Submission

Royal Commission into Victoria's Mental Health System

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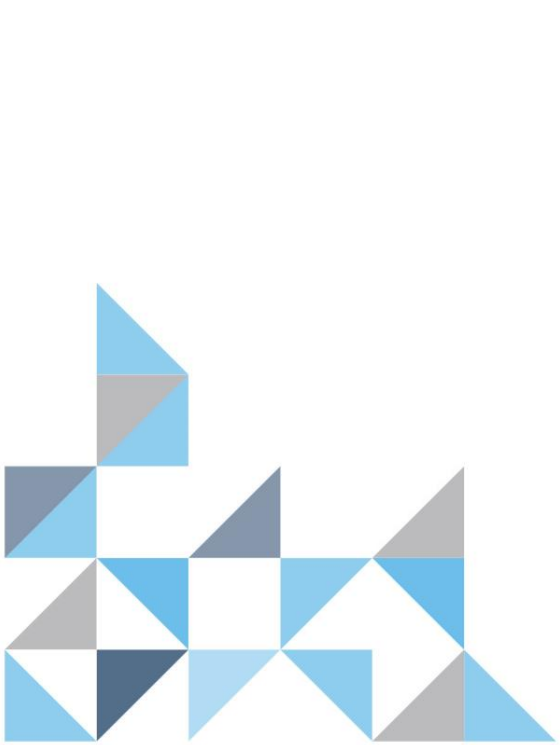

Royal Commission into Victoria's Mental Health System

Established in Sydney in 1964 by Paul Ramsay AO, Ramsay Health Care (RHC) is a global health care company with more than 50 years of experience in providing acute health care services. Ramsay facilities cater for a broad range of health care needs from primary care to highly complex surgery, rehabilitation and mental health care.

In Australia, RHC operates 72 hospitals with circa 25,000 beds, treats over 1 million patients each year and employs over 30,000 staff. Ramsay is the largest provider of private acute psychiatric services with 23 facilities admitting circa 70,000 patients each year.

Ramsay also operates a wide network of rural and regional hospitals across the country, many of which offer mental health services including Cairns, Rockhampton, Albury, Coffs Harbour, Newcastle, Gold Coast, Caloundra, Orange, and Shepparton, giving the Company a unique understanding of the challenges involved in delivering mental health services in rural and regional Australia.

In addition to its comprehensive range of private hospitals with mental health services, RHC also operates five public facilities in Australia on behalf of state governments, two of which have extensive public mental health services – Joondalup in Western Australia and Mildura in Victoria.

Joondalup Health Campus is a comprehensive teaching hospital with over 600 beds operating as one of the busiest emergency centres in the country, seeing over 110,000 presentations per annum. The hospital runs a 47-bed mental health unit, with an additional 10 bed mental health observation unit that within the emergency department. Mildura Base Hospital has a 12-bed inpatient facility as well as community mental health services. Ramsay also operates the local Headspace service on behalf of the local Primary Health Network, which sees 600 young people each year.

Globally, the company employs more than 77,000 staff and treats 8.5 million patients in its hospitals and primary care clinics located as far as Australia, France, the United Kingdom, Sweden, Norway, Denmark, Germany, Italy, Malaysia, Indonesia and Hong Kong.

THE CURRENT STATE OF MENTAL HEALTH

While Australia has made progress in caring for mental health patients, significant challenges remain. The number of patients with a diagnosed mental health condition is growing with one in five Australians experiencing a mental health condition this year. Approximately 11.5% will

have at least one diagnosed mental health condition and 8.5% will have two mental health diagnoses. There were more than 3,100 deaths from suicide in 2017, with the age group 15 – 44 having the highest rate of suicide. People with mental illness have a lower average life expectancy than the general population, with significant comorbidity issues. Eating disorders have one of the highest mortality rates of any psychiatric illness and the number of presentations is growing.

In addition to the significant personal toll mental illness inflicts, the economic consequences are immense. In the workplace, mild depression lowers labour productivity by an estimated 4 per cent, rising to approximately 10 per cent for severe depression.[1] In 2014, the cost of health care, welfare and lost productivity resulting from mental illness is estimated to have cost the Australian economy a staggering $56.7 billion.[2]

Nearly a million Victorians experience mental illness annually.[3] In 2016 it is estimated that approximately 20,000 Victorians attempted suicide and over 600 individuals died.[4,5] Nearly half of Victorian adults - some 2.2 million people - experience mental illness of some degree in their lifetime.[6]

According to Mental Health Victoria, the State's expenditure per capita on mental health services is the lowest in the country, and 13 per cent lower than the national average.[5] Access to mental health services is 40 per cent lower than the national average.[6] Crucial community services are being cut to fund the National Disability Insurance Scheme (NDIS), while at least 1,000 specialist mental health workers are set to lose their positions.

RHC therefore believes this Royal Commission into Victoria's Mental Health System is long overdue and welcomes the opportunity to make this submission.

We believe that too often, those in need of services at some of the worst periods of their lives are lost to a maze of mental health provision, with community mental health and the public system failing to interface properly. Clinical oversight is often poor as people navigate this system, and the State lacks the capacity to invest in the necessary infrastructure to meet burgeoning demand. Funding mechanisms discourage the full use of private services and are in need of overhaul to enable the use of the private sector effectively.

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[1] McTernan, W.P., Dollard, M.F., and LaMontagne, A.D., Depression in the workplace: An economic cost analysis of depression-related productivity loss attributable to job strain and bullying, Work and Stress, 27:4, p.321-338.

[2] Victoria Institute of Strategic Economic Studies, The Economic Cost of Serious Mental Illness and comorbidities in Australian and New Zealand, 2016, p.5, [prepared for the Royal Australian and New Zealand College of Psychiatrists]

[3] Mental Health Victoria, Saving Lives, Saving Money: The Case for Better Investment in Victorian Mental Health, June 2018, p.10.

[4] Ibid, p.13.

[5] ABS report 3303.0 - Causes of Death, Australia, 2017. Accessed 4th July, 2019. Intentional Self Harm, Key Statistics

[5] Saving Lives, Saving Money: The Case for Better Investment in Victorian Mental Health, p.4.

[6] Ibid.

Ramsay Health Care believes:

- That the current system is failing patients and not delivering best-value for the State.
- That the private sector can be better utilised in the delivery of mental health services, having credentials, credibility and clinical expertise is the sector.
- Integration between public, private and community providers must be improved, as does the mapping of the system, and the purchasing of services.
- That existing mental health funding arrangements are in dire need of overhaul.

ACUTE / INPATIENT MENTAL HEALTH CARE

As the largest provider of mental health and emergency care, public hospitals give priority to the treatment of disorders that are lower in prevalence, but that put patients at immediate risk to themselves or others. As a consequence, psychiatric wards in public hospitals are frequently unable to meet demand for the inpatient mental health care of higher prevalence but less critical disorders, and services are frequently stretched to capacity.

Delayed access to existing services is growing rapidly. Ninety percent of patients are not seen in an acute care facility and are not able to access care that provides a structured program to assist the management of the condition. In 2016-17, only 38 per cent of the 276,954 people who presented at public hospital emergency departments across Australia seeking care for mental health related illnesses were admitted or referred elsewhere.[7]

Conversely, in 2016/2017 there were 258,302 overnight admissions for a mental health disorder, with 52,039 of these in the private psychiatric wards. Of these admissions, in the public system schizophrenic disorders were responsible for 1 in 5 admissions compared to 1 in 40 admissions in the private sector. In the private sector, depressive disorders were responsible for 1 in 4 admissions.

Ambulatory care (treatment provided to a patient who is not an overnight inpatient) is also recognised as a crucial component of hospital-based mental health care. Ambulatory care can consist of a wide variety of specialist treatment therapies and programs delivered by multidisciplinary teams. It is an effective treatment option for patients with moderate to severe mental health conditions who do not require 24-hour inpatient care.[8]

Private Healthcare Australia reports that clinicians often note that hospital admission frequently assisted the recovery process by helping patients to recognise their own condition as a genuine

[7] *Australian Institute of Health and Welfare,* Mental health services: In brief 2018*, p.8, available at: https://www.aihw.gov.au/getmedia/0e102c2f-694b-4949-84fb-e5db1c941a58/aihw-hse-211.pdf.aspx?inline=true [accessed 5 July 2019).*

[8] *Australian Private Hospitals Association, Improved Models of Care – Mental Health, 25 September 2018, p. 10.*

sickness.[9] The Australian Institute of Health and Welfare reports that 72.5% of completed hospital stays in 2015-16 claim significant improvement in the admitted person's mental health.[10] That said, clinicians are raising questions about whether hospital admissions would be necessary if patients had better access to more appropriate care earlier. They also question whether day admissions for certain services have any clinical value or should be delivered in inpatient hospital settings at all.[11]

Public hospitals are not adequately resourced to treat or refer the majority of patients who present to them with mental health illnesses, and private hospitals are treating only a very small number of the most serious cases. There are sizeable gaps in services and supports for specific demographics, including youth, elderly, Indigenous Australians, individuals from culturally diverse backgrounds and carers of people with a mental illness.

The dedicated specialist knowledge about the treatment of higher prevalence mood and anxiety illnesses is often less developed in public sector hospitals. In order to fulfil involuntary treatment orders, or effectively treat patients with severe, low prevalence mental illnesses, inpatient care in the public sector is often custodial in nature.

Patients with higher prevalence mental health disorders are significantly more likely to seek the treatment they require, and treatment should be far more cooperative. Public hospitals are simply not equipped to manage non-psychotic, medium to higher prevalence disorders on an in-patient basis. Consequently, these conditions are the most common diagnoses in private psychiatric hospitals, without which these patients would have not public hospital-based treatment options.[12]

There is significant scope for private hospitals to provide access to mental health services to a far greater number of patients with severe, lower prevalence mental illnesses. In turn, this would alleviate the strain on public sector hospitals, allowing them to also provide better and more services (including community-based care) to the larger number of patients with high prevalence, less severe mental illnesses.

RHC believes there is a case for the private sector to operate public mental health, alleviating the State of the financial and organisational pressures. The private sector has the capital to do so, and with long term contracts could build and operate public mental health services with efficiency and clinical excellence.

[9] *Private Healthcare Australia, Submission to the Productivity Commission Inquiry into Mental Health, 5 April 2019, p.17.*
[10] *Australian Institute of Health and Welfare, Mental Health Services – in Brief 2018, 11 October 2018, p.32.*
[11] *Private Healthcare Australia, Submission to the Productivity Commission Inquiry into Mental Health, 5 April 2019, p.18.*
[12] *Australian Private Hospitals Association, Improved Models of Care – Mental Health, 25 September 2018, p. 4.*

Many countries run such models. For example, The Priory Group is a private operator that runs a range of public mental health and social services in the UK and provides beds for National Health Service patients in 87 of its hospitals, including for addiction, eating disorders and other higher prevalence mental health issues.

Inpatient services are just one aspect of mental health care, and hospital inpatient services appear to be compensating for a dearth of public access to more appropriate outpatient treatments, which in turn compounds pressure on the public system.

COMMUNITY PROVISION AND SERVICE MAPPING

There is a tension between the use of community providers for mental health services and the broader health system. Community mental health providers are strained, not easily located, mapped nor assessed. Importantly, community services are often opaque to consumers, who have to locate their own services. There is limited, if any available public data on accessibility, program offering, efficacy or costs. The purchasing of mental health services across the sector is a maze, with health services, private providers and central agencies all purchasing services[13][14].

Residential treatment for alcohol and other drugs, where people in acute need are asked to locate their own service often rely on twelve steps modalities and are residential in nature, with limited assessment of their completion rates or longer-term success[15].

The private sector provides a number of services which can easily be mapped and accessed. Much of these can be accessed through private health insurance, are evidence based, build life skills and deliver a continuity of care which gives patients the best chance of a full and successful life. The interface of these programs with the public system needs further exploration.

The private sector has the agility, clinical expertise, capital and experience to invest to meet growing demand in mental health facilities, which the State will be unable to do in the immediate future.

[13] *VAGO, Access to Mental Health Services, available at: https://www.audit.vic.gov.au/report/access-mental-health-services?section=33104--audit-overview, [accessed 24 June 2019).*

[14] *The Age, Nothing between GP and Emergency, available at: https://www.theage.com.au/politics/victoria/nothing-between-gp-and-emergency-victoria-s-mental-health-failure-20190227-p510ip.html, [accessed 24 June 2019).*

[15] *The Conversation, Drug rehab and group therapy: do they work? Available at: https://theconversation.com/drug-rehab-and-group-therapy-do-they-work-65413, [accessed 26 June 2019).*

OUTPATIENT MENTAL HEALTH SERVICES

While a period of hospitalisation may be necessary to stabilise a patient, there is a universal concern among clinicians about the lack of a graded, coordinated path for access to the mental health care system, with the result being that individuals do not always receive the appropriate treatment. Significant support exists among clinicians for a better mix of inpatient, outpatient and community care.

The failure to provide the right clinician, setting and treatment at the appropriate time is resulting in patients being admitted as inpatients to hospitals because the appropriate treatment modalities (that in many cases should precede hospitalisation) are not clear or accessible. As stated previously, the system is complex, difficult to navigate and poorly mapped.

There is also concern that hospitalisation unnecessarily and negatively reinforces the concept that patients are seriously sick and suffering ill-health, rather than the view that they are in the process of recovering their wellbeing.

A “stepped” mental health care system would retain the value of hospital admissions where clinical indicators support them, provide more appropriate treatment paths where necessary, thereby reducing pressure on already strained hospitals. It would also increase patient choice and empowerment in the treatment of their illness.

Community-based care can supplement hospital admissions by providing acute treatment and hospital-in-the-home type services in the patient’s home or similar community-based setting, instead of via admission to overburdened emergency departments. It also has potential to minimise social isolation commonly associated with inpatient care and can better facilitate the reintegration of patients within the community.

Continued clinical oversight and ease of navigation is a key to a successful, patient-focussed mental health system, and the private sector must form a part of the solution in delivering that.

Patients may alternate between services or progress from one modality to another in accordance with their treatment. These may be delivered by a mixture of private and public sector providers. While in many cases providing services the public sector simply cannot, community mental health services are not currently required to follow up, support or provide services in the community once patients are discharged, and it becomes extremely difficult for subsequent providers to access important patient information.[16] A lack of continuity of care

[16] *Private Mental Health Consumer Carer Network, Submission to the Productivity Commission Inquiry into Mental Health, 27 March 2019, p.13.*

exists across the mental health continuum and for those with episodic conditions, who may need access to services on an irregular, or non-continuous basis.

Other crucial services catered for by community-based or outpatient specialist care therefore include services such as case management. This provides regular weekly, fortnightly or monthly contact that aims to reduce relapses and support patients with illnesses who do not require acute care but are at risk of deteriorating if they do not receive specialist ongoing support. This would underpin a truly integrated mental health system.

Considering the divide that public sector inpatient services tend to focus on low-prevalence, severe and acute mental illness, many patients are left with no alternative but to seek treatment from private providers via private psychiatrist referral.[17] Private mental health services provided in the community are often subject to co-payments that cumulatively serve as a potent disincentive for consumers to access these services, making day-stay admissions more attractive for patients. This is despite clinical evidence questioning their efficacy, and the additional financial burden they place on providers.[18]

In addition to expanding inpatient treatments currently provided by private hospitals, clearly there is significant scope for the private health sector to help establish a clearer, graded, joined up treatment pathway and increase its share of community-based, outreach and outpatient treatment provision for mental illness. The better integration of inpatient and outpatient services provided by public and private providers is also a key element of the reforms necessary to improve mental health care in Victoria.

The private sector is eminently able to facilitate such reforms. For example, the Institute of Private Practising Psychologists (IPPP) argues that psychologists could play a key role in both these elements. Psychologists are trained to provide care in clinical or community settings, undertaking early assessments to evaluate the best treatment path, consultancy and advice to other organisations and individuals in the health system, or by providing broader case management of clients.[19]

However, less than 4 per cent of private health insurance payments constitute mental health specialist overlays, such as psychologists. The application of specialist and outpatient expertise is currently restricted by the nature of funding arrangements.[20] This is another crucial element of necessary reform.

[17] *Australian Private Hospitals Association, Improved Models of Care – Mental Health, p. 14.*
[18] *Private Healthcare Australia, Submission to the Productivity Commission Inquiry into Mental Health, 5 April 2019, p.18.*
[19] *Institute of Private Practicing Psychologists, Initial Submission for the Productivity Inquiry into Mental Health, 11 April 2019, p.3*
[20] *Ibid.*

CURRENT PRIVATE HEALTH FUNDING REGIMEN

Health insurance is not available to fund Medicare Benefits Schedule services outside of hospitals. Private health insurance is only available for treatments of individuals in the acute phase of psychiatric illness that would not otherwise be available in the public sector and legislation prevents health insurance covering medical services outside of hospital, already covered by Medicare.

Private health insurance is further prohibited from covering services constituting hospital substitute treatment where 85 per cent of the Medicare schedule fee is claimed. Hospital substitute treatment is defined as general treatment, and funds are generally prevented from covering Medicare schedule services that qualify as such.

This is despite the fact that abundant evidence exists demonstrating that private care can effectively treat high-prevalence mental health conditions that the public sector is comparatively poor at treating.[21] As a result, if patients seek to obtain access to these privately, they must frequently self-fund.

These restrictions are a significant obstacle preventing patients from accessing funds for outpatient treatment. Resolving this will at minimum require amendment to the *Private Health Insurance Act 2007* to alleviate the restrictions on private health insurers to cover out-of-hospital mental health care services.

Funding availability should be directly proportionate to efficacy, ensuring that hospital-based and hospital-substitute care is accessible *and* delivered on an evidence base. This is not currently the case. For example, Psychologists and the services they provide are well established, evidence-based sources of effective treatment for mental illness. However, the IPPP identifies that the current available rebates mean psychologists must charge a significant gap to adequately support the provision of their services and treatment.

Low income earners are often unable cover this gap meaning access to good psychologists is reduced, or, alternatively, psychologists cut corners to reduce costs for their patients. This frequently results in poorer service provision and the need for subsequent, and ultimately more expensive cumulative treatments.[22]

[21] *Kroenke, K., and Unutzer, J., Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care, Journal of General Internal Medicine. 32.4, 2016.*

[22] *Institute of Private Practicing Psychologists, Initial Submission for the Productivity Inquiry into Mental Health, p.4.*

RECOMMENDATIONS

RHC recommendations fall broadly into two categories; operational structure and funding.

With regard to the operational structure of mental health care:

- The public sector is overstretched. RHC recommends increasing the role of the private mental health sector in future reforms, including directly in the delivery of public mental health services.
- Further investigation should be undertaken into international models of the private sector's role in the delivery of public mental health services.
- RHC recommends introducing opportunities to better share work and patients between public and private settings, streamlining pathways from public Emergency Departments to available beds in the private sector. The private sector is well placed to assist in this, for example, via specialist psychologists with case management expertise.
- A census and mapping exercise for mental health services needs to undertaken with providers and accessibility visible in real-time, so consumers can get care when they need it.
- Reviewing the role of private cover for private acute mental health care and the important contribution this makes to the community and in reducing the burden on public hospitals.

RHC recommends significant overhaul of existing mental health funding arrangements by:

- Investigating changes to the mental health funding arrangements such that the Commonwealth assumes responsibility for funding all ambulatory mental health services and the design of their delivery systems and governance arrangements.
- Addressing the shortfalls of the Medicare rebate for psychiatry, increasing the attractiveness of psychiatry as a profession for medical trainees while also ensuring better access and standard or treatments.
- Exploring new and innovative funding mechanisms to ensure that cost becomes a less significant barrier for individuals looking to access mental healthcare.
- Considering options in rural and regional communities to have private organisations act as the fundholders of the mental health funding – providing all the mental health ambulatory services, inpatient, outpatient and community services, reporting against measurable outcomes and delivering real solutions for their communities.
- Ensuring that effective evidence-based treatments are appropriately covered in funding arrangements.
- Investigating the accessibility of the disability support pension for psychiatric conditions to access private inpatient or day patient mental health services.