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

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Hon Dr Michael Armitage
CHIEF EXECUTIVE OFFICER

Submissions – IHPA
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Dear Sir/Madam

Re: Development of the Australian Mental Health Care Classification – Public Consultation Paper 1

Thank you for the opportunity to comment on the work IHPA is undertaking in regard to the Australian Mental Health Classification Project.

Private Healthcare Australia is the Australian private health insurance industry's peak representative body that represents 21 health funds throughout Australia and collectively covers approximately 97% of the private health insurance industry. Private health insurance today provides healthcare benefits for over 13 million Australians.

Our goal is to ensure that private health insurance members receive the best possible healthcare at the best possible prices.

As you may be aware, separations from private hospitals account for approximately 30% of ALL separations from specialised psychiatric overnight inpatient care for adults. In the 2012-2013 year, private health insurers paid approximately $500M in benefits for these services, a cost that continues to increase at a significant rate each year. Given this quantum, any undertakings regarding the collection of data and development of mental health classification systems should include private sector representation. This will assist with the development of a truly representative dataset services provided to mental health patients across Australia.

Private Healthcare Australia (PHA) appreciates the opportunity to contribute to this important task and we thank you for taking the time to consider our submission. For simplicity, our responses follow the format of the questions posed in your paper.

General Comments

1. In the Executive Summary of the Consultation Paper, it states that "…the dataset to be developed by IHPA be derived from existing data collections which can be reported by states and territories where possible." Given the volume of patients treated in the private sector, and the comprehensive dataset readily available through the Private Mental Health Alliance's Central Data Management System, we would encourage IHPA to avail themselves of this information to ensure a more robust and representative overall data collection.
2. In the section headed "Why is the Australian Mental Health Care Classification being developed?" the paper states that *"A number of states and territories have signalled that the development of the AMHCC remains a priority for them irrespective of its association*

with pricing for Commonwealth funding." The private health sector supports – in principle – this view as a more robust system for classification of mental health patients is indicated.

3. The section headed "Mental Health Costing Study" outlines the work commissioned by IHPA for a six month costing study undertaken by HealthConsult. Whilst the paper states that the project involved *"...study at health services across Australia including both public and private hospitals, and community mental health services..."* we do have some concerns about how comprehensive the study was, particularly in regard to information obtained from the private sector, which seems to be minimal. We reiterate our point that a comprehensive and truly representative dataset is the cornerstone of the success of the classification project.

Consultation Questions

1. What are the most important factors to draw from international experiences in classifying mental health care?

    a. The studies undertaken internationally appear to be exclusive of private sector data and also the cohort of patients being treated for drug and alcohol addiction. In our view, any studies of this nature undertaken in Australia should include data from both these areas.

    b. Identifying and learning from both the successful and the unsuccessful elements of the work done at an international level will be inherently useful in the development of a classification system in Australia.

2. What are the most important considerations in the national context?

    a. A comprehensive and accurate data collection exercise is key to the development of a classification system. Collection and submission of data from hospitals should be mandated and enforceable and include a data validation system with a low tolerance error rate.

    b. Data collection should facilitate the collection of outcome data and the opportunity to provide an interface between performance, best practice and funding.

    c. It may be advantageous to facilitate the identification of patient/case outliers which inadvertently skew data. Examples of this could include exceptionally treatment-resistant long stay patients, psychiatric patients with complex medical conditions and any other event that could be deemed irregular in the context of general treatment parameters.

3. Are there any other principles that should be considered in developing the AMHCC?

    a. The role of the private sector in the provision of mental health care and the collection and analysis of data

b. The perspective of the patient and/or carer in the evaluation and treatment process

c. Current restrictions around innovative funding opportunities for private health insurers paying benefits for Members being treated in the public sector

4. Are there further data or other limitations of which the AMHCC should be aware?

a. A lot can be learnt from the CDMS and the data collected and submitted by the private hospital sector, particularly in the areas of collection, submission, analysis and reporting. A review of the CDMS should be an integral part of this overall project

5. Are there any other key considerations that should be taken into account in developing the AMHCC?

a. Data about the whole continuum of care is important. Tracking of the patient journey through all stages of care – from initial presentation at a GP, through to inpatient care at public and/or private facilities, readmissions to the same and to other facilities, day programs, outpatient services and community based care are key elements of a substantive dataset.

6. Are there other cost drivers that should be considered in the development of the AMHCC?

a. Patient access to care – how patients are navigating the mental health care system and processes that can be implemented to enable the best access, at the most appropriate time and in the most appropriate place for the patient.

b. Patients in Crisis – how is this currently managed and how can preventative or early interventions facilitate de-escalation of symptoms in acute patients

7. Are there any further considerations in relation to the proposed architecture?

a. Already addressed in this submission.

8. Is there any further evidence that should be considered in testing the proposed architecture?

a. PHA has no comment in regard to this question.

9. Which psychological interventions, if any, may be of significant in understanding the cost of care?

a. PHA has no comment in regard to this question.

10. Are there particular aspects or areas of the AMHCC that should be prioritised in its development, or aspects that should be developed at a later stage?

a. Already addressed in this submission.

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11. Are there any further considerations that should be taken into account when developing the AMHCC?

    a. No further comment.

If you have any questions please do not hesitate to contact Greg Kovacs on 02 6202 1000 with any queries.

Yours sincerely,

Michael Armitage

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CHIEF EXECUTIVE OFFICER

13 February 2015