

OCTOBER 2026

A SHARED REFORM AGENDA REIMAGINING MENTAL HEALTH CARE

Sector insights and reform priorities for
improving access, affordability and sustainability.



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In August 2026, HCF convened more than 40 senior leaders from across Australia's mental health ecosystem in Canberra for the Reimagining Mental Health Care Roundtable (the Roundtable). The Roundtable brought together perspectives from across the sector to consider new research and modelling presented through HCF's Evidence to Action report, explore the key challenges facing Australia's mental health system, and identify reform opportunities to improve access, outcomes and sustainability.

A NOTE FROM THE CEO

Mental health care affects individuals, families, workplaces and communities. Yet too many Australians still struggle to find timely, affordable and coordinated support, and too many reach a point of crisis before the right care is available.

As a member-owned, not-for-profit health fund, HCF exists to serve our members rather than shareholders. This shapes how we approach reform: with a focus on members' health, the affordability and value of their cover, and the long-term performance of the health system. We also reinvest in services, research and initiatives intended to improve members' health and wellbeing.

HCF commissioned this work to strengthen the evidence for reform and bring together people with different roles and perspectives across the mental health system. The Roundtable confirmed the scale of the challenge and made clear that no single organisation or sector can address it alone.

Mental health care remains complex and fragmented across public and private acute care, primary care and community services. When care is delayed, difficult to access or poorly connected, the consequences are felt by individuals and families, but also through workforce participation, productivity and broader social and economic outcomes.

The question at the centre of this paper is a simple but important one: how do we make sure people can access the right care earlier, in a way that is affordable, connected and sustainable?

This paper reflects the evidence and issues explored through the Roundtable, the options participants considered, and areas HCF believes warrant further work. It does not seek to address every factor influencing mental health or every aspect of the broader system. Rather, it is intended to support informed discussion about practical reforms that could improve access, affordability, continuity and outcomes without shifting costs or pressure elsewhere in the system.

Private mental health services form an important part of Australia's broader health system and provide an additional care pathway for many consumers. Their sustainability matters, but it cannot be considered in isolation. Any reform must be tested against its effect on care, affordability, workforce capacity and people with and without private health insurance.

I thank everyone who contributed their expertise and experience to this work. HCF will continue working with government and the broader sector to build the evidence for reform and support practical changes that improve access, strengthen coordination and deliver better outcomes for people experiencing mental ill-health.

Lorraine Thomas
Chief Executive Officer
and Managing Director, HCF



CO-CONTRIBUTORS

The following individuals provided feedback, review and insights that informed the development of this white paper:

Adj Prof Karen Price
Former President, RACGP and Chair HCF Research Foundation

Christine Gee AM
Director, Ramsay Mental Health Australia and President, Australian Private Hospitals Association

Dr Kelly Gough
President, Australian Psychological Society

Dr Rachel David
Chief Executive,
Private Healthcare Australia

Lisa Robins
CEO, Patients Australia

Matt Hanrahan
CEO, Healthe Care

Matthew Koc
CEO, Members Health Fund Alliance

Professor Dimity Pond
Chair, RACGP Expert Committee – Research

Professor Patrick McGorry AO
Executive Director, Orygen

Rachel Green
CEO, SANE Australia

OVERVIEW

ABOUT THE WHITE PAPER

Australians are finding it increasingly difficult to access timely, affordable and coordinated mental health care. This white paper builds on the challenges identified in HCF's Evidence to Action report and considers what governments, consumers, carers, clinicians, providers and insurers can do to improve access and outcomes.

HCF, supported by Nous Group, convened leaders from across Australia's mental health system to test the evidence and examine reforms worth pursuing.

The Evidence to Action report examines pressures affecting access, affordability, workforce capacity and system performance, including the role of the private health sector. The Roundtable tested those findings and considered possible responses.

The reform options are intended as priorities for further development rather than fully designed policy proposals. Each will require further evidence, consumer and clinical input, implementation design and assessment of costs, benefits, equity impacts and unintended consequences. Reform should improve access and outcomes without deepening inequity between people with and without private health insurance or shifting costs and workforce pressures elsewhere in the system.

SOURCES AND APPROACH

This white paper draws on three sources: the analysis and modelling presented in HCF's Evidence to Action report; discussion and prioritisation at the Reimagining Mental Health Care Roundtable; and feedback subsequently provided by Roundtable participants.

The Roundtable brought together perspectives from government, consumer and advocacy organisations, clinical practice, public and private healthcare delivery, professional bodies, research, private health insurance and life insurance. The discussion was designed to test the evidence, explore areas of alignment and identify different views on potential reform priorities.

References to Roundtable insights or participant priorities reflect the discussion and voting undertaken at the event. They should not be interpreted as unanimous views or as endorsement by every participant or contributor. Acknowledgement as an attendee or co-contributor does not imply support for every finding, statement or reform option in this paper.

HCF has considered the Roundtable discussion alongside the available evidence, contributor feedback and relevant sector positions, including material from Private Healthcare Australia and Members Health Fund Alliance. These inputs have informed, but do not determine, the conclusions reached in this paper. Where this paper advances an HCF position or proposed next step, this is expressly identified.

"We need cross-sector collaboration to break down the barriers that stop Australians from getting the care they need, at the right time, in the right setting."

Lorraine Thomas,
Chief Executive Officer and Managing Director, HCF

KEY REFORM OPTIONS

Roundtable participants prioritised five options for further development through facilitated discussion and voting. The prioritisation indicates relative interest among participants and does not constitute unanimous endorsement or a final HCF policy position.

Three potential reform levers were identified that together could improve access, affordability and sustainability across the mental health system:



LEVER 1

Shift demand through early intervention and care substitution.



LEVER 2

Rebalance risk and price signals across the PHI system.



LEVER 3

Expand effective supply through workforce and care model reform.

The five prioritised reform options are:

1A	Funding selected non-hospital treatments through private cover to incentivise prevention and support acute and chronic mental health conditions through alternate models of care.
1B	Allow for a flexible package of mental health support across the continuum of care , including hospital avoidance, prevention, chronic disease management and post-discharge support.
2A	Modernise risk equalisation settings to reflect mental health and chronic care exposure, to promote the sustainability and affordability of Gold cover.
2B	Consider positive, incremental changes to product tiering and allowable services under hospital cover to maximise private health insurance (PHI) participation.
3A	Boost workforce through initiatives such as increasing top-of-scope care to support and deliver non-hospital contemporary models of care.

ACCESS HCF'S EVIDENCE TO ACTION REPORT [HERE](#)



THE CHALLENGE AND THE IMPACT

HCF's Evidence to Action report identified four interconnected pressures affecting access to mental health care, including pressures within the private system. Together, they point to narrowing access, increasing complexity, constrained capacity and funding settings that provide stronger support for some forms of hospital care than for community-based, coordinated and post-discharge care. The evidence underpinning these challenges follows.

ACCESS TO MENTAL HEALTH SERVICES IS NARROWING

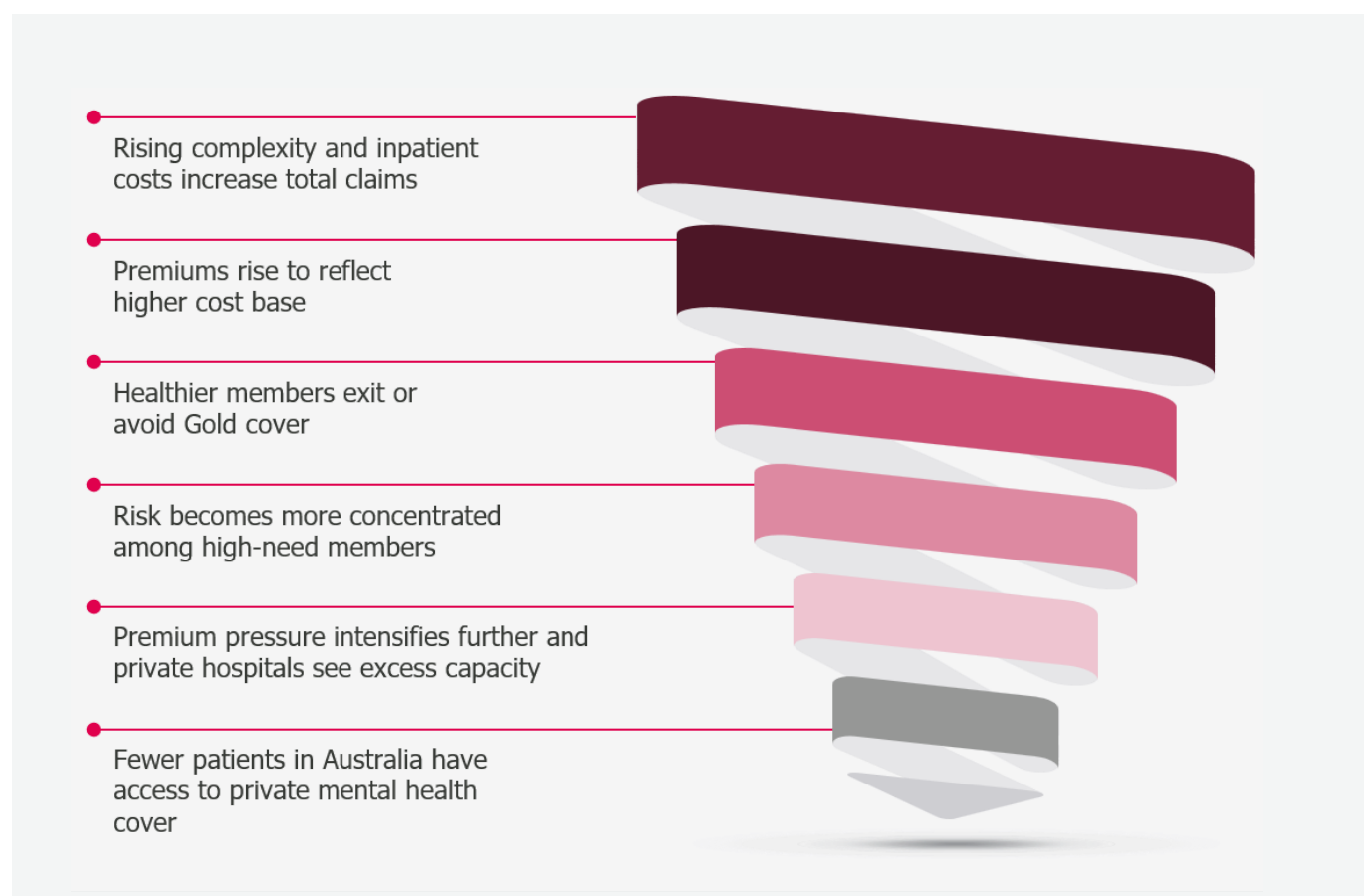
Public and private mental health services now play distinct but interdependent roles.

Public hospitals continue to provide substantial overnight care and manage a broader, more complex diagnostic mix, including psychotic disorders, dementia-related conditions, alcohol-related disorders and severe mental illness requiring involuntary treatment.

Private hospitals provide a significant source of capacity that helps relieve pressure on the public system, accounting for almost 30% of overnight mental health admissions and more than 90% of same-day mental health admissions¹. Increasingly, private hospitals are supporting people with affective disorders, anxiety and stress-related conditions, eating disorders, trauma-related disorders, and alcohol and other drug presentations.

However, access to much of this care increasingly depends on Gold-tier private health insurance cover. The proportion of Australians holding Gold cover has fallen in recent years², while premiums have continued to rise, creating an affordability challenge for consumers and reducing access to comprehensive private mental health care. Because unrestricted hospital psychiatric treatment is concentrated within Gold products, the costs associated with these services are largely funded through the Gold membership pool. As participation declines, the costs of maintaining comprehensive cover are shared across fewer policyholders, placing additional pressure on affordability.

Figure 1. The Gold Spiral



Note: An illustrative representation of the interaction between participation, claims concentration and premium pressure. It does not imply that each step is caused solely by the preceding factor.

¹ Australian Institute of Health and Welfare. Admitted patient mental health-related care to 2023-24. Updated August 2025.

² Australian Government Department of Health, Disability and Ageing. Hospital Casemix Protocol Annual Report, 2023-24.

Together, these trends may contribute to a self-reinforcing ‘Gold spiral’ illustrated in Figure 1, in which declining participation, increasing claims concentration and premium pressures can reinforce one another over time. This dynamic raises broader questions about whether current product tiering and risk-sharing arrangements support affordable and sustainable access to mental health care within the private system.

It also matters because of what it means for people and the broader health system. If consumers are unable to afford or retain the cover that gives them access to private inpatient mental health care, they may delay treatment, present later with more complex needs, or require more intensive support. Reduced access to private care can in turn increase pressure on other parts of the system, including public hospitals. Maintaining sustainable access pathways to private mental health care is therefore not only a question of private health insurance affordability, but also of broader system capacity and consumer choice.

CARE IS BECOMING MORE COMPLEX AND COSTLY

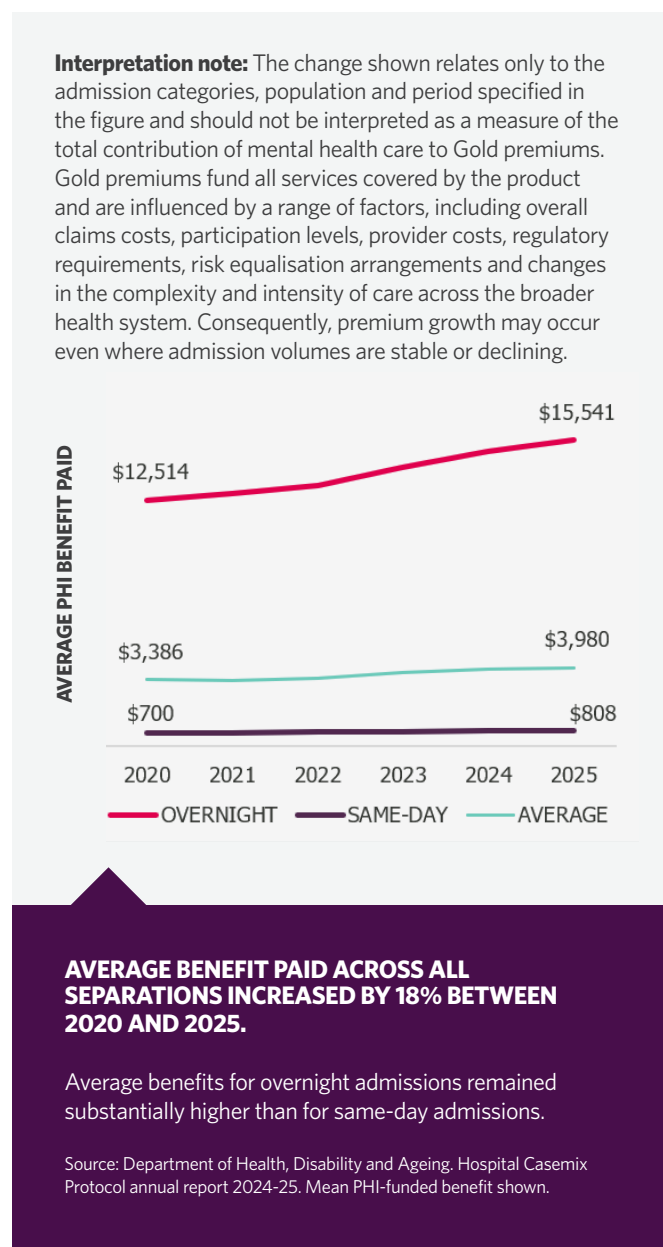
The system is increasingly supporting people with more complex and recurrent mental health conditions. While the number of privately funded mental health admissions has declined slightly in recent years, the overall cost of care has increased as patients are presenting with more complex conditions requiring longer and more intensive treatment. Growth in alcohol and other drug-related admissions and increasing rates of high-complexity presentations are among the factors contributing to rising costs.³

The average PHI benefit per mental health admission increased by 18% in the last five years, from \$3,386 in financial year 2020 (FY20) to \$3,980 in FY25. Possible contributing factors include changes in patient complexity, length of stay, and broader cost pressures.⁴

While admission volumes have declined modestly, the patients entering care are increasingly presenting with more complex needs that often require longer and more resource-intensive treatment. These trends contribute to rising claims costs, alongside other factors including provider costs, regulatory settings, risk equalisation arrangements and broader changes in service utilisation across Gold products.

The increasing complexity of care also has implications for workforce capacity and the system’s ability to meet demand for specialised mental health support.

Figure 2. Average benefit paid



WORKFORCE AND CAPACITY CONSTRAINTS ARE LIMITING ACCESS

Available evidence indicates workforce constraints across the mental health system, including maldistribution, an ageing specialist workforce and long training pipelines. Roundtable participants identified access to an admitting psychiatrist as a particular constraint across the system, with greater challenges in regional areas, alongside pressures on the mental health nursing and psychology workforces.

Public bed numbers have remained broadly stable, with private hospitals continuing to provide a significant share of specialised mental health capacity.⁵

³ Australian Institute of Health and Welfare. Admitted patient mental health-related care to 2023-24. Updated August 2025.

⁴ Ibid.

⁵ Australian Institute of Health and Welfare. Specialised mental health care facilities. Up to 2023-24.

⁶ Australian Government Department of Health, Disability and Ageing. Private Health Insurance 2018 Reforms Data, as of December 2025.

CURRENT SYSTEM SETTINGS FAVOUR LATER ACUTE CARE OVER EARLY INTERVENTION

Despite strong evidence supporting early intervention, community-based care and care coordination, funding structures continue to favour more intensive hospital-based treatment.

- Australia's mental health system spans private hospitals, public hospitals, primary care and community services, but current settings do not support care to move smoothly across this continuum.
- Current funding arrangements provide stronger support for some forms of hospital-based treatment than for community-based, coordinated and post-discharge care, and relapse prevention programs.
- Where timely support is unavailable, people may present later with more complex needs.

LOOKING AHEAD

The following projections show what could happen if current trends continue. They are based on the assumptions in the Evidence to Action report and are not forecasts.

- The number of people with Gold cover could fall from 3.6 million to 2.4 million over ten years.⁶
- Fewer insured people may access private inpatient care, while those who do may have more complex needs. Changes in the complexity and mix of care could increase length of stay in private hospitals.
- Higher care intensity and declining Gold participation could place further financial sustainability pressures on private mental health services.
- Access to these services may narrow, reducing consumer choice and potentially increasing demand elsewhere in the health system.



WHAT THE SECTOR SAID ABOUT THE CHALLENGE

Recognising that these challenges cannot be addressed by a single organisation or sector alone, HCF convened a roundtable of senior leaders from government, healthcare delivery, clinical practice, consumer organisations, PHI, life insurance and related sectors.

Participants considered key questions:

- What are the challenges for mental health care?
- What are the specific challenges for mental health care in the private health sector?
- What are the priorities in the short-, medium- and long-term to ensure access, high-quality outcomes and system sustainability?

The discussion brought together perspectives from across the system, including policymakers, clinicians, providers, consumer advocates, researchers and insurers. Many participants expressed concern that current arrangements would not meet future needs.

The following section summarises key discussion points and perspectives from the Roundtable.



ACCESS REMAINS DIFFICULT, INEQUITABLE AND UNAFFORDABLE

- The mental health system is fragmented, making it difficult for consumers to understand what support is available and navigate the system.
- Consumers attempt to access mental health care in multiple ways but often resort to emergency departments in the absence of alternatives.
- Access to psychiatrists remains a major challenge, with closed books, limited capacity and out-of-pocket costs restricting access for new patients. Competing demand across different service settings and funding models can further constrain the specialist capacity available for complex and multidisciplinary care.
- Psychology services can also be difficult to access, with confusing funding arrangements, limited availability and high out-of-pocket costs.
- Digital mental health tools and digital navigator models have the potential to simplify access and direct people to the right level of care, but awareness and uptake remain limited. They can also add complexity if they are not practical, easy to use and supported by trusted recommendations from GPs, insurers and community networks.

“People shouldn’t have to reach crisis before they receive the support they need. A better system is one that people can navigate easily, understand clearly and access when it matters most.”

Lisa Robins
CEO, Patients Australia

- The affordability of specialist mental health care is a critical challenge. Participants cited typical out-of-pocket costs of approximately \$500 to \$600 per consultation.
- Rising psychology costs and the affordability of private health insurance can lead consumers to delay seeking support, potentially worsening their condition.
- Australia faces a widening gap in mental health care capacity and quality, with pressure on both public services and private psychiatry. Those with the most severe mental illness and their families are bearing the greatest impact.
- Cost is also an increasing barrier to care. The National Mental Health Commission’s National Report Card 2025 shows that the proportion of Australians 15 years and over who cited cost as a reason for not seeing a mental health professional when needed rose from 12% in FY20 to 20% in FY24.⁷

⁷ National Mental Health Commission. (2026). National Report Card 2025. Australian Government. National Report Card 2025 | National Mental Health Commission

“There’s a growing gap in capacity and quality of mental health care in Australia. Even the affluent struggle to secure reliable and high-quality care.”

Professor Patrick McGorry AO
Executive Director, Orygen

- Some priority population groups face additional barriers to access, including people with disability, comorbid health conditions, trans people, older people and young people.
- Factors such as declining social connection and increasing levels of isolation will continue to increase demand for mental health support, resulting in people missing out on the care they need.

GAPS IN SERVICE MODELS LEAVE PEOPLE WITHOUT THE RIGHT LEVEL OF CARE

- More young Australians are being diagnosed earlier, and presentations are becoming more complex, with many people not fitting standard provider models.
- Earlier onset mental illness can have lifelong consequences, while delayed support may lead to increasingly complex needs. People with serious mental illness have a life expectancy around 15 years shorter than the general population.

“We need to find a pathway to a no-gap model of care for mental illness that does not depend on hospital admissions.”

Dr Rachel David
Chief Executive,
Private Healthcare Australia

- There is increasing patient complexity and acuity, with more complex conditions presenting in hospital settings. While many of these patients need hospital-based care, this contributes to rising healthcare costs and more complex care coordination requirements.
- People with needs that are too complex for primary care but do not meet the threshold for specialist or acute services can face significant gaps in support, known as the ‘missing middle’. This may contribute to them presenting later with more complex, higher intensity needs.

“There is a significant gap within the current private system model, where people – particularly those experiencing moderate to severe mental illness – face systemic barriers to accessing timely care, effectively delaying treatment until a clinical crisis occurs. Even then access to care is not guaranteed.”

Christine Gee AM
Director, Ramsay Mental Health Australia
President, Australian Private Hospitals Association

- Current service design and regulatory requirements may also unintentionally limit access. For example, highly prescriptive requirements for group therapy models, such as attending for minimum blocks of time, can limit access.
- Primary care is often the frontline for supporting people with mental health issues, but 20-minute general practitioner (GP) appointment lengths can make it difficult to assess and manage complex mental health needs.
- The number of admitting psychiatrists is constraining access to inpatient care. Participants argued that limited admitting psychiatrist capacity means consumers who are admitted are increasingly those with higher-acuity needs. This is consistent with the Hospital Casemix Protocol data suggesting that the complexity of private inpatient admissions is rising.
- Current service models do not consistently reflect people’s individual needs and circumstances, despite increasing expectations for more tailored support.

“Improving access, equity and outcomes in mental health requires understanding how different parts of the system interact, are funded and shape people’s experiences.”

Rachel Green
CEO, SANE Australia

WORKFORCE CAPACITY IS SIGNIFICANTLY CONSTRAINED ACROSS THE SYSTEM

- Shortages in specialist roles, including psychiatrists, and an ageing workforce will make it harder to continue delivering complex care.
- Highly skilled clinicians are not always supported to work at the top of their scope.
- Workforce challenges reflect not only shortages, but also declining specialist capability, training pipeline constraints and burnout among emerging clinicians. Workforce issues are felt particularly strongly in regional and rural areas.

CARE IS FRAGMENTED AND INSUFFICIENTLY COORDINATED

- Poor information sharing and transitions between providers also contribute to fragmented care, making it harder for consumers to move smoothly across services and access coordinated support.

"We are missing the concept of 'deep care'. Too often, we patch people up and put them back into the system, rather than helping them understand how to manage their condition and where to seek support before they reach crisis."

Adj Prof Karen Price

Chair, HCF Research Foundation
and Former President, RACGP

- Current models often focus on managing immediate risk rather than supporting sustained recovery. Participants emphasised that the current system does not consistently provide the coordinated and continuous care needed to support long-term recovery.
- There is a lack of coordination with primary care and digital services. For example, there are limited services offering mental health check-ins and other services that could support identification and early intervention.

"As a GP, I'd like to see a discussion on how private health insurance could contribute to funding primary care, opening up mental health care access to more people."

Professor Dimity Pond

Chair, RACGP Expert Committee – Research

- Primary care has a central role in coordinating mental health support, but current referral pathways can create delays, duplication and additional barriers to accessing specialist care.
- Roundtable stakeholders observed that there is a cohort of consumers who only gain admission on their fifth or sixth interaction with the system, increasing the risk of deterioration or self-harm in the interim.
- Families and carers often absorb the consequences of gaps in care and can become a central support mechanism when people cannot access appropriate support.

"Hospitals are, and will remain, a key component of the mental health system, providing essential care for people with acute and complex needs. Equally important is the availability of complementary services such as early intervention, intensive outpatient care, step-up and step-down programs, and effective discharge pathways that support recovery and improve long-term outcomes."

Matt Hanrahan

CEO, Healthe Care



FUNDING AND SYSTEM SETTINGS REINFORCE TRADITIONAL MODELS OF CARE

- Current Medicare Benefits Schedule (MBS) funding arrangements for psychology services can hinder continuity of care. Participants indicated the 10-session cap is often insufficient for people with ongoing needs, creating inefficiencies that increase costs for consumers, providers and the broader system.⁸

“If we invest earlier in effective psychological care, we can improve outcomes, reduce the need for costly hospital care, and give people more value from their cover.”

Dr Kelly Gough

President, Australian Psychological Society

- Current MBS settings and alternate funding streams can create stronger financial incentives for psychiatrists to consult in private rooms than to participate in inpatient or flexible multidisciplinary models of care.
- System settings and funding arrangements do not incentivise multidisciplinary-led care in the private sector.
- Current service models and funding arrangements remain focused on the clinical workforce, making it difficult to support peer workers and lived experience roles who can play an important role alongside clinical care, particularly when supported by clear governance, supervision and escalation pathways.

- Product and risk settings concentrate mental health costs in Gold products, adding affordability pressure and raising broader questions about how private health insurance products are designed.

PUBLIC AND PRIVATE SERVICES PLAY DISTINCT BUT COMPLEMENTARY ROLES

- Participants in the Roundtable highlighted that reform should not be viewed solely through the lens of PHI sustainability. Maintaining access to effective private mental health services is important because it may help preserve consumer choice, support system capacity and reduce pressure on already constrained public services.
- Public and private services have overlapping roles, and their service mix and patient profiles differ. Public services provide much of the crisis, acute and involuntary care, while private providers contribute capacity through admitted care, day programs and other services.
- Reduced access to private care does not remove the need for treatment and may increase demand elsewhere in the system.

“Earlier support and better-connected care can improve outcomes and help people get the right care before their needs become more complex.”

Julie Andrews,

Chief Officer Member Health, HCF

⁸ Australian Government Department of Health and Aged Care. Medicare Benefits Schedule Note MN.6.2: Provision of Psychological Therapy. Medicare Benefits Schedule. Accessed September 2026



OPPORTUNITIES FOR REFORM

Stakeholders agree that no single reform intervention will be sufficient to address the pressures facing Australia’s mental health system. Instead, meaningful change will require a coordinated approach that addresses demand, affordability, workforce constraints and care models. The reform options presented in this section focus on access to care in the current environment, not on addressing future demand

for care through prevention or addressing drivers of mental health demand.

Three potential reform levers were identified that together could improve access, affordability and sustainability across the mental health system:



Roundtable participants considered a range of reforms under each of the three levers and prioritised five options with the greatest potential to support meaningful change. HCF then reviewed those options against the evidence, contributor feedback, current regulation and their likely effects on consumers and the wider health system.

PRIORITY OPPORTUNITIES	
Selected by Roundtable participants	
Lever 1: Shift demand through early intervention and care substitution	
1A	Fund selected non-hospital treatments to incentivise prevention and support acute and chronic mental health conditions through alternative models of care.
1B	Allow for a flexible package of mental health support across the continuum of care, including prevention, hospital avoidance models, chronic disease management and post-discharge support.
Lever 2: Rebalance risk and price signals across the PHI system	
2A	Modernise risk equalisation settings to better reflect mental health and chronic care exposure, to promote the sustainability and affordability of Gold cover.
2B	Consider positive, incremental changes to product tiering and allowable services under hospital cover to maximise private health insurance (PHI) participation.
Lever 3: Expand effective supply through workforce and care model reform	
3A	Boost workforce capacity through initiatives such as increasing top-of-scope care to support and deliver non-hospital and contemporary models of care.

OTHER REFORM OPTIONS CONSIDERED BUT NOT PRIORITISED

Discussed during the Roundtable but not identified as priority opportunities by participants

- Longer consultation times for doctors to ensure continuity of care and enabling team-based care.
- Increase inpatient MBS fees compared to private outpatient settings.
- District of Workforce Shortage reform to include regional area-of-need allocation
- Integrating digital pathways and digital therapies, including AI-enabled tools
- Reducing out-of-pocket costs through approaches such as bundled payments
- Strengthening compliance and governance of the 'once-in-a-lifetime' mental health waiver.

The following section presents an overview of each reform option, including supporting evidence, key barriers and enablers, and next steps.





LEVER 1: SHIFT DEMAND THROUGH EARLY INTERVENTION AND CARE SUBSTITUTION

This lever seeks to address growing demand for hospital-based care by supporting earlier intervention, more coordinated care pathways and greater continuity of care across the mental health system.

Current PHI settings limit the ability of private health insurers to fund some forms of community-based, step-down and coordinated care outside hospital settings. As a result, opportunities to support earlier intervention, reduce fragmentation, and provide more seamless care across the treatment journey may be constrained. Separate to services funded through Medicare, including GP and specialist consultations, there may be a role for PHIs to support selected digital, online and psychological interventions beyond traditional ancillary cover.

This lever aims to improve access to clinically appropriate care earlier in a person's treatment journey and support care in settings outside hospital where appropriate. It also recognises the potential role of collaboration between PHIs, private hospitals and other providers in developing more connected models of care that extend beyond traditional inpatient treatment.

Participants emphasised that the objective is not simply to reduce hospital activity, but to ensure people can access the right care at the right time and in the right setting. Earlier intervention, care coordination and lower-intensity treatment options may improve outcomes, reduce avoidable deterioration and support a more sustainable mental health system.

OPTIONS FOR REFORM

OPTION 1A	FUNDING SELECTED NON-HOSPITAL TREATMENTS THROUGH PRIVATE COVER TO INCENTIVISE PREVENTION AND SUPPORT ACUTE AND CHRONIC MENTAL HEALTH CONDITIONS THROUGH ALTERNATE MODELS OF CARE.	
WHAT THE EVIDENCE SHOWS	- Current PHI settings limit funding for some forms of step-down, home-based and coordinated care that have shown benefits in some public-system settings. These models may support earlier intervention, recovery after discharge and reduced reliance on inpatient care. - The Australian Government is pursuing a range of initiatives to strengthen early intervention and out-of-hospital care. Any PHI models would need to complement, rather than duplicate or replace, these initiatives.	PROPOSED NEXT STEPS PHIs and other stakeholders to work with the Australian Government, including through the reform consultation process, to define the changes required to the Private Health Insurance Act 2007.
BARRIERS	- Expanding PHI funding into out-of-hospital care could create overlap between Medicare and PHI arrangements, increasing complexity and creating uncertainty about funding responsibilities if roles are not clearly defined. - New arrangements could widen differences in access between insured and uninsured consumers, duplicate existing services, or draw workforce capacity away from public and community-based care. - Clear clinical accountability, consumer safeguards and funding boundaries would be required to minimise the risk of unnecessary, inappropriate, or fragmented care.	
ENABLERS	Legislative change, including potential amendments to the Private Health Insurance Act 2007, may be required to enable funding for services such as step-down care, home-based treatment and care coordination.	

OPTION 1B**ALLOW FOR A FLEXIBLE PACKAGE OF MENTAL HEALTH SUPPORT ACROSS THE CONTINUUM OF CARE, INCLUDING HOSPITAL AVOIDANCE, PREVENTION, CHRONIC DISEASE MANAGEMENT AND POST-DISCHARGE SUPPORT.****WHAT THE EVIDENCE SHOWS**

- Mental health needs vary considerably between individuals and over time, requiring access to different forms of support as needs change.
- Earlier intervention, community-based treatment, digital services, chronic disease management and post-discharge support may improve access or continuity of care. However, these are distinct interventions with different evidence bases, target populations, clinical requirements and funding implications.
- Flexible support may be particularly relevant for people in the “missing middle”, whose needs can be too complex for primary care alone but may not meet the threshold for specialist or inpatient services. It may also support people following discharge, where continuity, relapse prevention and readmission avoidance are important objectives.

BARRIERS

- Current funding arrangements are fragmented across Commonwealth, state and territory governments, private health insurers, and consumers, creating challenges in designing integrated care pathways.
- Financial risk exposure for PHIs because of both product risk and the need to conduct detailed modelling to determine the associated pricing and benefits structures.
- Overlap and interaction between funding mechanisms, including PHI-funded and Medicare-funded services, creates complexity and uncertainty regarding payment obligations and responsibilities.
- Consumers may experience fragmented access where different parts of care are funded through separate programs, organisations or insurers, such as when a member has hospital cover with one PHI and extras cover with another.

ENABLERS

- Greater alignment and co-funding opportunities with government and PHIs to support wider access.
- Opportunities for co-funding or funding partnerships with non-government organisations to deliver innovative and blended models of care.
- Strong partnerships between governments, insurers, providers and non-government organisations to design and evaluate new models of mental health support.

PROPOSED NEXT STEPS

Stakeholders should explore opportunities to test more flexible models of mental health care that better meet consumer needs across the continuum of care, particularly for people in the ‘missing middle’. This should include consideration of funding arrangements, responsibilities, regulatory barriers, member/consumer and financial impacts of changes and mechanisms for evaluating outcomes.



LEVER 2: REBALANCE RISK AND PRICE SIGNALS ACROSS THE PHI SYSTEM

This lever considers whether current private health insurance funding and product settings appropriately reflect patterns of mental health service use and expenditure.

Current risk equalisation settings were introduced in 2007 and incorporate benefits paid for both high-cost claims over \$50,000 and claims for people aged over 55. While age-based pooling reflects the broader pattern that health expenditure generally increases with age, mental health services use and expenditure follow a different profile.

High-cost psychiatric claims can arise across a broader age range than many other forms of hospital care, meaning current settings may not align as closely with mental health expenditure patterns as they do for costs that are concentrated among older populations.

While further modelling is required to understand the extent of any impact, this highlights the importance of ensuring funding arrangements remain aligned with how mental health costs arise.

Product tiering reforms introduced in 2019 improved transparency and consistency for consumers but also concentrated on unrestricted private hospital psychiatric treatment within Gold-tier products. Together, these settings raise broader questions about affordability, participation and access, and whether current funding and product arrangements remain fit for purpose in supporting mental health care.

Key product tiering considerations include:

- Gold products include a concentration of higher-cost services, including unrestricted private hospital psychiatric treatment.
- Comprehensive cover may provide limited perceived value for consumers who do not expect to use higher-cost hospital services.
- Current product settings may provide limited flexibility to support different patterns of care outside traditional inpatient models.

OPPORTUNITIES FOR REFORM

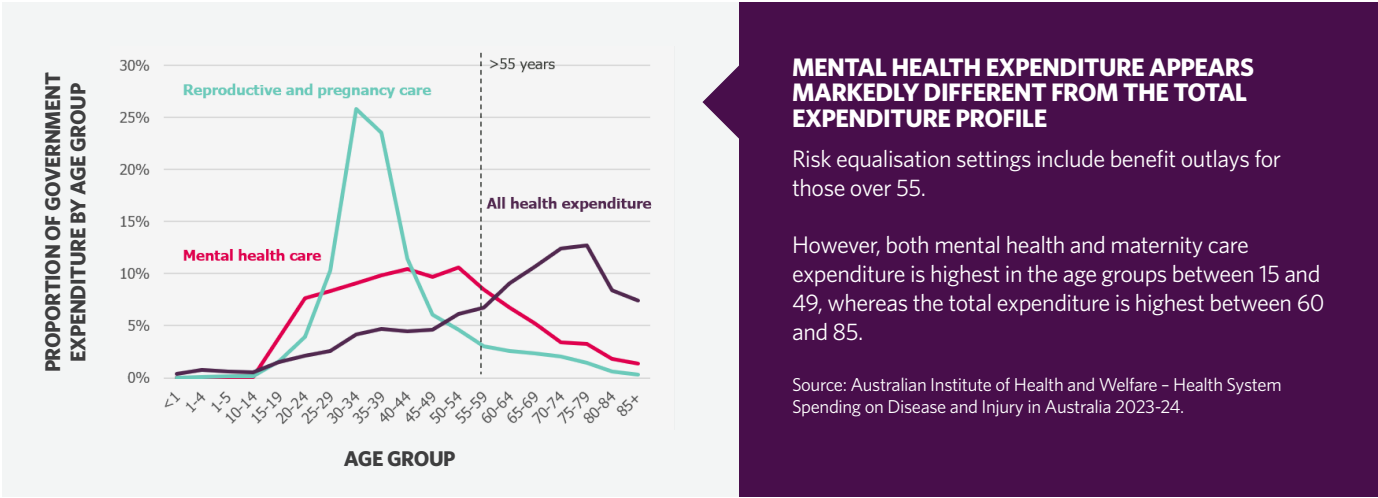
OPTION 2A	MODERNISE RISK EQUALISATION SETTINGS TO REFLECT MENTAL HEALTH AND CHRONIC CARE EXPOSURE, TO PROMOTE THE SUSTAINABILITY AND AFFORDABILITY OF GOLD COVER.	
WHAT THE EVIDENCE SHOWS	• Mental health service use and expenditure follow a different age profile from health expenditure across all conditions (Figure 3). • Risk equalisation determines how certain claims costs are shared across insurers. It does not directly improve clinical outcomes, reduce the underlying cost of care or create additional service capacity. • This matters because mental health service use and expenditure do not necessarily follow the age profile reflected in existing pooling arrangements. Where high-cost psychiatric claims arise among younger or more recently insured members, current settings may not redistribute those costs in the same way as costs associated with older members. Detailed modelling is required before concluding that this results in a material concentration of costs in particular products, insurers or member groups. • Risk equalisation reform has been examined through a range of government, academic and industry reviews, with strong consensus that the current risk equalisation system does not adequately reflect actual claims patterns or emerging cost drivers and could be improved.⁹	
BARRIERS	• Any change to risk equalisation settings would redistribute costs between insurers, products and member groups. Detailed modelling would be required to identify who would pay more or less under different options and assess the effects on affordability, participation and competition. • Changes to risk equalisation alone would not address the underlying drivers of mental health expenditure and would need to be considered alongside broader product and care-model reforms.	
ENABLERS	• Consultation processes in 2022, 2023 and 2026, alongside extensive research from experts across the sector, mean the evidence supporting reform is well established.	

PROPOSED NEXT STEPS

PHIs to work with the Australian Government to model options, assess the impact and agree on a preferred approach to ensure risk equalisation can better manage mental health claims costs.

⁹ Australian Government Department of Health and Aged Care. Consultation on the Private Health Insurance (PHI) Actuarial Study into Risk Equalisation. December 2022.

Figure 3. Lifetime health expenditure



OPTION 2B			CONSIDER POSITIVE, INCREMENTAL CHANGES TO PRODUCT TIERING AND ALLOWABLE SERVICES UNDER GOLD COVER TO MAXIMISE PHI PARTICIPATION.
WHAT THE EVIDENCE SHOWS		Current product settings concentrate unrestricted admitted psychiatric treatment within Gold cover. This contributes to affordability and participation pressures while limiting the ability of products to support selected lower-cost services outside traditional admitted care.	
BARRIERS		- Expanding comprehensive mental health coverage into lower tiers may increase utilisation and claims costs if not supported by funding, pricing and care model reform. Allowing out-of-hospital or lower-cost mental health services on products other than Gold could reduce concentration risk. - Greater flexibility and tier redesign could increase product complexity for consumers and insurers, particularly during transition, affecting comparability and market stability. The impact of changes on PHI participation must be well modelled to ensure no adverse consequences of any reform. - Poorly designed changes could create risks to PHI participation if they increase premiums, reduce perceived value or make products harder for consumers to understand.	
ENABLERS		- Alignment with risk equalisation reform to ensure high-cost claims are sustainably shared across the system. - This would be most effective if associated with the development of new, lower-cost service models that support earlier, less acute and less expensive care and help reduce overall system costs.	
			PROPOSED NEXT STEPS PHIs should work with the Australian Government to model how potential changes would affect participation and financial outcomes, and to identify improvements that could be implemented within existing regulatory arrangements. In conjunction with work under Option 1A, modelling should consider product tiering changes aligned with new treatment models.



LEVER 3: EXPAND EFFECTIVE SUPPLY THROUGH WORKFORCE AND CARE MODEL REFORM

Australia needs both a larger mental health workforce and better use of the workforce already available. Supporting clinicians to work at the top of their scope should sit alongside investment in specialist training, retention and services outside metropolitan areas.

Aligned to Lever 1, a more coordinated approach to workforce and capacity planning is essential to better meet system needs, support earlier intervention and enable multidisciplinary models of care. While psychiatrists and hospital-based services remain a critical part of the mental health system, current workforce constraints highlight the need to make better use of the broader mental health workforce, care settings and digital therapies.

OPPORTUNITIES FOR REFORM

OPTION 3A		BOOST WORKFORCE THROUGH INITIATIVES SUCH AS INCREASING TOP-OF-SCOPE CARE TO SUPPORT AND DELIVER NON-HOSPITAL CONTEMPORARY MODELS OF CARE.
WHAT THE EVIDENCE SHOWS	- Current workforce and funding arrangements are not aligned to support multidisciplinary, non-hospital care at scale, limiting the ability to deploy capacity where it is most needed. - Multidisciplinary care can make better use of different professional skills across levels of complexity, according to consumer need and professional scope of practice, while retaining specialist psychiatric involvement where clinically required. This should not reduce access to psychiatrists or hospital care where they are needed.	PROPOSED NEXT STEPS PHIs, private and public hospitals and colleges to work with the Australian Government to prioritise and consider the impacts of initiatives to boost workforce and deliver non-hospital contemporary models of care. Initial proposals include: - District of Workforce Shortage (DWS) reform to include regional areas of need allocation. - Expansion of specialist training positions in out-of-hospital models of care.
BARRIERS	- Inability to scale – workforce shortages and uneven distribution may limit the scale-up of non-hospital models, particularly without clear governance, supervision and referral pathways. - Current funding and incentives still favour hospital-based care, limiting providers' ability to shift activity into community, step-down, home-based settings or telehealth consultations. - Top-of-scope practice will not resolve the underlying shortage of mental health professionals. - Expanded roles need clear training, supervision, referral and escalation arrangements. - New services may draw clinicians from public, regional or community services that are already under pressure. - Clinical responsibility must remain clear when care is shared across several professionals or services.	
ENABLERS	- Workforce planning and expanded scope of practice. - Offering incentives for community-based care.	

A CALL TO ACTION

THE START OF AN IMPORTANT JOURNEY

The Roundtable highlighted strong agreement across a diverse group of stakeholders that current arrangements will not meet Australia's future mental health needs. While participants did not agree on every issue, there was common ground on the need for coordinated action. The sector now needs to continue working with government to build a mental health system that is sustainable, accessible and responsive to consumer needs.



CROSS SECTOR WORKING GROUPS AND THEIR SHORT-TERM WORK PLANS

The Roundtable demonstrated that there is both an appetite and a need for continued cross-sector collaboration. The next step should be to establish a forum through which government, consumers, clinicians, insurers and providers can jointly develop the reform options and convert them into an actionable program.

HCF supports reconvening the Private Mental Health Care Alliance (PMHA) to bring government, consumers, carers, clinicians, providers, professional bodies and insurers together to progress this work. This is a current reform option being considered by Government. Subject to agreement among participants, the PMHA could maintain oversight of the broader reform agenda while commissioning short-term working groups to examine specific priorities.

"No single organisation can solve Australia's mental health challenges alone. Progress will require consumers, clinicians, providers, governments and insurers to come together around a shared goal that puts people first"

Matthew Koce ,
CEO, Members Health Fund Alliance

BUILDING A DEEPER EVIDENCE BASE FOR THE REFORM OPTIONS

We welcome any input from experts across the mental health system to contribute their evidence, examples and proposals to progress these reforms. We suggest further evidence is needed to sharpen reform conversations, particularly on:

- Which innovative models of care are effective, for which conditions and cohorts, and at which points in the care continuum.
- The return on investment for these models of care from early intervention, including whether benefits can be attributed to healthcare spending and translate into avoided downstream acute care costs.

If you want to know more or have ideas to contribute, contact us through media@hcf.com.au.

APPENDIX A

GLOSSARY

KEY TERM	DESCRIPTION
Admitted care or admission	Hospital care where a person is formally admitted for treatment. This can include same-day care or an overnight stay.
Affective disorders	Mental health conditions that primarily affect mood, such as depression and bipolar disorder.
Alcohol and other drug (AOD) conditions	Health conditions related to alcohol or other drug use, including dependence, withdrawal or harmful use.
Bed days	A measure of hospital use. One bed day represents one patient occupying a hospital bed for one day.
Benefits paid	The amount paid by a private health insurer toward the cost of an insured member's hospital treatment and related medical services. In this report, average benefits paid are calculated by combining hospital benefits and fund-paid medical benefits for each diagnosis-related group.
Casemix	The mix of patients treated by a hospital or service, including their conditions, complexity and expected resource needs.
Clinical complexity	The level of difficulty, intensity or resource use involved in treating a patient. In AR-DRGs, complexity is assigned through national grouping rules based on coded clinical and demographic information, such as diagnoses, procedures, comorbidities, complications, length of stay and discharge details.
Gold cover	The most comprehensive private hospital insurance tier. In this report, Gold cover is important because unrestricted private hospital psychiatric benefits are generally available through Gold-tier products.
Gold spiral	A self-reinforcing cycle where higher-need members concentrate in Gold cover, claims costs rise, premiums increase and healthier members are less likely to join or remain in Gold cover.
Hospital Casemix Protocol (HCP)	A national dataset used to report private hospital activity and benefits paid by private health insurers.
Medicare Benefits Schedule (MBS)	The list of health services subsidised by the Australian Government through Medicare.
Mental health waiting period exemption	A once-in-a-lifetime rule that allows eligible private health insurance members to upgrade their hospital cover and access higher psychiatric benefits without serving the usual two-month waiting period.
Out-of-hospital care	Care delivered outside a traditional hospital admission, such as community-based, home-based, digital, step-up/step-down or coordinated care models.
Private health insurance (PHI)	Insurance that helps pay for private healthcare, including private hospital treatment and some extras services depending on the policy.
Risk equalisation	A mechanism used in private health insurance to share some claims costs across insurers, so funds with higher-cost members are partly compensated by the broader system.

APPENDIX B

ROUNDTABLE ATTENDEES

NAME	ORGANISATION
Daria Simic	Aurora Healthcare
Dr Kelly Gough	Australian Psychological Society
Jonathan Amirthanathan	Canberra Health Services
Judith Ingwerson	Canberra Health Services
Stacy Leavens	Capital Health Network
Ben Bartlett	Council of Australian Life Insurers
Christine Cupitt	Council of Australian Life Insurers
Sally Mackenzie	Delta Advisory
Paul McBride	Department of Health, Disability and Ageing
Gavin Matthews	Department of Health, Disability and Ageing
A/Prof Susan Wearne	Department of Health, Disability and Ageing
Dr Anna Colwell	Department of Veterans' Affairs
Leonie Nowland	Department of Veterans' Affairs
Matt Hanrahan	Healthe Care
Sarah Perkins	Koa Health
Matthew Koce	Members Health Fund Alliance
Ingrid Hatfield	Mental Health Australia
Prof Pat McGorry AO	Orygen
Lisa Robins	Patients Australia
Dr Rachel David	Private Healthcare Australia
Christine Gee AM	Ramsay Mental Health / APHA
Prof Dimity Pond	RACGP
Rachel Green	SANE
Dannielle Nagle	ACT Government
Jonathan Holt	St John of God Healthcare
Dr Mike Millard	St Vincent's / THIS WAY UP
Shane Mitchell	UnitingCare Queensland

NAME	ORGANISATION
Prof Sonja March	University of Southern Queensland
Prof Susan Cotton	Turner Institute for Brain and Mental Health
Lorraine Thomas	HCF
Kevin Keane	HCF
Julie Andrews	HCF
Tanner Strickland	HCF
Linda Opie	HCF
Ian Maytom	HCF
Josh Edwards	HCF
Joni Thomes	HCF
Sophie Giles	HCF
Dr Chris Pettigrew	HCF Research Foundation
Adj Prof Karen Price	HCF Research Foundation
Raj Verma	Nous Group
Monique Jackson	Nous Group
Ian Thompson	Nous Group
Bridget Seawright	Nous Group

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