PMHA | PRIVATE MENTAL HEALTH ALLIANCE

Australian Medical Association

Australian Private Hospitals Association

Australian Health Insurance Association

Australian Government

Private Mental Health Consumer Carer Network (Australia)

beyondblue – the national depression initiative

UPDATE ON FUNDING SERVICE DELIVERY FOR PRIVATE MENTAL HEALTH SERVICES

DISCUSSION PAPER 2010

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Comments should be received no later than 31 May 2010

Foreword from the PMHA Chair

In Australia, health is an industry in which some services are delivered publicly and some are delivered privately. The mix of public and private services is dependent on a range of factors including consumer choice and availability of resources. In relation to mental health, state and territory governments manage specialised public mental health services and the private sector comprises the range of treatment and care that was, until recently, largely provided by psychiatrists in office–based private practice, and those inpatient and day only services provided by private hospitals. Private sector services now also include those provided in general hospital settings and services provided by general practitioners, psychologists, mental health nurses, and other allied health professionals.

Well over half of all Australians with a mental health problem have, at some stage during their illness, received treatment and care in the private sector. The interrelationship between the sectors means that changes in policy in the public or private sector can have significant impact on other parts of the mental health system. This Discussion Paper provides an update on the funding of mental health services in the private sector and some of the recent reforms that have had an impact on those services. It also puts forward ideas for improvements, or innovations in the funding of mental health service delivery.

The Paper was developed under the auspices of the Private Mental Health Alliance (PMHA or Alliance). The PMHA was the result of a restructure of its antecedent the Strategic Planning Group for Private Psychiatric Services (SPGPPS) that took place in 2007. The SPGPPS was originally established in 1996 under the auspices of the Australian Medical Association to address issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation, and related topics as they affected the private mental health sector. Since the restructure of SPGPPS in 2007, PMHA stakeholders have been working carefully toward the expansion of the Alliance model largely in response to the concept of *Broader Health Cover* and the reforms initiated under the *COAG National Action Plan on Mental Health 2006–2011*. In November 2008, that work came to fruition when the PMHA established its Collaborative Care Models Working Group (CCMWG), which includes representatives of the other key clinical groups now involved in the provision mental health services in the private sector. Currently CCMWG is comprised of representatives from the following organisations.

1.	Australian Medical Association	AMA
2.	The Royal Australian and New Zealand College of Psychiatrists	RANZCP
3.	Australian Psychological Society	APS
4.	Australian College of Mental Health Nurses	ACMHN
5.	Australian Private Hospitals Association	APHA
6.	Australian Association of Social Workers	AASW
7.	Australian Association of Occupational Therapists	AAOT
8.	Private Mental Health Consumer Carer Network (Australia)	The Network
9.	Australian Health Insurance Association	AHIA
10.	Australian Government Department of Health and Ageing	DoHA
11.	Australian Government Department of Veterans' Affairs	DVA

Through the CCMWG, the Alliance is seeking to better engage with all the major stakeholders that now comprise the private mental health sector. One of the first tasks the CCMWG undertook for the PMHA was a review of the *Options for Funding Service Delivery for Private Psychiatric Services: Discussion Paper*, developed by the SPGPPS in 2006. Several of the options that were originally canvassed in the very early drafts of that paper have now been implemented and a wide range of reforms have also taken place. This next Discussion Paper is again intended to inform and stimulate debate concerning the current delivery of mental health services in the private sector. In its development, CCMWG reflected on the last twenty years of history of the major inquiries, reports and developments in mental health. Some of these have been briefly summarised for readers in **Appendix A**.

One of the major outcomes of our review has been the development of the following set of *General Principles for the Funding Private Mental Health Services*, which have been endorsed by the PMHA.

GENERAL PRINCIPLES FOR FUNDING PRIVATE MENTAL HEALTH SERVICE DELIVERY

The development of new models of private mental health service delivery and their associated funding arrangements should meet the following criteria.

1. Provide significant incentives for the implementation of evidence–based best practice models of service delivery.
2. Maximise coordination between all relevant providers of health services to improve the coordination of patient care. This includes the coordination between:
   (a) Providers who work independently.
   (b) Providers who work in the public sector and private sector.
   (c) Providers of services other than health services such as housing and protective agencies.
3. Eliminate or significantly reduce incentives for the provision of clinically unnecessary or inappropriate use of overnight inpatient care, or any other form of hospital–based, or other psychiatric care. New models of service delivery and their associated funding arrangements should be judged on the following criteria.
   - The effectiveness with which the needs of consumers and their carers are met.
   - The efficiency with which the required services are able to be delivered.
   - The extent to which financial risk is equitably shared between providers and payers, or is controlled by other mechanisms.
   - Best medical practice and care, including suitability and risk assessment to themselves and to others.

It is acknowledged that private health insurers and other payers are not able to fund all the services that it may be desirable to have available. Models of service delivery that clearly require increased expenditure by payers should also meet the following additional criteria.

- The disease, syndrome or condition for which services are to be delivered should be a recognised psychiatric condition.
- The proposed model of service delivery and its constituent therapeutic interventions should be based on evidence that they represent current best–practice.[1]

The development of new models of service delivery with associated funding arrangements are encouraged to provide appropriate funding for the implementation of evidence–based best practice models of service delivery. Such models should include the following.

(a) Scope
(b) Purpose
(c) Conduct
(d) Independent Evaluation
(e) Intended Implementation

1. This does not imply that the model of service delivery or all of its components must be evidence–based in the strict sense of that term. It is acknowledged that many aspects of service delivery and certain therapeutic interventions used in psychiatry may not have a firm evidentiary base. Accordingly, this criterion specifies that services should be modeled on what can be shown to be recognised by authoritative clinical consensus to be current best practice.

These General Principles support the substitution of overnight admitted patient care with other models of care, where those models of care result in the improvement, or at the very least maintenance, of the quality of patient care and the overall cost–effectiveness of service provision. Funding models to support such care should be directed toward achieving the optimum mix of services to support consumers and their carers in the most efficient and effective way possible, taking into account the sustainability of the model in an environment of ever diminishing resources. It is also acknowledged that there are perverse incentives in any type of funding model that, in the absence of any quality controls, may operate to reduce costs and the quality of care delivered.

The contributions and assistance of the members of the CCMWG in preparing this Paper is gratefully acknowledged.

PMHA–CCMWG

Chair and Secretary	Mr Phillip Taylor	PMHA Director
Members	Ms Janne McMahon OAM	The Network
	Mrs Ruth Carson	The Network
	Dr Choong–Siew Yong	AMA
	Dr Richard Astill	RANZCP
	Dr John Brown	APS
	Ms Carol Turnbull	APHA
	Ms Marilyn Gendek	ACMHN
	Mr Chris Kennedy	AAOT
	Ms Liz Sommerville	AASW
	Ms Helen Eriksson	AHIA
	Ms Robyn Milthorpe	DoHA
	Mr Peter Callanan	DoHA
	Mr Wayne Penniall	DVA

The views expressed in this Discussion Paper **do not** necessarily represent the views of all participating organisations. While the Discussion Paper explores innovative models of service delivery, these are by no means fully developed or endorsed by all participating organisations.

I hope you find the Discussion Paper useful and we look forward to receiving any comments you might wish to make.

Philip Plummer
PMHA Independent Chair

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CHAPTER 1: PRIVATE SECTOR MENTAL HEALTH SERVICES

In Australia, a mix of public and private service agencies and providers are responsible for the delivery of mental health services for people with a mental illness. State and Territory Governments manage specialised public mental health services. Private sector services are delivered by psychiatrists and general practitioners (GPs) in private practice, private hospitals with psychiatric beds (hereafter Hospitals), and other allied health professionals. These services account for over 60% of all people seen by the Australian specialist mental health sector.[1] It employs 9% of the national mental health workforce and provides at least 22% of total psychiatric beds.[2] The private sector provides a range of mental health care, which includes the services provided by psychiatrists in office–based private practice, which are funded through the Australian Government's Medicare Benefits Schedule (MBS), and Overnight and Day Only services provided by private hospitals for which private health insurers (hereafter Health Insurers) pay benefits. Over 90% of people with a mental health problem or mental disorder seeking hospital–based mental health services in the private sector are privately insured. The remainder include people covered by other third party payers including the Australian Government Department of Veterans' Affairs, compensation insurers or people who fund their own care.

The private sector plays an essential role in the overall provision of mental health services in Australia. Data from the PMHA's Centralised Data Management Service (PMHA–CDMS) has shown that for the 2007–08 Financial Year, private hospitals participating in the CDMS admitted 19,213 patients for psychiatric care. The demographic and diagnostic profiles of those patients are shown in Figures 1 and 2.

Figure 1: Demographic profile (Age group by Sex) of patients admitted to participating private hospitals

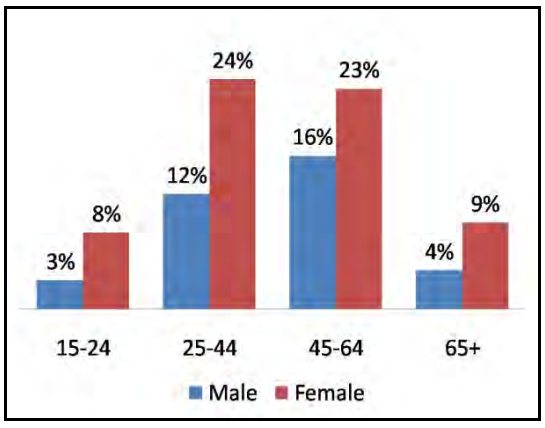
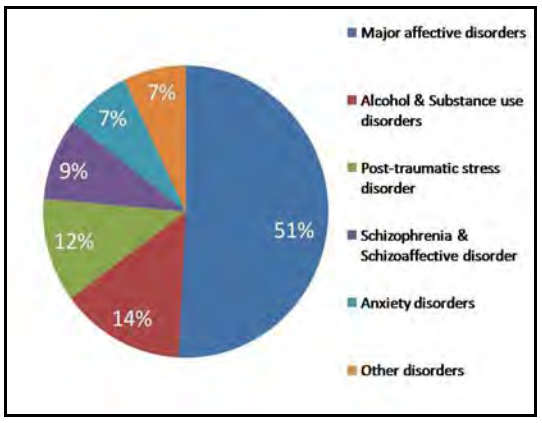


Figure 2: Diagnostic profile for separations from overnight inpatient care.



To give further context to these results, Figure 3 provides a comparison of patients' self–reported clinical status at admission and discharge against the data for the general population derived from the Australian Bureau of Statistics' National Health Survey conducted in 1995. Patients reported mental health, social and role functioning at Admission are worse than 95%

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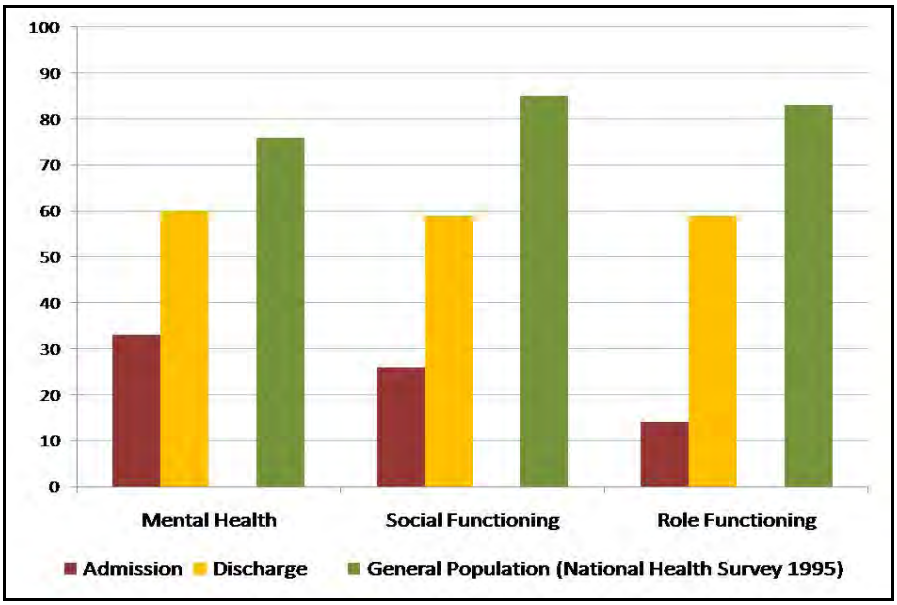
1 Derived from data contained in the Australian Government Department of Health and Ageing (2007), *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993–2005*. Commonwealth of Australia, Canberra.

2 Ibid p. 53

of the general population. By discharge they have improved greatly, but are still not as well on average as the general population.

Figure 3: Comparison of patients' self–reported clinical status at admission and Discharge with that of the General Population.



The available comparisons of the demographic and diagnostic profiles indicate that generally different groups of people are receiving mental health care in each sector.[3]

In 2009, the evidence base available in mental health is still extremely limited in providing information about applied mental health treatments. The emphasis in research remains focused on drug treatments and short–term treatments. Many mental illnesses are long term and involve comorbid illnesses. In many cases, these have not been sufficiently studied because research populations have been chosen to exclude those suffering comorbidity.

The statistical data presented in the rest of this Chapter has been largely drawn from information provided by the PMHA's CDMS and the key national reports that contribute to comprehensive information about mental health services in Australia: *National Mental Health Report*; *Mental Health Services in Australia (2007)*; and the *COAG National Action Plan on Mental Health 2006–2011: Annual Progress Report*. The purpose and scope of those three reports is outlined below.

National Mental Health Report (NMHR)

The National Mental Health Report is the principal report for monitoring progress of mental health reform in Australia and presents an analysis of reform against specified indicators. The Australian Government Department of Health and Ageing (DoHA) produces this report and the most recent edition was for 2007. That edition presented a summary of twelve years of reform in Australia's mental health services under the National Mental Health Strategy from 1993 to 2005. It is anticipated that the National Mental Health Report, covering 2007–08 data, will be released in the first half of 2010.

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[3] Refer to the relevant sections of the Australian Institute of Health and Welfare (AIHW) 2009 Report on Mental health services in Australia 2006–07. Mental health series no. 11. Cat no. HSE 74. Canberra AHIW.

Mental Health Services in Australia (MHSIA)

MHSIA presents detailed source descriptive data on the activity of mental health services, primarily based on annual National Minimum Data Sets (NMDS). It also includes descriptive information on activities of services operating beyond the health sector of relevance to mental health. The Australian Institute of Health and Welfare (AHIW) produces this report. The most recent MHSIA was for 2006–07. The content of both the MHISIA and the NMHR may change in response to the development of the Fourth National Mental Health Plan and other national policy reforms.

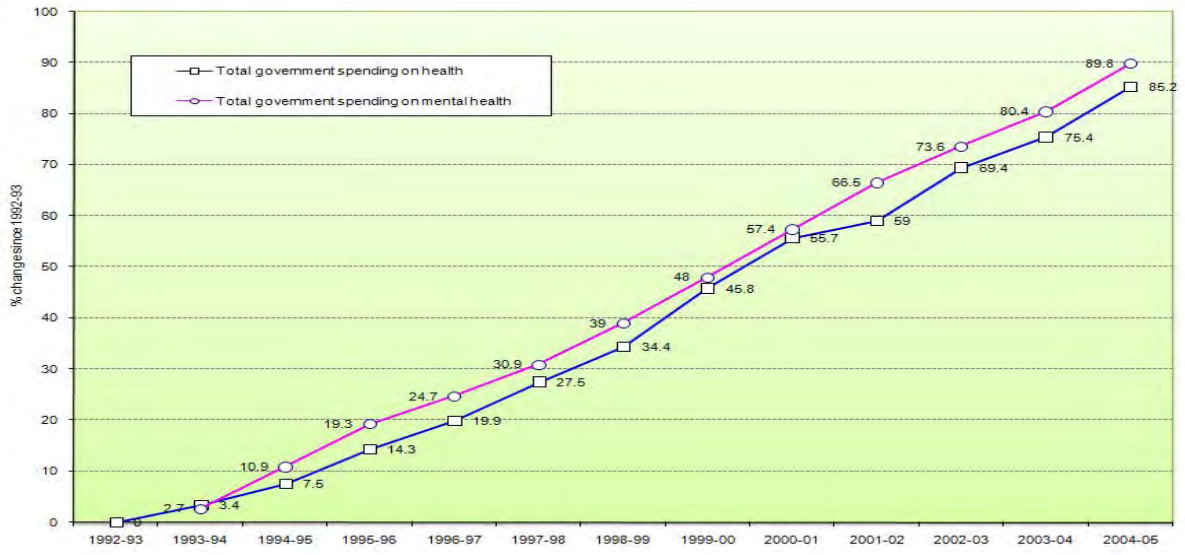
COAG Action Plan on Mental Health 2006–2011: Annual Progress Reports

The COAG Annual Report serves as the key accountability instrument for the Action Plan. It summarises progress in the implementation of the Action Plan and provides available data on outcomes, but does not include the broad statistical data contained in the NMHR or MHSIA. The first annual report to COAG, covering progress in 2006–07, was published in February 2008. The second report covering progress in 2007–08 is due to be published in early 2010. The third annual progress report will cover progress during 2008–09.

1.1 Total expenditure on mental health services

The growth in mental health expenditure compared to overall health expenditure over the from 1992–93 to 2004–05, is set out below.[4]

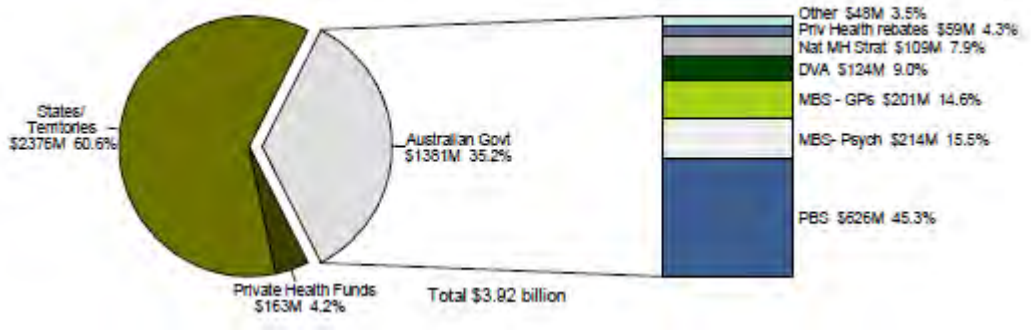
Figure 3 Growth in mental health expenditure compared to total health expenditure



[4] Op.Cit., *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993–2005.*

Total expenditure on mental health related services for 2006–07 was recently estimated by the Australian Institute of Health and Welfare to be $4,707 million. Of this total $1,623 million (34%) was expended by the Australian Government, $2,907 (62%) came from state and territory governments million and $177 million (4%) was expended by the private health insurance system.[5]

Figure 4 Distribution of recurrent spending on mental health services, 2006–07



Between 1997–98 to 2006–07, it is estimated that the average annual rate of funding increase for the Australian Government was 5.3% to 1.62 billion. For state and territory governments the increase was also 5.3% or 2.9 billion with health insurer expenditure approximated as having grown by 1%.[6]

1.2 The public and private hospital sectors

It is estimated, that in 2006–07 there were 6,407[7] psychiatric beds available in the public sector and 1,554 in the private sector.[8] By the end of the 2007–08 Financial Year the number of available psychiatric beds in the private sector had grown to approximately 1,700.[9]

In the public sector, it was estimated that in 2006–07 the number of Psychiatric care days for admitted patients in a designated psychiatric unit, or ward was 2,382,371.[10] In the private sector for the same period the estimated Psychiatric care days (including same day) was 599,234.[11]

The Australian Institute of Health and Welfare's comparison of Total mental health–related patient days for mental health–related separations by hospital type for the period 2001–02 to 2006–07 is set out in Figure 5.[12]

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5 Australian Institute of Health and Welfare (AIHW) 2009. Mental Health Services in Australia 2006–07. Mental health series no. 11. Cat no. HSE 74. Canberra AHIW. P. 167

6 Ibid.

7 Ibid., p. 134.

8 Ibid., p. 141

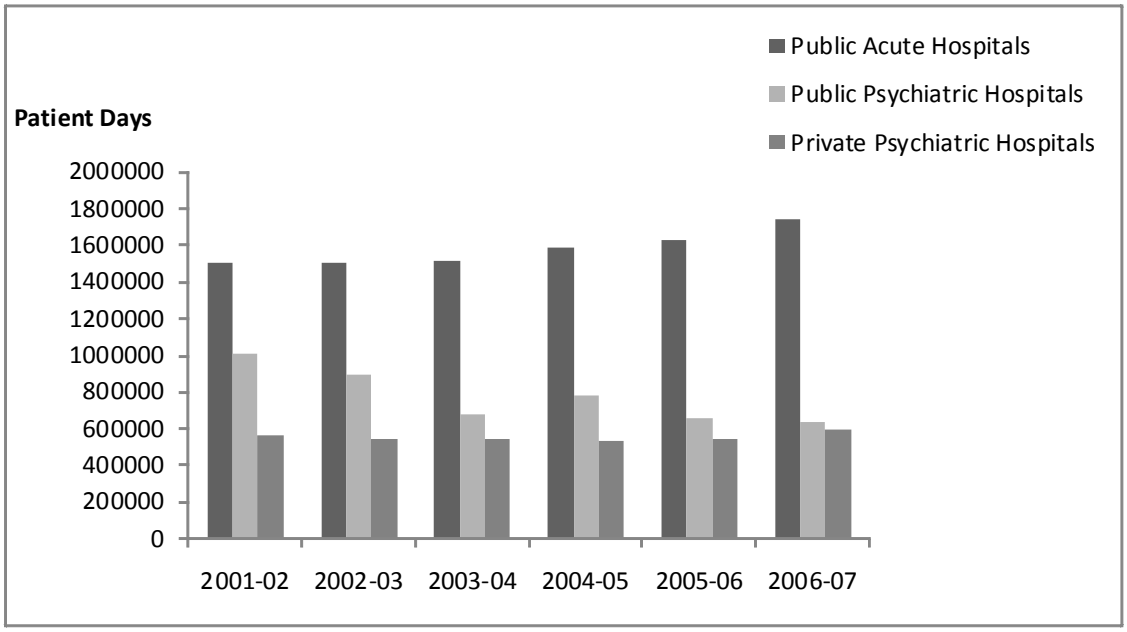
9 Private Hospital–based Psychiatric Services, Annual Statistical Report from the PMHA's Centralised Data Management Services regarding the services provided by participating Private Hospitals with Psychiatric Beds and Private Psychiatric Day Hospitals July 2009. P. 5.

10 Ibid., Table A–15, p. 120.

11 Ibid., Table A–46, p. 158.

12 Ibid., Table 7.1, p. 66.

Figure 5 Total mental health–related patient days for mental health related separations, by hospital type, 2001–02 to 2006–07



1.3 Non hospital–based mental health services

Most of the growth that has taken place in mental health related encounters between a person with a mental health problem and non–hospital based services has been due to the increased range of practitioners now able to provide mental health services in the private sector under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access). The Better Access initiative is one of a number of programs implemented under the *COAG National Action Plan on Mental Health 2006–2011* and focuses on improving access by integrating and improving the mental health care system across Australia. The COAG Mental Health package included $1.9 billion in funding allocated over 5 years for a suite of measures that included the Better Access initiative. The Better Access initiative provides rebates to clients for psychological services provided by eligible clinical and registered psychologists, occupational therapists and social workers through the MBS. These rebates are for provision of specific mental health services including the development of a Mental Health Treatment Plan (GPs) or assessment, evidence–based therapy and focussed psychological strategies. The reforms to the MBS are intended to:

- allow private psychiatrists to see more new patients and refer on those patients who could be more effectively treated by appropriately trained psychologists and GPs;
- encourage more GPs to participate in early intervention, assessment and management of people with a mental illness; and
- increase access to appropriately trained psychologists and allied mental health professionals on referral from a GP.

Figure 6 below[13] shows the uptake of the major MBS Items related to mental health between the 4th Quarter of 2006 to the 2nd Quarter 2009.

[13] Derived from the data that is publically available from the Medicare Australia Website: https://www.medicareaustralia.gov.au

Figure 6 – Demand for Major Mental Health MBS Items

MBS Items Nationally by Quarter from 4th Quarter 2006 to 2nd Quarter 2009														
Item Description	Item #	*Q4 2006	Q1 2007	Q2 2007	Q3 2007	Q4 2007	Q1 2008	Q2 2008	Q3 2008	Q4 2008	Q1 2009	Q2 2009	Total MBS Claims	Total Benefits Paid ($)
GP MH Care Plan	2710	60,909	116,910	118,984	117,784	116,126	125,283	143,612	144,100	144,869	156,826	159,430	1,404,833	215,240,412
GP MH Care Review	2712	529	12,469	25,490	34,715	37,952	40,960	47,987	50,200	51,730	56,485	58,285	416,802	42,779,650
GP MH Care Consultation	2713	30,296	79,963	100,965	116,520	125,193	126,298	151,260	168,186	183,618	183,942	192,272	1,458,513	98,815,136
Total for GPs		91,734	209,342	245,439	269,019	279,271	292,541	342,859	362,486	380,217	397,253	409,987	3,280,148	356,835,198
Clinical Psychologist Items	80000	120	1,238	2,470	2,639	2,987	2,875	3,826	3,616	3,930	3,316	4,326	31,343	2,447,438
	80005	16	52	53	261	382	168	202	116	146	245	214	1,855	180,490
	80010	8,019	62,697	113,188	136,557	148,339	147,051	194,996	204,265	208,880	210,676	248,973	1,683,641	194,879,370
	80015	33	363	738	906	1,212	1,077	1,514	1,671	2,172	2,169	2,874	14,729	1,997,212
	80020	5	144	810	1,090	1,263	755	1,277	1,541	2,053	1,571	2,081	12,590	431,447
Total for Clinical Psychologists		8,193	64,494	117,259	141,453	154,183	151,926	201,815	211,209	217,181	217,977	258,468	1,744,158	199,935,957
Psychologist Items	80100	1,317	5,053	6,847	6,784	6,781	6,012	7,418	7,341	7,309	7,532	8,208	70,602	3,945,060
	80105	123	446	549	775	889	586	1,098	1,061	1,013	844	1125	8,509	655,620
	80110	24,745	137,569	223,737	263,934	285,998	269,917	339,390	353,429	362,420	353,374	413,522	3,028,035	242,197,285
	80115	215	2,140	3,403	5,068	6,808	5,569	8,455	9,428	11,561	11,795	14,242	78,684	7,813,870
	80120	28	302	643	899	1,677	1,037	1,574	1,954	2,881	1,858	2,901	15,754	427,185
Total for Psychologists		26,428	145,510	235,179	277,460	302,153	283,121	357,935	373,213	385,184	375,403	439,998	3,201,584	255,039,020
Total for all Psychologists		34,621	210,004	352,438	418,913	456,336	435,047	559,750	584,422	602,365	593,380	698,466	4,945,742	454,974,977
Social Worker Items	80150	27	147	243	306	200	325	677	644	685	617	702	4,573	240,824
	80155	3	2	12	15	65	191	356	287	371	225	359	1,886	132,980
	80160	723	4,915	9,739	13,685	16,998	17,028	23,187	25,840	26,605	25,282	32,657	196,659	13,909,767
	80165	11	51	257	487	1,002	921	1,196	1,609	1,463	1,634	2,273	10,904	957,551
	80170	36	49	29	27	72	10	122	115	35	71	66	632	12,149
Total for Social Workers		800	5164	10280	14520	18337	18475	25538	28495	29159	27829	36057	214,654	15,253,271
Occupational Therapist Items	80125	4	52	91	149	231	190	306	296	376	372	528	2,595	129,305
	80130		3	4	9	9	10	42	50	86	105	135	453	31,525
	80135	24	594	1,536	2,511	3,239	2,839	4,100	4,528	5,206	4,722	6,262	35,561	2,695,153
	80140	5	38	132	247	324	494	464	776	554	537	614	4,185	400,515
	80145	6		13	33	86	73	83	226	218	125	171	1,034	29,552
Total for OTs		39	687	1776	2949	3889	3606	4995	5876	6440	5861	7710	43,828	3,286,050
Assessment & Management Plan, Psychiatrist	291	1,185	1,698	2,058	2,345	2,476	2,269	2,832	3,095	3,048	2,981	3,400	27,387	9,469,589
	293	97	142	145	242	311	270	374	417	422	416	544	3,380	737,293
Total Assessment & Plan Psychiatrist		1,282	1,840	2,203	2,587	2,787	2,539	3,206	3,512	3,470	3,397	3,944	30,767	10,206,882
Initial Consult, Psychiatrist	296	7,313	16,629	19,002	19,823	18,516	17,647	20,323	20,431	20,109	19,619	21,320	200,732	40,781,763
	297	242	1,451	1,898	2,173	2,153	2,161	2,243	2,542	2,669	2,618	2,676	22,826	4,015,573
	299	54	207	187	224	279	208	192	289	294	204	258	2,396	555,371
Total Initial Consult Psychiatrist		7,609	18,287	21,087	22,220	20,948	20,016	22,758	23,262	23,072	22,441	24,254	225,954	45,352,707
Total for Psychiatrists		8,891	20,127	23,290	24,807	23,735	22,555	25,964	26,774	26,542	25,838	28,198	256,721	55,559,589
TOTAL MBS ITEM UPTAKE		136,085	445,324	633,223	730,208	781,568	772,224	959,106	1,008,053	1,044,723	1,050,161	1,180,418	8,741,093	885,909,085

* Note:MBS items 291 and 293 existed prior to the introduction of the Better Access initiative, but the rebates for these items were increased significantly on 1 November 2006 under the Better Access initiative.

1.4 Access to mental health care

The key points of entry for people in need of mental health care include the following.

- GPs
- Private office–based or community–based psychologists, mental health nurses, social workers and occupational therapists.
- Public Hospital Emergency Departments
- Public Crisis and Acute Mental Health Services

Complex and interrelated issues affect access and these entry points, including workforce capacity, payment systems, insurance coverage and the availability of beds. Both office and hospital–based services have been affected by a shortage of skilled mental health professionals. Payment systems are the subject of ongoing and heated debate. Private health insurance coverage for mental health services often comes under scrutiny, and a shortage of acute and sub–acute beds keeps being reported by practitioners.

A range of reforms have been implemented and others are underway that are geared toward trying to deal with such issues and improve access to mental health care services in both the public and the private sectors. The remainder of this Chapter briefly sets out some of the reforms, regulatory arrangements and initiatives that affect access and the provision of mental health services in the private sector. Further more detailed information on these and other reforms are available from the Australian Government Department of Health and Ageing website at: www.health.gov.au.

Having adequate private health insurance in Australia is particularly valuable, because of the choice and quality of treatment available. People do not commonly plan their private health insurance based on the possibility of suffering a mental illness. Patient care is managed directly by the highly trained mental health professionals and access to private hospital treatment, if needed, is timely and flexible. The level of benefits payable for hospital–based psychiatric care should be considered when deciding whether to obtain private health insurance coverage, and which private health insurance product will provide the best value and security.

1.5 Private health insurance reform

The Private Health Insurance Act 2007 (the Act) and associated legislation initiated a number of key reforms for the private health insurance industry. The Act commenced on 1 April 2007. The primary purpose of the reforms is to provide value to consumers and ensure the sustainability of the sector. More detailed information concerning specific aspects of the changes is available on the internet at: http://www.health.gov.au/phi.

The key features of the new legislation are set out below.

1. It establishes an environment for "Broader Health Cover". Under the new legislation private health insurers may cover Hospital Substitute Treatment (HST) services and chronic disease management programs delivered by non–hospital providers in addition to traditional hospital and ancillary services.

2. Ministerial approval of outreach service providers was removed. As of 30 June 2008, each insurer must determine the services that it will recognise and the criteria/mechanism for approval. Minimum Benefits for outreach services were also removed effective 1 July 2008.

3. Clearer definition of the health insurance business. The primary purpose of a health benefits fund must be private health insurance business.

4. Introduction of uniform safety and quality criteria so that all privately insured services will be provided by an accredited facility and/or suitable qualified provider.

5. Removal of Lifetime Health Cover (LHC) loadings for members who have held private health insurance on which they have paid a loading for 10 years continuously.

6. Health insurers are required to provide Standard Information Statements for each hospital, ancillary and combined product. This information must be provided to members when joining the fund or changing products, on an annual basis and be available on request. The information must be kept up to date and provided to the Private Health Insurance Ombudsman (PHIO) for posting on the dedicated website; (www.privatehealth.gov.au/dynamic/agreement hospitals.aspx).

7. The implementation of risk equalisation (reinsurance) reforms that include:

    - the introduction of a graduated scale for assessing what hospital benefits are to be shared; 15% to 82% for ages 55 plus;
    - a high cost claims pool for claims greater than $50,000;
    - inclusion of HST;
    - Single Equivalent Units (SEUs) continue, but single parents to count as 1 (previously 2); and
    - all insurers to participate in all jurisdictions.

Key features retained from the old legislation are as follows.

1. Rebates are currently retained at previous levels of 30%, 35% and 40%.

2. LHC loadings – with the new exemption after 10 years.

3. Portability requirements.

4. No benefits for services such as those provided in an emergency department or for Type C procedures.

5. No direct or top–up benefits for:
    - Medicare beyond hospital treatment or HST;
    - Pharmaceutical Benefits Scheme expenditure; and
    - Aged care.
6. No limits on benefits for hospital treatment.
7. Second Tier Default continues.
8. The Hospital Casemix Protocol continues.

2009–10 Budget Measures

On the 12 May 2009 it was announced as part of the Federal Budget that additional Private Health Insurance reforms are proposed in order to provide, "fair and sustainable support for the future". It is anticipated that these changes will commence on 1 July 2010.

The key budget measures are:

1. The private health insurance rebate will be means tested; and
2. There will be associated changes to the Medicare Levy Surcharge (MLS).

It is proposed this be achieved by the introduction of a three tiered system that would see high income earners who have private health insurance receive either a reduced or nil 'rebate' whilst rebate levels will remain at the current levels of 30%, 35% and 40% for low to middle income earners.

The MLS would be increased for higher income earners who do not have private health insurance.

1.6 Australian Government legislative or regulatory restrictions

The *Private Health Insurance (Benefit Requirements) Rules* of the *Private Health Insurance Act 2007* (the Act) provides that the Minister for Health and Ageing (the Minister) (or delegate) may determine the minimum level of benefits payable by private health insurers for hospital treatment provided to their contributors, in a public hospital or private hospital with which the health insurer does not have a negotiated agreement (contract). These benefits are commonly referred to as the minimum benefits.

Note: Under the Act private day hospital facilities are classed as private hospitals.

Minimum Benefit The current minimum benefit has operated since 2007. It aims to ensure a minimum level of payment for shared ward overnight and day only accommodation to public and private hospitals that do not have a contract from a particular health insurer. The minimum benefit is not intended to reflect the true cost of delivering a service, rather it acts to ensure that health insurer contributors are guaranteed some level of reimbursement regardless of the hospital's contractual status when they are admitted. The Minister (or delegate) increases the minimum benefit for

overnight shared ward accommodation and day only accommodation benefits each financial year by March on March Consumer Price Index. The average rate is $294 per day for 2009–2010.

Note: Queensland public hospitals use the December to December Brisbane CPI – the average is $301.50 for 2009–2010.

Second Tier The Second–Tier Default Benefit arrangements were created in March 1998 to provide greater financial security for private hospitals, which meet certain administrative and quality criteria, but were unable to obtain, or do not wish to seek, a contract from a health insurer(s). Its introduction was primarily driven by concerns about health insurers commencing selective tendering processes. A Second Tier Advisory Committee, which has equal representation from the private hospital and health insurance sectors, considers applications from private hospitals seeking eligibility to receive Second Tier Default Benefits. The Committee then makes a recommendation to the Minister (or delegate) regarding whether each facility meets the second tier criteria. Once private hospitals are approved by the Minister (or delegate) as eligible for second tier they receive benefits which are no less than 85% of the average charge for the equivalent episodes of hospital treatment under the relevant health insurer's negotiated agreements.

1.7 Other relevant Australian Government initiatives

Some examples of other relevant national initiatives are briefly described below. These initiatives are related to the Australian Government commitment to improve mental health service delivery. They include programs to strengthen the capacity of mental health services as well as programs to address workforce shortages. These programs aim to maintain and improve mental health and facilitate recovery from mental illness by providing a range of prevention, early intervention, clinical and support services to consumers and carers.

Better Outcomes in Mental Health Care (BOiMHC) was introduced in 2001 and aims to improve the quality of care provided through general practice to Australians with a mental illness. The Program includes two components: the Access to Allied Psychological Services (ATAPS) initiative and the GP Psych Support service. ATAPS provides funding through Divisions of General Practice to GPs for referral of consumers, who have been diagnosed as having a mental health disorder, to an allied mental health professional to provide focused psychological strategies. The GP Psych Support service provides GPs with phone, fax and internet/email access to patient management advice from a psychiatrist within 24 hours of their request.

The Better Access initiative provides rebates to clients for psychological services provided by eligible clinical and registered psychologists, occupational therapists and social workers through the MBS. These payments and incentives are for provision of specific mental health services including the development of a Mental Health Treatment Plan, evidence–based psychological therapy and focused psychological strategies services. These reforms are intended to allow private psychiatrists to see more new patients and refer on those patients who could be more effectively treated by appropriately trained psychologists and GPs. The reforms are also intended to encourage more GPs to participate in early intervention, assessment and management of people with a mental illness, and increase access to psychologists and appropriately trained social workers and occupational therapists on referral from a GP.

Mental Health Nurse Incentive Program (MHNIP) provides non–MBS incentive payments to general practices, private psychiatrist services and other appropriate organisations (such as Divisions of General Practice) who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental health disorders. Mental health nurses engaged under the MHNIP must be credentialed. The incentive payment is paid in arrears, generally to the employing organisation, based on the number of sessions delivered by the nurse. Payment to the nurse is a matter of negotiation between the nurse and the eligible organisation.

The ***Expanding Suicide Prevention Programs*** initiative is intended to expand and enhance national and community–based projects under the National Suicide Prevention Strategy (NSPS). The NSPS promotes suicide prevention activities across the Australian population, as well as for specific at–risk groups. Its goal is to reduce deaths by suicide and reduce suicidal behaviour by:

- adopting a whole of community approach to suicide prevention to extend and enhance public understanding of suicide and its causes; and

- increasing support and care available to people, families and communities affected by suicide or suicidal behaviour by providing better support systems.

The Strategy supports national and community based initiatives and projects that enhance the capacity of individuals and services to access information and provide support and training on suicide prevention. These projects also aim to increase the number of individuals seeking help regarding their emotional and social wellbeing and increase the identification, referral and treatment of at risk individuals by service systems and professionals.

Alerting the Community to Links Between Illicit Drugs and Mental Illness. This campaign proposed to increase awareness of co–morbidity of illicit drugs and mental health problems and encourage at risk individuals to seek early assistance. Market research undertaken in 2006–07 found there is a considerable level of awareness amongst young people about potential mental health problems associated with illicit drug use, hence a specific campaign regarding the issue was not necessary. The mental health effects of illicit drug use will continue to be covered in a range of illicit drug information and health education materials.

Additional Education Places, Scholarships and Clinical Training in Mental Health initiative will increase the supply and quality of the mental health workforce. Additional mental health nursing and post–graduate psychology places will be provided, as well as full–time and part–time post–graduate scholarships to nurses and psychologists. Mental health competencies and mental health clinical training, including in Indigenous communities, will be increased across the health workforce, including medicine, psychiatry, nursing, psychology, occupational therapy and social work. The initiative will benefit the Australian health system through an increase in the number of health workers who are skilled in providing mental health services**.**

The Puggy Hunter Memorial Scholarships scheme provides financial assistance to Aboriginal and Torres Strait Islander people who are undertaking study or are intending to undertake study at an undergraduate or TAFE (Certificate IV and above) level across a range of health disciplines including mental health.

***Support for Day to Day Living in the Community* – a structured activity program** provides funding for additional places in existing structured and socially–based day activity programs that assist people with severe and persistent mental illness to improve their ability to live independently in the community and participate in social rehabilitation activities.

Telephone Counselling, Self–Help and Web–based Support Program provide funding to increase access to evidence based telephone and web–based mental health services, treatments and tools to supplement, or as appropriate offer an alternative to, existing face to face services for individuals with common mental health disorders. The initiative will target individuals across Australia who experience mild to moderate mental health disorders or who are in psychosocial crisis, particularly those who currently receive limited or no treatment.

Improved Services for People with Drug and Alcohol Problems and Mental Illness initiative funds the non–government drug and alcohol sector to provide treatment for clients who also have a mental health problem. A range of service improvement activities have been implemented, including training for the drug and alcohol workforce, and the development of more sustainable partnerships with the broader health network. The initiative will benefit people with comorbid mental illness and drug and alcohol problems by building the capacity of non–government organisations to better identify and respond to people with coinciding mental illness and substance abuse issues.

Mental Health Services in Rural and Remote Areas initiative funds services provided by appropriately trained allied and nursing mental health professionals including psychologists, social workers, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers, so people in rural and remote areas can access mental health services. The initiative will enable more people with a mental illness in rural and remote areas to access mental health services.

Mental Health in Tertiary Curricula initiative provides funding to increase the mental health content in tertiary curricula through the development of mental health training modules for registered nurses, including the culturally appropriate management of Indigenous patients, and will provide students with clinical training in multi–disciplinary teams that include allied health, medical and nursing students. The initiative will enable graduates from health courses to gain further skills and knowledge in the assessment, management and referral of people with a mental illness.

The ***Improving the Capacity of Workers in Indigenous Communities*** initiative provides funding to the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Department of Health and Ageing to train Aboriginal Health Workers, counsellors and other clinic staff in Indigenous–specific health services to identify and address mental illness and associated substance use issues in Indigenous communities, to recognise the early signs of mental illness, and to make referrals for treatment where appropriate. Support staff, such as transport and administration staff, will be trained in mental health first aid. The initiative also provides for an additional ten mental health worker positions nationally. The initiative will benefit Indigenous Australians and Aboriginal Health Services nationally, through increased access to trained professionals and better referral and treatment options.

The ***Early Intervention Services for Parents, Children and Young People*** initiative provides funding to assist parents and schools to better identify children at risk of mental illness and to offer early referral for appropriate treatment. Resources, information and training for parents and schools will be provided to promote the availability of new mental health services for children and young people with complex mental health conditions. The KidsMatter suite of activities is the centrepiece of the workplan for the initiative, and includes:

- national roll–out of the KidsMatter Primary School initiative;
- preparation for the commencement of a KidsMatter early childhood initiative;
- development and implementation of KidsMatter parent initiatives;
- provision of support for groups at highest risk: children who have experienced significant trauma, loss and grief, children of parents with a mental illness, and children of Aboriginal and Torres Strait Islander background; and
- expansion of the Response Ability Teacher Education Initiative to early childhood workers.

The ***Mental Health Support for Drought Affected Communities Initiative*** is part of a broader Australian Government response to the drought which recognises the impact of severe drought on rural and regional communities, the environment and the broader Australian economy. The Initiative provides funding over three years (2007–2010) to build the capacity of drought affected communities to respond to the psychological impact of drought. The Initiative's activities include:

- crisis counselling for distressed individuals, families and communities;
- community outreach activities including forming relationships with key community organisations (eg schools, councils);
- establishing and developing linkages with key organisations and local General Practitioners to improve community awareness and knowledge of mental illness;
- education and training for health workers and community leaders; and
- coordination and support for Community Support Workers engaged under the Initiative.

The ***National Perinatal Depression Plan*** aims to improve prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing depression. The following key elements are integral to the National Perinatal Depression Plan:

- routine and universal screening for perinatal depression;
- follow up support and care for women assessed as being at risk of or experiencing perinatal depression;

- workforce training and development for health professionals;
- research and data collection;
- national guidelines for screening for perinatal depression; and
- community awareness.

The ***Program of Assistance for Survivors of Torture and Trauma*** (PASTT) promotes the physical health and psycho–social recovery of entrants to Australia under the Humanitarian Program who have pre–migration experiences of conflict and human rights abuses, which makes them vulnerable to developing mental health problems. PASTT provides a range of activities including, medium to long term individual and group counselling and related support services such as referrals to mainstream health and other services. PASTT also provides community development, education and systemic advocacy and education and training to other service providers on the needs of torture and trauma. PASTT is delivered through eight specialist torture and trauma agencies, one in each State and Territory.

Mental Health Workforce Advisory Committee **(MHWAC)** provides advice to the Australian Government on mental health workforce related issues. MHWAC's role includes the following:

- Providing advice on workforce related issues that may be appropriate for cross–jurisdictional or national action;
- Implications of broader health and other workforce issues/initiatives for mental health;
- Facilitating information sharing on workforce related initiatives between the jurisdictions;
- Facilitating communication between training bodies and professional associations, and other mental health workforce stakeholders;
- Reviewing the collection of national mental health workforce data and make recommendations to the Australian Government and other relevant bodies on strategies to improve data collection;
- Analysing and reporting on that data with a view to assisting mental health workforce planning;
- Encourage the development of consumer led services in jurisdictions; and
- Undertaking specific workforce related tasks as directed by the Australian Government.

Current work includes the following:

- Web–based Professional Education Project (MHPOD);

- National Practice Standards for the Mental Health Workforce Implementation Project;
- Mental Health Skills Articulation Framework between the Vocational Education and Training and Higher Education Sectors Scoping Report;
- Jurisdictional Workforce Templates;
- National Mental Health Workforce Strategy and Plan;
- Mental Health Nurse Education Taskforce; and
- Consumer and Carer Workforce.

The ***National Eating Disorders Collaboration*** brings together eating disorder experts in mental health, public health, health promotion, education, and research, as well as the media to help develop a consistent approach to the prevention and treatment of eating disorders. This initiative will contribute to ensuring that young people with eating disorders are able to access evidence–based, consistent information through avenues such as schools, the media and health service providers.

Headspace provides mental and health wellbeing support, information and services to young people and their families across Australia. It was established and funded by the Australian Government in 2006. Headspace is the National Youth Mental Health Foundation. The people that work at Headspace are providing solutions for young people aged 12 to 25 years. Its primary focus is the mental health and wellbeing of all Australians. Getting help early is the key to resolving these problems quickly. With 30 one–stop–shops, Headspace has a range of youth friendly health professionals who can help with:

- General health
- Mental health and counselling
- Education, employment and other services
- Alcohol and other drug services.

The ***National Advisory Council on Mental Health*** (NACMH) was established in 2008 by the Minister for Health and Ageing as part of the Rudd Government's election commitment. NACMH provides independent and confidential advice to Government on mental health issues as requested by the Minister. It provides a formal mechanism for the Australian Government to gain independent advice from a wide range of experts to inform national mental health reform. NACMH consists of individuals who have been appointed as experts, rather than representatives of particular organisations, professions, or constituency groups.

1.8 Collaboration, coordination and communication (the Three Cs)

The range of professionals now working in the private sector demand a high level collaboration, coordination and communication. In the course of the development of this Discussion Paper the following issues were identified as important to the Three Cs.

- Private hospitals, psychiatrists and GPs have critical roles to play in the private sector as the key points of focus for achieving continuity of care, particularly given the difficulties some consumers and carers experience in firstly accessing, and then negotiating, their way through the system.

- The primary treating clinician is generally best placed to provide continuity of care. However, often an ongoing relationship is not formed with a GP, or multiple GPs are used. While no model is perfect, potentially there is a better chance for coordination to be effective in the private sector because, generally, the same primary care clinician is responsible for the patient in both the private hospital and in the community. There is also scope for much more focussed service delivery at home. Where the Three Cs work well, there is usually a central point of contact, such as the local private hospital, involved in coordination of the services provided. It is also evident from the Mental Health Nurse Incentive Program that Mental Health Nurses are also fulfilling that role (see Chapter 3).

- People living in regional and remote areas have difficulty in accessing psychiatrists. One solution would be to make private hospital services more flexible in larger regional centres to enable access to outreach type services. Another option is to include access to psychologists in rural areas. Hospitals and other mental health service providers could be encouraged to include psychologists, social workers, and occupational therapists in private practice in ongoing patient care. One of the issues is that patients are discharged with no on–going care and if they do happen to see a private practitioner it is very difficult to gain access to information from the hospital, impacting on the continuity of care.

Another crucial aspect of the Three Cs is *networking*. The Mental Health Interdisciplinary Networks Project, or MHIN, is a good example of an initiative geared toward improving networking between the mental health professionals. It is a project of the Mental Health Professionals' Association and has been funded by the Australian Government as part of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule* (Better Access) initiative, to develop an integrated education and training package in support of collaborative care arrangements in delivery of primary mental health care.

The objective of the MHIN project is to provide clinicians engaged in mental health service delivery with the necessary support and resources to assist with the establishment and maintenance of collaborative care networks in their local area, including information and advice on the appropriate, effective and efficient use of the new (and existing) MBS item numbers and provide opportunities to network so that GPs, psychiatrists and paediatricians can make effective referrals to psychologists, mental health nurses, social workers and occupational therapists. The project incorporates the following activities.

- A thorough environmental scan of current workforce issues, referral pathways and working relationships between the professions.
- Development of a comprehensive multidisciplinary clinical education and training package.
- Development and maintenance of a multidisciplinary web based resource portal.

There are funding implications for the three Cs, which relate to the amount of largely non–patient contact time that clinicians spend collaborating, coordinating and communicating, and the paper work that involves.

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CHAPTER 2: CONSUMERS AND THEIR CARERS

The experiences of consumers and carers have long been the subject of description and debate. Significant, moving and often critical stories have been recorded and subject to scrutiny over decades and ultimately have appeared to play a part in the legislative moves to include both consumers and carers in consultations on issues of policy and service provision. It is this notion of consultation that remains to be challenged because that discussion goes to the heart of the nature of real inclusion for both consumers and carers.

It is still of interest that in this period so much further on than say the Burdekin Report (1993) or the MHCA's "Not for Service" (2005), the same expectations re–appear and are evidently still not being met. In the comments that follow this is clearly demonstrated. The call for the lived experiences of consumers and carers to be heard and translated into practice is still not clear enough after all this time. This therefore raises the question as to why this should be so. On their own, these stories do not establish truth

The vehicle for imparting information is usually in the form of consultation. But beyond that process there appears to be little significant interaction between participants, between the experts and the lay people, between expert and lay knowledge where neither arena is privileged, but from which dialogue might emerge meaningful knowledge.

It is clear that the lived experiences of consumers and their carers provide an essential source of information about the quality, effectiveness, accessibility and appropriateness of mental health services. They know what does, and what does not, work for them. Therefore, models of service delivery and their associated funding mechanisms must be judged on their capacity to meet the fundamental expectations of consumers and their carers. Services must:

1. facilitate continuous and coordinated high quality care that is delivered by a range of services across a variety of settings;
2. provide access to a range of specialist treatment and support services;
3. respond to the needs of consumers and their carers in a timely and efficient manner that promotes recovery and support gains made;
4. provide a choice of treatment programs;
5. provide the most facilitative environment for appropriate treatment and care;
6. prevent co–payments and out–of–pocket expenses[14]; and
7. protect patient privacy and confidentiality.

Prior to the introduction in 2007 of the concept of "Broader Health Cover", there were some very complex legislative and regulatory arrangements, together with other economic issues that prevented the funding of the full range of services that consumers and carers wished to receive. Since "Broader Health Cover", the funding for, and delivery of innovative services within the community setting, has opened up a wide range of opportunities.

The following three key areas have been identified as crucial in addressing the expectations identified above.

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[14] Co–payments and out–of–pocket expenses may be a health insurance product issue arising from choices made by a consumer.

2.1 Effective involvement of and support for Carers

Models of service delivery are required that ensure the meaningful engagement of carers by facilitating the provision of *education, practical information, support*, and *inclusion*.

Carers need *education* about mental illnesses and *practical information* on issues such as self–care, conflict resolution, and negative emotions towards the one they care for. There is an urgent need to provide programs that promote and support family relationships to both consumers and *carers* alike. Mental illness places massive and negative stressors on relationships, particularly partner and wider family relationships. Additionally, medications used to treat mental illness can interfere with a large range of personal problems. When the family unit becomes dysfunctional, this often creates an environment that exacerbates mental illnesses, with poorer outcomes.[15]

Carers require *support* for their own needs and information on what counselling and support services are available for carers and how to directly access such services. All health professionals and health care organisations should be required to provide carers with such information.

With the approval of the patient, carers must be *included*, in admission and discharge processes of private psychiatric hospital–based services, and in office–based practice. Without these needs being met, then the more general requirement of inclusion is downgraded.

An urgent need for review of the MBS funding item to facilitate the involvement of carers in processes in office–based practice is required to eliminate restrictions in its current application.

Hospitals are supportive of the effective involvement of, and support for, carers in mental health programs but, historically and prior to "Broader Health Cover", the programs that have been implemented by hospitals are for the most part unfunded. Exceptions to this are some programs funded by the Department of Veterans' Affairs, such as Post Traumatic Stress Disorder (PTSD) and Drug and Alcohol programs. Models of service delivery and funding need to ensure the involvement of *carers* in all discharge processes. Frequently, the carers informed knowledge of the circumstances that surround the care they are expected to offer will enhance the chances of a satisfactory progress towards some level of recovery.

2.2 Access to alternatives to private hospital–based care

Consumers and carers need models of service delivery and funding innovation that will provide access to a comprehensive range of alternatives to private hospital–based inpatient care. These should include early interventions that aim to prevent the need for hospital admission in the first instance, together with other service models that aim to reduce Length–of–Stay and the need for re–admission.

Outreach type services are critically important to mental health consumers and their carers. Prior to 1 April 2007, public or private hospitals could apply to the Commonwealth Minister of Health and Ageing for approval to provide outreach type services such as Hospital–in–the– Home (HITH) to privately insured patients. Since

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15 Sane Australia – Intimacy and mental illness. SANE Research Report 8, 2009. This paper is available from www.sane.org

1 April 2007, HITH services have been able to be included in the concept of "Broader Health Cover" provided by private health insurers without needing to be approved by the Minister. It is, therefore, up to individual health insurers to decide whether or not they offer outreach type services as part of "Broader Health Cover". Hospitals need to negotiate directly with health insurers for the provision of HITH services. Despite the range of complexities that are currently involved with providing and funding outreach type services, they are critically important to mental health consumers and their carers as they are capable of providing the treatment and care required for both mental **and** physical disabilities outside of a hospital setting. Those services that are in place should, therefore, be retained and the model expanded as an important component of the range of community–based services that are available outside of the Hospital inpatient setting.

Telepsychiatry, telephone or internet counselling services are important strategies, particularly for rural and remote communities where private services are almost non–existant and where service delivery is inhibited by the enormous distances involved as well as inadequacies in transport services. The development and funding of such services would also go some way to easing the impact of stigmatisation of mental illness in some rural communities.

Informal drop–in type services should be provided in the private sector to assist in the difficult task consumers face in re–joining society and enhancing their quality of life through alleviation of isolation and loneliness.[16] Ideally, such services should be based on a non–threatening model that promotes active participation in social and vocational rehabilitation.

2.3 Post discharge, rehabilitation services and social inclusion.

Funding arrangements need to support post discharge and rehabilitation services that enhance recovery, social rehabilitation and social inclusion. These services are based on the premise of inpatient service alternatives aimed at reducing the need for hospitalisation, and work toward the ultimate aim of self–management, or recovery. Psychological, behavioural and community focused interventions are crucial components of this phase of service provision.

In 2009, community–based models of service delivery that offer the essential components of clinical care, living skills, social interaction, and social inclusion, are still urgently required. Consumers and carers have identified that these services need to provide such things as coping skills for living with mental illness for both consumers and their carers, together with relapse prevention strategies and supports to improve quality of life. Dealing with living skills and functioning in the family context, in the community, and life activities are paramount when considering types of services and models of care. While some outreach type services and other models are now beginning to develop that touch on some of these components, comprehensive models are still rare.

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16 SANE Australia, *Mental illness and social isolation*, SANE Research Report 1, 2005. This paper is available from www.sane.org.

Diversional therapy is a model that needs to be developed further and promulgated in the private sector. It recognises that the promotion of creative arts is an important part of therapeutic processes and has strong support from consumers as it does not involve medication. Additionally, consumers and carers feel very strongly, that models of service delivery and funding need to be able to support different treatment modalities.

Consumers and carers strongly support models of service delivery and funding that enable *case management* to be provided. This is preferably linked to the hospital–based setting where psychiatrists have an ongoing relationship with the clinicians delivering this type of service. Involvement with, and support of the treating psychiatrist is seen as a critical link. Case management is a need–identified process. Not every consumer with a mental illness would necessarily require case management. Rather, a consumer with a mental illness involving instability, poor compliance with medication or with a mental illness that affects the consumer's ability to participate in social or vocational situations may benefit greatly from case management. This is not to be confused with Outreach Services, which is indicative of longer term management. A *continuing care* program in the private sector would require a multidisciplinary team to provide case management based on a treatment plan developed with consumers and where possible their carers. Consumers suffering with difficult mental illness particularly after discharge from hospital, have needs, which cannot be met by other more generic services including more assertive follow–up. There are models well recognised in the public sector, as being efficient and effective.

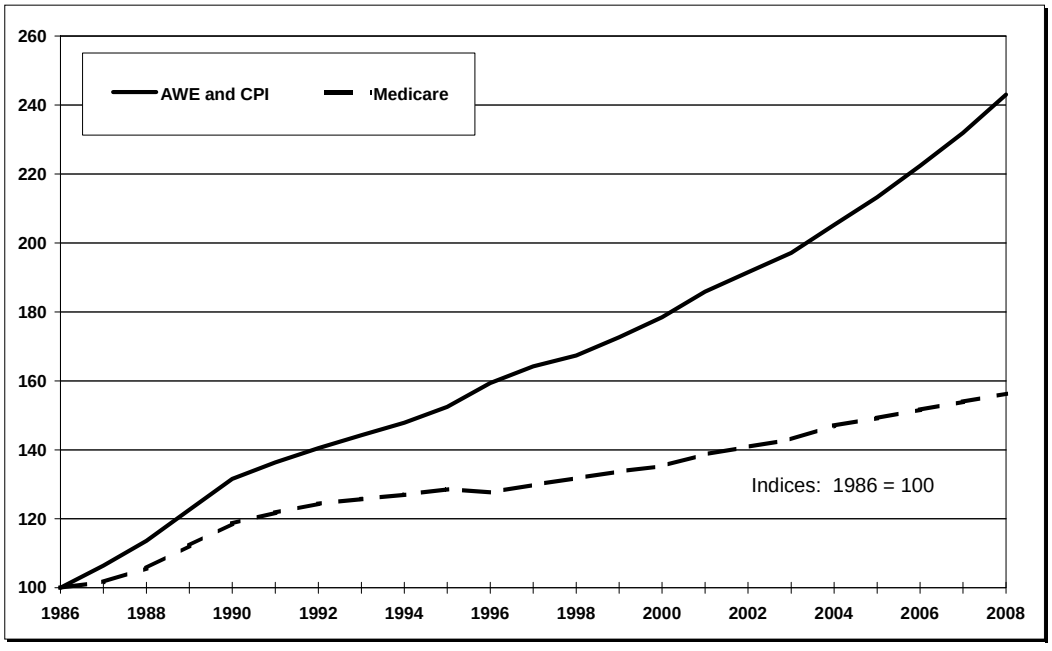
There is, therefore, an urgent need for such models of service delivery and funding arrangements to support them, to enable consumers and *their carers* to access *crisis intervention services 24 hour 7 day, on–call or mobile,* in the private hospital–based setting. It is acknowledged that whilst there are different forms of crisis intervention services provided in the public sector, these can often be difficult if not impossible, to access.

CHAPTER 3: OFFICE–BASED MENTAL HEALTH SERVICES

This Chapter sets out what constitutes office–based practice and the role played by each type of office–based practitioner. The recent reforms to the MBS have enabled several different, and often independent, private sector clinical providers to now be involved in the provision of services outside the traditional hospital setting. Clinicians working in the private mental health sector now include psychiatrists, GPs, psychologists, mental health nurses, occupational therapists and social workers. These clinicians comprise a complex system that largely determines the level effectiveness and overall cost–efficiency of the private sector that was discussed in Chapter 1.

Office–based practitioners provide their own infrastructure, including offices, secretaries, insurances and consumables. These cost, together with the time spent on paperwork, phone calls and case conferences, are all a necessary part of providing a high standard of mental health care. These costs must be recovered by practitioners being adjacent to a significant population referral base, with at least some of the population being able to afford a sufficient fee to cover the considerable and increasing costs of running a practice (especially in recent years), particularly when patient MBS rebates, in historic dollar terms, are declining. This has lead to a gradual divergence between the level of rebate increase, and the rising level of practice costs (See Figure 9). Clinicians, therefore, find it necessary to increase their fees in order to keep their practices running.

Figure 9 The Medicare problem,[17] as it pertains to medical practitioners, who have been included in Medicare insurance funding over the period covered in the graph.



Clinicians other than medical practitioners are facing similar practice cost increases as time evolves, and as more demands for accountability are required of these practitioners. Whilst it is appropriate for funders to try to obtain services at the lowest reasonable cost, there is a risk of moral hazard, where the system which is poorly supported can become rapidly unviable; which in this case could risk lives.

[17] Figure 9 was prepared by the AMA Federal Secretariat and is derived from data from the Australian Bureau of Statistics and the MBS.

3.1 Psychiatrists

Office–based psychiatrists provide psychiatric services from their own rooms. These services are funded by the fees paid by patients to those psychiatrists, and supported by the Australian Government's universal Medicare health insurance funding (Medicare).

Psychiatrists are medical doctors who have trained for a further five years in an apprenticeship style training, where they learn about people's psychological difficulties and illnesses, and the social and cultural implications of these conditions. After training, the psychiatrist may decide to work in the public sector mental health services run by State and Territory Governments in Australia; they may decide to work full–time in the private sector, usually renting or setting up their own office, or they may work part–time in each sector. A number of psychiatrists, including some women psychiatrists, decide to work part–time in the longer term.

Most private psychiatrist services are not provided in private psychiatric hospitals. Ninety percent of private psychiatrists' services are provided in the community, at their offices. Most private psychiatrists do not limit their services to those people with private health insurance. Many people from all walks of life are seen by private psychiatrists, but if people without private health insurance require hospital treatment, then services in the public system will be needed, if they are available.

Talking therapies are an essential component of private psychiatric treatment. Because GPs generally refer people whose condition is significant or has not responded to the GP's treatment, it is sometimes necessary to think of using medications alongside the talking therapy approach. Modern psychiatric medications are very effective with few side effects. For people with private health insurance, it is now possible for them to gain extra support from a private hospital's outreach or day treatment program, from excellent health professionals working with the private psychiatrist, to prevent the need for hospital admission.

Private psychiatrists treat people without private health insurance, and this is part of providing a comprehensive service to GPs. The level of care provided in the community is essentially the same as that provided to people with private health insurance cover. Any access to hospital care for those without private health insurance is dependent on admission processes, which are controlled by State and Territory Government's public mental health services. Access to such hospital services is commonly very limited, even where severe conditions are involved. Private psychiatrists try to cope with the public sector limitations as best they can.

The working relationship between private psychiatrists and the public sector services varies considerably based on variations of service, attitude and experience in different regions and over time. Services provided by public sector mental health services are largely free of cost to the patient.

3.2 General Practitioners (GPs)

In Australia, people do not usually seek treatment directly from specialist medical practitioners such as private psychiatrists. Under Medicare, a significantly higher rebate can be recovered by the patient, when they have been referred to see a mental health specialist (including private psychiatrists and psychologists) by a GP. This is a good system because GPs are very knowledgeable about mental health problems, and they can make the initial assessment of both physical and psychological conditions and their severity, and organize the most appropriate pathway to effective ongoing treatment and care. GPs are capable of treating a number of psychological conditions effectively themselves.

Some GPs have received extra training in psychiatric conditions, and can provide specific useful treatments for people with a mental health problem or disorder. But if more specialist care is required, then the GP will know of the nearest most appropriate mental health care available, including care from private psychiatrists, psychologists, mental health nurses, and other allied health professionals.

The MBS now allows patients to receive a much higher rebate from Medicare for the fee charged by the private psychiatrist, if the visit to the psychiatrist is used to provide extra information to the GP to undertake that patient's treatment themselves. This allows the GP to obtain specialist advice about the condition concerned and its most effective treatment, with the convenience for the consumer of being treated by the GP they know well. An added benefit is the extra rebate provided to the consumer for the psychiatrist's fee. This arrangement does not prevent the consumer receiving full care from the private psychiatrist, should that be necessary because of a change in their condition.

In early 2010, a new MBS Item was introduced for GPs who have not undertaken accredited Mental Health Skills Training. Those GPs who have undertaken the training accredited by the General Practice Mental Health Standards Collaboration since the commencement of the Better Outcomes in Mental Health Care program on 1 July 2001 continue to be able to access the current schedule fee for developing a Mental Health Treatment Plan under MBS item 2710.

Completion of Mental Health Skills Training assists GPs to better diagnose and develop Plans for people who have a mental disorder, and identify those who may need general counselling to help them deal with situational distress such as grief or relationship counselling and refer them appropriately. Those GPs who have not completed the training are still be able to refer patients to allied mental health professionals in line with current arrangements. However, they access the lower schedule fee for doing so.

3.3 Psychologists

Psychologists in private practice may work alone in their own rooms, or alternatively in group practices in which each psychologist runs their own business. Alternatively, some may be employed or contracted within a private practice and may work from GP or specialist group practices. Referrals come from a variety of sources, the most common being GPs – more so since the introduction of Medicare Items for psychological services. However, psychologists also see people who are self–referred or come through third parties such as WorkCover or State–based Motor accident insurance providers.

For psychologists to function in a private practice capacity, they must be registered with their State Registration Board. All Psychologists undertake 6 years of training to be fully registered. There are two common pathways: a four–year undergraduate degree followed by two years of supervised practice (internship); completion of a postgraduate Masters degree following the four–year undergraduate qualification. Many psychologists currently go on to complete a professional doctorate.

There are two categories of Medicare items that can be provided by psychologists: one for *psychologists* and the other for *clinical psychologists*. Clinical psychology items can only be provided by fully registered psychologists who are eligible to use the title 'clinical psychologist' as determined by the Australian Psychological Society's (APS) College of Clinical Psychologists. There are several pathways to eligibility. The main pathways are completion of an accredited Masters Degree in clinical psychology (or similar) plus additional supervised experience and professional development, or completion of an accredited professional Doctorate. Clinical psychologists are considered to be mental illness specialists and are endorsed as such by the new mental health Medicare Items. Together with psychologists, clinical neuropsychologists, clinical health psychologists and counselling psychologists they do much work with mental illness patients.

A recent survey of members who provide services under the Better Access initiative, carried out by the APS, (2009) revealed that at least 24% of psychologists are providing Medicare services in regional and rural areas and that the majority of psychologists (56%) are bulk billing clients in financial need.

The introduction of psychological services through Medicare has resulted in an increase in the number of clients consulting a psychologist for the first time, many of whom are presenting with more severe mental health problems which cannot be treated with only 12 sessions. Respondents to a survey of practitioners estimated that 77% of their clients would have been unable to afford psychological services without the Medicare rebate.

Psychologists in private practice work closely with GPs, psychiatrists (both in the public and private sectors), as well as other treatment providers. The limited interface between the public and private sectors severely limits the ability of private psychologists to accept referrals of clients with serious conditions and in some cases the nature of the condition simply prevents private practitioners from accepting these clients. This puts additional pressure on the public mental health care services.

3.4 Mental Health Nurses

Mental health nursing is a specialised field of nursing which focuses on meeting the mental health needs of the consumer, in partnership with family, significant others and the community in any setting.

The range of client–focused services specialist mental health nurses provide are truly holistic, assisting people to maximise their life potential by overcoming the illness, or coming to terms with its impact on their lives. Mental health nurses' primary tool to understand a patient's inner world is the therapeutic nurse–patient relationship.

A mental health nurse, as described by the Australian College of Mental Health Nurses (ACMHN), is a nurse registered to practice nursing, with specialist qualifications in mental health nursing. Currently, a few state and territory registration authorities endorse registered nurses as who have undertaken accredited courses in mental health nursing as mental health nursing specialists. The ACMHN Mental Health Nurse Credential for Practice Program, however, is the only national program that recognises the knowledge, skills, expertise and experience of nurses who are practicing as specialist Mental Health Nurses. Credentialed mental health nurses meet eligibility criteria for allied health professionals providing Medicare services as Mental Health Workers.

Mental health nurses practice across a range of settings including private hospitals and primary health care. They may work as private practitioners, or as employed mental health team members, and in the private sector they may bring particular expertise in areas such as drug and alcohol problems, child and adolescent mental health, and older persons mental health.

The scope of practice of mental health nurses includes expertise in mental health assessment, psycho–pharmacy and monitoring of medications, health promotion, psycho–education, focused psychological strategies, and family therapy. Many mental health nurses have expanded their scope of practice in sub–specialist therapeutic skills such as cognitive behavioural therapies and psychotherapy. While their practice is focused on consumers, mental health nurses also work in collaboration with the range of health professionals to address not only mental health needs, but also broader health and social needs.

Special Medicare Australia related programs in which mental health nurses may also participate include the following.

- Mental Health Nurse Incentive Program.
- Better Outcomes in Mental Health Care.
- Access to Psychological Services.
- Non–Directive Pregnancy Support Counselling.

3.5 Social Workers

Social workers in all fields of practice will see clients with mental health problems, often in combination with other difficulties. They work with clients across the lifespan. Social workers in the mental health field undertake a variety of roles including specialist mental health service, both public and private, working with individuals and families and in policy, service development and management in all levels of government, and in non–government agencies. Social Workers are one of the five core professional groups working in the mental health field

An accredited Mental Health Social Worker is a social worker who has been assessed by the Australian Association of Social Workers (AASW) as having specialist mental health expertise. They are a very experienced workforce. A recent survey by AASW indicated that 60% of mental health social workers in private practice have over 15 years experience and 84% over 10 years experience working as a social worker. Of this group approximately half have over 15 years experience working in the mental health field. The survey also indicated that over a third of mental health social workers practice in regional, rural and remote areas of Australia. Accredited mental health social workers have completed a four–year Bachelor Degree, or a qualifying Masters Degree, and a minimum of two years supervised social work practice in a mental health or closely related field. The majority of practicing mental health social workers have completed considerable post graduate education and training to enhance their knowledge and skills in mental health. All accredited Mental Health Social Workers must participate in the AASW CPE program and submit evidence of mental health specific professional development annually.

An accredited Mental Health Social Worker in private practice is eligible to provide services through the Commonwealth–funded programs, *Better Access to Mental Health Care, Chronic Disease Management, and Access to Allied Psychological Services*.

Social workers use a bio–psychosocial model to aid their understanding of mental health and mental illness, and to guide their practice. Within this model the special focus of social work is the impact of social, economic and cultural factors on individual and societal mental health and wellbeing. According to the "Practice Standards for Mental Health Social Workers" (AASW 2008) a social workers central concern is the social context and social consequences of mental health problems.

Social workers recognize the complexity of human experience, and look beyond the limits of the illness, diagnosis and treatment labels. Accordingly, social workers recognize that people are more than an illness or diagnostic label, and that individuals have broad human needs beyond specific treatment needs. There is recognition of the importance of family, friendship and community relationships. A guiding principle for practice is a respect for the lived experience of mental illness and consequences for individual consumers, families and other carers.

Social workers seek to identify factors influencing the person's mental health problems, and also to understand the impact of mental illness on the person, their relationships, and their life chances, including educational and employment opportunities. Strengths, abilities, values and hopes are identified as well as

limitations. The broader policy and service context is also part of this assessment, particularly the way this context may limit or expand pathways to recovery.

Mental Health Social Workers have particular expertise in helping individuals whose mental disorders co–exist with other problems such as family distress, drug and alcohol abuse, unemployment, disability, poverty and trauma. They help individuals to resolve associated psychosocial problems and improve their quality of life. This may involve family as well as individual counselling, and group therapy. Like other allied health professional, Mental Health Social Workers use a range of interventions in helping people with mental disorders including the focused psychological strategies and therapies as outlined by Medicare Australia. They are experienced in working collaboratively with other health professionals.

3.6 Occupational Therapists

The purpose of occupational therapy is to assist people from all age groups whose experience of life or whose ability to cope independently has been adversely affected by injury, illness or disease. Occupational therapists use "occupations" or "meaningful life roles and tasks" as the therapeutic method to assist recovery, restoration of function and return to wellbeing.

Occupational therapists are tertiary qualified health professionals who undergo a course of study that includes the systems of the body [anatomy, physiology] the systems of the mind [psychology and psychiatry] and social systems [sociology, systems theory] in order to understand the person in the context of their social and environmental circumstances. Occupational therapists understand that a person's lack of independence and functional performance is a function, not only of injury, illness or disease but how these problems manifest in that person's unique social circumstances.

The purpose of occupational therapy is to promote health, wellbeing and independence and to minimise or compensate for the limitations brought about by injury, illness and disease through engagement in occupations or meaningful life roles. Occupational therapists use activity analysis to understand the cognitive, social, emotional and physical dimensions of occupation. Occupational therapists use this information to work with the individual and other relevant people in their social environment to identify the barriers to engagement in meaningful roles. A plan is developed in collaboration with the individual to engage them in graded activities that promote recovery and independence. This is done with the knowledge of the complex bodily systems that all interact to create the unique individual.

Occupational therapists have a valuable role to play in assisting people with a mental illness when the presence of a mental illness interferes with their ability to participate, experience and enjoy life. The occupational therapist will work with the individual, other medical and allied health providers and relevant people in their social environment to gain an understanding of the impact of their condition in functional terms. The occupational therapist will then work with the individual to establish a plan that will assist them to maximise independence.

Occupational therapists who specialise in mental health work with people who have one or more of the following conditions.

- adjustment disorder
- alcohol disorders
- anxiety disorders
- autism spectrum disorder
- bereavement disorder
- bipolar disorder
- conduct disorder
- depression
- dissociative disorders
- drug use disorders
- eating disorders
- hyperkinetic [attention deficit] disorders
- obsessive compulsive disorders
- panic disorders
- phobias

- post–traumatic stress disorder
- psychosis
- schizophrenia
- other conditions that impact upon performance

Occupational therapy can assist to address problems with:

- budgeting
- domestic tasks [cleaning, home maintenance, laundry, etc]
- education [primary, secondary, tertiary]
- general planning
- grocery shopping
- meal planning and preparation
- participation in sport, leisure and recreation
- public transport
- self care
- social interaction
- work

Some of the techniques used by occupational therapists who work in mental health include:

- activity scheduling
- anger management
- behaviour modification
- cognitive interventions
- communication training
- stress management
- graded exposure
- guided imagery
- interpersonal therapy
- problem–solving skills training
- relaxation
- stress management
- time management

Assessment and intervention may occur in one or more of the following settings:

- community settings [clubs, public transport, shops, etc]
- clinics
- home
- hospitals [public and private]
- residential care facilities
- schools
- supported employment centres
- workplaces

Intervention may occur individually, in small or larger groups.

Occupational therapists usually receive referrals via the treating medical practitioner or another allied health provider. Individuals may attract rebates under Medicare. In order to be eligible for Medicare rebates, the individual must be referred by a medical practitioner who has developed a mental health plan. In addition, the occupational therapist must be credentialed by the Occupational Therapy Australia. However, self–funded individuals may self–refer.

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CHAPTER 4: PRIVATE HOSPITAL–BASED MENTAL HEALTH SERVICES

According to the PMHA's CDMS Annual Statistical Report, during the 2007–08 Financial Year there were 25 stand–alone private psychiatric hospitals and 20 psychiatric units located within private general hospitals in operation in Australia. Together these Hospitals had approximately 1,700 psychiatric beds. The hospitals that participated in the PMHA's CDMS during that financial year accounted for approximately 72% of all private psychiatric beds.

During the financial year the 33 private Hospitals participating in the CDMS admitted 18,305 patients for psychiatric care. Of those patients, 14,890 had a total of 20,834 separations from overnight inpatient care (excluding brief overnight admissions for sameday procedures) with an average length of stay of 19 days. The demographic and diagnostic profiles of those patients are shown earlier in the discussion paper in Figures 1 and 2. For the 9,486 patients who received any care on a Sameday or Outreach basis (referred to under the National Model as Ambulatory care) the average number of Days of care per patient was 16. Of those patients seen in the Ambulatory Care service setting, 5,096 also had at least one overnight inpatient admission.

Unlike many other areas of health care, private mental health facilities do not provide a parallel service to the public sector. Rather, the private sector provides effective and necessary care to a large group of patients who are unable to be cared for in public mental health services (refer to Figures 1 and 2).

If a person needs admission to a private hospital, the private psychiatrist arranges the time of admission as quickly as possible. The psychiatrist looks after their patient in hospital, and is responsible for their overall management. They receive high quality support from trained nursing staff and allied health professionals who act in cooperation with the psychiatrist in managing their care. With their express permission, greater efforts are now being made to consult with their family and carers about the care they receive, and especially about their discharge from Hospital.

Whilst in hospital, the patient will receive accounts from both the Hospital and the private psychiatrist. The Hospital account will include items for the overnight stays, some medication and any procedures performed. Hospitals and Health Insurers try to keep out–of–pocket costs for the patient to a minimum. Such out–of–pocket costs will depend largely on the level and type of health insurance a person has, and can include *excesses or co–payments*, or *known gap* costs.

The private psychiatrist's fees per service should be known to their patient before admission, but the exact number of times a person is seen by the psychiatrist will depend on their illness and the psychiatrist's type of treatment. Medicare will rebate a lower amount for services provided by a psychiatrist in a hospital (75% instead of 85% of the MBS fee; 85% of the MBS fee being the rebate provided by Medicare for outpatient psychiatrist services). However, Health Insurers will provide an additional rebate of at least 25% of the MBS fee for their private psychiatrist's visits. Where there are specific arrangements between the Health Insurer and the patient's private psychiatrist, the Health Insurer will often provide greater rebates leading to little or no out–of–pocket costs.

Private psychiatrists do not participate in the contractual arrangements that are negotiated between Hospitals and Health Insurers. Psychiatrists, therefore, have no obligation to share

the financial risk of an inpatient stay. Patients share indirectly in those agreements, through contracts they have entered into with their Health Insurers. An absence of direct contracting between insurers and psychiatrists is seen as an advantage by some patients and psychiatrists.

Psychiatrists may, to a limited degree, enter an agreement with a Health Insurer to accept a certain fee schedule for inpatient fee–for–service visits, so that the patient experiences a *no–gap* bill for a hospitalisation. Private psychiatrists share the financial risk of caring for a patient to a much greater degree than may at first be apparent. The reason that the risk is not readily visible is that the psychiatrist's care (and financial risk) is not confined to the brief time of hospitalisation, but can extend over a period of years for treatment of a chronic, or a treatment resistant condition.

4.1 Outcomes of private hospital–based mental health care – PMHA's CDMS

The PMHA's Centralised Data Management Service (CDMS) was setup by the SPGPPS under the auspices of the AMA in June 2001. The CDMS is jointly funded by participating private hospitals with psychiatric beds (Hospitals), private health insurers (Health Insurers), and the Australian Government under an Agreement with the AMA. Under this Agreement, the CDMS is required to:

- assist participating Hospitals with the implementation of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures* (National Model); and
- provide Hospitals and Health Insurers with a data management service that routinely prepares and distributes standard reports regarding the quality, effectiveness and efficiency of private hospital–based psychiatric services.

The analysis and reporting framework employed by the CDMS operates under the Guidelines specified in the National Model to ensure that the privacy and confidentiality of the participating Hospitals and Payers is protected. Essentially, the Guidelines require that aggregate statistics be partitioned on the basis of the identity of the responsible Hospital and Payer, with each Hospital or Payer then only being provided with identified statistical information about their patients' or members' care. Aggregate statistics about other Hospitals or Payers may only be provided in a format that ensures the responsible Hospitals or Payers cannot be identified. For example, each Hospital's report is individualised so that they can identify themselves within charts and tables, but are unable to identify any other hospital.

Under the National Model, Hospitals collect two measures of patients' clinical status, the HoNOS and MHQ–14, at key points in the clinical path — at Admission and Discharge from episodes of care, and where episodes are of extended duration, at Review every 91 days. That information is linked with administrative and clinical data already recorded by hospitals under the Hospitals' Casemix Protocol (HCP), and submitted on a quarterly basis to the CDMS in a personally de–identified format for analysis. On the basis of that data, the CDMS prepares and distributes Standard Quarterly Reports to participating Hospitals and Payers.

The CDMS provides material support to Hospitals in their ongoing implementation of the National Model through the provision of Guides and References Manuals for Hospital staff, Training Resources, and the Hospitals Standardised Measures database application (HSMdb).

4.2 Participation rate

In January 2010, all private hospitals with psychiatric beds across Australia were participating in the PMHA and its CDMS as set out below.

New South Wales

1. Albury Wodonga Private Hospital
2. Brisbane Waters Private Hospital
3. Campbelltown Private Hospital
4. Dudley Private Hospital
5. Lingard Private Hospital
6. Mayo Private Hospital
7. Mosman Private Hospital
8. The Hills Private Hospital
9. The Northside Clinic
10. Northside Cremorne Clinic
11. Northside West Clinic
12. St John of God Hospital Burwood
13. St John of God Hospital Richmond
14. South Pacific Private
15. The Sydney Clinic
16. Sydney South West Private Hospital
17. Warners Bay Private Hospital
18. Wesley Private Hospital Ashfield
19. Wesley Private Hospital Kogarah

Victoria

20. The Albert Road Clinic
21. Beleura Private Hospital
22. Delmont Private Hospital
23. Essendon Private Hospital
24. The Geelong Clinic
25. The Melbourne Clinic
26. Malvern Private Hospital
27. Mitcham Private Hospital
28. Northpark Private Hospital
29. St John of God Hospital Warrnambool
30. St John of God Pinelodge Clinic
31. The Victoria Clinic

Australian Capital Territory

32. Calvary Private Hospital

Queensland

33. Belmont Private Hospital
34. Brisbane Private Hospital
35. Greenslopes Private Hospital
36. New Farm Clinic
37. The Palm Beach Currumbin Clinic
38. Pine Rivers Private Hospital
39. St Andrews Private Hospital Toowoomba
40. The Sunshine Coast Private Hospital
41. Toowong Private Hospital

South Australia

42. The Adelaide Clinic
43. Fullarton Private Hospital
44. Kahlyn Day Centre

Western Australia

45. Hollywood Private Hospital
46. Joondalup Health Campus
47. The Marian Centre
48. Niola Private Hospital
49. Perth Clinic
50. Sentiens Clinic

Tasmania

51. The Hobart Clinic
52. St Helens Private Hospital

Through their implementation of the National Model these private hospitals have been able to put in place an efficient system for the routine collection of data that enables the quality and efficiency of mental health service delivery to be evaluated and reported on every quarter.

The PMHA, as the successor organisation to the SPGPPS, is responsible for oversight of the operation of the CDMS. The PMHA enables clinicians, private health insurers, private hospitals, consumers and carers, and the Australian Government to be actively engaged in the management of the service. This helps ensure that any problems or issues that may arise are dealt with in an open and transparent manner.

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CHAPTER 5. OPTIONS RELATED TO OFFICE AND COMMUNITY–BASED MENTAL HEALTH CARE

This Chapter deals with the progressive evolution of funding options for models that are largely related to office–based and community–based mental health care in the private sector. Several of the options that were originally canvassed in the early drafts of the *SPGPPS Options for Funding Service Delivery for Private Psychiatric Services: Discussion Paper 2006*, have now been implemented. Any new options or models are also included under this section. Direct recommendations concerning the way that contractual relationships might be developed are avoided. Funding options for models should be directed toward achieving the optimum mix of services to support consumers and their carers in the most efficient and effective way possible, taking into account the sustainability of the model in an environment of ever diminishing resources.

5.1 Use of improved MBS rebates for consultations with carers

The Item numbers, which are available under the MBS for services to carers of patients being treated under that schedule for mental illnesses, have been reviewed. There are two existing Item numbers available under the schedule so that relatives or carers of people with mental illnesses can be seen by psychiatrists without further referral of those people from the GP, and without specific patient referral being required. For a number of reasons, those Item numbers were not used very frequently. The recent revision of the Items has incorporated an increase in the schedule fee that can be raised for such a service, so the rebate available to the patient is more adequate. This change should mean that consultations with carers of consumers will be more acceptable for consumers and carers, and less of a barrier for doctors.

5.2 MBS Item for Carers

It is recognised that the whole area of carer involvement is very complex. It is known that consumers can sometimes feel very differently about whether they actually want a carer involved in their treatment, who that person should be, and in what capacity, and to what extent someone can, or should, act on their behalf. This is particularly relevant when a consumer is subject to mental health legislation. It is also recognised that most carers currently view their involvement within mental health service processes as very inadequate and often tokenistic.

Much has been written over a number of years regarding the desirability of involving carers in the care and treatment of people with a mental illness. Policies and legislation have been developed to reflect this philosophy. A large volume of literature also exists clearly describing the needs of carers. However, current service delivery continues to be individually focussed with carers largely unidentified and uninvolved despite a large body of research which documents the greater input of carers into the treatment, management and care of consumers the better their outcomes will be.

The National Mental Health Strategy, implemented over the last 15 years, has had a primary focus on consumer rights. Unfortunately, carer rights did not receive the same level of attention. This was recognised in 2008 when the House of Representatives Standing Committee on Family, Community, Housing and Youth conducted an Inquiry into better support for carers. Their Report titled, *Who*

Cares...?: Report on the inquiry into Better Support for Carers, was released in April, 2009.

Carers have an important role to play in all situations where a person has an illness particularly in situations where their role is likely to be ongoing and over an extended period of time such as when they are caring for a person with a long term mental illness. The 2007 national *Identifying the Carer Project* conducted by the Network across both public and private mental health sectors confirmed that consumers, carers and service providers share the common goal of improved treatment outcomes, relapse prevention and recovery. The achievement of these goals will be greatly facilitated by all parties working in partnership.

Whilst private psychiatrists do have access to an existing MBS Item to consult with carers of their patients, there are some fundamental flaws. These are largely that no MBS Item currently addresses the individual rights and needs of carers to have input, receive information and be engaged in the treatment and care process. The current MBS Item is poorly funded and requires the bill for the service to be the responsibility of the consumer, rather than being paid by the carer.

As a matter of urgency, consumers and carers are recommending an MBS Item be raised to enable private psychiatrists the ability to engage with their patients' carers to better enhance their patients' outcomes. Currently under Medicare, people claiming must suffer a diagnosable medical condition in order to receive benefits. Consumers and carers believe a private psychiatrist should have the ability to see a carer in their own right, not as a patient, but rather to have direct input into the issues which surround treatment, care and ongoing management, or chronic condition self–management of the person for whom the carer is responsible.

We also believe that there should be improved training (both initial training and continuing professional development) for all mental health professionals, in the adequate inclusion of carers into the treatment planning for a consumer, and how this can be best achieved.

BENEFITS	RISKS
Better outcomes for consumers	Patient could feel threatened
Greater engagement of carers	Risk of interruption of therapy
Greater input into the treatment process	Conflict of interest
More focussed treatment options	Carer could become patient
Greater understanding of the family dynamics	Carers could interpret their consultation as an illness
Preserves the personal integrity of carers	Practitioners do not accept a need exists
Preserves the separate identity of the carers and legitimates their need.	
Potentially increases the capacity of the carer to care by reducing stressors	
Significance of carers will not be obscured	
Physical as well as emotional impacts of caring could be addressed.	

Principles of Implementation

- Practitioners would have to recognise that carers have needs that arise from the caring role and should be supported as a right.

- Issues of privacy and confidentiality are not compromised but are not deployed as a barrier to involvement

- Other service providers are acknowledged and included, systemic or bureaucratic inhibitors are transparent.

5.3 MBS Item numbers for Allied Health Professionals

In 2006, new MBS item numbers were made available under limited circumstances, for consultations provided by allied health professionals. Such professionals include psychologists, social workers and occupational therapists. The Better Access initiative, as this model is known, has had a real impact on mental health service delivery in Australia. It has substantially improved access and enhanced the capacity of the private sector to treat both people with private health insurance and those without. At the end of 2008, the significant uptake of these new items was continuing with the demand for services showing few signs of abating (refer to figure 6 above).

However, clients are often referred with a current mental health diagnosis that is underpinned by a history of abuse or trauma, or in combination with any of the following situations: a dual diagnosis; existence of unstable housing, employment; social isolation; grief and loss or physical health problems. These factors significantly shape the identity of those persons and their ability to respond to mental health problems.

> *Research and practice experience show that to be effective, mental health reform should be based on a broad understanding of the origins and impact of mental illness, and the ways these can be ameliorated or resolved. Mental illness occurs in the context of families and communities. It adversely affects people's capacity to engage in everyday living…Helping people overcome the impact of mental illness typically requires coordinated access to supported employment and quality housing. This approach is fundamental to social work practice in mental health, and is well supported by research. (p.3 AASW submission to Senate Inquiry into Mental Health Services in Australia 2007)*

Social workers are uniquely placed to appreciate the impact of these socio–cultural complexities on the therapeutic needs of the clients and to shape the therapeutic response accordingly, both in individual, group or family therapy and in coordination of other community services that are appropriate.

In situations where clients are subject to a number of contexts that contribute to their mental distress, consultations often need to be longer, and contact between appointments may be necessary to facilitate best outcomes and co–ordinate services between multiple community agencies and health professionals.

Allied Health Professional organisations, supported by consumers and carers, are recommending further reform requires appropriate rebates to reflect the complexity of referrals.

- Longer consultation times to aid therapeutic engagement, psychosocial assessment, treatment and planning. Provision may be made for eligibility including specific criteria or limited number of sessions.

- Telephone consultation in between appointments to provide therapeutic support.

- Case conferencing capacity for allied health to be remunerated.

- Inclusion of Family Therapy in the evidence–based interventions forming the 'Focused Psychological Strategies' specified by Medicare Australia.

BENEFITS	RISKS
More effective service delivery	Definition of "complex"
Clients experience acknowledgement of complex difficulties	Documentation issues with phone consultations
Increased capacity for collaborative practice	
Decreased stress for professionals as necessary work remunerated	

5.4 Psycho–social rehabilitation projects

An initiative that could have significant benefits, would be the initiation of psychosocial rehabilitation projects in the private sector catering to both the private hospital insured group, but also allowing for some involvement of non–insured patients. This would require some negotiation with the State and Territory jurisdictions. Such programmes could be set up on a collaborative team based model, and possibly involve some non–government organisations as collaborators as well. Such projects would combine input from psychiatrists and private hospitals, into development of collaborative active rehabilitation modules for people suffering mental illnesses.

Modules set up in this way would receive continuing assistance from the psychiatrists and hospitals involved, to ensure ongoing relevance and expertise in the management of the programmes. It may be harder to prove that the involvement of private hospital insured patients in such programs would definitively prevent further hospital admissions, but an outcome measurement process could be involved in any such project, and it would be possible to monitor over a period of time whether there was a decrease in the number of hospital admissions as a result of such rehabilitation processes. A decreased hospitalisation outcome would be highly likely. Perhaps these projects could be initiated on a pilot basis, until the results are provable, and the effective model was defined.

BENEFITS	RISKS
Such projects are very likely to reduce hospitalisation times. A pilot project could demonstrate this.	May require greater capital investment.

Principles of Implementation

- Careful clarification of the nature of the rehabilitation project would be required

so it was not just socialisation, but a targeted and focussed rehabilitation project.

- There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

- Team co–ordination issues would have to be considered.

5.5 Increased psychiatrist rebates

MBS rebates for consumers of private psychiatrists' services have declined in real terms over the last 20 years. There has been a deliberate policy of the Australian Government to limit the increase of rebates for specialists other than GP specialists, which includes private psychiatrists. That policy has been successful in keeping MBS rebates at a lower–level, and the consequence is that it is very difficult to run an adequately resourced psychiatric practice infrastructure, if a psychiatrist charges at, or close to the MBS rebates. It should be understood that many patients suffering from psychiatric illnesses, especially those that suffer from ongoing illnesses, are quite financially disadvantaged, even if they manage to maintain their private health insurance premium payments (or perhaps, particularly if they do so). Most private psychiatrists would apply some form of discounting to the fees charged to financially disadvantaged patients. Many private psychiatrists have in recent times increased the fees that they charge patients, particularly those patients that have employment. It is only possible to afford adequate secretarial assistance and other infrastructure management support, if one charges well above the rebate level to a significant proportion of patients in psychiatrist's private practice.

It is risky for the rebates to be kept artificially low when one is dealing with a population group, which is often financially disadvantaged, and where there is a significant amount of unmet need in the general population. The provision of treatment by private psychiatrists is much less expensive than public mental health care costs, particularly to government, and it would make sense to make some upward adjustments in rebates to match appropriate fees charged by the specialty, and which could easily be justified by information derived from the Relative Value Study.

The AMA and the RANZCP, supported by consumers and carers, strongly recommend that rebates for private psychiatry services be increased, so that the burden to financially disadvantaged patients seeking treatment in the private sector can be alleviated.

BENEFITS	RISKS
It would increase access to private psychiatrists office–based services since, at present, many psychiatrists have had to depart from MBS rebate level of fees.	Net increase to expenditure for MBS, but relatively small.

Principles of Implementation

- Australian Government procedures.
- There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.
- Psychiatrists would be more available.

5.6 Telepsychiatry, telephone and internet–based models

New technologies bring with them new opportunities to develop innovative ways in which to deliver services. These are particularly relevant to people who reside in rural or remote locations, those house–bound because of physical or mental illness and those who may prefer this as an option, rather than face–to–face consultations with a mental health professional.

Whilst telepsychiatry has been available for a while now allowing psychiatrists to assess, manage and consult directly with patients, there are difficulties with this MBS Item, mostly in terms of amount of remuneration paid for services provided and the infrastructure costs involved with establishing such services. There are no MBS Items specific to telephone service delivery. Neither of these, or any like services, are available under the Better Access initiative for isolated consumers to access psychologists, mental health nurses, occupational therapists or social workers.

To ensure appropriate, effective, cost efficient services are delivered in the least restrictive environment to geographically or isolated consumers and carers, health professionals and consumers and carers believe there is an urgent need for an MBS Item to encourage the use of these alternative forms of electronic, internet and telephonic technology.

There is a range of technologies currently available that could be used to facilitate the consultation including computer linked 'skype', internet and telephone, whereby the health professional could directly link in real time, with the consumer and/or their carer or family member on a truly face to face basis, regardless of distance.

BENEFITS	RISKS
Obviates distances	Costs
Engages in a manner not currently available	Acceptability by Government
Potentially inspires confidence that advice is immediately available and therefpre relieves anxiety and stress.	Potential users deploy the technologies as a defence against seeking advice or assistance.
Offers the possibility of 24 hour access.	Facilities are not used constructively.
	Loss of privacy

Principles of Implementation

- Australian Government procedures to establish new MBS Item(s)
- Range of technologies required are available in rural and remote areas
- Education and training in their use in order that potential users are familiarised with them, including appropriate security considerations for services provided over the internet.

5.7 Informal consumer operated/consumer led drop–in type models

Consumers talk a lot about the effects of social isolation. The Australian Government has heard this message. They have a vision of a socially inclusive society as one in which all Australians feel valued and have the opportunity to participate fully in all aspects of their life and that of the community. The Government believes that to achieve this vision, all Australians will have the resources, opportunities and capability to:

- learn by participating in education and training;
- work by participating in employment, in voluntary work, and in their family;
- engage by connecting with people and using their local community's resources; and
- have a voice so that they can influence decisions that affect them.

With the issues facing the mental health workforce particularly around dwindling numbers of university enrolments, increasing retirements, recruitment, retention and other factors, greater use of mental health consumers and carers must now be considered. They are in position as 'experts by experience' and whilst not perhaps trained in the health disciplines, are nonetheless able to provide, with appropriate training and information, meaningful and critically needed services that would complement those provided by health professionals.

Consumers who have received their treatment and care from mental health services, recovered and gone on to meaningful engagement with family, friends, employers and the community could play a unique role in this type of service. Carers could be engaged in a similar way, offering a significant, if different perspective. It is envisaged that a private hospital could provide the venue, information and training for these support workers. It is also envisaged that health insurers could provide some funding toward this type of service, especially under broader health for their members to access. It is acknowledged that it is the re–engaging with life more broadly that encourages, assists and motivates people to recover.

This is a type of service not currently provided within the private hospital sector, yet it is one which consumers and carers have been calling for, for a long time now. Much has been written to ably demonstrate the effectiveness of this type of service. It is not envisaged that this would entail much cost, yet the effectiveness and benefits would be immense.

BENEFITS	RISKS
Peer support	Appropriate training and education
Re–engagement with others	Acceptability by providers and funders
Social interaction	Rejection by employers/trainers and stigma re–inforced.
Motivation	
Less reliance on mental health services	
Involved in productive activity	

Principles of Implementation

- Support of private hospitals to provide the hub for the service.
- Private health insurance rebates to encourage participation.
- Services external to the private hospital to be encouraged and interest engaged.

5.8 Community–based models

There are currently a limited number of Non Government Organisations involved in delivering community–based care. At present, the private hospital sector provides very limited outreach or Hospital–in–the–Home type services for people who have been inpatients. Private health insurers pay benefits for these services where the hospital and private health insurer have agreed to cover these services. In addition, a person with health insurance will need to have the appropriate cover. It is not compulsory for insurers to offer cover for such services.

The outreach service needs a referral from a psychiatrist. The private hospital has a trained health clinician who visits the consumer in their home to assess their health and see how they are going with things like managing medications, managing the home, cooking, shopping managing finances and potential employment opportunities.

Consumer and carers would like to see an expansion of this type of service, or an additional model, which goes beyond that currently offered. It is envisaged that such a model would address not only the essential components of clinical care, but also include living skills, social interaction, and social inclusion. This could encompass assistance with managing the home, managing finances, cooking, shopping and social interaction. The incorporation of social interaction and social inclusion is imperative to the recovery of individuals.

A health insurer could quite rightly ask for justification for payment for a 'social' type service yet, if piloted and proved successful in terms of good outcomes and cost effectiveness, such a model would go a long way to addressing the current lack of these services.

BENEFITS	RISKS
Cost effective	Health insurers concerns around funding 'social' type services
Good consumer outcomes	Costs
	Acceptability by funders and providers

Principles of Implementation

- Private hospital and health insurer support.

5.9 Chronic condition self management, or recovery focussed services

Chronic condition self management or recovery focussed services can and should be delivered within the community setting. It is acknowledged that many health professionals do encompass chronic condition self management within their consultations but may not specifically identify it as such. Chronic condition self management is also a new concept in mental health for many consumers and carers, whilst recovery is the new mantra. One could genuinely ask, what is the difference?

The Australian Government understands the need for chronic disease self management and through the COAG process of November 2005 the Australian Health Ministers' Conference (AHMC) endorsed a national strategic policy approach to manage and improve chronic disease prevention and care in the Australian population. This saw the establishment of the Chronic Disease Strategy focussed on asthma, cancer, diabetes, heart, stroke and vascular disease and osteoarthritis, rheumatoid arthritis and osteoporosis. Interestingly this did not include mental health.

Some health insurers have their own models of chronic disease self management such as Medibank Private's *better health* program, for conditions such as diabetes. The concept for the mental health area could be based on a study by the Flinders University,[18] which defines chronic condition self–management as:

> *a process that includes a broad set of attitudes, behaviours and skills. It is directed toward managing the impact of the disease or condition on all aspects of living by the patient with a chronic condition. It includes, but is not limited to, self–care and it may also encompass prevention*

Health insurers together with allied health professionals such as psychologists, mental health nurses, social workers and occupational therapists could play a particularly relevant role in chronic condition self management by providing access to supports.

A program or service, which is delivered in a community setting could include the following.

- Increasing the knowledge of the mental illness.
- Adopting a self management care plan with clearly identified goals.
- Actively participating in all decisions associated with self management and self care.
- Assisting in identifying early warning signs.
- Managing the impact of the mental illness on things such as work, education, family, social and other relationships.
- Identifying and adopting lifestyle changes which enhance good health.[19]

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18 *Flinders Model of Chronic Condition Self–management:* http://som.flinders.edu.au/FUSA/CCTU/self_management.htm

19 Ibid., http://som.flinders.edu.au/FUSA/CCTU/self_management.htm

- Establishes an ongoing evaluation which demonstrates the effectiveness or otherwise of the program.

BENEFITS	RISKS
Long term Cost effective	Costs
Good consumer outcomes	Acceptability by funders and providers
Ultimate relief of the burden of care on the carer	
Encourages an holistic approach to management	

Principles of Implementation

- Principles of self management built into case planning at both admission and discharge.
- Health insurer and allied health professionals support

CHAPTER 6: UPDATE ON OPTIONS FOR PRIVATE HOSPITAL–BASED MENTAL HEALTH CARE

This Chapter deals with the funding options for hospital–based mental health care in the private sector. Of the five models described in this Chapter, the *Bundled prospective payment model* has been successfully introduced in South Australia (SA), and the *Casemix–based per–diem payment model* is now being introduced in Medicare–funded inpatient psychiatric facilities throughout the United States of America (US).

As for Chapter 4, any direct recommendations concerning the way that contractual relationships might be developed are avoided.

6.1 Programme–based per–diem payment model

With some variation across Health Insurers and Hospitals, the most common payment model at the end of 2008 was one in which benefits for both overnight in–patient and ambulatory care are stratified by program and paid on a per–diem basis. Common programs are 'General', 'Drug and Alcohol', and 'Eating Disorders' etc. Patients are allocated to a program by the hospital in consultation with the patient's doctor.

The benefit payable is calculated by multiplying the daily rate by the number of days spent in the program taking into account 'step down' points. These step down points are set on the basis of highly aggregated length of stay estimates per program. As there are relatively few different programs, patients with diverse casemix characteristics are aggregated into common programs for the purpose of calculating Health Insurer benefits. Limitations may also be applied to the number of ambulatory services including both sameday episodes and outreach visits. The weakness of this model is that common benefits are paid to patients with dissimilar characteristics.

The definition of programmes and their associated step–down points and ambulatory service limitations are not based on any generally agreed classification system or payment schedule. Accordingly, programme definition, step down points and ambulatory service limitations may vary from hospital to hospital and payer to payer. In principle, this inherent flexibility could allow substantial room for innovation by hospitals.

However, providers that move from the delivery of services principally within the overnight inpatient service setting to alternative settings, including sameday and outreach, may face clear financial disincentives. In a strictly financial sense, this funding arrangement can make it costly for providers to change their practices. The corollary is that, for payers, the existing payment model exposes them to uncapped growth in the utilisation of overnight in–patient services and little capacity to give hospitals effective incentives to provide care in less restrictive or more efficient service settings. From a quality assurance perspective, the wide variation in programme definition makes it very difficult if not impossible to compare costs and outcomes for programmes across hospitals.

BENEFITS	RISKS
Simplicity of payment arrangements	Common benefits are paid to patients with dissimilar characteristics.
Less funder controls over clinical care	Limitations to individual patient needs.
	Lack of a standard industry program nomenclature (cannot compare apples with apples).
	Does not support benchmarking between programs/facilities.
	Does not encourage innovation in service delivery.
	Remains a program–based funding model with associated approval requirements on Hospitals.

Principles of Implementation

1. Current Model.

2. There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

6.2 Enhanced programme–based per–diem payment model

This option contemplates the retention of Option 1 above, albeit with the following enhancements. An industry recommended program nomenclature would be developed. Rather than there being more than perhaps 10–15 different program names, there would be no more than 5–6. It is envisaged that for each program the positioning of stepdown points as well as pricing would be subject to individual Health Insurer and Hospital negotiations.

Using an agreed classification system it may be possible to also map specific episode types to specific programs. This would provide Health Insurers with confidence that episodes of care are being billed under the most appropriate program and would further allow the benchmarking of the same program at different hospitals.

A third enhancement to Option 1 would be the inclusion of clear guidelines around peer review of cases exceeding an agreed Length of Stay (LOS). Agreed Peer Review LOS thresholds would be set for each program taking into consideration the expected average length of stay of that program.

BENEFITS	RISKS
Less change from the current system than other options.	Remains a program–based funding model with associated approval requirements on Hospitals.
Provides a standard program nomenclature.	May be difficult to fit individual care into a decreased number of program models.
Introduces concept of second opinion for long stay cases.	Highly aggregates patients into small number of funding categories (programs) such that patients with dissimilar characteristics still attract common benefits.

Principles of Implementation

1. Hospital and Health Insurer would have to agree the nomenclature, the classification system and the Peer Review Guidelines for cases exceeding an agreed LOS.

2. There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

6.3 Casemix–based per–diem payment model

Under this model patients are classified under an agreed casemix classification system, for example, the Australian Refined Diagnosis Related Groups (AR–DRGs). A specific per diem payment schedule is agreed for each casemix group. Based on analyses of historical data, Health Insurers and hospitals would, in the course of their normal commercial in confidence negotiations, agree the positioning of step down points as well as the quantum of benefits payable for each day. This model is effectively the one that was implemented in 2005 by the Federal US Government's Centers for Medicare and Medicaid Services (CMS) in the Medicare funding of Inpatient Psychiatric Facilities. Previously, the CMS had pursued a casemix–based episodic payment model. However, under advice from the American Psychiatric Association, CMS undertook a detailed statistical comparison of the performance of per–diem versus episodic casemix–based payment models and concluded that the per–diem model was significantly better able to account for variations in costs.[20] The principal benefit of this model, from the perspectives of both hospitals and payers, is that it provides a potentially less complex and very much more consistent basis for the negotiation of contractual agreements and subsequently for the evaluation and comparison of hospital performance. However, it is important to note that existing Australian casemix classifications for ambulatory psychiatric services are poorly developed and generally apply only to admitted episodes, that is Sameday services.

BENEFITS	RISKS
More specificity in benefits and step down points (step down in line with case mix).	More complicated. Will not necessarily decrease overall cost.
Ability to analyse data for homogeneity within casemix.	Availability of group DRG data.
Hospitals no longer restrained by program approval.	Hospitals must seek prior approval for any new program
Allows Health Insurers to talk best practice with providers (standardised – comparing apples with apples).	Casemix classification systems are not well developed for ambulatory mental health care.
Creates a dialogue, which will improve cost–effectiveness at an episodic level (eventually).	Possible neglect of clinical needs of casemix outliers.

[20] The primary source materials regarding the background to and details of this payment model can be obtained from the CMS web site. There are also a number of other papers from the American Psychiatric Association that provide useful background to the latter organisation's involvement in the development of the model.

BENEFITS	RISKS
Reviewed annually depending on: (a) new/first admission; (b) re–admits; and (c) high users.	Less able to account for variations in costs.
AR–DRG's are widely used in private sector acute health in Australia.	

Principles of Implementation

1. Complex assessment and diagnostic categories would need to be established and Implementation would be a matter for negotiation between hospitals and Health Insurers.

2. There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

6.4 Casemix–based episodic payment model

Under this model patients are classified under an agreed casemix classifications system (e.g. AR–DRG's). A specific per episode payment schedule is agreed for each casemix group. Based on analyses of historical data, Health Insurers and hospitals would, in the course of normal commercial in confidence negotiations, agree the quantum of benefits payable for each episode. The principal feature of this model, and that which distinguishes it from per–diem based funding models is that hospitals and Health Insurers are required to share the financial risk associated with variations in consumers' needs for care.

The model also provides a potentially less complex and very much more consistent basis for the negotiation of contractual agreements and subsequently for the evaluation and comparison of hospital performance. Casemix–based episodic funding has been implemented quite extensively in the private sector and in some jurisdictions in the public sector for acute general private hospital–based services.[21] Again however, it is important to note that existing Australian casemix classifications for ambulatory psychiatric services are poorly developed and generally apply only to admitted episodes, that is Sameday services. The largely experimental MH–CASC classification does clearly define ambulatory casemix groups, but as yet there has been limited opportunity to adequately examine the implications of its application in the funding of private services.

BENEFITS	RISKS
Potentially less complex and very much more consistent basis for the negotiation of contractual agreements and subsequently for the evaluation and comparison of hospital performance.	Existing Australian casemix classifications for ambulatory psychiatric services are poorly developed and generally apply only to admitted episodes, that is Sameday services.
Hospitals and Health Insurers share risk more equitably	Wide variations in practice may make agreement on casemix classification time periods difficult.

[21] A useful overview can be found in *Walker (2004) Casemix funding in Australia*.

BENEFITS	RISKS
Already familiar to most providers as acute health care is largely funded in this manner.	Episodic model is often difficult to apply to chronic conditions.
Allows simplified billing by the Hospital and payment by Health Insurer.	
Encourages innovation in service delivery.	
AR–DRG's are widely used in private sector acute health in Australia.	

Principles of Implementation

1. Experimental as yet and would require negotiation and development of AR–DRG's.

2. There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

6.5 Prospective case payment model

Under this model, hospitals are paid a fixed sum for the provision of care to the patient for an identified period, most probably the twelve months following their initial admission to the hospital. The amount of the payment would depend on the initial assignment of the patient to one or other case classification.

The prospective payment would be expected to cover all aspects of the patient's care as determined by the hospital in consultation with the patient's treating psychiatrist. Within that context of joint responsibility with the treating psychiatrist for the patient's care, the hospital is free to allocate that funding as required.

The principal feature of this model, and that which distinguishes it from both per–diem and episode–based funding models is that hospitals take a much greater share in the financial risk associated with variations in patients' needs for care. It should be clear that the feasibility of this model depends almost entirely on the accuracy of the hospital's initial assignment of the patient to one or other case classification. Given that no existing case classification system has been developed that can adequately account for costs in private hospital mental health care, it is unlikely that this model could in fact be effectively implemented. It is identified here so as to enable the features of the bundled prospective payment model to be more fully elucidated.

BENEFITS	RISKS
Within the context of joint responsibility with the treating psychiatrist for the patient's care, the Hospital is free to allocate funding as required.	Given that no existing case classification system has been developed that can adequately account for costs in private hospital mental health care, it is unlikely that this model could in fact be effectively implemented.
Hospitals and Health Insurers share risk more equitably.	Implementation may be difficult, but not impossible, in a competitive market place.
Allows Hospitals to be rewarded for efficient and innovative practice.	Risk of neglect of clinical outliers.

Principles of Implementation

1. Difficult unchartered territory and would require improved triage and assessment processes.

2. There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

6.6 Bundled Prospective Payment model

In this Bundled Prospective Payment Model (BPPM), Health Insurers and Hospitals would negotiate a bundled payment, which would then used by the hospital to provide care to *all* of the Health Insurer's members who might require care in the period covered by the payment.

The quantum of the payment would be based on an analysis of the historical service needs of the Health Insurer's members at that hospital in an agreed period preceding the drafting of the contractual agreement between the Health Insurer and the Hospital. The agreed period on which that analysis would be based might be twelve months. However, the analysis might also take into account expected changes in members needs, based on recent (e.g., over the preceding three years) historical trends in the demographic profile of the Health Insurer's membership in the hospital's catchment area and in changes in the provision of services by the hospital to the Health Insurers' members. The period to be covered by the Bundled Prospective Payment (BPP), and the frequency with which it is to be renegotiated, is determined by the parties to the individual contractual agreement.

Financially, the most important feature of the model is that during the period over which the BPP is fixed, hospitals share equally with Health Insurers in the financial risk associated with variations in members' needs for care. Both parties would also agree to a range of Key Performance Indicators (KPI's) that would apply and which would address matters such as material changes in the Health Insurer's market share, or under–servicing and selective–servicing by the hospital, together with the safety, quality and effectiveness of the services provided.

Given those appropriate safeguards, the basic methodology of the BPPM provides strong incentives for the provision of clinically optimum services, particularly for the replacement, where clinically indicated, of overnight inpatient care with appropriate forms of ambulatory care. The BPP would be expected to cover all aspects of all patients' hospital–based care as determined by the hospital in consultation with those patients' treating psychiatrists. Within that context of joint responsibility with the treating psychiatrists for the care of patients, the hospital is free to allocate that funding as required. Thus the implementation of a BPPM is likely to have significant implications for the relationship between the hospital and its admitting psychiatrists.

The BPPM, which has been successfully implemented in South Australia (SA), has been thoroughly discussed by the PMHA and its' CCMWG and will not be summarized in this paper. Stakeholders have questioned the way in which this model might be applied in competitive market places such as exist in Brisbane, Sydney and Melbourne. It has been suggested that this model is able to be implemented in SA only because of the one private hospital provider situation, and may be logistically

very difficult to operate in areas of multiple hospital owners. Indeed, it should be noted that the BPPM can be described as a type of capitated payment model.

These models are characterised by payment being tied to a specific, defined population of patients with care being prepaid at a predetermined, per–capita rate.[22] Capitated funding models are most commonly discussed in Australia with reference to the funding of public sector health services. In New South Wales (NSW) for example, the resource allocation formula used by NSW Health to fund Area Health Services can be seen as a type of capitated funding model.[23]

This has possibly led to the view that the BPPM can only be based on a defined general population. However, close examination of the actual model used in SA indicates that it is not in fact based on an analysis of the general insured population's need for private hospital based psychiatric services, but instead is based primarily on the contracted hospital's prior history of service provision. However, there are legitimate questions to be addressed in respect to the implementation of a BPPM in a competitive environment.

First, would the implementation of BPPM funding inhibit competition between established hospitals? Second, how would newly established hospitals enter into BPPM funding arrangements? Third, could hospitals specialise, that is legitimately engage in selective–servicing, under a BPPM funding arrangement? Also, experience in South Australia has indicated that the changes in the mix of services that are likely to follow on from the implementation of the BPPM will give rise to an increase in acuity of the hospitals overnight inpatients as the alternate treatment methods become available.

As less acute patients have been appropriately cared for in the community, the average acuity of those patients requiring in–patient care has risen. Such changes would need to be taken into account during the re–negotiations of the BPPM.

BENEFITS	RISKS
Involves attractive components of the Option 5 by allowing hospitals to become more efficient without requiring selective contracting.	Greater change to status quo.
Encourages innovation in service delivery.	Capping of expenditure requires managed care.
Greater variety of treatment methods.	Individual episodes of care or occasions of service still need to be tracked and reported on.
Allows greater number of patients to be treated.	Implementation may be difficult, but not impossible, in competitive market place.
Has been shown to work in South Australia.	Risk over time that innovation of clinical models would be inhibited.
Increase in quality controls.	

[22] An excellent overview and discussion of capitated payment models can be found in a policy paper made available by the British Columbia Medical Association on their website.

[23] A discussion of the funding of public sector health services in Australia using this approach can be found in Peacock S, Segal L. *Capitation funding in Australia: imperatives and impediments.* Health Care Management Science 2000, 3, pp. 77–88.

Principles of Implementation

1. There is a major issue in terms of its workability of this option in Brisbane, Sydney and Melbourne because of travel requirements of patients. It would be easier to operate in a smaller city such as Adelaide. This option would require explicit KPIs to ensure minimum standards are met. Under–servicing trends may be less conspicuous in a competitive market and there will be a greater need to have regular oversight or review every twelve months, which involves consulting psychiatrists.

2. There are no legislative or regulatory barriers that would require reform to enable this option to be implemented.

GLOSSARY

AAOT	Australian Association of Occupational Therapists
AASW	Australian Association of Social Workers
ACMHN	Australian College of Mental Health Nurses
AHIA	Australian Health Insurance Association
AHMAC	Australian Health Ministers Advisory Council
AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
APS	Australian Psychological Society
BoiMHC	Better Outcomes in Mental Health Care program
BPP	Bundled Prospective Payment
BPPM	Bundled Prospective Payment Model
CCMWG	PMHA Collaborative Care Models Working Group
CDMS	PMHA Centralised Data Management Service
CMS	Centers for Medicare and Medicaid Services
COAG	Council of Australian Governments
Contractual agreement(s)	The agreement(s) that are negotiated between Hospitals and Health Insurers
DoHA	Australian Government Department of Health and Ageing
EPC	Enhanced Primary Care
GP(s)	General Practitioner(s)
Health Insurer(s)	Private Health Insurers that pay benefits for mental health care
Hospital(s)	Private Hospital(s) with psychiatric beds
HSMdb	The CDMS Hospitals Standardised Measures Database of outcome measures
KPI(s)	Key Performance Indicator(s)
LOS	Length of Stay
M	Millions of dollars
MBS	The Australia Government's Medical Benefits Schedule
MH–CASC	Mental Health Classification and Service Costs
MHIN	Mental Health Interdisciplinary Networks Project
MHNIP	Mental Health Nurse Incentive Program
MHWAC	Mental health Workforce Advisory Committee
NETWORK	Private Mental Health Consumer Carer Network (Australia)
NMHWG	AHMAC National Mental Health Working Group
PTSD	Post Traumatic Stress Disorder
RACGP	The Royal Australian College of General Practitioners
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
PMHA	Private Mental health Alliance
SPGPPS	Strategic Planning Group for private Psychiatric Services

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Year	Some of the major inquiries, reports and events since 1983
1983	The Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (The Richmond Inquiry) in New South Wales reports.
1988	The Eisen/Wolfenden Report is released.
1989	Australian Health Ministers Advisory Council (AHMAC) establishes a National Working Party to anaylse the Eisen/Wolfenden Report
1990	The Royal Commission of Inquiry into Deep Sleep Therapy at the Chelmsford Hospital in New South Wales reports.
1991	▪ The inquiry into the Administration of Lakeside Psychiatric Hospital in Victoria reports ▪ The Report of the Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit (Ward 10B) of Townsville General Hospital in Queensland is released. ▪ National Mental Health Statement of Rights and Responsibilities is adopted by all Australian Health Ministers. ▪ United Nations adopts Resolution 98B: Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care ▪ Australia Endorses UN Resolution 98B
1992	▪ Australian Health Ministers endorse the principles and the plan for reform under a National Mental Health Strategy. The National Mental Health Policy and the First National Mental Health Plan represent the first attempt to coordinate mental health care through nationally agreed activities. ▪ AHMAC Establishes National Mental Health Working Group ▪ National Mental Consumer Advisory Group established (Title amended in 1993 to National Community Advisory Group – NCAG)
1993	▪ National Health Strategy Issues Paper No 5: Help Where Help is Needed–Continuity of care for people with chronic mental illness is published. ▪ National Mental Health Workforce Committee releases its discussion paper on Mental Health Workforce Issues. ▪ Burdekin Report released. ▪ Report for the Mental health Workforce Committee on medical workforce financing arrangements completed (Solomon/Buckingham/Epstein Report). ▪ National Mental Health Strategy is incorporated into the 5 year Medicare Agreements.
1994	▪ First National Mental Health Report is released. ▪ Draft report on the Measurement of Consumer Outcome in Mental health submitted to the National Mental health Information Strategy Committee. ▪ Discussion Paper, Model Mental health Legislation, released for community consultation.
1997	Evaluation of the First National Mental Health Plan released.
1998	▪ Australian Health Ministers endorsed the further development of the reform agenda through a Second National Mental Health Plan. ▪ Second National Mental Health Plan commences and is incorporated into the 5–year Australian Health Care Agreements.
2001	International Mid–Term Review of the Second National Mental Health Plan released.
2003	▪ Evaluation of the Second Mental Health Plan is released reporting that significant progress has been achieved. The extent and pace of progress, however, is not viewed as satisfactory, with progress constrained by the level of resources available for mental health and by varying commitment to mental health care reform. Effective implementation is seen as lacking, the failures due not to a lack of clear and appropriate directions, but to failures of investment and commitment. ▪ National Mental Health Plan 2003–2008 released. http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/doha–plan–1 ▪ Australian Health Care Agreements 2003–2008 signed.

Year	Some of the major inquiries, reports and events since 1983 (continued)
2005	Report of the consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission is released titled, Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia. It raises public concerns over the state of mental health services in Australia. http://www.mhca.org.au/notforservice/
2006	▪ Senate Inquiry into the Provision of Mental Health Services in Australia is released confirming that all states and territories are experiencing increased demand pressures for mental health care right across the health sector, particularly for acute and emergency care. Workforce shortages are reported in all jurisdictions affecting both the quantity and quality of care. http://www.aph.gov.au/senate/committee/mentalhealth_ctte/ ▪ The Council of Australian Governments (COAG) recognises mental health as a major problem for the Australian community. COAG develops and signs a National Action Plan for Mental Health 2006–2011. The Plan is intended to provide sustained improvement in services to the mentally ill and includes the primary health care initiatives to improve access to Psychiatrists, Psychologists, GPs and Mental Health Nurses through the Medical Benefits Schedule, Pharmaceutical Benefits Scheme and Commonwealth Government incentives. It supports significant national reform activities including provision of funding to States and Territories for national mental health reform, and monitoring and reporting on progress. http://www.coag.gov.au/coag_meeting_outcomes/2006–07–14/index.cfm ▪ House of Representatives Standing Committee on Health and Ageing, Report on the Inquiry into Health Funding titled, The Blame Game is released, which identifies that the division of responsibility between the Commonwealth and the states weakens political accountability to the community, for actions taken by government to address health care issues.
2007	▪ Broader Health Cover legislation is implemented that enables Health Insurers to offer products that pay benefits for services that are part of, prevent, or substitute for hospital services, removing the boundary that existed between "hospital" and "ancillary" insurance. Insurers are able to include outreach Hospital–in–the–Home services in a Broader Health Cover product without needing the approval of the Federal Government. ▪ Implementation of the Mental Health Nurse Incentive Program (MHNIP) provides non–MBS incentive payments to fund community–based general practices, private psychiatric practices and other appropriate organisations to engage Credentialed Mental Health Nurses to assist in the provision of coordinated clinical care for people with severe mental health disorders. Mental Health Nurses work in collaboration with psychiatrists and general practitioners to provide services in a range of settings, such as clinics or patient's homes and are provided at little or no cost to the patient. Support provided under this initiative targets patients with severe mental health disorders during periods of significant disability.
2008	▪ The Australia Government establishes a National Health and Hospitals Reform Commission (NHHRC) to develop a long–term health reform plan for Australia. The Commission is tasked to provide the Plan to the Government by mid 2009. http://www.nhhrc.org.au/ ▪ The National Advisory Council on Mental Health (NACMH) is established to provide independent and confidential advice to Government on mental health issues as requested by the Commonwealth Minister for Health and Ageing. The inaugural meeting of the Council is held on 27/28 August 2008, and the second meeting is held 15/16 October with a third planned for early 2009. http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/National+Advisory+Council+on+Mental+Health ▪ COAG National Action Plan for Mental Health 2006–2011: Progress Report 2006–07 is released. http://www.coag.gov.au/reports/index.cfm#mental ▪ COAG meets in November and agrees to consider in 2009 an ambitious program of reforms to roles and responsibilities for funding and delivery of services to the community. The goals of such reforms will be to deliver more integrated and responsive services for individuals and families, to clarify accountabilities between governments and to improve performance of service systems. COAG requests officials to bring back specific proposals in relation to community mental health, disability services and aged care in the first half of 2009 as part of this program. http://www.coag.gov.au/coag_meeting_outcomes/2008–11–29/index.cfm ▪ NHHRC Interim report released: *A Healthier Future For All Australians – Interim Report December 2008.* ▪ Summative Evaluation of the National Mental Health Plan 2003–2008 completed. ▪ Senate Community Affairs Senate Community Affairs Committee Inquiry into Mental Health Services in Australia

Year	Some of the major inquiries, reports and events since 1983 (continued)
2009	▪ The Australian Government releases the *National Mental Health Policy 2008* that articulates the differing role of the Policy and the *Fourth National Mental Health Plan* and their relationship with the *COAG Action Plan for Mental Health 2006–2011*, and other policy frameworks and activity at the National level. It is intended that the Policy will overlap and then eventually overtake the COAG Plan
	▪ NHHRC Final Report released: A Healthier Future For All Australians – June 2009
	▪ Australian Council on Quality and Safety in Health Care Report
	▪ On 4 September 2009 the Australian Health Ministers' Conference (AHMC) endorsed the *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014.*
	▪ On 14 September 2009, the Australian Government's *National Mental Health and Disability Employment Strategy* was released.
2010	▪ On 28 January 2010 *A Stronger, Fairer Australia – a new social inclusion strategy* was launched.