



Mental Health in Multicultural Australia's submission to: Independent Hospital Pricing Authority

Mental Health in Multicultural Australia (MHIMA) is a national project currently funded by the Commonwealth Department of Health and Ageing until June 2014. MHIMA's mission is to build capacity and to support inclusion. Underpinning this mission is MHIMA's vision of an open and inclusive society committed to human rights and diversity in which everyone requiring mental health services is able to access culturally responsive services equitably regardless of culturally and linguistically diverse (CALD) background.

MHiMA's mission expresses our intent for communities and health service providers to address the mental health needs of Australia's immigrant and refugee population in a culturally inclusive and responsive manner. MHIMA is committed to achieve this mission by:

- Providing a national focus on issues relevant to mental health and suicide prevention for people from CALD backgrounds by offering advice and support to government, non-government providers and service users.
- Supporting primary health care professionals, including general practitioners and allied health practitioners, to address the mental health needs of consumers from CALD backgrounds and their carers.
- Supporting the development of mental health services that are culturally responsive, evidence-based and recovery-oriented.
- Working to promote effective and culturally responsive services that are capable of meeting the diverse needs of the Australian population across the lifespan.
- Developing effective and respectful collaborations with relevant stakeholders in every state and territory that are of mutual benefit and advance our common objectives by adopting a flexible approach that is responsive to issues arising in a rapidly changing environment.

MHiMA welcomes the opportunity to provide feedback about the pricing of mental health care. We note that considerations around costs of care and developing a national 'efficient price' are the responsibility of the Independent Pricing Health Authority. We also note that the setting of the national 'efficient price' for mental health care will result in the implementation of Activity Based Funding for mental health services commencing 1 July 2013, in keeping with the National Health Reform Agreement signed by all jurisdictional Ministers of Health across Australia.

MHiMA supports the principle of pricing mental health care to achieve optimal value for money and a sustainable and safe high quality health system accessible to all who need it when required. It is therefore crucial that when considering the price of mental health care that the cost of doing so in a safe and effective way accounts for the increasing cultural diversity of the Australian population as confirmed in the 2011 census. **The 2011 census reveals that 27 per cent of Australia's population was born overseas and a further 20 per cent had at least one overseas-born parent.**

MHiMA supports IHPA's approach of ensuring that the basis for pricing is evidence based. Currently there is no empirical evidence concerning the relative cost of providing mental health services to clients and families who are not fluent in English, or to those where cultural issues have a substantial impact on practice, or to refugees or asylum seekers. This means that for a substantial proportion of the population there is an inadequate basis for determining the impact of new funding or pricing arrangements. The risk of new funding arrangements not factoring in the potential different costs of providing care to CALD consumers; and failure to understand what the true costs of care poses the undesired risk of adopting a mono- cultural (and therefore a largely mono logic costing model).

MHiMA would therefore welcome the opportunity to work collaboratively with IHPA to produce the necessary evidence and to ensure that where there are significant differences in the price of providing the same service, these differences are incorporated into new arrangements. MHiMA believes caution and further work is needed before transitioning to a model of funding that is exclusively activity-based without understanding the contextual issues relating to the respective processes and costs of delivering mental health care activities for CALD populations. Specifically, the key areas where MHiMA would seek engagement with IHPA to ensure there is a thorough understanding and factoring in of costs that is reflected in 'efficient pricing' for mental health care accessed by consumers of CALD backgrounds are as follows:

- Ensuring that the National Hospital Cost Data Collection (NHCDC) annual collection of hospital costs for acute care services, emergency departments, acute, sub acute and outpatient services captures and provides reportable data on:
 - The profile of consumers from CALD backgrounds, which MHiMA believes should include broader data variables, rather than just collection of country of birth, as is currently the case. MHiMA has done some work in this area to inform the thinking of the National Mental Health Commission. Our findings could be of practical use in terms of the methodological process to guide annual data collection processes.
 - Types and frequency of service access and utilisation by CALD populations and additional costs associated with delivering that care such as language support and meeting cultural needs to enable recovery and discharge outcomes into community care.

- Engaging with IHPA on a collaborative basis by ensuring NHDC data is available in an accessible and meaningful form for use by the National Health Performance Authority (NHPA) as the new body charged with monitoring and reporting on health system performance. MHiMA believes that this work will be essential for providing a clear understanding on access to mental health care and the clinical and social outcomes of care for CALD populations. We believe integration of this type of reporting and information will result in changes to routine practice which in turn will drive service improvements and outcomes for consumers and carers from CALD backgrounds.
- Engagement in the development of the new National Minimum Data Sets (NDMS) so that the agreed definitions by which data are collected and reported include CALD populations within Patient Classification Systems across all tiers of the health system across Australia.

MHiMA would welcome this level of strategic engagement in order to contribute in a practical way to the development of evidence-based pricing. We believe such an approach will contribute to evidence-informed policy outcomes that will improve access and care outcomes for CALD consumers and carers of CALD backgrounds accessing mental health services. Further exploration and development of this work will enable the establishment of reliable cost data that is reflective of the true cost of delivering such care in a safe and equitable manner for CALD populations. For instance, MHiMA notes, welcomes and supports the fact that current efficient pricing already has the scope to build in patient-related adjustments associated with the costs of care for people from Aboriginal and Torres Strait Islander backgrounds. A similar approach is both desirable and necessary for CALD populations.

MHiMA notes that the development of Activity Based Funding (ABF) and the development of a national efficient price will be phased in and will require refinement to ensure optimal balance is achieved in relation to value for money, true costs of care and equitable healthcare outcomes for all Australians. As this approach develops, MHiMA would welcome engagement with IHPA as this work is being developed and would be available to contribute and if necessary become a member of the Mental Health Working Group that is currently shaping the framework around national ABF pricing.

Furthermore, MHiMA believes the move to ABF should be incrementally phased in with a robust evidence base, and that the continuation of block grants alongside ABF should remain. We believe such an approach is necessary to minimise inadvertent negative impacts being institutionally built into arrangements that could further disadvantage and impair systematic understanding related to the access and care outcomes for CALD populations without sufficient evidence being in place that can be tested and evaluated.

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