AHIA Submission to the Senate Select Committee on Mental Health

INTRODUCTION

1. The Australian Health Insurance Association is the industry body representing 26 registered health funds which provide cover for 93% of all Australians with private health insurance. As at December 2004, 43% of all Australians held a policy that provided cover for hospital admissions.

2. The AHIA would like to take this opportunity to thank the Senate for allowing it to contribute to this inquiry. This submission provides a general overview on the current contribution from the private sector towards the provision of mental health services in Australia, and provides comment on issues that the AHIA considers need to be addressed.

3. The AHIA is committed to improving the treatment and funding of mental health services in the private sector, with a particular emphasis on improving outcomes whenever possible. Equally AHIA and its members are extremely conscious of the need to ensure that people with chronic illnesses, who almost by definition are on relatively lower incomes, can afford to remain privately insured and access quality private health care services. Unless affordability can be sustained many people who currently benefit from private health insurance will in the future be unable to do so. In this respect AHIA believes it is incumbent on private care providers to ensure the services they provide are reasonably priced, necessary and appropriate, both in terms of the type of treatment offered and the setting in which it is given. It should be noted that private health insurance aims at protecting the health interests of contributors, not the financial interests of providers. This is not always understood, and may at times result in tensions between health funds and health care providers. AHIA hopes this submission will go some way to creating better understanding of the pressures that face health insurers in trying to ensure members can access the most appropriate health care at prices they can afford and are prepared to pay. We would make the point that a hospital is not always the most appropriate setting for some health treatments. Indeed, hospitals may have a financial interest in providing the most lucrative form of treatment.

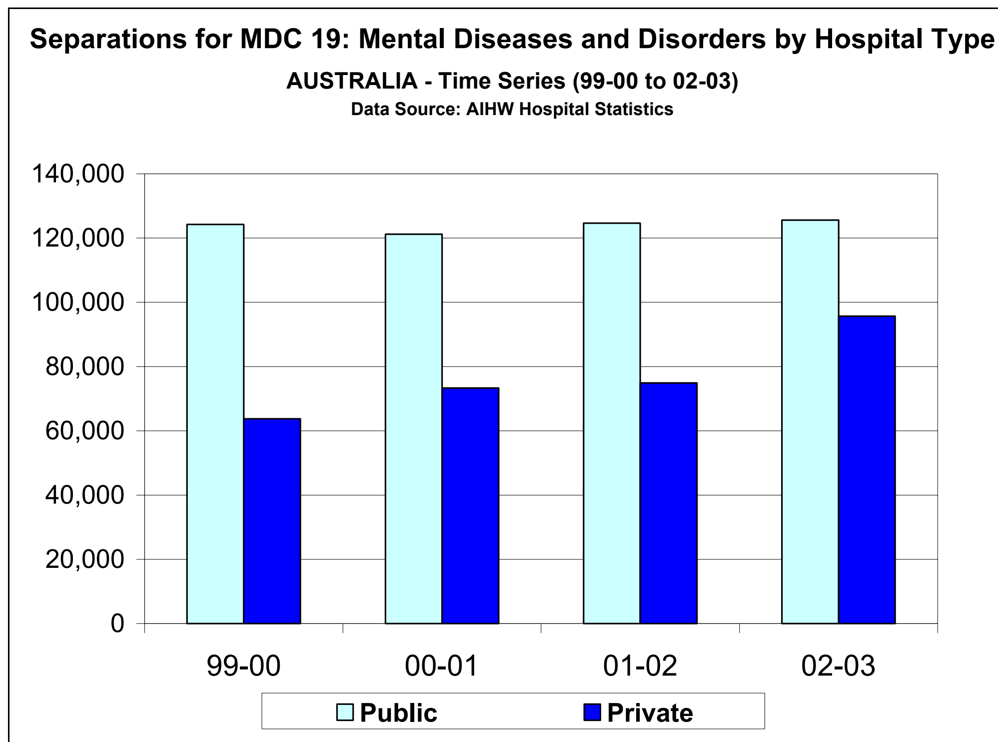
4. This paper outlines AHIA's involvement and the private health insurance industry contribution to date. It also details AHIA's objectives and perceived criteria for future provision of mental health services in Australia.

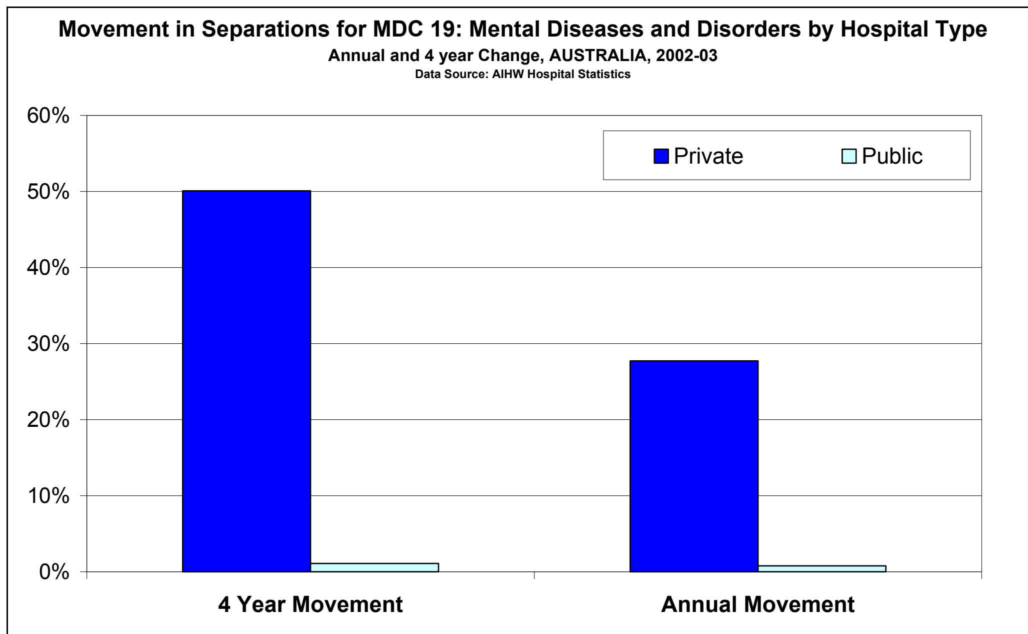
5. The AHIA would welcome any opportunity to formally present its findings to the Committee if public hearings are held.

PRIVATE SECTOR CONTRIBUTION TO MENTAL HEALTH SERVICES.

6. The private health sector plays a significant role in the delivery of in-hospital mental health services to the Australian community. In 2003-03 private hospitals treated 43.2% of all hospital treatments for "mental diseases and disorders" in Australia.

7. The contribution of the private sector to hospital treatments for mental diseases and disorders has been increasing substantially over the last few years, as shown in the graphs below. Conversely the graphs show that public hospital admissions have remained relatively static. Between 1999 and 2003 the number of hospital treatments in private hospitals for mental diseases and disorders increased by 50%. Public hospital treatments only increased by 1% over the same period. Between 2001-02 and 2002-03 private hospital treatments for mental diseases and disorders increased by 28%. Over the same period public hospital treatments have increased by 0.8%.





8. Hospital episodes of care are classified into 661 Australian Refined Diagnosis Groups (AR-DRG). These are further classified into 24 Major Diagnostic Categories (MDC). MDC 19 Mental Diseases & Disorders contains 13 AR-DRG's listed in the table below.

MDC 19	Mental Diseases and Disorders
U40Z	Mental Health Treatment, Sameday, W ECT
U60Z	Mental Health Treatment, Sameday, W/O ECT
U61A	Schizophrenia Disorders W Mental Health Legal Status
U61B	Schizophrenia Disorders W/O Mental Health Legal Status
U62A	Paranoia & Acute Psych Disorder W Cat/Sev CC or W Mental Health Legal Status
U62B	Paranoia & Acute Psych Disorder W/O Cat/Sev CC W/O Mental Health Legal Status
U63A	Major Affective Disorders W Cat or Sev CC or (Age>69 W/O Cat or Sev CC)
U63B	Major Affective Disorders Age<70 W/O Catastrophic or Severe CC
U64Z	Other Affective and Somatoform Disorders
U65Z	Anxiety Disorders
U66Z	Eating and Obsessive-Compulsive Disorders
U67Z	Personality Disorders and Acute Reactions
U68Z	Childhood Mental Disorders

9. The table above details those hospital procedures that are classified within MDC 19. There may be other DRG's that may eventually relate to mental health but are not explicitly linked to the MDC 19 definitions.

10. For example MDC20 "Alcohol/drug use and alcohol/drug induced organic mental disorders" lists the following AR-DRG's but are not specifically related to a mental disease or disorder

MDC 20	Alcohol/drug use and alcohol/drug induced organic mental disorders
V60Z	Alcohol Intoxication and Withdrawal
V61A	Drug Intoxication and Withdrawal W CC
V61B	Drug Intoxication and Withdrawal WO CC
V62A	Alcohol Use Disorder and Dependence
V62B	Alcohol Use Disorder and Dependence, Sameday
V63Z	Opioid Use Disorder and Dependence
V64Z	Other Drug Use Disorder and Dependence

11. The Private sector contribution towards hospital admission that relate to MDC 19 Mental Disease and Disorders is substantial and has increased. In the last 12 months the proportion of all mental disease and disorders treatments performed in the private sector increased by 5.7%, from 37.5% to 43.2% (2001-02 compared to 2002-03, Data Source AIHW)

12. The private sector provided 95,672 in-hospital treatments for mental diseases and disorders in 2002-03. This included 73,137 same day separations and 22,535 overnight admissions. On average each overnight admission had an average length of stay of 16.4 days. The private sector provided 443,210 patient days in private hospitals for mental diseases and disorders.

13. In 2002-03 the private sector contributed at minimum $135 million toward the funding of in-hospital treatments for mental diseases and disorders.

AHIA's COMMITMENT TO MENTAL HEALTH ISSUES

14. The AHIA has supported the SPGPPS (Strategic Planning Group for Private Psychiatric Services) since its inception. The SPGPPS brings together private insurers and third party payers, hospitals, clinicians, consumers, carers and the Commonwealth as a forum for the discussion and resolution of pertinent issues. AHIA is a major funder and stakeholder in the SPGPPS. It contributes to the cost of a consumer representative on the Group. AHIA has also established a Mental Health Committee (MHC) to assist in developing common proposals for regulatory matters affecting health insurers in the mental health area and to discuss issues that might arise within the SPGPPS. (This committee does not attempt to determine common commercial policies, activities or benefit payments or other matters of a commercial or marketplace nature.)

AHIA OBJECTIVES AND CRITERIA

15. As part of its objectives for 2004 /2005 tabled within the SPGPPS, AHIA seeks acceptance of the principle that contracted services should reflect a demonstrated need within the particular catchment area. This is against a background of increasing benefits paid by funds nationally while the number of members remains stable.

16. Further, AHIA through the MHC continues to explore with other stakeholders, particularly providers, innovative funding models with accent on:

    - A range of suitable clinical and cost-effective services available to substitute for overnight admission.
    - Delivery of the appropriate treatment in the appropriate setting
    - Appropriate utilisation.

17. At the SPGPPS (meeting 11th June 2004) the MHC presented an overview of industry cost drivers and insurer concerns as well as concrete examples of innovative funding arrangements based upon profit-sharing, appropriate utilisation and delivery of the appropriate treatment in the appropriate setting. The aim was to reinvigorate discussion of funding reform within the industry based upon the principles above.

18. Following our lead, at subsequent SPGPPS meetings other stakeholders presented their views.

19. The SPGPPS Innovative Models Working Group (IMWG) is currently drafting a discussion paper that will attempt to describe some possible alternative approaches to the funding of hospital based private psychiatric services. All key stakeholders are contributing to this important piece of work.

20. AHIA's MHC intends to continue these discussions, in particular making clinicians more aware of industry cost drivers and the cost of services. The health sector may be unique in that those ordering services (clinicians) are not part of funding arrangements. The MHC would like to see psychiatrists at least aware of costs, cost increases, funding issues and to have some input into as to the best use of the funding that is available.

21. AHIA believes it is essential to develop and implement appropriate performance measures that ensure clinically effective, efficient and cost-effective outcomes for members and explore the inclusion of these in the CDMS (Centralised Data Management Service).

22. The Reports from the CDMS (also partly funded by the AHIA) already contain comparisons of objective measures across almost all private psychiatric facilities nationally and are available for individual insurers to use in negotiations.

23. A number of further statistical indicators suggested by insurers are scheduled for inclusion in the CDMS Reports, including:

    - Average total number of days in hospital per patient.
    - Average total ambulatory services per patient.
    - Ratio of ambulatory care to inpatient care by hospital.

24. It is anticipated this work will be completed early 2006.

25. The consumer and carer Network (NNPPSCC) is also exploring a national consumer perception of care outcome measure that could be included in the CDMS. Hospitals are willing to trial such a measure with funding from DoHA.

26. A third objective of the Committee is to apply agreed criteria as a minimum for fund recognition of new and existing private psychiatric services.

27. The criteria include a substantial raft of quality and other standards beyond simply Accreditation, and rivals criteria used in the public sector. Individual Insurers are able to use these standards in the selection of and contracting with private psychiatric hospitals.

28. The criteria provide standards for insurers to use in the selection of & contracting with private mental health providers. These are as follows:

"Delivery of psychiatric services requires a specialised set of skills if health fund members are to receive adequate care. The AHIA MHC endorses the position that all funding negotiations regarding ability to deliver such care be based on a hospital's ability to comply with the following nationally agreed guidelines and practices

- *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-Based Mental Health Care [Commonwealth Circular PHI 18/04 issued 7/04/2004]*
- *The National Mental Health Standards*
- *Accreditation of private mental health services to the National Mental Health Standards*
- *The National Mental Health Workforce Standards*
- *Guidelines for the Treatment of Alcohol Problems, National Alcohol Strategy, 2003 [where appropriate]*
- *Guidelines on the administration of ECT, RANZCP Clinical Memorandum #12, April 1999 revision (GC1/99, R40)*
    - *Clinical Practice Guidelines published by RANZCP. To date consumer & carer and clinician versions are available for six specific disorders or conditions:*
    - *Anorexia nervosa*
    - *Bipolar disorder*
    - *Deliberate self harm (youth and adult)*
    - *Depression*
    - *Panic disorder and agoraphobia*
    - *schizophrenia*
- *The documentation provided by hospitals needs to clearly reflect their ability to adhere to these Guidelines and practices.*
- *Visits to hospitals are also recommended to determine if the practice adheres to the documentation provided and is delivered in flexible manner tailored to meet the needs of individuals. Provided this is separate from funding negotiations this process could be carried out, in participation with providers, by Funds, Funds working together, or by a person or persons with the necessary skills on behalf of all Health Funds."*
- *Participation in an agreed national minimum data set.*

MISCONCEPTIONS – MENTAL HEALTH AND THE PRIVATE SECTOR

MISCONCEPTION 1: Severe mental health problems are dealt with within the public sector. Only the relatively easier problems are seen by the private sector.

29. The private health sector provides 43.2% of all in-hospital treatments in Australia for mental diseases and disorders.

30. As well as general psychiatric admissions for problems such as schizophrenia, paranoia, personality and bipolar disorders, a wide range of other programs are available within the private sector including for Adolescent Problems, Substance Abuse, Eating Disorders, Anxiety & Mood Disorders.

31. Those cared for include a core group of members with intensive service needs and a high profile of ongoing & repeated hospital admissions.

32. A number of health funds provide benefits for intensive psychiatric care units, and in 2 States (Queensland and SA) severe cases are admitted as involuntary patients within the private sector. It is theoretically possible to also do this in WA. In other states legislation prevents involuntary admission into the private sector.

33. From 2001-02 to 2002-03 the number of in-hospital treatments in the public hospital sector increased by 970 or 0.8% (from 124,627 to 125,957). But in the private sector the in-hospital treatments increase by 20,759 or 28%.

MISCONCEPTION 2: The cost of private health insurance is forcing people out of private mental health care and into the public sector.

34. Conversely, quite the opposite is true. The private sector is increasingly filling widening gaps in the public system. The result is one reason for the increasing costs to the private insurance industry and ultimately the consumer.

35. A recent article in "The Australian" * reported people with mental health problems "are being forced to take out private health insurance because public hospitals have cut programs to treat many conditions".

36. According to Executive Director of SANE Australia, Barbara Hocking, the lack of public and community programs to treat mental illness was alarming. She said "someone who requires hospitalisation for depression generally cannot get help unless they have private insurance".

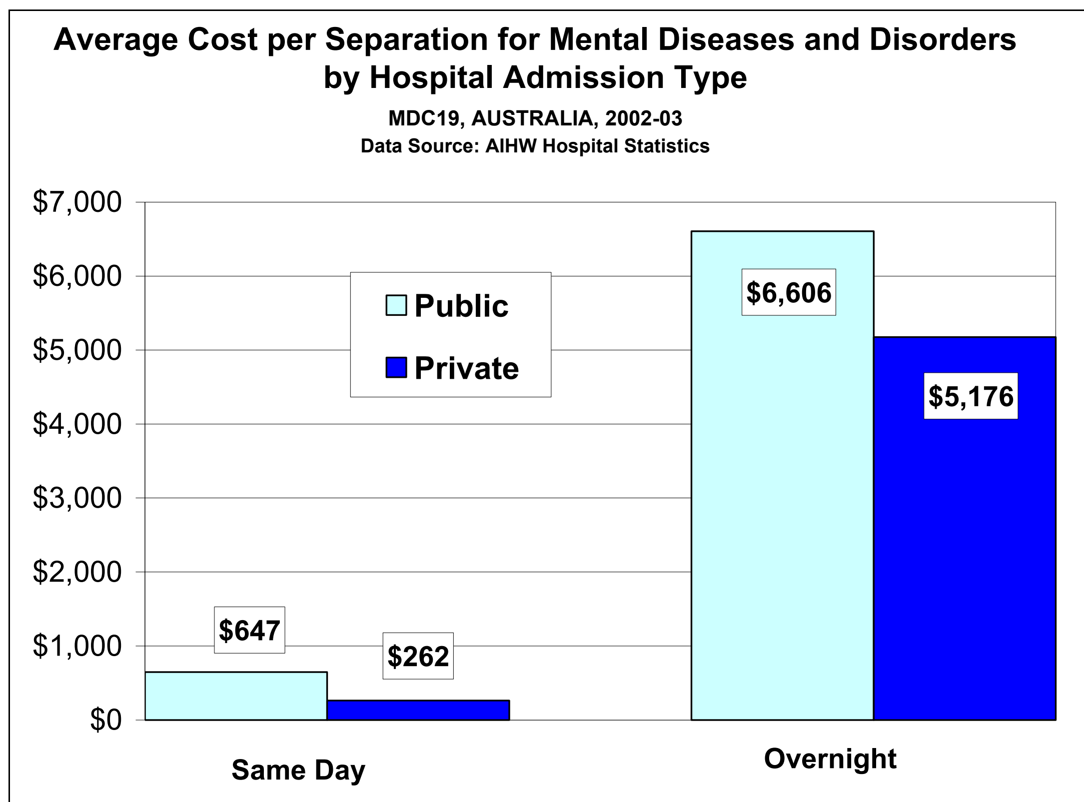
37. Adviser to BeyondBlue Professor Ian Hickie commented that public hospitals had reduced the number of beds and services for mental health problems during the past decade. The Professor is quoted as saying "…now nearly all of our programs for those disorders [depression and anxiety] are in the private sector. The public system has restricted its services…" * Medical Reporter Clara Pirani, "The Australian" 28 March 2005, p3.

MISCONCEPTION 3: Private mental health care is far more expensive.

38. Compared to what? The Medicare levy contributes in the order of one ninth of costs. The real cost of public health care is far higher.

39. Funds strive to keep premiums (and increases) as low as possible to attract and retain members. Given the problems noted above in the public sector, private insurance (and Government support through LHC and rebates) gives patients options they otherwise wouldn't have, when they need them.

40. The graph below illustrates the cost by admission type – overnight and same day admission) by hospital type. The graph illustrates that the average cost per separation is lower in the private sector in both same day and overnight procedures as compared to the public hospital sector.



MISCONCEPTION 4: The public sector has better modes of care to accommodate and fit with the needs of patients, eg: outreach programs, day programs, morning, weekend and evening programs.

41. The private sector has a similar range of funded modalities available including outreach home visits, day and half day programs, outpatients or combination of these, and has also trialled services such as telepsychiatry. In fact 68 percent of same day mental health programs are conducted in the private sector (and the majority are covered by health funds).

42. However health funds can only provide benefits for "admitted in-patients" of a hospital from their hospital table. While funds may pay benefits for a visit to a psychologist from their ancillary table, they are prevented from paying for services provided by a psychiatrist unless the patient is admitted to a hospital. This limits fund assistance to the highest cost settings and prevents them from exploring the provision of more efficient and, for the patient, more appropriate treatment in alternative environments.

43. Besides a range of options, various private hospitals specialise in niche treatment programs. The public system however is ostensibly a one program fits all type structure. The uniqueness of the individual can more readily be taken into account within the private system.

MISCONCEPTION 5: The public sector has better support services when a patient is discharged from hospital

44. All of the support services listed above are available in the private sector.

45. Public patients rely partly upon community and council services. In some areas these are becoming scarce or have long waiting times.

46. However the current reinsurance system discourages insurers from covering any service that is not supplied by a hospital and the patient must continue to be regarded as an "admitted patient". If a fund makes arrangements for the provision of services other than those provided by a hospital the fund is unable to debit the costs of eligible patients to the reinsurance pool. AHIA believes the reinsurance arrangements should be changed to allow insurers to include within reinsurance the costs of treatment for non admitted patients if the treatment is genuinely substitutable for hospital treatment or is demonstrably preferable to hospitalisation.

MISCONCEPTION 6: The public sector better caters for specific patient needs such as Drug and Alcohol Programs and Adolescent Programs.

47. In principle such programs should be clinically based and of high quality in either sector.

48. In the 12 months to June 2004 the private sector provided over 2,900 overnight inpatient episodes nationally for Substance Abuse and 578 for Childhood and Adolescent and Eating Disorder problems (the latter problems invariably affecting younger members). **

** SPGPPS CDMS Reports Q3 2003 to Q2 2004

MISCONCEPTION 7: The public sector has better outcomes of treatment.

49. The private sector has established a model for the routine collection of two objective measures from private mental health facilities nationally:

- The clinician-completed HoNOS (Health of the Nation Outcomes Scales), and
- The consumer rated MHQ-14 (Mental Health Questionnaire).

50. The Centralised Data Management service (CDMS) of the Strategic Planning Group for Private Psychiatric Care (SPGPPS) links this data with that from the Hospital Casemix Protocol (HCP), and prepares and distributes de-identified Quarterly reports to both hospitals and private insurers.

51. The Model is jointly funded by the AHIA, APHA and CDHAC. Through the CDMS, the private sector is therefore able to demonstrate outcomes of treatment. For example, hospitals can be compared on such outcomes as length of stay, percentage of long stay patients, patient acuity and change in health status from admission to discharge. We understand the public sector is currently working towards implementing a similar system for reporting outcomes nationally.

AREAS OF FURTHER CONSIDERATION

Private Sector Recognition

52. The important role of the private sector in relation to mental health be recognized.

Community Support

53. There is evidence that privately insured patients may be losing access to community type services provided for mental illness, and a growing expectation, in some areas, that private patients will receive community support type programs provided by the private sector. Patients are often not referred to, or have access to community funded programs - the health insurance status of a patient seems to be the determining factor.

Outreach Services

54. Greater rigour around the provision of 'out-reach' services is recommended. The current guidelines do not provide sufficient direction for the services provided, do not limit the number of services a hospital can provide a patient and do not have sufficient checks and balances to ensure the appropriateness of those services as an absolute substitution to in hospital accommodation, and may not achieve any set outcomes.

55. A focus on the expanding role of the private and public sectors in supporting and treating people in their own communities and consideration of the effectiveness of this approach should be further explored.

Private Hospital Funding

56. PHI funded treatment for inpatient based programs (eg. mood disorder, anxiety disorder), has became the be all and end all of service delivery. Patients are 'forced' into programs despite the diversity of their needs. Some hospitals have developed set time programs and negotiated for funding to cover these time periods. Often this time period is utlised, irrespective of the patients needs – i.e. everyone might receive 21 day programs. Health funds firmly believe that all treatment programs should reflect the needs of individual patients. A scenario has emerged whereby people come to hospital, stay anywhere between 21-42 plus days in order to complete set time programs and then are discharged back into the care of their psychiatrist with little/no access to any support mechanisms designed to then keep them out of hospital. The PHI industry needs to be able to consider other programs of care that will provide alternatives to these inpatient programs.

Accreditation of facilities providing psychiatric services

57. Facilities providing psychiatric services need to be encouraged to undertake their accreditation survey in conjunction with the National Mental Health Standards.

Better Coordination between Public and Private Hospitals

58. There is a need to explore the availability of suitable hospital facilities to manage the acutely ill psychiatric patient between hospitals in the private sector and the interface between the public and private sectors in situations where a patient is being managed in the private sector and requires transfer to a public hospital for management of an acute episode.

59. The effects of an ageing population should also be considered as well as trends that may impact the changing management and treatment needs of the mentally ill aged person with respect to mental health services provided by both the public and private sectors

Benchmarking

60. In order to achieve the best practice and improved patient outcomes for all patients at the best possible funding level a method of benchmarking performance between the public and private sectors should be developed.

CONCLUSION

61. The level of commitment of AHIA fund members to our contributors with mental health problems is demonstrated by the significant and increasing level of funding directed to their care.

62. The AHIA is a joint funder and participant of the SPGPPS and CDMS, and has taken the lead within the industry in progressing principles that services should be necessary, cost-effective, appropriate and in accordance with best practice.

63. In the interests of our members, AHIA has encouraged fund awareness of a range of quality and other standards ensuring that treatment provided should also be subject to review, with measurable outcomes and reflect Evidence Based Medicine (EBM) and professional Clinical Practice Guidelines (CPGs). More and more, private insurers are using these standards in the selection of and in their agreements with providers in efforts to promote best practice.

64. Historically, per-diem and similar funding arrangements with providers of mental health services focused upon inpatient benefits. The level of funding is therefore linked to length of stay. There is little incentive for hospitals to invest in or provide alternative non-inpatient services that, if true substitution, potentially reduce revenue to the hospital from inpatient admissions.

65. In recognition of the limitations of current arrangements private insurers have endeavoured to introduce innovative funding models designed to create a greater choice of services and ensure funding is used to the best advantage, in the interests of members.

66. The AHIA continues to encourage funding arrangements furthering these aims, as well as promoting industry sustainability (and profitability) between insurers and providers. To do otherwise would expose private insurers, and hence our members, to continued unsustainable cost increases.

67. Some of the barriers to moving forward include current re-insurance arrangements and lack of a more open public/private interface permitting better comprehensive care. Privately insured members should be able to access, on an equal footing to that of the general population, some of the existing high-quality services available in the public sector.

68. All stakeholders should be aware of the cost pressures and constraints within the private health sector. Clinicians in particular should be able to give constructive input as to how and where funding is best spent and be prepared to order cost-effective services.

69. Finally, we would suggest treatment needs to move from a structure around programs of set lengths to a focus on individual needs.

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