STRATEGIC PLANNING GROUP FOR
SPGPPS
PRIVATE PSYCHIATRIC SERVICES

INNOVATIVE MODELS WORKING GROUP

DISCUSSION PAPER

THE ASSESSMENT OF MODELS

OF

FUNDING SERVICE DELIVERY

FOR

PRIVATE PSYCHIATRIC SERVICES

INTERIM DRAFT

AUGUST 2005

INSTRUCTIONS TO READERS

This year, the Strategic Planning Group for Private Psychiatric Services (SPGPPS), Innovative Models Working Group (IMWG) has been meeting to prepare a Discussion Paper to assess models for funding service delivery for private psychiatric services. The IMWG's brief in developing the paper is to propose **options** that are feasible and practical for private sector stakeholders.

It was originally intended that a final draft of the Discussion Paper would be submitted to the SPGPPS toward the end of 2005. All being well, the Discussion Paper would then be available for public comment and debate early in 2006.

After the June 15 2005 IMWG Meeting, however, the SPGPPS was asked to consider the recent deliberations of the Promoting Private Health Group (PPHG), which is comprised of the Australian Medical Association, the Australian Private Hospitals Association, the Australian Health Insurance Association and the Catholic Healthcare Association. The PPHG is particularly interested in putting practical options to the Australian Government's Minister for Health and Ageing before the end of the year that would enable the extension of private health cover to improve access to psychiatric care. At the 4 July 2005 PPHG meeting it was agreed that the IMWG would accelerate the development of its Discussion Paper, with a draft to be completed by end of August 2005. Accordingly, the 14th IMWG meeting was rescheduled for 14 July 2005 to enable the IMWG to revise its work program and undertake further development of the Discussion Paper.

This current draft of the Discussion Paper was completed after the 15th IMWG Meeting held on 9 August. It will be provided to the PPHG at the end of August 2005 as work on options that could be progressed in the shorter-term has been largely completed. However, the bulk of the Discussion Paper addresses options that will require consideration and development over the longer term.

The IMWG is now at a stage in the development of this paper where your critical and constructive comments are required. The purpose of seeking your feedback at this stage in the development of the paper is NOT to obtain your endorsement of any particular model. Rather we ask you to carefully consider the benefits, costs, hazards and possible unintended consequences that may be associated with each option and provide the IMWG with your views.

Please forward any comments you might wish to make to the undersigned by close of business on **Friday, 23 September 2005**.

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EXECUTIVE SUMMARY

In 2003, the SPGPPS established the IMWG to encourage the uptake of innovative models of mental health care and funding in the private sector and to enhance co-ordination of care between general practitioners (GP(s)), psychiatrists and private hospitals.

To achieve that goal, IMWG developed a set of *General Principles and Recommendations*, which were endorsed and adopted by the SPGPPS in June 2003. These General Principles supported the substitution of overnight admitted patient care with less restrictive models of care, where those less restrictive models of care resulted in the improvement, or at the very least maintenance, of the quality of patient care and the overall cost–effectiveness of service provision.

In progressing the *General Principles and Recommendations*, it became clear that markedly different views were held in the private sector concerning the practicality, efficacy and feasibility of such models. In response, the SPGPPS significantly broadened the IMWG Terms of Reference in 2004 to increase the focus on the merits, or otherwise, of different models of care and funding and the barriers to their uptake in the private sector.

To inform this work in 2004, the IMWG invited providers, funders, and consumers and their carers, to put their perspectives on alternative models of mental health care and funding to the SPGPPS. At the 36th SPGPPS Meeting, held in March, private health insurance funds (Health Funds) provided their perspective. This was followed by presentation of psychiatrist's perspectives, and that of consumers and their carers, at the 37th Meeting of the SPGPPS in September 2004. Private hospitals with psychiatric beds (Hospitals) and the Department of Veteran's Affairs presented their perspectives in November, at the 38th SPGPPS Meeting.

On 7 February 2005, the IMWG met in Canberra to analyse these different perspectives. In doing so, the IMWG considered several models of funding service delivery including:

1. Program-based Model;
2. Case Management Model;
3. Prospective Payment Model; and
4. Outreach Model.

The outcome of that meeting was agreement for the IMWG to prepare this Discussion Paper to assess models of funding service delivery for private psychiatric services and a further meeting was held on 15 June 2005 for that purpose.

The discussion paper firstly identifies what are the agreed fundamental expectations of consumers, and their carers. It then goes on to discuss some of the options available for the funding of comprehensive models of service delivery that would enable the needs of consumers and carers to be most effectively met. Certain of the options could be implemented or at least trialed in the short term whilst the remainder will most likely require further consideration and debate. Any legislative or regulatory constraints, and how they might be addressed, are also discussed.

A detailed economic analysis of the funding models proposed exceeds the scope of this paper. It is proposed that consideration be given to the appointment of an appropriately qualified health economist to undertake this function.

1 FUNDAMENTAL EXPECTATIONS OF CONSUMERS AND THEIR CARERS

1.1 Introduction

The National Network of Private Psychiatric Sector Consumers and their Carers (hereafter National Network) represents Australians who contribute to private health insurance funds (Health Funds) and who receive treatment and care within the Australian private sector, for their mental illness or disorder. 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 is the authoritative voice for consumers and carers concerning the policies and practices of provider and funder organisations within the private mental health sector.

People who access mental health services within the private sector generally report good continuity of treatment and care. However, they do have to contend with issues different to those that public sector consumers face, such as the impact of private health insurance legislation. Of note, funding arrangements between hospitals and health funds change from time-to-time and these can have a bearing on the accessibility of services.

The National Network has welcomed the opportunity to participate in the development of this Discussion Paper. The National Network will continue to work in a positive way with providers and funders to ensure that consumers and their carers have direct input into how the services they currently receive are delivered and funded, and any changes to those arrangements that might be proposed.

It is clear that the lived experiences of consumers and their carers provide an essential 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. Therefore, models of service delivery and their associated funding mechanisms must be judged on their capacity to meet the fundamental expectations of consumers and their carers. Services must:

- **facilitate continuous and coordinated high quality care that is delivered by a range of services across a variety of settings;**
- **provide access to a range of specialist treatment and support services;**
- **respond to the needs of consumers and their carers in a timely and efficient manner that promotes recovery and support gains made;**
- **provide a choice of treatment programs;**
- **provide the most facilitative environment for appropriate treatment and care;**
- **prevent co-payments and out-of-pocket expenses[1]; and**
- **protect patient privacy and confidentiality.**

The National Network understands that there are some very complex legislative and regulatory arrangements, together with other economic issues that may prevent the funding of the full range of services that consumers and carers can envisage. Accordingly, the following four key areas have been identified as crucial in addressing the expectations identified above.

[1] Co-payments and out-of-pocket expenses may be a health insurance product issue arising from choices made by a consumer.

1.2 Key Area 1: Effective involvement of and support for Carers

Models of service delivery are required that ensure the meaningful engagement of carers by facilitating the provision of *education, practical information, support*, and *inclusion*. Carers need *education* about mental illnesses and *practical information* on issues such as self-care; conflict resolution; negative emotions towards the one they care for, and personal relationship issues, particularly partner relationships. Carers require *support* for their own needs and must be *included* in admission and discharge processes of private psychiatric hospital-based services, and in psychiatrists' office-based practice.

1.3 Key Area 2: Access to alternatives to private hospital-based care

Consumers and carers need models of service delivery and funding innovation to provide access to a comprehensive range of alternatives to private hospital-based inpatient care. These should include early interventions that aim to prevent the need for hospital admission in the first instance, together with other service models that aim to reduce length of stay and the need for re-admission. The latter would include services such as approved Outreach programs and community-based services. In situations where such alternative services are not available at a particular private psychiatric hospital, then models must support appropriate referral processes to one that does. Innovative models must also be introduced to private psychiatric hospitals to enable the provision of appropriate electronic or telephone support services for consumers *and their carers* living in rural and remote areas of Australia.

1.4 Key Area 3: Post discharge and rehabilitation services

Funding arrangements need to support post discharge and rehabilitation services that enhance social rehabilitation and reduce isolation and loneliness.[2] Clearly, these services are based on the premise of inpatient service alternatives aimed at reducing the need for hospitalisation, and work toward the ultimate aim of self-management, or recovery. These services need to provide programs that include such things as coping skills for living with mental illness. Relapse prevention strategies are imperative, as are supports to improve quality of life. Dealing with living skills and functioning in the family context, in the community, and life activities are also paramount when considering types of services and models of care.

1.5 Key Area 4: Hospital-based Clinical Psychologists

There is an imperative that the services of clinical psychologists be available to consumers in the hospital setting. Clinical psychologists provide various forms of psychological intervention. The costs of accessing psychologists' office-based practices can be prohibitive, particularly in situations where consumers, because of their choice of health fund products, are not rebated or rebated at a low level by their Health Funds.

1.6 Other service needs

While the four key areas identified above are considered a priority by the National Network, some of the other programs and services consumers and carers believe will enhance positive consumer outcomes are set out below.

Discharge services

Urgent review of current Commonwealth Medicare Benefits Schedule funding arrangements to facilitate the involvement of carers in processes, including discharge from psychiatrists'

[2] See SANE Australia. Mental illness and social isolation. SANE Research Report 1, 2005. This paper is available from www.sane.org.

office-based practice, and models of service delivery and funding need to ensure the involvement of consumers and their carers in discharge processes from private psychiatric hospital-based services.

Informal drop-in type services

If this type of service can be provided in the private sector, consumers and carers believe it can assist in the difficult task for consumers of re-joining society and enhancing quality of life through alleviation of isolation and loneliness. Such services should be based on a non-threatening model that promotes active participation in social and vocational rehabilitation.

Family therapy

Programs are strongly recommended which promote and support family relationships. Mental illness places massive and negative stressors on relationships, particularly partner relationships. Additionally, medications used to treat mental illness can interfere with a large range of personal issues. There is an urgent need to provide access to such programs to both consumers *and carers* alike. When the family unit becomes dysfunctional, this often creates an environment that exacerbates mental illnesses, with poorer outcomes.

24-Hour 7-Day on call/mobile crisis intervention services

There is an urgent need for models of service delivery and funding arrangements to support them, to enable consumers and *their carers* to access these types of services in the private hospital-based setting. It is acknowledged there are different forms of acute crisis intervention services provided in the public sector, but sometimes access is difficult.

Diversional Therapy

Models that recognise that the promotion of creative arts is an important part of therapeutic processes have strong support from us.

Dialectical Behavioural Therapy

Consumers and carers feel very strongly, that models of service delivery and funding need to be able to support different treatment modalities that have been shown to be effective, such as Marsha Linehan's model for people living with personality disorders and life skill issues.

Case managers

Consumers and carers strongly supports models of service delivery and funding that support case managers provided from within the hospital-based setting, to oversee a consumer's treatment and well being as part of continuity of care particularly after a period of hospitalisation. This is a model that is well recognised in the public sector, as being efficient and effective. There is added imperative particularly in cases where a consumer has a chronic, or treatment resistant mental illness.

2. PSYCHIATRIST'S PERSPECTIVE

2.1 Introduction

Psychiatrists wish to reinforce the points made in their presentation to the SPGPPS concerning Innovative Models development. To summarise the important principles, we believe that the private mental health system is a complex system, which is balanced in a particular way at present, which has led to high effectiveness and high cost-efficiency. Positive outcomes have been achieved for patients, as measured on discharge, by reference to the SPGPPS Centralised Data Management Service's Outcome Measurement database. Any

changes to the homeostasis of the system at present may lead to cost inefficiencies and poor outcomes, and so we advocate for evolutionary change, not revolutionary change.

As part of that change process, it is important to start with consumer and carer preferences for change, and then move from that basis, to the development of models that are likely to work as a complement to the present system. Ethical and moral hazards should be considered when developing new models, and the clinician's imperative to "First Do No Harm" is important to consider as part of such a standpoint.

An area of tension is the fact that current private health insurance arrangements focus on admitted patient care, that is provided either in the hospital or under the hospital's duty of care, in the home. Besides the fact that Hospital Tables are legislatively restricted to providing insurance for hospital costs only, it is natural and reasonable that Health Funds should act within such limitations. Otherwise, any Fund that proposed to ignore such restrictions would be likely to either be non-financial in a short period of time and/or facing compliance action (by the Minister or his Delegate).

Australians purchase health insurance products on the basis they can be readily admitted to hospital, if they require it. It would be perverse and probably counterproductive in the long term, if we developed systems that limited hospital-based care where it was clinically indicated and where substitution would not result in an outcome of the same quality.

It is one of the sharp contrasts between the public and private mental health sector, that in most jurisdictions throughout Australia, consumers can achieve private psychiatric hospitalisation when they really need it. Whereas, consumers of public mental health services often cannot achieve such psychiatric hospitalisation, even when they are desperately unwell, as evidenced by acutely unwell psychiatric patients in many jurisdictions around Australia, having to spend long periods receiving 'treatment' in an emergency department. At present, South Australia and Western Australia are the only two jurisdictions that we are aware of, where some private sector bed access issues have been reported.

Responsibility for developing options for any new and innovative funding models should not rest solely with Health Funds. A number of different funding options should be considered. Such funding options may include self or family funding (eg. for psycho-education services), but other options may be worth considering. It may be possible through innovative development of private office-based practice for a number of extended service delivery programmes to be offered via Commonwealth Government funding. The Health Funds may have an interest in part funding of such projects. If pilot studies or pilot projects are undertaken, it is important there is some commitment to ongoing funding of such initiatives, if successful, to ensure valuable work and progress is not lost.

2.2 Major Recommendation: Health Insurance Reform, Introducing Full Lifetime Community Rating

In the process of discussion in IMWG, psychiatrists have been made aware of severe economic and structural problems faced by private health insurance funds. Health Funds are facing increasing demand for services (including for mental health services), but their premium base is not tending to increase to match the demand for services. There is strong political pressure to keep premiums down, and yet health care costs will rise. An inevitable economic crunch is likely to occur unless this issue is addressed. This economic pressure is likely to drive Health Funds to try to inhibit cost escalation, and if desperate enough, the funds may act to limit costs in less politically popular health areas like mental health, with major adverse patient outcomes.

Psychiatrists therefore believe that problems in funding for appropriate care in less politically popular health care areas like mental health will require major Australian health insurance reform. In particular, full lifetime community rating within private health insurance should be implemented. Private health insurance becomes viable when a particular age group population cohort contributes premiums for their health care throughout their working lives. Premiums they commence paying at 20 to 25 years old are likely to remain similarly low throughout life. Their contributions truly are sufficient to cover their later health care needs. Full health services can be provided; even ones that people don't like to think about needing: like mental health care. It is unlikely that Health Funds will advocate for such reform by themselves, so government action and regulation will be necessary.

2.3 The Issue of Further Economic Analysis

It would be helpful to undertake some broader economic analysis of the private mental health sector to provide a firm ground on which to base innovative model evaluation. If innovation is desired in order to limit costs in psychiatric care, then some analysis of that, given the reported level of unmet need, seems appropriate. If innovation is desired in order to create more allied health service availability in the privately insured community, then there may be other cost effective strategies to achieve that. Further economic analysis with economic modelling of outcome scenarios would assist decision-making.

Psychiatrists have expressed concerns about capitation models as recommended by Health Funds. Capitation contains the severe moral hazard that health service providers are put in the position of deciding between self-interest and patient interest. There is also a problem that capitation may over time stifle innovation, because new treatment approaches which are likely to cost more initially, are not taken up. Capitated health care has been trialled extensively in the USA, and in a more regulated and slightly softer capped manner in public sector Australian health care. Neither situation could be viewed as a shining example of success.

Psychiatrists would prefer to see only limited extension of Health Fund coverage to outpatient care, and then only with meaningful external controls. The Health Funds have limited expertise in this area, there is a risk of diminished funding for essential inpatient services, and a risk of decreased innovation through vertical integration.

2.4 Psychiatrists Already Share Financial Risk Through Fee Discounting

Private psychiatrists are often seen by Health Funds to NOT be sharing in the economic risk associated with patient care in hospital. Private psychiatrists do not participate in the contracts occurring between hospitals and Health Funds. Psychiatrists therefore have no obligation to share the financial risk of an inpatient stay. Patients share indirectly in those contracts through contracts they have entered into with their Health Funds.

It is useful to Health Funds, that they do not have significant contracts with private psychiatrists. This situation allows the Health Funds to avoid much moral hazard, and the Funds can justifiably claim that they do not significantly adversely influence the treatment offered to patients. Psychiatrists may, to a limited degree, enter an agreement with a Health Fund to accept a certain fee schedule for inpatient fee-for-service visits, so that the patient experiences a "no-gap" bill for a hospitalisation. Psychiatrists have eschewed contracting with hospitals and Health Funds at a deeper level to avoid the resulting conflict of interest that might adversely affect their unswerving intent to treat a patient in the very best way possible.

Private psychiatrists do in fact share the financial risk of caring for a patient to a much greater degree than hospitals or Health Funds might do, especially when the financial risk is considered in proportion to the income generated by the psychiatrist. The reason that the risk is not visible to Health Funds (or to a lesser extent, hospitals) is that the psychiatrist's care (and financial risk) is not confined to the brief time of hospitalisation, but can extend over a period of years, for treatment of a chronic or treatment resistant condition. It is common therefore for psychiatrists to discount the fees charged to patients who are financially disadvantaged, or who have high medical related costs. Direct evidence for a high level of discounting comes from many years of Medicare statistics relating to private psychiatrist services, which indicate that psychiatrists have bulk billed their patients to a similar extent as Australian GPs. Private psychiatrists are already contributing more than sufficiently to financial risk sharing. Psychiatrists reject the argument that they have an obligation to share in financial risk for hospitalisation. That said, psychiatrists have a responsibility to incorporate any concerns identified by Health Funds or hospitals about their practices, or cost implications of them. Mechanisms for review of psychiatrists' aggregated and de-identified practice patterns could readily be set up under SPGPPS and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) structures.

Psychiatrists would like to present the following innovations for a progressive evolution of a system of mental health care in the private sector that may be able to work more seamlessly for the benefit of consumers and carers. A number of new initiatives are suggested and the types of legislative requirements that may be necessary in order to implement those new initiatives are identified. Direct recommendations concerning the way that Health Funds and hospitals might develop contracts are avoided. Psychiatrists do not have sufficient information or expertise to produce adequately nuanced economic models. However, we have commented in detail under the relevant section below, regarding our assessment of the models suggested by hospitals and Health Funds.

2.5 OPTIONS

Option 1 Improve Remuneration for Consultations with Carers

A review should occur of the item numbers, which are available, under the Commonwealth Medical Benefits Schedule (CMBS), for services to carers of patients being treated under that schedule for mental illnesses. There are two existing item numbers available under the schedule so that relatives or carers of people with mental illnesses can be seen by psychiatrists without further referral of those people from the GP, and without specific patient referral being required. Those items are used occasionally, but not used a great deal. There are a number of reasons that those item numbers are not used more commonly. One reason is that there are limited timescales incorporated into the two item numbers available. Another reason is that the rebate provided for remuneration to the psychiatrist is so inadequate, that it is often more convenient to see the relatives with the patient, and not provide separate billing administration functions required if the carer were seen separately. That tends to mean that the relatives or friends will be seen always together with the patient, which in general is not a bad thing. However, it discourages the possibility of more intensive education programs for the relatives and carers of those suffering mental illnesses.

It is necessary to allow longer, and better remunerated consultations with carers of the patient, and that there should be more such items available in any separate calendar year than are available at present. The rebates for such consultations should be significantly increased, and should be made much closer to, or greater than the rebate available for seeing the patient themselves. These changes would be likely to make the inclusion of carers in the therapeutic process much easier.

Option 2 New Item Numbers for Allied Health Professionals Under Medicare Funding

CMBS item numbers could be made available under limited circumstances, for consultations provided by allied health professionals under the supervision of psychiatrists. Such professionals might include clinical psychologists, psychiatric nurses, social workers and occupational therapists, but only on referral from a psychiatrist who has assessed the patient. Occasionally other professionals may be appropriate to include, such as physiotherapists. This initiative would allow private psychiatrists to be able to extend their capacity to treat people, and therefore improve access to the services of private psychiatrists for both people with private hospital insurance, and also those without.

We would suggest that such rebate should be available under limited circumstances. There is a good initial model available within the Better Outcomes in Mental Health Program (BOiMH), as it applies to allied health professionals working with GPs. It is understood that under a private psychiatrist initiative, the allied health professionals would be working not in primary care, but would be working together with the private psychiatrists in a secondary care model. It is suggested that such rebates would only be available in batches of a limited number of consultations, such as 10 to 15 sessions, after referral from the private psychiatrists in a formalised way, similar to the referral system that occurs between GPs and other specialists already.

Whilst the rules around such item numbers would need much more extensive development, it would be suggested that the psychiatrist would remain professionally in charge of that patient throughout the time of their care, whether being seen by the private psychiatrist specifically, or after referral to the allied mental health professional. There should be a requirement that a meeting, at least by teleconference, would occur with the allied health professional on a regular basis, such as every five sessions, so that the progress of the treatment by the allied professional can be monitored and adequately supervised by the psychiatrist, and to ensure a team-based best practice result. Psychologists under this scheme would be restricted to members of the Australian Psychological Society College of Clinical Psychologists, those psychologists being trained for work with people suffering from psychiatric illness.

Such an item number would recognise that many mental illnesses and problems are ongoing, or at least take some years to achieve full recovery, or well maintained health. Longer term specialised mental health interventions are necessary to achieve good recovery outcomes, and prevent hospitalisations. Some GPs may also participate in such longer-term management processes, but there, the medico-legal and CMBS arrangements are already well defined. Such an initiative has the possibility of radically reducing the unmet need for mental health intervention in our community. The benefits would not be confined to the privately insured sector consumers. However, it would be likely that many of the initial working arrangements would be developed between private psychiatrists and allied health professionals working in association with private hospitals, because the competency of such allied health professionals would be known to the psychiatrists, and could be relied upon.

Option 3 A Health Insurance Fund Financed Allied Health Initiative

A new opportunity has arisen during the process of discussion by the IMWG. The Promoting Private Health Group has suggested that it would be useful to include referral to psychologists as part of product enhancements in the private health insurance area. Whilst extras cover includes some of such services at present, the intention was to introduce the services more intimately within the existing medical and hospital product arrangements. Private mental health services that are available under existing private insurance products are one of the major attractions for people taking out private insurance. An enhancement to such services, by the inclusion of allied health services supervised by private psychiatrists should

increase the attraction of such products.

It would be useful if any new enhancements to health insurance products were designed in such a way as to be likely to control cost blowout, and therefore avoid the risk of diversion of services from those with more significant illness. It would also be useful if any new product enhancements were designed to NOT require any great change in legislation, so that they could be implemented quite quickly, and provide benefits to consumers very rapidly.

The model outlined below has been designed as a rapid response to a perceived time of political opportunity. It is fortunate that the IMWG has been working exhaustively around these issues for at least a year before this recent proposal. Whilst the new proposal does not clearly conform to the model of development suggested by consumers and psychiatrists, it could benefit privately insured consumers, and strengthen private health insurance attractiveness.

The Suggested New Model

It is suggested that the new product enhancements would be advertised in the community, but before that, there would be specific education of both GPs and private psychiatrists in the implementation of the new enhancements.

The GP would see a patient who they believed might benefit from assessment by a psychiatrist, and possibly be eligible for the enhanced allied health contact. The GP would then refer that patient to a psychiatrist for assessment and necessary further referral. It is possible that such an assessment by a psychiatrist might represent a CMBS Item 291 type referral, which attracts a higher rebate for the patient. There may need to be some minor change to the rules surrounding this particular item number, to allow its use for such referrals from GPs.

The private psychiatrist would then assess the patient and assess the needs in a wholistic manner. If in the opinion of the psychiatrist (and probably this opinion should be expressed in writing) the referral to another allied health professional is likely to decrease the future need for inpatient treatment, either physical or psychiatric, then the psychiatrist would be able to refer that patient on to an allied health professional appropriate to the particular needs identified. The patient would be seen for up to ten (10) sessions by the allied health professional, and after that time, or beforehand if necessary, the patient would be further assessed by the psychiatrist. If necessary, and upon ratification by the psychiatrist, a further five (5) treatments by the allied health professional could be provided.

There would be no absolute specification of the allied health professional, because it is envisaged that a range of allied health professionals may be appropriate in different circumstances. Such flexibility is needed if this product enhancement is really going to add value to the care provided by a psychiatrist. Bear in mind that this treatment approach will be an enhancement of secondary treatment provided to the patient.

In many cases, it may be helpful to provide access to a clinical psychologist who is able to provide cognitive behaviour therapy for mild to moderate anxiety or depressive conditions, likely to become worse, and with probable future hospitalization required. It is possible that this enhancement could provide some additional consultations with a community psychiatric nurse, who may assist in long-term ongoing management of the patient, by providing more frequent supportive follow-up visits than the psychiatrist can provide alone. Such supportive treatment may very well prevent much hospitalisation. It may also be appropriate for a patient to be referred to a well-trained physiotherapist for treatment for problems such as conversion disorder, and other possible complex psychological and physical conditions.

If a broad range of allied health professionals is to be available, then it is envisaged that there may be need of a "Standards and Credentialing Group" with appropriate membership from learned bodies. An alternative strategy would be to limit the initial version of this model to only one group, such as clinical psychologists registered with the College of Clinical Psychologists of the Australian Psychological Society. As an added safeguard, the secondary care provided by allied health professionals in this model is under the strict guidance of the private psychiatrist, and we would encourage mechanisms to be put in place for the RANZCP to undertake extra training of private psychiatrists in effective case management.

The visits to the allied health professional would be paid for by the Health Fund with the understanding that there is a limitation on the number of services provided through Health Fund channels. If the full amount of such services are not to be covered by the Health Fund rebates, then it is important that informed financial consent be provided for the patient. It would be desirable that a wide range of allied health professionals are available for on-referral from psychiatrists, and that the range of professionals is not limited by artificial barriers, or preferred provider arrangements.

There would be encouragement for the application of outcome measurements to the process of referral and treatment. It would be expected that the psychiatrist would provide a letter of referral to the allied health professional, and a letter back to the referring GP explaining the treatment process. The psychiatrist would take on a case management role, and appropriate training mechanisms would have to be provided through the RANZCP.

Since the psychiatrist certifies their belief that the allied health services are likely to avoid future hospitalisation (either psychiatric or physical), there should be no need for time consuming legislative change, as it will be a service substituting for hospitalisation. There appear to be two possible legislative approaches that might be viable. There may be some room for the extension of existing legislative amendments, which were originally made to account for community outreach care under existing legislation. Another approach would be to utilize sections under the act, which have been developed in the past to allow trial projects to occur to test the viability of a new model of care.

Reinsurance is interesting, because the proposal is likely to involve younger people at least as much as it will involve older people. Since the proposal will move into treating the less obviously immediately sick cohort, these individuals are likely not to have been identified as high utilizers, certainly of psychiatric services.

Finally, another massive potential benefit may be to alter the perception in the community of "mental health services". If an appropriate advertising campaign is used, people may start to perceive the huge benefit that appropriate highly trained assessment, treatment and preventive mental health care can provide.

Option 4 Psycho-social Rehabilitation Projects

Another initiative that would be slightly more complicated, but could have significant benefits, would be the initiation of psychosocial rehabilitation projects in the private sector catering to both the private hospital insured group, but also allowing for some involvement of non-insured patients. This would require some negotiation with the State and Territory jurisdictions. Such programmes could be set up on a collaborative team based model, and possibly involve some non-government organisations as collaborators as well. It may be harder to prove that the involvement of private hospital insured patients in such programs would definitively prevent further hospital admissions, but an outcome measurement process could be involved in any such project, and it would be possible to monitor over a period of time whether there was a decrease in the number of hospital admissions as a result of such

rehabilitation processes. A decreased hospitalisation outcome would be highly likely. Perhaps these projects could be initiated on a pilot basis, until the positive results were provable, and the effective model was defined.

Option 5 Increased Private Psychiatrist Rebates

CMBS rebates for private psychiatrists have declined in real terms over the last 20 years. There has been a conscious policy of the Commonwealth to limit the increase of rebates for specialists other than GP specialists, which includes private psychiatrists. That policy has been successful in keeping CMBS rebates at a lower-level, and the consequence is that it is impossible to run an adequately resourced psychiatric practice infrastructure, if a psychiatrist charges at, or close to the CMBS rebates. It should be understood that many patients suffering from psychiatric illnesses, especially those that suffer from ongoing illnesses, are quite financially disadvantaged, even if they manage to maintain their private hospital insurance premium payments (or perhaps, particularly if they do so). Most private psychiatrists would apply some form of discounting to the fees charged to financially disadvantaged patients. Many private psychiatrists have in recent times increased the fees that they charge patients, particularly those patients that have employment. It is only possible to afford adequate secretarial assistance and other infrastructure management support, if one charges well above the rebate level to a significant proportion of patients in one's private practice.

It is inappropriate for the rebates to be kept artificially low when one is dealing with a population group, which is often financially disadvantaged, and where there is a significant amount of unmet need in the general population. The provision of treatment by private psychiatrists is much less expensive than public mental health care costs, particularly to government, and it would make sense to make some upward adjustments in rebates to match appropriate fees charged by the specialty, and which could easily be justified by information derived from the Relative Value Study. It is strongly recommended that rebates for private psychiatry services be increased, so that the burden to financially disadvantaged patients seeking treatment in the private sector can be alleviated.

3. ALTERNATIVE MODELS FOR FUNDING HOSPITAL-BASED PSYCHIATRIC CARE

3.1 Introduction

It is acknowledged that the current per–diem based funding models provide strong financial disincentives for hospitals to change from the delivery of services principally within the overnight inpatient service setting, to alternative settings, including sameday and outreach.[3] Accordingly, the IMWG seeks to encourage the development of new models of service delivery with associated funding arrangements that:

(a) Provide significant incentives for the implementation of evidence-based best practice models of service delivery that provide an appropriate mix of acute overnight inpatient, non-acute overnight inpatient, sameday and outreach services required under those models.

(b) Eliminate or significantly reduce incentives for the provision of unnecessary or inappropriate use of overnight inpatient care, or any other form of hospital– based, or

[3] See Willcox S. *Buying best value health care: Evolution of purchasing among Australian private health insurers.* Australia and New Zealand Health Policy 2005, 2:6. This article is available from: http://www.anzhealthpolicy.com/content/2/1/6.

other psychiatric care. Such 'innovative' models of service delivery and their associated funding arrangements should be judged on the following criteria.

1. The effectiveness with which the needs of consumers and their carers are met.
2. The efficiency with which the required services are able to be delivered.
3. The extent to which financial risk is equitably shared between providers and payers, or is controlled by other mechanisms.

It is also acknowledged that private health insurance funds and other payers are not able to fund all the services that it may be desirable to have available. Models of service delivery that clearly require increased expenditure by payers should also meet the following additional criteria.

4. The disease, syndrome or condition for which services are to be delivered should be a recognised psychiatric condition.
5. The proposed model of service delivery and its constituent therapeutic interventions should be based on evidence that they represent current best–practice.[4]

In this paper we identify the following five alternative models of funding of hospital-based psychiatric services.

3.2 OPTIONS

Option 1 Programme-based per-diem payment model.

Option 2 Casemix-based per-diem payment model.

Option 3 Casemix-based episodic payment model.

Option 4 Prospective case payment model.

Option 5 Bundled prospective payment model.

Each of these models is described in the following sub-sections. Of the five models described, the *Bundled prospective payment model* has been successfully introduced in South Australia (SA), and the *Casemix-based per-diem payment model* is now being introduced in Medicare-funded inpatient psychiatric facilities throughout the United States of America (US).

Option 1 Programme–based Per–diem Payment Model

With some variation across Health Funds and Hospitals, the most common payment model at present is one in which benefits for both overnight inpatient and ambulatory care are stratified by program and paid on a per–diem basis. Common programs are 'General', 'Drug and Alcohol', and 'Eating Disorders' etc. Patients are allocated to a program by the hospital in consultation with the patient's doctor. The benefit payable is calculated by multiplying the daily rate by the number of days spent in the program taking into account 'step down' points. These step down points are set on the basis of length of stay estimates per program. Limitations may also be applied to the number of ambulatory services including both sameday episodes and outreach visits.

[4] This does not imply that the model of service delivery or all of its components must be evidence–based in the strict sense of that term. It is acknowledged that many aspects of service delivery and certain therapeutic interventions used in psychiatry may not have a firm evidentiary base. Accordingly, this criteria specifies that services should be modelled on what can be shown to be recognised by authoritative clinical consensus to be current best practice.

The definition of programmes and their associated step–down points and ambulatory service limitations are not based on any generally agreed classification system or payment schedule. Accordingly, programme definition, step down points and ambulatory service limitations may vary from hospital to hospital and payer to payer. In principle, this inherent flexibility could allow substantial room for innovation by hospitals. However, providers that move from the delivery of services principally within the overnight inpatient service setting to alternative settings, including sameday and outreach, may face clear financial disincentives. In a strictly financial sense, this funding arrangement can make it costly for providers to change their practices. The corollary is that, for payers, the existing payment model exposes them to uncapped growth in the utilisation of overnight inpatient services and little capacity to give hospitals effective incentives to provide care in less restrictive or more efficient service settings. From a quality assurance perspective, the wide variation in programme definition makes it very difficult if not impossible to compare costs and outcomes for programmes across hospitals.

Option 2 Casemix–based Per–diem Payment Model

Under this model patients are classified under an agreed casemix classification system, for example, the Australian Refined Diagnosis Related Groups (AR-DRGs). A specific per diem payment schedule is agreed for each casemix group. Based on analyses of historical data, Health Funds and hospitals would, in the course of their normal commercial in confidence negotiations, agree the positioning of step down points as well as the quantum of benefits payable for each day.

This model is effectively that which is now being implemented, as of January 2005, by the Federal US Government's Centers for Medicare and Medicaid Services (CMS) in the Medicare funding of Inpatient Psychiatric Facilities. Initially, the CMS had pursued a casemix–based episodic payment model. However, under advice from the American Psychiatric Association, CMS undertook a detailed statistical comparison of the performance of per–diem versus episodic casemix–based payment models and concluded that the per–diem model was significantly better able to account for variations in costs.[5]

The principal benefit of this model, from the perspectives of both hospitals and payers, is that it provides a potentially less complex and very much more consistent basis for the negotiation of Hospital Purchaser Provider Agreements (HPPA(s)) and subsequently for the evaluation and comparison of hospital performance. However, it is important to note that existing Australian casemix classifications for ambulatory psychiatric services are poorly developed and generally apply only to admitted episodes, that is Sameday services.

Option 3 Casemix–based Episodic Payment Model

Under this model patients are classified under an agreed casemix classifications system (e.g. AR–DRG's). A specific per episode payment schedule is agreed for each casemix group. Based on analyses of historical data, health funds and hospitals would, in the course of normal commercial in confidence negotiations, agree the quantum of benefits payable for each episode. The principal feature of this model, and that which distinguishes it from per–diem based funding models is that hospitals share more equally in the financial risk associated with variations in patients' needs for care.

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[5] The primary source materials regarding the background to and details of this payment model can be obtained from the CMS web site. There are also a number of other papers from the American Psychiatric Association that provide useful background to the latter organisation's involvement in the development of the model.

The model also provides a potentially less complex and very much more consistent basis for the negotiation of HPPAs and subsequently for the evaluation and comparison of hospital performance. Casemix-based episodic funding has been implemented quite extensively in the private sector and in some jurisdictions in the public sector for acute general private hospital-based services.[6]

Again however, it is important to note that existing Australian casemix classifications for ambulatory psychiatric services are poorly developed and generally apply only to admitted episodes, that is Sameday services. The largely experimental MH–CASC classification does clearly define ambulatory casemix groups, but as yet there has been no opportunity to adequately examine the implications of its application in the funding of private psychiatric hospitals.

Option 4   Prospective Case Payment Model

Under this model, hospitals are paid a fixed sum for the provision of care to the patient for an identified period, most probably the twelve months following their initial admission to the hospital. The amount of the payment would depend on the initial assignment of the patient to one or other case classification. The prospective payment would be expected to cover all aspects of the patient's care as determined by the hospital in consultation with the patient's treating psychiatrist. Within that context of joint responsibility with the treating psychiatrist for the patient's care, the hospital is free to allocate that funding as required. The principal feature of this model, and that which distinguishes it from both per–diem and episode-based funding models is that hospitals take a much greater share in the financial risk associated with variations in patients' needs for care. It should be clear that the feasibility of this model depends almost entirely on the accuracy of the hospital's initial assignment of the patient to one or other case classification. Given that no existing case classification has been developed that can adequately account for costs at the episode level, let alone at the continuum of care level, it is unlikely that this model could in fact be effectively implemented. It is identified here so as to enable the features of the bundled prospective payment model to be more fully elucidated.

Option 5   Bundled Prospective Payment Model

In this Bundled Prospective Payment Model (BPPM), Health Funds and Hospitals would negotiate a bundled payment, which would then used by the hospital to provide care to *all* of the Health Fund's members who might require care in the period covered by the payment.

The quantum of the payment would be based on an analysis of the historical service needs of the Health Fund's members at that hospital in an agreed period preceding the drafting of the HPPA. The agreed period on which that analysis would be based might be twelve months. However, the analysis might also take into account expected changes in members needs, based on recent (e.g., over the preceding three years) historical trends in the demographic profile of the Health Fund's membership in the hospital's catchment area and in changes in the provision of services by the hospital to the Health Funds' members. The period to be covered by the Bundled Prospective Payment (BPP), and the frequency with which it is to be renegotiated, is determined by the parties to the individual HPPAs.

Financially, the most important feature of the model is that during the period over which the BPP is fixed, hospitals share equally with health funds in the financial risk associated with variations in members' needs for care. Both parties would also agree a range of Key Performance Indicators (KPI's) that would apply and which would address matters such as

6 A useful overview can be found in *Walker (2004) Casemix funding in Australia.*

material changes in the Health Fund's market share, or under-servicing and selective-servicing by the hospital, together with the safety, quality and effectiveness of the services provided.

Given those appropriate safeguards, the basic methodology of the BPPM provides strong incentives for the provision of clinically optimum services, particularly for the replacement, where clinically indicated, of overnight inpatient care with appropriate forms of ambulatory care. The BPP would be expected to cover all aspects of all patients' hospital-based care as determined by the hospital in consultation with those patients' treating psychiatrists. Within that context of joint responsibility with the treating psychiatrists for the care of patients, the hospital is free to allocate that funding as required. Thus the implementation of a BPPM is likely to have significant implications for the relationship between the hospital and its admitting psychiatrists. The BPPM, which has been successfully implemented in South Australia (SA), has been thoroughly discussed by the SPGPPS and its' IMWG and will not be summarized in this paper. Stakeholders have questioned the way in which this model might be applied in competitive market places such as exist in Brisbane, Sydney and Melbourne. It has been suggested that this model is able to be implemented in SA only because of the one private hospital provider situation, and may be logistically very difficult to operate in areas of multiple hospital owners. Indeed, it should be noted that the BPPM can be described as a type of capitated payment model. These models are characterised by payment being tied to a specific, defined population of patients with care being prepaid at a predetermined, per-capita rate.[7] Capitated funding models are most commonly discussed in Australia with reference to the funding of public sector health services. In New South Wales (NSW) for example, the resource allocation formula used by NSW Health to fund Area Health Services can be seen as a type of capitated funding model.[8]

This has possibly led to the view that the BPPM can only be based on a defined general population. However, close examination of the actual model used in SA indicates that it is not in fact based on an analysis of the general insured population's need for private hospital based psychiatric services, but instead is based primarily on the contracted hospital's prior history of service provision. However, there are legitimate questions to be addressed in respect to the implementation of a BPPM in a competitive environment. First, would the implementation of BPPM funding inhibit competition between established hospitals? Second, how would newly established hospitals enter into BPPM funding arrangements? Third, could hospitals specialise, that is legitimately engage in selective-servicing, under a BPPM funding arrangement?

Also, experience in South Australia has indicated that the changes in the mix of services that are likely to follow on from the implementation of the BPPM will give rise to an increase in acuity of the hospitals overnight inpatients as the alternate treatment methods become available. As less acute patients have been appropriately cared for in the community, the average acuity of those patients requiring in-patient care has risen. Such changes would need to be taken into account during the re-negotiations of the BPPM.

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7 An excellent overview and discussion of capitated payment models can be found in a policy paper made available by the British Columbia Medical Association on their website.

8 A discussion of the funding of public sector health services in Australia using this approach can be found in Peacock S, Segal L. *Capitation funding in Australia: imperatives and impediments*. Health Care Management Science 2000, 3, 77-88.