Independent Private Psychiatrists Group
PHI Change Response

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Overview

The Federal Government has a strong incentive to ensure the viability of the privately insured healthcare sector in general, and particularly in relation to mental health. Private psychiatrists see around 400,000 Australians suffering from severe mental illness every year, which is around the same number that is seen by the public mental health sector. As determined by outcome measures collected over more than 15 years, the illness severity of private psychiatrists' patients is similar to those patients treated in the public sector. The work of private psychiatrists costs the Federal Government $360 million each year, whereas the public sector seeing the same number of people, costs $10 billion. The demise of private sector mental health services provided by psychiatrists would lead to those services being transferred to the public sector, which would almost certainly not be able to cope - or it could well cost $20 billion.

There are three major overarching problems associated with the private health insurance recommendations in their consultation paper. The changes as recommended will not save private health insurance from failure in Australia. A more visionary generational change to private health insurance in Australia must be considered, if we are to have a viable health system in years to come. The consultation paper provides no significant evidence to back up the policy suggestions made in this paper. We would also note that there has been a total lack of consultation with private psychiatrists who practice full time in their private practices, and whose ability to practice is adversely affected by the suggested changes in the paper. Patients treated in private psychiatric hospitals would be damaged by the changes the PHI suggest.

Private health insurance requires a generational change in the insurance that is provided to people. It is not good enough for the private health insurance industry to try to restrict the practice of private psychiatrists, to try to save a small amount of money, whilst it does not provide any indication of the ability to actually do their own job properly: namely developing the mechanism to insure people appropriately for their health care needs within Australia. We would suggest that the Australian Government should develop either a medical savings account system similar to that operated in Singapore, or else provide whole of life health insurance policies that the private health insurers can offer. The implementation of either of those strategies would have to occur over a period of some 25 years, where the community rating system that operates presently would be decommissioned gradually, and the new insurance structure would replace it gradually over that time. Such a system would require strong Federal Government regulation.

A number of specific suggested changes to current health insurance arrangements have been suggested in the consultation paper, and a number of these suggestions would have extremely adverse effects on the correct and legitimate practice of psychiatry. Given that there is absolutely no good evidence produced in this consultation paper at all, and in

particular, no scientific evidence to back up the changes recommended, those changes recommended that affect private psychiatrist providers should be utterly rejected.

In the past, there was an organisation called the private mental health alliance, which brought together private health insurers, private hospitals, psychiatrists and consumers and carers (and originally the Colleges of Psychiatry and General Practice) to determine how to develop innovative models of practice in our sector. In 2016, the private health insurers were instrumental in dismantling that organisation. If there was ever a time where that sort of consultation process was necessary, it is right now. There has been a total lack of consultation with private psychiatrists who work full time in their private practices, in relation to the suggestions made in this paper, either by PHI, or by the Federal Government. As a result, naive and possibly deliberately destructive suggestions have been made, which would adversely affect high-quality psychiatric practice. These suggestions have been made by private insurers, and allowed by Government representatives to exist in this consultation paper. This is an absolute disgrace, and probably reflects a desperation in the private health insurers, and a lack of mental health expertise in Federal Government bureaucracy.

Problematic Details Within the Consultation Paper

On page 5 of the consultation paper, the need to attract young people is emphasised. We would entirely agree with that, but believe that the current suggestions will not significantly help with that. We understand that the suggestion of allowing dependent children to continue on a family health insurance membership was suggested by the Federal AMA, and we are not against this, and indeed believe it is a very useful strategy. However, we would note that it will almost certainly mean that private health insurers will retain young people that they probably do not want to retain, namely those people with ongoing and chronic illnesses.

Also, on page 5, There is the suggestion that home-based care will be highly desired by consumers, based on evidence apparently coming from rehabilitation providers. On the same basis it appears, home-based care is recommended for people suffering from mental illnesses. As far as we can see, there is no evidence to support a strong mental health consumer-led movement who wish for home-based care when suffering severe illness. Our experience is that when patients are suffering severe conditions, their families are in some level of desperation, and are very relieved to have their loved ones placed in hospital safety, and adequately treated. We would suggest that mental health care delivery in the home is both likely to be highly expensive, (which we suspect the health funds in their naivete or cynicism have decided not to calculate), or is likely to not be so highly desired by consumers or their carers.

On page 13 we come to the old problem of the preferred criteria of disability to be used to warrant a hospital admission. This is a return to the same issues that occurred in 1993, and led to the formation of an industry body, which eventually became the private mental health alliance. There is an attempt to be able to define admission criteria so that some admissions can be negated by the health funds, on some sort of spurious admission criteria grounds. As we found in 1993, admission criteria are almost impossible to develop, because of the complexity of mental illness presentations, and the need for caution, to prevent suicide. It is vital that Psychiatrists can be free to admit patients into hospital on grounds that they clinically determine, so that lives will not be lost, and so that adequate treatment can be provided to people who have private health insurance. The health funds provide no scientific evidence of the use of other admission criteria that have been

associated with better consumer outcomes. In total contradistinction to that, recent scientific studies have shown the necessity of longer admissions for severely ill psychiatric consumers.

On page 18, there is some analysis about what might be desired in rehabilitation services. We are not expert rehabilitation medicine physicians, but we wonder how satisfied such physicians would be with the proposals made in this paper. We suspect they would not be very satisfied at all.

On page 20, there is discussion about the use of chronic disease management plans to be able to employ other types of healthcare providers, and presumably also relatively inexpensive unqualified healthcare providers, to provide care in the home particularly. We wonder where the evidence base is to show that such care will actually be useful, and not just be a drain on private health insurance funds. We do not believe that there is any significant scientific evidence base to support the suggestions made. The suggestions seem to be based on a rather naive view of what is now called the “missing middle”: which is the idea that if these people are seen in the community earlier on, you will prevent severe illnesses such as schizophrenia and bipolar disorder. Given that those severe illnesses are almost certainly produced by biological illness processes, it is most likely that such interventions will make no difference to the trajectory of people suffering these illnesses, and will probably cost health funds enormously for little result, and almost certainly lead to increased suicide of inadequately treated patients.

On page 23 there is mention of inappropriate certification of mental health certificates in private hospitals. Presumably such “inappropriate certification” is alleged to occur by the actions of private psychiatrists. Once again, we believe no significant evidence has been produced in this paper to justify this claim. This may be a belief of private health insurance funds, and they may have some sort of evidence that they think supports this claim, but this evidence has never been tested, and has not been provided in the consultation paper. We personally have tried over many many years to collaborate with private health insurers in investigating areas in which they believe private psychiatrists are either not filling out forms correctly, or are inappropriately treating people in hospital. At no stage have the private health insurers been willing to engage in an appropriate mode of discussion about their own concerns, and to do so in a way that might achieve results for them, by working with private psychiatrists. Then a corrupted process like this one is presented to us.

On page 24, and coming out of the previously noted adverse criticisms of private psychiatrists, there is a suggestion of the need for a self-regulated industry panel. This concept has not been properly worked through. We used to have a self-regulated industry panel in the form of the private mental health alliance. The health funds decided to eliminate that body. If the intention of the health funds is to somehow take a managed-care approach to the care of people with mental illness treated by private psychiatrists, then that should not be agreed to by any medical body. If the intention is to develop a collaborative process to look more generally at the best ways of treating people in the private sector, then, with appropriate funding, the re-instigation of the private mental health alliance may well be an appropriate re-introduction. In this regard, the private insurers appear to be behaving perversely.

Again, on page 24 there is the suggestion of developing new clinical practice guidelines in private hospitals to improve patient care. Our sector has been collecting outcome measurement data for the last 15 years from private hospitals, and this data proves that the people treated in private psychiatric hospitals have illnesses of a very serious nature

(of a very similar severity to those admitted for public hospital psychiatric treatment), and they improve markedly due to their treatment in hospital. We do not need to develop new clinical guidelines that may impair the practice of private psychiatrists, but if we were to re-develop the private mental health alliance, then there would always be the possibility of reviewing the guidelines as a whole industry sector. That is something that the private mental health alliance previously did, approximately once every five years, and such reviews could be worthwhile.

On page 25, the private health insurers suggest that private psychiatrists could be referred to the professional services review process for examination, if they err in some way when they fill out private health insurance forms. This proposal should be utterly rejected. It is an attempt at crude managed-care, and seems to ignore the numerous ways doctors can be examined already, such as through the medical board, litigation, and occasionally criminal conviction. There is no evidence that there is sufficient wrongdoing occurring by private psychiatrists to warrant any process that might refer the psychiatrist to the professional services review panel.

On page 27, it is suggested that standardised certification forms should be developed to satisfy the private health insurers. They should note that none of the forms private psychiatrists already sign, are forms that we have had any involvement in developing. We would also note that we are not paid for these services. We would suggest that, if the private health insurers want to change their forms, then it would be much better for them to do so in collaboration with private psychiatrists. They should also note that they are producing, through their aggressive program, a medico legal document, and that private psychiatrists should properly claim medico legal fees for filling out the forms so developed, especially if that involves greater form-filling requirements than are already required.

Summary

In summary, this supposed consultation is a very disappointing process, which has not involved the input of actively practicing private psychiatrists, until this late-stage opportunity was provided, possibly at a deliberately difficult time of year in which to mount responses. None of the PHI suggestions will resolve the problems that PHI faces. Generational reform imposed by the Federal Government, but which can involve the existing PHI as participants, will be required to “turn the ship around”. As private psychiatrists, we want private health insurance to be successful. For a small number of our consumers, at times of real risk and suffering, private psychiatric hospitalization can be life-saving.

The consultation document, and the process involved: involving no consultation with actively practicing private psychiatrists, is most unfortunate and concerning. It reflects very badly on the lack of capacity or vision of the private health insurers. It reflects badly on the Federal Government and its Health Department, that such a biased and undemocratic process should have been allowed to occur, and gives the impression that this Government is listening mainly to large corporations, rather than small business medical providers and consumers.

The consultation paper fails to provide any evidence, either of PHI conjecture, let alone of scientific studies, to support the suggested changes. The suggested changes would likely cripple the ability of private psychiatrists to adequately treat their patients in private hospitals, due to a process of gross managed care. The PHI do not seem to care at all

about mental health consumers or their carers. Perversely, a number of their suggestions will cost them a lot more money, but achieve worse outcomes.