

CHAPTER 12

PAYING FOR MENTAL HEALTH CARE

12.1 Mental health services are funded and delivered through both public and private sectors. The types of services delivered, and cost to the consumer in accessing these services, can vary greatly. Public sector mental health services include stand-alone psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services.¹ Other health services, such as hospital emergency departments are also provided by the public system and, as discussed in Chapter 8, now provide a large component of mental health crisis care. Private sector services include private psychiatrists, general practitioners, private psychiatric hospitals and private allied health professionals such as psychologists.²

12.2 The development of these two parts of the mental health sector has been characterised by four features:

- an 'illness divide' between the public and private sectors, with gaps developing that neither effectively addresses;
- growth in the private hospital system, raising questions about how this accords with the NMHS;
- a lack of coordination between the two sectors, which is a common complaint in mental health generally; and
- problems with the costs of access to care and with private health insurance.

12.3 The National Mental Health Strategy 2003-2008 sets out bold principles regarding access and equity:

Australia's universal health care system guarantees access to basic health care (including mental health care) as a fundamental right. Individuals in need of care should not only have timely access to such care, but the services they receive should be of a quality that is at least consistent with other developed countries, if not better. Access to and quality of care should be equitable, and people should not be disadvantaged by, for example, being on a relatively low income, having particularly complex needs or living in a rural area.³

12.4 Submitters questioned the extent to which the current mental health care system meets these access and equity principles. As one witness put it: 'Evidence

1 Australian Government, *Submission 476*, p. 6.

2 Australian Government, *Submission 476*, p. 6.

3 Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 10.

abounds of the financial and geographical barriers to timely access to equitable health care'.⁴

An illness divide?

12.5 Mental health professionals working in the public sector are overburdened tending to consumers with low prevalence, acute disorders. There is very limited capacity to provide services to those with high prevalence disorders such as anxiety and depression, or to engage in early intervention and prevention strategies. The committee repeatedly heard stories of how seriously ill people are being turned away from public services. One clinician memorably remarked they were at the point of triaging 'the more suicidal from the less suicidal'.⁵

12.6 Evidence suggests that a divide is developing in the hospital system, with the public system stretched in catering for the most acute cases, while the private sector is providing services for people with high prevalence disorders. For example, in 2002-03, among patients receiving specialised psychiatric care in public hospitals, schizophrenia was the most common principal diagnosis, followed by depressive episodes and bipolar affective disorders. By contrast, in private hospitals the most common principal diagnoses were depressive episodes, recurrent depressive disorders and reaction to severe stress and adjustment disorders.⁶ The differences between the two systems were highlighted by a private provider:

It is becoming increasingly apparent that advanced trainees and medical graduates who go on to become general practitioners are being exposed to a very narrow spectrum of mental illnesses in the public sector. Given the projected growth in conditions such as depression and anxiety, it would be beneficial to rotate medical staff into the private sector so that they can gain greater experience in the treatment and management of patients with high prevalence disorders.⁷

12.7 It is possible to see the two sectors as complementing each other in the provision of mental health services.⁸ However, there appears to be at least one significant problem with this view. All consumers may be able to obtain acute care in the public system (though there are serious issues in this area, outlined in the chapter on inpatient and crisis care). Wealthy consumers and consumers with private health insurance can gain assistance with serious high prevalence disorders (depression, substance abuse, and anxiety). However those consumers with high prevalence

4 Doctors Reform Society, *Submission 220*, p. 1.

5 Dr Andrew Chanen, Consultant Psychiatrist and Senior Lecturer, ORYGEN Youth Health and ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 7.

6 Australian Institute of Health and Welfare, *Mental Health Services in Australia 2002-2003*, Canberra, AIHW Mental Health Series no. 6, pp. 124-25. Data refer to hospital separations for patients who received specialised psychiatric care.

7 Healthscope Ltd, *Submission 82*, p. 4.

8 Australian Private Hospitals Association (APHA), *Submission 143*, p. 2.

disorders, who are not in an acute enough state to receive care in public hospitals and not fortunate enough to have the financial resources to obtain private treatment, are at risk of falling through the divide between the public and the private systems.

12.8 In addition, the divide between public and private services in other areas of the health system impacts on people with mental illness:

People with mental illness quickly acquire a backlog of health complaints that remain largely undiagnosed and/or untreated. Dental care is beyond the reach of most people with mental illness as well as their families unless they are able to afford private health insurance.

...‘You don’t have to be mentally ill for long, before you can’t afford basic health care. Add in becoming homeless and you soon gather a number of health complaints.’⁹

The growth of private hospitals

12.9 Under the NMHS there has been a targeted reduction in public sector psychiatric beds. The NMHS continued a process of closing stand-alone public psychiatric institutions that had begun in the 1960s. Acute care psychiatric beds were brought into general hospitals and there was an intention to expand community-based services. However, as public sector psychiatric beds numbers have reduced, the number of private sector beds has increased. Between 1993 and 2003, psychiatric beds in private hospitals increased by 37 per cent. By 2003, psychiatric beds in private hospitals provided 22 per cent of all psychiatric beds in Australia, up from 14 per cent in 1993. However, unlike beds in public hospitals most beds in private hospitals (72 per cent in 2003) are in stand-alone psychiatric hospitals.¹⁰

12.10 The funding arrangements between private health funds and private hospitals effectively encourage inpatient services and are at odds with the NMHS’s policy position on moving to community-based care. The Committee is concerned about this trend. The mental health funding tensions for the health funds and private providers is discussed later in the chapter.

Coordination between the sectors

12.11 There was a common call for the public and private sectors to work together more effectively to produce better outcomes for people experiencing mental illness. A lack of coordination was described at many levels, including at the policy level,¹¹ and in private practitioner care of individual patients:

9 Mental Health Community Coalition of the ACT Consumer and Carer Caucus, *Submission 214*, p. 3.

10 Australian Government, *National Mental Health Report 2005*, pp. 56; 160. Stand-alone private psychiatric hospitals were defined as those private hospitals in which psychiatric beds made up more than 75 per cent of all available beds. See *Mental Health Report 2005*, p. 157.

11 APHA, *Submission 143*, p. 2.

Integration and partnerships between public and private mental health services and the ability of consumers to traverse seamlessly between settings is required if optimal outcomes are to be achieved. For example, a person may be admitted to the public sector setting during an acute exacerbation of their illness under the care of a multidisciplinary team. When discharged, they return to their treating psychiatrist in private sector office based practice setting. Whilst this appears to be an ideal situation, the facts are that once the consumer enters the public mental health sector, there is very little, if any, consultation with their treating private psychiatrist. Medication regimes are often changed, treatments altered, and discharges occur without the private psychiatrist being aware of such changes. This represents the norm rather than isolated incidences. In these cases, there is a communication breakdown between sectors, and this needs to be addressed.¹²

12.12 Submitters from both the public and private sectors supported calls for increased collaboration. The Australian Private Hospitals Association (APHA) said:

Available data on the ageing of the population, increasing acuity of patients and increasing prevalence of mental illness all point to the need for the public and private sectors to work much more closely together to ensure appropriate and comprehensive care is provided throughout the episode of care.¹³

12.13 The Australian Healthcare Association (AHA) said

The AHA supports more effective partnerships between the public and private hospital sectors including improved mechanisms for collaboration. Implementation of greater coordination and collaboration would require the involvement of health funding bodies and the health insurance industry. A revised system could incorporate mechanisms to fund private hospital mental health service providers to become more involved in crisis response and initial care and to facilitate greater consultation with primary care practitioners.¹⁴

12.14 Additionally, it would be beneficial if private sector patients had improved access to public services such as allied health practitioners (eg. occupational therapy) and rehabilitation, for more inclusive and comprehensive care.¹⁵

Constraints on services and the cost of care

12.15 One carer, looking back over years of caring for her daughter with treatment-resistant paranoid schizophrenia, recalled one of the early consultations:

12 National Network of Private Psychiatric Sector Consumers and their Carers, *Submission 189*, p. 14.

13 APHA, *Submission 143*, p. 3.

14 Australian Healthcare Association (AHA), *Submission 169*, p. 11.

15 AHA, *Submission 169*, p. 11.

At the consultation the Psychiatrist said that our daughter was mildly psychotic, that it was probably a one-off incident and in all likelihood she would be better within six months. We also received from this specialist the best and most practical advice, which could have been given, which was to sign her up for private medical cover.¹⁶

12.16 As this carer's experience suggests, affordability of mental health services is a major issue. There are three reasons it is such a problem: limited access to care in the public system; the high cost of private mental health care; and, the often low incomes of people with mental illness.

Limited access to public health care

12.17 As already mentioned above, and in other chapters, public mental health care services are generally hard to access for all other than the most serious cases. These constraints are often felt most keenly by those seeking to access the assistance of specialist mental health professionals, particularly psychiatrists and psychologists.

12.18 While psychiatrists and psychologists are employed in the public sector, the strain on resources in this sector means that services are limited. Psychiatrists working in the public sector are so busy coping with acute crises that they are often unable to provide prevention and early intervention treatments or deal with the high prevalence disorders. While the public sector is a major employer of psychologists, evidence suggests that the sector increasingly employs psychologists in generic positions, such as case managers, rather than in clinical positions to provide psychological assessment and treatment. As with psychiatrists, psychologists in the public sector report being overburdened with the most severe disorders, leaving those with nevertheless complex and disabling high prevalence disorders unattended.

12.19 Given the pressure on the public sector, access to mental health care in general, and psychiatrists and psychologists in particular, is often only possible through the private sector.

High costs

12.20 The federal government subsidises the cost of private sector services in a number of ways. For all patients, the PBS subsidises access to many pharmaceuticals. Under the Medicare Benefits Schedule, rebates are provided for GP and psychiatrist consultations. However, as noted in Chapter 6 not many psychiatrists bulk bill, and although GP bulk billing rates have largely been restored to 2002 levels following government incentives, there are still many parts of Australia where bulk billing rates are low or non-existent.¹⁷ Many submissions argued that the Medicare schedule fee structure discourages the long GP appointments which are often required for mental health care.

16 Name withheld, *Submission 208*, p. 3.

17 The Australian Council of Social Services (ACOSS), *Submission 457*, p. 11.

12.21 Public funding to assist with access to private psychologists is even more restricted, with no direct rebates available. As discussed in Chapter 6, under the Better Outcomes initiative, accredited GPs can refer patients for psychological treatment, with minimal costs incurred to the consumer. However, this requires that an accredited GP is available, and the number of funded sessions is limited. GPs can also refer patients for psychology services through the Chronic Diseases Management scheme. This does not require the consumer to find an accredited GP, but the rebate is a set price and the cost to consumers remains high. Also, consumers must have a complex and chronic condition to qualify for the service. Therefore, while public funds subsidise consultations with private mental health professionals to some extent, accessibility is an issue and cost remains a major barrier for many consumers.

Low incomes

12.22 Using private health insurance to access private mental health service requires that consumers can both afford the insurance in the first place and also afford any remaining gap payments. Many cannot:

The role of private mental health services is such that unless mental health consumers have a private income, have employment which affords them paying for private health care, then the private mental health services are simply way out of the reach of mental health consumers.¹⁸

12.23 Micah Projects Inc commented:

...the capacity to pay is beyond the means of many who present to Micah with mental illness so private providers are not an option for the poor, those living below the poverty-line.¹⁹

12.24 The Australian Council of Social Services (ACOSS) said:

...a disproportionate number of people with mental illness live on low incomes, cannot afford co-payments and do not hold private health insurance.²⁰

12.25 Submitters expressed concern that government funding to support the private sector effectively reduces funding to the public sector, where it is most likely to assist those on low incomes. Anglicare Tasmania said:

...access to private services largely remains the domain of those able to afford private health insurance. The development of this sector should not occur at the expense of the public system.²¹

18 Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 8.

19 Micah Projects Inc, *Submission 67*, p. 6.

20 ACOSS, *Submission 457*, p. 11.

21 Anglicare Tasmania, *Submission 464*, p. 19.

12.26 The federal government's 30 per cent rebate on private health insurance provides some assistance. However those that cannot afford private health insurance, including many people with mental illness, are not able to benefit from this subsidy.

Conclusions

12.27 In the area of mental health, a divide is becoming clearly evident between the public and private sectors:

The risk here is that some will continue to fall through the cracks of each sector - with no where to go except onto the streets and into prisons.

Another concern is that a two-tiered mental health system is emerging – one based on a user-pays regime and one based on resource-strapped public provision. This has serious implications for access and equity.²²

12.28 In an environment of high costs and impaired ability to earn an income, holding private health insurance can be critical to gaining access to affordable and adequate care. The widespread lack of private health insurance amongst people with mental illness means that private services are commonly not an option, particularly amongst those for whom mental illness has contributed to poverty and ongoing hardship. Complex issues regarding private health insurance were raised with the committee during its inquiry, and it is to this that the report now turns.

Private health insurance in Australia

12.29 As at 30 June 2005 there were approximately 8 699 000 Australians covered by private health insurance.²³ There are currently 40 registered health funds in Australia. Of these 40 funds, 26 are open to any Australian resident over 16 years of age, and 14 are restricted to a specific group of people, generally employees of organisations or members of some unions.²⁴

12.30 Private health insurance is different to most other types of insurance offered in Australia in that it is community rated, not risk rated, meaning that a person 'should not be discriminated against in obtaining or retaining insurance coverage'.²⁵ That is, 'in setting premiums or paying benefits, funds cannot discriminate on the basis of health status, age, race, gender, sexual orientation, religious belief, use of hospital, medical or ancillary services or claiming history'.²⁶ Funds must accept all applicants, within

22 Micah Projects Inc, *Submission 67*, p. 6.

23 Membership Statistics, Australian Government, Private Health Insurance Administration Council, <http://www.phiac.gov.au/statistics/membershipcoverage/hosquar.htm>, (accessed 14 September 2005).

24 The Private Health Insurance Ombudsman (PHIO), *The State of the Health Funds Report—2004*, p. 8.

25 Australian Government, *Submission 476*, Attachment 1, p. 1.

26 Australian Government, *Submission 476*, Attachment 1, p. 1.

certain membership categories. In principle, this means that 'private health insurance policies (and premiums) are the same for people who need mental health care as for people needing any other type of health care'²⁷ and 'community rating institutionalises cross subsidies from fund members who make relatively little use of health care services to fund members who have relatively high use of those services'.²⁸

12.31 There has been much conjecture about whether the community rating approach is working, including whether '[t]he community rated 'community' is now largely made up of older and sicker Australians'²⁹ and what impact this may have on insurance premiums. This has led to some watering down of the strict application of the community rating system, through the imposition of 'excesses' and 'exclusions' by health funds. In a submission to the Industry Commission inquiry into Private Health Insurance in 1997, MBF had this to say about the need for innovative arrangements:

Unless 'innovative' packages attract previously uninsured people and the contribution paid contains a subsidy component for higher claiming members, the main effect is to reduce the funding available from standard cover participants. Over time, the prices of cover for those people most likely to need hospital care will rise to levels such that an increasing number of people cannot afford to maintain membership for the benefit entitlement they need— and the problems for Medicare will grow larger.³⁰

12.32 The Australian government has addressed the reduced take up of private health insurance by legislating on portability, providing \$2.5 billion in 30 per cent rebates on premiums in 2003–04³¹ and a lifetime health coverage regime, to attract and retain new entrants. The advantages of private health insurance cover for in-patient mental health treatment, the fear that premiums would become unaffordable and doubts that the public sector could provide such services, were outlined:

I am one of the lucky ones in that I have private health cover at the moment, a psychiatrist I am able to trust and one of the few that bulk bills... To date I have been hospitalised on three occasions. I have been able to receive this high quality of treatment at short notice purely on the basis of my having private cover. Given our dwindling financial situation I am afraid that I shall be unable to maintain my current private health cover and

27 Australian Government, *Submission 476*, Attachment 1, p. 1.

28 Industry Commission (Productivity Commission), *Private Health Insurance*, Report No. 57, 28 February 1997, p. 34.

29 Industry Commission (Productivity Commission), *Private Health Insurance*, Report No. 57, 28 February 1997, p. 35.

30 Industry Commission (Productivity Commission), *Private Health Insurance*, Report No. 57, 28 February 1997, p. 36.

31 Australian Institute of Health and Welfare, *Health Expenditure Australia 2003–04*, p. 27, <http://www.aihw.gov.au/publications/hwe/hea03-04/hea03-04-c03.pdf>, (accessed March 2006).

will become another burden on the Public that seems unable to cope with people in my position...³²

Pension rates do not allow people with mental illnesses to access private health insurance and decent quality services.³³

12.33 Health funds are becoming 'innovative' in the way they interpret the 'complex'³⁴ legislative regime governing insurance and the way they construct the products that they offer. Accordingly, the actions of private health insurance funds, in complying with the community rating methodology, are continually under the microscope.

Mental health service entitlements within private health insurance

12.34 Regulation of health funds is administered by the Private Health Insurance Branch of the Department of Health and Ageing, under the *National Health Act 1953*.³⁵

12.35 Only funds registered under this act are able lawfully to carry out the business of health insurance, with the 'conditions of registration covering such matters as: categories of membership, waiting periods for benefits, transfer arrangements between tables and funds, the types and levels of benefits, and requirements about contracting with hospitals and doctors'.³⁶

12.36 The Minister for Health and Ageing can apply conditions of registration requiring them to provide certain product offerings.³⁷ Sanctions for non-compliance with these conditions include deregistration.

12.37 Under regulation, each fund must offer:

- at least a minimum specified level of benefit (ie the basic or default benefit), for all public and private hospitals for all conditions covered in the policy taken out by the fund member; and
- cover in every (ABA) policy for in-hospital psychiatric, rehabilitation and palliative care, at least at the default level.³⁸

32 Name withheld, *Submission 78*.

33 Name withheld, *Submission 208*.

34 Ms Christine Gee, Vice-President, Australian Private Hospitals Association; Chair, Psychiatry Committee, Australian Private Hospitals Association, *Committee Hansard*, 4 July 2005, p. 51.

35 Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing (DoHA), *Committee Hansard*, 7 October 2004, p. 73.

36 Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 47.

37 Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2004, p. 73.

12.38 The reason for mandatory coverage for psychiatric care was best summed up in the Industry Commission report in 1997 by the National Community Advisory Group on Mental Health:

The extent of mental illness is not well understood or accepted by the community. Members and potential members of health funds are likely to seriously underestimate their risk in requiring psychiatric treatment. Therefore, psychiatric care is not an appropriate form of treatment to be excluded from insurance products.³⁹

12.39 Community rating in private health insurance should mean fund members with mental illness are not discriminated against but the Committee heard evidence that this was not the case. The National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC) said:

The National Network calls on the Senate Select Committee on Mental Health to address the steady attempt by private health insurers to restrict their coverage for services that are accessed by private consumers who have a chronic mental illness.⁴⁰

12.40 Catholic Health Australia said:

The packaging by some private health funds of mental health as an 'optional' extra, rather than an essential component of health, leads many people without cover for mental health and psychiatric services. Even when mental health is included in the insurance coverage, portability of private health insurance can be problematic and is an area that could be markedly improved with appropriate policy and legislative responses.⁴¹

12.41 They also argued that:

Private health insurers have placed too many restrictions on the types of services they will fund and by their rigid funding controls have essentially defined how private mental health and psychiatric services are delivered in Australia.⁴²

12.42 While blueVoices, the consumer and carer arm of beyondblue, identified a key concern as:

Discrimination in insurance preventing people with common disorders like depression and anxiety from taking out private insurance or resulting in

38 Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 53.

39 Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 57.

40 The National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC), *Submission 189*, p.7.

41 Catholic Health Australia, *Submission 276*, p. 19.

42 Catholic Health Australia, *Submission 276*, p. 20.

high premiums charged to persons who may have a history of these conditions (even if not a current diagnosis).⁴³

12.43 This concern was also raised by ACOSS.⁴⁴

What benefit payments do health funds provide in general?

12.44 In general terms, private health insurance provides three types of benefit:

- a supplement to the Medicare rebate for doctors' fees for in-hospital treatment, which can vary from an amount equivalent to 25 per cent of the Medicare Benefits Schedule (MBS) fee, to a higher amount under a gap cover arrangement;
- payments towards hospital accommodation costs; and
- ancillary benefits.⁴⁵

12.45 Regarding the supplement to the Medicare rebate: '[w]hen a doctor's charge exceeds the MBS fee, legislation allows health funds to pay benefits to eliminate or reduce the out-of-pocket payment required from the consumer, providing there is a formal agreement or gap cover scheme in place'.⁴⁶

12.46 There is much variation to what hospital costs a fund will provide from full to limited coverage, depending on the insurance cover purchased, and whether the fund has a contract with the hospital: '*The National Health Act 1953* requires health funds to pay at least the Commonwealth determined default benefits for hospital services where a private consumer is treated in a public hospital, or in a private hospital that does not have a contract with the consumer's health fund'.⁴⁷

12.47 Hospitals and health funds are able to enter into contracts for payment of accommodation costs above the Commonwealth default rates, however, these agreements may:

- place conditions on the payment of psychiatric benefits;
- vary between 100 per cent cover for hospital related costs to partial cover with the consumer paying a known co-payment; and

43 blueVoices, *Submission 259*, p. 4.

44 ACOSS, *Submission 457*, p. 3.

45 Australian Government, *Submission 476*, Attachment 1, p. 1.

46 *Submission 476*, Attachment 1, p. 2.

47 *Submission 476*, Attachment 1, p. 2. As at 1 July 2005 the default amount was set at approximately \$261 for overnight treatment in a shared ward and \$157 per day for outreach services, although these figures are subject to adjustment and may now be higher. See Department of Health and Ageing, *Private Health Insurance Circular—PHI 45/05*, 29 September 2005.

- cover the payments of benefits on a total or episodic basis, that is, in a lump sum payment.⁴⁸

12.48 These arrangements allow flexibility for health funds to 'determine benefit levels in light of the overall needs of their contributors and the desire to keep contribution rates affordable for as many people as possible'.⁴⁹

12.49 'Health funds may also pay benefits for non-admitted services offered by allied health care professionals, such as clinical psychologists from their ancillary tables', however, these ancillary benefits are less regulated and cannot provide coverage from which a Medicare benefit is payable.⁵⁰ Furthermore:

These ancillary benefits are usually capped at a dollar figure per service and/or a total annual dollar figure.⁵¹

Portability

12.50 During the late 1980s funds were imposing significant waiting periods for members who wished to change funds; costs were high and funds were not competitive. The government viewed true 'portability' between funds as the panacea to redress these concerns.

12.51 Portability of private health insurance from one fund to another, without automatically resetting waiting periods, was effected through the *Community Services and Health Legislation Amendment Act 1988* (No. 79 of 1988), adding sections (1a) to (1f) to Schedule 1 of the *National Health Act 1953*.

12.52 The second reading speech by the Minister for Housing and Aged Care said :

The bill also provides for increased freedom of choice for members of health insurance funds currently locked into a single health benefits organisation. This will be done by removing existing impediments to transfer between organisations.⁵²

12.53 The Minister continued:

The National Health Act is also amended to allow contributors to health insurance who wish to transfer from one health benefits organisation to another, because of factors such as lower contribution rates and other benefits, to do so without having to face difficulties through the imposition of new waiting periods. These measures improve the freedom of choice for that half of Australia's population which currently has private health

48 Australian Government, *Submission 476*, Attachment 1, p. 2.

49 *Submission 476*, Attachment 1, p. 2.

50 *Submission 476*, Attachment 1, p. 2.

51 *Submission 476*, Attachment 1, p. 2.

52 *House Hansard*, 21 April 1988, p. 1991.

insurance. Members will be able to transfer from one organisation to another without the imposition of waiting periods, or with reduced waiting periods where part or whole of the waiting period has been served in the previous organisation.⁵³

12.54 When this legislation passed each fund published the benefits they would pay for each type of service covered. Benefit tables were also broadly comparable.

Until October 1995, the Commonwealth Government defined a set of benefits that all health organisations had to pay as a minimum when an insured person was treated in any recognised (public) hospital, or licensed private hospital (including day hospital facility). This set of benefits included basic table hospital costs, as determined by the minister for Health and Family Services. Health funds could also offer supplementary cover for the additional costs for treatment in a private hospital (or a single room in a public hospital). The level of supplementary benefits was not regulated.⁵⁴

12.55 Where a person transferred from one fund to another they were covered up to the level of coverage they held in the previous fund. The Australian Health Insurance Association explained:

...the original portability entitlement was based on the dollars that a fund paid. So if fund A paid \$300 per day and a member transferred to a fund that paid \$350 per day, the entitlement they took with them was not the new fund's benefit, but the old fund's \$300 for the first 12 months of membership, after which they would get the increased amount. This was to make sure that a member—or, for that matter, a provider talking to them—could not strategically upgrade their cover by changing funds, whereas they would not be able to upgrade their own cover within a fund without being subject to a waiting period.⁵⁵

The changing environment—Purchaser/Provider Agreements (contracts)

12.56 Debate on the current portability arrangements intensified when published benefits were replaced with a direct contracting system between health funds and hospitals:

In 1995, the Keating government legislated to allow purchaser/provider agreements (contracts) between funds (as the "purchaser") and hospitals and doctors (as the "providers"). These provisions were amended in late 2000 by the Howard government to permit medical gap cover without contracts.

53 *House Hansard*, 21 April 1988, p. 1991.

54 Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, Box 3.19, p. 53.

55 Mr Russell Schneider, CEO, AHIA, *Committee Hansard*, 4 July 2005, p. 63.

Another very important initiative in 2000 was the introduction of Lifetime Health Cover.⁵⁶

12.57 The Industry Commission advised:

From 29 May 1995...health funds were able to negotiate different agreements with different hospitals. Applicable Benefits Arrangements (ABAs) came into existence. This term describes an arrangement between a health fund and its contributors under which contributors are covered for fees and charges related to hospital treatment (including medical charges). ABAs are more flexible than the basic and supplementary table system.⁵⁷

12.58 Mr Schneider expressed the view of insurers:

About 10 years ago, contracting of health funds and hospitals moved in to replace the old system of published benefits. So the dollar amount became invisible. The question then became one of whether the fund had a contract with a hospital or not. Our problem is that contracts do not run all the time and they can be broken by one party or the other. When they are broken, it is often the hospital which will initiate the cessation of the contract simply because it does not consider the benefits being paid by one fund are adequate and at times the breaking of the contract may be a strategic part of the whole negotiation process.⁵⁸

12.59 Under this system what a fund will pay a hospital or doctor for a treatment remains confidential to the parties. Accordingly, whilst a person may transfer from one fund to another for a number of reasons, for example, to ensure they retain the same treating physician or to change the type of cover, the negotiated payment between the fund and the hospital for a particular treatment will be different for each fund. Also, and probably just as importantly, negotiations can result in a fund and hospital not agreeing to contract, or contracting to provide some services but not others, ultimately meaning that a member has no, or in the case of treatment for psychiatric illness, only the Minister's prescribed default coverage if they choose to be treated at that hospital.

12.60 This has ramifications for fund members receiving mental health treatment who wish to maintain a relationship with the treating specialist.

12.61 The APHA argued:

Services offered by private mental health facilities are also influenced by private health insurance funds. For the most part, private mental health facilities receive the bulk of their funding via private health insurance funds

56 Access Economics Pty Ltd, *Enshrining Portability of Health Insurance*, Final Report for the Australian Private Hospitals Association, June 2005, p. 2.

57 Industry Commission (Productivity Commission), *Private Health Insurance*, Report No. 57, 28 February 1997, Box 3.19 p. 53.

58 Mr Russell Schneider, CEO, AHIA, *Committee Hansard*, 4 July 2005, p. 63.

under Hospital Purchaser Provider Agreements (HPPAs) which operate within a regulatory framework of the *National Health Act 1953*. For many private mental health facilities, this is a flawed framework that does not deliver a level playing field.⁵⁹

12.62 APHA, however, did not go into specific details as to how the playing field is affected.

The Private Health Insurance Ombudsman

12.63 In 1995 the Australian Government, through the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*, set up the office of the Private Health Insurance Complaints Commissioner (PHICC) with five key roles:

- deal with complaints and conduct investigations;
- publish aggregate data about complaints;
- make recommendations to the Minister and Department of Family Services;
- make available and publicise the existence of the Private Patients Hospital Charter; and
- promote an understanding of the Complaints Commissioner's functions.⁶⁰

12.64 The office of the PHICC was replaced in 1998, through amending legislation (*Health Legislation Amendment Act (No.2) 1998*), by the office of the Private Health Insurance Ombudsman (PHIO). The role and functions of the PHIO were essentially the same as the PHICC, however, there was some minor strengthening.⁶¹

12.65 Prompted by continuing concern with the way the portability legislation had been interpreted by the various players in the industry the PHIO determined to undertake a review during 2000. The PHIO concluded:

...the provisions fail because there is a dispute on what constitutes a broadly comparable benefit and the effect of different components within products to establish beyond doubt the relevant part of the relevant benefit.⁶²

12.66 In his 2001 Annual Report, the PHIO advised:

59 APHA, *Submission 143*, pp. 3–4.

60 Private Health Insurance Complaints Commissioner (PHICC), *Annual Report 1997*, p. 9.

61 To allow the PHIO to 'arbitrate disputes between private hospitals and health funds regarding second-tier benefits payable in respect of health fund members', PHIO, *Annual Report 2001*, p. 13.

62 PHIO cited in Access Economics Pty Ltd, *Enshrining Portability of Health Insurance*, Final Report for the Australian Private Hospitals Association, June 2005, p. 12.

A second area where consumers have consistently faced difficulty is in the area of product portability. The National Health Act as it relates to portability is extremely complex and again it is an area where the interpretation and subsequent application of the provisions by funds has been inconsistent.⁶³

12.67 On speaking about the results of the review the PHIO went on to further say:

The Ombudsman's office, in liaison with officers of the Department of Health and Aged Care, together with health funds industry representatives combined to produce a set of twenty seven recommendations in a comprehensive review of portability arrangements. The review was completed and published in December 2000.

The basic principle underpinning all of the recommendations is that any member transferring from one product to another, either within a fund or between funds, will never be placed in a more adverse position than a new member entering that product for the first time. Although outwardly this principle seems so evident as to not need stating, it was not the position universally adopted and as a consequence aberrant practices led to significant disputes.⁶⁴

12.68 The review appeared to arrive at an industry consensus as to what behaviour was required to ensure that the industry would not come under such focus as to require more vigorous regulation. In essence, a voluntary adherence to the recommendations of the review appeared to be a preferable option by the industry.

12.69 However, in his 2004 Annual Report, the PHIO advised, once again, of the perennial issues arising through complaints to his office. These issues were listed as:

- the rights of consumers when changing health funds;
- the impact of hospital/health fund contract negotiations;
- the adequacy of information provided to consumers about what costs their health insurance will and won't cover;
- reasonable advance notice of the costs of hospital services in hospitals (Medical Gaps); and
- the application of the pre-existing ailment waiting period provision.⁶⁵

12.70 The current PHIO, Mr John Powlay, advised the committee that of the 2 600 complaints received by his office annually approximately 25 have related exclusively to psychiatric treatment, however, he suggested that complaints are dealt with which

63 PHIO, *Annual Report* 2001, p. 8.

64 PHIO, *Annual Report* 2001, p. 8.

65 PHIO, *Annual Report* 2004, p. 7.

may involved issues of psychiatric treatment which are not recorded as such.⁶⁶ In any case the number directly attributed to psychiatric treatment was small.

12.71 The PHIO further advised:

The range of issues about which we have received complaints includes restrictions on the level of benefit for psychiatric treatment, hospital contracting where the hospitals were psychiatric hospitals or the contracting issue involved payment for psychiatric treatment, the application of co-payments where psychiatric programs occurred over a number of weeks and a small number about billing practices of psychiatrists in private practice.⁶⁷

12.72 Dr Wayne Chamley, an accredited health surveyor, in a personal submission, suggested that private patients with mental illness were being discriminated against by the:

- Introduction of co-payments for persons attending Day Program activities. The introduction of the co-payment has been done without any recognition of the patient's prior membership of the fund and it has placed a large cost-burden upon the person with chronic illness.
- Inability of patients with mental illness to exercise their full right of portability.
- Dispute between an individual service provider and an individual insurer can cause great distress to patients and in some cases the patient has been forced to find a new treating psychiatrist.⁶⁸

12.73 Whilst the industry as a whole has attempted to resolve a number of issues, it appears that in the eyes of some stakeholders this has failed. The National Network of Private Psychiatric Sector Consumers and their Carers (NNPPSCC) raised as ongoing problems 'portability between health funds, exclusionary health insurance products, limitations on benefits paid for hospital-based care, co-payments for day programs, and disputes between hospital providers and health funds'.⁶⁹

Portability: issues of concern

12.74 Whilst the intent of the portability arrangements was to enable people to transfer between funds without incurring additional waiting periods, some processes and practices have developed which appear to impact upon this principle.

66 Mr John Powlay, Private Health Insurance Ombudsman (PHIO), *Committee Hansard*, 28 October 2005, p. 15.

67 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 15.

68 Dr Wayne Chamley, *Submission 339*, p. 10.

69 NNPPSCC, *Submission 189*, p. 7.

Contract disputes

12.75 Whilst most funds do cover a significant range of hospitals and doctors under contract arrangements, each contract has a definite life and will need to be reviewed at some stage and can be broken by either party. During these contract negotiations and disputes consumer protection is often at risk. The PHIO stated:

It is disappointing to record that on a number of occasions during this year vulnerable consumers were placed in a position of heightened anxiety when hospitals and health funds were in dispute concerning the outcome of contract negotiations. My office was called upon to placate very frightened elderly, pregnant and sick consumers who were informed by hospitals, that they were no longer covered by their health funds.

Hospitals, which were unable to negotiate benefits they considered appropriate, contacted past and prospective patients directly, informing them that their health fund would not honour previous levels of benefit and as a consequence the patient would be better off changing funds.⁷⁰

12.76 The PHIO was particularly disturbed to see both the hospitals and health funds engaging patients in the disputes and that these disputes were causing concern for consumers and their families:

Some families continue to pay private hospital insurance to ensure that their relative can access private hospitals; however there can be difficulties since one of the largest private health insurance funds in Victoria no longer has a contract with one of the largest private psychiatric hospitals.⁷¹

12.77 Dr Michael Coglin, Chief Medical Officer, Healthscope Ltd said health funds are actively discouraging people with psychiatric illnesses from obtaining memberships by selectively contracting with hospitals:

Australia's largest health insurer, Medibank Private, is currently engaged in a large-scale exercise the purpose of which is to discriminately choose – as they would have it—hospitals where the members can be treated, and therefore they do not have contracts with hospitals where their members would be disadvantaged. A patient choosing or preferring that hospital needs access to portability if they do not agree with their health insurer's purchasing choices. That person is entitled to say, 'I don't like the fact that Medibank Private doesn't contract with the hospital I have been going to for 20 years, and therefore I would like to transfer to some other fund that does'.⁷²

12.78 The most prominent dispute was between BUPA health funds and the Healthscope hospital group. Both parties were large providers and given the ease of

70 PHIO, *Annual Report 2001*, p. 10.

71 ARAFEMI Victoria Inc, *Submission 536*, p. 5.

72 Dr Michael Coglin, Chief Medical Officer (CMO), Healthscope Ltd, *Committee Hansard*, 5 July 2005, pp. 16–17.

transferability under the portability regime there was great concern by other health funds of the risk of large scale transfers of members from BUPA funds to their funds, seeking immediate cover, putting their funds under enormous financial strain.

12.79 Mr Schneider discussed the effect of this dispute as follows and appears to infer that the providers of health care, being the private hospitals and doctors, may be manipulating the portability provisions through their direct interaction with health fund members:

The problem with portability at the moment came about from a dispute that took place between a health fund and a private hospital group in South Australia and Victoria [BUPA and Healthscope Inc dispute] in which the hospital group went out of contract with the fund and then actively encouraged members of that fund to go to other health funds. This was at the point of hospital entry. At the hospital gate people were told that they could either produce their credit card or go to another health fund. My understanding is that in some cases the people were presented with membership forms of another health fund, and all they had to do was sign to move there.

In the current environment, hospitals know what each health fund pays. Doctors know it too. They are in a position where, if the existing arrangements as they are currently interpreted are applied, providers of health care can effectively arbitrage the system.⁷³

12.80 Ms Susan Williams, National Program Manager, Psychiatry, Healthscope Ltd, disagreed:

The doctors are not as sinister as the health funds make out. They are not really interested in the commercial aspects of the hospital and the health funds; they are interested in continuity of care for their patients.

But there are reasons why the doctors are encouraging patients to move. They may have had a 10- or 15-year relationship with a patient, they no longer have a contract with the hospital, and they have said, 'move to this health fund and I can continue to treat you.' That is the reason why they are encouraging their patients to move.⁷⁴

12.81 Regarding this dispute the PHIO stated:

Both the hospital group and the health fund agreed to implement the transitional arrangements previously recommended by the Ombudsman in the "Review of Portability Arrangements for Private Health Insurance" as well as other protections for affected members. These arrangements should have provided sufficient assurances for BUPA members and reduced the incidence of fund transfers. However, other actions and decisions by the hospital group and the fund as well as extensive media coverage led to a

73 Mr Russell Schneider, CEO, AHIA, *Committee Hansard*, 4 July 2005, p. 62.

74 Ms Susan Williams, National Program Manager, Psychiatry, Healthscope Ltd, *Committee Hansard*, 5 July 2005, pp. 18–19.

high incidence of fund transfers, including (apparently) by many people who would have been protected by the agreed transitional arrangements.⁷⁵

12.82 The PHIO advised the committee:

During the dispute, Healthscope aggressively promoted the idea that patients should transfer to other health funds. Medibank and Australian Unity were most significantly affected by this mass transfer of BUPA members. The estimate of the numbers transferring is around 50 000 health fund members. These funds initially indicated that they had refused to guarantee full portability for BUPA members transferring—that is, that they would not extend the benefit of their contracts with Healthscope to transferring BUPA members. But, following intervention from me and the department, both funds agreed to do so before contract arrangements ceased.⁷⁶

12.83 The PHIO further advised:

Both Medibank and Australian Unity experienced substantial benefit payments from transferring BUPA members. Most of those members were transferring at the point at which they were having expensive hospital treatment. Most of these transfers occurred in South Australia and were not related to psychiatric or rehabilitation treatment. BUPA and Healthscope settled their dispute and established full contracts with the key Adelaide acute hospitals. But BUPA and Healthscope reached an agreement between them whereby BUPA would provide only minimum benefits for some rehab hospitals and all Victorian psych hospitals and there would be high out-of-pocket costs for BUPA members. I stress this was not a situation where the fund and the hospital went out of contract; the fund and the hospital agreed between themselves that the payment the hospital would receive would be just above the minimum amount. So there was an incentive for BUPA members to transfer. Australian Unity decided to protect itself and its members against the additional cost of these transfers by implementing these benefit limitation periods on psych and rehab for all its products. The department decided not to recommend disallowance, in part because it had previously approved similar rules for BUPA.⁷⁷

12.84 As a result of the significant movement of members from BUPA to other funds, these funds determined to put in place protection mechanisms to minimise the risk posed by this large scale movement.

12.85 These risk minimisation strategies appear to be counter to the intent of the original portability legislation, however, have been allowed to continue under the self regulation regime. The common practices, which had some application prior to the

75 PHIO, *Annual Report 2004*, p. 7.

76 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 16.

77 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 16.

BUPA dispute, include the use of benefit limitation periods, benefit exclusions and restricted benefits.

12.86 APHA advised the committee through their submission that the current contracting process between hospitals and private health funds are circumventing the intent of the regulatory arrangements:

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.⁷⁸

12.87 These practices are effectively the imposition of waiting periods (new member surcharges) under various guises. Waiting periods and the pre-existing ailment rules are aimed at providing a defence to 'hit and run' activity by fund members 'on an itinerant basis, to snare benefits'.⁷⁹ It also appears that these practices impact more greatly upon psychiatric and rehabilitation services.

Benefit limitation periods

12.88 APHA claimed that 'funds have found creative ways around...legislative requirements by introducing 'benefit limitation periods', 'restricted benefit periods' or similar'. For example, BUPA (HBA and Mutual Community Health funds) 'have restricted benefits for mental health services ranging from one year ("Top Hospital cover") to the entire life of the policy ("Hospital saver")'.⁸⁰

12.89 Benefit limitation periods are not specifically identified in the relevant legislation. Sections (l) through to (lf) of Schedule 1, *National Health Act 1953* provide the portability provisions of the legislation and refer to terms such as 'relevant person', 'relevant benefit', and 'broadly comparable benefit', although these terms are also not defined.

78 APHA, *Submission 143A*, p. 3.

79 Access Economics Pty Ltd, *Enshrining Portability of Health Insurance*, Final Report for the Australian Private Hospitals Association, June 2005, p. 23.

80 APHA, *Submission 143A*, pp. 2–3.

12.90 Benefit limitation periods need to be differentiated from waiting periods *per se*. In his pamphlet titled *The Right to Change—Portability in Health Insurance* the PHIO clarifies the difference of these two concepts. In terms of waiting periods:

In some circumstances, it would be unfair to the wider membership if a transferred member could immediately access the higher benefits of a new product. Federal legislation therefore allows health funds to apply waiting periods in a range of circumstances.

The 'Legislated Waiting Periods' provide for a 12 month wait for pre-existing ailments and obstetric conditions and a two month waiting period for all other conditions for new members and those upgrading their hospital cover.⁸¹

12.91 It therefore, stands to reason that 'where the previous fund product has a benefit limitation, and the member is seeking to transfer to a product without a benefit limitation, the fund has the right to apply the legislated waiting periods before the member is entitled to the higher benefits under the new fund product'.⁸²

12.92 During 2004 the PHIO had asserted:

Recently some funds have sought to limit transferring members' access to their hospital benefits if their previous fund did not have an agreement with a particular hospital; thereby exposing transferring members to larger out-of-pocket costs, for a period. Some of those funds have also introduced rules limiting benefits for certain treatments such as psychiatry and rehabilitation for a period after transfer. While the actions of these funds do protect their existing members from additional costs (which would need to be passed on in premiums), they also threaten to seriously undermine an important consumer right for all health insurance contributors.⁸³

12.93 The PHIO advised the committee:

Under the Health Act, funds do have to pay at least the minimum benefit for psychiatric treatment on all their products. Most of the larger open membership funds have what are called benefit limitation periods.

Benefit limitations periods pay benefits for some specified treatments but the benefit is limited to the minimum for an initial period of membership—generally between one and three years. Benefit limitation periods are more common in Victoria, South Australia and Western Australia because originally they were designed by AXA, now BUPA health funds, which have a significant share of those markets. The treatments that are most commonly subject to benefit limitation periods are psychiatric treatment,

81 PHIO pamphlet, *The Right to Change—Portability in Health Insurance*, <http://www.phio.org.au/showbrochure.php?id=70>, (accessed September 2005).

82 PHIO pamphlet, *The Right to Change—Portability in Health Insurance*, <http://www.phio.org.au/showbrochure.php?id=70>, (accessed September 2005).

83 PHIO, *The State of the Health Funds Report—2004*, p. 6.

rehabilitation, heart surgery, joint replacement, eye surgery, IVF and obstetrics.⁸⁴

12.94 The PHIO also stated:

Until April 2004 all funds, except the BUPA health funds, waived benefit limitation periods on transfer if the person already had the requisite period of membership with their previous fund. BUPA apply benefit limitation periods on all transfers, including people who transfer between products within their fund. In April 2004 Australian Unity introduced benefit limitation periods covering just psychiatric and rehabilitation on all its products. They applied these benefit limitation periods to all new joiners, including transfers from other funds. As I said, no other fund, other than BUPA and Australian Unity, applies these limitations on transfer. The distinguishing features of the Australian Unity arrangements are that they apply across the full product range for Australian Unity; most funds have at least one product that is not subject to these limitations. The Australian Unity arrangements relate to psych and rehab only across all their products.⁸⁵

12.95 It would appear that funds impose benefit limitation periods for a number of reasons, including limiting benefits for all new members to the fund where the member had no previous private health insurance, or where there has been a significant time lapse. The rationale for this application of benefit limitation appears to be to prevent 'hit and run' practices whereby a person would be able to join a fund on full cover, receive immediate benefits and then once treated opt out of the fund. Also, the practice is seen as a risk protection measure to mitigate wholesale transfers of members from one fund to another.

12.96 Ms Gee, Vice-President of APHA, also in reference to Australian Unity advised: 'one particular health insurer has been given the right to discriminate against consumers with mental illness' and, '[t]his follows the decision of the Department of Health and Ageing [DoHA] to permit that insurer to impose a 12-month limit on benefits for people, transferring to it from other insurers, who need private treatment for mental illness, regardless of whether these consumers have already served their waiting periods with another insurer'.⁸⁶

12.97 The NNPPSCC supports the view of APHA implicating DoHA in allowing the funds to impose limitations on benefits:

[DoHA] approved an application from the Health Fund, Australian Unity, to impose a twelve-month limitation for benefits only for *psychiatric* and *rehabilitation* services. This meant that consumers of private psychiatric services transferring to Australian Unity would have their benefits paid at

84 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 15.

85 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, pp. 15–16.

86 Ms Christine Gee, Vice-President, APHA, *Committee Hansard*, 4 July 2005, p. 51.

the default level, which would leave the consumer with significant out-of-pocket expenses, regardless of the level of their private health insurance cover.⁸⁷

12.98 The NNPPSCC have approached DoHA about this issue and were advised that '*portability* is under review and that they are not currently in a position to make a decision'. The NNPPSCC expressed disappointment that 'the review has been on-going for over a year'.⁸⁸

12.99 In summary, up until April 2004 all funds except BUPA waived benefit limitation periods on transfer if the new member had served the period with the previous fund. BUPA apply benefit limitation periods on all transfers (internal and external) and in April 2004 Australian Unity introduced benefit limitation periods on all its products for psychiatric and rehabilitation services to all new members, including those transferring from other funds. No other funds, at this time, have moved to apply benefit limitation periods to transferring members where the member has already served the appropriate waiting period.⁸⁹ However, many funds will be keenly watching the actions of Australian Unity.⁹⁰

12.100 In evidence to the committee, Ms Addison, Assistant Secretary, Private Health Insurance Branch, DOHA, acknowledged that Australian Unity had imposed a benefit limitation period of 12 months upon new members transferring to its fund. Ms Addison advised that the fund did so as it felt it was financially 'at risk' given the number of transferring members due to the BUPA dispute.⁹¹

Since that time there have been ongoing discussions at an industry level to resolve the concerns related to portability. Portability, as provided under the National Health Act, is about people being able to transfer to a comparable product without having to re-serve waiting periods. There is a school of thought that says that benefit limitation periods are waiting periods. Certainly the Private Health Insurance Ombudsman believes they are. The imposition of a benefit limitation period was seen as the imposition of a further waiting period, which people were concerned about.⁹²

87 NNPPSCC, *Submission 189*, p. 8.

88 NNPPSCC, *Submission 189*, p. 8.

89 Information provided to the Committee by the PHIO, 26 August 2005, unpublished.

90 Dr Michael Cogle, CMO, Healthscope Ltd, *Committee Hansard*, 5 July 2005, p. 16.

91 Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2005, p. 73.

92 Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2005, p. 73.

12.101 Ms Addison indicated that the imposition of benefit limitation periods was the only area of discrimination against people with mental illness that has been brought to DoHA's attention.⁹³

12.102 As a result of the initial consultation process, requested by the Minister for Health and Ageing, the Minister circulated a 'Condition of Registration Pursuant to Subsection 73B(1) of the *National Health Act 1953*' to private health industry representatives. This proposed legislative instrument was designed to 'prevent a health fund from imposing (in any form) a benefit limitation period on any hospital cover for contributors or dependants transferring to the fund from another fund'.⁹⁴

12.103 Section (a) of this condition states:

In relation to contributors or dependants transferring from one organisation to another organisation, the receiving organisation must not impose (in any form) a benefit limitation period on any of its applicable benefits arrangements.⁹⁵

12.104 Section (b) of the condition directs funds to cease to impose the benefit limitation period currently being served by a person who has transferred and provides a time limit for this to take effect.

12.105 Importantly, the proposed condition provides the following definition of a benefit limitation period:

(c) For the purposes of paragraphs (a) ...of this condition of registration a benefit limitation period is a period of time set by the organisation during which a contributor or dependant is eligible to receive, in relation to one or more episodes of hospital treatment covered by the applicable benefit arrangement:

- (i) for hospital treatment, minimum benefits only [Ministerial default];
- (ii) some other form of lesser benefit, including but not limited to, a period of time during which a contributor receives no benefit for an episode or episodes of hospital treatment (that is, a time limited exclusion outside the waiting period times permitted by the *National Health Act 1953*), or, a period of time during which a contributor receives a lesser benefit due to co-payment, excess or front end deductible.⁹⁶

93 Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2005, p. 74.

94 DoHA, *Private Health Insurance Circular—PHI 45/05*, 29 August 2005.

95 DoHA, *Private Health Insurance Circular—PHI 45/05 (Attachment A)*, 29 August 2005.

96 DoHA, *Private Health Insurance Circular—PHI 45/05 (Attachment A)*, 29 August 2005.

12.106 Accordingly, the intention of the Minister appears to be to outlaw the imposition of benefit limitation periods not considered to be legitimate waiting periods. Although the instrument has not been signed off by the Minister at this time it is expected that this condition of registration will be formalised. The PHIO was also of the view that this 'condition would go ahead fairly shortly'.⁹⁷

Benefit exclusions/restricted benefits

12.107 Health funds offer a range of products with benefit exclusions or restrictions, targeting specific audiences with more limited products and applicable levels of treatment. Furthermore, funds were not properly advising funds members and prospective fund members of the limitations of the products they were purchasing.

12.108 The PHIO advised the committee:

I have been very critical of the health funds in terms of the quality of information that they provide when people join, particularly around these areas where there are restricted benefits. I have put the view that I think the funds need to specifically acknowledge when people are joining those areas that are subject to restricted benefits. Pretty well all of the complaints that I get from consumers when they have had a hospital episode and only been paid these restricted benefits, is that they did not understand that that was the limit of their coverage when they signed up.⁹⁸

12.109 The PHIO confirmed that 'all health funds have one or more products that restrict benefits on psychiatry and psychiatric treatment—that is, they pay the minimum benefit amount' only.⁹⁹

12.110 In terms of benefit exclusions and restrictions 'some members may choose, for lifestyle reasons or to reduce the cost of premiums, a product where the benefit on some or all hospital procedures are limited to a level significantly below the hospital charge, or the cost of admission as a private patient in a public hospital'.¹⁰⁰

12.111 APHA, however, criticised the range of products targeted at young people which have restrictions on mental health services for the entire life of the policy. APHA warned 'the inability of any person to foresee the future onset of illness render such health insurance products as not fit for purpose...quite simply, such products should be prohibited by law'.¹⁰¹

12.112 Dr Coglin, of Healthscope private hospitals stated:

97 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 17.

98 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 22.

99 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 15.

100 PHIO pamphlet, *The Right to Change – Portability in Health Insurance*, <http://www.phio.org.au/showbrochure.php?id=70>, (accessed September 2005).

101 APHA, *Submission 143A*, p. 3.

There are a number of other techniques which I believe are being employed by some health funds to discourage people with psychiatric illnesses from joining and remaining as members or, if all else fails, from accessing reasonable benefits.

The first of them involves the provision of exclusion products under which people are invited to take out membership of a particular table and then unexpectedly suffer from a disorder. It could be heart disease, a pregnancy requiring obstetrics admission or, in the case we are talking about here, a mental health disorder. The product they have chosen on the trade-off of price says, 'we don't cover you for certain diseases.' Our view is that products containing a mental health exclusion are not fit for purpose and should not be allowed to be offered by health insurers, because of the unpredictability and prevalence of mental illness in the community.¹⁰²

12.113 The PHIO agreed, advising the committee:

I have particular concerns with psychiatric treatment being limited in this way and I am particularly concerned that many of the products that are developed by funds and that target young people restrict psychiatric treatment. My concern is that it is very difficult for anyone to assess the risk of becoming mentally ill. A further concern is that in many cases the publicly provided options are not adequate. In some kinds of emergency treatment and so forth—or even, say, heart surgery—at least you know that there is the public system to fall back on. But in many cases with mental illness—particularly involving drug dependency—there is not the availability of treatment in the public system that people would like to see. That is part of the reason why people take out private insurance. As I said, I am concerned about those products that target young people because the indications are that most of the complaints that I receive are about young people. Indeed, the complaints are made on their behalf by parents. In many cases the parents will be funding the private health insurance for the young person.¹⁰³

12.114 When asked to clarify how funds target young people, the PHIO advised:

The theory of private health insurance companies targeting young people particularly in their advertising is that young people are less of a risk in terms of expenditure.

With many of these products that target young people, the funds feel they have to be made cheaper and more affordable for young people and, in that way, more attractive. Younger people tend to be more interested in some of the ancillary and alternative therapy benefits, so the sorts of products that you see coming onto the market will offer reasonable benefits in relation to alternative therapies but only offer basic benefits in relation to most hospital treatments, including psych. One fund has recently started marketing a product exactly like that. It only provides hospital cover in the

102 Dr Michael Coglin, CMO, Healthcope Ltd, *Committee Hansard*, 5 July 2005, p. 16.

103 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 20.

case of accidents or sporting injuries. For most things it provides only the minimum, restricted benefit, including for psych.¹⁰⁴

12.115 The argument put by APHA that these types of products limiting benefits to young people are 'not fit for purpose' certainly has merit when considering the legislation as it stands. Under private health fund registration requirements 'each applicable benefits arrangement...must provide for benefits to be payable in respect of all kinds of hospital treatment that are one or more of the following; palliative care; rehabilitation; psychiatric care'.¹⁰⁵ The legislation also provides that the waiting period for such benefits 'will not exceed 2 months'.¹⁰⁶

12.116 In terms of products where there are exclusions the PHIO advises:

Some members may choose products that exclude certain procedures, to reduce the costs of premiums or for lifestyle reasons.

Where the previous fund product has an exclusion attached, and the member is seeking to transfer to a product without an exclusion, the fund has the right to apply the legislated waiting periods before the member is entitled to the higher benefits under the new fund.¹⁰⁷

12.117 Ms Gee, APHA, said:

You would be aware that health insurers are prohibited by law from excluding benefits for mental health services in their products. However, some insurers have found creative ways around this by, for example, imposing a limitation on how many occasions a patient may receive benefits for a particular type of service in a calendar year or refusing outright to fund particular types of programs. Another way around this ban is for health insurers to pay benefits for private mental health services at only the default safety net rate, which is set well below the cost of providing patients with the care they need. The result is patients either facing large out-of-pocket costs, seeking care in the overburdened public health system or forgoing treatment altogether and risking deterioration of their illness.¹⁰⁸

12.118 The NNPPSC advise that the 'default rate can be \$150 to \$200 per day below the actual service cost'.¹⁰⁹ Dr Coglin, suggests that the out-of-pocket expenses are even greater than this:

104 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 20.

105 *National Health Act 1953*, Schedule 1, para. 1(bf).

106 *National Health Act 1953*, Schedule 1, para. 1(ja).

107 PHIO pamphlet, *The Right to Change – Portability in Health Insurance*, <http://www.phio.org.au/showbrochure.php?id=70>, (accessed September 2005)

108 Ms Christine Gee, Vice-President, APHA, *Committee Hansard*, 4 July 2005, p. 51.

109 NNPPSCC, *Submission 189*, p. 8.

They would get what is called the ministerial default benefit, which is the minimum statutory benefit, which typically is about half the contracted price that would exist were a contract exists between Australian Unity or any other fund and the hospital. In a mental health hospital, the fund would have as its contracted price—in round figures—\$500 a day. The minimum default benefit would be \$250¹¹⁰ a day. The patient would have to find the other \$250 a day above that.¹¹¹

12.119 Dr Coglin also advised 'that the average length of stay at the Melbourne Clinic is around 18 days' and 'people with chronic mental illness typically are occasional participants in the work force and do not have high levels of income and savings, so the imposition of a \$250 a day out-of-pocket cost for a protracted hospital stay, with the possibility of recurring admissions going forward, is not an option'.¹¹²

12.120 Accordingly, it is not difficult to see how out-of-pocket expenses for privately covered mental health patients could soon become overwhelming, particularly as patients require longer-term hospitalisation.

12.121 Ms Gee also went on to say:

Allied to this issue 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.¹¹³

12.122 Ms Susan Williams, National Manager Psychiatry, Healthscope hospitals, said private hospitals strive very hard to develop alternatives to inpatient care and that Healthscope have 'something like 70 per cent growth in... day programs' and 'about 80 per cent growth in outreach' programs where they visit people in their homes. She also raised concerns that every time they attempt to 'substitute in-patient care through either day patient care or home based care', they have a fight with the health funds.

12.123 Ms Williams explained:

They see it as an add-on; they do not see it as a substitute. We have been able to demonstrate that the readmission rate and the length of stay for chronic patients who are cared for in outreach are significantly reduced as a result of that. There are a number of hospitals across Australia that have approval federally to provide hospital care in the home, but the health funds

110 The Ministerial default amount as at 1 July 2005 is \$261 for overnight treatment in a shared ward and \$157 per day for outreach services. DoHA, *Private Health Insurance Circular—PHI 45/05*, 29 September 2005.

111 Dr Michael Coglin, CMO, Healthscope Ltd, *Committee Hansard*, 5 July 2005, pp. 17–18.

112 Dr Michael Coglin, CMO, Healthscope Ltd, *Committee Hansard*, 5 July 2005, p. 16.

113 Ms Christine Gee, Vice-President, APHA, *Committee Hansard*, 4 July 2005, p. 51.

will not provide a viable rate for them to provide the service in the community.¹¹⁴

12.124 Ms Williams and Dr Coglin referred the committee to a Commonwealth funded and sponsored 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 committee was also advised 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'.¹¹⁵

12.125 Dr Coglin, advised the committee, however, that one insurer did not participate in the project simply because the payments were not subject to the reinsurance pool, 'they are borne only by the fund that the patient belongs to and are not shared collectively by all health funds', regardless of the actual savings identified.¹¹⁶

12.126 Ms Williams and Dr Coglin were also concerned that some health funds were capping Healthscope outreach services, saying 'we're going to limit it to 20 visits a year' with the resultant effect of these persons returning to in-patient care if they relapse. There was particular concern that this figure of 20 seemed arbitrary and was not based upon any clinical assessment of the fund member.¹¹⁷

12.127 Mr Russell Schneider, on behalf of the private health insurers asserted:

Some of the most innovative funding arrangements in the private health area have occurred in the area of mental health, despite a number of legislative barriers. Arrangements are currently based on principles of ensuring that there is a range of suitable alternative services, if possible, to substitute for hospitalisation, an emphasis on delivering the appropriate treatment in the appropriate setting and ensuring the appropriateness of utilisation.¹¹⁸

12.128 Mr Schneider explained:

114 Healthscope Ltd, *Committee Hansard*, 5 July 2005, pp. 20–21.

115 Ms Susan Williams and Dr Michael Coglin, Healthcope Ltd, *Committee Hansard*, 5 July 2005, p. 21.

116 Dr Michael Coglin, CMO, Healthcope Ltd, *Committee Hansard*, 5 July 2005, p. 21.

117 Dr Michael Coglin, CMO, Healthcope Ltd, *Committee Hansard*, 5 July 2005, p. 21.

118 Mr Russell Schneider, CEO, AHIA, *Committee Hansard*, 4 July 2005, p. 59.

Insurers believe that there should be more emphasis, whenever appropriate, on community programs in lieu of hospitalisation, particularly if those hospitalisations are repeated but avoidable.¹¹⁹

12.129 And further:

I think we have to realise that health insurers are always in an exquisite dilemma of trying to combine two conflicting situations. One is the provision of benefits to the level which providers would like; the other is ensuring that premiums are kept sufficiently affordable for the consumer to be able to be insured. As a result of that there are at times some restrictions on benefits, particularly those that are lower priced, because the only way you can provide people with access to a low-priced product is obviously to do one of two things; firstly, restrict people who take out that product to people who are unlikely to claim or, secondly, reduce the benefits that you are going to pay.¹²⁰

12.130 Whilst this approach appears to equate to commercially sound practice, it is questionable as to whether it conforms to the principles of the community-rating model. On its face the practice appears to discriminate against people suffering from mental illness on the basis that the costs cannot be shared across the fund. The approach appears to be more risk-rated.

12.131 The removal of the rigidities in relying upon in-patient care for persons suffering from poor mental health has been recognised by some health funds.

12.132 The PHIO advised the committee that 'some programs offered by private hospitals involve an element of out-patient care and sometimes there can be disputes with funds or different attitudes taken by different funds as to how much of that program they will be prepared to fund'.¹²¹

12.133 The PHIO further 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.¹²²

12.134 The PHIO highlighted an innovative model currently being offered though the BUPA private health insurance fund and Ramsay's hospital in South Australia. Under this model the fund provides, in essence, a capital grant to the hospital for each member with psychiatric illness as opposed to funding on an episodic basis. The

119 Mr Russell Schneider, CEO, AHIA, *Committee Hansard*, 4 July 2005, p. 59.

120 Mr Russell Schneider, CEO, AHIA, *Committee Hansard*, 4 July 2005, p. 60.

121 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 21.

122 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 21.

hospital then designs the most appropriate program to treat the patient, including the provision of in-patient care, out-patient care, community or even home-based care. The PHIO saw this as a very flexible model, but emphasised that specific legislative authorisation was needed to allow the piloting of the program.¹²³

12.135 The AHIA provided further information about the funding model, referred to as 'Prospective Payment Model':

As part of the model, RHC [Ramsay Health Care] are paid an agreed annual figure spread over 12 monthly payments of equal value within each year. Therefore, for the first time, hospitals are assured of a known and regular income and able to plan for financial investment in alternative services.¹²⁴

12.136 This model therefore 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.

12.137 AHIA reported the positive outcomes of the Prospective Payment funding model, stating: 'Since inception the Model has seen more members cared for with a greater range of services'.¹²⁵ Some of the outcomes included: 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.

Concluding remarks

12.138 Whilst there have been a number of issues of concern raised by stakeholders the PHIO advised the committee:

Despite all of the rhetoric and arguments around portability, there is an effective portability regime operating in health insurance at the moment. I have seen no instances of hospitals denying people portability rights on transfer, even when there has been contract dispute.¹²⁶

12.139 The PHIO further advised:

No fund has broken ranks on portability, and no other fund has sought to adopt the AU [Australian Unity] approach of benefit limitation periods on psych people transferring. My assessment is that there has been no real impact on consumers as a result of the AU changes – other than the fact that the opportunity for them to join Australian Unity is not there. But, in most

123 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 21.

124 Hon. Dr Michael Armitage, CEO, AHIA, *Submission 292a*, p. 3.

125 Hon. Dr Michael Armitage, CEO, AHIA, *Submission 292a*, p. 3.

126 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 16.

cases, consumers have between 12 and 15 other funds that they can transfer to without detriment, and most have taken that opportunity.¹²⁷

12.140 The Commonwealth government's circulated condition of registration relating to benefit limitations periods and evidence provided by the PHIO indicates that the practice of imposing benefit limitation periods will soon be outlawed, therefore the main criticism of the portability regime will no longer be applicable. However, issues pertaining to the nature of health insurance products, including the use of product restrictions and exclusions, particularly those targeted at and marketed to young people, will continue to remain an issue even though there is a minimum default level of cover for psychiatric patients.

12.141 The committee heard evidence from the private hospital sector that they have capacity to provide innovative services relating to in-patient care and intensive home based care, however were being frustrated by health funds not providing sufficient coverage for their members. They also argued, as did the PHIO, that the public system does not have the capacity to effectively deal with patients who drop out of the private system.

12.142 Dr Chamley too suggested:

The amber light ought to be flashing for state governments here also. I predict that if contributors to private health insurance come to a view that, in respects of coverage for mental health, the private insurers can sidestep some of their prudential obligations, then over time consumers will terminate their private health cover and this is going to put even more pressure upon the public mental health services. Maybe this is the real game of plan of the insurance providers.¹²⁸

12.143 The committee notes however that evidence in other chapters suggests that the many inadequacies of public mental health services and the fact that only the most seriously ill receive attention means that the 'pressure' of people exiting the private system would scarcely make a difference to the already great level of unmet demand.

12.144 The private health insurance sector, nonetheless, advised the committee that they were very much interested in identifying innovative community program approaches to mental health service delivery and the committee is aware that this would likely require legislative change but is not in a position to endorse or otherwise such change.

12.145 The committee received evidence about a successful collaboration between BUPA and the Ramsay's hospital group in South Australia. By moving away from an episodic fee for service model, the program enables individually tailored treatment

127 Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 17.

128 Dr Wayne Chamley, *Submission 339*, p. 11.

programs to be developed, including in-patient, out-patient, community and home-based care. The positive results of the program are clear:

...since the introduction of the new funding model the focus of care has become more tuned to the individual, with staff taking more time to determine what is the best treatment option for each person. With a variety of services now available, staff are able to recommend the treatment approach that is most suitable.¹²⁹

12.146 This program indicates that there can be innovative service delivery amid collaboration between private hospitals and the health insurance sector. However, the Committee remains concerned that the private hospital sector, by focussing predominantly on in-patient services, provides a largely institutionalised approach to mental health services. This focus runs against the continuing public policy of deinstitutionalisation and increased provision of community-based services.

12.147 The committee agrees that health insurance products that do not provide adequate care for psychiatric illnesses, regardless of the ministerial default payments, are 'not fit for purpose' and the Commonwealth government should take action to outlaw such products.

129 Ramsay Health Care, quoted in AHIA, *Submission 292a*, p. 3.