**Submission No 20**

# PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

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## Submission by the Commonwealth Ombudsman

# Inquiry into the Prevention of Youth Suicide in New South Wales

Submission by the Commonwealth Ombudsman, Michael Manthorpe

**30 August 2017**

# Background

In the Commonwealth Ombudsman's role as the Private Health Insurance Ombudsman, we protect the interests of consumers in relation to private health insurance.

The Ombudsman is an independent body that resolves complaints about private health insurance at all levels within the private health industry.

The Ombudsman also reports and provides advice to industry and government about these issues.

# Response to Terms of Reference

The Committee requested input from the Office regarding the following issues:

1. "*The nature and scope of private health insurance coverage available to young people with a mental illness"* and
2. *"The effect a history of mental illness or attempted suicide may have on a young person's private health insurance or, if they were not previously insured, their ability to access private health insurance in future.*"

## 1. The nature and scope of private health insurance coverage available to young people with a mental illness

Australian private health insurance covers some but not all aspects of private mental health treatment, under either hospital or general treatment policies.

Private hospital policies cover private patient admissions to public or private hospitals. General treatment policies (also known as 'extras' or 'ancillary') can cover psychology and some counselling services.

Some items are not covered by private health insurance at all, such as outpatient psychiatric consultations and public patient admissions to a public hospital. These services are covered by the public health system and cannot also be covered by private health insurance.

### *a) Private hospital insurance*

Private hospital insurance covers the cost of hospital accommodation, a portion of the medical fees and the patient's choice of doctor. The patient pays any applicable excess or co-payment on their hospital policy, and the difference or 'gap' between the doctor's charge and rebate paid by Medicare and their insurer.

Not all policies include full cover for psychiatric services. Generally, only the top hospital policies cover this item. These policies are generally amongst the most expensive to purchase, and because a lot of people, particularly younger people and those on lower incomes, choose less expensive policies, these groups may not be fully covered.

Most low or medium level policies will only cover psychiatric services for a "restricted" benefit. A restricted benefit is sufficient to cover the cost of a shared room in a public hospital. If admitted to a single room or a private hospital, then any further hospital cost above the shared room public hospital rate is required to be paid by the patient. Costs for psychiatric hospital admission can be significant if the patient needs to pay a few hundred dollars a day, because hospital admissions

tend to be for several days or weeks. In practice, due the size of costs that an individual patient needs to contribute to their admission, using a "restricted" psychiatric services benefit can be difficult for consumers to utilise in the private hospital system. In the public hospital system, the Ombudsman understands that there is generally very limited access to private psychiatric services.

The Office does not collect data on complaints specifically relating to hospital admissions for mental health and psychiatric treatment. We do collect data on the overall number of complaints made about hospital exclusions and restrictions, as summarised below. We note the proportion of complaints made about mental health and psychiatric admissions is likely to be small, relative to the total number of exclusion and restriction complaints.

*Hospital Exclusion & Restriction complaints (includes all types of service exclusion or restriction)*

| | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| Number of complaints | 320 | 275 | 308 |

*b) General treatment insurance*

Some general treatment policies provide benefits towards psychology services and counselling. The health insurer pays either a set benefit or percentage of the cost of the service and the patient pays the rest. Benefits are payable up to an annual limit, usually renewing per calendar or financial year.

Generally, this item is only included on medium to comprehensive levels of general treatment policies, which are usually the more expensive policies to purchase.

In order for benefits to be paid, the provider needs to be registered with the health fund – not all providers are registered with all insurers.

Some health insurers may also impose extra conditions on access to these benefits. For example, at least one major insurer will only pay psychology benefits if the consumer has exhausted their Medicare entitlements for psychology. This means consumers who do not meet the Medicare criteria for psychology benefits or who choose not to utilise their Medicare benefits cannot claim under this insurer's policies.

Waiting periods apply to general treatment benefits. The waiting period is usually 2 or 6 months for psychology and counselling.

**2. The effect a history of mental illness or attempted suicide may have on a young person's private health insurance or, if they were not previously insured, their ability to access private health insurance in future**

Under the *Private Health Insurance Act 2007* (Cth) (the Act), Australian private health insurance is 'community-rated'. This means that everyone is entitled to buy the same product, at the same price, and is guaranteed the right to continue their health insurance policy. A health insurer cannot refuse to insure a person or refuse to sell any policy they want to buy on the basis of their state of health, history of illness, or frequency of claims. A history of mental illness or attempted suicide will have no effect on a person's ability to access private health insurance (for the relevant section of the Act, see **Attachment A**).

There are some exceptions to community rating in regards to price - for example, some individuals will have to pay a higher premium based on their age under Lifetime Health Cover loading rules. However, health insurers cannot charge a higher premium or refuse to insure a person on the basis of their medical history.

There is a special provision to assist mental health patients in the private health insurance system. Normally claims for treatment considered a pre-existing condition are subject to a 12-month waiting period. An exemption is made for psychiatric benefits that limits the maximum waiting period a health insurer can apply to 2 months regardless of whether the condition is pre-existing. This is an important provision, and it would assist many patients who find themselves requiring psychiatric treatment; however, some may be unable to delay treatment for a 2 month period.

## Attachment A: "Community Rating" provisions in the *Private Health Insurance Act 2007* (Cth)

***Part 3 2—Community rating***

***Division 55—Principle of community rating***

**55 1 What this Part is about**

To ensure that everybody who chooses has access to health insurance, the principle of community rating prevents private health insurers from discriminating between people on the basis of their health or for any other reason described in this Part.

**55 5 Principle of community rating**

(1) A private health insurer must not:

(a) take or fail to take any action; or

(b) in making a decision, have regard or fail to have regard to any matter;

that would result in the insurer *improperly discriminating between people who are or wish to be insured under a *complying health insurance policy of the insurer.

(2) ***Improper discrimination*** is discrimination that relates to:

(a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or

(b) the gender, race, sexual orientation or religious belief of a person; or

(c) the age of a person, except to the extent allowed under Part 2 3 (lifetime health cover) or subsection 63 5(4); or

(d) where a person lives, except to the extent allowed under subsection 66 10(2) or section 66 20; or

(e) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for *hospital treatment or *general treatment; or

(f) the frequency with which a person needs hospital treatment or general treatment; or

(g) the amount or extent of the benefits to which a person becomes entitled during a period under a *complying health insurance policy, except to the extent allowed under section 66 15; or

(h) any matter set out in the Private Health Insurance (Complying Product) Rules for the purposes of this paragraph.

*Source: https://www.legislation.gov.au/Details/C2016C00911*