Consultation 3:
Out of hospital mental health services

Bupa Submission

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Problem definition

The Productivity Commission's Inquiry Report on Mental Health (2020) noted that in any year, approximately one in five Australians experiences mental ill-health and far too many people seeking treatment for moderate to severe conditions are not receiving the level of care they need. Suitable support is difficult to find and access, and the support people do receive is often well below best practice, not sustained as their condition evolves and unconnected with other clinical services.

Mental health is a core part of the private health insurance value proposition. Private Health Insurers (PHIs) pay for 76% of same day mental health treatment and 54% of all hospital admissions for mental health (AIHW, Australian hospital statistics 2018–19). In 2019 Bupa paid benefits of $207 million for our members receiving mental health treatments, 91% of this was associated with benefits paid for overnight admissions. The average length of stay in a mental health hospital was 17 days and 16% of Bupa members claiming for overnight psychiatric services are readmitted within 28 days.

Restrictive and outdated regulation is driving unnecessary use of inpatient facilities and admissions, because PHIs are generally unable to fund community based mental health care, meaning people face deterrently high out-of-pocket costs for pursuing treatment in community settings.

As a result, over the past five years there has been a 5% annual increase in private psychiatric beds per 100,000 population, with a 3.6% annual increase in length of stay (AIHW, Mental Health Services in Australia). This exposes patients to potential harms including institutionalisation and dependency, distress from enforced social proximity to others, separation from friends and family, development of unhelpful coping strategies and stigma.

Our claims data shows that utilisation of and expenditure on mental health services has grown substantially. Between 2017 and 2019:

- total hospital benefits paid increased 12.4%
- hospital benefits paid per member increased 17.1%
- ancillary mental health benefits grew 19.2%
- ancillary mental health services grew 16.7%.

Analysis of high cost claims (>$10,000) for 2019 shows that for members under 40, hospital psychiatric services are the highest ranked clinical category by total benefits paid.

Yet readmission rates and the findings of multiple government inquiries and commissions suggests this spending is not resulting in discernible improvements in outcomes or experience for those with mental illness. As the National Mental Health Commission notes, the effects of social determinants on mental health and wellbeing are dynamic, complex, and cannot be addressed by the current medical model of interventions alone (Monitoring mental health and suicide prevention reform: National Report 2019).

As well as helping people manage clinical symptoms, the mental health sector must also support people to lead a contributing life, through shared care management, personal choice and control. Community focused care models are likely to be more compatible with meeting these objectives.

Incentivising value-based care

Suppliers of health care services are paid according to the services they provide rather than the quality of the outcome achieved for the patient in their care. There are few incentives to provide the right care, in the right setting, at the right time. For example, when psychiatric care services are provided in a hospital, Part 2(4) of the *Private Health Insurance (Benefit Requirements) Rules 2011* stipulates that the policy must cover its cost even if no Medicare benefit is payable for the service.

Unfortunately, the consequence of these 'minimum benefits' can be the provision of low value care that does not contribute to enhanced mental health outcomes or improvements commensurate to their cost.

Examples of low value mental health care

Low value care occurs where a member is repeatedly attending day programs:

a) That do not include interventions that are evidence based and clinically relevant for that individual; and/or
b) They are not seeing a corresponding improvement in their mental health outcomes.

An example of such low value care is day programs for which no treatment plan is created or monitored, which means there is no pathway for the person to transition back into the community and activities with little therapeutic value designed to keep participants occupied.

Bupa's auditing process reveals many private psychiatric providers offer these types of low value mental health care to our members. Our auditing has also revealed:

- many inpatient programs do not require patients to attend the services or group sessions that are on offer in the facility on the days the patient is there
- many mental health facilities only provided therapeutic interventions on weekdays, meaning patients admitted to or staying in hospital over a weekend have no access to treatment, despite continuing to pay the same daily rate.

To address concerns such as these, we have sought to introduce contractual requirements that ensure services are provided every day of a member's admitted stay and that members are supported to be an active agent in their recovery journey by attending inpatient therapeutic group programmes.

Greater utility for our members would be achieved through an investment in an evidenced based, tailored care plan that follows a treatment path with progress tracked and outcomes measured over time. This allows for patients' treatment progress to be monitored and changes made to their care plan as required. It allows for a person's care to move and adapt to their changing support needs and circumstances which is vital when the end goal is to help that person transition back into the community and/or help to manage their mental health.

We want reform to support the provision of high value care as defined by improved health outcomes divided by the cost of providing that care. By this measure, value is improved by either improving health outcomes, decreasing the costs of providing care, or both.

To improve service planning and outcomes it is essential that more data of higher quality is made available and used to interrogate whether spending is effective, efficient and informed by evidence, and assesses whether people's needs are being met.

Insurers need access to meaningful outcome data collections such as ICHOM, HONOS and others, linked to care settings and claims or cost data, that can be used to measure the impact of different patient pathways to 'test and learn' what works best for people and contribute to a learning health system.

About Bupa's mental health offerings

We spend around $200 million each year on mental health treatment on behalf of our members, with the majority at the acute end of the care continuum. Since 2017, Bupa has been making considered investments in evidence based alternatives via pilots across the spectrum of support including:

- a community-based care model capable of replacing hospital admission for many different mental health conditions (Mind Care Choices); and
- a preventative early intervention that can be delivered at scale, supporting recovery from mild to moderate depression and anxiety which are the most prevalent mental health concerns with the highest non-fatal burden of disease (This Way Up).

Mind Care Choices

Bupa were the first private health insurer to pilot a community based mental health model of care for our members. Mind Care Choices was developed as an alternative to hospital-based care (using external providers) in response to member preferences to access mental health care in the community.

Under this program support is provided by a multidisciplinary team of mental health professionals encompassing psychiatrists, psychologists, mental health nurses, social workers and occupational therapists. Services can be provided at a clinic (on an individual or group basis), in their own home or via telehealth depending on an individual's needs and preferences.

The program is active in three states Victoria (since Sept 2017), NSW (since Aug 2019) and Queensland (since Feb 2020). We will be expanding the program into ACT and TAS in 2021.
The expected benefits of the Mind Care Choices Program are:

- Reduction in overnight hospital bed days (readmissions);
- Reduction in day program utilisation; and
- An improvement in patient reported outcome measures (as measured through PHQ-9; GAD 7 and WHODAS2.0).

A recent evaluation of the program shows positive outcomes, with overnight stays per member substantially lower, driving a reduction in benefits payable. For example:

- Comparing member outcomes 12 months pre-admission in Mind Care Choices with the 12 months post shows the average overnight episodes and days per member have reduced by ~1/3 the rate preadmission, driven by the community nature of the service.
- Yet to be formally evaluated, the patient reported outcomes indicated a reduction of symptoms. Formal evaluation using a Third-Party Provider will commence in mid-2021.

The Sax Institute was commissioned to design a rigorous evaluation framework which will be used to inform continuous improvement in program design and implementation.

This Way Up internet-based cognitive behavioural therapy
We were also the first private health insurer to offer full-fee rebate-able internet-based cognitive behavioural therapy (iCBT) via This Way Up (TWU) which offers outcomes equivalent to face-to-face CBT and are longer lasting than medication.

In 2018 a review of Bupa mental health offerings revealed a gap in support for those at risk or living with mild mental illness, so we piloted full-fee rebate-able internet-based cognitive behavioural therapy (iCBT).

Bupa conducted a pilot inviting a cohort of Bupa members who had not previously made claims for mental health services (hospital or ancillary) to access iCBT programs provided by This Way Up. Nine paid courses focusing on management of depression and/ or anxiety related disorders and three free wellbeing courses focussed on stress management, introduction to mindfulness, and insomnia were offered. Where a fee was involved, members paid the $59 course fee directly to TWU at the time of registration and were able to claim the full fee rebate upon completion of the course.

Approximately 115 members from all over Australia participated in the pilot, including 25% from regional, remote and very remote areas. Almost two-thirds registered for a paid course.

We found higher than expected levels of psychological distress among participants with over half recording moderate or severe scores at baseline. The expectation was that people suffering from moderate or severe mental disorders would have previously made claims for hospital or ancillary treatment related to their illness and would therefore be excluded from the sample population for the pilot. The results indicate that this is not the case.

Results showed TWU paid courses are successful at reducing symptoms of psychological distress. Only 1 in 5 were considered likely to be well at baseline, rising to 3 in 5 after completing all 6 lessons, while the number of people considered to have a moderate or severe mental disorder at baseline reduced to less than 1 in 10 or 8.6% upon full course completion. Completing 4+ lessons produced an average reduction in distress symptoms of 6.9 points.

The completion rate for paid courses was 54% and 27% for free courses. This is more than double the completion rate expected by TWU based on completion rates for the broader population (25%). Incentivising course completion to receive a full fee rebate increased the rate of completion.

As a result of the pilot, we've made TWU iCBT available to all our members with mental health cover, continuing the funding arrangement of reimbursement with receipt of a certificate of completion from This Way Up. This helps motivate course completion, which is necessary to experience positive results. Bupa continues to explore options to increase our digital mental health offering to members across the age range.

Proposed policy

Part one: benefits payable for preventative mental health treatments to all patients

We welcome the proposal to allow insurers to fund preventative mental health services from the hospital treatment pool, regardless of whether they have a previous hospital episode, based on criteria we set to ensure appropriate targeting.

It is likely that insurers will need to develop new products and/or adjust the pricing of hospital products depending on what preventative treatments or services are offered and the eligibility criteria for accessing them.

Effective preventative mental health treatments and services need to be appropriately designed and targeted to the patients who are at risk, focussed on improving clinical outcomes and delivering the functional outcomes that matter to those patients. Currently, the capacity for insurers to identify which of our members are most in need of preventative interventions is limited to looking at previous hospital admissions or utilisation of ancillary mental health services. Insurers will need to work with other parts of the health ecosystem to develop more sophisticated methods for earlier identification of those for whom early intervention and prevention will be most clinically and cost effective. For example, working in collaboration with Primary Health Networks to identify those members that would benefit and jointly promote such offerings.

Evolving mental health care to reflect a value-based approach and improve health outcomes can only be achieved with a focus on delivering and measuring patient outcomes and using these insights to further inform expenditure, models of care and the experience of receiving and giving care.

Preventative programs will need embedded implementation evaluation and rapid-cycle continuous quality improvement. Innovation and rigorous test, learn, adapt approaches must be encouraged. Other regulatory change may be needed to facilitate this shift. For example, redefining detrimental product changes and associated requirements for this context to ensure they are not a barrier discouraging funds from introducing new offerings within a continuous improvement paradigm.

Part two: chronic disease management programs (CDMPs) provided to a wider range of professional groups

In mental health, the services provided by mental health nurses, social workers and community pharmacists play a key role in supporting the patient. We support changes that would allow us to decide which providers we want to fund to deliver chronic disease prevention and management services to our members. We also need the ability to ensure that these providers are appropriately experienced and qualified to support people with mental health conditions.

Expanding the range of clinically appropriate health services provided through CDMPs that are eligible to be risk equalised will improve incentives for PHIs to fund chronic disease prevention and management. For example, as medicines play a central role in mental health treatment (AIHW, Mental Health Services in Australia) program design could include pharmacogenomic testing in order to identify the most appropriate medicines more quickly, minimising adverse events to inform ongoing medication management.

While this proposal is valuable, we believe a more effective policy change would be enabling PHIs to top up payments for mental health MBS items or enabling an MBS funding approach similar to that for inpatient care where insurers pay 25% and MBS the remainder. This would overcome the biggest barrier for PHI members accessing community-based mental health care, which is the significant out of pocket costs.

Top ups of this nature are the mechanism we are using to deliver the Mind Care Choices pilots mentioned above. They would also ensure there are no out of pocket expenses for accessing services not covered under a CDMP, psychiatrists being a notable example. We believe this is a more attractive customer value proposition.

Further, additional regulatory reform to funding mechanisms is essential to securing a pathway for taking successful programs, such as Mind Care Choices, from pilots into the broader PHI offer. There is limited incentive for insurers to invest in developing and refining alternative models or in building sector capacity if there is limited scope to transition and scale successful interventions.

Part three: Expanded payments for CDMP expenses to include indirect service delivery of low cost interventions

While we support this proposal in principle, it is important that any interventions be evidence based and not replicating or replacing the free or low cost digital mental health assessment and treatment services that are already available.

There are myriad digital mental health and wellbeing apps that are not evidence based and subscription focussed, meaning that funds could be paying for interventions or services that are of low value or simply not used enough to produce beneficial outcomes.

Our experience through the iCBT pilot demonstrates this. At least four or more of the six lessons in a course need to be completed for the average symptom reductions of 6.9 points to be realised. Completing three or fewer lessons results in symptom reduction of 2.6 points by comparison. TWU completion rates in the broader Australian population are 25%. Our pilot demonstrated that free course offerings achieved a similar completion rate of 27%, compared with 54% for a paid course, the cost of which was only rebated on evidence of completion.

Other recommendations

- Changes should only apply to members who hold hospital products that include full psychiatric cover, not those with restricted benefits.

- Community based models of care are still in their infancy with insurers testing different approaches through pilot programs and evaluating them using data on reductions in overnight stays and day attendances pre and post community-based intervention as well as measuring patient reported outcomes is essential. For this reason, it is important that the mental health waiver remains applicable to those accessing hospital psychiatric care only.

  Our data suggests that around 25% of those who make claims after using the waiver, subsequently cancel their policies (8%) or downgrade to a lower level of cover, which does not include comprehensive mental health services (17%). This is of concern given mental health is often a long-term chronic condition that requires on-going management, with people's needs fluctuating in intensity and over time.

  In the longer term, government should also consider whether the investment in the waiver is an optimal use of resources.

- Trials or pilots of co-commissioning models between health insurers, primary health networks (PHNs) and local health/hospital networks (LHNs) should be encouraged as part of developing and refining:
  - productive blended funding models
  - effective methods for identifying those at risk to target with preventative programs and early intervention
  - clear and seamless care pathways incorporated into single care plans for people with complex needs. Global evidence supports that the creation and sustaining of these pathways is best achieved at a local level
  - how to monitor outcomes in real time (preferably via a digital platform).

- Discourage low value mental health care by shifting funding towards the value (cost effectiveness) rather than volume of services and bolstering guidelines for determining minimum payable benefits by health insurers.

- Insurers already have clear incentives aligned to offering and funding out of hospital mental health services. Any extension of minimum default benefits to out of hospital services is unnecessary and must be avoided. Paying for services that lack contractual specifications and expectations results in low value and/or poor-quality care.

- Bupa would be concerned with being overexposed to the risk of providing benefits for services that are already delivered in the community and funded by other means. For example, if public hospitals were permitted to treat private patients in alternative settings (that are not admitted) this would expose insurers to the risk of significant increases in benefit outlays, impacting PHI premiums.

TABLE 1: CONSULTATION QUESTIONS REFERENCE SUMMARY	
1. What additional mental health services funded by insurers under this proposal would be of value to consumers?	Digital mental health services that are evidence based (CBT focussed self-directed modules) including those that provide an assessment of need then direct to appropriate evidence-based modules.
2. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?	The list should be focussed on mental health initially to test whether there are issues implementing and managing the expansion. The range of professionals could be widened to include nurses, pharmacists and social workers.
3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?	Yes, standards, specific education and qualification levels for staff providing services will be needed to ensure appropriate handling of clinical incidents and manage professional liability and indemnity issues.
4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?	Currently this must be coordinated by a person who has accepted responsibility and it could be expanded to note the value of a team-based approach.
5. Are there any mental health services insurers should not be permitted to fund?	Yes it is not appropriate that PHIs fund: • Non evidenced based care. • Care without outcome reporting. • Digital services that are do not meet the National Safety & Quality Digital Mental Health Standards.
6. How should the relevant patient cohort be identified as eligible for services?	Insurers should be responsible for identifying eligibility criteria for community based mental health programs centred on value-based care objectives.
7. Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?	Yes. Insurers should set eligibility criteria and work with other parts of the health ecosystem to identify relevant patient cohorts.
8. What are appropriate metrics for measuring the impact of this proposal?	Policy numbers, retention, upgrades, cancellations, movements to other funds and patient reported mental health outcomes.
9. What is the regulatory burden associated with this proposal?	We are not able to estimate this without more information on how the proposal will be implemented.