27th April, 2005

Mr. Ian Holland
Secretary
Senate Select Committee on Mental Health
Parliament House
CANBERRA ACT 2600

Dear Mr Holland,

Re: Inquiry by The Senate Select Committee on Mental Health

Please find attached Healthscope's submission to the inquiry by The Senate Select Committee on Mental Health.

Healthscope Limited is the second largest private hospital operator in Australia and is the largest provider of private inpatient and same day psychiatric services.

Healthscope representatives would be happy to provide any further information regarding the private psychiatric sector or any issues raised in this paper.

Yours sincerely,

Mr. Bruce Dixon.
Managing Director
Healthscope Limited.

Senate Committee on Mental Health

This submission explores two terms of reference (TOR):

(d) The appropriate role and function of the private sector in the provision of mental health services in Australia.

(i) Opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce and for services to be consumer-operated.

KEY POINTS OF THIS SUBMISSION

TOR (d):

1. The private sector has developed innovative models to cater for patients with high prevalence conditions including severe depression, anxiety and substance abuse disorders and is a major contributor to the mental health system.
2. A severe bed shortage for psychiatric patients awaiting admission in public hospital emergency departments is now the norm.
3. Fortunately the growth in psychiatric diseases has been in the domain of private psychiatric hospitals
4. It is more cost effective and less traumatic to access private beds than to introduce agency nurses into public hospital emergency departments to deal with mental health presentations
5. The private sector could be utilised to alleviate bed block in the public sector in the following ways:
    - Temporary placement of patients requiring acute admission until a public bed becomes available
    - Decanting of more stable patients into the private sector as a mechanism of freeing up more acute beds
    - Temporary purchase of beds pending capital works
6. Services are being duplicated between public and private hospitals resulting in waste and competition for scarce resources.
7. The private sector could provide assistance in training of medical staff in the treatment and management of high prevalence disorders such as depression and anxiety

TOR (i):

1. Changes introduced by health funds, have resulted in the erosion of the portability of health insurance and imposed an increasing number of restrictions on benefits paid for mental health services. This is of major concern to consumers.
2. Failure to address these issues could see an increasing number of patients relinquish their private health insurance, placing increasing pressure on an already over-burdened public mental health system.

The private sector can play a far more vital role in the care of patients experiencing mental health problems, however this needs more innovative and lateral thinking at both federal and state levels in order to break down traditional barriers that have no place in a contemporary and well-structured health system. The following information briefly introduces relevant issues with proposed solutions.

Term of Reference (d): The appropriate role and function of the private sector in the provision of mental health services in Australia

Background

The public system has generally focussed on the treatment and diagnosis of schizophrenia, other psychoses and severe depression. This in part has been due to a legal obligation in most states to accept all involuntary patients in the context of major service delivery over the last thirty years. A severe bed shortage for psychiatric patients awaiting admission in public hospital emergency departments is now the norm[1].

In contrast, the private sector has undergone considerable growth to deal with more common psychiatric conditions such as depression, severe anxiety disorders and drug dependency.

Available data suggests that the situation will get worse. National Mental Health surveys[2] show that one in five Australians 18% (3.8 million) suffer from some form of mental illness, and that that much of the disease burden is associated with depression and anxiety disorders. The World Health Organisation predicts that by the year 2020, depression will contribute the second largest share to the burden of disease worldwide.

The private sector in Australia provided 43% of all hospital-based mental health services and 68% of same day mental health services in 2002/3[3]. It has also been at the forefront in developing innovative models of care including community outreach services whenever and wherever private health insurers have been willing to allow this to occur. Such growth has elevated the relative contribution made by the private sector in providing psychiatric care across Australia.

Access

While the public sector appears to be burdened with excess demand, the private sector has the flexibility to increase its capacity to cope with periods of excess demand. Although the private sector is primarily committed to providing psychiatric services to privately insured patients, the private sector's ability to increase its capacity could be utilised to improve access during periods of bed block. This could be achieved in a number ways:

- Temporary placement of patients requiring acute admission until a public bed becomes available
- Decanting of more stable patients into the private sector as a mechanism of freeing up more acute beds
- Temporary purchase of beds pending capital works

The basic economics of this solution is compelling. A patient cared for in the Emergency Department for 24 hours by an agency nurse will cost $1500 per day, when a bed could be purchased in the private sector for approximately $500 per day.

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[1] "State looks for private bed cure for shortage", *The Age*, 22/2/05
[2] National Survey of Mental health and Well-Being
[3] Australian Institute of Health and Welfare, *Australian Hospital Statistics, 2002-3*

Approaches to state mental health branches regarding these issues have been met with little enthusiasm. The complex nature of healthcare funding is thought to be a major disincentive to these more creative solutions.

Duplication of Services

The private sector also offers a number of specialty inpatient and day programs including; dual diagnosis services, psychogeriatric, personality disorder and eating disorder programs. Where there is a shortage or need for a specialty service it may be worthwhile considering accessing the programs in the private sector rather than duplicating services. A pilot project providing access to service expertise could be considered in circumstances where there is a:

- Waiting list for admission
- Specialty service is not available

Deskilling of Medical Staff

It is becoming increasingly apparent that advanced trainees and medical graduates who go on to become general practitioners are being exposed to a very narrow spectrum of mental illnesses in the public sector. Given the projected growth in conditions such as depression and anxiety, it would be beneficial to rotate medical staff into the private sector so that they can gain greater experience in the treatment and management of patients with high prevalence disorders. A number of private facilities have academic appointments and would be willing to oversee training provided funding was available.

Term of Reference (i)
Opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce and for services to be consumer-operated.

A number of changes introduced by health funds in recent months, has resulted in the erosion of the portability of health insurance and the imposition of limitations and restrictions on benefits paid for mental health services. This is of major concern to consumers and carers in the private sector.

Under the Health Act, the right of a health fund member to freely transfer membership between health funds is guaranteed by law. Prior to the dispute between Healthscope Ltd and BUPA (trading as HBA in Victoria) in October 2003, it was universally understood by health funds, hospitals and consumers and independently reinforced by the industry watchdog the Private Health Insurance Ombudsman, that “portability” meant the right of a member to transfer from his or her insurance fund (the relinquishing fund) to a comparable table of any other fund (gaining fund) and that if all relevant waiting periods had been served prior to the date of transfer, then no additional waiting periods would be imposed on the consumer by the health fund.

As a consequence of the protracted and large-scale dispute between Healthscope and BUPA, there was a significant number of transfers from BUPA to other health funds. (Estimated to be 6-10,000 transferring members). In the experience of the gaining funds, the transferring members tended to be high risk i.e. patients facing imminent admission to hospital or members suffering from chronic relapsing illnesses such as congestive cardiac failure, diabetes, chronic lung disease and psychiatric disorders such as depression.

This risk transfer was understandably viewed by the gaining funds as inequitable and imposed significant financial burdens (in terms of treatment and claims cost) on the gaining funds and their members who were not party to the dispute. Discussions between health insurers, private hospitals and the Commonwealth Department of Health and Aging to address this apparent anomaly are in progress. However pre-empting these discussions, one fund namely Australian Unity (a for profit medium sized Victorian based health fund) has introduced a fund rule change involving the imposition of a benefit limitation, the effect of which is to require a member suffering from a mental illness or who requires long term rehabilitation who elects to transfer from their existing fund to Australian Unity, to serve a waiting period of 12 months before becoming eligible for benefits to be paid. This rule change only applies to patients requiring psychiatric or rehabilitation services/care.

The conduct of Australian Unity can be criticised on two grounds:

1. The position they are taking significantly reduces the opportunity for consumers to freely move between health funds, as under the Australian Unity scheme, transferring members are required to serve a waiting period of 12 months to become eligible for benefits.
2. The restrictions on benefits paid to members by Australian Unity are limited to patients with certain diseases e.g. mental illness requiring treatment at specialty hospitals. This restriction is discriminatory, as Australian Unity does not seek to impose the same benefit limitations on patients with other forms of illness.

The current contracting environment has also enabled health funds to place an increasing number of limits on benefits paid for psychiatric and rehabilitation services. The introduction of a co-payment for attendance at a Day Program for patients with intermediate health cover for example, has resulted in chronic patients incurring additional costs of up to $2500 per annum.

Private hospitals are also being encouraged to develop substitutes for inpatients care however some health funds are unwilling to pay for out-of-pocket hospital care that is not reimbursed by the reinsurance pool. This is a problem that both health funds and hospital operators agree needs to be reviewed as the current reinsurance design gives funds no incentive to create new policies covering care outside hospitals. Table 1 summarises key restrictions being imposed by major health funds on privately insured patients with a mental illness.

Consideration needs to be given to legislative changes that reaffirm the rights of consumers to portability of their health insurance and to prohibit covert discrimination through the imposition of limitations and restrictions on benefits paid for mental health services. Failure to resolve these issues will see an increasing number of patients return to the public sector, placing greater pressure on an already over-burdened system.

Summary

The options raised above are an initial attempt at identifying key areas where the private sector may be able to provide assistance in the provision of mental health services across Australia. Healthscope representatives would be happy to provide any further information regarding the private sector or to be involved in discussions expanding on these options or in identifying other potential areas of collaboration.

Table 1

Fund	Inpatient Issues	Day Program Issues	Outreach (Out -of-hospital) Issues
Medibank Private	* Patients with a drug or alcohol dependency who have a psych exclusion, only receive basic benefits when admitted to psych facility, even though Healthscope psychiatric sites have licensed medical beds, and patient may have full **Medical** cover.	* Co-payments were introduced in 2002 for patients on intermediate cover attending day programs/hospitals. This was particularly problematic for patients with chronic illnesses e.g dialysis, oncology and psychiatric patients. For intermediate members, co-payments are now applicable to day programs, and are uncapped. For a chronic patient, this could mean $50/attendance x 1/week x 50 weeks potentially $2500 of extra out of pockets/year. This is particularly unfair for members who were on this level of cover prior to day program co-payments being introduced. * For patients with excesses that are applicable to each episode of care (following a break in treatment of 7 or more days), Health Funds are able to reapply excesses where the break is more than 7 days due to a public holiday, through no fault of the patient. Eg. Structured program, which runs each Monday.	* A number of health funds are refusing to pay an appropriate amount for out-of-hospital services such as community outreach as they are not reimbursed by the reinsurance pool. * MBP propose to cap the number of outreach visits to 20 per episode or 40 visits per year. Patients with a chronic mental illness will have restricted access to outreach services going forward or may require admission to hospital for care if their quota is exceeded. This is not necessarily the best option for patients with a chronic mental illness and is inconsistent with the push towards day program and outpatient based care.
HBA	* Only emergency admissions i.e. those patients with a completed Emergency Admission Certificate, stating that the patient is at risk to themselves or others are fully covered by HBA. Other patients are required to go to another hospital and establish a relationship with a new doctor or pay significant out of pocket expenses if their diagnosis does not fit within this narrow definition. This may be a particular problem for patients seeking treatment in a specific program such as eating disorders.		
MBF	* Not funding any new inpatient psychiatric services pending a review. No timelines have been provided. * An episode of care is deemed to continue unless there is a 28-day break. Patients requiring readmission within this period are funded at significantly lower rates, disadvantaging the hospital.		
HCF	* Not funding any new inpatient psychiatric services pending a review. Review has been going for over 12 months.		
Australian Unity	* Patients transferring to Australian Unity now may have Psych restrictions reapplied to their cover, even though they had served benefit limitations on their previous cover with their previous fund. This has now extended to other health funds.		