26 April 2019

Dr Stephen King
Presiding Commissioner
Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Via online: www.pc.gov.au/inquiries/current/mental-health/submissions

Dear Dr King

THE SOCIAL AND ECONOMIC BENEFITS OF IMPROVING MENTAL HEALTH

Bupa welcomes the Productivity Commission's inquiry into mental health. The inquiry provides an opportunity to consider how Australia can build a mentally healthy population that contributes to the social and economic life of our country. Importantly, it also provides an opportunity to consider how to most effectively support those experiencing issues with their mental health both now and into the future – namely by improving access to and the quality of mental health services across the spectrum.

Bupa has significant experience in this area and is well-placed to contribute to the inquiry:

- As Australia's largest health insurer, we support more than 4.7 million customers in their health and wellbeing. Health insurers are the most significant funders of health services in Australia, apart from governments. It is in our interest to ensure health care services improve the wellbeing of customers, are effectively and efficiently delivered, and respond to customer preferences and needs. Our significant experience as a funder of mental health services has provided unique insights into the issues Australia's mental health sector faces, and these have informed the innovative care models in which we are investing. These insights and models of care inform much of this submission.

- We are also Australia's largest private provider of aged care, supporting around 6,700 residents across 72 care homes. Bupa's aged care homes are increasingly supporting residents with higher and more complex mental health care needs including schizophrenia, depression, anxiety, drug seeking behaviours, alcoholism, polypharmacy and other mental and behavioural issues. These conditions escalate in complexity when combined with dementia.

- Among other things, Bupa's broader health services offering includes responsibility (from 1 July 2019) for the health care delivered to Australia's Defence Force personnel on behalf of the Australian government. We also provide medical assessment services to some 250,000 onshore visa applicants annually through our national network of purpose-built medical centres and more than 160,000 case reviews by a skilled medical team of complex offshore cases on behalf of the Australian government.

- The Bupa Health Foundation is one of Australia's leading corporate foundations dedicated to health, most recently with a focus on research into mental health. Over the past 10 years, the Foundation has invested almost $30 million in over 100 projects that focus on translating Australian research into real health and care improvements.

- We have approximately 17,000 employees in Australia and consider an investment in their mental health a priority.

We would be pleased to discuss the attached response further with Commissioners.

Please contact Amanda Lean, Head of Government Relations and Public Policy should you require further information.

Yours sincerely

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Bupa submission

Productivity Commission Inquiry:
The social and economic benefits of improving mental health

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1 Executive summary

1.1 The outcomes we are seeking

The Productivity Commission's inquiry into mental health provides a unique opportunity to consider how we build a mentally healthy Australia by improving access to and the quality of mental health care. These are key focus areas for Bupa and inform our recommendations for reform.

As Australia's largest health insurer and the largest private provider of aged care, we want our customers to have access to the right care, at the right time, in the right setting. Our customers need seamless transitions along their care continuum.

We want their preferences and clinical needs to be reflected in the care they receive.

We want our customers to have access to mental health services that are integrated across providers and events.

Most importantly, we want the focus to be on the best possible mental health outcomes for consumers in an environment of affordable care.

1.2 The case for change

Health outcomes that enable Australians to live a productive and fulfilling life to the best of their ability should be at the core of the nation's mental health system. Instead, for people navigating the mental health system, the pathway is complex.

Mental health services are fragmented and uncoordinated and delivered across multiple levels of government as well as by private providers.

Too often, the focus is on inputs rather than outcomes. Services are not delivered in a timely manner, nor are they responsive to consumer needs or preferences. There are inadequate resources dedicated to prevention and early intervention.

There are also inadequate community-based services for people with moderate to severe mental health conditions. This is evidenced by a lack of access in both the public and private healthcare systems, and in the private sector, by the inappropriate use of inpatient facilities.

It is significant that there is a National Mental Health Plan but no clear and transparent process for the implementation of such a plan, nor clear accountabilities for federal and state health authorities.

The mental health care system is in drastic need of an overhaul with a view to permanent change.

Provision of mental health care requires a unique approach due to the burden, complexity and scope of mental health services and its interaction with other comorbidities. The opportunity is, therefore, to undertake reform that delivers support, care, treatment and follow-up in the most appropriate setting, and which aligns to consumer preferences. This requires a funding model that follows the individual and caters to their unique requirements and preferences.

1.3 Summary of recommendations

For Australians to have access to the right mental health care, at the right time, in the right setting, we make the following recommendations:

Putting the consumer, quality outcomes and choice at the centre of our mental health care system

1. Mental health support, treatment and funding should be more responsive to individuals' needs and preferences.
2. Those experiencing issues with their mental health should be encouraged to receive care in community settings (rather than acute settings) where it is their preference to do so and is clinically appropriate. Public and private investment should reflect these preferences. A greater focus on the quality of treatment outcomes is necessary and must be underpinned by a redesign of the funding model away from fee for service and towards fee for outcomes.
3. The approach to mental health needs to be along a continuum of care – from prevention to acute – with integrated service provision and information sharing to reflect this.
4. There must be greater funding for mental health services that cater to the at-risk and mild risk populations.

Actions required to address the above recommendations are listed in proposed action i.

Enabling private health insurers to assume a greater role in supporting customers in quality, customer centred and timely care

5. Private health insurers should have a greater role in supporting their customers in mental health care through:
    a. Amendments to the rules that would enable health funds to invest in early intervention and prevention activities;
    b. Amendments to the rules that would enable private health insurers to support their customers to receive care in the community rather than in acute settings where it is the customer's preference and clinically appropriate;
    c. Changing the incentive structures that determine how customers are treated, such as fee for service payments, and incentives for treatment in hospital where it is the costliest; and
    d. Encouraging health funds to invest in innovative care models.

Actions required to address the above recommendations are listed in proposed actions ii to v.

Addressing waste and allocating resources where they are most effective

6. Shining a light on low value care and discouraging it by shifting funding towards value-based outcomes (where value equals health outcomes that matter to patients divided by cost) rather than volume of services.
7. Undertaking a post implementation review of the long-term effectiveness and efficiency of the mental health waiver.
8. Support PHIs in directing resources to the care that will yield quality outcomes for their customers by reviewing guidelines that require minimum benefits be paid for certain services, which do not have a basis in evidence.
9. Establishing a Mental Health Clinical Trials Network.

Actions required to address the above recommendations are listed in proposed actions vi to x.

Aged care

10. Public financing of allied health services be restructured to incentivise mental health care in residential aged care homes.
11. Increased public investment in specialist facilities, such as psychogeriatric facilities, that cater for senior Australians living with challenging behaviours, mental health issues and/or dementia who cannot optimally be cared for within either an acute or mainstream aged care facility.

Actions required to address the above recommendations are listed as proposed actions xi and xii.

Workplace mental health

12. Provide the environment for greater investment in mentally health workplace initiatives which will directly impact on workplace productivity

Action required to address workplace mental health is listed as proposed action xiii.

1.4 Bupa's experience in mental health

Bupa has significant experience in mental health and is well-placed to contribute to the inquiry:

- As Australia's largest health insurer, we support more than 4.7 million customers in their health and wellbeing. Health insurers are the most significant funders of health services in Australia, apart from governments. It is in our interests to ensure health care services improve the wellbeing of customers, are effectively and efficiently delivered, and respond to customer preferences and needs. Our significant experience as a funder of mental health services has provided unique insights into the issues Australia's mental health sector faces and have informed the innovative care models in which we are investing. These insights and models of care inform the majority of this submission.

- We are also Australia's largest private provider of aged care, supporting around 6,700 residents across 72 care homes. Bupa's aged care homes are increasingly supporting residents with higher and more complex mental health care needs including schizophrenia, depression, anxiety, drug seeking behaviours, alcoholism, polypharmacy and other mental and behavioural issues. These conditions escalate in complexity when combined with dementia.

- Among other things, Bupa's broader health services offering includes responsibility (from 1 July 2019) for the health care delivered to Australia's Defence Force personnel on behalf of the Australian Government. We also provide medical assessment services to some 250,000 onshore visa applicants annually through our national network of purpose-built medical centres and more than 160,000 case reviews by a skilled medical team of complex offshore cases on behalf of the federal government.

- The Bupa Health Foundation is one of Australia's leading corporate foundations dedicated to health, most recently with a focus on research into mental health. Over the past 10 years, the Foundation has invested almost $30 million in over 100 projects that focus on translating Australian research into real health and care improvements.

- We have approximately 17,000 employees in Australia and consider an investment in their mental health a priority.

2 Putting the consumer, quality outcomes and choice at the centre of our mental health care system

All efforts to improve the healthcare system are to be commended. However, in Australia, reform has generally been undertaken at the margins, when a systemic overhaul is required. This is particularly evident in mental health with existing funding and delivery structures increasingly unable to provide outcomes consumers want and need.

The healthcare system we have today developed as a treatment system in response to patients needing care when they were acutely unwell. We are now living longer and living differently; the greatest burden of disease has shifted from infectious disease and acute injuries to chronic long-term conditions, yet the system has largely stayed the same.

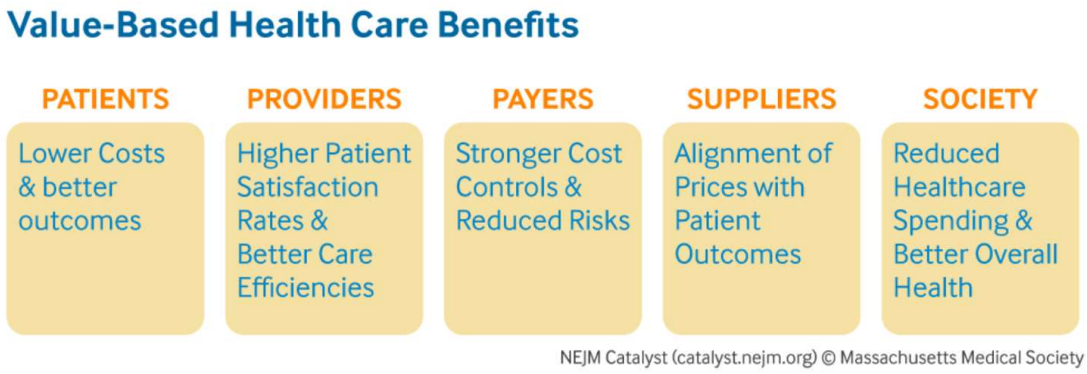
2.1 Incentivising value-based outcomes

Suppliers of health care services are paid according to the services they provide rather than the quality of the outcome achieved for the patient in their care. This is the most significant structural flaw within the current healthcare system. It means there are few incentives to provide the right care, in the right setting, at the right time. Because the consumer is not at the centre of the care journey, care is neither coordinated nor well connected.

This is particularly problematic for mental health care which requires a unique approach due its burden, complexity and scope, as well as its interaction with other comorbidities.

Substantive change within the health sector based on value-based principles is required, where value equals health outcomes that matter to patients divided by cost. This is consistent with Bupa's experience that consistently shows consumers hold greater expectations and want more understanding of what care they would like to receive and what they expect from their health journey.

As the diagram below highlights, a value-based approach to healthcare will improve health outcomes that matter to patients by evolving how we receive and provide care. This will be achieved with a focus on delivering and measuring health outcomes and using insights to further inform expenditure, clinical models and the experience of receiving and giving care. A value-based approach to mental health care would yield substantial results in both achieving enhanced outcomes for patients and more efficient delivery of care.



2.2 Providing a seamless mental health 'experience' for consumers

From a consumer's point of view, a health event either has a beginning and end or it is an ongoing issue that requires management over time. This is not always the case with mental health, which can be relapsing and remitting. A fundamental structural flaw within our health system is that it does not respond to health events in an integrated manner, but sees them, and the care required to manage them, as episodic. Events are categorised as either hospital or out-patient episodes, with funding following these classifications rather than the consumer 'journey'. Further complicating this distinction are systems and records that are siloed and inhibit the flow of relevant information between healthcare providers.

Parts of the health care system are trying to move towards alternate settings of care, which are more efficient and offer a more integrated customer experience, however, the historic funding models are stifling this. Continuing the categorisation of services as either in or out-patient is not serving consumers' best interest and is limiting choice. A best practice mental health system would see funding follow the patient, their needs, and their preferences, along the continuum of care. This would be aided by the measurement of health outcomes which provides evidence of where and when the best care should be provided.

Compounding this issue is the shortage of publicly funded community-based mental health services which means Australians who may require care have suboptimal access to services that would enable them to live well in their community. Those experiencing a mental health issue often have limited options other than to pay significant out-of-pocket costs, continue to deteriorate and/or be (re)admitted to hospital. This 'revolving door' perpetuates the worst inefficiencies of the system; that is, a lack of funded community mental health services increases demand for expensive in-patient mental health care.

Actions required:

i. **Consider a roadmap for the adoption of value-based principles in the delivery of mental health care in Australia and a funding model that would support such an approach.**

3 Enabling private health insurers to assume a greater role in supporting customers in quality, customer centred and timely care

Private health insurers have a meaningful role to play in reducing the financial burden on both consumers and the sector by funding out of hospital mental health services for their customers. This could include community-based care options. Unfortunately, the rules that dictate what health insurers can and cannot fund for customers do not enable delivery of such services. In an environment where integrated, outcomes focussed care is the objective, such rules no longer make sense. We recommend an overhaul of such rules.

Bupa has sought to navigate these structural deficiencies by developing alternative models of care at the moderate to severe end of the care continuum with hospital substitution models (General Treatment when the care is provided by a non-hospital provider) being a key focus. These demonstration models are examples of customer-centred care delivered by different providers and funders. We have included at Appendix 1 six case studies of such demonstration models:

- Mind Care Choices (case study 1)
- This Way Up (case study 2)
- Kids Helpline (case study 3)
- Mobile Recovery Support (case study 4)

These models allow customers the choice of receiving care in their community, rather than in hospital, if that is their preference and it is clinically appropriate. Trying to offer this seemingly simple choice to the 45% of Australians who choose to insure themselves through illness and injury reveals a material structural weakness – health insurers are unnecessarily hamstrung by funding rules that can obstruct care that will provide the best health outcomes.

3.1 Barriers to provision

A large structural weakness inherent in the current system relates to the classification of what constitutes admitted and non-admitted hospital services. Certain programs, and how they are defined within legislation, have specific funding rules that determine what health insurers can fund as an alternative to in-hospital care.

Bupa knows that our customers find these distinctions meaningless, and when they come to us to claim for a mental health condition, they are wanting a solution to their current health need rather than added complication in choosing care based on the fund rules of what constitutes “in-hospital” or “admitted” patient care.

People with a mental health need require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care. Mental health services should be funded and delivered according to a continuum of care model and a range of specialist treatment and support services should be available.

There are major variations in the cost of providing care in different settings, with community-based care being more efficient than costly in-hospital settings. As well as being more efficient, this would also reflect consumer preferences about community-based care options. 84% of our customers believe psychiatric care should be conducted at home or in the community rather than in hospital[1].

[1] Bupa Member Attitude and Sentiments Survey: 7 June 2016

Bupa believes that more flexibility is required to help funds deliver mental health and psychiatric care in the community, either at home or in community-based facilities, rather than the current, more expensive model of inpatient services at hospitals.

3.2 Hospital Substitution and Medicare

There is a need to clarify the role of Hospital Substitution and how it operates and interacts with Medicare. Currently, customers can access Medicare funded mental health programs (for example, the *Better Access Scheme*) as well as health insurer funded hospital substitution services. Although at first glance one might think accessing these services simultaneously would complement care, it only adds to customer confusion.

The division between Medicare and non-Medicare funded services means if customers access Medicare funded services and face an out-of-pocket cost, as can occur with the *Better Access Scheme*, health insurers are not able pay the gap. The reverse is also true - Medicare cannot be used to co-fund a Hospital Substitution service offered by health insurers.

These two completely distinct pools of funding do not make sense from a customer point of view. There is a need in the mental health space for these services to be better integrated, to better link and integrate care and to maximise the efficiency and efficacy of both public and private funding. This would enable the best outcome for patients along a continuum of care.

Private Health Insurance (Health Insurance Business) Rules (Business Rules)

Private health insurers are subject to Business Rules which, in conjunction with the *Private Health Insurance Act 2007* and the *Private Health Insurance (Prudential Supervision) Act 2015* provide requirements as to how health funds operate. Among other things, the Business Rules provide that certain items listed in the Medicare Benefits Schedule can be covered by Private Health Insurers under the banner of 'Hospital Substitution'.

This list helps to encourage Hospital Substitution services by levelling the playing field of what medical professionals can expect to be remunerated for giving the same care as in hospital, but in a different setting. This list has been extremely helpful in encouraging innovative models of care, which Bupa has seen in the Oncology specialty. Many funds now offer cancer treatment at home as an option for consumers. However, the items that can be provided as Hospital-Substitute under the MBS has not 'kept-pace' with the evolution of alternative models of care.

Updating this list with a comprehensive selection of MBS item numbers from selected mental health services would help to remove barriers currently preventing health insurers offering genuine Hospital Substitution services to our customers.

3.3 Chronic Disease Management Programs

Mental health is, for many people, a chronic condition. We support a review of the regulatory restrictions that affect the offering of chronic condition prevention and management programs by health insurers. Particularly, rule 12 of the Private Health Insurance (Health Insurance Business) Rules 2015, which defines the requirements of chronic disease management programs.

It is our experience that rule 12 is drafted in a manner which prevents us from doing all we can to assist our customers. We believe rule 12 does not promote best practice evidence, which would support a wider variety of providers (such as mental health nurses) in the provision of chronic condition prevention and management.

Specifically, we suggest the removal from rule 12 of the reference that programs must involve an allied health service, from a prescriptive list, to be eligible for a benefit. We believe this is unnecessarily restrictive and we support a change to the rule that would allow the us to decide which providers (for example nurses and social workers) we want to fund to provide chronic disease prevention and management services to our customers.

Actions required:

ii. **The Productivity Commission fully investigate how the definitions of admitted or non-admitted patient care within mental health affect patient outcomes and hinder a continuum of care model.**
iii. **Removal of the current division between Medicare and non-Medicare funded services to better link and integrate care and to maximise the efficiency and efficacy of both public and private funding.**
iv. **Update the MBS to include a comprehensive selection of MBS item numbers for selected mental health services to remove barriers currently existing within the PHI fund rules.**
v. **Removal of rule 12 from the PHI business rules which currently allow only programs involved with an allied health service to be eligible for a benefit.**

4 Addressing waste and allocating resources where they are most effective

Health insurers should be required to fund mental health services for their customers that yield the best outcomes. There are two principal barriers to achieving this:

- As foreshadowed in section two, health insurers are limited in their ability to fund mental health care for their customers, which is sub-optimal both for customers and the health sector.

  Bupa spends around $190 million each year on mental health treatment on behalf of our customers, with the majority of this spent at the acute end of the care spectrum. Ideally, investment would be better targeted further upstream into prevention and early intervention services to help customers stay mentally well, however, there are limitations to our doing this.

- The other significant issue is the provision to customers of in-patient care options that do not contribute to improved mental health outcomes for consumers. This is known as low value care and is a consequence of the broader structural problem that compensates service providers based on episodes of care rather than the outcomes they produce.

Bupa supports the provision of high value care as defined by improved health outcomes that matter to patients divided by the cost of providing that care. By this measure, value is improved by either improving health outcomes, decreasing costs of providing care, or both. Inherent in this is the importance of identifying health outcomes that matter to patients, measuring these and using the data to inform clinical decision making and improving quality of care. This is a value-based approach to health care.

4.1 Delivery models and incentives

In recent years there has been a significant increase in the supply of mental health beds in the private sector, which has seen mental health outlays grow at a faster rate than overall private health fund claims growth. This is largely due to incentives inherent in the current system such as fee for service payments, incentive structures for psychiatrists to treat in hospital, and third-party arrangements between hospitals and psychiatrists.

In Australia, the average cost per mental health community treatment day is $305, compared to the average cost per patient day in general acute inpatient units of $1,061.

We can better meet the needs of patients, offer them a higher quality of life, and alleviate costs if we deliver more mental health care in the community or at home, rather than in hospital.

Bupa statistics suggest this is not occurring. In recent years, there has been a significant increase in the supply of mental health beds in the private sector, which has seen mental health outlays grow at a faster rate than overall claims growth:

Bupa spent over $167 million in 2015-16 for hospital and medical benefits relating to mental health:

- Total benefits increased 9% in the last year, and 40% in the last four years
- 11% of our total mental health spend was on same day visits
- Between 2014-15 and 2015-16, spend on hospitals stays increased by 38% (from $136.5m to $150.6m) whereas outpatient only increased by 0.3% (from $16.1m to $16.2m)

4.2 Low value care is a problem

Low value care is defined as care that is not evidence-based and either does not improve health outcomes for patients and/or is increasingly costly without a corresponding increase in outcomes. In general, low value care services are of low, no or even negative impact on patients. It also includes services delivered in an unsafe or inefficient manner.

Under current rules, health insurers are legislatively obligated to fund such low value care which is of little or no value to consumers and ties up mental health funding in, at best, wasteful and, at worst, frivolous, service provision.

Greater utility for our customers would be achieved through an investment in an evidenced-based, tailored care plan that follows a treatment path with progress tracked and measured over time. This allows for patients' treatment progress to be monitored and changes made to their care plan if required. It allows for a person's care to move and adapt to their changing circumstances which is vital when the end goal is to help that person integrate back into society and/or help to alleviate them of their mental health symptom burden.

Examples of low value mental health care

Low value care occurs where a customer is repeatedly attending day programs:

a) That do not include interventions that are evidence based and clinically relevant for that individual; and/or
b) They are not seeing a corresponding improvement in their mental health outcomes.

An example is a day program in which no treatment plan is created or monitored. Most often, this means there is no pathway for the customers utilising these services to transition back into the community, which leads to over servicing.

Another example is a day program that includes activities designed to keep participants occupied, such as Art Therapy, including colouring-in and photography.

Bupa's auditing process reveal most private psychiatric providers offer these types of low value mental health care to our customers.

Concerningly, our auditing has also revealed:

- many inpatient programs do not require patients to attend the services or group sessions that are on offer in the facility on the days the patient is there
- many mental health facilities only provided therapeutic interventions during the week, Monday to Friday but charge the health insurer for services provided on Saturdays and Sunday

Many factors combine to create the environment where these examples of low value care can continue. From a customer point of view, they often feel they are receiving value from these day programs as they do not encounter an out of pocket cost for the psychiatrists they see that day, they receive free meals, and activities are arranged for them. The issue from a system and productivity perspective is that this is a high expense and inefficient use of funds. Health insurers could better use the funding expended on such services in more targeted mental health interventions.

Actions required:

vi. Recognition that low value care is a problem and increasingly work to discourage it by shifting funding towards value (where value equals health outcomes that matter to patients divided by cost) rather than volume of services.

vii. Minimum guidelines for determining minimum payable benefits by health insurers should be bolstered.

4.3 The need for mental health clinical trials to underpin evidence-based care

The delivery of mental health services that improve outcomes for consumers rely on the development of treatment options with an evidence base. The lack of a strong evidence base is central to many of the problems within the sector, including the reliance on low value care, which is explained in section three.

Institutions such as The Bupa Health Foundation fund cutting edge mental health research (see Case Studies 5 and 6 below), however, a more comprehensive and coordinated effort is required.

One barrier to the development of a strong evidence base in mental health care is the lack of a clinical trial network for mental health.

Clinical trials provide definitive evidence about which treatments work and are most cost effective in clinical settings and the real world. It would help decision makers with the evidence base to achieve closer coordination of various health and mental health services. Australia is a world leader in the design and conduct of clinical trials through the work of the Australian Clinical Trials Network.

There are currently around 40 Clinical Trial Networks across Australia that from 2004 – 2014 alone have implemented over 1,000 world-first clinical studies, have engaged over 1 million patients/participants, and been awarded over $1 billion in competitive research funding. The established Clinical Trial Networks cover therapeutic areas such as cancer, kidney disease, neurology, and epilepsy and specific disciplines (primary care, intensive care, anaesthesia).

No Clinical Trial Networks currently exist in any area of mental health research, despite mental and substance use disorders ranking third in contribution to disease burden (14.6%). The extensive disease burden in mental health disproportionately affects adolescent and early adulthood phases of life with 75% of mental disorders emerging before the age of 25 years, providing vital opportunities for prevention and early intervention.

We propose Australia's first Mental Health Clinical Trial Network be established in partnership with the Australian Clinical Trials Alliance (ACTA) and key mental health research institutes, key partners and stakeholders including patients with lived experience/patient advocacy bodies across Australia. The Clinical Trial Network could focus initially on young people, as this is where the major impact of mental disorders occurs and there has been extensive new clinical infrastructure assembled in recent years in which large scale clinical trials (with subsequent translation of outcomes) are now feasible.

The long-term goal for the Mental Health Clinical Trial Network would be to cover the whole lifespan and the full spectrum of mental health disorders. This may be achieved by a single Clinical Trial Network or by multiple linked Clinical Trial Networks. The establishment of a Clinical Trial Network in mental health will mean that much larger and more impactful clinical trials will be conducted in Australia and produce new evidence regarding the sequence and effectiveness of existing and novel therapies in mental health.

Action required:

viii. A Mental Health Clinical Trials Network be created to sit under the National Network umbrella.

4.4 Mental health waiver

Whilst Bupa supports the intention of the mental health waiver announced in October 2017, we recommend a review of its effectiveness. The waiver allows consumers with limited private health insurance the option to upgrade their cover to access higher psychiatric treatment benefits without serving an ordinarily applicable waiting period. This waiver of waiting periods is offered by all health insurers on a once-off basis.

The waiver is a comparatively costly way to deliver mental health care. It is also offered at a time when patients are acutely unwell. Bupa's experience is that a number of those who took the opportunity to upgrade, have now dropped back to a lower level of cover, which does not include comprehensive mental health services. This is of concern given mental health is often a long-term chronic condition that requires on-going management, with people's needs fluctuating in intensity and over time.

The opportunity exists to consider whether the investment in the waiver is an optimal use of resources.

Action required:

ix. A post implementation review of the long-term effectiveness and efficiency of the mental health waiver be undertaken.

4.5 The role of health insurance in funding mental health

Bupa would like to see a shift in how health insurers are able to fund mental health care for our customers. Rather than being a largely passive funder of in-patient treatment once a customer has deteriorated to the point of needing this level of care, a shift is required towards more proactive and targeted care that is influenced by customers' preferences and clinical need. Health insurers should have the capacity to assist customers receive the right care, at the right time, in the right setting along the continuum of the customer journey – from preventative to acute care.

Current state

Our research shows that customers want their health insurer to cover a higher proportion of the out of pocket costs of receiving mental health care:

How can Bupa better support mental health?

"More rebates for outpatient psychiatric care."

"Access to fully funded services. I think people tend to hold back when there is a gap in payments."

Barriers to achieving good mental health?

"Paying for psychologist bills."

"Not knowing where I could go to get help."

"The need to attend to other family members' needs…"

We have conducted significant research to better understand the needs and wants of our customers when it comes to mental health. Of note, almost 4 in 5 customers agree that "health insurance should play a role in helping them to manage their mental health and wellbeing." Nearly 4 in 5 believed that "Bupa is a company in a strong position to provide support in this area and acknowledge the importance of mental health and wellbeing in reducing long-term burden on individuals and the health system." The 1 in 5 who disagreed did so on the basis that they thought *it is up to the individual seeking assistance to decide where to seek support, and that medical professionals should provide the support whilst Bupa's role is to help make it affordable.*

One of the structural funding weaknesses in the mental health system is that the lived experience of consumers is contrary to these preferences. Mostly, consumers are forced to navigate the complex mental health system themselves with medical professionals on hand at certain points in the journey to assist.

As discussed in section two, health insurers are limited in their ability to meaningfully help people manage their mental health (as opposed to simply navigating them to services) due to legislative restrictions.

Action required:

x. **That a wide-ranging evaluation take place on the cost effectiveness of the ways health insurers are currently able to support the mental health of their customers with a view to examining and maximising the utility of each dollar spent (as opposed to reducing costs altogether).**

5 Residential aged care

Australia is facing an ageing population with increasingly complex care needs.

Bupa cares for more than 6,700 older or otherwise vulnerable Australians across our 72 residential aged care homes. Our aged care homes are increasingly supporting residents with higher and more complex mental health care needs including schizophrenia, depression, anxiety, drug seeking behaviours, alcoholism, polypharmacy and other mental and behavioural issues. These conditions escalate in complexity when combined with dementia. Around 50% of residents in Bupa aged care homes have been formally diagnosed with dementia and a further 20% live with another form of cognitive impairment.

There are several sector-wide issues which can make it difficult for aged care providers to access appropriate mental health care and support for our residents. This inquiry provides a timely opportunity to consider the mental health needs and challenges of senior Australians, including provision of access to mental health services.

5.1 Support for Australians living with dementia and their carers

Strong connections between the aged care and broader health sector are fundamental to providing quality care for Australians as they age and improving their health outcomes.

However, there is currently a lack of coordination between the aged care sector and the broader health system which results in barriers for aged care residents to access appropriate care, including mental health services. These barriers include:

1. Access to mental health MBS items for aged care residents; and
2. Limited services for residents living with dementia and/or mental health conditions.

Access to mental health MBS items for aged care residents

Bupa supports the Government's 2018-2019 Federal Budget commitment of $82.5 million to fund mental health services for residents of aged care homes and encourage greater funding for mental health specialists to visit residential aged care homes, particularly psychologists and grief counsellors.

However, we believe more needs to be done to promote greater mental health support for residents living in aged care. This includes re-structuring government financing of allied health services to greater incentivise care in residential aged care homes, including:

1. Amending the Better Access to Mental Health Care provisions of Medicare to remove the discriminatory exclusion of people living in residential aged care from accessing mental health services; and

2. Encouraging the Federal Government to trial greater access to telehealth MBS items for mental health nurses to aid the delivery of ongoing care to residents with high fragility and complex care needs.

Limited services for residents living with dementia and/or mental health conditions

There is a general shortage of services and there is a lack of funding for residents with dementia and/or mental health conditions who exhibit challenging behaviours. The Commonwealth Department of Health 2017-18 consultation paper on Specialist Dementia Care Units identified the aged care sector's limited capability, outside a small number of specialised facilities, to appropriately meet the needs of people with very severe behavioural and psychological symptoms of dementia[2],

[2] 2017. Department of Health. *Specialist dementia care units.* Consultation paper. Available here. Page 16.

including unpredictable aggression, sexual disinhibition, suicidal ideation and severe depression. By way of example, the Garrawarra Centre located in New South Wales is one of the few facilities which provides high-level care for those living with dementia who exhibit challenging behaviours and cannot be accommodated within a mainstream residential aged care setting.

A shortage of such facilities means that those experiencing challenging behaviours are often cared for within a mainstream residential aged care service, with admission to an acute hospital setting often required when behaviour becomes very difficult to manage. It is much costlier to deliver care in an acute, hospital setting. The average revenue available to provide care in the residential aged care sector is approx. $260 per day, significantly less than the private ($1,239) and public ($1,400) hospital sector.[3]

Actions required:

xi. Public financing of allied health services be restructured to incentivise mental health care in residential aged care homes.

xii. Increased public investment in specialist facilities to cater specifically for those living with dementia and experiencing challenging behaviours, including psychogeriatric facilities.

[3] Australian Bureau of Statistics, *Private hospitals – Australia*, 2014-15; NSW Auditor-General's Report to Parliament, *Managing length of stay and unplanned readmissions in NSW public hospitals*, 2012-13; Palliative Care Australia, Submission to National Commission of Audit, January 2014, p2

6 Mentally healthy workplaces

6.1 Encouraging mentally healthy workplaces

Workplace mental health is directly correlated to productivity. Mental health deterioration at work is also a significant reason workers seek mental health care. As the employer of around 17,000 people in Australia alone, Bupa would like to see an emphasis of the creation of *mentally healthy workplaces* in Australia. From a treatment perspective, we believe it is important for people experiencing an issue with their mental health to keep working as the norm, rather than the exception.

Action required:

xiii. Amendments be made to workplace health and safety legislation and regulations to explicitly incorporate the identification of psychosocial risks and appropriate control measures.

The greater accountability that flows from this will encourage quicker uptake and implementations of measures that mitigate the risk of psychological injury in workplaces.

6.2 Bupa's workplace mental health approach

Bupa's experience in workplace mental health involves our global *Smile* program as well as Mental First Aid training.

Smile

Smile, Bupa's global employee health and wellbeing program was launched in Australia in May 2016 to 400 site locations and 15,000 people. The focus is to engage our people and assess their health and wellbeing.

The Smile program varies within each country, but at local level businesses across Bupa use employee insights to deliver tailored products and services centered on four quadrants — healthier bodies, healthier minds, healthier cultures and healthier places.

At the heart of Smile is Performance Energy. Designed in partnership with a clinical psychologist this leader-led program gives insights, tips and ideas on ways in which our people can better manage their energy to be at their best mentally and physically, at work and at home.

Performance Energy focuses on three core building blocks: physiology, choices and mindset to help our people to prioritise what is most important to them.

Given the diverse nature of our employee population we have developed multiple delivery channels to suit different needs, ranging from three-hour face-to-face sessions run by a network of specially trained Performance Energy Coaches in partnership with leaders, through to a self-paced digital version for our call centre and retail employees.

Mental Health First Aid

The Mental Health First Aid (MHFA) program certifies participants as mental health first aiders in the workplace. Participants do not become qualified to diagnose and treat mental illness, but learn practical information about key mental illnesses so they can identify risks in the workplace, and provide assistance if someone is experiencing a mental health issue.

The MHFA program provides a first aid process for non-crisis intervention, which can be applied to someone experiencing depression, anxiety, psychosis and the effects of an alcohol or substance disorder.

This program also provides a process for dealing with crisis situations for suicidal thoughts, feelings or behaviours, panic attack, severe psychotic episodes, and high levels of intoxication (sometimes with aggressive behaviour). MHFA is a highly interactive course and the key outcomes are:

- Improved confidence and skill when dealing with a mental health problem in the workplace
- A greater awareness of mental health, and reduced stigma about mental illness
- Better promotion of good mental health and wellbeing in the workplace
- Early intervention techniques which lead to faster recovery for people experiencing mental health problems

Bupa has seen advantages of both of these programs in the workplace through employees having better control over their job demands which leads to job satisfaction and retention; greater awareness, understanding and confidence to appropriately recognise and support mental health conditions; and prompt support and early intervention for employees to reduce severity and impact of any mental health condition.

Appendix

A community mental health program in Victoria – case study 1

Finding:

Based on the results from our pilot, considering ways to encourage community care over in-patient care makes sense from an outcomes, experience and affordability standpoint.

As part of Bupa's Mind Care Choices suite of services, we partnered with an organisation to provide a community mental health program for eligible customers in Victoria. This program is made available at **no additional cost to the customer**. The program means customers can choose to receive mental health care in their community, rather than in hospital. The service commenced on 1 September 2017 and is a pilot program approved by the Department of Health for two years. During the first year of the program, **almost 100 customers accessed the program**.

Results

At 12 months post launch we assessed preliminary results. The Patient Health Questionnaire 9 (PHQ-9) was employed to measure depression scores and the Generalised Anxiety Disorder 7 (GAD 7) to measure anxiety scores. Full results below. Importantly, **clinical outcomes measurably improved for most groups of customers in the program**. Some customers' score improved to the point they are **clinically regarded as in "recovery"*.**

In addition to outcome improvements for customers, the rate of psychiatry claims reduced for all admission types. Particularly noteworthy, **the rate of outpatient psychiatry claims for program participants halved** since starting the program. Further, the **average cost of mental health admissions per customer has reduced two-thirds** compared to costs when the program commenced.

While these preliminary results are indicative only (as the pilot continues further results continue to come in and averages are continually adjusted), they are incredibly promising.

Importantly, the Net Promotor Score (NPS) of the program is +82. Thus, patients did not see the change of setting as deleterious. NPS is the patient reported experience measure we are using to evaluate the program, it is a widely used metric to measure customer satisfaction and loyalty. An NPS result of over +50 is generally considered excellent.

Patient Health Questionnaire 9-(PHQ-9)*

Length of Treatment	Average Baseline Score	Average Score as of 31 August 18	Clinical change
10-12 months	17.7	9.3	Recovery
7-9 months	13.8	10.5	Improved
4-6 months	13.3	11.5	Improved
0-3 months	14	9.5	Recovery
All Active	14.6	9.3	Recovery

Generalised Anxiety Disorder- 7(GAD-7)*

Length of Treatment	Average Baseline Score	Average Score as of 31 August 18	Clinical change
10-12 months	13.7	9.3	Improved
7-9 months	10	10.3	On-going treatment
4-6 months	7.4	9	On-going treatment
0-3 months	13.1	7.2	Recovery
All Active	11.7	9.3	On-going treatment

*Definitions of scores: **Clinical case** (person needing intervention/ongoing intervention) defined as: PHQ-9 score of 10 or higher and/or GAD-7 score: 8 or higher. **Improvement** is a reduction in end of intervention scores compared with baseline: PHQ-9: -5.2 points or more and/or GAD-7: -3.5 points or more. **Recovery** defined as: PHQ-9 score: <10; GAD-7 score: <8; proportion of participants whose end of intervention scores have decreased. A participant will be considered as recovered if their PHQ-9 and/or GAD-7 score meets the definition of recovery at any point in their intervention.

'This Way Up'– case study 2

Finding:

Based on the results from our pilot, consideration should be given to offering iCBT (internet-based cognitive behavioural therapy) to the wider population.

A review of the mental health programs available to our customers demonstrated that the level of support available for those *at risk* or living with *mild* mental illness was low. We also knew through consumer research that 84% of customers would prefer home or community treatment for mental health care (where clinically appropriate). We realised then there was a gap in our mental health offering and therefore an opportunity to fill this gap for our customers.

After much research on the best way to proceed, we decided to pilot full-fee rebate-able internet-based cognitive behavioural therapy (iCBT) to customers who are at risk of or are living with mild mental illness.

Further context

Cognitive behavioural therapy (CBT) is one of the most effective treatments available for depression[1] and for all types of anxiety[2]. CBT has traditionally been delivered face to face, in individual or group settings[1,2], however it can also be delivered digitally, making treatment accessible to a broader population in a cost-effective way.

This Way Up (TWP) offers a series of confidential iCBT programs that cover a range of mental and emotional health issues, including depression and anxiety among many others. The programs are delivered over a 3-month period.

iCBT delivered via TWU is effective for most people – clinical trials have shown that 80% of people who complete their iCBT courses respond well to treatment, with 50% improving to the point of no longer being troubled by their anxiety or depression[3]. Treatment outcomes are equivalent to traditional CBT, and longer lasting than medication[3].

Our pilot was implemented to primarily investigate the customer appetite and uptake for a Bupa funded iCBT program delivered by TWU. The pilot sought to explore the following questions:

1. What is the uptake for iCBT?
2. What level of adherence is observed?
3. What impact does course participation have on mental health outcomes?

Method

A representative sample of over 100,000 customers who had not previously claimed a private hospital admission (inpatient or outpatient) nor extras services related to a mental health condition, was identified. They were then sent an email to participate in one of nine paid courses focussed on anxiety or depression related disorders offered by TWU. Three free wellbeing courses focussed on stress management, introduction to mindfulness, and insomnia were also available. Customers were required to pay the $59 course fee directly to TWU at the time of registration and were eligible to claim the full fee rebate upon completion of the course.

The TWU pilot achieved a click rate of 5.8%, with 4.5% (114) of these customers registering for a course. The rate of uptake (0.1%) was lower than expected when compared to other Bupa marketing campaigns (1%). The courses were attractive to members of all ages (ranging from 18 to 73 years). The average age was 42 and 70% of those who registered were female. Members from across Australia participated, including 25% from regional, remote and very remote areas. Almost two-thirds registered for a paid course. While most emails were sent to the policyholder, the program offering was passed on to other members on the same policy as well as friends and family not included in the email, indicating that this offering for mental health support is appealing to customers.

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Clinical results

Results show TWU paid courses are successful at reducing symptoms of psychological distress. For customers who completed a 6-lesson paid course, only 1 in 5 were considered likely to be well at baseline, rising to 3 in 5 after completing all 6 lessons. More than half were considered to have a moderate or severe mental disorder at baseline, but this figure reduced to less than 1 in 10 (8.6%) after completing all 6 lessons.

Importantly, there is a dose-response relationship with greater improvement in distress symptoms achieved when more lessons are completed. There was an average reduction of 6.9 points for members completing 4 or more lessons compared to a reduction of 2.6 points for those only completing 3 or fewer lessons. Free courses also result in greater improvement in distress symptoms when more lessons are completed, although to a lesser degree than for paid courses.

Wider results

The level of psychological distress of participants was higher than expected. The pilot originally intended to target members with mild mental illness. It was assumed that people suffering from moderate or severe mental disorders would have previously made claims for hospital or ancillary treatment related to their illness, and so would have been excluded from the sample population. The results of this pilot indicate that this is not the case.

Results indicate that members reporting more severe distress symptoms are more likely to participate in a disorder specific paid course than a free wellbeing course. At baseline, 48.5% were considered likely to have moderate or severe mental disorders, three quarters of whom elected to participate in a paid course. A further 26.7% were considered likely to have a mild mental disorder, two-thirds of whom elected to participate in a paid course. The remaining 24.8% were considered likely to be well and of these, only half elected to participate in a paid course.

To date, the completion rate for paid courses is 54% and for free courses is 27%. This is more than double the completion rate expected by TWU based on completion rates for the broader population (25%). Incentivising course completion to receive a full fee rebate increased the rate of completion.

Next steps

As a result of these findings, we are exploring ways to make iCBT available for our customers aged over 18. We are also starting to look at iCBT options for customers aged under 18 years.

[1] Jorm, A., et al. 2013. *A guide to what works for depression: 2nd Edition.* Beyondblue, Melbourne. Available here
[2] Reavley, N., et al. 2013. *A guide to what works for anxiety: 2nd Edition*. Beyondblue, Melbourne. Available here
[3] This Way Up. (n.d.). Internet-delivered Cognitive Behavioural Therapy (iCBT). Available here

Bupa and Kids Helpline – case study 3

To build and support a generation of emotionally well and resilient, young Australians.

Finding:

Based on our experience and learnings from this partnership, early and barrier free access for young people to mental health support can increase resilience and improve their mental health more generally. As such, investment in this area makes sense from economic, outcome and customer experience perspectives.

Underpinned by a commitment to improve the mental health and wellbeing of young people in Australia, in 2017 Bupa entered into a partnership with Kids Helpline (KHL). KHL is Australia's only free, private and confidential 24/7 phone and online counselling service for young people aged 5 to 25. Working together, KHL and Bupa aim to enable every young person/student in Australia to have access to the tools and resources necessary for mental wellbeing.

At any given time, 1 in 4 young Australians experience mental health challenges. To meet this growing demand and better target children's needs, KHL developed Kids Helpline @ School (KAS), an early intervention program focused on issues impacting children's mental health and wellbeing. The program offers free primary school classroom sessions with a counsellor via conferencing technology to talk openly about issues and break down barriers for children who are afraid or anxious to reach out for help.

In its first year, KAS reached more than 13,000 students across 70 schools. Bupa and KHL have a joint desire to grow the program to support more schools and students.

The shared objectives of the Bupa and KHL partnership include:

- Increasing the resilience and mental wellbeing of young people in Australia;
- Driving and meeting demand for help-seeking behaviours across the community; and
- Providing support and guidance on the mental wellbeing of young people, particularly to parents.

Results so far

The program far exceeded its targets achieving close to quadruple its schools target (276%) and more than doubling its student reach (154%). Of the 163 teachers who responded to the teacher's survey, 96% believed the KAS Wellbeing session was likely to positively influence students' future choices and decision-making.

Mobile Recovery Support Service – case study 4

Finding:

Based on results from this pilot, considering ways to encourage community care makes sense from an outcomes, experience and affordability standpoint.

The Mobile Recovery Support Service (the Service) has been provided through a partnership between Bupa and Toowong hospital since April 2017. The Service is for eligible customers living with a mental illness, who are at risk of admission to hospital and require support in relation to self-management of their wellbeing. The Service is aimed at supporting customers in their community to prevent further hospitalisations and, additionally, to reduce the length of stay if they are admitted for an in-patient service. The service builds strength and resilience by teaching customers skills and providing them with support to enable them to achieve maximum wellness in their community without undue reliance on professional support.

Method

The Service is delivered by Registered Nurses and Allied Health Professionals who work collaboratively with the customer, treating psychiatrist, and any other health professionals, carers and/or significant others that the customer identifies and consents to having involved in their care. This helps to develop and deliver an **integrated care and treatment plan**. The service is delivered either face to face in the form of outpatient clinic reviews or in the community as home visits or via telephone consultations.

41% of customers participating in the Service were aged 45-64 years, 21% aged 35-44 and 18% aged 25-34. Each of the remaining 10 year age bracket groups had about ~5%. 84.5% of all participants were female. 70% of participants had Major Depressive Disorder.

Results

To date a total 99 patients have accessed the service since its inception. Of these 65 have been discharged during this period with 34 continuing with the program. A range of outcome measures were employed to monitor customers' symptoms, both at entry and discharge and during the course of the Service. Many customers (65) have been discharged from the program with 37 (57%) noting that their mental health had improved to the point of *'no longer requiring service'*. These outcome measures were demonstrated by moderate to large effect sizes.

Ongoing patients are reviewed every ninety days and there are clear trends of mental health improvement during participation in the program, across a range of mental health outcome measures (overall mental health (HoNOS, MHQ-14 Mental Health, K10), social functioning (LSP16 Withdrawal, LSP16 Antisocial) and reduction in symptoms of depression, anxiety and stress (DASS Depression, Anxiety, Stress)).

In 2018 The Bupa Health Foundation announced their Foundation Grants Program will be investing $1 million dollars in research on improving mental health models of care in Australia. More than 150 expressions of interests were received from the health and medical research community. Following a two-stage evaluation process The Bupa Health Foundation awarded $500,000 to two research projects which each demonstrated innovative research that ultimately aims to improve the mental health and wellbeing of the Australia population.

Bupa Health Foundation – case study 5

Follow my journey: a data-linkage project to establish effectiveness, efficiency and sustainability of a stepped care model

This research project involves a Queensland consortium of primary health providers and hospital services within a large regional and rural population to evaluate an innovative stepped care approach for mental health. The stepped care model for mental health is an evidence-based, staged system comprising of multiple levels of interventions, from the least to the most intensive, matched to the individual's needs. While stepped care is central to guiding mental health activity by Primary Health Networks (PHNs), little is known about an individual's movement through the various stepped services or the effect on their emotional and physical wellbeing.

After introducing an innovative centralised intake and triage system for stepped care in their region, the Central Queensland Wide Bay Sunshine Coast PHN will **use data linkage and consumer feedback to assess patterns of service usage** across the system and also the experiences of patients as they access care. This will be **the first time that health outcome data and health administrative data have been linked for stepped care research**.

The data captured over the two-year research project will provide evidence of the impact of the new model of care on patients and health services in the region, which will **inform future system design to alleviate pressure points, improve access to and quality of care**.

Bupa Health Foundation – case study 6

Best Care, First Time: can digitally-supported care pathways deliver better care for young people with emerging mood or psychotic disorders?

This project **brings together organisations from the health research and care communities** who are committed to ensuring young Australians get the right mental health care they need, at the right time, by using innovative digital technologies.

These organisations include health research organisations, The Brain and Mind Centre at the University of Sydney and The Sax Institute (a national leader in promoting the use of research evidence in health policy), with several mental health service providers in Sydney representing the multiple care pathways for an individual including primary care, specialist care, outpatient and hospital settings.

The **project aims to address the current siloed approach to providing mental health care for young Australians.** This siloing leads to situations where young people find it difficult to find the right mental health care matched to their unique needs. It also creates care that is episodic rather than continuous with transfers needing to happen between health services. This impacts young people's health and wellbeing now and also into the future.

The project will test whether implementing a digitally supported care protocol with linked IT system across multiple service settings will **better coordinate care for young people with emerging mood or psychotic disorders**. The digital platform will be managed by the young person, and will support them to access the right care for their needs at the right time. A component of the project will also focus on supporting health organisations and their partners in a geographic area make decisions on **what combinations of services and interventions at the local level will result in the most optimal health outcomes** for young people.

After two years, the research will provide evidence on the impact of introducing digitally-directed coordinated care on clinical safety and service quality for each participating service, as well as the improved health outcomes of young people with mental illness and overall experience of young people, their families and their health professionals.