

Private Healthcare Australia
Better Cover. Better Access. Better Care.

Submission to the Productivity Commission Inquiry into Mental Health

Private Healthcare Australia

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Acknowledgements

This report was prepared by Evaluate on behalf of Private Healthcare Australia. Evaluate was formed in September 2016 to bring fresh thinking to policy and economic questions, particularly those in the social sphere. Alastair Furnival and Catherine McGovern are Principals at Evaluate.

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Executive Summary

Private Healthcare Australia (PHA), the peak body representing Australia's private health insurance industry, welcomes the opportunity to provide this submission to the Productivity Commission's Inquiry into The Social and Economic Benefits of Improving Mental Health.

Inpatient treatment of subacute and chronic mental health conditions forms a major part of the value proposition for private health insurance (PHI) as this treatment is not readily accessible in the public hospital system. This value proposition is increasingly clear in the area of high-prevalence mental health treatment where PHI members are able to rapidly access a highly varied range of both inpatient and outpatient treatment services. In addition, inpatient treatment for chronic depression, anxiety, personality and eating disorders, drug and alcohol addiction is mostly provided by the private sector.

Given the experience of the private health insurance funds, this submission covers a number of issues relevant to the scope of the inquiry, particularly matters relating to the effectiveness of current programs and initiatives and the settings in which these are delivered; the investment currently made in mental health and the value of this to individuals, their families and the economy; how these matters are dealt with internationally; and consumer and clinical views.

Importantly, potential policy solutions to some of the current challenges within the mental health environment are suggested with substitute services and the benefits to productivity clearly identified.

Recommendations contained include:

- The need to acknowledge drug and alcohol treatment services within the scope of the inquiry (p.14);
- The Productivity Commission utilise patient outcome data from the Private Psychiatric Hospitals Data Reporting and Analysis Service to inform future analysis of the benefits, costs and productivity gains available from alternative treatment settings (p.18);
- Capturing the productivity gains available from enabling private health funds to support patients through forms of care demonstrated to deliver improved outcomes and patient choice. This would involve the releasing of restrictions that currently prevent health insurance funds from insuring out of hospital care and enable the adoption of the proposed community-based stepped model of care to best support patients and avoid hospital admissions (p.19, 21, 22); and
- Working with PHI, government, medical professionals and nursing groups to pilot a community-based stepped model of care (p.28).

PHA would welcome the opportunity to engage with the Productivity Commission on our submission and to work towards outcomes-based models of mental health care that deliver social and economic benefits to Australians experiencing mental ill-health.

Mental Health and the PHI Value Proposition

The inpatient treatment of subacute and chronic mental health conditions forms a major part of the value proposition for private health insurance (PHI) as this treatment is not readily accessible in the public hospital system. Health fund members are provided with access to their choice of suppliers, with minimum delay, for necessary health interventions.

This value proposition is increasingly clear in the area of high-prevalence mental health treatment, where PHI members are able to rapidly access a highly varied range of both inpatient and outpatient treatment services. In addition, inpatient treatment for chronic depression, anxiety, personality and eating disorders, drug and alcohol addiction is mostly provided by the private sector.

Complementing the value proposition to members, PHI for mental health also delivers two benefits which address the broader public goals, including rebate funding:

- It provides expanded access to care for those who prioritise insurance, which has flow-on economic benefits in terms of participation and other outcomes reliant on health and wellness; and,
- It reduces consumption of public health services, particularly drawing unnecessary attendance away from emergency departments.

At the moment, a substantial share of these services is being provided via admission to private hospitals. It is the view of Private Healthcare Australia that some of this treatment may be safely and appropriately delivered in an outpatient or community setting, which would provide savings to both consumers and government by reducing pressure on premiums.

Delivering this outcome requires new models of care as well as some changes to current regulations governing PHI funding. The need to err on the side of caution is critical however. This is particularly important in the case of low-prevalence mental illnesses, such as schizophrenia and other psychoses as well as for people who are at risk of self-harm. Beyond these, deference continues to be given to psychiatric expertise in selecting mode and duration of treatment. This expert referral should be the basis of any revised approach to privately-funded mental health treatment. In addition, there is a need for the best available medical evidence to be brought to the table in support of models of care and models for payment. These must have the primary objective of returning the patient to a productive life in the earliest possible timeframe and minimising the potential for relapse and readmission.

While the value proposition of PHI is broadly well-reflected in mental health, productivity dividends are available. The general proposal from PHA on this issue is to amend the *Private Health Insurance Act 2007* to release the restrictions on health funds insuring out-of-hospital care for forms of care that have been demonstrated to deliver patients improved choice and outcomes. This could be readily achieved without impacting the overall regulatory environment for PHI.

This submission explores these issues, the risks they present and potential solutions that better align privately funded access to appropriate mental health services with the model and mission of PHI.

Overview of Mental Health and Illness in Australia

Australia's framework for mental health services is a complex mix of delivery by both the public and private sectors funded variously by the Commonwealth, state and territory governments, individuals and private health funds.

Mental health has long been of key interest to policy makers, funders and service providers and a source of significant policy review. Between 2006 and 2012, there were 32 reports and inquiries into mental health in Australia¹ with many undertaken both previously and since at federal, state and territory level as well as by interested parties.

The findings of these inquiries, surveys and reports tend to be consistent. Conducted in 2007, the Australian Bureau of Statistics' (ABS) Survey of Mental Health and Welfare found 45% of Australians will experience a mental disorder during their lifetime with 20% of people experiencing one in the previous year.²

Similarly in 2008, work undertaken at the University of Western Australia reported of the 1 in 5 people in Australia that experience a mental health issue, only 10% sought help for it. 3% would access specialist mental health services as part of that support with equal numbers seeing a private psychiatrist or public mental health service.³

Work undertaken into the mental health of children and adolescents reports 560,000 young people between the ages of 4 and 17, or almost 14% of people in that cohort, experienced a mental disorder in the year before being surveyed.⁴

These figures are supported by the most recent National Health Survey which estimates 4.8 million Australians, or 20.1%, experienced a mental or behavioural condition in 2017-18. An increase in the number of people seeking support for anxiety, depression or feelings of depression was noted.⁵

The burden of disease as a result of mental ill-health is high: at 12.1% of the total national burden of disease, it is the third highest in Australia. In 2011, the Australian Institute of Health and Welfare (AIHW) *Burden of Disease Study* found that Australia lost a total of 52,554 years of healthy life as a result of mental and substance use abuse disorders in the previous year.⁶

¹ Sebastian Rosenberg, 'From Asylums to GP clinics: the missing middle in mental health care', *The Conversation* September 15 2015. <https://theconversation.com/from-asylums-to-gp-clinics-the-missing-middle-in-mental-health-care-46345> Accessed 19 February 2019.

² Australian Bureau of Statistics (ABS), '4326.0 - National Survey of Mental Health and Welfare: Summary of Results, 2007', 2007. <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0> Accessed 19 February 2019.

³ Smith, G. and Williams, Theresa, 'Policy in Action: 15 years of mental health reform in Australia', UWA Mental Health Policy and Practice Seminar (slides), 18 September 2008. http://www.health.wa.gov.au/mhpr/docs/Policy_in_Action_15years_of_mh.pdf Accessed 15 February 2019.

⁴ Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR, *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Welfare*, Department of Health, Canberra, 2015. [http://www.health.gov.au/internet/main/publishing.nsf/content/9DA8CA21306FE6EDCA257E2700016945/\\$File/child2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf) Accessed 19 February 2019.

⁵ ABS, '4364.0.55.001 - National Health Survey: First Results, 2017-18', 2018. <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70> Accessed 19 February 2019.

⁶ Australian Institute of Health and Welfare (AIHW), Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, 2016. <https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights> Accessed 19 February 2019.

In terms of the economic burden, the National Mental Health Commission reported in 2016 that the cost of mental ill-health in Australia equated to around \$4,000 per person or \$60 billion for the nation as a whole.⁷

The same year, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) estimated severe mental illness cost Australia \$56.7 billion per annum. This reflects both the direct economic costs of health and other services and people's loss of productivity due to the inability to work as a result of their mental ill-health.⁸

Analysis has also been done in relation to the cost of mental ill-health to employers. Mental Health Australia published a report finding mental ill-health in the workplace cost \$12.8 billion in Australia in 2015-16. This equates to an average cost of \$3,200 for each employee experiencing mental illness and up to \$5,600 for those employees whose mental illness was considered severe.⁹

Critically, while it has long been considered a source of pride that Australia dismantled the institutional hospitals where people with mental illness were once treated, the literature is universal in its opinion Australia has failed to provide appropriate community care as a replacement.¹⁰ As a result of this, other parts of the social services system are placed under stress, including the justice system, homelessness services and so forth. In addition, the lack of affordable community care means for many people, there are few alternatives for treatment between their GP's surgery and the hospital emergency department.¹¹

The need for multi-disciplinary teams to assess and treat people with a mental illness as well as deliver case management and coordination support is clearly outlined in the literature. These types of teams, whilst now common in Australia in the treatment of diseases such as cancer, are not similarly established in the area of mental health with some reports indicating that more of these teams were operating effectively in 2000 than now.

The evidence is strong demand for mental health care is better served in the private than the public environment. While this supports the value proposition for PHI, there is a separate equity issue which requires address in the public sector, and for which the benefits in reduction in burden of disease are clear.¹²

⁷ National Mental Health Commission, *Economics of Mental Health in Australia*, 8 December 2016. <http://www.mentalhealthcommission.gov.au/media-centre/news/economics-of-mental-health-in-australia.aspx> Accessed 19 February 2019.

⁸ The Royal Australian and New Zealand College of Psychiatrists, *The economic cost of serious mental illness and comorbidities in Australia and New Zealand*, 2016. <https://www.ranzcp.org/files/publications/ranzcp-serious-mental-illness.aspx> Accessed 19 February 2019.

⁹ Mental Health Australia and KPMG, *Investing to Save: the economic benefits for Australia of investment in mental health reform*, May 2018. https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf Accessed 19 February 2019.

¹⁰ Stephen Leeder, 'Telling the story of mental health', *Medical Journal of Australia*, 2015 202 (4): 161. <https://www.mja.com.au/journal/2015/202/4/telling-story-mental-health> Accessed 12 February 2019.

¹¹ Sebastian Rosenberg, 'From Asylums to GP clinics: the missing middle in mental health care', *The Conversation* September 15 2015. <https://theconversation.com/from-asylums-to-gp-clinics-the-missing-middle-in-mental-health-care-46345> Accessed 19 February 2019.

¹² <https://www.aihw.gov.au/getmedia/466fe218-f07e-43ee-89af-75297c3818e7/AW15-7-2-How-are-people-with-mental-illness-faring.pdf.aspx>

Current Settings – Funding of Mental Illness & its Evolution

In 1992-93, \$1,972.2 million was spent on mental health services in Australia. \$1,327.3 million of this was paid for by state and territory governments, \$516.9 million by the Commonwealth and \$128.0 million by private health funds.

By 2002-03, this funding had increased substantially to \$2,732.0 million. This was largely driven by Commonwealth Government funding which had increased by 133.7% to \$1,208.1 million although state and territory funding had also increased substantially, by 48.9% to \$1,375.8 million, and remained the largest funding source. Private health funds had also increased their funding, by 15.8% to \$148.1 million.¹³

Since then, funding for mental health has increased even more significantly with the AIHW identifying that \$9.0 billion was spent on mental health related services in Australia in 2015-16. Of this, 59.8% or \$5.4 billion was funded by state and territory governments, 35.0% or \$3.1 billion by the Australian Government and 5.2% or \$466 million paid for by private health funds.¹⁴

Private Funding

Looking at the 2017-18 financial year for PHI payments for the 21 most common mental health and drug and alcohol-related mental health DRGs,¹⁵ private health funds paid benefits, excluding Medicare benefits, totalling \$546,166,387. Including PHI contributions for MBS item gap cover, this increases to \$612,752,712.

Comparing this to the previous year's total expenditure by health funds of \$15.859 billion,¹⁶ this represents 3.9% of total PHI expenditure. Notably this represents an increase of more than 100% over the eight years from the 2010-11 financial years where expenditure was \$288,743,194, or 2.9% of health funds' total benefit outlay.

This growth likely reflects greater awareness of the potential availability of PHI to fund mental health. There will inevitably be some ceiling of demand for these services but, for the moment, we are still seeing some latent demand.

The particular value proposition is characterised by immediate access, unrestricted by hospital waiting lists and short lengths of stay. This means neither of the constraints of the public system comes into play, viz.:

- Prioritisation of some Diagnosis-related Groups (DRGs) over others, e.g., cancer and cardiac over orthopaedics and anxiety; and,
- Prioritisation of individual patients by acuteness of need within the waiting list for that DRG.

¹³ Smith, G. and Williams, Theresa, 'Policy in Action: 15 years of mental health reform in Australia', UWA Mental Health Policy and Practice Seminar (slides), 18 September 2008. http://www.health.wa.gov.au/mhpr/docs/Policy_in_Action_15years_of_mh.pdf Accessed 15 February 2019.

¹⁴ AIHW, *Mental health services – in brief 2018*, Cat. No. HSE 211. Canberra: AIHW, 2018.

¹⁵ This is discussed in greater detail below.

¹⁶ AIHW. *Australian Health Expenditure 2016-17*. Cat. no. HWE 74. Canberra: AIHW, 2018.

Current Settings - Incentives

Private Hospital Admissions

Private health insurance can cover psychiatric treatment and/or drug and alcohol rehabilitation in a private hospital. PHI will then cover the cost of the hospital accommodation and some of the medical fees also.

As with all private health insurance, to utilise PHI cover in a private hospital an individual must be admitted into that hospital as a patient. That hospital admission can be for an extended period of time but can also be for a shorter period including overnight or day only admission, where the patient is admitted, treated and discharged on the same day.

Current Settings - Expenditure

Amount per Patient

Private funding for mental health services is predominantly paid by private health funds who, in 2016-17, paid for:

- 1,039,056 patient hospital days; or,
- 98.5% of admitted day payments.¹⁷

The remainder of payments are either patient out-of-pocket, or 'other' payments. This is an exceptionally small percentage of non-insurance private funding compared to healthcare consumption generally.

Growth Trajectory

Looking at the available data, there is a significant disparity in funding of mental health between the private (PHI) and public sectors.

The following tables show expenditure by funding source across a range of DRGs for mental health treatment.

¹⁷ HCP1 Data supplied (2016-17).

Table 2: Admitted Patient Days for Mental Health DRGs by Funding Source (2016-17):¹⁸

MDC 19 Mental diseases and disorders ¹⁹						
AR-DRG Version 7.0 Code	Description	Public patient	PHI	Self-funded	Other	TOTAL
U40Z	MH ²⁰ Treatment Same Day With ECT	13,082	8,368	97	893	22,440
U60Z	MH Treatment Same Day Without ECT ²¹	24,036	110,465	3,534	17,091	155,126
U61A	Schizophrenia Disorders With MH Legal Status	1,237,346	16,860	987	8,708	1,263,901
U61B	Schizophrenia disorders Without MH Legal Status	375,320	54,475	722	189,602	620,119
U62A	Paranoia & Acute Psych Disorder W Cat/Sev CC ²² or With MH Legal Status	62,127	3,738	909	1,056	67,830
U62B	Paranoia & Acute Psych Disorder W Cat/Sev CC ²³ or Without MH Legal Status	29,639	7,053	524	5,044	42,260
U63A	Major Affective Disorders Age >69 or With Cat/Sev CC	138,768	78,379	957	8,912	227,016
U63B	Major Affective Disorders Age <70 Without Cat/Sev CC	254,218	316,299	7,112	31,877	609,506
U64Z	Other Affective and Somatoform Disorders	69,467	60,568	1,960	7,420	139,415
U65Z	Anxiety Disorders	40,034	49,769	826	3,482	94,111
U66Z	Eating and Obsessive-Compulsive Disorders	39,884	56,319	474	517	97,194
U67Z	Personality Disorders and Acute Reactions	150,411	95,171	4,593	51,568	301,743
U68Z	Childhood Mental Disorders	11,826	4,867	*****	*****	16,907

- The use of the U60Z code is substantially greater, more than 4:1, in the private sector. This is something of a catch-all for same-day admissions.
- Schizophrenia and other acute psychiatric disorders are predominantly treated in the public sector. This appears to be driven by both emergency entry and the reservation of secure ward facilities to public hospitals.

¹⁸ NMDS: Data supplied.

¹⁹ Independent Hospital Pricing Authority (IHPA). *Australian Refined Diagnosis Related Groups Version 6.x*, 2012. https://www.ihs.gov.au/sites/default/files/publications/ar-drg-v6_x-addendum_0.pdf

²⁰ Mental Health.

²¹ Electro-Convulsive Therapy.

²² Catastrophic or Severe Complication and/or comorbidity.

²³ Catastrophic or Severe.

- A tendency for older patients, and those with significant complications, to be looked after in the public sector and for younger patients without complications or comorbidities to receive greater access with PHI. While this has complex drivers, we would expect an intersection between:
 - Greater waiting list priorities for patients with complications, and of greater frailty;
 - Simply more private hospital access due to the absence of waiting lists; and,
 - Entry. Those with catastrophic or severe complications are more likely to enter through emergency departments;
- Higher numbers of anxiety and eating disorders in the private system.
- Children’s treatment is much more common in public hospitals. This appears to be driven by emergency entry associated with self-harm or suicidal ideation.

There is strong evidence here for the value proposition of mental health in the private sector. In particular, the private sector is not limited by the length-of-stay constraints which characterise the public sector. This is predominantly due to the public sector’s capital need to respond to demand for emergency services.

Looking to actual cost, the following table shows numbers of separations and expenditure by source for the same timeframe:

Table 3: Numbers and Expenditure on Hospital Admissions for Insured Patients (2016-17) ²⁴						
AR-DRG Version 7.0 Code	Number of Unique Patients ²⁵	Total Separations	Total Fund Benefits Paid ²⁶	Total Medicare Benefits	Total Charges	Weighted Mean Patient Age ²⁷
U40Z	968	7,397	\$4,281,883	\$1,242,101	\$5,631,321	48.7
U60Z	9,808	118,230	\$37,651,803	\$1,370,258	\$40,661,223	44.2
U61A	13	15	\$119,977	\$12,783	\$134,461	42.7
U61B	1,394	2,600	\$32,378,473	\$2,726,965	\$36,016,844	42.8
U62A	20	21	\$287,379	\$32,680	\$332,984	57.0
U62B	365	392	\$3,924,877	\$341,552	\$4,458,063	45.8
U63A	1,742	2,680	\$38,045,826	\$4,036,483	\$43,203,315	70.9
U63B	9,539	15,851	\$192,927,328	\$18,087,947	\$217,292,052	43.8
U64Z	2,684	3,501	\$36,405,704	\$3,205,424	\$40,956,550	45.7
U65Z	2,509	3,068	\$29,467,993	\$2,764,254	\$33,540,510	46.8
U66Z	1,179	1,877	\$28,178,466	\$2,260,464	\$31,350,679	28.2
U67Z	4,026	5,300	\$53,451,783	\$4,492,054	\$60,230,589	38.4
U68Z	188	217	\$2,350,302	\$169,366	\$2,597,115	26.8

²⁴ Based on HCP1 (Insurer to Department) Data supplied.

²⁵ Based on unique combination of Fund Id, Person Id, Sex, Date of Birth from HCP1.

²⁶ Excluding Medicare Benefits.

²⁷ By total episodes admitted.

Two items particularly stand out here:

- The U60Z code shows an average of 12.05 admissions per year for each unique patient at a mean non-MBS cost of \$318.46 per separation; and,
- The relatively high cost of eating and associated disorders (U66Z) at a non-MBS expenditure of \$15,011.44 per admission.

If we look to some actual fund data to provide illustration of this table, Medibank Private advise that:

- In calendar 2018, Medibank funded 82,592 separations with an associated depression or anxiety diagnosis. Of these separations, 65% were same day and 35% were overnight admissions.
- Of Medibank members with a “first” mental health admission in calendar 2017 (n= 5,287), 39% had a subsequent mental health admission within 12 months.
- For members admitted for a first depression/anxiety admission in 2015, examples of individual 4 year journeys for the top 30 most intensive claimers follow:

Figure 1: Medibank 4 year pathway for members admitted for “first” anxiety/depression admission in 2015, includes all subsequent mental health admissions (members ranked by greatest length of stay): Highest users of benefits

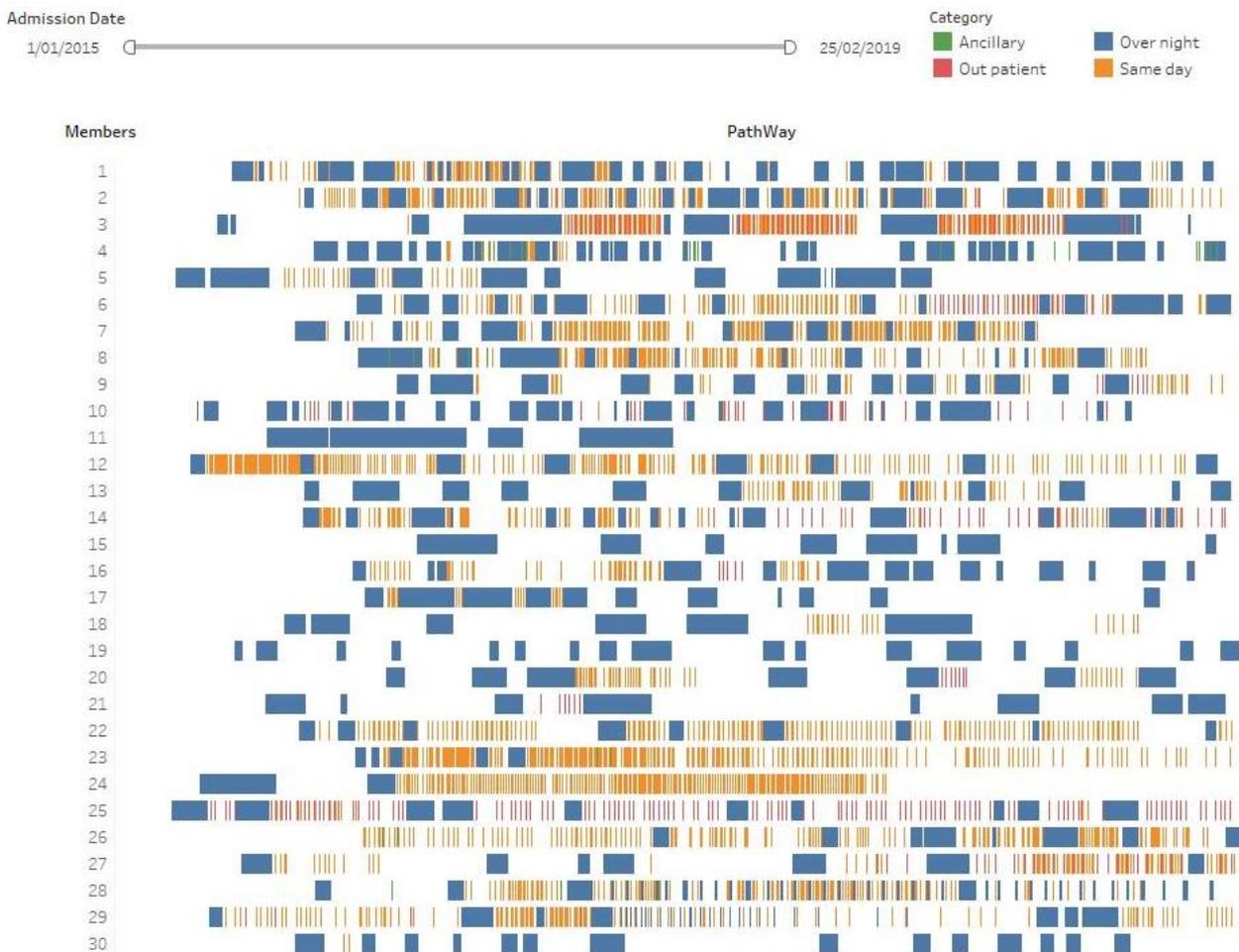


Figure 1 illustrates not only the potential dominance of a small group of patients in the growth of mental health expenditure by PHI, but also the extremely heterogeneous admission pathways they take over a four-year period. This emphasises the flexibility of the PHI value proposition.

One benefit which both professional and patient groups note as a benefit of PHI-funded mental health care is the destigmatisation of conditions, which contributes to stabilisation and recovery.

Drug and Alcohol

Similar tables exist for mental health admissions associated with drug and alcohol abuse:

Table 4: Admitted Patient Days for Mental Health Disorders Associated with Drug and Alcohol Abuse by Funding Source (2016-17)						
AR-DRG Version 7.0 Code	Description ²⁸	Public patient	PHI	Self-funded	Other	TOTAL
V60A	Alcohol Intoxication and Withdrawal With CC	12,506	2,307	46	490	15,349
V60B	Alcohol Intoxication and Withdrawal Without CC	17,102	3,025	213	327	20,667
V61Z	Drug Intoxication and Withdrawal	82,821	5,675	622	2,506	91,624
V62Z	Alcohol Use Disorder and Dependence	40,386	98,474	1,996	5,843	146,699
V63Z	Alcohol Use Disorder and Dependence, Same-day	6,367	10,733	401	636	18,137
V64Z	Opioid Use Disorder and Dependence	20,022	30,716	881	808	52,427
V65Z	Treatment for Alcohol Disorders, Same-day	9,560	18,837	466	786	29,649
V66Z	Treatment for Drug Disorders, Same-day	4,009	6,958	131	105	11,203

Again, if looking at actual numbers and expenditure, there is a similar pattern to non-alcohol or drug mental illness:

Numbers and Expenditure on Hospital Admissions for Insured Patients (2016-17) for Mental Health Treatment Associated with Drug and Alcohol Abuse						
AR-DRG Version 7.0 Code	Number of Unique Patients	Total Separations	Total Fund Benefits Paid	Total Medicare Benefits	Total Charges	Weighted Mean Patient Age
V60A	170	180	\$949,768	\$103,830	\$1,099,248	54.1
V60B	371	433	\$1,494,110	\$166,904	\$1,773,065	48.7
V61Z	297	333	\$2,624,972	\$217,752	\$2,950,914	36.7
V62Z	3,500	5,851	\$61,388,849	\$5,350,027	\$69,287,563	47.6
V63Z	486	647	\$6,827,267	\$594,963	\$7,668,738	38.3
V64Z	1,314	1,767	\$18,357,995	\$1,522,009	\$20,803,959	32.7
V65Z	1,741	18,690	\$5,904,729	\$331,041	\$6,464,427	49.5
V66Z	694	6,732	\$1,879,066	\$64,416	\$2,002,504	36.9

²⁸ IHPA, *Australian Refined Diagnosis Related Groups Version 6.x*, 2012, and Australian Consortium for Classification Development, *AR-DRG V.8.0*, 31 October 2014. The latter allows distinction of high and low complexity within selected DRGs, but for time-series, we only have access to aggregate numbers.

Key data are:

- Comparing the two tables, there is an average of 12.8 days per separation for residential detox:
 - This in turn gives a mean cost per day (ex-MBS) of \$411.51 per day;
- If looking at same-day treatment, then there is:
 - A mean of 10.74 admissions for patients with alcohol-related mental disorders, with an average ex-MBS payment of \$313.46; and
 - A mean of 9.7 days for patients with drug-related mental disorders with an average ex-MBS payment of \$270.06 for drug disorders.

Again, the value proposition for PHI for drug and alcohol treatment is clear.

Pattern of Growth

Looking at a time-series of selected data above, we see the following table:

Growth in PHI-Funded Consumption of Four Indicative DRGs						
DRG	Description	Year	Hospital Days with PHI	Unique Patients	Number of Separations	Expenditure (ex-MBS)
U60Z	Same-day MH Treatment without ECT	2017-18	- ²⁹	10,057	120,812	\$39,543,691
		2016-17	110,465	9,808	118,230	\$37,651,083
		2015-16	99,943	9,833	114,373	\$36,105,731
		2014-15	95,704	9,609	111,458	\$34,313,547
		2013-14	90,648	8,719	100,899	\$30,767,815
		2012-13	79,438	7,832	88,458	\$26,193,392
		2011-12	71,149	6,381	74,398	\$21,350,929
		2010-11	66,081	5,982	63,953	\$17,917,558
U66Z	Eating and Obsessive-Compulsive Disorders	2017-18	-	1,249	1,947	\$30,199,783
		2016-17	56,319	1,179	1,877	\$28,178,466
		2015-16	56,914	1,137	1,820	\$27,921,558
		2014-15	54,791	1,088	1,697	\$27,343,065
		2013-14	55,704	1,002	1,640	\$23,922,224
		2012-13	49,723	875	1,432	\$20,679,253
		2011-12	48,630	883	1,444	\$21,126,263
		2010-11	43,625	808	1,279	\$18,056,538

²⁹ Data not yet available for 2017-18.

Growth In PHI-Funded Consumption of Four Indicative DRGs						
DRG	Description	Year	Hospital Days with PHI	Unique Patients	Number of Separations	Expenditure (ex-MBS)
V62Z	Alcohol Use Disorder and Dependence	2017-18	-	3,649	5,869	\$64,363,541
		2016-17	98,474	3,500	5,851	\$61,388,849
		2015-16	87,114	3,247	5,246	\$54,863,543
		2014-15	87,845	3,321	5,197	\$54,187,873
		2013-14	84,939	3,176	4,972	\$48,754,998
		2012-13	77,206	2,864	4,531	\$43,006,970
		2011-12	74,884	2,822	4,444	\$40,941,348
		2010-11	69,466	2,592	3,840	\$32,249,102
V65Z	Treatment for Alcohol Disorders, Same-day	2017-18	-	1,819	21,228	\$6,786,814
		2016-17	18,837	1,741	18,690	\$5,904,729
		2015-16	19,312	1,785	20,590	\$6,398,162
		2014-15	19,765	1,936	22,291	\$6,890,781
		2013-14	20,426	1,752	18,998	\$5,700,455
		2012-13	17,869	1,588	16,296	\$4,718,798
		2011-12	16,772	1,335	14,144	\$4,038,603
		2010-11	16,351	1,337	12,741	\$3,565,918

Leaving aside some observable year-to-year variance, there is a clear upward trajectory in consumption and expenditure across these sub-acute mental health and alcohol-related mental health interventions. If the number of separations is taken as the indicative measure,³⁰ then over an eight-year period there is:

- 88.9% increase in separations for same-day mental health treatment without ECT;
- 52.2% increase in separations for eating and other obsessive-compulsive disorders;
- 52.8% increase in separations for alcohol use disorder and dependence; and,
- 66.6% increase in separations for same-day alcohol disorder treatment.

As noted above, these data illustrate the capacity of PHI to meet latent demand for mental healthcare as patients are made more aware of their options.

³⁰ This is not subject to price inflation and reflects the claimed tendency to increase hospital admissions for each cohort of patients, regardless of duration.

Demographics

Looking to private services across our 21 DRGS, we find that:

- In 2010-11, the mean consumption of PHI-funded hospital days for each unique patient was 34.8. Looking at individual separations, this figure reduces to 16.6 days;
- In contrast, by 2016-17, these figures have reduced to 24.2 and 5.3 days respectively; and,
- At the same time, the number of unique patients has increased by 114% and the number of separations by 363%.

Clearly the growth in the patient cohort and the mean annual number of separations dominates the reduction in admission days. Shorter average admissions suggest less acute conditions.

The complete data set on which these and other calculations are based is available for further calculation.

Current Settings – Potential Effects on PHI

Premiums

Over the period covered by the data above, the percentage of PHI expenditure allocated to mental health services has risen from 2.9 to 3.9% over an eight-year period. While this is still only one fortieth of total expenditure, this change represents an increase of 34% of expenditure in real dollars adjusted for inflation.

While this is a substantial increase in an isolated area of care, it is not responsible for a substantial share of premium growth.

Participation and the One-Time Upgrade

Part of the value proposition of PHI for members who do not anticipate mental health issues is the 'one-time-only' opportunity to increase from a basic policy to coverage which includes more comprehensive benefits for mental health services.

The one-time upgrade is actually an important mechanism – whose introduction was supported by the PHI sector – for members with high-impact mental health issues, including suicidal ideation. It was intended this would not only ensure appropriate treatment in exigent circumstances, but would also meet the PHI mission of reducing demand on the public system.

Evidence for the effectiveness of this initiative is strong. Medibank have recently noted that 700 customers have used the option in the first nine months with the Fund covering some 20,000 patient days. The median 'wait' between waiver application and admission was three days followed by a mean admission of 28 days, indicating that the reforms are achieving their objective of providing rapid access to mental health care for acutely unwell Australians.

Outcome Evidence

Around one in five people between the ages of 16 to 85 experience one of the high-prevalence mental illnesses in any one year. Anxiety related and affective disorders tend to be the most common and around 25% of people will experience more than one disorder. In addition to anxiety, conditions such as post-traumatic stress disorder and obsessive-compulsive disorder are grouped within the high-prevalence category.

The practical reality is there remain substantial productivity gains available from improved treatment of depression, anxiety and other common mental health disorders. Recent evidence looking at higher rates of global investment in such treatment finds:

- A benefit-cost ratio between 2.3:1 and 3.0:1 if we simply consider economic gains; and,
- A ratio between 3.3:1 and 5.7:1 if we incorporate non-economic health gains (consumer welfare).³¹

The growth in PHI-funded care should harvest some of these gains. However, there is a paucity of data around private mental health care outcomes, and cost-efficiency is difficult to determine. One option here would be for a central agency such as the Productivity Commission to assess patient outcomes captured in the existing Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS). It would be useful if these data were made available to the PHI sector on a seasonal basis.

Value of Hospital Admission

Clinical Views

Clinicians report a number of views about the value of hospital admission. Chief amongst these is in order to stabilise a patient effectively a period of hospitalisation can be necessary. While clinicians support hospital services, however, they are also calling for more of a stepped mix of inpatient and community-centred care.

A number of reasons were provided for this and, while cost was one of them, it was not the critical factor. More importantly a number of clinicians questioned whether bringing people together in a hospital environment unnecessarily reinforces the concept that they were 'sick' and, rather than supporting recovery, reinforces an ongoing view of ill-health rather than wellbeing.

There is also a view admitting a patient to hospital enables them in some cases to recognise their own condition as a genuine sickness and thus assist them in beginning a path to recovery. No suggestion was made that ongoing or recurrent admissions were more effective in achieving this.

³¹ Chisholm, Don et al, 'Scaling-up treatment of depression and anxiety: a global return on investment analysis', *Lancet Psychiatry* 2016, 3

Clinicians also universally reported concern regarding the lack of ‘stepped’ care in the mental health care system. The need to have clear coordinated pathways for patient care such that individuals were treated in the right setting at the right time by the right person is clearly considered critical and is also reflected throughout most of the Australian literature over the last twenty years. This is an area in which Australia is failing patients with the result that some end up in hospital care due to lack of earlier, more appropriate care.

Thus, whilst the Public Mental Health Services Key Performance Indicators report 72.5% of completed hospital stays in 2015-16 claim significant improvement in the admitted person’s mental health,³² clinicians have questioned whether these hospital admissions would have been clinically necessary had an individual received earlier, more appropriate care. At the same time, they are clearly questioning whether day admissions for certain services have any value as day admissions at all and whether many of those services should be delivered in alternative settings.

The cumulative co-payments associated with private mental health services provided in the community are a significant disincentive for consumers to access these services even when they have been appropriately referred and the services are available. Day stay admissions for the same service are therefore more desirable at the patient level as they don’t typically attract copayments, but they are much more costly for the health funds to provide when the additional health benefit is not demonstrated in the clinical evidence. This is a perverse incentive that should be addressed to provide more choice and better care for an appropriate subset of patients.

This is an area in which PHI could add value by changing their funding allocation to co-fund appropriate models of community-based stepped care. As discussed later in this submission, regulations would need to change to enable this transfer which would in turn facilitate the delivery of more appropriate patient care in the most appropriate setting.

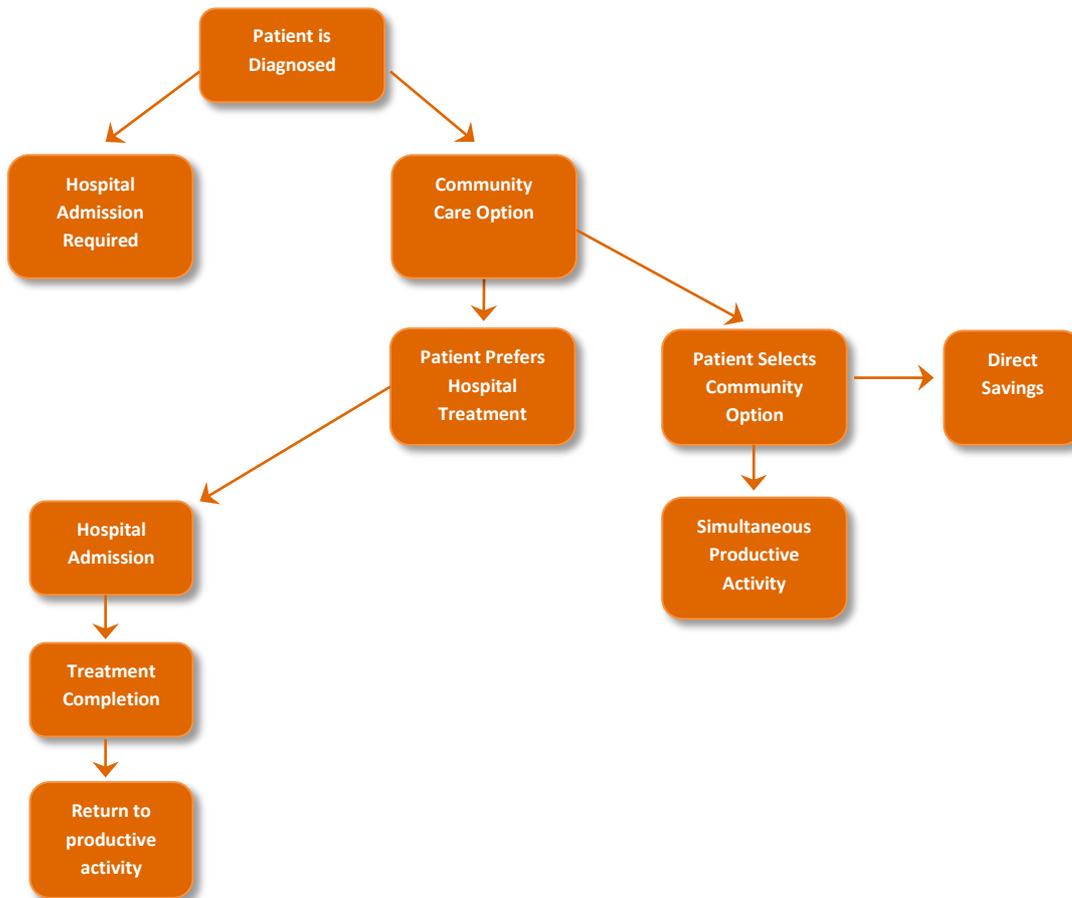
From the viewpoint of the PHI value proposition, the ‘stepped care’ model:

- Retains the value of hospital admission for care where this is clinically indicated; but,
- Provides a less onerous option for continuing care, which is particularly consistent with participation in the workforce; and,
- Maximises patient choice.

³² AIHW, *Mental health services – in brief 2018*, Cat. No. HSE 211. Canberra: AIHW, 2018.

While the growth in consumption of mental health services is not the primary driver of premium growth, the mixed hospital/community model will deliver productivity dividends:

Figure 2: Productivity pathway for clinician/patient-directed mixed service model:



The benefits here are in terms of direct savings to the health system, as well as productive labour force participation or other activity. There is an allocative efficiency in terms of PHI expenditure.

Consumer Views³³

Australia does not have a consistent approach across our states and territories to collecting or collating information regarding consumers' views of their inpatient experience or the value that they place on this. This is despite the fact that this work has long been a critical goal and component of the National Mental Health Strategy.

A project managed by the Victorian Department of Health and Human Services and funded by the Commonwealth Department of Health developed a survey called *Your Experience of Service (YES)* and this survey will be a key plank in reporting against the goals of the Fifth National Mental Health Suicide and Prevention Plan.³⁴

³³ AIHW, 'Consumer Perspectives of Mental Health Care', 2018. <https://www.aihw.gov.au/getmedia/00c93c69-71ce-468f-9f9c-462ea338350a/Consumer-perspectives-of-mental-health-services-2016-17.pdf.aspx> Accessed 19 February 2019.

³⁴ Endorsed by the Council of Australian Governments, *Fifth National Mental Health Suicide and Prevention Plan*, August 2017. <https://apo.org.au/sites/default/files/resource-files/2017/10/apo-nid114356-1220416.pdf> Accessed 19 February 2019.

To date, however, the survey has only been adopted by New South Wales, Queensland and Victoria and only data from New South Wales and Queensland is available. This represents a clear limitation but, regardless, *YES* remains the clearest, non-anecdotal voice of the consumer available.

Whilst limited, the data is significant with more than 24,000 surveys collected from 64 mental health service organisations during 2016-17. Of the 24,322 surveys completed, 15,222 were from patients who had been admitted for their treatment. Over half of these patients had been admitted for between one day and two weeks whilst slightly more than 10% had been admitted for over six months.

Of the admitted patients, which are those considered in this section, 52% identified as male and 10.7% as indigenous. In terms of age, 21.4% were under the age of 25; 43.3% between 25 and 44; and 7.3% 65 and over. This is noteworthy considering the earlier statistics about hospital admissions and other mental health care. 46.5% of patients were admitted on an involuntary basis.

Unsurprisingly patients with *voluntary mental health legal status* tended to report positively about their experience of admitted care service compared to those with *involuntary status*. Regardless of status however, all categories – voluntary status, involuntary status, status not reported – were more positive than negative with the exception of involuntary status patients in Queensland of whom only 44.1% were positive. This was the lowest rating by more than 10% with the highest being voluntary status patients in NSW of whom 73.6% reported a positive experience of service. Overall, the rates of patients reporting a positive service experience were 67.6% and 51.4% for NSW and Queensland respectively when the different categories were combined.

Care was also reported positively with 85.8% of admitted patients in NSW and 73.2% in Queensland reporting that they received good, very good or excellent care.

Potential Policy Solutions

While there is substantial value in PHI-funded mental health care, there are a range of initiatives which can increase the productivity of that expenditure. In particular, we would recommend the capacity for a better designed ‘stepped’ approach which did not restrict private funding to hospital admission. This would permit more patient-directed care, and address economic goals, while ensuring maintenance of treatment.

Gatekeepers

Currently, admission to a private hospital for mental health treatment may be by general practitioner referral or by a hospital-based doctor. This differs from public hospitals, where admission will either be through the emergency department or via a psychiatric assessment.

One approach to ensuring appropriate allocation of care, is to require specific psychiatric referral, either from a public hospital emergency department or from a consulting psychiatrist. This could potentially lead to a substantial reduction in opportunistic admission but will not be a complete panacea.

Restrictions on care

To maximise productivity, PHA is of the view that, where possible, mental health care should occur in the community or in outpatient settings. This removes unnecessary expenditure on hospital admission, particularly for same-day treatment.

However, currently PHI is not able to fund MBS services outside hospitals. This is despite the fact the evidence shows many mental health services for high-prevalence conditions can be effectively provided in the community.^{35 36}

Resolving this will require change to the regulations around PHI. The current restriction is on the funding of hospital substitute services in specialists' rooms: legislation currently prevents private health insurance from covering medical services that are provided out-of-hospital and covered by Medicare.

Current restrictions on PHI are:

1. It is prohibited from covering services under hospital substitute treatment where 85% of the MBS fee is claimed (see the table in s72-1 of the *Private Health Insurance Act 2007*) – this means funds are not able to fund services provided in a specialist's rooms; and,
2. Because hospital substitute treatment is defined as general treatment, funds are generally prevented from covering MBS services within hospital substitute treatment, except for limited circumstances set out in clause 10 of the *Private Health Insurance (Health Insurance Business) Rules 2018*. The definition of general treatment excludes the rendering in Australia of a service for which a Medicare benefit is payable, unless the *Private Health Insurance (Health Insurance Business) Rules 2018* provide otherwise (see s 121-10 of the *Private Health Insurance Act 2007*).

These restrictions broadly prevent funds from funding outpatient treatment intended to prevent progression of disease or other condition.

While the importance of maintaining this restriction as a general rule in order to support the value proposition and sustainability of PHI is recognised, there is merit in specific exceptions, particularly where these both:

- Reduce the expenditure burden on PHI without reducing patient outcomes, thus supporting lower premiums and general efficiency; and,
- Reduce pressure on public services, thereby building toward equity goals.

The general proposal from PHA on this issue is to amend the *Private Health Insurance Act 2007* to release the restrictions on health funds insuring out-of-hospital care for forms of care that have been demonstrated to deliver patients improved choice and outcomes. This could be achieved by introducing a formal schedule of exceptions rather than a general removal of the rule.

³⁵ Dewa, C.S. & Hoch, J.S., "Barriers to Mental Health Service Use Among Workers With Depression and Work Productivity", *Journal of Occupational and Environmental Medicine*, 57:7 (2015)

³⁶ Kroenke, K. & Unutzer, J., "Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care", *Journal of General Internal Medicine*, 32:4 (2016)

Substitute Services

To maximise the value proposition for health fund members, options for low or no-copayment community-based treatment should be introduced. This would involve rolling out and funding new services as substitutes for hospital admission.

The general question to be addressed by substitutes for hospital-based services is: How can the mental health needs of people who currently receive treatment through hospital admissions but prefer outpatient treatment be met? Programs such as counselling and twelve-step programs are readily available in the community at low or no cost through not-for-profit providers and other groups. These will continue to be available without competition from similar services based on hospital rents.

Case Studies

A range of literature looking at non-admitted and community-based mental health services both in Australia and internationally has been examined and an overview of some key studies provided here.

First, looking to the Australian environment, there is interesting evidence of the potential for maintenance services for mental health based on the ubiquitous smartphone platform. This has even been extended to smartphone-based suicide management plans, with strong compliance and positive outcomes for patients referred from a tertiary mental health service.³⁷

While such apps are a far from complete solution to mental health needs, they are an interesting extension to address the shortage of psychiatrist time. That they are effective in the area of suicide only underscores how useful they may be in the case of less acute symptoms. Further, they address a twin-productivity goal: to keep people working and in the community; while addressing the productivity limits imposed by mental disorders.

This is not simply relevant for patients whose primary diagnosis is psychiatric. There is strong evidence of the efficacy of e-mental health across a range of chronic conditions, including diabetes management, to address some of the consequent anxiety, depression and lack of wellness.³⁸

This also works in the other direction. People with serious mental illness have a much higher likelihood of developing a chronic disease. A solution to this is health literacy communications,³⁹ for which digital platforms may be an important option.

As well as apps, there is good evidence mental health recovery is aided by a digital portal to access information and patient records from tertiary mental health facilities. The likelihood of follow-up attendance (see below) is also 67% greater for web portal users.⁴⁰

³⁷ Glenn A. Melvin et al, 'Evaluating the Feasibility and Effectiveness of an Australian Safety Planning Smartphone Application: A Pilot Study Within a Tertiary Mental Health Service', *Suicide and Life Threatening Behaviour*: 2018. <https://onlinelibrary.wiley.com/doi/pdf/10.1111/sltb.12490>

³⁸ For an outline see: Donald M. Hilty, Barb Johnston, and Robert M. McCarron. 'How e-Mental Health Adds to Traditional Outpatient and Newer Models of Integrated Care for Patients, Providers, and Systems', in D. Mucic, D.M. Hilty (eds.), *e-Mental Health*, Switzerland: Springer, 2016: 129-149.

³⁹ Whitney Clausen et al, 'Health Literacy Among People with Serious Mental Illness', *Community Mental Health Journal*, 22 September 2015, https://www.researchgate.net/profile/Shinobu_Watanabe-Galloway/publication/282658883_Health_Literacy_Among_People_with_Serious_Mental_Illness/links/5ae479e6aca272ba507effda/Health-Literacy-Among-People-with-Serious-Mental-Illness.pdf

⁴⁰ Sarah Kipping et al., 'A Web-Based Patient Portal for Mental Health Care: Benefits Evaluation', *Journal of Medical Internet Research*: 18:11, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5131190/>

There is an interesting philosophical issue addressed here. It is commonly asserted mental health patients seek a high internal locus of control that allows them to 'take charge' of their illness. However, some recent research shows that this is highly equivocal, particularly with people experiencing high-intensity illness who benefit psychologically from trust in their doctor (an external locus of control).⁴¹ This kind of portal has the potential to link the two and therefore to give a sense of continual access to care.

At the other end of the spectrum, efficiency at hospital admissions, and particularly the prospect of high demand from mental health presentations increasing waiting times for other patients, is of key interest. There is strong evidence in the Australian market for the introduction of emergency department assistance for mental health led by nurse practitioners.

This type of assistance acts as a clearing mechanism and is highly valued by mental health patients presenting to the ED. It would primarily remove some of the current pressure on public hospital services, but would also be useful in triaging people into non-hospital and nurse-led community services.

This is demonstrated in particular by the introduction of a Mental Health Liaison Nurse at the Royal Prince Alfred Hospital in Sydney which has evolved into an emergency department-based outpatient service for mental health patients.^{42,43} This is a useful extension model to reduce hospitalisation and to manage frequent visitors with ongoing mental health needs.

Tertiary outpatient clinics are particularly effective at addressing patient satisfaction without competing for hospital services and inpatient funding. An international study of 1100 patients found 87.28% satisfaction levels.⁴⁴ Given the complexity of mental illness, this is a remarkably high figure.

However, one of the problems which is identified with outpatient treatment is failure to show for scheduled appointments. This is in the nature of many mental disorders which are somewhat cyclical, particularly where the patient's sense of need does not equate to the appointment cycle, and lead to compliance failures. A recent US study has shown positive outcomes in addressing this problem through the two initiatives of:⁴⁵

- Outpatient referrals for previously admitted patients, scheduling an orientation even five days after discharge. This is attractive, given that our consultation raised the issue of poor continuity between hospital discharge and ongoing care; and,
- Self-referrals, with walk-ins leading to screening. This is a useful triage which will capture the more compliant patients.

⁴¹ Carlos de las Cuevas et al., 'What Do Psychiatric Patients Believe Regarding Where Control Over Their Illness Lies? Validation of the Multidimensional Health Locus of Control Scale in Psychiatric Outpatient Care', *The Journal of Nervous and Mental Disease*: 203:3, 2015. https://www.researchgate.net/profile/Carlos_De_las_Cuevas/publication/266624311_To_what_extent_psychiatric_patients_feel_involved_in_decision_making_about_their_mental_health_care_Relationships_with_socio-demographic_clinical_and_psychological_variables/links/54f0236e0cf2495330e3d38d/To-what-extent-psychiatric-patients-feel-involved-in-decision-making-about-their-mental-health-care-Relationships-with-socio-demographic-clinical-and-psychological-variables.pdf

⁴² Timothy Wand et al., 'Evaluation of a nurse practitioner-led extended hours mental health liaison nurse service based in the emergency department', *Australian Health Review*, 39, 2015. https://www.researchgate.net/profile/Timothy_Wand/publication/268506585_Evaluation_of_a_nurse_practitioner-led_extended_hours_mental_health_liaison_nurse_service_based_in_the_emergency_department/links/559b483b08ae99aa62ce3d87/Evaluation-of-a-nurse-practitioner-led-extended-hours-mental-health-liaison-nurse-service-based-in-the-emergency-department.pdf

⁴³ Timothy Wand and Kathryn White, 'Building a Model of Mental Health Nurse Practitioner-led Service Provision in Australia', *The Journal for Nurse Practitioners*, 11:4 April 2015. <https://www.sciencedirect.com/science/article/pii/S1555415515000781>

⁴⁴ Shivananda Jena and Manushree Gupta, 'A survey of patient satisfaction of patients attending a psychiatry outpatient clinic at a tertiary care centre', *International Journal of Community Medicine and Public Health*, 5:5:2018. <https://www.ijcmph.com/index.php/ijcmph/article/view/2819/2030>

⁴⁵ Bernadette A Cullen, 'Altering the Attendance Rate Successfully for New Patients at an Outpatient Mental Health Clinic', *Psychiatric Services*, 69:12 December 2018) <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800161>

This appears to capture both previously diagnosed and undiagnosed patients and bears further consideration in Australia alongside the nurse practitioner model. International evidence shows similar positive results in geriatric psychiatry, for patients who are neither self-risks nor have cognitive disorders.⁴⁶

There is also strong evidence of the linkage between community services and hospital demand, particularly for emergency departments. A tracking study of the health of 11 million adults in Ontario showed over a nine-year period, reduction in mental health presentations to psychiatrists and general practitioners led to a concurrent increase in presentation at hospital emergency departments, predominantly for anxiety and addiction.⁴⁷

This reinforces the fact for many Australians who do not have PHI, but have mental disorders – even those which do not require hospitalisation – the ED is currently a primary care substitute.

This is an important factor in any proposed change to the modal makeup of mental health services. It is why this submission does not suggest there be any change for either acute services or services which necessitate continuous observation. However, services provided in the community remain a better substitute for many hospital services, whether public or private.

A recent example of this in Australia is a Monash small pilot of outpatient treatment for borderline-personality-disorder, using dialectical behaviour therapy. This not only showed patient satisfaction and positive clinical outcomes, but demonstrated clinically appropriate reductions in emergency department presentations and hospital admissions.⁴⁸ While it is a small sample, it is indicative of how good community-based interventions and maintenance treatment might cost-effectively replace hospital services.

One note of caution here is while disease-specific approaches such as the Monash dialectic behaviour therapy trial are highly efficacious for patient outcomes, the benefit-cost may be less clear. A recent US study of a specialist depression service shows that the economic return of improved management given greater cost is somewhat equivocal.⁴⁹

If a comprehensive approach is sought which addresses equity, but does not result in inefficient expenditure, all international evidence is a tiered approach is needed, rather than the current parallel and inequitable two-speed model in place in Australia.

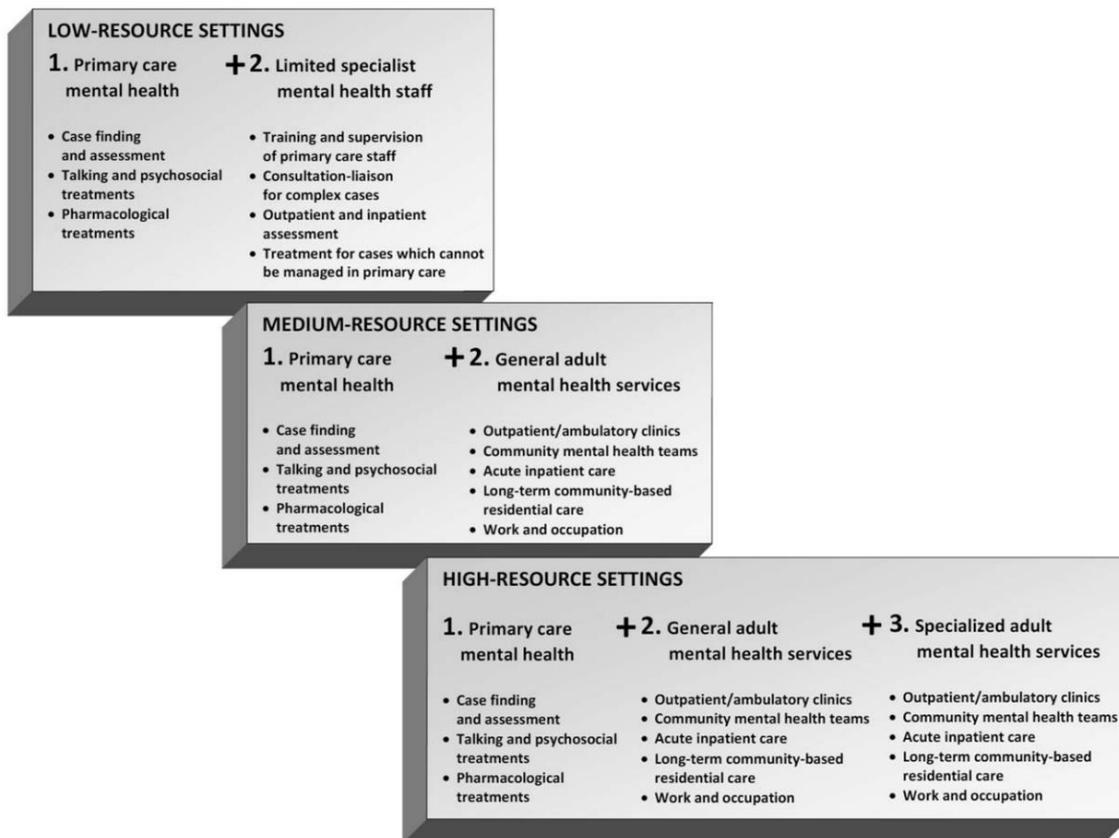
⁴⁶ Esther Teverovsky et al., 'The Implementation and Effectiveness of a Higher Level Outpatient Mental Health Care Program for Older Adults', *The American Journal of Geriatric Psychiatry*, 26:3 2018. [https://www.ajgp-online.org/article/S1064-7481\(18\)30189-1/abstract](https://www.ajgp-online.org/article/S1064-7481(18)30189-1/abstract)

⁴⁷ Maria Chiu et al., 'Temporal Trends in Mental Health Service Utilization across Outpatient and Acute Care Sectors: A Population-Based Study from 2006 to 2014', *The Canadian Journal of Psychiatry*, 63:2 2018. <https://journals.sagepub.com/doi/pdf/10.1177/0706743717748926>

⁴⁸ Lillian Nejad et al., *Clinical And Cost-Effectiveness Of Dialectical Behaviour Therapy (Dbt) In A Melbourne Adult Public Mental Health Outpatient Service*, June 2015. https://www.researchgate.net/publication/281210292_CLINICAL_AND_COST-EFFECTIVENESS_OF_DIALECTICAL_BEHAVIOUR_THERAPY_DBT_IN_A_MELBOURNE_ADULT_PUBLIC_MENTAL_HEALTH_OUTPATIENT_SERVICE

⁴⁹ Richard Morriss et al., 'Efficacy and cost-effectiveness of a specialist depression service versus usual specialist mental health care to manage persistent depression: a randomised controlled trial', *The Lancet Psychiatry*, August 3, 2015. [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(16\)30143-2/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30143-2/fulltext)

An optimal set of mental health services for an economy such as ours is described in the following graphic.⁵⁰



What this model shows is a cascade of settings (and therefore expenses) relative to demand. This would be an effective filter for a redesign of Australian mental health care services and finance. The concept of funding by the resources of settings supports the argument that lower-value admissions might be better replaced by community care.

On the other hand, there is merit here in both public and private sources being able to contribute on a discretionary basis to lower-resource services in order to reduce hospital and emergency demand and to maintain population health. The substitution of long-term community-based care is of particular interest here.

Community management is also important in managing high-cost patients. Maintenance of patients in the community places a significant downward pressure on costs by increasing compliance and engagement with illness. While this is not specific to mental health, North American data shows the issue is compounded in this sphere: high-cost mental health patients – compared to average patients – cost 30% more than other high-cost patients.⁵¹

⁵⁰ Graham Thornicroft, Tanya Deb and Claire Henderson. 'Community mental health care worldwide: current status and further

⁵¹ Claire de Oliveira et al., 'Patients With High Mental Health Costs Incur Over 30 Percent More Costs Than Other High-Cost Patients', *Health Affairs*, 35:1 2016. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0278>

Looking finally to health plan design, we see the effects of the US experience in insisting on parity for mental health and addiction services, which have typically been more restricted than physical health interventions.

Interestingly, the US experience is removing quantitative limits on mental health consumption is not a significant problem, with little evidence that insurers removed mental and addiction services entirely.⁵² This illustrates the core value proposition of PHI.

Aged Care

The template for a community mental health program in Australia is also found in our aged care system. This is a system which, without private insurances, seeks to balance equity and access. The five pillars of the system which drive this, and which could be applied to both private and community mental health care are:

- Availability based on assessed need. State government gatekeepers assess whether an individual should have access to the Commonwealth-funded aged care system, so that services are not consumed unnecessarily;
- A preference for home-based rather than residential care. While the government funds care in residential environments, the cost of housing is predominantly borne by the consumer. This is to ensure that only those who cannot (or prefer not to) receive treatment in their own homes are housed in aged care facilities. These facilities are also limited in numbers and by accreditation;
- A mix of professional services. This is a distinction between nursing services and care services, as aged care is primarily focused on activities of daily living. It is possible to distinguish between psychiatrist, nurse-practitioner and counsellor services in a similar way for mental health and substance abuse;
- Grouping of services. Funding is determined in the Aged Care Finance Instrument (ACFI) by the particular needs of the person. This leads to funding of a specific basket of services rather than provider-determined need which could lead to opportunism; and,
- A degree of patient-centred care, insofar as funding attaches – as a voucher – to the patient, who can then select their care provider.

This is a system which effectively makes sure patients receive what they require. It uses a stepped mix of services similar to those proposed above for mental health services.

⁵² Constance H Morgan et al., 'Health Plans' Early Response to Federal Parity Legislation for Mental Health and Addiction Services', *Psychiatric Services*, 15 September 2015. <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400575>

Design

We would propose to draw heavily on the evidence discussed above to replace some hospital care – and extend some community care to the uninsured – through a cascade of:

- In-home service visits from a range of appropriate practitioners, including:
 - Nurse-practitioners;
 - Psychologists; and,
 - Counsellors; complemented by:
- Community-based facilities run by nurse practitioners, but also utilising the other professions, to address workforce issues. These would have scheduled individual and group appointments;
- Digital solutions, to maintain continuity of care; and,
- Third-party (commonly not-for-profit) services to provide community groups, twelve-step programs and similar.

The final design and pricing of this set will require extensive clinical input and will require some pilots. The PHI sector would be pleased to work with relevant medical and nursing groups, as well as with the Government, to design such a pilot.

At this stage, there is not strong data on potential pricing, which will depend on the clinical rules for allocation to each service. Community aged care services and NDIS-funded community disability services will be instructive here.

Finance

Once the model is agreed, the PHI sector is broadly interested in allocating any savings to community-based services. The scale of this will depend upon the model.

Funding of extended community services could have two components:

- A contract fee to deliver particular services in central locations; and,
- A capitation fee for individual home care.

Again, we want to avoid extension of the MBS or general PHI funding, which could create perverse incentives and an inflationary effect.

Workforce Issues

The aged care experience indicates that there is a shortage of nurses and there will be a greater shortage of nurse practitioners. This requires further investigation and will likely require a mix of training and immigration to address.

Anecdotally, there does not appear to be an undersupply of qualified psychologists and counsellors, and a changed model will deliver an attractive alternative source of income for those sectors.

Productivity Benefits

Broadly speaking, each of the initiatives described above is a productivity benefit. In particular, the opening up of public services by efficiently funding private alternatives is a benefit across the economy. Private Healthcare Australia has commissioned prior work regarding the opportunity cost of waiting lists and recommends this to the Productivity Commission as a starting point.⁵³

More broadly, and looking to the economy as a whole, the World Health Organisation estimates:⁵⁴

- For 2016, Australia lost some 802,400 disability-adjusted life years (DALYs) due to mental illness; and,
- Almost a quarter of these DALYs, or 199,600, were lost due to depression; and,
- A further 209,800 were lost due to alcohol and drug disorders, dominated by opiate misuse.

Overall, this represents 14.4% of our total productivity loss from illness. This is a fertile field for improvement of outcomes. PHI is making a substantial contribution to this and that this will only increase with the productivity measures proposed.

⁵³ Alastair Furnival et al, The Relative Efficiency of The Private Health Insurance Rebate v. Direct Public Health Expenditure, 1 August 2017. <https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Evaluate-Report-Relative-Efficiency-of-PHI-Rebate-versus-Direct-Public-Health-Expenditure-1Aug2017.pdf>

⁵⁴ WHO DALY Estimates by Country 2016. https://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html

ABOUT PRIVATE HEALTHCARE AUSTRALIA

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body that currently has 22 registered health funds throughout Australia and collectively represents 97 per cent of people covered by private health insurance. PHA member funds today provide health care benefits for over 13 million Australians.

Private health insurance is provided through organisations registered under the *Private Health Insurance Act 2007*. The financial performance of registered health funds is monitored by the Australian Prudential Regulation Authority, an independent Australian Government body, to ensure solvency and capital adequacy requirements are met.

All members of PHA are registered as health benefits organisations with the Commonwealth Government and comply with Government standards and regulations on benefits and solvency.

