Australian Health Insurance Association Ltd

(ABN 35 008 621 994 - A COMPANY LIMITED BY GUARANTEE - INCORPORATED IN THE A.C.T.)

PRESIDENT:
Mr Terry Smith MBE RFD ED

CHIEF EXECUTIVE
Hon Dr Michael Armitage

NATIONAL SECRETARIAT:
4 Campion Street
Deakin ACT 2600

Telephone: (02) 6285 2977
Facsimile: (02) 6285 2959
Email: admin@ahia.org.au

Senator Lyn Allison
Chair
Senate Select Committee on Mental Health
Room S-1-33
Parliament House
CANBERRA ACT 2600

SENT BY e-mail 7/3/2006

Dear Senator

I refer to the attendance of the former Chief Executive Officer, Mr Russell Schneider, before the Public Hearing of the Senate Committee Inquiry into Mental Health on 4 July 2005 and would like to thank you for the Hansard proof which I understand was provided to him in mid-August 2005. Please accept profuse apologies from the Association on his behalf that, due to his retirement, his response was inadvertently overlooked and not sent to the Committee.

On reading the transcript, Mr Schneider had discovered an error of fact on page 59 — the first page of his evidence — in that the figure of $153 million should, in fact, have read $135 million (as in our submission, paragraph 13 on page 4 refers). Unfortunately, due to the passage of time, I accept that it will not be possible for the transcript to be corrected accordingly. But I would be grateful if the Committee was made aware of the correct figure. In fact, I understand that Mr Schneider may have already sent this correction to the Committee.

In addition Mr Schneider was asked to clarify a number of points:

The first related to portability and AHIA's position on this question. To assist the Committee I would draw its attention to the *attached* extract from a submission the Association made to a House Committee inquiring into health insurance matters. I think it provides both background to, and a recommended solution to, this very complex problem. In brief, as Mr Scheider said in evidence, our proposal aims at ensuring both hospitals and health funds share financially in making sure members/patients can transfer between health funds without any penalty arising from their state of health. At the same time this proposal would reduce the incentive for a provider - hospital or doctor - to actively encourage a patient to switch funds to allow the provider to maximise income, or arbitrage the system.

During the hearing Mr Schneider was asked whether the four percent of total hospital benefits for mental health patients was appropriate. I would make the point that this is an identifiable amount of benefits paid for mental health treatment, but, due to the way claims may be made, benefits paid for hospital treatment arising from psychiatric conditions may exceed this amount. More importantly, however, it should be noted that total hospital benefits include costs of theatres and associated technology facilities in relation to advanced surgical procedures which - I believe surgical hospitals would argue - represent much higher cost structures than are needed in psychiatric hospitals. Any increase in the amount currently paid for mental health treatment in private hospitals could only be increased as a percentage of total benefits by either increasing premiums or reducing benefits paid for other treatments. I would be interested if the Australian Private Hospitals' Association might advise how the percentages for the various specialties within its membership should be divided without an increase in premiums. I have no doubt health funds would look at that accordingly.

As Mr Schneider mentioned during his evidence last July, provider expectations of higher income are not necessarily consistent with optimal care for patients. Indeed, while reimbursement of medical and hospital treatments are based on piecework arrangements - i.e., fee for service or charges based on hospital days or episodes of care - there must be a perverse financial incentive to provide more services to gain more fees. In health care "more" does not always equate with "better."

The *attachment* provides an example of how the provision of good mental health care can potentially be compromised by providers seeking to attract patients to maximise their income.

I hope the Committee would agree that in mental health care, or, for that matter, any health care, the system should focus on trying to achieve the optimal outcome for the patient at the minimum cost. This combination means that treatments should be designed to achieve best results, but at prices consumers and/or taxpayers are able and prepared to pay. It is the only way the scarce health care dollar can be used to ensure maximum benefit for society as a whole, and particularly for those who need care.

During evidence the Association representatives mentioned the health insurance industry's willingness to explore alternate funding arrangements for mental health with a particular emphasis on programs and treatments being tailored to patient needs rather than rigid charging arrangements. The following is an outline of a funding arrangement in South Australia which has, I understand, the support of all involved - providers, funders, and most importantly, patients.

Prospective Payment Model for Private Psychiatric Care in South Australia

Per-diem based and other similar funding arrangements for mental health services in the private sector focus upon payment for in-patient psychiatric services retrospective to their delivery. There is little incentive for providers to invest seriously in a range of alternative programs or to provide non-inpatient services that are true substitution for, and not an add-on, to the cost of inpatient care.

In October 2000 BUPA Australia worked with **Ramsay Health Care (RHC)** to introduce innovative funding arrangement in South Australia designed instead to encourage a range of psychiatric care services.

At the time major objectives of *The National Mental Health Strategy* included establishing the greater part of psychiatric services in non-hospital settings, the development of innovative funding models and partnerships, and consumer and carer participation. The Federal Government demonstrated a commitment to *The National Mental Health Strategy* and to private health funds and hospital providers working together. This set the scene for the introduction of the Prospective Payment Model.

The objective was to jointly establish a payment model facilitating:

(i) The provision of a continuum of care for members requiring psychiatric care, and
(ii) an increased choice of services available to both members and clinicians.

The expansion of private out of hospital mental health services is limited by establishment costs and loss of revenue to hospitals from in-patient benefits. This lack of financial incentive was one of the drivers for the Prospective Payment Model.

As part of the model, RHC are paid an agreed annual figure spread over 12 monthly payments of equal value within each year. Therefore, for the first time, hospitals are assured of a known and regular income and able to plan for financial investment in alternative services. The Model includes mechanisms for addressing issues such as new members under LHC, compensable claims and an approved method of reinsurance reporting, while in no way interfering with the decision making process of clinicians over admission and treatment options. In fact, the Model creates an environment conducive of a greater choice of alternative services available to both consumers and clinicians.

Through preferential adoption of this arrangement by health funds other than BUPA Australia, at least 80% of RHC's work in South Australia is now funded under the Model.

Results

Since inception the Model has seen more members cared for with a greater range of services, and with the following changes in RHC service profile in South Australia:

(i) RHC has commented that "bed occupancy has reduced as our new services are clearly seen as a substitution for in-patient admission."
(ii) Opening of Fullarton Day Hospital in May 2002.
(iii) Subsequent conversion of Kahlyn Hospital, closure of Fullarton Day Hospital, and transfer of all Day programs to Kahlyn Day Hospital from October 2003.
(iv) Opening of a Day program ('Bridges Program') at The Adelaide Clinic for acute Elderly Program patients.
(v) A statistically significant increase particularly in community (Outreach) psychiatric home visits run from both The Adelaide Clinic and Fullarton Private Hospital.
(vi) Out-patient based Assessments for patients attending Elderly services.
(vii) Introduction of Pre-Admission Assessments where appropriate for other Programs.
(viii) Introduction of family counselling and telephone counselling services within the Model.

The above is in stark contrast to the continued reliance on in-patients and in-patient funding in other States and hospitals where numbers of private psychiatric beds continue to increase, and with no or minimal replacement by alternative services.

The Model has also served to reduce hospital administration time, with the invoicing process being replaced essentially with activity reports, and the chasing of forms from doctors unnecessary. Advantages from streamlined administrative procedures have also been found by BUPA Australia.

RHC report that *since the introduction of the new funding model the focus of care has become more tuned to the individual, with staff taking more time to determine what is the best treatment option for each person. With a variety of services now available, staff are able to recommend the treatment approach that is most suitable.*

The Model also provided for the establishment of a Quality Committee to oversee the changes and outcomes. A Consumer and Carer Advisory Committee has also been formed and continues to meet.

Evaluation

The Prospective Payment Model in South Australia has been the subject of two favourable external and formal evaluations conducted with the participation of the Commonwealth Department of Health and Ageing.

Extension of the Model into Victoria

In anticipation of similar benefits to other of our members, BUPA Australia is now seeking to implement the same funding arrangement with RHC in Victoria.

From 1 April 2004 RHC, owners of the Albert Road Clinic (ARC) in Victoria, have been funded as per the model in South Australia in return for providing, through a continuum of care, for all of the mental health care needs of our members at ARC.

RHC will set up or acquire other services as necessary as in South Australia, in order to better care for members under the Model.

From the above it is clear that, provided both hospitals and health funds are willing to adopt financing arrangements other than episodic fee for service, new and more efficient care services, which emphasise patient satisfaction and better outcomes can be developed.

AHIA would urge the Committee to encourage moves away from "piecework" funding to those which encourage providers to share risk and emphasise better outcomes.

Yours sincerely

Michael Armitage

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER
Enclosure

7 March 2006