Additional information requested at public hearing of the Senate Select Committee on Mental Health held 4 July 2005

1. Inconsistencies between private health insurance funds: exclusions and restrictions on benefits for people with mental illness

The information below relates to Question on Notice 1 (page 52 of the *Proof Hansard*) and Question on Notice 2 (page 54 of the *Proof Hansard*).

Inconsistencies in health insurance products

In its submission to the Senate Select Committee on Mental Health and during its appearance before the Committee on 4 July, the APHA Psychiatry subcommittee voiced its concerns that private health insurance funds are not providing a consistent coverage of services for people with mental illness. The APHA Psychiatry subcommittee has conducted a survey of member hospitals to obtain their feedback on inconsistencies and gaps in coverage of private health insurance for patients with mental illness and the following information is provided to assist the work of the Committee.

Schedule 1 (Conditions of registration of an organisation) of the *National Health Act 1953* sets out the requirements that must be met by private health insurance funds. One of these conditions (paragraph bf) is a requirement that all private health insurance products must include benefits for psychiatric care, rehabilitation care and palliative care. Another requirement (paragraph ja) is that the waiting period that a fund may apply before benefits are payable for psychiatric care, rehabilitation care and palliative care may not exceed 2 months.[1]

These two requirements indicate clearly the importance that the Parliament places on ensuring that private health insurance meets the needs of people with mental illness.

The APHA Psychiatry subcommittee contends that a number of private health insurance funds have found creative ways around these two legislative requirements by introducing 'benefit limitation periods', 'restricted benefit periods' or similar restrictions on benefits. Under a waiting period, no benefits are payable. Under a benefit limitation period or a restricted benefits period, a fund imposes an additional waiting period, in some cases for the entire life of the policy, before full benefits are payable for mental health services.

A list of these restrictions is attached for the Committee's consideration. Indicative examples include:

[1] http://www.comlaw.gov.au/ComLaw/Legislation/ActCompilation1.nsf/current/bytitle/D998D6A3D896D59BCA2570300080FE72?OpenDocument&mostrecent=1

BUPA (HBA and Mutual Community Health funds)

- ✍ All health insurance products with the exception of "Ultimate Health cover" have restricted benefits for mental health services ranging from 1 year ("Top Hospital cover") to the entire life of the policy ("Hospital saver"); and

NIB

- ✍ Top hospital cover includes a limitation of 30 days per calendar year for same day admissions and a total of 65 days (same day and overnight admissions) in a calendar year which attract full benefits for mental health services

Of perhaps greatest concern to the APHA Psychiatry subcommittee are those health fund products targeted specifically at younger people that include restricted benefits for mental health services. Some such products actually restrict benefits for mental health services for the entire life of the policy. It is the view of the subcommittee that the incidence of mental illness among younger people and the inability of any person to foresee the future onset of illness render such health insurance products as not fit for purpose. Quite simply, such products should be prohibited by law.

Recommendation 1

All health insurance products that restrict or limit in any way the benefits paid for mental health services, including those that impose an additional qualifying period before full benefits are paid in excess of the statutory 2 month waiting period, should be prohibited by regulation. Such products are unsafe, discriminatory, and do not meet the needs of privately insured consumers.

Inconsistencies, restrictions and exclusions imposed by health insurance funds under their contracting arrangements with private hospitals

The other means by which health funds are circumventing the intent of the regulatory arrangements is via the contracting process (Hospital Purchaser Provider Agreements or HPPAs) with private hospitals. Feedback from private hospitals indicates that the following restrictions are being imposed by health funds specifically for the treatment of patients with mental illness:

- ✍ Refusal to fund Approved Outreach programs. These programs have been subject to an exhaustive assessment process overseen by the Australian Department of Health and Ageing and are developed in order to offer innovative means of meeting the needs of patients with mental illness. Treatment is provided in the patient's home or other locations that suit patients' needs

- ✍ Refusal to fund half-day programs (ie requiring all patients to attend full day programs even where a patient's individual circumstances may make this impossible)

- ✍ Restrictions on the number of days of mental health treatment that a patient can receive in a calendar year

- ✍ Restrictions on the number of same day programs that a patient may attend in a given period

- ✍ Restrictions or capping of the number of particular types of treatment that a patient may receive in a given period; and

- ✍ Redefining the length of stay for treatment of particular conditions to levels which are out-of-step with clinical practice

These types of restrictions and inconsistencies inhibit flexibility and innovation and severely limit the capacity of private hospitals to offer programs that meet the individual needs of each individual patient. In addition, there is a lack of certainty for patients with mental illness that their private health insurance will provide them with the cover they need at the times when they need treatment.

Perhaps most importantly, these restrictions and limitations are not always disclosed to consumers but only become apparent when a course of treatment is recommended by the patient's treating clinician. Furthermore, because these limitations and restrictions are imposed by private health funds through the contracting (HPPA) process there is no external scrutiny of them by any Government agency.

Recommendation 2

Private health insurance funds are currently subject to five performance indicators with oversight provided by the Department of Health and Ageing. An additional performance indicator should be developed requiring each private health insurance fund to report annually to the Department of Health and Ageing on the limitations and restrictions on services for patients with mental illness that are included in any HPPA or similar arrangement with a private hospital. This would include, but not be limited to, the exclusions and restrictions listed above.

In addition, the consolidated report on these limitations and restrictions should be provided by the Department to the Australian Competition and Consumer Commission (ACCC) to assist the Commission in the preparation of its biennial report to the Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance.

Comments on evidence by the Australian Health Insurance Association to the Senate Select Committee on Mental Health

Evidence to the Senate Select Committee on Mental Health provided by representatives of the Australian Health Insurance Association (AHIA) on 4 July indicates that it is perhaps the chronic nature of mental illness that appears to disturb the private health insurance industry. For example:

"In many respects the problem is that it is difficult to get objective measures of the necessary treatments for mental health. They do vary and they do not lend themselves to, say, a surgical procedure. With a surgical procedure there is a very clear need and the procedure is done. In mental health there is a need for treatment there is no doubt about that, but the questions is: if you are paying for it, how confident can you

feel that what you are paying for is delivering a proper outcome or is it simply a way of ensuring a cash flow to the people who provide it, without getting the outcomes that you might believe are in the patient's interest." [2]

Leaving aside the gratuitous insult to doctors and private hospitals providing mental health services, this is an intriguing perspective given that private mental health facilities have actually led the development and implementation of outcome measures of care through the independent Centralised Data Management System (CDMS). As the APHA Psychiatry subcommittee advised in its submission, 93% of private hospitals with psychiatric beds collect and report outcomes data to the independent CDMS. As the CDMS is also well-used by health funds, which scrutinise each report on hospital activity, Mr Schneider's comments above indicate that he is out-of-touch with current activity in the private mental health sector.

In addition, this perspective is clearly not informed by the facts, given that less than 4 cents in every dollar paid in benefits by private health insurers actually funds services for people with mental illness. Also, over the decade since 1993-94, the number of specialist private mental health facilities has fallen from 27 to 25, while the number of beds has increased very marginally, by 2% or 32 beds. Over the same period, the number of mental health wards/units located in medical/surgical private hospitals has fallen from 21 to 19.[3] Clearly, if the provision of private mental health services is all about the provision of cash flow and funding the "most lucrative form of treatment" (as described by the AHIA in its submission to the Committee) the trend would be moving in the other direction.

In this context, it is worth noting data contained in the AHIA submission to the Committee in which it compares the average cost per separation for Mental Diseases and Disorders, across the private and public sectors. The AHIA figures indicate that the cost per separation is approximately 28% lower in the private sector for overnight episodes and around 150% lower for same day admissions. These differences are no doubt due to a number of factors but the health insurers' own data would appear to indicate that the private mental health sector is certainly not overfunded nor are patients being hospitalised for unnecessarily long periods of time as is stated or implied in the AHIA's evidence and in its submission.

The AHIA makes reference at several points in its evidence and its submission to what it regards as regulatory limits on the types of services that can be funded from hospital insurance tables. Private mental health facilities do not believe that all services need to be delivered within hospital walls. Indeed, this is a key reason why many private mental health facilities have developed innovative outreach programs that can be delivered in a setting that best suits the needs of the individual patient. However, the acceptance of these programs by private health insurance funds has been very disappointing, despite these programs having been subject to an exhaustive assessment process overseen by the Australian Government Department of Health and Ageing.

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[2] Senate Select Committee on Mental Health, *Transcript of Evidence*, 4 July 2005: p. 61-62
[3] Australian Bureau of Statistics, *Private Hospitals*, 1993-94, 2003-04

An insight into why this has occurred can be found in the submission by the AHIA to the House of Representatives Standing Committee on Health and Ageing's Inquiry into Health Funding. In this submission there are a range of proposals for out-of-hospital services that insurers might like to fund which would either seem to duplicate Medicare or appear remarkably similar to the sort of services/programs many health funds are refusing to fund at the moment under the Approved Outreach program.

Interestingly, the AHIA submission also includes the following recommendations:

"Health funds should be permitted to pay for medical or other health or health related services outside hospital ***at their discretion****"; and*

"the new environment should be permissive rather than mandatory: ***i.e. insurers should be able to choose whether and which services they will fund…".***[4] (emphasis added in both points)

Clearly, such proposals can lead to only greater inconsistencies between health funds and accompanying gaps in treatment available for people with mental illness.

As was detailed in APHA's submission to the Committee's Inquiry, the private mental health sector provides a wide range of vital treatments for privately insured patients with mental illness. However, its capacity to continue to meet the needs of all patients, for example through the provision of innovative programs and co-ordination of services across the continuum of care, is hamstrung by the lack of flexibility and lack of consistency by private health insurance funds.

[4] Australian Health Insurance Association, Submission to the House of Representatives Standing Committee on Health and Ageing, Inquiry into Health Funding: p.2-3

Analysis of private health insurance fund products with mental health restrictions*

Health Fund	Name of Product	No Mental Health Restrictions	Mental Health Restrictions	Waiting Period	Comments	
AHM	Step One Hospital	X		12 months		
	Hospital Cover	X		12 months		
	Basic Hospital		*	12 months	refer note 1a	
Australian Unity	Comprehensive Hospital Cover	X		12 months		
	Basic Hospital		#		refer note 2a	
	Smart Combination	X		12 months		
	Smart Start Cover		*	12 months	refer note 2b	
CBHS	Hospital a	X		12 months		
	Hospital b		*	12 months	refer note 3a	
	Hospital c		*	12 months	refer note 3a	
Grand United	Premier Hospital	X		12 months		
	Priority Hospital		*	12 months	refer note 4a	
	Price Point Hospital		*	12 months	refer note 4a	
	Primary Hospital		*	12 months	refer note 4a	
HBA	Top Hospital Cover		*	12 months	refer note 5a	
	Hospital Saver		*	12 months	refer note 5b	
	Hospital Saver Plus		#		unknown	
	Family Essentials Hospital Cover		*	12 months	refer note 5c	
HBF	Top Hospital	X		12 months		
	Intermediate Hospital	X		12 months		
	Healthy Saver Hospital		*	12 months	refer note 6a	
	Young Singles Saver Hospital		*	12 months	refer note 6a	
	Basic Hospital		*	12 months	refer note 6a	
	55 Plus Twin Pack	X		12 months	refer note 6a	
	Smart Saver Twin Pack		*	12 months	refer note 6a	
	Young Singles Saver Twin Pack		*	12 months	refer note 6a	

Health Fund*	Name of Product	No Mental Health Restrictions	Mental Health Restrictions	Waiting Period	Comments	
HCF	Top Plus Cover	X		12 months		
	Hospital Savings		*	12 months	refer note 7a	
	Hospital Advanced Savings Cover		*	12 months	refer note 7b	
MBF	Budget Hospital	X		12 months		
	Standard Hospital	X		12 months		
	Healthsmart Hospital	X		12 months		
	Advantage Hospital	X		12 months		
	Premium Hospital	X		12 months		
	HealthLink		*	2 years		
	Hospital Healthlink Advantage		*	2 Years		
	Healthlink Classic		*	2 years		
	Healthlink Essentials		*	2 years		
	Corporate		*	3 years		
Medibank Private	First Choice Hospital		*	12 months	refer note 8a	
	First Choice Saver Hospital		*	12 months	refer note 8a	
	Smart Choice Hospital	X		12 months	co payments apply	
	Blue Ribbon Hospital	X		12 months	excess apply	
NIB	Gold		*	12 months	refer note 9a	
	Singles Plus		*	12 months	refer note 9a	
	Bodyguard		*	12 months	refer note 9a	
NIB	Top Private Hospital		*	12 months	refer note 9a	
	Couples Plus		*	12 months	refer note 9a	
	Safeguard		*	12 months	refer note 9a	
Teachers' Union Health	Ultimate Choice	X		12 months		
	Easy Choice	X		12 months		
	Total Care Hospital	X		12 months		
	Basic Hospital	X		12 months		

Note 1
a) restricted services
Note 2
a) not suitable for Private Hospitals
b) only available for same day procedures or when treatment is required as a result of an accident
Note 3
a) Limited benefits payable. There will be significant out-of-pocket expenses when treated in a Private Hospital.
Note 5
a) Limited benefits are payable during restricted benefit period - 1 year.
b) Restricted benefits for the duration of this cover
c) Benefits are not adequate to cover Private Hospital costs.
Note 4
a) Limited benefits payable.
Note 6
Will pay psychiatric benefits for treatment with approved programs, however this is not usually 100% cover. Limits apply to some day programs.
a) Limited hospital benefits cover the cost of a shared room in a public hospital
Note 7
a) An annual time applies , 30 days per person per calendar year. A lifetime limit applies, 100 days in a person's lifetime.
b) Minimum benefit on all psychiatric conditions treated in a private hospital. Benefits vary by hospital, state and length of stay.
Note 8
a) Restricted services
Note 9
a) Day only basis, up to 30 days per calendar year. Overnight basis, up to 65 days (day and overnight included in this 65 day limit.) .
Once these limits have been reached or where readmission or psychiatry and rehabilitation occurs within the same calendar year lower benefits are payable

*Sources and caveat:

All care has been exercised in the preparation of the information in the table above, which has been sourced from private health insurance fund websites. However, due to the complex nature of health fund products and the lack of clarity of the information on some health fund websites, caution should be exercised in the use of the information.

2. De-funding of the National Hospital Cost Data Collection in relation to private hospitals

Attached as a separate document is correspondence from the Australian Department of Health and Ageing in relation to its decision to cease funding for the National Hospital Cost Data Collection in relation to private hospitals. This information relates to Question on Notice 3 (page 58 *Proof Hansard*).