Private Healthcare Australia
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Getting more value from mental health care funding and investment consultation

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Private Healthcare Australia (PHA), the peak body representing Australia's private health insurance industry, welcomes the opportunity to comment on your consultation paper: 'Getting more value from mental healthcare funding and investment.'

About PHA

PHA members include 24 registered health funds from across Australia who collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for 14.7 million Australians – 55% of the population.

Private health insurance for mental health services

Many Australians are attracted to private health insurance for mental health care because insurers fund a range of inpatient, outpatient and community based mental health services not readily accessible in the public system.

As a result, Australia's private health system cares for most Australians receiving hospital based mental health care. Data from the Australian Institute of Health and Welfare show private hospitals performed about 55% of inpatient mental health care in 2021-22, and that overnight admissions for mental health treatment steadily increased by an average rate of 5% each year for the past decade.

In 2022, psychiatric, addiction and behavioural disorders were the top cause of hospital admissions for private health insurance members aged under 50, and the pandemic has coincided with a significant increase in long hospital stays among people aged under 30. Since 2019, there has been a spike in the number of people under 30 receiving hospital care costing more than $10,000 per admission. Between 2019 and 2022, these 'high-cost claims' increased 4% among members aged under 30, and 5% among members aged 15 – 24. For these high claimants under 30, the average length of stay in hospital for their mental health treatment episode of care was around 26 days.

Combined with rising rates of mental disorders reported by the Australian Bureau of Statistics this year, high cost claims are a worrying trend that suggest demand for expensive, lengthy hospital care will continue to increase. With re-admission rates of up to 43% within a year of discharge and rising costs to deliver hospital-based care, reform is urgently needed to deliver more value-based care and ensure the sustainability of our health system.

Private health insurers are ready to act. For many years, insurers have wanted to deliver new models of mental health care because they know consumers want more convenience, including digital options, out-of-hospital services, and care delivered by a broader range of workers. However, health funds have been severely restricted by current funding rules and regulations that stymie innovation. For this reason, PHA supports MUCHE's goal to explore how Australia can move beyond the Productivity Commission's 2022 report

recommendations and implement the 2022 Mental Health and Suicide Prevention Agreement.

The pandemic proved that with enough political will, new models of care such as telehealth can be rapidly expanded to increase the efficiency and reach of our health system. This, together with advances such as virtual emergency departments, has re-set expectations for consumers who want health care in the right place at the right time and from the right person for their needs.

PHA wishes to comment on the following issues raised by your consultation:

PHA agrees with the Productivity Commission recommendation that Government review regulations preventing private health insurers from funding community-based mental healthcare. This should be a priority over the next two years.

Health insurers across Australia offer Chronic Disease Management Plans (CDMPs) to assist people living with mental health conditions. The objective of these programs is to return our members to a productive life as fast as possible, and to reduce preventable hospitalisations.

CDMPs are governed by the *Private Health Insurance (Health Insurance Business) Rules 2018* (the Business Rules). These Rules currently prohibit health funds from providing CDMP services which include, among others, mental health peer support workers and nurses (including nurse practitioners). The defined list of health professionals listed in the Rules as eligible to provide these services is out of step with current best practice and should be removed altogether.

PHA has engaged with Mental Health Australia and Mind Australia on improving the services available to Australians with a mental health condition, and these organisations advise that a range of practitioners should be employed to provide care. Mental health peer support workers are a clear example of a profession where the evidence base has increased significantly in recent years, yet the current Rules prohibit health funds from providing support to these services.

PHA has also spoken with the Australian College of Nurse Practitioners, who highlight the role that nurse practitioners can play in supporting people with chronic disease, including mental health care.

Along with a developing academic literature base supporting the use of a wider range of practitioners in CDMPs for people with mental health conditions, the Australian Government has several policy positions that support the advocated changes, including:

- The Productivity Commission Mental Health Inquiry (November 2020) which recommended the Australian Government "review the regulations that prevent private health insurers from funding community-based mental healthcare with a

view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions."

- The Nurse Practitioner Workforce Plan (2023) has a goal "to remove barriers affecting the [nurse practitioner] workforce."
- The Strengthening Medicare Taskforce Report (2023) articulates a vision where "health care professionals work to their full scope of practice."
- The Unleashing the potential of our workforce – Scope of Practice Review which is examining how health practitioners can work to the full extent of their skills and training, so Australia optimises its workforce across a stretched primary care sector.

Removing the out-of-date definitions for CDMPs within the Rules would address the Commonwealth Government's goals and provide more flexibility to funds to undertake mental health programs. This announcement would then provide incentives for the sector to participate in more detailed discussions of specific models using the best available workforce.

PHA wants the Government to remove incentives for unnecessary hospital treatment and increase incentives for out-of-hospital models of care approved by clinicians. This should be a priority over the next two years.

The crisis in mental health is not caused by a lack of resources alone, but a misallocation. The market for mental health services in Australia is characterised by problems with supply, demand and incentives which are aligned with low-value services in the wrong setting of care. These issues have been exacerbated by the COVID-19 pandemic lockdowns, and socioeconomic issues arising from the pandemic.

There are currently too many incentives for in-hospital mental health care without enough alternatives that may be preferred by consumers. Australia's funding system is rewarding health professionals for intervening in ways they are familiar with, and hospitals are paid for throughput, not better health outcomes that matter to consumers. There is also a lack of investment in prevention and early intervention, which is known to be beneficial and cost-effective.

Clinicians universally report concern about the lack of 'stepped' care in the mental health care system. There is concern that many people could be receiving earlier intervention to prevent hospital admission, and that people receiving day hospital admission care could be receiving that care in lower cost settings that are more convenient for consumers.

PHA's 2023 report 'There's no place like home: reforming out-of-hospital care' found Australia was lagging the world in its delivery of out-of-hospital care options for people with mental health disorders. International benchmarks suggest there is an opportunity to provide up to 60% of mental health and substance abuse management-related care in community settings, which would result in about $150m in system savings (~14% of baseline

cost). This value arises from avoided hospital admissions and decreased length of stay for both mental health and substance abuse cases through at-home services such as mental health in the home.

For major affective disorders and personality disorders, Australia's average length of stay (ALOS) is 21 days and 18.7 days, compared to 13 and 11.6 days respectively for the US. This is further reduced in the UK where ALOS for personality disorders is 9 days. Almost all inpatient substance abuse-related admissions for patients without specific contraindications (e.g., history of withdrawal seizures) or risks, could be delivered in home settings safely with international benchmarks indicating up to 20% reduction in cost, driving ~$41m in system savings.

There are many potential benefits for consumers, too. While there will always be some people who need inpatient care, many are likely to manage their symptoms well when they are supported in their community and in their everyday lives. Removing someone from their home, their family and their employment or education is disruptive, and is less likely to build the skills required to manage day to day.

To reduce incentives for in-hospital care and encourage more out-of-hospital models, PHA recommends the Commonwealth Government:

- 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 amendment to the *Private Health Insurance Act 2007* could be readily achieved without impacting the overall regulatory environment for private health insurance.

- Amend legislation governing the default benefits system that incentivises private hospitals to create more inpatient mental health services in areas of over-supply. The default benefits system incentivises in-hospital care over some out-of-hospital models of care that produce better outcomes for consumers at lower costs, leading to upward pressure on health insurance premiums. This, in turn, makes private health insurance more expensive, undermining its sustainability over time.

PHA supports a new mental healthcare investment framework.

PHA has previously advocated for the establishment of a clinically led advisory group to review and approve new models of care submitted by community organisations, general practice or other parties which could be funded by health insurers.

At the same time, PHA can see merit in MUCHE's recommendation for a unified national approach to mental healthcare investment, with a systematic, transparent, and risk-based approach to the investment assessment procedure. There is a need for governments,

insurers, providers, clinicians, and consumers to see the comparative value of potential investments to improve mental health outcomes, including areas where disinvestment in services is worthwhile.

PHA supports:

- A unified national approach administered by an appropriate federal government department or agency to provide transparent objective recommendations on worthwhile investments (and disinvestments) to ministers.
- The need for swift, timely advice to ministers to avoid undue delays in implementation.
- The establishment of an independent expert committee to recommend (or not) investments to proceed, such as a committee that operates similarly to the Pharmaceutical Benefits Advisory Committee, which is established through the National Health Act 1953 to provide independent expert advice to the Minister within the Department of Health and Aged Care.

PHA does not support the establishment of an independent value based payment authority.

While PHA supports the need for more value based healthcare, PHA does not support the concept of an independent value based payment authority. Mental health is too important to the community to remove ministerial authority and parliamentary accountability. PHA supports an advisory body to undertake research and analysis, but with decision-making and accountability remaining with ministers accountable to the electorate. This could be delivered by a Cooperative Research Centre, for example, with fewer risks.

Conclusion

PHA wants to see urgent action to facilitate more value based mental health care in Australia and is urging the Commonwealth Government to seize policy options available now. Rising rates of distress, the cost-of-living crisis, and chronic workforce shortages should prompt immediate change to increase access to care, rather than drawn-out debates about a complete rebuild of our system. The private health insurance industry stands ready to work with Government on rolling out new, evidence-based ways of delivering mental health care, so all Australians get faster access to cost-effective treatment in the private and public health systems they rely on.