Consultation paper: private health insurance reforms – second wave

National Mental Health Commission (NMHC) Response

8 February 2021

About the National Mental Health Commission

The National Mental Health Commission (NMHC) provides cross-sectoral leadership on policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia. There are three main strands to the NMHC's work: monitoring and reporting on Australia's mental health and suicide prevention systems; providing independent advice to government and the community; and acting as a catalyst for change.

Background

The NMHC's underpinning principle is the Contributing Life Framework. This framework acknowledges that a fulfilling life requires more than just access to health care services. It means that people who experience mental illness can expect the same rights, opportunities, physical and mental health outcomes as the wider community.

We support the proposed reforms that work to:

- Improve access to PHI for younger people and those with a disability (including a psychosocial disability). Supporting mental health and wellbeing in younger years can reduce distress, disadvantage and disability over the lifetime and the associated costs. Early intervention is key to preventing mental illness later in life.
- Improve access to a wider range of allied health and other mental health professionals.
- Expand the range of service options that can be tailored to a person's level of need.

The NMHC will continue to monitor the PHI industry to ensure that products and policies respond adequately to the community's need to access an appropriate level of care across the sector.

CONSULTATION 1: INCREASING THE AGE OF DEPENDENTS TO ENCOURAGE YOUNGER PEOPLE AND ALSO PEOPLE WITH A DISABILITY TO MAINTAIN PRIVATE HEALTH INSURANCE

1. Should the maximum age for child dependents be 31 or when LHC typically applies (i.e.? 1 July following an individual's 31st birthday)?

2. Should eligibility of a dependent continue to be limited to people without a partner?

3. Should the age ranges of different categories of child dependents be standardised for all Private health insurers?

4. Should the conditions of dependence for the different categories of child dependents be standardised for all private health insurers?

5. Should the definition of 'dependent child' be simplified?

The definition of dependent is limited to the relationship between child and parent. Consideration should be given to a broader definitional range of that accounts for diverse family structures and

legal circumstances. For example a 'dependent child' living in a guardianship arrangement with a family member.

6. What purpose does the distinction between non student and student dependents serve and should this be retained?

7. Should the current 10 insured groups be rationalised by removing groups not being used by insurers?

8. What is the preferred criteria and mechanism for determining eligibility of people with a disability?

9. Should there be standardised arrangements for determining eligibility of people with a disability, or is it preferable to allow each insurer to determine its eligibility criteria?

10. Should eligibility of a dependent with a disability be limited to people without a partner?

Should there be a difference between the private health insurance benefit for a person with a disability according their status as a dependent or as part of a couple; this difference should be removed.

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

12. What is the regulatory burden associated with this proposal?

CONSULTATION 3: OUT OF HOSPITAL MENTAL HEALTH SERVICES

Background

The NMHC supports the expansion of out of hospital funded services that could increase access to the most appropriate services for consumers and carers. A skilled mental health multidisciplinary workforce extends beyond the clinical disciplines to appreciate the contributions a wide range of professionals can make across all types of care in the stepped care model, from frontline prevention and identification through a range of treatments, to recovery support and research. The skill mix necessary to provide essential components of care and meet the needs of presenting clients may vary between individual professionals, services and communities.

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

The Productivity Commission's Report into Mental Health 2020, describes the mental health Allied Health workforce as occupational therapists (OTs), physiotherapists, dieticians, some community mental health workers, some Aboriginal and Torres Strait Islander health workers, and some social workers. In addition, other professionals — such as counsellors and psychotherapists, peer Lived Experience Workers, youth workers, arts and music therapists, and people focusing on CALD interfaces with other services — provide key supports, primarily in non-clinical settings.

The NMHC supports Peer (or Lived Experience) Workers as an important part of the multidisciplinary mental health workforce.

Consideration should also be given to funding rehabilitation-type services. *Aftercare* is an emerging type of suicide prevention support. There is evidence of it reducing subsequent suicide attempts, Often in Australia, it's been provided by a combination of clinicians (e.g. nurses, psychologists) and peer workers. Initial evaluations of aftercare services have found the role of the peer (Lived Experience) workers is perhaps the most critical to a positive consumer experience.

2. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?

The NMHC supports access to an expanded list of allied health services to a broader range of conditions within a CDMP given the overlap between poor health outcomes and mental illness. The NMHC 2019 National Report noted evidence that the life expectancy gap is widening for people with severe mental illness, and that people across the continuum of severity of mental illness are experiencing poorer physical health outcomes than the general population.

3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

The NMHC supports the building of capability of the allied health professionals and mental health workforces to ensure that staff are equipped to understand and deliver effective mental health services. Lived Experience workers are an emerging part of the mental health workforce. There is work underway by the NMHC to develop guidelines to support the implementation of this valuable and as yet under-utilised allied health workforce.

4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?

Care co-ordination between primary and acute care and alcohol/mental health services needs to be strengthened. Additionally, care planning should consider the impact of social determinants and other risk factors such as economic, housing, employment, trauma and crisis events, marginalisation, poor physical health and nutrition, adverse childhood events and vulnerable communities.

As discussed in the NMHC Vision 2030 Blueprint, the complex range of health and social experiences means that people can fall through service gaps when their specific combination of need cannot be met. The intersection of mental health and other co-occurring health and social issues is a necessary consideration in enabling services to be delivered in a well-coordinated, integrated system with consistent, appropriate quality care available across the spectrum to each individual.

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

Services that do not have a scientific evidence base.

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

Identification of eligibility should be based as far as possible on the principles of equity and access. Insurance product design, pricing, underwriting, limitations and exclusions should give equitable access to insurance cover to a person who experiences mental illness.

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

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

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

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