Consultation paper: private health insurance reforms – second wave

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Executive summary

Beginning in 2019, Minister Hunt began looking into private health insurance reform that would increase the prevalence of and access to privately funded specialist treatments delivered outside hospitals.[1]

With the most recent Federal budget, Minister Hunt announced a second wave of private health insurance reforms to make private health insurance more affordable and make home and community-based care more accessible for mental health and general rehabilitation services, with an initial focus on mental health and orthopaedics.[2]

Whilst, since 1998, Australia's public patients have been able to readily access hospital treatment in the convenience of their homes and communities, through the Australian Health Care Agreements, private patients have had to navigate much less certainty when accessing healthcare.

For private patients, funding for hospital treatment delivered in the convenience of their homes was available from the year 2000 with default benefits payable to accredited outreach services until the reforms of 2007.

With the reforms of 2007, funding was restricted to only those instances where a private health insurer agreed to pay for the service.

In the ensuing years, private health insurers did not readily adopt the optimal clinical care models being delivered by hospitals across the hospital, home and community.

On 6 October 2020, the Government acknowledged "since the 2007 Broader Health Cover reforms, to date very few services are delivered under these arrangements", citing perceived barriers to uptake / prevalence as "the current regulatory regime and funding structures".

Whereas a key finding of the Private Health Ministerial Advisory Committee's Improved Models of Care Working Group was "In most cases, the regulation does not appear to present a barrier for alternatives to in hospital rehabilitation."

It would appear, the only barrier to private patients accessing hospital treatment delivered in the convenience of their homes and communities is the willingness of private health insurers to pay for the service.

The lack of support is unsurprising given there is no definitive research that hospital treatment delivered in the home and community is unequivocally and ubiquitously more cost effective than hospital settings.

There is also the risk the proposed reforms (which expand the definition of rehabilitation care and propose shifting existing costs into hospital policies) may be cost additive- for example, for the 90,000+ private hip and knee replacements patients each year the reforms recommend:

- 100% of patients claim Medicare benefits for case conferencing prior to surgery to create the rehabilitation plan; and

[1] https://www.smh.com.au/politics/federal/hospital-in-the-home-revolution-hunt-s-plan-to-shake-up-private-health-insurance-20191125-p53dy2.html, viewed 17 January 2021
[2] The Hon Greg Hunt MP Media Release 6 October 2020 - Budget 2020-21

- 70% of patients, ordinarily discharged to outpatient physiotherapy services, begin receiving hospital benefits under a rehabilitation plan.

In this context, the current scope of the consultation and assumptions underpinning the proposed reform options will be inadequate to deliver on Minster Hunt's aspirations.

To realise Minster Hunt's aspirations, reforms must focus on: establishing certainty of funding for healthcare providers; ensuring the patient is actively engaged in the best care pathway for their individual needs and circumstances; and maintaining consistent clinical practices, safety, quality and outcomes across the whole sector.

Ramsay Health Care Australia recommends the following reform principles:

1. **Best Interests of the Patient test**:

    a. Referral (or not) to a service must be based on the patient's preference (and their family / carers) after being informed of their treatment options, the likely outcomes of each option and the likely out-of-pocket costs of each option;

    b. Conflicts of interest and financial incentives must be clearly disclosed to patients by private health insurers, doctors, hospitals and other relevant stakeholders; and

    c. Private health insurers must be prevented from further undermining of the principles of community rating and interfering in clinical care, by preventing insurers from introducing their own definitions of when (and how often) hospital benefits will be paid for patients, programs and providers.

    d. Accessibility of information about private health insurance, certainty of coverage and comparability of insurance between private health insurers must be the foundations to any reforms.

2. **Scope of General Treatment / Hospital Treatment Policies**:

    a. The definition of Hospital Treatment (and the rights and obligations that accompany that classification, such as: risk equalisation; minimum benefits; and accreditation) should be updated to reflect the importance of stepped care clinical models but should not be further extend to services that are not delivered by, or under the direction control of, a declared hospital (such as hospital-substitute treatment).

3. **Hospital Treatment in the Home / Community – Rehabilitation**:

    a. Delivered by therapists under the leadership of a Rehabilitation Physician;

    b. Delivered in accordance with a written multidisciplinary rehabilitation plan, prescribed by a Rehabilitation Physician;

    c. Genuine alternative for the frequency and intensity of inpatient hospital treatment, or part of a stepped care model (including before any hospital admissions);

    d. Clinical governance, oversight, equipment, co-ordination and therapy delivered by declared hospitals; and

    e. Patient remains under the care of a declared hospital or a person under the control or direction of the hospital.

4. **Hospital Treatment in the Home / Community – Mental Health**:

    a. Delivered by therapists under the leadership of a Consultant Psychiatrist;

    b. Delivered in accordance with a written plan, prescribed by a Consultant Psychiatrist;

    c. Genuine alternative for the frequency and intensity of inpatient hospital treatment, or part of a stepped care model (including before any hospital admissions);

    d. Clinical governance, oversight, equipment, co-ordination and therapy delivered by declared hospitals;

    e. Patient remains under the care of a declared hospital or a person under the control or direction of the hospital; and

    f. No reforms relating to CDMP or prevention should be considered, without first conducting wide consultation with clinicians and consumers to clearly define the clinical models, scope, regulations and barriers to success.

5. **Certainty of Funding**:

    a. Minimum Benefit to be payable for each day Hospital Treatment in the Home / Community is delivered face to face;

    b. Medicare benefits (on an admitted patient basis) to be payable for telehealth attendances by Rehabilitation Physicians / Psychiatrists, during an episode of Hospital Treatment delivered in the Home / Community;

    c. Medicare benefits (on an admitted patient basis) to be payable for face to face attendances by Rehabilitation Physicians / Psychiatrists, during an episode of Hospital Treatment delivered in the Home / Community; and

    d. General Treatment benefits for therapy which is similar to, but not within the definition of, 'episode of Hospital Treatment delivered in the Home / Community' to only be included in risk equalisation when the private health insurer has covered the full cost of that treatment and that treatment is for recovery following previous inpatient Hospital Treatment.

6. **Type B and Type C Certification**:

    a. The Department must work with private hospital operators to better understand the issues of certification, implement the most appropriate solution that ensures private patients can access care (that is readily available in the public hospital sector) and uphold the primacy of the doctor's independent clinical practice.

Background

Outreach services began emerging in the public hospital sector in Australia during the 1980's, with Australian private hospitals establishing outreach services in the mid 1990's with a focus on rehabilitation, psychiatry and palliative care.[3]

Since 1998, Australia's public patients have been able to readily access hospital treatment in the convenience of their homes and communities, through the Australian Health Care Agreements.[4]

In 1999, then Minster for Health, Dr Wooldridge embarked on legislative reforms to deliver equality of access to healthcare for private patients – through the pilot of six 'Hospital In The Home' trials funded by private health insurers (for the delivery of psychiatric, rehabilitation, post-operative and palliative care) "**Outreach**".[5]

Following the inclusion, in 2000, of Outreach services as hospital treatment payable by private health insurers, a default benefit was also introduced[6] – giving private patients certainty of equal access to services already funded for public patients.

With the publication of new private health insurance legislation in 2007, the default benefit and accreditation process for Outreach services were withdrawn – restricting private patient access to hospital treatment in their home and communities to only those services where their private health insurer had contracted with the patient's service provider.[7]

Unsurprisingly, the withdrawal of default benefits for home and community care delivered by an accredited Outreach provider significantly reduced the hospital treatment patients could access in the home and community – inhibiting healthcare teams from implementing optimal clinical models (many of which were already readily available for public patients).

On 6 October 2020, the Government acknowledged the market failures within the private health sector adopting optimal models of care in the home and community "since the 2007 Broader Health Cover reforms, to date very few services are delivered under these arrangements", citing as barriers "the current regulatory regime and funding structures".[8]

Australia's private hospital operators do not believe legislation has prevented the implementation of optimal models of care in the home and community.

Since the initial reforms of 2000, private hospitals have actively engaged with private health insurers to deliver hospital treatment in the optimal setting based on the individual needs and circumstances of patients – consistent with the bio-psycho-social approach to care delivery, patient centred care and the sustainability of our healthcare system.

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[3] A review of the private sector outreach services legislation, 13 NOV 2009, Department of Health, https://apo.org.au/sites/default/files/resource-files/2009-11/apo-nid19672.pdf, viewed 17 January 2021

[4] The Commonwealth's proposal for the 1998-2003 Health Care Agreements, Australian Health Review21(2) 8 – 18, Ian Bigg, Susan Amzi and Charles Maskell-Knight

[5] Health Legislation Amendment Bill (No. 3) 2000 (Cth), Bills Digest No. 194 1999-2000

[6] Determination made under Schedule 1, paragraph (bj) NATIONAL HEALTH ACT 1953 (Cth) (HIB 11/2005), Schedule 8

[7] Fees Procedures Manual For Public Health Organisations, NSW Government Ministry of Health, 2.55.2.9

[8] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.5

This is consistent with a key finding of the Private Health Ministerial Advisory Committee's Improved Models of Care Working Group "In most cases, the regulation does not appear to present a barrier for alternatives to in hospital rehabilitation."[9]

Disappointingly, the observations of the Australian Private Hospital Association (during the 2005 Senate Select Committee on Mental Health) still apply today:

"Feedback from private hospitals indicate that the following restrictions are being imposed by health funds specifically for the treatment of patients with mental illness:

- Refusal to fund Approved Outreach programs…;
- Refusal to fund half-day programs…;
- Restrictions on the number of days of mental health treatment that a patient can receive in a calendar year;
- Restrictions on the number of same day programs that a patient may attend in a given period;
- Restrictions or capping of the number of particular types of treatment that a patient may receive in a given period; and
- Redefining the length of stay for treatment of particular conditions to levels which are out-of-step with clinical practice."[10]

Australia's private health insurers have been slow and reluctant to pay benefits to private hospitals for delivering optimal clinical models of care (particularly where care involved deliver in the home and community), leaving private patients with access to lesser services than their public patient counterparts.

This reluctance is deeply disappointing given the reported clinical and financial benefits of providing a funding model which supports the implementation of optimal clinical models:

"… pilot which evaluated the cost of in-patient care to intensive home based care of a cohort of so called 'frequent flyers'. The result of treating these patents in intensive home based care reduced the cost from $80 000 the previous year as in-patients to $20 000 under the pilot scheme… the clinical outcomes, the satisfaction of carers – that is, psychiatrist and mental health nurses - and the satisfaction of families was at least comparable in the intensive home based model for the same patients as the outcomes in the previous year for hospital based care."[11]

"Based on [HCF's] internal analysis of the [Helping Hand] program and an independent external review, the Helping Hand program provided positive and encouraging results in all three areas:

[9] Ibid, p.14
[10] A national approach to mental health – from crisis to community First Report, Senate Select Committee on Mental Health, 2006, 12.86
[11] Ibid, 12.124

- Health improvement - There was a mean reduction in the K10 score from 26.8 to 21.3;
- Satisfaction – A survey showed median respondents agreed that 'HCF is concerned for my well-being and lifestyle and helps me make wise health care choices'; and
- Financially – A small reduction in the average length of stay and a shift towards same-day from overnight admissions (when compared with reference group) indicate that the intervention was financially viable."[12]

Table 1: Hospital In The Home benefits as % of total Hospital benefits[13]

Growth in hospital in the home benefits are not keeping step with overall hospital benefit outlays and does not demonstrate the anticipated higher growth rate of in-hospital hospital benefits expected (based on patient feedback and private hospital optimal clinical models).

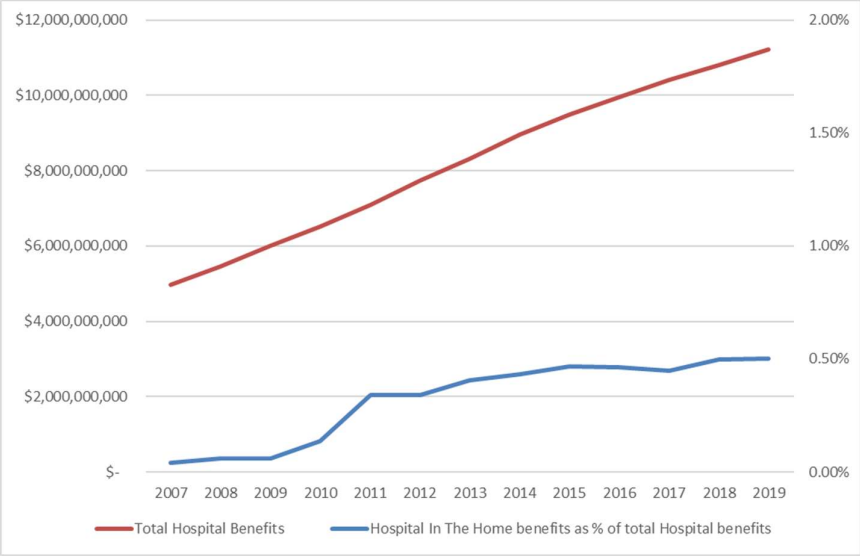
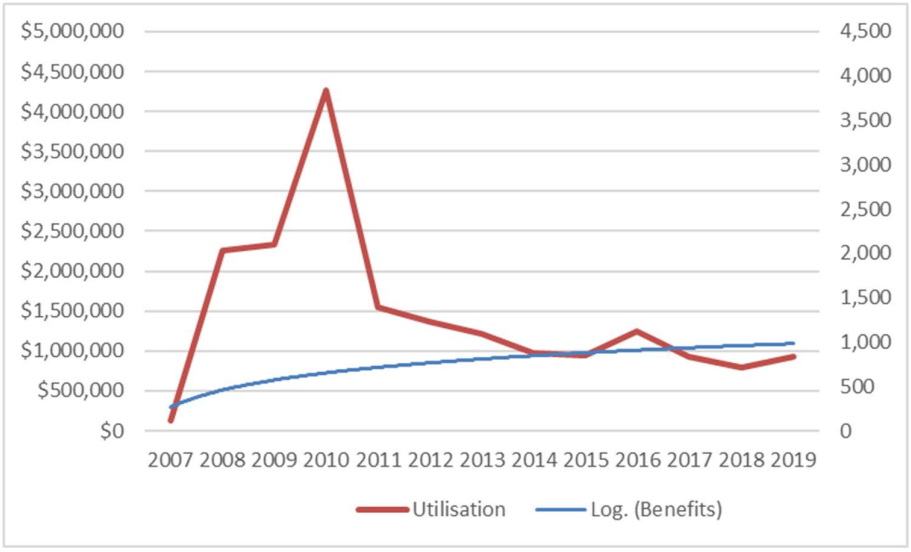


Table 2: Chronic Disease Management Program - Mental Health Utilisation [14]

Adoption of chronic disease management programs for mental health conditions has significantly reduced and the average yearly benefit outlay remains low at ≈$1m compared to nearly $25b in premiums.

[12] http://www.apha.org.au/wp-content/uploads/2009/04/final-ph-april-09.pdf, viewed 1 February 2021
[13] TotalAcuteBens - Private health insurance membership and benefits, Australian Prudential Regulation Authority
[14] BenefitsPaidForCDMPsXProgram - Private health insurance membership and benefits, Australian Prudential Regulation Authority



It is possible that private health insurers have not funded these optimal models of care offered by private hospitals, because they do not perceive a financial benefit, which would be contrary to

the Department of Health's opinion that "services provided in the home or community can be significantly more cost effective than similar services provided in a hospital".[15]

At this time, there is no definitive research to support the opinion that universal hospital treatment delivered in the home and community is unequivocally and ubiquitously more cost effective than hospital settings.[16]

It is common sense that the delivering the level of intensity and frequency of hospital treatment in settings that require the transportation of equipment and staff between different physical locations cannot be more cost effective than moving patients to a single (shared) location.

Stakeholders must be vigilant that clinical models purporting to deliver Hospital Treatment in the home and community actually deliver the requisite objectives (intensity, frequency, quality, safety and outcomes of team based care) expected of such a service. It would be ill-advised for patients to accept models which rely on a reduction in the care provided in order to be more cost-effective.

Even though private health insurers have attempted to quantify the cost effectiveness of home and community care settings,[17] commentary regarding the reliability of patient selection in these studies is a major concern[18] which raises the concern that any cost

[15] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.15
[16] Chapter 12 Alternatives to hospital care Emergency and acute medical care in over 16s: service delivery and organisation - NICE guideline 82, National Institute for Health and Care Excellence, December 2017
[17] https://www.medibank.com.au/livebetter/newsroom/post/new-study-identifies-60-000-hospital-days-can-be-saved-through-changes-to, viewed 17 January 2021
[18] Rehabilitation Pathways Following Hip and Knee Arthroplasty, Royal Australasian College of Surgeons 2018, p.3

efficiency may be the result of less care being delivered than would be provided in a hospital.

Table 3: Comparison of outcomes between Inpatient Rehabilitation and Rehabilitation In The Home

The patient selection underpinning the study of Buhagiar, et al (comparing the outcomes between care settings) [19] did not reflect the disability and function of those patients who are ordinarily clinically indicated for hospital based rehabilitation in the study of Schache, et al[20] and demonstrates the superior outcomes of hospital led rehabilitation programs.

		Buhagiar		Schache
		Inpatient	HITH	Inpatient
Admission	KOOS 4	32	31	42
	>100 degrees flexion	65%	65%	9%
	6 minute walk test	317	319	186
	Admission FIM	111.5		97.7
	Discharge FIM	116.5		115.3
	FIM Change	5		17.6
Review 6-10 wks	KOOS 4	66.9	66.7	70.5
	>100 degrees flexion	71%	70%	91%
	6 minute walk test	386	383	415
Review 6 mths	KOOS 4	75.7	73.7	83
	>100 degrees flexion	83%	78%	99%
	6 minute walk test	391	405	476

In this context of private health insurance funding of hospital treatment delivered in the home and community, it is concerning that the consultation paper includes many opinions that are unsubstantiated and not consistent with accepted clinical practice:

- "The appropriate medical practitioner, whether it be the orthopaedic surgeon, rehabilitation physician or GP, would be responsible for developing a rehabilitation plan"[21] –
    - "Decisions about the type and model of rehabilitation should rest with the rehabilitation physician and team, obviously taking into account patient preferences (rather than the other way round which is inferred in the paper). I don't think the surgeon/referring doctor is the best person to determine the specific rehab program either";[22] and
    - "Any approach to novel models of rehabilitation (both in and outpatient) should ensure there is great flexibility (at both clinician and financial level) in my opinion, to allow for unexpected complications, delays, and the need to adjust given the individual patient's needs/ wants led in no small part by the

[19] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2731681, viewed 17 January 2021
[20] https://www.sciencedirect.com/science/article/pii/S1836955319300554?via%3Dihub#ec1, viewed 17 January 2021
[21] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.15
[22] Email from Dr Simon Chan (Staff Specialist in the Division of Rehabilitation and Aged Care, Hornsby Ku-ring-gai Hospital; Fellow of the Faculty of Rehabilitation Medicine; Visiting Medical Officer Sydney Adventist Hospital, Mt Wilga Private Hospital, Lady Davidson Private Hospital, and Macquarie University Hospital), 12 January 2021

input of the multidisciplinary team and co-ordinated by the rehabilitation physician"[23];

- "Care outside hospital is often preferred by patients, can deliver improved outcomes and can be more cost effective"[24] –
    - "Home and community based rehab models of care should be encouraged and supported, BUT the decision as to which model is most appropriate (Inpatient vs Community)should be decided by a Rehab Specialist (often in consultation with the patient as well as a surgeon or GP, or other Medical Practitioner). Also whilst it is agreed that the community based services CAN be more cost effective, it CANNOT be assumed (or implied!) that community based services will ALWAYS be more cost effective";[25] and
- "…private patients in private hospitals receive significantly more rehabilitation in hospital than public patients in public hospitals"[26] –
    - speaking to colleagues in the public sector about differences in referral rates into hospital treatment delivered in the hospital (compared to the private sector), there is concern the lower rates in the public sector do not represent need, rather the lack of availability of public beds.[27]

Future consultation regarding any reforms is vital, with any publications and recommendations made with open and transparent citation of the relevant research, articles, reports, stakeholder consultations and opinions being relied upon.

[23] Email from Dr Andrew Wesseldine (Western Australia State Stroke Director; Director of Clinical Innovation and Reform and Deputy Director Medical Services Joondalup Health Campus), 6 January 2021
[24] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.14 and p.20
[25] Email from Associate Professor Michael Pollack (Pain Specialist Physician and Senior Staff Specialist at Hunter New England Local Health District, Conjoint Associate Professor at University of Newcastle, District Director of Rehabilitation Medicine at Hunter New England Health, Director of Hunter Stroke Service), 6 January 2021
[26] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.14
[27] Interview with Jenny Haig, National Rehabilitation Program Director – Ramsay Health Care Australia, 28 January 2021

Protecting the Best Interests of the Patient

With the growing threat of US-style managed care entering Australia,[28] through payors acquiring providers, financial incentives to healthcare providers for changing referral pathways and payors refusing payment based on differing clinical decisions, the Government must prioritise reforms which uphold clinical independence, care in the best interests of the patient and compliance with laws.

Clinical independence

With an increase in the number of private health insurers employing health practitioners and directly incentivising changes in their clinical practice,[29] it is vitally important that private patients receive transparent, simple and proactive disclosure of likely and possible conflicts of interests and financial inducements.

All health practitioners and private health insurers need to be held to the same level of disclosure and practice standards when providing care, advice and information to private patients – using the Medical board of Australia's 'Good medical practice a code of conduct for doctors in Australia' as a minimum requirement.[30]

Private health insurers and health practitioners should:

- act in a patients' best interests when making referrals (or not making referrals) and when providing or arranging treatment or care, or giving advice;[31]
- inform patients when the person giving advice has an interest that could affect, or could be perceived to affect, their advice, decision making or the patient care;[32]
- not offer, ask for, or accept any, inducement, gift or hospitality of more than trivial value, from any person, or provide services to a person that may affect, or be seen to affect, the way you prescribe for, treat, advise or refer patients;[33]
- not offer inducements or enter into arrangements that could be perceived to provide inducements;[34]

[28] https://www.abc.net.au/news/2019-05-24/doctors-warn-private-health-sector-heading-towards-us-system/11147120, viewed 20 December 2020
[29] https://www.afr.com/companies/healthcare-and-fitness/medibank-poised-to-snap-up-myhealth-from-crescent-capital-20210119-p56v59, viewed 20 January 2021; https://www.nib.com.au/media/2019/10/nib-partners-with-surgeons-to-guarantee-no-out-of-pockets-for-members, viewed 17 January 2021; https://healthdispatch.com.au/news/medibank-acquires-share-of-sydney-short-stay-hospital, viewed 11 August 2020; https://www.amansw.com.au/no-gap-pregnancy-programs/, viewed 17 January 2021; https://www.nexushospitals.com.au/no-gap-surgery-for-patients-requiring-joint-replacement/, viewed 17 January 2021;
[30] Good medical practice: a code of conduct for doctors in Australia - October 2020, Medical Board of Australia
[31] Ibid, 10.12.2
[32] Ibid, 10.12.3
[33] Ibid, 10.12.6
[34] Ibid, 10.12.8

- not allow any financial or commercial interest in a hospital, other healthcare organisation, or company providing or manufacturing healthcare (or healthcare related) services or products to adversely affect the way you treat / advise patients.[35]

Best interests of the patient

Given the information asymmetry between patients and the healthcare system, it is important that any reform establish key principles that payors and healthcare practitioners prioritise:

- the promotion of health literacy;
- explaining the realistic and achievable outcomes between different care options; [36]
- using appropriate and sensitive language and practice; [37]
- explaining cost and out-of-pocket differences between care options; [38]
- prescribing and delivering care according to the bio-psycho-social model; [39]
- collaborate with the patient's family and carers;[40] and
- respect the primacy of the existing relationships between patients and clinicians,

to deliver individualised healthcare planning and delivery.

Any reforms must strengthen the decision making between patients and their treating doctors, recognising patients are active participants in choosing their optimal care pathways, by safeguarding agreed care prescriptions from interference from payors.

Compliance with laws

Any reforms must not increase the administrative and compliance burdens nor the uncertainty of funding for private patients and private hospitals. This means the Department of Health must have appropriate authority, controls, expertise and resources to ensure compliance with both the spirit and the intent of the laws.

With the first wave of private health insurance reforms focused on improving the transparency, comparability and value of private healthcare, it is disappointing when a private health insurer takes an interpretation which would go against these principles, such as:

[35] Ibid, 10.12.9
[36] Referring to other medical specialists: A guide for ensuring good referral outcomes for your patients, The Royal Australian College of General Practitioners 2019
[37] The Royal Australian College of General Practitioners. Standards for general practices. 5th edn. East Melbourne, Vic: RACGP, 2020, Criterion GP2.3 – Engaging with other services
[38] Ibid, Criterion C1.5 – Costs associated with care initiated by the practice
[39] Ibid, Criterion C5.2 – Clinical autonomy for practitioners
[40] Ibid, Criterion C2.1 – Respectful and culturally appropriate care

- preventing private patients from receiving benefits for rehabilitation treatment, unless the rehabilitation treatment relates to recovery from an Acute Catastrophic Illness or Injury (which is not a requirement under the Act);[41] and

- improving education for consumers about 'Gold' policies that cost less than 'Silver' policies offered by the same insurer, even though the services covered are higher under 'Gold' policies.[42]

Informed Consumers

The success of Minister Hunt's first wave reforms of private health insurance, delivering "the most significant reforms to private health insurance in over a decade, which is making private health insurance simpler to understand and more affordable for Australians"[43] must not be diluted by subsequent waves of reforms.

It is concerning that the reforms contemplate the expansion of excluded services, particularly as they relate to excluding individual aspects of care within a standardised clinical category / care plan (such as: reforms which strengthen private health insurers ability to: create their own definitions of conditions / illnesses; and limit access to services through restrictive provider networks and provider contracting). [44]

The issue of information asymmetry and complexity impeding the consumer's ability to make informed decisions about their private health insurance is not new, but the key principles of concern (that must be considered in these second wave reforms) are worth repeating:

- "…there are market failures due to asymmetric and imperfect information. This leads to complexity in private health insurance policies, which reduce consumers' ability to compare policies and make informed choices";[45]

- "…increasing policy limitations and exclusions leading to higher numbers of consumers having policies with less cover than they expected. This leads to an increased risk of consumers facing unexpected out-of-pocket expenses and general dissatisfaction with the system";[46]

- "[Both consumer and industry bodies submitted] the range of potential policy benefits and exclusions, preferred provider arrangements, policy variations and differing terminology between funds which makes comparison difficult";[47]

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[41] Australian Health Management Group Fund Rules – December 2019, E2.4(3)(b); Frank Health Insurance Fund Rules – 1 October 2019, E2.6(c)(ii); nib health funds Fund Rules [viewed June 2020], E2.9(b); Defence Health Fund Fund Rules – 1 July 2020, E2.7

[42] https://www.choice.com.au/money/insurance/health/articles/rip-off-silver-plus-health-insurance, viewed 17 January 2021

[43] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/the-lowest-private-health-insurance-premium-change-in-19-years, viewed 17 January 2021

[44] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health

[45] Information and informed decision-making: A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance, Australian Competition & Consumer Commission, 2015, p.39

[46] Ibid, p.39

[47] Ibid, p.1

- "[The Ombudsman advised]: In general, in designing their policies the funds do not distinguish between what particular psychiatric services there are. However, sometimes in a contracting arrangement a hospital may propose that the fund pay for certain programs that may include both in-hospital and an out-hospital element. In some cases, funds will agree to do this. Some funds will not";[48] and

- "[Allied to the issue of the cumulative out-of-pocket costs for mental health patients] is the inconsistency that privately insured patients with mental illness face when they use their insurance in a private hospital. For example, there are inconsistencies between health insurers in their funding of in-patient programs, differing limitations on the funding of day treatments, blanket bans on funding half-day programs and inconsistencies in funding approved outreach for hospital in-the-home services.[49]

[48] Mr John Powlay, Private Health Insurance Ombudsman, The Senate Select Committee on Mental Health, Hansard 28 October 2005, p. 21

[49] Ms Christine Gee, Vice-President Australian Private Hospital Association, The Senate Select Committee on Mental Health, Hansard 4 July 2005, p. 51

Hospital Treatment in the Home / Community – Rehabilitation

What is Rehabilitation?

Rehabilitation involves the prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments, the management of disability in physical, psychosocial and vocational dimensions, and improvement of function.[50]

Rehabilitation services are units of patient care providing comprehensive rehabilitation services for inpatients and noninpatients as well as in the community, with each patient's clinical management being under the supervision of a physician specialist trained in rehabilitation.[51]

A rehabilitation service aims to assist people with loss of function or ability due to injury, surgery or disease to attain the highest possible level of independence (physically, psychologically, socially and economically) following that incident, surgery or illness. This is achieved through a combined and coordinated use of medical, nursing and allied health professional skills. The process involves individual assessment, treatment, regular review, discharge planning, community integration and follow-up of people referred to that service.[52]

Medical recovery, recuperation, convalescence and other care, before a patient has attained an adequate and appropriate level of medical stability and performance, is not rehabilitation.[53]

Clinical services where patients are under the care of a medical practitioner who is not a rehabilitation medicine physician (or other specialist medical practitioner with equivalent, relative and appropriate scope of practice), that does not require a multidisciplinary service, or that do not meet criteria 1.3 to 1.8 [of the Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals February 2019] are not considered specialist rehabilitation medicine services.[54]

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[50] Standards for the provision of rehabilitation medicine services in the ambulatory setting 2014, Australasian Faculty of Rehabilitation Medicine, clause 1.2; Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals February 2019, Australasian Faculty of Rehabilitation Medicine, clause 1.1; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016, Criterion 1

[51] Standards for the provision of rehabilitation medicine services in the ambulatory setting 2014, Australasian Faculty of Rehabilitation Medicine, clause 1.5; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016, Appendix 1

[52] Standards for the provision of rehabilitation medicine services in the ambulatory setting 2014, Australasian Faculty of Rehabilitation Medicine, clause 1.6; Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals February 2019, Australasian Faculty of Rehabilitation Medicine, clause 1.1; Rehabilitation medicine physicians delivering integrated care in the community Early Supported Discharge programs in stroke rehabilitation: an example of integrated care March 2018, Australasian Faculty of Rehabilitation Medicine, page 8; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016, Criterion 5

[53] Standards for the provision of rehabilitation medicine services in the ambulatory setting 2014, Australasian Faculty of Rehabilitation Medicine, clause 1.4

[54] Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals February 2019, Australasian Faculty of Rehabilitation Medicine, clause 1.8; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016

What Rehabilitation in the Home and Community should be payable as Hospital Treatment?

The intent of hospital treatment delivered in the home and community is to prevent the need for inpatient care (acute or subacute) or reduce the duration of this care. It can constitute a continuation of an inpatient episode of rehabilitation, be a new episode of rehabilitation commencing after hospitalisation or support timely discharge from the hospitals (both from acute care and rehabilitation facilities).[55]

For hospital benefits to be paid for hospital treatment delivered in the home and community, those services must be explicitly documented in the written rehabilitation plan, and that plan is:

- prescribed by the Rehabilitation Physician (or other specialist medical practitioner with equivalent, relative and appropriate scope of practice);
- patient-centred;
- state the patient's needs and limitations;
- states the patient's goals of the plan;
- is prepared by a multidisciplinary team;
- requires the provision of multidisciplinary therapy;
- involves participation of the patient, their family and carers;
- includes provision for continuing care, review and discharge. [56]

The services are delivered by, or under the direction and control of, a rehabilitation service that has the requisite equipment, experience, staffing, clinical governance and accreditation to provide an organised system of care in a hospital setting, an ambulatory setting (including outpatient clinics, day hospitals or community centres) and in a residential setting (including residential care facilities, or domestic or community settings).[57]

What are the requirements to be an accredited Home and Community Rehabilitation Provider?

Based on the needs of the patient, a rehabilitation service must have the infrastructure to provide:

- physical therapy equipment

[55] Standards for the provision of rehabilitation medicine services in the ambulatory setting 2014, Australasian Faculty of Rehabilitation Medicine, clause 1.12
[56] Ibid, clauses 4.3 and 4.4; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016
[57] Ibid, clause 1.5; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016, Criterion 1

- gait training facilities
- functional electrical stimulation equipment for patients with neurological impairment
- ultrasound bladder scanner
- equipment for aerobic fitness training
- equipment for training activities of daily living
- equipment for recreation, including toys and games when children and young people are treated
- equipment to provide vocational retraining
- Equipment to support complex communication needs (e.g. augmentative and alternative communication systems)
- Videoconferencing equipment for telehealth consultations
- Equipment for fabrication of upper limb splints, orthoses and prostheses. Where the service does not have all the equipment available on site, there are documented arrangements for referral to facilities able to provide them.[58]

The rehabilitation service must have sufficient staffing in accordance with the key disciplines that should be involved in treating different types of impairment (according to patient mix) and the indicative relative time associated with each discipline:[59]

	Rehabilitation physician	Nurse	Physiotherapist	Occupational therapist	Speech language therapist	Social worker[11]	Clinical psychologist / Neuropsychologist	Dietician	Prosthetist / Orthotist	Exercise physiologist	Recreational / Diversional therapist	Allied health assistant
Neurological (includes stroke, acquired brain injury)	++	+	+++	+++	+++	+++	+++	+	+	+	++	++
Spinal (includes spinal cord injury and diseases)	++	++	+++	+++	+	++	+	+	++	+	++	++
Amputee (includes congenital limb deficiency)	+	++	+++	+++		++	+	+	+++	+		++
Orthopaedic (following orthopaedic injury or elective surgery)	+	+	+++	+++		+		+	+	++		++
Reconditioning (generally older people with reduced functioning following a variety of health conditions)	+	++	+++	+++		++	+	+		++	+	++

\+ = Low relative time associated to the discipline
++ = Medium relative time associated to the discipline
+++ = High relative time associated to the discipline
No + = No relative time associated to the discipline

[58] Ibid, clause 3.16; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016, Criterion 1
[59] Ibid, clause 2.15; Guidelines for Recognition of Private Hospital based Rehabilitation Services August 2016, Criteria 1 and 2

A rehabilitation service: is accredited with the national safety and quality accreditation scheme of the National Safety and Quality Health Service Standards of the Australian Commission on Safety and Quality in Health Care;[60] has a quality improvement and risk management framework with appropriate activities and projects addressing consumer involvement, access, appropriateness, effectiveness, safety and efficiency; has a quality improvement and risk management framework with appropriate activities and projects addressing staff risks and work health and safety issues;[61] and externally benchmarks its outcomes and performance.

[60] Ibid, clauses 1.20, 1.21 and 5.2
[61] Ibid, clause 5.1

Hospital Treatment in the Home / Community – Mental Health

The Mental Health model in private health insurance

Even though hospital based mental health care is proven to assist the recovery process (by helping patients to recognise their own condition as a genuine sickness)[62] and significantly improve an admitted person's mental health,[63] health professionals agree the time is now for reform to ensure the optimal provision of mental health care.[64]

For too long the private health insurance benefit structures for mental health have reinforced a siloed health system (pitting primary, secondary and tertiary healthcare against one and other), rather than supporting team-based healthcare across the entire community, focusing on patient-centred and recovery oriented care.[65]

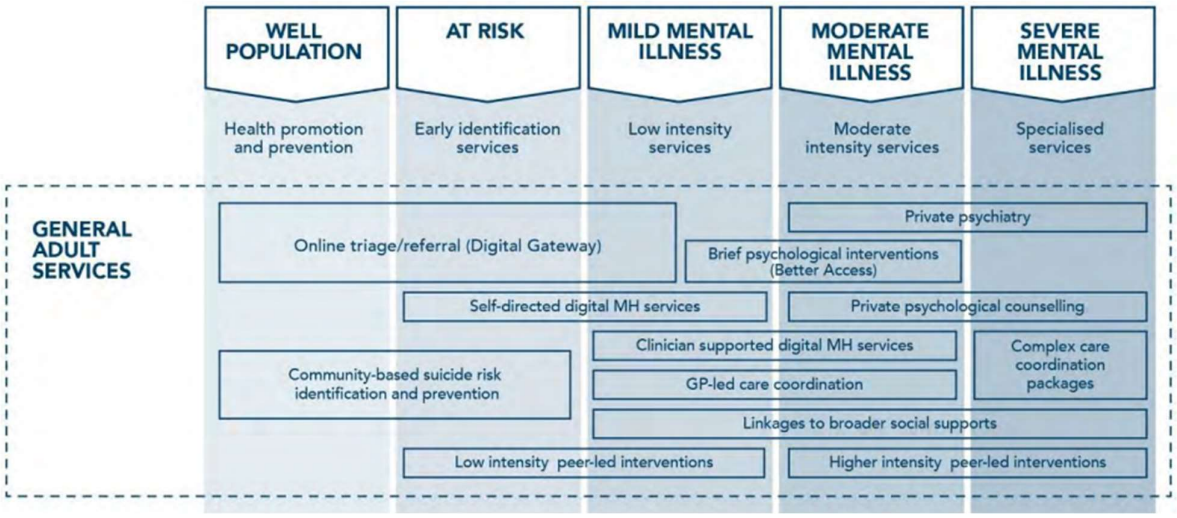
Additionally, private health insurance funding models have their origins in the medical model of clinical care, which predominantly focus on short-term funding for acute mental health events (demonstrated by the low psychology limits on general treatment policies, minimal funding of chronic disease management programs for mental health and only funding Ramsay Health Care in South Australia to deliver mental health care across the entire community).[66]

There is general consensus that, as a chronic health condition with a predominance for comorbidities,[67] mental health services require a higher level of integration amongst patients, carers and clinical teams – focusing on team-based and recovery oriented care, delivered across the whole community, that address the bio-psycho-social determinants and needs of patients: [68]

[62] Private Healthcare Australia, Submission to the Productivity Commission Inquiry into Mental Health, 5 April 2019, p.17
[63] Australian Institute of Health and Welfare, Mental Health Services – in Brief 2018, 11 October 2018, p.32
[64] https://www.ranzcp.org/news-policy/news/%E2%80%9Cthe-time-is-now%E2%80%9D-psychiatrists-call-for-mental-he, viewed 17 January 2021
[65] Response to the Productivity Commission Mental Health Draft Report, January 2020, Consumers Health Forum of Australia, p.27
[66] Submission to the Productivity Commission Inquiry into Mental Health, June 2019, Ramsay Health Care Australia
[67] https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/private-health-insurance-policies-for-psychiatry, viewed 17 January 2021
[68] Fifth National Mental Health and Suicide Prevention Plan August 2017, National Mental Health Commission

A crucial component of transitioning to the private health insurance funding to the stepped care model is the importance of ambulatory care (treatment provided to a patient who is not an overnight inpatient), which consists of a wide variety of specialist treatment therapies and programs delivered by multidisciplinary teams.[69]

Given the broad range of services that public health systems provide to patients, based on the patient's acuity and needs, [70] it is unlikely that incremental reforms will have a substantial impact on transitioning private health insurance to the stepped care model:



Priority must be given to the most appropriate evidence based, recovery oriented, and cost–effective treatment options for each individual patient.[71]

The following factors need to be considered when selecting the most appropriate setting for care delivery.

- Patient acuity, level of distress and disability.
- Level of social support in the home.
- Geographical considerations.[72]

The three crucial reform priorities to transition private health insurance to the stepped care clinical model are:

- funding certainty for hospital treatment delivered in the home and community;
- funding for early intervention and self-care; and
- funding for relapse prevention,[73]

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[69] Australian Private Hospitals Association, Improved Models of Care – Mental Health, 25 September 2018, p. 10
[70] Mental Health Stepped Care Model, South Eastern Melbourne Primary Health Network, p.17
[71] Guidelines For Determining Benefits For Private Health Insurance Purposes For Private Mental Health Care 2015 Edition, p.7
[72] Ibid, p.7
[73] Ibid, p.8

under the direction and prescribed therapy plan of a Consultant Psychiatrist and an accredited mental health service.

Ramsay Health Care Australia is uniquely placed as Australia's only fully funded and integrated private mental health stepped care model, through its dedicated mental health service in South Australia (refer to **Appendix 1**).

This innovative model, originally offered through a partnership with the commonwealth in 1998 and subsequently adopted by BUPA in 2000, is essentially based on a prospective bundled payment as opposed to episodic funding meaning the hospital can design and implement the most appropriate program to treat the patient, including the provision of in-patient care, out-patient care, community or even home-based care.[74]

Dr Michael Armitage, then CEO of Australian Health Insurance Association (the predecessor to Private healthcare Australia), commented on this innovative model being the "first time, hospitals are assured of a known and regular income and able to plan for financial investment in alternative services".[75]

This comment further reinforces the importance of funding to preceding the delivery optimal care models,[76] with Dr Armitage commenting further that the model "overcomes some of the financial disincentives for development of private out-of-hospital services, such as establishment costs and loss of revenue from in-patient benefits" through:

- a reduction in bed occupancy;
- expansion of day programs;
- significant increases in psychiatric home visits;
- use of out-patient assessments and pre-admission assessments;
- introduction of family counselling and telephone counselling services; and
- a reduction in hospital administration time.[77]

Mental Health Prevention / Chronic Disease Management Programs

To "prevent" literally means "to keep something from happening", however this does not directly translate to mental health where the focus is often on: the incidence of a condition; relapses; the associated disability; and the consequential risks of the condition, leading to confusion regarding the term prevention as it relates to mental health.[78]

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[74] Mr John Powlay, Private Health Insurance Ombudsman, The Senate Select Committee on Mental Health, Hansard 28 October 2005, p.21
[75] A national approach to mental health – from crisis to community First Report, Senate Select Committee on Mental Health, 2006, 12.136
[76] Ibid, 12.136
[77] Ibid, 12.136
[78] Mrazek PJ, Haggerty RJ. New directions in definitions. In: Mrazek PJ, Haggerty RJ, eds. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington DC, Institute of Medicine, National Academy Press, 1994: 19-29

Unlike public health systems that, via primary health care and other social services, have the scope to fund universal primary prevention (targeting the general public or a whole population group), private health insurers have the scope to fund care that is targeted to individuals or subgroups of the population whose risk of developing a mental health condition is significantly higher than that of the rest of the population (selective / indicated primary prevention) and relapse prevention and disability reduction (secondary prevention).[79]

In this context, Hospital Treatment should be extended to include those relapse prevention (including care transition) services which a consultant psychiatrist prescribed to a patient, diagnosed with a mental health condition, and delivered by an accredited mental health service.

General Treatment should be extended to include primary prevention services which have been prescribed by a consultant psychiatrist (or General Practitioner) and other low-intensity / low-cost self-referred services (to address delays in accessing services as a result of the stigma associated with mental health care) – in both instances, delivered by a regulated mental health service.[80]

Mental Health Hospital Treatment

For patients who:

- have a diagnosed psychiatric illness classified by either ICD–10–AM or DSM–5; and
- require specialised intervention, treatment or support in an appropriate care setting or range of settings, with an expected measurable outcome; and
- have a level of distress and/or disability that demonstrably impacts on their ability to function in day–to–day living and their relationships with others; or
- have a mental health plan, prescribing a range of care options by a consultant psychiatrist, for the provision of acute management, relapse prevention, independent living and symptom management under the direction and control of an accredited mental health service,

benefits for mental health services should be payable as Hospital Treatment.[81]

It is acknowledged that early intervention for people with a mental health condition is particularly important in minimising the impact of first episodes, the incidence of relapse, maximising recovery and reducing the length of hospital stay.[82]

Genuine alternatives to overnight patient services should be reflected in a patient's mental health plan and reflect the importance of direct admission to an appropriate same–day

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[79] https://www.who.int/mental_health/media/en/545.pdf, viewed 17 January 2021
[80] https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/benefits-e-mental-health-treatments-interventions, viewed 17 January 2021; https://www.safetyandquality.gov.au/sites/default/files/migrated/Discussion-Paper-Certifying-digital-mental-health-services-March-2019.pdf; Therapeutic Goods (Excluded Goods) Amendment (Software-based Products) Determination 2021 (Cth)
[81] Guidelines For Determining Benefits For Private Health Insurance Purposes For Private Mental Health Care 2015 Edition, p.8
[82] Ibid, p.8

program (half or full–day), attendance at outpatient services[83] and digital / electronic services, where available and clinically appropriate, in the stepped care clinical model.

In formulating and delivering the mental health plan, it is crucial there is a consideration of the:

- patient's level of acuity, distress, or disability;
- patient's level of risk or harm to self and others;
- patient's capacity to self-manage and comply with treatment, self-care and household roles;
- need, expectations and capacities of the patient's family and carers;
- appropriateness of the environment on the patient's recovery;
- out-of-pocket costs to the patient when accessing services; and
- measurable goals, outcomes, experiences and efficacy of mental health services,[84]

and it should include:

- documented treatment and care options;
- discharge planning and considerations of transitions in levels of care;
- be developed collaboratively and regularly reviewed with the patient, and with the patient's informed consent, their carers, and be available to them;[85]
- a brief integrated psychiatric formulation focussing on the biological, psychological and physical factors;
- education, including a list of any handout material available to help people understand the nature of the condition;
- medication recommendations;
- the most appropriate mode of psychotherapy required, such as supportive psychotherapy, cognitive and behavioural psychotherapy, family or relationship therapy or intensive explorative psychotherapy;
- non-medication recommendations, such as lifestyle changes including exercise and diet, any rehabilitation recommendations and ECT / rTMS; and
- social measures, including issues which may have triggered or are contributing to the maintenance of the problem in the family, workplace or other social environment.[86]

[83] Ibid, p.8
[84] Ibid, p.9
[85] Ibid, p.10 and P.21
[86] https://www.ranzcp.org/files/resources/college_statements/practice_guidelines/referred_patient_assessment_and_management_guideli.aspx, viewed 17 January 2021

Treatment must be under the supervision of the treating consultant psychiatrist irrespective of care setting.[87] A patient treated under the mental health plan by an accredited mental health service, regardless of how they enter the program, are admitted patients of the hospital, and therefore remain under the jurisdiction of the hospital.[88]

With certainty of funding of a patient's mental health plan as Hospital Treatment, it is crucial that the patient, as soon as clinically safe and appropriate, be transitioned to the next level (more acute / less acute) in the continuum of care prescribed in the plan.[89]

What are the requirements to be an accredited Home and Community Mental Health Provider?

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.

In addition to any accredited mental health service being licensed to deliver mental health care in the relevant State/Territory, it should:

- comply with the National Standards for Mental Health Services and the ACSQHC National Safety and Quality Health Service Standards;[90]
- implementation of clinical practices that are based on best available evidence, supported by a cycle of ongoing review and measurement;
- include where available, the use of, and implementation of clinical pathways where supported by an evidence base;
- have in place processes and policies that are consistent with safe and quality use of medication;
- regularly evaluate, measure and survey the quality, safety and experiences of the mental health service (including the perspectives of patients, staff, carers and medical practitioners);
- document, and make available to relevant healthcare practitioners, information regarding any admission / acceptance criteria, discharge / exclusion criteria, pathway choices and education material;
- provide informed financial consent compliant with the National Safety and Quality Health Service (NSQHS) Standards;[91]

[87] Guidelines For Determining Benefits For Private Health Insurance Purposes For Private Mental Health Care 2015 Edition, p.10
[88] https://apo.org.au/sites/default/files/resource-files/2009-11/apo-nid19672.pdf
[89] Ibid, p.9
[90] Guidelines For Determining Benefits For Private Health Insurance Purposes For Private Mental Health Care 2015 Edition
[91] Summary of Guidelines for Outreach Services under the Health Legislation Amendment Act (No 1) 2001

- comply with the National Safety and Quality Health Service Standards for community mental health services;[92]
- involve the clinical oversight of a lead consultant psychiatrist, in consultation with a panel of treating consultant psychiatrists;
- incorporate the practice and experience of a range of mental health workers,[93] working as a multidisciplinary team; and
- involve engagement of consumers, family, carers and people with lived experience as partners in development and delivery of stepped care services.[94]

[92] https://www.safetyandquality.gov.au/sites/default/files/migrated/Guide-to-the-NSQHS-Standards-for-community-health-services-February-2016.pdf, p.8
[93] https://www.apra.gov.au/sites/default/files/HRF%2520601%2520Data%2520Dictionary.pdf, p.18, viewed 17 January 2021
[94] PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance – Consumer and carer engagement and participation, Australian Government Department of Health, p.18

Type B and Type C Certification

With the explicit introduction of Type B and Type C Certification into legislation in 1989[95], for the purpose of creating a new regulatory framework for determining the minimum benefits payable from private health insurers to hospitals, it is time that a comprehensive review of the intent, scope, operation and suitability of the relevant instruments.

The Department indicated in the virtual consultation with stakeholders (29 January 2022) that it was their intention that reforms extend beyond the scope of the current consultation paper, specifically:

- every medical admission requires Type C Certification [in FY18, this accounted for 1.4m admission in private hospitals];[96]
- the type and number of admissions classified as Type C Certification will increase; and
- the inappropriateness of medical practitioners duplicating a certification across multiple admissions (even where the admissions relate to the same patient).

This representation does not reflect the consensus interpretation of the legislation nor the customary application of the legislation throughout the industry.

Using the Western Australia Type C Non-Admitted Procedures List FY19[97] and the AIHW FY18 procedures and healthcare interventions dataset,[98] there were more than 1.5 million instances of an intervention (described as requiring Type C Certification but excluding the therapeutic interventions sub-chapter) across the hospital sector:

	Same Day	Overnight
Type C	1,003,774	509,048
1600-1660 Skin and Subcutaneous Tissue	120,303	92,569
0457-0461 Oral Surgery	178,856	10,600
1920-1922 Pharmacotherapy Interventions	177,951	10,737
0465-0469 Restorative Dental Services	94,729	2,347
1344-1347 Postpartum Procedures	3,323	86,604
0568-0572 Other and Multiple Sites of Respiratory System	4,275	67,799
1550-1580 Musculoskeletal - Other Sites	44,275	26,947
0928-0942 Rectum, Anus	54,757	7,754
0453-0455 Preventative Dental Services	61,138	1,126
1259-1273 Uterus	48,675	6,885
0957-0973 Gall Bladder and Biliary Tract	1,747	44,148
1820-1866 Diagnostic Interventions	26,662	16,341

[95] Community Services and Health Legislation Amendment Act 1989 (Cth), ss. 20,21,22 and 23

[96] https://www.aihw.gov.au/reports/hospitals/hospitals-at-a-glance-2017-18/contents/admitted-patient-care/what-services-were-provided, viewed 1 February 2021

[97] https://www.healthywa.wa.gov.au/~/media/Files/Corporate/Policy%20Frameworks/Information%20management/Policy/Admission%20Readmission%20Dischargeand%20Transfer%20Policy/Supporting/WA-health-system-type-C-non-admitted-procedure-list-2018-19.pdf, viewed 1 February 2021

[98] https://www.aihw.gov.au/getmedia/afa09e2b-9f91-421b-bcf2-dd62419fa2d7/Procedures_data_cube_2017-18.xlsx.aspx, viewed 1 February 2021

1160-1170 Prostate and Seminal Vesicle	28,413	2,434
0060-0086 Peripheral Nervous System	15,180	10,351
1909-1912 Anaesthesia and analgesia	87	25,249
1089-1111 Bladder	9,245	7,729
1786-1800 Radiation Oncology Procedures	6,332	10,248
0559-0567 Chest Wall, Mediastinum and Diaphragm	514	15,956
1421-1438 Forearm	6,275	8,929
2015 Magnetic Resonance Imaging (MRI)	9,157	5,242
0307-0316 Eardrum and Middle Ear	8,247	3,175
0209-0214 Posterior Segment - Retina, Choroid and Posterior Chamber	6,080	3,595
1279-1288 Vagina	8,674	675
0462-0464 Endodontics	9,122	211
0721-0739 Veins	3,055	5,990
0251-0256 Conjunctiva	4,726	3,083
1040-1064 Kidney	7,494	52
0740-0777 Other vascular sites	5,556	1,601
1274-1278 Cervix	6,009	1,088
0450-0452 Diagnostic Dental Services	6,718	313
0470-0477 Prosthodontics	6,319	358
0400-0408 Mouth, Palate and Uvula	4,495	1,761
0300-0306 External Ear	2,804	1,256
0241-0250 Ocular Adnexa - Lacrimal System	3,671	137
1952-1966 Computerised Tomography (CT) Scan	1,870	1,869
0390-0394 Tongue	2,063	1,363
1330-1332 Antepartum Procedures	668	2,582
0456 Periodontic Interventions	2,326	819
1439-1474 Hand, Wrist	2,010	938
1394-1406 Shoulder	1,326	1,392
0370-0381 Nose	1,335	1,372
1740-1759 Breast	636	2,050
1967-1988 Radiography	1,571	1,041
1940-1950 Ultrasound scan	1,066	746
1341-1343 Procedures Assisting Delivery	1,396	403
0160-0165 Eyeball	1,112	648
0694-0720 Arteries	89	1,532
0479-0483 Orthodontics	1,463	113
1296-1299 Other Gynaecological Procedures	1,146	399
1005-1011 Other and Multiple Sites of Digestive System	657	838

0166-0176 Anterior Segment - Cornea	954	508
0230-0240 Ocular Adnexa - Eyelid	1,007	164
1360-1371 Head	856	313
0382-0389 Nasal Sinuses	427	583
1989-1991 Angiography	512	367
1408-1419 Humerus and Elbow	327	509
1526-1548 Ankle, Foot	260	567
1112-1125 Urethra	411	356
0870-0890 Stomach	309	432
0001-0028 Skull, Meninges and Brain	5	676
2000-2014 Nuclear Medicine Imaging	435	244
1177-1189 Testis, Vas Deferens, Epididymis and Spermatic Cord	639	5
1171-1176 Scrotum and Tunica Vaginalis	273	343
0395-0399 Salivary Glands and Ducts	395	205
0647-0666 Heart - Other Sites	174	318
0029-0059 Spinal Canal and Spinal Cord Structures	3	448
1190-1202 Penis	224	138
1495-1524 Knee Joint, Leg	117	203
0416-0422 Pharynx	146	164
1661-1692 Plastic Procedures on Soft Tissue	130	175
0490 Miscellaneous Dental Services	40	172
0177-0184 Anterior Segment - Sclera	59	137
1289-1295 Vulva and Perineum	106	53
0891-0903 Small Intestine	1	153
0110-0117 Thyroid and Parathyroid Glands	21	128
0221-0229 Ocular Adnexa - Orbit	110	21
0951-0956 Liver	10	77
0850-0869 Oesophagus	64	20
1914-1915 Client Support Interventions	3	80
0215-0220 Ocular Adnexa - Extraocular Muscles	55	12
0204-0208 Aqueous, Vitreous	44	20
0983-1004 Abdomen, Peritoneum and Omentum	26	25
1476-1493 Pelvis, Hip	12	23
0185-0192 Anterior Segment - Iris, Ciliary Body and Anterior Chamber	9	6
0800-0803 Bone Marrow	6	4
1951 Tomography	6	4

Additionally, it is concerning the Department's consultation paper presents an inadequate, and in parts inaccurate exploration, of the issue, specifically:

- "The Private Health Insurance (Benefit Requirements) Rules 2011 (The Rules) set out the minimum default accommodation benefits payable by private health insurers for hospital treatment, depending on the relevant MBS item"[99] – whereas these Rules set out benefits where no MBS item applies, being same day band 1[100] and other overnight accommodation;[101]

- "The Department has been made aware of issues relating to the inappropriate certification of Type B and Type C procedures by a small number of providers"[102] – both the Australian Private Hospitals Association and Catholic Health Australia, representing about 200 hospitals, have reported concerns regarding the operation of the Type B and Type C rules;

- "The main issues raised include confusion and lack of awareness of certification requirements resulting in a lack of detail or incorrect information provided by hospitals and medical practitioners to insurers"[103] – payors have: broadened the types of admissions for which Type C Certification rules apply;[104] and questioned the clinical judgement of the medical practitioner certifying the Type C admissions;[105] and

- "Establishment of a self-regulated industry panel to manage disputes[106]… expansion of the PSR's authority and functions, particularly in relation to investigating hospitals"[107] – which is inconsistent with the operation of the Rules, which ordinarily contemplates certification by a medical practitioner[108] and requires the certification be 'it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital'.[109]

There are also a number of other issues relating to certification under the Private Health Insurance Act, specifically the:

- applicability of nursing home type patient rules (and thus the need for acute care certification) for psychiatric care, palliative care and rehabilitation care;

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[99] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.23
[100] Private Health Insurance (Benefit Requirements) Rules 2011 (Cth), Schedule 3, Clause 4(2)
[101] Private Health Insurance (Benefit Requirements) Rules 2011 (Cth), Schedule 1, Clause 9(1)
[102] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.23
[103] Ibid
[104] https://www.healthywa.wa.gov.au/~/media/Files/Corporate/Policy%20Frameworks/Information%20management/Policy/Admission%20Readmission%20Dischargeand%20Transfer%20Policy/Supporting/WA-health-system-type-C-non-admitted-procedure-list-2018-19.pdf, viewed 1 February 2021
[105] https://www.dermcoll.edu.au/wp-content/uploads/Criteria-for-Type-C-Banding-Certification-ASPS-ACD-GSA-AMA-June-2018-FINAL.pdf, viewed 1 February 2021
[106] Consultation paper: private health insurance reforms – second wave, Commonwealth Department of Health, p.24
[107] Ibid, p.25
[108] Private Health Insurance (Benefit Requirements) Rules 2011 (Cth), Schedule 1, Clause 10(2)(a) and Schedule 3, Clause 7(2) and Schedule 1, Clause 11(2)
[109] Private Health Insurance (Benefit Requirements) Rules 2011 (Cth), Schedule 1, Clause 10(2) and Schedule 3, Clause 7(2) and Schedule 1, Clause 11

- applicability of nursing home type patient rules to sub-acute admissions where the continuous period of hospitalisation is less than 35 days;
- applicability of nursing home type patient rules to individual days / sequences of days, within an admission; and
- permissibility of private health insurers to deviate from standard clinical definitions and restrict access to clinical categories, through the implementation of restrictive certification requirements.

Questions for all stakeholders

Rehabilitation Services

1. **Which procedures and/or MBS item numbers should have a rehabilitation plan?**

   Rehabilitation is multidisciplinary therapy delivered with the intent to prevent and reduce functional loss, activity limitation and participation restriction arising from impairments, the management of disability in physical, psychosocial and vocational dimensions, and improvement of function.

   A written rehabilitation plan is appropriate for all patients undertaking rehabilitation treatment in a rehabilitation service, thus it would not be appropriate to limit the payment of rehabilitation treatment on the basis of procedures or MBS items.

2. **How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?**

   A rehabilitation plan must be prescribed by a Rehabilitation Physician and include:

   - clearly stated multidisciplinary goals and outcomes of the planned rehabilitation;
   - multidisciplinary therapies;
   - recommended frequency and intensity of therapy;
   - predicted period of rehabilitation;
   - measurement of functional change;
   - planned discharge destination;
   - reflect the needs of the patient, family and carers as well as all members of the multidisciplinary team;
   - meet industry-accepted reporting requirements.

3. **What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?**

   Establish an attendance MBS item for rehabilitation physicians to claim when coordinating with the multidisciplinary care team, patient and carer network to prescribe the rehabilitation plan.

   The review of a rehabilitation plan is a clinical function and is not the purview of payors.

4. **It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?**

   The rehabilitation plan is a clinical document and should only be disclosed to those persons who are reasonably required to access the information to deliver care under the rehabilitation plan.

   Payors and non-clinicians should be explicitly precluded from accessing, storing, collecting or using the rehabilitation plan in its entirety or individual parts.

   Payors already access the information necessary for the calculation of benefits, via the Rehabilitation Certificate and, where the Privacy Act permits, the AN-SNAP data.

5. **What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community based rehabilitation services and oblige insurers to fund these services?**

   The Minister for Health should publish a list of approved healthcare providers who are eligible for hospital table benefits, where hospital treatment is delivered in the home / community, based on the providers ability to comply with safety, quality, clinical governance, reporting, staffing, equipment and accreditation requirements.

6. **What transition arrangements and timeframe would be appropriate to implement this reform?**

   All healthcare providers who have delivered hospital treatment in the home / community, in the last three months, should be grandfathered for three months as 'approved'.

7. **What are appropriate metrics for measuring the impact of this proposal?**

   The safety, quality, clinical and experiential outcomes and the utilisation of episodes, days and individual therapy sessions, for hospital treatment delivered in the home / community.

   Equivalent and comparable metrics for hospital treatment delivered in the hospital should be used, to compare and contrast the value of each clinical model.

8. **What is the regulatory burden associated with this proposal?**

   No comments at this time.

9. **Service providers: what services would you deliver under this proposal?**

   Given the Department of Health proposed reform options will not change the status quo of services eligible for hospital benefits, there is no foreseeable change in the type of services provided.

   With the introduction of default benefits, it is expected there will be a significant improvement in the accessibility to (and availability of) services, particularly for those in regional and rural Australia.

Mental Health Services

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

   Consistent and reliable funding of care which forms part of a patient's mental health plan, prescribed and delivered by clinicians with a pre-existing therapeutic relationship, will be crucial to the efficacy and quality of patient care, compliance with the care plan and the safe transition to home/community.

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?**

   Only those disciplines which have robust and nationally acceptable accreditation and quality standards, endorsed by the Royal Australian and New Zealand College of Psychiatrists, should be permitted to deliver mental health care which is funded by private health insurance.

   The expansion of disciplines for other conditions should be subject to endorsement of the accreditation and quality standards by the most relevant and specialised medical college / association.

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?**

   In addition to compliance with the Guidelines for Determining Benefits For Private Health Insurance Purposes For Private Mental Health Care and other regulatory instruments (such as those government the regulation of software based mental health services) nationally acceptable accreditation and quality standards must be endorsed by the Royal Australian and New Zealand College of Psychiatrists.

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?**

   No changes are required, beyond requiring anyone providing coordination and planning services have the requisite level of training, expertise, accreditation, skills and safety and quality management frameworks to safely and effectively deliver the necessary services – as endorsed by the most relevant and specialised medical college / association.

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

   In expanding the mental health care for which private health insurance is payable, it is crucial this is limited to only those services for which there are appropriate and relevant standards of safety, quality and operations that are nationally recognised and endorsed by the most relevant and specialised medical college / association.

   It is crucial that the affordability of hospital treatment policies are not negatively impacted by shifting the cost of general treatment mental health care from general treatment policies to hospital treatment policies.

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

   Access to mental health care must not be restricted and defined by private health insurers (whether by diagnosis, frequency of use or other characteristics).

   All patients with a mental health diagnosis, for whom a consultant psychiatrist has provided a written care plan, should have equal access to private health insurance funded hospital treatment.

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

   Access to mental health care must not be restricted and defined by private health insurers (whether by diagnosis, frequency of use or other characteristics).

   All patients with a mental health diagnosis, for whom a consultant psychiatrist has provided a written care plan, should have equal access to private health insurance funded hospital treatment.

8. **What are appropriate metrics for measuring the impact of this proposal?**

   The Royal Australian and New Zealand College of Psychiatrists, Australian Private Hospitals Association, Catholic Health Australia, Australian Commission On Safety And Quality In Health Care and patient / carer networks should agree appropriate and relevant measures of the clinical and experiential outcomes from these reforms.

9. **What is the regulatory burden associated with this proposal?**

   No comment at this time.

10. **Service providers: what services would you deliver under this proposal?**

    Given the Department of Health proposed reform options will not change the status quo of services eligible for hospital benefits, there is no foreseeable change in the type of services provided.

    With the introduction of default benefits, it is expected there will be a significant improvement in the accessibility to (and availability of) services, particularly for those in regional and rural Australia.

Type B and Type C Certification

1. **Should an industry mediation panel be established to resolve hospital certification disputes?**

   Given certification under the rules requires the determination of, and evaluation against, accepted medical practice, it would be wholly inappropriate for an administrative body to resolve disagreements under the rules and define accepted medical practice.

2. **If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?**

   No further comments.

3. **What parties should be involved in the development of advice on the appropriate criteria for certification?**

   The rules require certification that "because of the medical condition of the patient specified in the certificate; or because of the special circumstances specified in the certificate, it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital".

   Given this is a clinical matter, those clinical parties involved in the clinical delivery of Hospital Treatment should be the only stakeholders responsible for advising on the appropriate criteria for certification.

4. **Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?**

   PSR has an existing right to investigate, make recommendations and take action where inappropriate billing practices have occurred under the Medicare Benefits Schedule.

   If a medical practitioner has claimed inpatient benefits for an service which is not part of Hospital Treatment (ie there is no appropriate Type C or Type B Certification under the rules), that medical practitioner would have made an incorrect claim and it would be permissible for PSR to initiative its ordinary proceedings.

5. **Should there be a specified list of 'special circumstances' allowable for Type C certificates?**

   Type C and Type B Certification reasons are intended to reflect accepted medical practice, therefore any 'list' must have sufficient mechanism to remain contemporary and accommodate novel and unique circumstances.

6. **Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?**

Hospitals already face funding uncertainty, forcing patients to pay for unexpected out-of-pocket costs or hospitals to deliver the service free-of-charge.

Already there is a disproportionate risk for hospitals to deliver treatment, under the advice and certification of a medical practitioner, that may not be funded by the arbitrary administrative decision of a private health insurer overriding the clinical judgement of the treating medical practitioner.

Legislative reform should deliver funding certainty for private hospitals, as experienced by public hospitals treating public patients.

7. **What is the likely impact upon premiums of this proposal?**

   No comments at this stage.

8. **What is the likely impact on the number of people and/or policies covered of this proposal?**

   Based on the recent opinions expressed by the Department, every policy will be negatively impacted through the withdrawal of funding certainty, increased out-of-pockets and service access inequality compared to public patients, for upwards of one million admissions per year.

9. **What are appropriate metrics for measuring the impact of this proposal?**

   The objectives of the reforms are imprecise and inaccurate, therefore metrics cannot be discussed.

10. **What is the regulatory burden associated with this proposal?**

    No further comments at this stage.

11. **Are there any other reform options that should be considered?**

    The Department must immediately convene a working group of hospital operators and medical practitioners, to identify the issues, define the objectives and recommend a workable and reasonable reform option.

Appendix 1 – Summary: Ramsay Health Care Australia South Australian Mental Health Model

As the only provider of private inpatient mental health services in South Australia, Ramsay recognised the opportunity to provide a suite of services that concentrated on supporting patients with mental health disorders throughout their continuum of care, not only in an inpatient setting but also within the community.

23 years ago, we were in a similar situation as is evident in the health industry today, with Health Funds reluctant to fund service providers for inpatient care, especially in the Rehabilitation and Psychiatric areas. This is not new, and I refer to a quote from 1994:

> *"…whilst health funds have concerns about the high level of payments for psychiatric hospital care, the type of benefits they offer have historically encouraged inpatient care and provided little incentive for other forms of care such as same day care, crisis intervention and home care" - National Mental Health Report 1994*

In 1998, Ramsay Health Care SA trialled a Community service for Psychiatric patients in Adelaide in conjunction with the Commonwealth Government.

In 2000, Ramsay Health Care SA entered into an agreement of shared risk with BUPA - the first health fund to fund Mental Health Services under a prospective payment model. By 2002, the majority of health funds were on board with this model in SA. We currently have approx. 80% of our funding on a prospective payment basis.

We have operated under this model since then, during which time we have reduced our inpatient beds, expanded our offsite day programs and developed an extensive Community service covering the Adelaide Metropolitan area and areas as far north as Gawler and as far south as Port Noarlunga.

Also, in 2000, we established a state-based Consumer and Carer Advisory Committee which remains active today and led to the development of the National Private Consumer and Carer Network.

We agreed to have an external Quality report undertaken after 12 months of operating this model, and again after 3 years, to monitor progress and allay fears of "managed care". This was conducted by Professor Robert Goldney and showed that the focus on clinical outcomes and care had been maintained and that the Health Funds, Hospital, doctors and patients were happy with the care received.

The Prospective Payment Model (PPM) provides a pool of money for the provision of mental health services for the privately insured population of South Australia. The fixed monthly payment provides Ramsay Health Care SA Mental Health Service with the ability to provide the most appropriate services to patients in the most appropriate environment. (Right treatment at the right time in the right place).

This funding model has allowed for the provision of community nursing services both pre and post admission to hospital. It has enabled Ramsay to develop a dedicated, off site, day only patient facility. This has resulted in improved clinical outcomes with a reduced patient dependence on the inpatient facility.

Innovative treatments including TMS (Trans Cranial Magnetic Stimulation), Dialectical Behaviour Therapy, ACT/Mindfulness programs and specific Balancing Bipolar programs

have positioned Ramsay Mental Health Services South Australia as a leader in Mental Health.

THE ADELAIDE CLINIC

The Adelaide Clinic is a purpose-built Psychiatric hospital (84 beds) surrounded by parklands and within 3 kms of the city of Adelaide, making it the largest private Psychiatric hospital in South Australia. We are also a gazetted facility able to admit involuntary patients.

First licensed in July 1988, the Adelaide Clinic has established an enviable reputation for the assessment and treatment of patients with mental health disorders. As a market leader in the provision of health care services, the Adelaide Clinic continues to attract a team of dedicated professionals with a commitment to improving the healthcare of patients and their carers.

The hospital, which is a teaching facility of the University of Adelaide, provides a full range of general, acute and specialised psychiatric services.

As well as excellence in private psychiatric care, the Adelaide Clinic embodies the Ramsay Health Care ethos of “People Caring for People” hence patient care is the primary concern.

The Adelaide Clinic offers a diverse range of specialised treatment programs developed by staff with input from Psychiatrists, consumer and carers. The clinic specialises in the treatment of acute adult psychiatric illnesses including:

- Mood disorders
- Anxiety disorders
- Schizophrenia
- Personality disorders
- Drug & Alcohol detoxification

The Adelaide Clinic has specialised areas to which patients can be admitted depending on their needs:

- **Electro Convulsive** Therapy for the treatment of severe depressive illness, mania and other forms of psychosis. The ECT suite has excellent facilities and is staffed by Registered Nurses experienced in post anaesthetic recovery.
- An **inpatient programme** offers a wide range of groups to facilitate the recovery process and the successful transition from inpatient treatment back into the community.
- Recently discharged patients who may still require support are encouraged to attend the outpatient programme conducted at Kahlyn Day Centre, Magill.

The outpatient program can also be utilised for the treatment of patients for whom an inpatient program may not be suitable. Attendance at the Day Programme can be full day, half day or on a sessional basis. In addition to our specialist group treatment programs, Kahlyn Day Centre provides individually tailored therapy programs, developed in consultation with the patient's psychiatrist.

Drug & Alcohol Detoxification

An integrated service is provided for problems of drug and/or alcohol dependence and abuse. Our Drug and Alcohol Unit is staffed by a highly experienced multi-disciplinary team of health care professionals and offers the following treatment components and options:

- Assessment
- Detoxification
- Rehabilitation; and
- Outpatient follow-up

The Drug & Alcohol Unit is specifically designed to cater for the medically controlled, safe withdrawal of both alcohol and other drugs, whilst minimising the discomfort experienced by patients. The nature of the withdrawal procedure is determined by the nature and extent of the individual's substance dependence. The relapse prevention program, (a Cognitive Based Therapy program provided at Kahlyn Day Centre) commences at the completion of detoxification and includes both group and individual counselling sessions.

An open program at the Kahlyn Day Centre provides general information regarding the physical and emotional problems associated with the use of alcohol and drugs and the development of coping strategies.

The outpatient program ensures the provision of ongoing support and allows the early detection for relapse preventive measures to be instigated. Individual and family counselling are important components of outpatient follow-up.

KAHLYN DAY CENTRE

There has been a shift in emphasis on how mental health services should be best delivered. Whilst recognising the need for inpatient treatment for the more severe and acute presentations, alternatives to this type of care, including outpatient programs and community services can offer a more appropriate treatment setting.

To meet this challenge of delivering mental health care treatment options, Kahlyn Private Hospital evolved in 2003 to become Kahlyn Day Centre and offers the following services:

- Assessment and treatment of patients with drug and alcohol problems
- A Clozaril™ Clinic; and
- Innovative Day programs, tailored to meet the needs of the individual e.g. DBT, CBT, Balancing Bipolar etc

The Day Patient Program provides day therapy to assist patients in gaining further insight into themselves and their problems. We offer a selection of groups and individual sessions designed to meet the needs of the individual.

The main objective of the Day Program is to provide a supportive environment created by professional staff dedicated to maintaining and enhancing the independent functioning of each patient. The aim of the Day Program is to:

- Reduce or eliminate the frequency of inpatient hospitalization.
- Develop self-recognition of symptoms and a management plan.

- Promote awareness and teach skills, which allow patients to take responsibility and control their own lives.
- Assist recently discharged patients who may still require support. The outpatient program can also be utilised for the treatment of patients for whom an inpatient program may not be suitable.

Attendance at the Day Unit program can be full day, half day or on a sessional basis. In addition to our specialist group treatment programs, the Day Unit provides individually tailored therapy programs, developed in consultation with the patient's Psychiatrist.

Kahlyn Day Centre offers a welcome atmosphere with large gardens providing space and serenity. The staff at Kahlyn Day Centre are committed to providing high quality care in all aspects of a patient's needs; emotional and physical. The professionals involved in the treatment and programmes are accredited consultant psychiatrists, psychologists, medical consultants, clinical nurse specialists, registered nurses and other allied health professionals (physiotherapists, dieticians and social workers).

Kahlyn Day Centre is purely a day centre with no overnight activity. The facility has communal lounge/ recreation areas, therapy rooms and separate rooms used for interviews. No ECT is performed at Kahlyn.

Day Program Services

The Day Program includes specialised therapy modules such as DBT, CBT, Balancing Bipolar, ACT/Mindfulness, Relaxation, Assertiveness training, Anxiety management and support, discussion groups and a range of art, craft, leisure and daily living issues to assist patients in gaining further insight into their condition.

The Program staff have built a reputation for understanding the needs of the mentally ill. The best interests of the patient are their only interest and this attitude forms the basis of the programs.

Specialised programs provide an opportunity for people to learn more about their illness and develop coping skills to better manage their lives. Programs aim to have the patient learn the relationship between thinking, feeling and behaviour – to develop problem-solving strategies and be able to discriminate between irrational and rational thinking. The expected outcome for the patient will include an improvement to their organisational ability, their judgement and reasoning skills. Along the way they will gain an increased awareness of socially accepted behaviour and also improve their self-image. These processes will also help the individual to increase their self-initiative and function more independently in the community setting.

Programs available include:

- New Ways
- Diversional Therapy
- Stress/Anxiety Management
- Self-Awareness
- Depression Management
- Relaxation

- Implementing change
- Personal Growth
- Cognitive Behavioural Therapy
- Assertive Training
- Dialectical Behaviour Therapy
- ACT/Mindfulness
- Balancing Bipolar

Referrals into any of the programs require a referral from a Psychiatrist.

COMMUNITY SERVICES

Ramsay Mental Health Services South Australia provides a community service that enables registered nurses, enrolled nurses and occupational therapists to visit patients in the community both pre and post admission. The service covers the whole of the Adelaide metro area from Gawler through to Port Noarlunga.

The service consists of 8 staff, has a fleet of 5 cars and safety systems to ensure the security of staff.

Currently there are approx. 200 patients being seen in the Community by this service. Many of these people would have required inpatient treatment or, at the very least, longer admissions without this service.

Because of our model, we have been able to introduce early intervention services, admission avoidance, early discharge and Community maintenance programs to prevent relapse. All these services have contributed to less inpatient care overall.

Treating Psychiatrists

There are 117 Psychiatrists with reciprocal admitting rights to the facilities in Ramsay Health Care SA Mental Health Services.