### **Private Health Insurance Consultation - Second Wave Reforms**

We are private and public sector psychiatrists working in hospital and community based settings.

We welcome the opportunity to provide feedback on the proposed reforms.

Before specific commentary, we make the following points on process:

- We note the apparent driver for these reforms being the insurance industry, rather than it having origins involving ALL stakeholders, in determining a collaborative plan around the critical issue of the maintenance and growth of a robust and effective private health sector
- The whole stakeholder consultation process occurred during a period dominated by Covid
- This feedback period being during the Christmas holiday period

We trust that these are not indicative of a casual approach to inputs from outside the insurance sector. Those points made, we turn to the issues that we are most concerned with.

#### **Consultation 3**

The principles of quality care for those with mental illness and disorder are that services are clinically led, and deliver the right treatment, at the right time, in the right place. We agree with the principle of avoiding unnecessary hospitalisation, where possible.

We assert the primacy of the therapeutic relationship, and its role in continuity of care. These are essential ingredients to good outcomes for those with chronic mental health disorders. It must also be noted that those receiving services in the private hospital setting have moderate to severe mental disorders, requiring sophisticated and coordinated clinical inputs.

Private hospital services adhere to appropriate clinical standards, have clear clinical governance arrangements, with psychiatrists playing a crucial role in leading clinical decision-making. A similarly robust level of clinical governance and responsibility should underlie decisions about out of home hospital care, with clinical care plans, within the multidisciplinary frame, developed by psychiatrists in consultation with consumers, carers and other clinicians, with clear delineation of role responsibilities.

Developing the out of home mental health workforce to include non-clinicians requires the provision of appropriate training and education standards, and accreditation processes. Such workers should only provide services in the context of the multidisciplinary care plan, developed under the direction of the treating psychiatrist and other senior clinicians.

The decisions, then, about clinical care, must always be made by clinicians. The situation where insurers are in the position of making clinical care decisions must never occur, and would threaten the integrity of the PHI sector.

#### Conclusion

We welcome reforms to bolster the sector and expand its scope. That said, implementing reforms must have protections built in to ensure the following:

- decisions about out of hospital clinical care needs remains the responsibility of the treating psychiatrist
- Insurers never being decision-makers about clinical care requirements.
- expansion of the MH workforce to non-clinicians should not occur without the development of appropriate standards and accreditation processes.

And a final point about the vertical integration that is occurring in the PHI sector. The obvious concern is with insurers only purchasing products that they own, heralding managed care type arrangements, which would spell the end of the extraordinarily successful PHI sector. The sector's success is built on the capacity of consumers to choose their treating clinicians, the therapeutic relationship between them and the primacy of clinicians as clinical decision makers.

Alp

Angelo Virgona (NSW) 8 February 2021

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