SUBMISSION BY
THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION
PSYCHIATRY SUBCOMMITTEE
TO THE INQUIRY BY THE
SENATE SELECT COMMITTEE ON MENTAL HEALTH

Background

APHA Psychiatry subcommittee

The Australian Private Hospitals Association (APHA) Psychiatry subcommittee is a subcommittee of the APHA National Board. As such, it has a national focus of advocacy and policy development on behalf of private mental health facilities. Committee members are drawn from hospitals with both independent and group ownership. The Committee also includes, in an observer capacity, the Chair of the National Network of Private Psychiatric Consumers and Carers.

Industry profile

According to the latest available data from the Australian Bureau of Statistics[1], there are 25 specialist mental health facilities with some 1463 beds located across Australia. In addition, mental health wards/units are located within a further 21 medical/surgical private hospitals.

The latest data from the Australian Institute of Health and Welfare[2] indicates that private mental health facilities provide a vital range of services for privately insured patients. Almost 100,000 patients were treated in 2002-03. Services provided include:

- 68% of all sameday mental health services;
- 43% of all hospital-based psychiatry services; and
- 91% of all sameday alcohol disorder and dependence services.

In addition:

- 93% of private hospitals with psychiatric beds collect and report outcomes data to the independent Centralised Data Management System; and
- 90% of private hospitals are accredited by an industry recognised and approved accreditation agency.

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[1] Australian Bureau of Statistics, *Private Hospitals 2002-03*, 21 September 2004.
[2] Calculated from: Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002-03*, 2004

Term of reference (a)

The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and barriers to progress

From a private hospitals perspective, the National Mental Health Strategy represents a missed opportunity. As with several other 'national' initiatives that are developed largely if not entirely through discussions between governments, the involvement of the private hospitals sector is very much at the margins, if indeed there is any involvement at all. It is acknowledged that there is now a private sector representative on the National Mental Health Working Group.

Generally speaking, the private hospitals sector is not well understood by Health Ministers and their officials on the Australian Health Ministers Advisory Council (AHMAC) and therefore national initiatives and strategies are often less than fully effective because of their inability to take a system-wide perspective. These comments are developed further in response to term of reference (c) below.

Term of reference (c)

Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care

There is tremendous scope for improvement in the areas encompassed by this Term of Reference. Even the way in which the term of reference is framed underlines the challenges facing the efficient delivery of care to ensure optimum outcomes for patients. Coordination, funding and service delivery is not all about government. As can be seen from the data presented earlier in this submission, there is a vigorous and effective private hospitals sector that is providing a range of quality services. More can and should be done but one of the biggest challenges is changing the mindset of Health Ministers and AHMAC in particular, to whom national initiatives appear to be something that involves only public sector services.

The Productivity Commission recently reported that Australia faces a great many challenges in the near to medium term in the sustainable delivery of health services to an ageing population. Meeting these challenges will require a vigorous private hospitals sector that continues to complement the work of the public hospitals sector within Australia's mixed health care system. The APHA Board has identified that potential may exist for the expansion of services offered by the private hospitals sector in the future, including boosting the sector's capacity to deliver care across the continuum.

The Productivity Commission has identified jurisdictional issues as a key inefficiency in the delivery of public hospital services. It is worth noting that the private hospitals sector doesn't suffer from Federal/State jurisdictional problems and is therefore an

appropriate model for consideration of options for improvements in the delivery of health care, particularly around the continuum of care.

Available data on the ageing of the population, increasing acuity of patients and increasing prevalence of mental illness all point to the need for the public and private sectors to work much more closely together to ensure appropriate and comprehensive care is provided throughout the episode of care. For its part, the APHA Psychiatry subcommittee is always prepared to work with all other stakeholders to ensure a system-wide approach to improvements in service delivery to patients with mental illness.

Term of reference (d)

The appropriate role of the private and non-government sectors

From a private hospitals perspective, the APHA Psychiatry subcommittee is somewhat at a loss to address this Term of Reference which calls for an evaluation of *"the appropriate role of the private and non-government sectors"*.

The distinction between differing ownership types within the private mental health sector is artificial and is not one recognised by the APHA Psychiatry subcommittee which includes in its membership both for-profit and not-for-profit private mental health facilities. There is no data that the subcommittee is aware of that indicates differences in casemix or access by patients between private mental health facilities operating under different ownership structures. Indeed, private metal health facilities operated on both for-profit and not-for-profit basis regularly benchmark their activities, processes and programs to ensure optimum outcomes for patients.

As with the broader private hospitals sector, private mental health facilities provide services on a complementary basis with publicly funded facilities within Australia's mixed health care system. It is very much a truism that no one part of the system – public or private – can possibly hope to accomplish everything in health care provision.

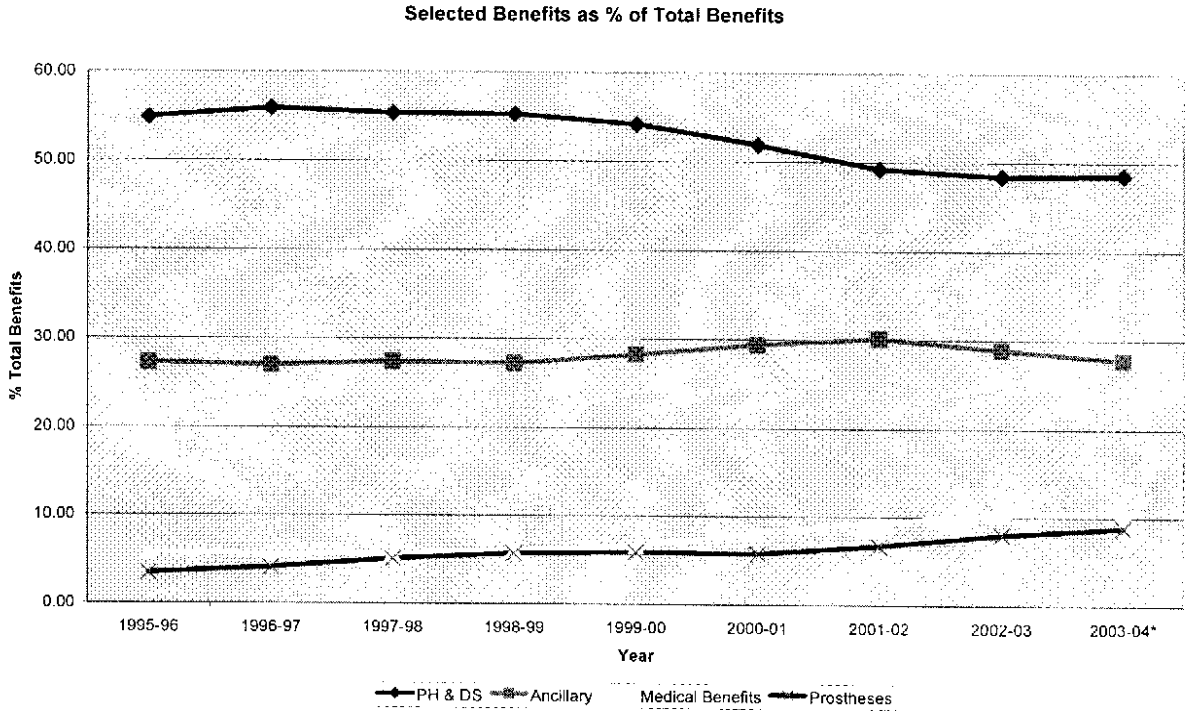
The role played by private mental health facilities in terms of services permitted to be provided is governed by State and Territory legislation, as well as requirements of the Commonwealth's *National Health Act 1953*. It is arguably these Commonwealth, State and Territory regulatory frameworks that determine what each jurisdiction regards as an "appropriate" role for private mental health facilities. Differences are apparent between jurisdictions in terms of the services able to be provided by private mental health services in areas such as the treatment of involuntary patients.

The APHA Psychiatry subcommittee observes that if there is a choice to be made between consistency and inconsistency, then consistency is usually the preferred option. How this consistency is achieved is a matter for government to assess.

Services offered by private mental health facilities are also influenced by private health insurance funds. For the most part, private mental health facilities receive the bulk of their funding via private health insurance funds under Hospital Purchaser

Provider Agreements (HPPAs) which operate within a regulatory framework of the *National Health Act 1953*. For many private mental health facilities, this is a flawed framework that does not deliver a level playing field.

A useful example of these shortcomings can be found in the table below which indicates the growth and decline of the proportion of benefits paid by private health insurance funds under their 'hospital' tables. Please note that the table contains data on all services as health funds do not report their expenditure on specific services, including mental health services.



More recent data released by the Private Health Insurance Administration Council indicates that ccomparing calendar years 2004 and 2003:

- Episodes in private hospitals increased by 7.36% to 1.69 million episodes
- Benefits paid to private hospitals increased by 6.14% to $3.53 billion
- Episodes in day hospital facilities increased by 11.0% to 303,377 episodes
- Benefits paid to day hospital facilities increased by 11.63% to $160.4 million
- Benefits paid to public hospitals increased by 15.5% to $355.13 million

Term of reference (i)

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

Consumers and Carers and Private Mental Health Facilities

As noted above, the Chair of the peak body for private sector mental health consumers and carers, the National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC), is a permanent observer at meetings of the APHA Psychiatry subcommittee, which ensures regular two-way communication between representatives of consumers, carers and private mental health facilities.

In addition, many private mental health facilities now have in place Consumer and Carer Advisory Committees that assist in informing the development and monitoring of hospital policies across a range of domains. These Committees elect a representative from each State to the NNPPSCC.

Key areas of concern to privately insured consumers of mental health services and their carers include the erosion of portability of private health insurance and the imposition of limitations and restrictions on benefits for mental health services. These are discussed below.

Portability of private health insurance

The *National Health Act 1953,* which governs private health insurance, also provides for portability between health insurance companies for health fund members.

What this means is that once a waiting period is served with one health fund, if consumers chose to move to another health fund for the same level of cover, the waiting period does not have to be served again with the new health fund.

It has become apparent that the current portability provisions of the *National Health Act* are unclear and are therefore subject to differing legal interpretations. In a recent Discussion paper circulated to stakeholders, the Private Health Insurance Ombudsman (PHIO) acknowledged that

"it is probable that the wording of the legislation does not prohibit the imposition of waiting periods for HPPA benefits in some transfer situations," although he does also note 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."*

This uncertain legal situation has permitted several private health insurance funds to undermine portability for consumers.

In the most recent and concerning case, last year the Australian Government Department of Health and Ageing approved an application by the Australian Unity private health insurance fund to impose a 12 month benefit limitation period (**for psychiatric and rehabilitation benefits only**) on members of any other health fund who wish to transfer to Australian Unity, regardless of whether these members have already served a similar waiting period at another health fund.

This means that during this second, additional 12 month waiting period, benefits for patients who receive hospital-based mental health services will be paid by Australian Unity at only the basic default benefit.

This default benefit is basically a safety-net and is set well below the costs of providing quality private mental health services. This change has therefore placed affected patients at risk of substantial out-of-pocket costs, regardless of their level of private health cover.

This vital protection mechanism for patients receiving care and treatment for a mental illness is now gone for health fund members transferring to Australian Unity. This is unfair and discriminatory. It is even more concerning, is that there is nothing to stop any other health fund from introducing a similar benefit limitation at any time.

Exclusions, Limitations and Restrictions on Benefits

Limitations on benefits can take several forms. The most obvious, and public, example is Australian Unity, with its additional 12 month Benefit Limitation Period imposed only on patients receiving psychiatric and rehabilitation services. While very concerning, this example is at least transparent and is included on the fund's website.

Other limitations on benefits are not transparent because they are included within the contracting arrangements (Hospital Purchaser Provider Agreements or HPPAs) between health funds and private hospitals. Health funds generally do not seem to alert their consumers to these limitations on the benefits paid for mental health services. Some examples include:

- Health funds are prohibited by law from excluding benefits for mental health services. However, some funds have found very creative ways around this by, for example, imposing a limitation on how many occasions a patient may receive benefits for a particular type of service in a calendar year (see ECT example below).

- Another widely used way around this ban is for health funds to pay benefits for private mental health services at only the default, safety net rate, which is set well below the cost of providing patients with the care they need. The result is patients either facing large out-of-pocket costs or seeking care in an overburdened public health system.

- In addition, a recent survey of member hospitals by the APHA Psychiatry subcommittee indicates that it is the policy of many private health insurance funds to limit in some way the benefits paid for ECT services.

- A concerning finding of the survey is that even within the one health fund, caps on ECT treatment may be imposed in some HPPAs and not others and/or are set at various levels in different HPPAs. So, regardless of the level of the contributor's cover, it may depend on where a particular patient lives or which hospital is attended, as to whether the patient requiring treatment with ECT may have a cap of 12 treatments, or 15 treatments or 18 treatments or indeed no cap at all in a 12 month period for which benefits will be paid. It is unclear whether contributors have been made aware of these caps on ECT services for which benefits are paid by some health funds.

What can be done?

Health funds have very wide discretion to introduce at any time benefit limitations and restrictions on benefits such as those outlined above. Many of these benefit limitations and restrictions on benefits are targeted at privately insured patients requiring treatment for mental illness. Ideally, legislative change is required to 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 against patients seeking care and treatment for mental health services in the private sector

In advance of legislative change, immediate courses of action to overcome this discrimination against people with mental illness include:

- A public statement by the Minister for Health and Ageing that health funds may not discriminate against any class of patient, including those requiring treatment for mental illness. Note that non-discrimination is already a requirement under the *National Health Act 1953* but creative ways around this requirement have been found by at least some health funds. The statement should prohibit the use of Benefit Limitation Periods and should also prohibit within HPPAs all restrictions and limitations on the payment of benefits by health funds for mental health services that are outside of clinical guidelines issued by the RANZCP.

- The Reinsurance Pool is the appropriate mechanism for spreading the claims for benefits of patients who exercise their choice of moving between health funds under the portability provisions. Where these movements occur on a large scale and/or unduly impact on an individual health fund, the reinsurance arrangements need to be modified so that the Pool can make adjustments accordingly.

- A major cause of the imposition of Benefit Limitation Periods is the very large number of different types of health fund products, many of which differ only very marginally from other products. As a way forward, all health fund hospital table products should be categorised by the industry regulator, the Private Health Insurance Administration Council, so that patients will have certainty in their movements between funds. Once implemented, this process should also be administratively simpler for health funds.

Term of Reference (o)

The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards

Strategic Planning Group for Private Psychiatric Services

The APHA Psychiatry subcommittee elects, on behalf of participating hospitals, two representatives to the Strategic Planning Group for Private Psychiatric Services (SPGPPS). The SPGPPS is a *Private Mental Health Alliance* that brings together all the major stakeholders involved in providing private mental health services to Australians to identify and agree issues in order to provide better mental health services in the private sector. This undertaking is supported in partnership by the following organisations.

- Australian Medical Association
- The Royal Australian and New Zealand College of Psychiatrists
- The Royal Australian College of General Practitioners
- Australian Private Hospitals Association
- Australian Government Department of Health and Ageing
- Australian Private Health Insurance Association
- Australian Government Department of Veterans' Affairs
- Mental health consumers and carers

This Alliance takes into account the relationships which exist between all stakeholders. The SPGPPS has been critically acclaimed in both the public and private health sectors as a model for facilitating achievement of common goals, while respecting the rights and contributions of all parties in order to build on shared opportunities and strengths. While there are many differences between constituent groups, the SPGPPS model has enabled participants to find consensus and a way forward on many difficult and contentious issues.

Centralised Data Management System

A key success of the SPGPPS has been the development of an outcomes-based data collection and reporting mechanism, the Centralised Data Management System (CDMS). The CDMS is an achievement of the private mental health sector that should not be underestimated and is very relevant to this term of reference.

Under the CDMS, participating Hospitals collect two measures of patient's clinical status at key occasions during the provision of care: Admission and Discharge from episodes of Overnight inpatient care; Admission and Discharge from episodes of

Ambulatory care (eg, day programs); and where episodes of care are extended over longer periods, at Review every three months.

The two measures of clinical status are: a twelve item clinician-completed rating scale, developed by the Royal College of Psychiatrists (UK) and known as the HoNOS, and; a fourteen item patient-completed questionnaire, derived from the Medical Outcomes Study Questionnaire used in the Rand Health Insurance Experiment (USA), and for convenience known as the MHQ-14. This clinical data is recorded and then linked with data collected under the Hospital Casemix Protocol (HCP) using the Hospitals Standardised Measures database (HSMdb) software provided to participating hospitals by the CDMS.

The two sets of linked data are then submitted, in a de-identified format, to the CDMS by hospitals. The data submitted by all participating hospitals forms the basis for the Standard Quarterly Reports that are prepared and distributed to hospitals and health funds by the CDMS.

In accordance with the specifications in the SPGPPS's National Model, reports are prepared for the purpose of providing information to support improvements in the quality, effectiveness and efficiency of private hospital-based psychiatric services.

Discussion around the collection, reporting and benchmarking of outcomes-based data has been ongoing in the health arena for some considerable time. Together with the SPGPPS, private mental health facilities have made this discussion a reality.

National Hospital Cost Data Collection

The APHA Psychiatry subcommittee has been concerned to learn that the Department of Health and Ageing has decided to withdraw funding for the National Hospital Cost Data Collection (NHCDC) in relation to private hospitals, including private mental health facilities.

The Department will continue to fund the NHCDC in relation to public hospitals. The net result of this decision is that the Department will retain ongoing knowledge of the costs of public hospital care but will forgo this knowledge about the private hospitals sector. There data collection will also no longer provide a basis for comparison of costs across the two sectors.

Concluding Comments

Private mental health facilities, as part of the broader private hospitals sector, are delivering on the promise of a unique Australian, balanced health care system, meeting growing community expectations about quality, choice, safety, access and affordability and thereby avoiding the fiscal extremes of health systems such as those operating in the United Kingdom and in the United States, both of which have problems of access and sustainability.