Mental Health Care* (Guidelines).[6]

The Guidelines appear at **Appendix A** to this Submission.

The Guidelines are intended to assist Health Funds when approving psychiatric care programs for the purpose of paying private health insurance benefits. They cover the range of services that can be delivered by private hospitals with psychiatric beds. As such they provide an excellent guide to the kind of services that *should* be provided across the continuum of care. In reality, many of the services identified in the Guidelines are not necessarily available in all private hospital-based settings. For example, approved outreach services are limited to only 12 of 46 facilities, there are no ***dedicated*** after hours crisis services, and respite care is non-existent. Ideally, if the full range of services were provided, then consumers and their carers would indeed have a true continuum of care incorporating a number of different services that could be provided in a variety of settings. Health Funds have difficulty in allocating funding for these specific services. There needs to be an appreciable shift, including regulatory or legislative changes, to enable funding models to be developed to support these types of services, which are currently denied private sector consumers and their carers.

The Guidelines state:

> *It is recognised that people with a mental illness, or mental disorder ideally require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care.*
>
> *There should be a range of specialist treatment and support services available for patients. Funding for some of these services will be provided by health funds, while other services will be funded through the CMBS, the Australian Government, State and Territory and Local Governments, other funders, and by the patients themselves.*
>
> *The continuum of care may include the following.*
> - *Early intervention*
> - *Crisis assessment*
> - *Domiciliary/community care*
> - *Outpatient services*
> - *Day, half-day, partial-day and evening services*

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6 Commonwealth Department of Health and Ageing Circular, HBF 694 PH 433, *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care.*

- *Hospital programs*
- *Admitted overnight services, where necessary*
- *Maintenance and supportive care*
- *Patient and carer education*
- *Preventative care*
- *Discharge Planning*

Additionally, the Guidelines call for care delivery as follows:

> *Care delivery should, where applicable to private patients, meet the principles for guiding the delivery of care as recommended by the National Standards for Mental Health Services[7], and should include the following.*
>
> *Choice, and access to a range of treatment options in consultation with the patient and, where appropriate, their family or carer(s).*
>
> - *Social, cultural and developmental context, meeting social and cultural values, beliefs and practices.*
> - *Continuous and coordinated care delivered via a range of services across a variety of care settings.*
> - *Comprehensive individualised care, access to treatment and support services able to meet specific needs during the various stages of the individual's illness.*
> - *Treatment in the most facilitative environment.*
> - *Care, which is documented and transparent, for example, through the use of Clinical Care Pathways and Clinical Practice Guidelines.[8]*
> - *Priority given to the most appropriate effective and cost–effective treatment options."*

Whilst these Guidelines provide guiding principles, there is no requirement for private hospitals with psychiatric beds, nor private health insurance funds, to implement them as part of their contractual arrangements under their Hospital Purchaser Provider Agreements. The Guidelines are also not recognised by the authorised accreditation agencies in Australia, as part of the accreditation processes. No reference is made to the Guidelines in the Australian Government's National Standards for Mental Health Services.

After much consideration, the National Network believes these Guidelines represent current best practice for private sector mental health services. As guidelines, however, they lack the ability to have any real impact on the sector. There is no requirement on hospitals and health funds to demonstrate that the best practice articulated in the Guidelines, is actually being followed.

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7 Commonwealth of Australia, *National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996, National Mental Health Strategy*, January 1997.

8 Clinical Practice Guidelines (CPGs) are systematically developed statements intended to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. Their main purpose is to improve health outcomes for patients by improving the practice of clinicians. As they become available, CPGs for psychiatric disorders are placed on the internet at http://www.ranzcp.org.

RECOMMENDATION 2

That the *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care* be strengthened to ensure that mental health services provided in private hospitals with psychiatric beds comply with the Guidelines. Compliance with the Guidelines should also be a requirement of approved accreditation authorities in Australia.

RECOMMENDATION 3

That a review of regulatory or legislative requirements is implemented, to support Health Funds appropriate funding models for the types of services required to provide a true continuum of care incorporating a number of different services that could be provided in a variety of settings.

8 INNOVATION - INCLUDING INTEGRATION TO ACHIEVE OPTIMAL OUTCOMES

8.1 Integration between public and private psychiatric hospitals

Integration and partnerships between public and private mental health services and the ability of consumers to traverse seamlessly between settings is required if optimal outcomes are to be achieved. For example, a person who does not have private health insurance cover will be admitted to the public sector setting during an acute exacerbation of their illness under the care of a multidisciplinary team. When discharged, they return to their treating psychiatrist in private sector office-based practice settings. Whilst this appears to be an ideal situation, the facts are that once the consumer enters the public mental health sector, there is very little, if any, consultation with their treating private psychiatrist. Medication regimes are often changed, treatments altered, and discharges occur without the private psychiatrist being aware of such changes. This represents the norm rather than isolated incidences. In these cases, there is a communication breakdown between sectors, and this needs to be addressed.

Unfortunately, despite the efforts made under the National Mental Health Strategy, it seems that Federal, State and Territory Governments continue to fail to recognise that the private mental health system actually exists, other than the work being done by consultant or visiting private psychiatrists who are an integral component of the public mental health sector. There are areas where the public sector has expertise that is lacking in the private sector. Community mental health nurses give public sector consumers better support and comprehensive care, once in the system. The problem is in accessing these services in the first place. The public system also has multi-disciplinary teams that provide intensive case management that the private sector lacks.

If Australia is to look to ways where people holding private health insurance continue to see its value, then services provided in private sector settings must improve to that offered publicly, or at the very least provide access to those public sector services.

8.2 Rural and remote communities and mental health services

All residents either public, or privately insured, needing mental health services in rural and remote areas of Australia are severely disadvantaged due to the unavailability of services, outside major metropolitan centres. Metropolitan centres concentrate on provision of services to locally accessible consumers and are not able to consider the provision of support outside of that area. Resources are too stretched to undertake this development and to reach out to the isolated. The result is often that the first point of call for someone in crisis is the GP, ambulance, or police. There is an argument that these providers should have a higher level of training in the management of people suffering from a mental illness than their city counterparts.
Greater integration of urban-based psychiatrists and rural-based GPs, consumers and their carers can be achieved by use of the new e-technologies such as telepsychiatry. This is already under way in the private sector, but to a limited extent. Federal, State and Territory Governments need to take responsibility and put in place the necessary measures to enable the provision of this type of service more broadly.

Urban-based providers in the private sector should encourage their consumers and carers in rural and remote communities to make greater use of government, non-government, community mental health services, resources and support groups where available. It must be acknowledged, however, that heightened stigma in rural and remote communities remains an obstacle to the utilisation of mental health services partly due to the size of the communities and the close association people have with each other in social, community and employment situations.

8.3 Integration of psychologists into private hospital-based care

There is a need for greater integration of psychologists into the private psychiatric hospital setting. Psychologists 'value add' to service provision, particularly in behavioral focused therapies. Psychologists play a far greater role in service delivery in the public sector than they do in the private sector.

The main avenue for private sector consumers to access psychologists is through those in private practice. The cost of these services are prohibitive ($120-$150 per one hour session) and unless consumers contribute to high cost, top cover benefits tables of private health insurance funds, they pay for these services themselves. This is no longer appropriate, and the Australian Government needs to take responsibility and address this situation.

9 References

1. Australian Health Ministers (1992), *National Mental Health Plan,* Canberra.
2. Australian Health Ministers (1998), *Second National Mental Health Plan,* Mental Health Branch, Commonwealth Department of Health and Family Services, Canberra.
3. Australian Health Ministers (2003), N*ational Mental Health Plan 2003-2008,* Australian Government, Canberra.
4. Australian Institute of Health and Welfare (AIHW) (2004), *Australian hospital statistics 2002–03.* AIHW cat. no. HSE 32. AIHW (Health Services Series no. 22) Canberra.
5. Commonwealth of Australia (2004), *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care.* As circulated by the Department of Health and Ageing under Circular, HBF 694 PH 433, Canberra.
6. Commonwealth of Australia (1997), *National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996, National Mental Health Strategy*, Canberra.
7. Commonwealth of Australia (2003), *National Mental Health Report 2004, Eighth Report – Summary of changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002*, Canberra.
8. Morris-Yates A and the Strategic Planning Group for private Psychiatric Services Data Collection and Analysis Working Group (2000), *A National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services.* Commonwealth of Australia, Canberra.
9. Strategic Planning Group for Private Psychiatric Services (SPGPPS) (2002). *SPGPPS National Forum 2002, Innovative Models of Service Delivery and Funding for Private Sector Mental Health Services: Edited Forum Proceedings.* SPGPPS Secretariat, AMA Federal Office, Canberra.
10. Commonwealth of Australia (1997), *National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996.* Canberra.
11. Morris-Yates, A. (2004) *Report on the implementation of the Strategic Planning Group for Private Psychiatric Services (SPGPPS) National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services, 1st July 2001 to 31 December 2003.* SPGPPS Secretariat, AMA Federal Office, Canberra.
12. Private Health Insurance Ombudsman (2000), *A Review of Portability Arrangements for Private Health Insurance,* Australian Government Department of Health and Ageing under Circular, HBF 688 PH 428.

GUIDELINES FOR DETERMINING BENEFITS FOR HEALTH INSURANCE PURPOSES FOR PRIVATE PATIENT HOSPITAL-BASED MENTAL HEALTH CARE

PREAMBLE

The private sector provides a range of mental health care services for which benefits are payable under the Medicare Benefits Schedule. Services provided by psychiatrists in private practice attract Medicare benefits, as do those services provided in private hospitals, which also attract benefits from private health funds. In addition, overnight and admitted day-only patient services provided by private hospitals attract benefits paid by both Medicare and private health insurance funds. Funds may also pay benefits for a range of ancillary services. The remainder are people covered by other third party payers, including the Australian Government's Department of Veterans' Affairs, compensation insurers, or people who fund their own care.

In 1987, the Australian Government in consultation with health funds, private hospitals with psychiatric beds (hospitals) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), finalised a set of *Guidelines for Determining Benefits for Psychiatric Inpatients*. The Guidelines were intended to assist health funds when approving psychiatric care programs for the purposes of health insurance benefits. These original Guidelines were distributed by the Australian Government, under cover of HBF Circular No 100, dated 8 September 1987.

In 2000, a Working Party comprising representatives of RANZCP, health funds and hospitals revised the Guidelines, in consultation with the then Commonwealth Department of Health and Aged Care (CDHAC), Private Health Industry Branch. The revised Guidelines were titled, *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-based Psychiatric Care*. The Guidelines were endorsed by the Strategic Planning Group for Private Psychiatric Services (SPGPPS)[1] on 23 February 2001 and distributed under cover of the CDHAC HBF Circular No 694 PH 433, 5 March 2001.

The Guidelines are now reviewed on an annual basis and will assist in determining facility selection and appropriate funding levels for private health insurance purposes.

It is recognised that the Guidelines cannot be prescriptive and are intended solely to provide guidance for hospitals and health funds in the determining of health fund benefits for private patient hospital-based mental health care.

Definition of Terms as applied in these Guidelines

Hospital-based	Services provided to an admitted patient of a hospital participating in an approved program.
Continuum of care	The provision of the necessary range of multidisciplinary services and care that is provided across a range of settings appropriate for people with a mental illness or mental disorder. Phases of treatment include pre-admission assessment, admission, immediate assessment and intervention, continued diagnostic evaluation and refinement of treatment, clarification of treatment goals and discharge criteria, progress towards and achievement of goals, discharge, and transition to appropriate aftercare or follow up. A full continuum of care ranges from acute admitted (overnight) treatment to day hospital, outpatient, rehabilitation and

[1] The SPGPPS is a national industry alliance comprising representatives of the RANZCP, Australian Medical Association, Royal Australian College of General Practitioners, consumers, carers, Australian Health Insurance Association, Australian Private Hospitals Association, and the Australian Government's Department of Health and Ageing, and Department of Veterans' Affairs.

community care. Care may continue through a series of phases for an individual patient.

Mental Illness or Disorder The term mental illness, or disorder is used in these Guidelines to refer to a diagnosed psychiatric illness, or disorder classified under either ICD-10-AM or DSM-IV-R.

1. PRINCIPLES

The following key principles underpin these Guidelines.

1.1. Private patients have a right to high quality private mental health services focused on symptomatic and functional recovery.

1.2. Consumer, and where appropriate, family/carer participation will be encouraged in all aspects of private mental health service provision.

1.3. Priority will be given to the most appropriate, evidence-based and cost–effective treatment options delivered in the most appropriate environment.[2]

1.4. The Guidelines support private mental health care services being delivered in accordance with a continuum of care and encourage hospitals to provide care in this manner.

1.5. Health funds and hospitals are expected to develop funding models in support of the continuum of care.

1.6. Private mental health services should comply with the following, where applicable.

- National Health Act 1953
- Health Insurance Act 1973
- Relevant State and Territory Mental Health Acts
- Australian Government Privacy Act 1998 (as amended)
- National Health Data Dictionary
- SPGPPS Glossary of Terms: Speaking a Common Language and Towards a common electronic language
- National Standards for Mental Health Services (NSMHS)
- National Practice Standards for the Mental Health Workforce (NPSMHW)
- In accordance with the NSMHS a model for data collection and analysis enabling the monitoring and evaluation of improvement in the quality of services provided by the hospital. It is strongly recommended that hospitals analyse and use such data within a collaborative framework that enables benchmarking with best practice.
- Disability Discrimination Act
- National Mental Health Policy

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[2] While it is acknowledged that evidence-based practice can be applied in the majority of cases, there will be situations where evidence-based practice cannot be applied, due to the complexity of some psychiatric problems and the nature of some forms of psychotherapeutic treatment.

1.7. Both hospitals and health funds are encouraged to develop the appropriate expertise to implement these Guidelines to achieve high quality, consumer and service outcomes, in accordance with best practice.

1.8 Approval and funding of private hospital–based mental health services should ideally reflect demonstrated need for services. However, ultimate decisions remain a matter between hospitals, health funds, health fund members, and the Australian Government through its regulatory function.

1.9 Private hospital-based mental health services should actively engage in recognised quality assurance processes, including review of services against the National Standards for Mental Health Services, by an independent accreditation agency and implementation of quality assurance plans arising from such external review.

2. SERVICE PROVISION

It is recognised that people with a mental illness, or mental disorder ideally require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care.

There should be a range of specialist treatment and support services available for patients. Funding for some of these services will be provided by health funds, while other services will be funded through the CMBS, the Australian Government, State and Territory and Local Governments, other funders, and by the patients themselves.

Mental health services should be delivered and funded according to a continuum of care model. The continuum of care may include the following.

- Early intervention
- Crisis assessment
- Domiciliary/community care
- Outpatient services
- Day, half-day, partial-day and evening services
- Hospital programs
- Admitted overnight services, where necessary
- Maintenance and supportive care
- Patient and carer education
- Preventative care
- Discharge Planning

3. CARE DELIVERY

Care delivery should, where applicable to private patients, meet the principles for guiding the delivery of care as recommended by the NSMHS,[3] and should include the following.

- Choice, and access to a range of treatment options in consultation with the patient and, where appropriate, their family or carer(s).
- Social, cultural and developmental context, meeting social and cultural values, beliefs and practices.

[3] The SPGPPS has endorsed the NSMHS, where applicable, for implementation in private sector mental health services.

- Continuous and coordinated care delivered via a range of services across a variety of care settings.
- Comprehensive individualised care, access to treatment and support services able to meet specific needs during the various stages of the individual's illness.
- Treatment in the most facilitative environment.
- Care, which is documented and transparent, for example, through the use of Clinical Care Pathways and Clinical Practice Guidelines (see footnote 4).
- Priority given to the most appropriate effective and cost–effective treatment options.

4. CHOICE OF SETTING

The following factors need to be taken into consideration when selecting the most appropriate setting for delivery of care.

1. Patient Acuity, Level of Distress and Disability
2. Level of social support
3. Funding options
4. Evidence-Based Best Practice (see Footnote 1)

4.1. PATIENT ACUITY, LEVEL OF DISTRESS AND DISABILITY

Patients should have:

- a diagnosed psychiatric illness classified by either ICD-10-AM or DSM–IV-R and have a level of distress, and/or disability that demonstrably impacts on their ability to function in day-to-day living and their relationships with others; and
- require specialised intervention, treatment or support in an appropriate care setting or range of settings, with an expected measurable outcome.

It is acknowledged that early intervention, for people with a mental illness or mental disorder, is particularly important in minimising the impact of first episodes, the incidence of relapse, maximising recovery and reducing the length of hospital stay. Direct admission to an appropriate same-day program, or attendances at outpatient services (half or full-day), rather than overnight services, should be considered as an alternative to admitted patient services.

4.1.1 Admitted Overnight Services

Following mental health assessment by the treating psychiatrist, level of distress and/or disability is assessed as acute, serious or severe as evidenced by, but not confined to:

- high risk of harm to self or others;
- incapacitating symptoms or distress, which may be evidenced by a highly disorganised state impacting on self care and/or physical health, including inability to comply with treatment, resulting in a need for 24 hour care;
- need to establish the nature of a serious disorder, initiate and/or stabilise complex treatment modalities, such as pharmacotherapy and Electroconvulsive Therapy (ECT);
- significant problems in initiating treatment or continuing treatment in another setting.

As patient acuity, dysfunction and available support change, the patient should, as soon as possible, be relocated to an appropriate level in the continuum of care, in consultation with the patient and, where appropriate, their family/carer.

Admitted overnight length of stay should be determined by individual patient acuity, not by length of program.

4.1.2 Admitted Same Day Patient and Community Services

Admitted same-day services should be the setting of choice for early intervention and when the patient exhibits a level of acuity, distress, or disability that is assessed as:

- manageable risk of harm to self or others; and
- lower indicators of severity and comorbidity than those necessitating admitted overnight stay; and
- able to comply with treatment and self care; or
- able to cope with their usual environment.

As patient acuity, distress and disability, and available supports change, the patient should, as soon as possible, be relocated to an appropriate level in the continuum of care, in consultation with the patient and, where appropriate, their family/carer(s) and with consideration of funding options.

All occasions of service must be determined on an individual basis. This may include participation in a structured program of defined interventions and duration, where it is indicated by best practice

5. TREATMENT AND CARE OPTIONS

At all times, in the selections of treatment options, the focus needs to be on individual needs and restoration or stabilisation of function, taking into account environmental factors for the patient, patient preferences and the patient's support systems.

Care options should include a comprehensive continuum of care model, incorporating appropriate multidisciplinary services and care across a range of settings appropriate for the patient, including access to 24-hour psychiatric emergency care, and with reference to relevant Clinical Practice Guidelines[4].

Phases of treatment include pre–admission assessment, admission, immediate assessment and intervention, continued diagnostic evaluation and refinement of treatment, clarification of treatment goals and discharge criteria, progress towards and achievement of goals, discharge, and transition to appropriate aftercare or follow up. A full continuum of care ranges from intensive admitted overnight treatment to day hospital, outpatient, rehabilitation and community care.

[4] Clinical Practice Guidelines (CPGs) are systematically developed statements intended to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. Their main purpose is to improve health outcomes for patients by improving the practice of clinicians. As they become available, CPGs for psychiatric disorders are placed on the internet at http://www.ranzcp.org.

It is expected that program modules designed to develop/increase skill levels to prevent or minimise relapses will be primarily conducted on a same-day, outpatient, half or full-day basis, where possible and clinically appropriate.

Admission, treatment and care must be under the supervision of the attending psychiatrist irrespective of care setting.

Treatment and care options based on biopsychosocial principles, should be negotiated with the patient and, where appropriate, their family/carer(s). It is acknowledged that there will be two possible scenarios:

1. the patient is able to make an informed decision regarding the involvement of their family/carer(s) in their treatment and care options; or
2. the patient is unable to make an informed decision concerning the involvement of their family/carer(s).

In the second situation, the attending psychiatrist is responsible for determining the level of involvement of family/carer(s) in the consideration of treatment and care options.

A care plan should be developed as part of the assessment process and documented prior to commencement of specialist treatment. Regular reviews of the care plan should occur at intervals appropriate to the care setting and include those members of the multidisciplinary team involved in the treatment. Care plans and reviews must always reflect the needs of the patient. and include those members of the multi-disciplinary team and appropriate and relevant families/carers.

The care plan should:

- document chosen treatment and care options;
- take into account transitions in levels of care;
- include discharge planning
- clearly state goals and outcomes. For example, detail functional improvement, and include an estimate of length/duration of treatment(s); and
- be developed collaboratively and regularly reviewed with the patient, and with the patient's informed consent, their carers and be available to them.

Care and treatment options should be selected from Evidence-based treatment choices, such as the following.

- Individual, group, family and other psychotherapies.
- Psychopharmacotherapy.
- Electroconvulsive Therapy (in accordance with guidelines of the RANZCP and the Australian and New Zealand College of Anaesthetists[5]).
- Other Evidence-based treatment modalities.
- Specific rehabilitation and education services to facilitate return of function.
- Outreach services to facilitate return of function, maintain function or prevent relapse.

[5] The Royal Australian and New Zealand College of Psychiatrists, *Guidelines on the Administration of Electroconvulsive Therapy (ECT)*, can be obtained from the internet at: http://www.health.gov.au/privatehealth/providers/circulars02-03/799_528.htm

- Education, promotion, prevention and support services.

6. QUALITY STANDARDS

Service providers should implement appropriate quality improvement processes taking account of relevant sections of the NSMHS and the National Practice Standards for the Mental Health Workforce, including but not limited to the following.

- Accreditation by an industry recognised body.
- Demonstrated quality improvement activities.
- Ongoing collection and benchmarking of industry agreed and validated outcome measures, both patient and clinician rated.
- Data collected are stored and reported in a manner which ensures confidentiality and complies with relevant legislation and the SPGPPS National Model.
- Mechanism for clinical case review of patients.
- Ongoing peer review and/or clinical supervision as appropriate for all health professionals involved in patient care.
- Patient, family and carer participation and feedback mechanisms.
- The quality initiatives of the SPGPPS.

7. STAFFING LEVELS, SUPERVISION AND CONTACT HOURS

All treatment, irrespective of care setting, is to be provided by appropriately trained and qualified health professionals.

The term ***Professional*** is defined as:

(i) **Psychiatrists**

(ii) **Psychiatric Registrars**.

(iii) **Registered Nurses** with either a minimum of two years experience in psychiatry, a postgraduate qualification in psychiatry, or with a certificate from a recognised professional program approved by the relevant College of Nursing (or by its equivalent overseas or interstate body). Sixty percent (60%) of the nursing staff should meet this experience level but the desired level is 75% subject to availability of appropriately trained staff.

(iv) **Allied Health Professionals** with proven/substantiated and relevant clinical experience in direct therapy, who are registered members of their relevant professional body.

(v) **Nurse Therapists** who are registered nurses who have completed postgraduate qualifications in a specialist therapy discipline and have proven/substantiated and relevant clinical experience in direct therapy.

There must be a continuing education and development program for staff, which takes cognisance of the National Standards for Mental Health Services and National Practice Standards for the Mental Health Workforce.

All clinical staff must be credentialled by the service and participate in regular peer evaluations and reviews. Clinical case assessments must be performed where appropriate and

documented. Clinical supervision of all nursing and allied health professional staff, including nurse therapists, must be undertaken on a regular basis.

All staff must be aware of, and comply with, the obligations specified under the Privacy Act 1998 (as amended).

7.1 Outpatient and Community Services

Services must be delivered by appropriately trained and qualified health professionals.

7.2 Admitted Same-day Patient Services

Services must be delivered by appropriately trained and qualified health professionals for specific contact hours. Contact hours include:

- Participation in group therapy programs that have clearly defined clinical outcome goals
- One-to-one counselling sessions.

Contact hours should not include time allocated for meal and tea breaks, unless they are part of an eating disorders program.

Same-day Programs – *full-day*

A minimum number of five hours of structured therapeutic contact hours per day, except where agreement has been reached for alternative arrangements.

Same-day Programs – *half-day*

A minimum number of three hours of structured therapeutic contact per day, except where agreement has been reached for alternative arrangements.

7.3 Admitted Overnight Services

Services must be delivered by appropriately trained and qualified health professionals. The minimum standards for staffing for admitted overnight patient services are as follows.

a) The minimum number of professional hours per patient day will be an average of 4.2 hours per patient day over a seven (7) day period. Notwithstanding any criteria agreed in respect of individual programs, at least fifteen percent (15%) of these 4.2 professional hours will include therapy by allied health professionals with relevant experience and will exclude any psychiatrist consultation time. Registrars, medical officers and staff specialists are eligible for inclusion based on direct patient contact hours only.

b) Twenty-four hour access through a roster for consultant psychiatrists or hospital registrars/medical officers, or both are encouraged.

University affiliation and collaboration are encouraged.

8. FACILITIES

Facilities must be licensed by the relevant State/Territory health authority or approved as equivalent by the Australian Government Department of Health and Ageing. Licensing arrangements vary significantly from one location to another. The following minimum requirements are therefore suggested.

8.1 Hospitals

A hospital building or unit designed and built specifically for the purpose of providing psychiatric care, or another type of hospital building which has been converted or modified to meet the special purposes and incorporates the following.

Therapy rooms: There should be sufficient purpose designed rooms to cater for the needs of all admitted overnight and same-day patients, based on the **maximum** size of groups not exceeding 12 participants.

Lounge/recreation rooms: Properly furnished rooms and/or areas should be set aside for admitted overnight and same-day patient relaxation. Access to an outside leisure area is recommended. Private areas should also be set aside for admitted overnight to meet with relatives and friends.

Interview rooms: There should be an adequate number of rooms provided for use by clinicians to interview/consult with patients on a confidential basis.

Dining rooms: Fully equipped dining rooms should be provided adequate to meet the needs of the total service including admitted overnight and same-day patients, day patients and staff.

ECT Facilities: If ECT is administered, three rooms should ideally be available (pre-operative, procedure, post-operative) and should be designed to permit a direct flow of patients. Hospitals must comply with State licensing requirements for ECT where they exist. In all States guidelines for the administration of ECT are to be in accordance with those set by the Royal Australian and Australian and New Zealand College of Anaesthetists.

Facilities for specialist programs: Hospitals providing specialist programs, e.g. ICU, Parent/Infant Units, Alcohol Detoxification Programs must be able to demonstrate the existence of appropriate facilities and equipment. In some cases this may require the designation of specific special purpose areas within the hospital.

Wards: Wards should be comfortable with adequate bathroom facilities and, in shared wards, screens or curtains to ensure individual privacy for each patient

Each facility should have an appropriate number of single bed wards to permit observation and monitoring of progress.

9. GUIDELINES REVIEW

These Guidelines shall be reviewed on an annual basis by health funds, Service Providers, the RANZCP, and consumers and carers, in consultation with the Australian Government Department of Health and Ageing, and the SPGPPS.

These Guidelines were last reviewed in December 2003.

10 REFERENCES

1. Australian Health Ministers' Conference. Mental health: statement of rights and responsibilities. Canberra: AGPS, 1991.
2. Criteria for NSW Psychiatric Hospitals formulated by the NSW Joint Funds/PHA-NSW Psychiatric Working Party (1 April 1998).
3. National Practice Standards for the Mental Health Workforce

4. National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996. Canberra: National Mental Health Strategy, January 1997.

5. Strategic Planning Group for Private Psychiatric Services. Strategic Plan 2000–2003. Kingston, ACT: SPGPPS/AMA, September 1999.

11 GLOSSARY

AHMAC	Australian Health Ministers' Advisory Council
AMA	Australian Medical Association
NHMRC	National Health and Medical Research Council
NPSMHW	National Practice Standards for the Mental Health Workforce (in draft)
NSMHS	National Standards for Mental Health Services
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
SPGPPS	Strategic Planning Group for Private Psychiatric Services