SUBMISSION

Consultation Paper: Private Health Insurance Reforms – Second Wave

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Lived Experience Australia Ltd (LEA) formerly the Private Mental Health Consumer Carer Network (Australia) Limited was formed in 2002 and currently operates as the recognised peak body for private sector mental health consumers and carers across Australia.

LEA is pleased to provide our perspectives into this Consultation and welcome the opportunity to have further involvement.

LEA has had representation on the Government's Improved Models of Care Working Group, the Improved Models of Care Mental Health Working Group, the former Private Mental Health Alliance (PMHA) and the PMHA's Centralised Data Management Service, now the Private Psychiatric Hospital Data Reporting and Analysis Service, and for the purposes of private health insurance clinical categories also representation on the Medicare Benefits Schedule Review Psychiatry Clinical Committee and the Primary Mental Health Committee.

For these reasons, LEA believes we are best placed to provide lived experience perspectives into this Consultation Paper. Furthermore, LEA has recently conducted a national survey of lived experience perspectives around the 'missing middle' a phrase coined by the Productivity Commission Inquiry into Mental Health. We have used some respondents quotes and statistics within this Submission.

Key Points

To enable access and choice, LEA believes these are the key points for consideration from a lived experience perspective.

➢	Any initiatives must be led by a mental health professional, most particularly the private psychiatrist involved in the care
➢	Any initiatives must be approached with and by a multidisciplinary team
➢	Concerns this will add greater complexity to health insurance products
➢	Concerns about the variability of coverage, i.e. which level of cover will apply if CDMPs are attributed to hospital cover
➢	There are restrictions applied to mental health still on the gold cover
➢	Health insurers offering their own services i.e., both provider and funder
➢	Changes should be across ALL funds for clarity and they must be set within the regulatory framework
➢	Community rating must be retained
➢	Criteria for access must be determined by and within the scope of the *Guidelines for Determining Benefits for Private Health Insurances Purposes for Private Mental Health Care.*
➢	Lived Experience Australia is the relevant national organisation in mental health and must be involved in the decision making and co-designing processes
➢	**Full support for increasing age of dependents to 31 and removing age limit for those on disability**

1 Overview

LEA has been a strong supporter of the Government's health insurance reforms as they apply to mental health service delivery.

During Minister Greg Hunt's term as Minister for Health, we have seen the supporting and acknowledgment of the need for consumer choice and transparency which now underpins the categorisation of health insurance policies so that consumers can review and compare policies, choose the best one that fits their requirements, and which they can afford. The ability to immediately upgrade, offers access, something which we believe supports the value of private health insurance.

What health insurance members need, is to be able to rely on Government policies and not lose confidence in the private health insurance industry. There is also a message coming through about risk and we are concerned that if health insurers take this aspect as to meaning accessibility to services offered based on a risk rating rather than clinical need, is a most concerning aspect. Community rating is the cornerstone of health insurance, provides confidence of the Australian community and underpins the viability and affordability of health insurance.

Despite the Government's initiatives, LEA is aware of consumer concerns around health insurer restrictions relating to complexity of health insurance products, what cover people actually have under their policy, accessibility, choice, and how these issues relate to the perception of 'value for money' of their health insurance. These proposals will add to the complexities around how consumers compare products if they are not standard across all products and/or health insurers. If health insurers can determine criteria around say their preferred providers, diagnoses, conditions, their members' usage of services, LEA believes this will make choice far more difficult as to which policy best suits their needs.

We know people on government benefits, i.e., Disability Support Pension, go without in order to pay for their health insurance. The reason they do this, is to be able to access a private hospital when they need to, to avail of high-quality programs and care which meets their needs, and most importantly provides choice.

2 The 'Missing Middle' - Responses from people with a lived experience

LEA recently distributed and analysed a national survey of people with lived experience of the 'missing middle', why people do not engage and why those that do, disengage from mental health support.

There are some recurring themes. One is the cost of private health insurance, the other is the value of having that cover for mental health, i.e., choice, access, quality, responsiveness etc.

Here is what some respondents said.

Costs

It's just too expensive and health insurance doesn't cover enough but I couldn't afford higher cover to pay for it anyway.

At the moment I am not using any of the private mental health services, but if I need to go into hospital for mental issues I will not be covered as I am not in the top cover which I think is not fair. For the amount of money that we pay for health, I should be able to go first class into a private hospital.

I guess because the cost bearing factor has risen enormously.... I would be inclined going to the Public Hospital...and that's only if need be.

I can't afford the level of private Health insurance required to receive adequate mental Health cover.

I can access services because I have private health insurance. However, when I go to claim for my health fund, they cover less and less. Last year I had to take out a payment plan to pay off my treatment. My Fund would not cover anything.

Perceived value of health insurance

Responses:

It's an insurance policy to have an option for a safe admission if I need one. I will not return to a public mental health unit – I will kill myself instead. I will not risk being sexually harassed, assaulted, restrained or secluded, suicide is a much better option. I'm done.

Generally easier to get admitted – but you have to be able to cover the cost. Sometimes a wait list depending on the severity of your situation.

A safe environment. Having likeminded people around me. All levels of staff keeping me engaged while communicating with one another to monitor my progress.

Have had access to private MH hospitals in the past but have had to travel to QLD to access the treatments required which has mainly been covered by my health insurance in the past but at great personal cost e.g.: stress, anxiety and co-ordination etc.

It takes one call to make a referral and you're know within 24 hours. The staff and services provided as an inpatient and outpatient.

When we asked if people had been able to access private hospital services when needed:

Responses:

traumatic ED experience, no getting shoved out after 24/48 hours dosed up on meds (I've heard horror stories from friends) instead I was able to stay for several weeks and get intensive help, 24/7 Support, but also be in a safe and calm environment with like-minded patients, access to specifically trained nurses and doctors, where the focus was on sustainable recovery and not sedation/discharge as soon as possible.

Private health insurance and access to the care needed

Responses:

I have extras cover but it doesn't cover hospital. I've used it for psych sessions after I've used my 10 but you barely get any money back so it's hardly even worth it.

In patient & outpatient programs, psychologist, but still cost prohibitive – I can't afford to pay for the level of cover needed to access those services.

3 Removal of perceived barriers to improved models of care

As LEA was represented on the Improved Models of Care Working Group, it was apparent that health insurers actively sought out alternatives to inpatient care. It is also true that members were surprised by the application of the regulatory regime in that there seems to be no real barriers to providing this type of service.

Whilst mental health service delivery is more complex than rehabilitation, mental health consumers also in the main, would like to see more innovation in the mental health area too especially in relation to alternatives to inpatient care.

The difference between rehabilitation and mental health is the therapeutic relationship between the consumer, the hospital, the patient's psychiatrist and other clinicians involved in their care. People in the private sector do not experience mental ill-health in isolation, many are impacted.

As the Consultation Paper explains, health insurers have been able to pay for a range of services since the 2007 Broader Health Cover reforms, something that LEA has been aware of and has been actively advocating for over time.

4 Community rating

The other critical issue as mentioned above is that of 'community rating'. This underpins affordability, access, value for money etc. This must continue if we are to see a private health system funded through health insurance products remain sustainable and affordable.

5 Consultation 1 – Increase the age of dependents to 31 years and removing age limit for those with a disability

LEA strongly supports increasing the age of dependents especially as more young people are needing mental health care. LEA strongly supports removing the age limit completely for those with a disability which would also be as in the NDIS, those with psychosocial disability. This initiative would offer certainty to those struggling to meet the costs of health insurance.

LEA refers to the need for more young people to invest in health insurance. Increasing the age of dependent to 31 years offers them more understanding of the value of health insurance. The easy transition to a policy of their own on attaining the age of 31, makes good sense to avoid the associated loading.

Here are some quotes in this regard from our national survey.

I did have private health insurance until I turned 25 and was removed from my parent's policy and because I couldn't justify paying for private health insurance with no real existing medical conditions, I have only been using the free services. In saying that now that headspace is no longer available to me, I have looked into getting private health insurance to afford more mental health services outside of the 6-10 free sessions.

Parents support to finance private health insurance.

6 Consultation 3: Out of Hospital Mental Health Services

Patient choice is the motivating factor of why people pay health insurance provided in a safe and quality service. Most people do not wish to go to a hospital setting unless it is for their own safety or those of people around them, preferring to be supported in their own environment. There is also a benefit in this approach in that clinicians who treat people in these home settings can view their surroundings which are often a good insight into how they are progressing.

Here is a response we received to our national survey:
Access and availability. Choice and self-direction.

Proposed policy part one: Benefits payable for preventative mental health treatment to all patients.
LEA supports this principle but has some queries.

1. What and who will determine the definition of 'preventative' if it is funded from the hospital treatment table.
2. Is 'preventative' meaning:
    - Prevention of mental illness?
    - Prevention of an acute episode?
    - Prevention of relapse?
    - Prevention of hospital admission/readmission?

3. Determining the criteria LEA believes should be undertaken in consultation with Lived Experience Australia in a true co-design process, and not determined by health insurers which are not clinical providers.

As is the current case, preventative initiatives are usually covered under the ancillary/extras cover for things such as diet, exercise, weight loss, smoking cessation etc.

Proposed policy part two: Chronic disease management programs provided to a wider range of professional groups

LEA supports the expansion of professionals able to provide services to patients as part of a CDMP. We have been lobbying for the greater uptake of peer workers within the private system. It makes sense to LEA that a greater number of providers would allow a greater range of services whilst allowing the engagement of mental health professionals within the acute setting.

Proposed policy part three: Expanded payments for CDMP expenses to include indirect service delivery of low-cost interventions

This part refers to subscriptions to apps amongst other things. Many Australian mental health apps now are freely available and apply across a range of diagnoses. These are available on the Government site 'Heath to Health', and provide consumers access these, comfort in knowing they have been scrutinised as relevant and suitable, and fit for purpose.

The Australian Commission on Safety and Quality in Health Care has undertaken work relating to the certification of apps for the Australian context. Any apps developed for this purpose must align with these Guidelines.

LEA's concern is that this type of features could become a strategy to attract members such as gym membership, gym shoes, etc and the policy may not meet the needs of people needing access/admission to private psychiatric hospitals. These approaches brought a lot of criticism in the past.

Regulatory Burden Estimate

LEA is concerned that the introduction without clear definitions, guidelines, criteria developed by health insurers, private hospitals, professionals, government and LEA in a co-design process as an 'industry group' will lead to further complexity, and more restrictions that currently exist under the contracts between health insurers and private hospitals (HPPAs).

The thrust of the government initiatives has been to *decrease* complexity, so that people joining up to health insurance products have greater transparency and understanding of what they are purchasing. Despite government initiatives, restrictions still remain on health insurance products as they relate to mental health and access to private psychiatric hospitals. Health insurance cover differs between health insurance funds, insurance products, private hospitals and states and territories.

LEA believes these restrictions undermine the sense of health insurance being 'value for money'. When a person is so mentally ill that they need inpatient hospitalisation for example, they are in no state to contact the private hospitals to enquiry the costs associated with treatment and care and which then is the best and most affordable to be admitted to.

7 Questions for ALL stakeholders: Mental Health Services

1. *What additional mental health services funded by insurers under this proposal would be of value to consumers?*

LEA believes the following would fit with the private hospital sector as clinical providers and which should be funded under health insurance.

a. Fund a care coordinator whose role it is to coordinate services and service providers in order to provide 'wrap around' cover for those with severe and enduring mental illness. This could prevent crises and hospital admission/readmission and support recovery.
b. Assertive outreach on an 'as needs' basis, this is distinct to 'community outreach' or 'hospital in the home'. This would hold a person with acute mental illness for a period until an inpatient bed is available. It would also assist and support someone in crisis and potentially avoid hospital admission.
c. Assertive follow up/ups after inpatient admission.
d. Assertive aftercare for suicidal thinking or suicide attempt.
e. More choice of support services that are lower value in costs, but provide the connection needed for supported recovery, i.e., art therapy, support groups, etc.
f. Peer led support groups and other activities for consumers AND carers.

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?*

LEA believes yes, in order to offer good ongoing support, having an expanded workforce would focus on strengths of patients and areas of specialisation of the provider and covered by that provider's credentials. This must include peer workers as the value and principles of peer work is gaining support throughout the mental health system.

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?*

LEA believes yes, code of conduct, professional standards and ongoing CPDs are very important to keep abreast of contemporary practice and service delivery. Professional membership is also needed to confirm to patients and families, that the provider is acting within their scope of practice.

LEA has been instrumental in advising the government and the National Mental Health Commission about the need for the establishment of a national member-based organisation for the peer workforce. This is gaining momentum and we expect funding to following providing that critical professional body. With the establishment of this organisation, peer workers would be professionally connected just as all other providers in the sector.

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?*

LEA is not aware of how this is currently defined or funded. However, we refer to our point in a) above about this critical need.

LEA believes this is a role for the private hospital as a clinical setting, so that current therapeutic relationships are maintained, and value added. Additionally, any coordination should be separated from the funding body to preserve that clinical focus.

5. *Are there any mental health services insurers should not be permitted to fund?*

LEA believes that any services health insurers as providers offer, should not be permitted to fund themselves i.e., provider AND funder.

6. *How should the relevant patient cohort be identified as eligible for services?*

LEA is of the view that patient groups could be identified by private hospitals or health insurers but the decision to access services must be via a clinical referral.

a. Patients using a large volume of services should be reviewed by a clinical team to ascertain what services would be best fit their needs.

b. Patients using a large volume of services with very little progress.
c. Patients on long term psychotropic medications or in receipt of ongoing inpatient care.
d. Patients recently discharged from either inpatient care or day programs.

7. Who should identify relevant patient cohorts, and should insurers set criteria for which members would be eligible?

Identification could be undertaken by private hospitals, psychiatrists or health insurers. As noted above, referrals should be by a clinician i.e., referral by private psychiatrist, GPs, clinical psychologists etc.

Insurers have a critical part in ensuring services are of a high quality with good outcomes for patients as well as ensuring their policies offer a range of choices. But LEA believes the *'Guidelines for Determining Benefits for Private Health Insurances Purposes for Private Mental Health Care'* developed by the industry including LEA as the representative consumer and carer voice must be reviewed in light of these proposals, to determine the criteria. The review must be undertaken by a working group inclusive of LEA, PHA, APHA, government, RANZCP, APS.

GPs as referrers would offer great access to mental health treatment and care that is currently mostly prohibited except for the referral under a Mental Health Treatment Plan to a psychologist. Access to a greater number of services that best meets a patient's needs would offer the GP much greater support and options.

There is still complexity and confusion regarding health insurance coverage for mental health and unless it is universal and can be incorporated within the current system, it will make it more difficult for a person to navigate. It would also make choosing health insurance policies more difficult and complex.

I would welcome further clarification and discussion with the Government in relation to this Submission and this initiative.

Yours faithfully,

Janne McMahon

Janne McMahon OAM
Founder and Executive Director