Private Mental Health
Consumer Carer Network (Australia)
engage, empower, enable choice in private mental health

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SUBMISSION

National Health and Hospital Reform Commission
Interim Report December 2008
'A healthier future for all Australians'

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance and receive their treatment and care, and those that care for them, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

The Network is committed to working with the Government and would be pleased to work with the National Health and Hospitals Reform Commission in addressing the needs of people with a mental illness. Mental health brings with it many challenges. As a consumer and carer organisation we are in a unique position to provide direct lived experiences and would welcome the opportunity to engage in further consultations, either independently or with other relevant organisations.

Introduction

The Network was very pleased to provide a Submission to the Commission previously, numbered 409. We were also very pleased to participate in the Special Interest Group for Mental health held in Sydney on 25 August, 2008. A subsequent letter regarding discussions of this meeting was forwarded to the Chair Dr. Christine Bennett of 1 October, 2008 is attached.

The Network strongly supports health prevention strategies including support for the Health Minister's Preventative health agenda. Another important aspect for those with chronic illness is that of self management.

It is also crucial that organisations such as ours, that is those which are demonstrated key national consumer and carer advocacy peak bodies are embodied in the planning of the reform process.

The Network is keenly aware of the USA model of 'managed care' and whilst we are both objective and impartial, we do have great concerns that any options of funding mental health services , or health services generally, never loose the capacity of the consumer to make choices. Choice as to practitioner, hospital or health service, timely access or type of medical treatment and care. In other words the choice as to who, where, when and how that health service is provided. We resist fundamentally, any health funding decision overriding clinical decisions.

We would like to address some of the key consultation questions as follows.

1 How can we advocate for greater consumer and carer participation in the reform process?

We can tell you that consumer and carer participation in the main, across both public and private mental health organisations is very much dependent on the management of the day. The Network is committed to consumer and carer advocacy; to consumers and carers being involved in the development of services; to consumers and carers being involved in the ongoing monitoring and evaluation of those services. Who better to know what works and does not work than those in receipt of those services and those that care for them?

In terms of how can this be demonstrated, the Network believes that the only way of ensuring consumer and carer participation in any reform process within mental health services both public and private, is to make consumer and carer participation mandatory. This can be achieved by way of the accreditation process.

If the thrust is toward a greater picture of reform across the health care system, then the reform process must have the inclusion and engagement in a meaningful manner, of consumers and carers to inform the process.

2 Is there a need for the recognition of the critical role of a strong private sector?

Within mental health, the private sector is a crucial component of the mental health system. Public sector services are predominantly focused on schizophrenia, psychotic illnesses and bi-polar disorder, the low prevalence disorders, whilst the private sector caters in the main, for the high prevalence disorders of depression, anxiety and personality disorders.

Around 60% of psychiatrists work within the private sector, giving some hours per month to the public sector.

Please see data on the private sector at 6 below.

3 It is crucial that a strong private sector is both supported and strengthened.

Again, the data at 6 below proves beyond any doubt that the private health sector plays a critical role both in general health and in our area, mental health.

The public sector services within mental health are already overburdened and under resourced. Whilst there have been legislative restrictions in the past, with the advent of broader health cover, health insurers can now offer to pay for a range of services beyond the hospital setting. This opens up a whole new world in terms of treatment and care within and by community settings.

4 What evidence is there that research and funding into services that deliver outcomes are valued by the consumer?

In terms of evidence, this is an area in which the Network does not have sufficient expertise. What we can offer however is anecdotal or qualitative evidence from a 'lived experience' that consumers *do* value *good* outcomes. Mental health is most often chronic and debilitating in nature and good outcomes are what health services must strive for.

5 What is the impact for the practice of psychiatry and the service system in the future?

Whilst the Network strongly supports the 'Better Access' initiative which offers Medicare rebates for psychologists and other allied health professionals, we believe that the practice of psychiatry is an essential component of the Australian health care system.

Psychiatrists are firstly medical doctors, and in this sense have a unique understanding of the impact of psychotropic medications including side effects on the general health of their patients. The Network understands that psychiatrists are currently the lowest paid of all medical specialists, most notably because they do not conduct procedures as such, perhaps other than ECT.

If the Australian health care system were to drop the fee for service practice currently suggested, the mental health system would not be able to service consumers at the current levels, even though it is generally acknowledged that the levels are inadequate. We have already seen via the ABS National Mental Health and Wellbeing Survey 2007 that 65% of all Australians who consider they have had a mental health issue in the preceding 12 months did not seek assistance.

The Network does not support the purchasing of care via a fund holder, for a mental health consumer currently the subject of one of the Commission's options. We dedicate considerable energy monitoring the health system in Australia in terms of 'managed care'. Australia has some issues around equity and access, but nonetheless we still have one of the best health care system in the world.

Any changes to the current system of the practice of psychiatry in Australia would be of great concern for the Network. Private psychiatrists deliver good services to people who cannot access the public sector. Without this opportunity many more Australians would not have contact with specialist mental health professionals.

6 Why do we need to invest in the Private sector?

The Network believes the data below goes a long way to demonstrating the need for investment into the private mental health sector.

The Private Sector

In Australia, a mix of public and private service agencies and providers are responsible for the delivery of mental health services for people with a mental illness. State and Territory Governments manage specialised public mental health services.

Private sector services are delivered by psychiatrists and GPs in private practice, and private hospitals with psychiatric beds (hereafter Hospitals). These services account for over 60% of all people seen by the Australian specialist mental health sector.[1] It employs 9% of the national mental health workforce and provides at least 22% of total psychiatric beds.[2]

The private sector provides a range of mental health care, which includes the services provided by psychiatrists in office–based private practice, which are funded through the Australian Government's Medicare Benefits Schedule (MBS), and

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1 Derived from data contained in the Australian Government Department of Health and Ageing (2007), *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993–2005*. Commonwealth of Australia, Canberra.

2 Ibid p. 53

Overnight and Day Only services provided by private hospitals for which private health insurers (hereafter Health Insurers) pay benefits.

Over 90% of people with a mental health problem or mental disorder seeking hospital–based mental health services in the private sector are privately insured. The remainder include people covered by other third party payers including the Australian Government Department of Veterans' Affairs, compensation insurers or people who fund their own care.

2006-2007 Profile of Private Mental Health Sector

There were 25 specialist private mental health facilities located across Australia and mental health wards/units are contained within a further 21 medical/surgical private hospitals. Total beds are approximately 1,700.

Together, these hospitals treated 124,000 patients in 2006-07. Services that these hospitals provide include:

- 70% of all sameday mental health services;
- 43% of all hospital-based psychiatry services; and
- 93% of all sameday alcohol disorder and dependence services.

(calculated from latest data from Australian Institute of Health and Welfare - Australian Hospital Statistics 2006-07).

Unlike many other areas of health care, private mental health facilities do not provide a parallel service to the public sector. Rather, the private sector provides effective and necessary care to a large group of patients who are unable to be cared for in public mental health services.

2007-2008 Profile of Private Mental health Sector

During the 2007-08 financial year Australia had 27 stand–alone private psychiatric hospitals and 22 psychiatric units co–located in private general hospitals. Together these hospitals had approximately 1,700 psychiatric beds.

Data collected via the Private Mental Health Alliance's Centralised Data Management Service (CDMS)

During that year 37 of the 49 private hospitals participating in the CDMS admitted 19,213 patients for psychiatric care. Of those patients, 15,100 had a total of 20,818 separations from overnight inpatient care (excluding brief overnight admissions for same day procedures) with an average length of stay of 19 days.

Of the 8,066 patients who received any care on a Same day or Outreach basis (referred to under the National Model as Ambulatory care) 3,953 also had at least one Overnight inpatient admission.

7 Should we mention preferred treatment models especially advocating for follow-up and transition of adult care?

We would like to raise the issue from what we have heard is that early intervention services for psychosis in young people, is not at this time truly evidence based. The emerging data suggests that early intervention in young people would seem probable, but in terms of evidence based, we understand there is still debate around

this specific issue. This is the type of concerns that the Network raises herewith in determining funding via preferred treatment models.

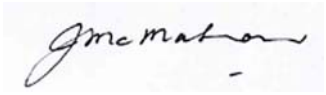
However, when some type of treatment model seems to be improving the outcomes for young consumers this must warrant strong consideration. The Network is very aware of the *Orygen* and *headspace* programs and the good work in these areas. Many good treatment options can be omitted because they may not necessarily be evidence based or this evidence may be very scarce. If health care never tried new things, there would never be any improvements or breakthroughs in care. If projects or pilots were never embarked upon, there may never be any thing at a later date to improve upon.

In terms of this area however, the Network suggests caution in determining by the NHHRC any preferred treatment models. This could be interpreted as fundamentally removing choice, the corner stone of the Australian health care system.

8 Conclusion

How better to shape the health system, than from within; that is from a lived experience on what works and what does not and why; what needs to change and what is working effectively. In other words the question is 'what are the intervening variables'.

The Network would welcome engagement with the Commission in any capacity. We thank the Commission for the opportunity of commenting herewith on the Interim Report.



Janne McMahon
Independent Chair
16 March, 2009

Appendix 1
COPY OF LETTER 1 October, 2008

Private Mental Health
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National Secretariat,
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Dr. Christine Bennett,
Chair,
National Health and Hospitals Reform Commission.
Per email:
C/- Nancye Fleming - nancye.fleming@nhhrc.org.au

Dear Dr. Bennett,

Roundtable on Mental Health
held Monday 25 August, 2008

There have been quite some difficulties in arranging a mutually convenient time to discuss mental health with Dr. Kevin Cheng unfortunately, as time was of the essence and I understand that his Interim Report to you has been submitted.

I do however hope that in future consultations, I have the opportunity of providing a consumer perspective to the Commission.

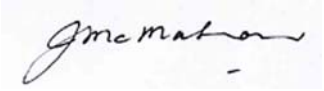
I have some concerns relating to discussions held at the Roundtable held in Sydney on 25 August of which I was a participant, most particularly in relation to alternative models of funding mental health care. It was noted that the Department of Veterans Affairs purchases care for their veterans and that this model offers good outcomes, very cost effectively. It must be noted however that DVA purchases the care on an 'uncapped' basis most often from services delivered within the private mental health sector including private hospitals with mental health beds.

If this type of funding model was incorporated into say first presentation and onset of psychosis, for the Australian health system to be viable long term, we believe we would see this requiring a 'capped' basis. This holds grave concerns for mental health consumers and carers in that it ultimately would deny treatment and care based on best clinical decisions and removes the choices available for both the treating practitioner and the consumer.

It must be noted that most mental illnesses are chronic and requiring lifetime health and chronic care management. Whilst this would seem to be advantageous from a funding perspective, we have grave concerns this would affect the best possible outcome for the consumer.

I would be grateful if you would consider our concerns within your deliberations.

Yours faithfully,



Janne McMahon OAM
1 October, 2008