Attachment 1

Private Health Insurance

The private sector offers a full range of psychiatric services, from acute interventions through to ongoing care for the chronically ill. Treatment may be provided on an overnight stay basis, by attendance at day only programs, at outpatient clinics, or at outreach services such as hospital in the home.

Private health insurance is different from most other types of insurance because it is community rated, not risk rated. The principle of community rating is that persons should not be discriminated against in obtaining or retaining insurance coverage. 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. Community rating has underpinned the operation of Australia's private heath insurance industry for many years.

The portability provisions of the *National Health Act 1953* enable health fund members to transfer between funds to broadly comparable products, without having to re-serve waiting periods. The provisions were essentially designed to support the movement of individuals between funds. Concerns have been raised about the portability of private health insurance for people with mental illness. The government and the industry are presently working together to clarify members' entitlements should they wish to transfer to another fund, particularly where the move is prompted by a contract dispute between a hospital and health fund.

Payment of Private Health Insurance Benefits

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. This can largely be attributed to the principle of community rating, which Australia adopted in the late 1950s.

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

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

This applies to all privately insured patients, not only those seeking mental health services.

Doctors' Fees

When 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.

Hospital Accommodation

Health funds will also cover some or all hospital accommodation costs for care, which may be provided as an admitted overnight consumer, on a day basis or an outreach basis (usually in the consumer's home). 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. This amount is currently an average of $250 for overnight treatment in a shared ward and $153 per day for outreach services.

Hospitals and health funds are able to enter into contractual agreements for payment of accommodation rates above the Commonwealth determined default rates. These agreements are widely used and may also:

- place conditions on the payment of psychiatric benefits;
- vary between 100 % cover for hospital related costs to partial cover with the consumer paying a known co-payment; and
- cover the payment of benefits on a total or episodic basis, that is, in a lump sum payment.

The flexibility allowed by the contracting arrangements recognises the right of 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.

Nonetheless, there is nothing to preclude private hospitals from charging a rate above the default benefit rate (when there is no contract with the health fund), in which case the consumer would be responsible for the difference.

Ancillary Benefits

In addition, health funds may also pay benefits for non-admitted services offered by allied health care professionals, such as clinical psychologists from their ancillary tables. Health funds are less regulated in relation to ancillary health benefits, with the main restriction being that benefits cannot be paid for non-admitted hospital services for which a Medicare benefit is payable, for example a general practitioner or specialist psychiatrist service.

Individual health funds have considerable scope to determine the nature of the goods and services that attract ancillary benefits and any limitations on such benefits. However, the legislation does require that these tables be community rated. These benefits are usually capped at a dollar figure per service and/or a total annual dollar figure.

Benefits paid for Mental Health Services

Private health insurance funds provide benefits for a range of services provided by psychiatrists, general practitioners and hospitals. In 2001-02, they provided $145 million, or 5% of all direct funding (see Table 1).

Health insurance benefits for psychiatric care in private hospitals are generally paid for services provided within psychiatric treatment programs which have been approved by individual health funds. Guidelines to assist health funds with the approval process have been developed by the Strategic Planning Group for Private Psychiatric Services (SPGPPS) which is a representative body consisting of private sector providers, consumers, and the Australian Government. The guidelines are also available to State and Territory health authorities for use in public hospitals. These Guidelines are available on the SPGPPS website at:
http://www.spgpps.com.au/spgpps/general_documents.html

Health funds will cover some or all hospital accommodation costs for care, which may be provided as an admitted overnight consumer, on a day basis or an outreach basis (usually in the consumer's home). In addition, health funds may also pay benefits under ancillary tables, for non-admitted services offered by allied health care professionals, such as clinical psychologists from their ancillary tables. Ancillary benefits cannot be paid for non-admitted hospital services for which a Medicare benefit is payable, for example a general practitioner or specialist psychiatrist service.

Number of Services

Hospital Casemix Protocol (HCP) data, collected by the Department of Health and Ageing, is a valuable source of information about the private health insurance industry. HCP data shows a significant increase in the number of private mental health services delivered in Australia. In the four years since 1998/1999, the number of services provided has increased from approximately 32,000 to 69,000. This represents a growth of around 113% from 1997-98 to 2002-03, as shown in Table 1. As a proportion of all private health insurance funded episodes, this is an increase from 2.1% to 3.2%.

Amount of Benefits

The amount of benefits paid for private mental health services has remained static at 2.4% of all hospital benefits paid by health funds. The average cost per episode has fallen over the period 1997-98 to 2002-03. This may be due to more care being delivered on day only basis (from 9% to 14% of all private mental health episodes) or on an outreach basis.

TABLE 1: Mental Health Episodes, Charges and Benefits

Year	Mental Health episodes	As a proportion of total episodes	Charges	Private health insurance benefits	As a proportion of total private health insurance hospital benefits
1997-98	32,406	2.10%	$74.2m	$69.7m	2.38%
1998-99	32,329	2.11%	$74.1m	$67.2m	2.19%
1999-00	39,576	2.37%	$84.4m	$72.4m	2.29%
2000-01	46,416	2.49%	$97.4m	$87.4m	2.35%
2001-02	59,385	2.70%	$112.8m	$108.7m	2.44%
2002-03	69,053	3.16%	$127.6m	$116.0m	2.39%

Service Delivery and the Role of Private Hospitals

The private hospital sector in Australia provides a significant level of hospital treatment for people with mental illness. There are 42 private hospitals with psychiatric beds out of approximately 300 private hospitals. The distribution of private hospitals offering a comprehensive range of psychiatric services is shown in the following table.

TABLE 2: Private Hospitals and Mental Health Services

State/Territory	Stand alone psychiatric hospitals	Hospitals with designated psychiatric programs	Hospitals with psychiatric outreach programs	Total
NSW	9	3	3	12
VIC	6	3	7	9
QLD	5	6	5	11
WA	2	2	-	4
SA	3	-	2	3
NT	-	-	-	-
ACT	-	1	-	1
TAS	1	1	1	2
Australia	26	16	18	42

(Source: Strategic Planning Group for Private Psychiatric Services and Department of Health and Ageing)

The advent of private outreach services, established by the Australian Government, has been one of the most important developments for the health insurance and private hospital sectors in recent years. Treatment provided through an outreach service is a direct substitute for the treatment that would have been provided to the patient in a hospital or day hospital facility. Commonly known as Hospital in the Home, outreach services are particularly well suited to the provision of mental health care. Private hospitals that wish to deliver services on an outreach basis must go through a rigorous application and assessment process with the Department of Health Ageing to ensure that there are appropriate quality controls in place for this model of care. Currently 33 service providers have been approved, covering 44 facilities across the country. Of these, 12 are psychiatric services provided out of 18 facilities.