Department of Health
Private Health Insurance Reforms
Second Wave

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and emerging, for they hold the dreams of Indigenous Australia.

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Table of Contents

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Introduction

- The Australian Psychological Society (APS) is the peak body for psychologists in Australia representing over 25,000 members. Our psychologists work to improve people's lives, including consumers who use and wish to use Private Health Insurance (PHI) to cover physical and psychological services on a daily basis.
- We welcome the consultation on further PHI reforms. Purchasing health insurance can be confusing. People often have to make trade-offs between what they want covered and what they can afford and are prepared to pay for. This can lead to sub optimal coverage and thereby health outcomes. Reforms therefore need to be carefully considered and PHIs need to be focussing on wellbeing and ill health prevention, as well as treating health disorders. It is critical that this includes focus on mental health as one of the largest areas of unwelcomed growth in the health area.
- The Department of Health's consultation paper covers multiple questions under 4 key areas, these are very specific in scope and so exclude many of broader themes that are relevant to psychologists. For this reason we have provided feedback under consultation headings 1-3, rather than answering all questions.

PHI reform discussions need to consider that many PHIs place limits and barriers on the psychological services that can be claimed at a time when Australians need increased access to, and affordability of mental health care. We also need increased treatment and care options for those with a pre-existing mental health diagnosis. This is to reduce the burden that poor ongoing mental health creates for individuals, families, communities and the government.[1]

Current PHI limits and barriers include:

- Very limited coverage of psychological services - even under preventative/wellness policies.
- Low caps on insurance payments relative to service costs - resulting in limited access to psychological treatment; in most cases insufficient to achieve an effective outcome for members.
- Removal of customer choice in accessing psychologists - where PHIs encourage consumers with a Mental Health Treatment Plan to exhaust Medicare rebates prior to using their insurance policies.
- Overly restrictive claims criteria - focussed on which type of psychologist can be consulted in order to receive a rebate.
- Diminished privacy - where PHIs require their members to see their GP under Better Access prior to being able to use their policy to claim rebates for psychological services.

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1. Increasing the age of dependents to encourage younger people and also people with a disability to maintain private health insurance

In principle the Australian Psychological Society supports simplification of the categories and definitions as outlined in the consultation paper. We also advocate for standardisation of age ranges and conditions of dependents, plus broader inclusivity across PHIs to minimise barriers to inclusion, as outlined on pages 7-12.

Part 1: Increase the maximum allowable age for dependents in PHI from 24 years to 31 years

- The APS supports increasing the age of dependents to encourage young people to maintain PHI. Ultimately increasing the age to 31 will help safeguard coverage for this less affluent demographic and protect older members by spreading the cost burden.
- We are supportive of the standardisation of cover for dependents to the age of 31 irrespective of their relationship status, with standardisation of different dependent child categories and conditions of dependence across health insurers. This will ease purchase comparison.
- We also advocate that the definition of 'child' be simplified, and that the distinction between student and non-student be removed to limit barriers to cover and so broaden healthcare accessibility.

Younger people utilise PHI (including hospital services) relatively less than older people. However, their need is great. There are approximately 600,000 children in the 4-17 year category alone who experience a mental health disorder each year. That is 1 in 7 children.[2,3] In addition, an estimated 50 percent of adult mental illness begins before 14 years of age.[4] Given the current mental health crisis being experienced by young people, the value proposition of PHIs for this demographic would be significantly enhanced through increased coverage of psychological services.

Part 2: Remove the age limit for dependents with a disability

- The APS supports removing age restrictions for those with a disability irrespective of their relationship status - whilst protecting against prohibitive premiums.
- We support standardised coverage across all PHIs to enable ease of comparison and portability.
- For the sake of consistency, the APS supports the 'disability definition' used by the NDIS. However, where there is a severe impact on functioning and ongoing dependence on a parent, we advocate for a broader perspective that includes: all levels of psycho-social disability, non-permanent injury or illness, and a more inclusive definition of neurological disorders (e.g. Level 1 Autism).
- Where there is doubt about a person meeting a definition for a neurological disability or psychosocial disorder with regards to PHI coverage, they should be assessed by an appropriately qualified psychologist (i.e. clinical-neuro, educational and developmental, clinical or counselling psychologist[5]).

We endorse an inclusive approach to increasing the age of dependents to encourage younger people and people with a disability to maintain PHI. Increasing the age of dependents will help PHIs retain members, build uptake, and thereby provide better health outcomes across the board.

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2. Expanding home and community based rehabilitation care

Whilst the Australian Psychological Society supports the development of orthopaedic rehabilitation plans that include out of hospital care, we believe that psychologists can play a key role here and are not being considered in the current PHI reform agenda. All hospital in the home initiatives (many of which have been well received by patients and found to be cost effective by insurers) need to include the patient having the option of psychological wellbeing services, delivered by a psychologist of choice and negotiated prior to hospital discharge.

Development of a rehabilitation plan that includes out of hospital care

- Community-based rehabilitation care extends beyond medical appointments. Addressing patient engagement, adjustment to injury and acute and chronic pain management as key areas of a rehabilitation program requires effective, evidence-based psychological treatment to ensure optimal outcomes.
- Psychologists have specific expertise in assisting patients with overcoming barriers to treatment, e.g. mental health disorders and low motivation to participate in their rehabilitation.
- Cognitive difficulties can impact progress in orthopaedic rehabilitation settings, e.g. an underlying neurodegenerative condition may be unmasked by surgery or hospital admission, orthopaedic injury may be accompanied by a neurological injury, and/or underlying cognitive issues may not have been factored into a rehabilitation plan. Such issues can negatively impact on length of stay, cost and ultimately, physical recovery. Access to neuropsychological assessment services will serve to enhance community-based rehabilitation plans.

The Australian Psychological Society is ready to work with Department of Health and PHIs to determine which rehabilitation services offered by psychologists should feed into orthopaedic rehabilitation plans. Provision of psychological services in such programs should be evidence-based and standardised. We could develop and provide certified training for psychologists who contribute to orthopaedic rehabilitation.

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3. Expanding funding to at home and community based mental health care

The Australian Psychological Society advocates for community-based mental health services supported by PHIs in line with the Government's broader mental health reform agenda, as outlined in the Productivity Commission (PC) Inquiry into Mental Health: Final Report.[6]

Benefits payable for preventative mental health treatment to all patients

- The APS supports PHIs funding preventative mental health services for members, regardless of whether they have had a previous hospital episode or not, and advocates for access to such services for all consumers. Limiting access to a targeted group who meet a set of specified criteria contradicts the nature of a preventative service. In addition, the cost-benefit of providing preventative/early intervention measures in the area of mental health is well documented - with improved mental, and general health outcomes being achieved.[7]

To further meet community mental health needs, and ensure high value care in the right setting at the right time, the APS advocates for the following preventative measures to be included under PHI in this reform:

- Access to out of hospital mental health services for people with a physical illness (e.g. heart disease and cancer) who are at risk of developing a mental illness (e.g. depression).
- Access to psychological interventions where an existing mental health issue is impacting on the patient's adherence to medical treatment recommendations and putting them at risk of hospitalisation for an underlying chronic disease (e.g. depression could impact adherence to diabetes self-management activities e.g. blood sugar level monitoring, lifestyle changes or taking medication).
- Individual consultations with a psychologist to address the impact of a health, or any other concern that affects optimal functioning.
- Psychometric, neuropsychological, functional and complex clinical assessments, including the capacity to claim for multiple services on the same date when indicated.
- Professional care team diagnostic and case conferencing where this is recommended best practice (e.g. Autism Spectrum Disorder).[8]
- In line with current recommendations, provision for the optimal number of sessions (of optimal duration) for trauma processing interventions with a psychologist e.g. Eye-Movement Desensitisation Reprocessing (EMDR)[9] and other exposure therapies.[10]
- Family sessions, child-focussed parenting work, couples therapy and carer support work with a psychologist.[11]
- Psychological therapy-based group participation.

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Chronic disease management programs (CDMPs) provided to a wider range of professional groups

- Allowing PHI funding of mental health services provided by peer workers, and other practitioners who do not have specific mental health qualifications or regulations, raises concerns regarding potential risks to consumers. Additional costs to health insurers may also be incurred due to double handling of consumers through the need for 'on referral'. The Mental Health Peer Workforce study (2014) notes that peer workers may be employed with "insufficient preparation", with uncertain boundaries existing between themselves and consumers, and poor understanding of the issues related to both confidentiality and personal disclosure (p. 13 - 14).[12] Therefore, expanding the mental health workforce to include non-clinical practitioners should only occur if appropriate standards are in place, along with a tightly regulated accreditation process. In addition, the treatment pathway should be determined by an appropriately qualified clinician; with the choice of treating practitioner being driven solely by the consumer - not the PHI.

- Caution is required in terms of assessing the benefits of expanding the list of allied health professionals able to provide mental health services funded by PHIs due to the associated cost of the regulatory burden associated with this proposal. As a safety and quality-assured, highly regulated, accredited psychological workforce already exists, consideration needs to be given to expanding this workforce, rather than introducing less qualified, unregulated service providers.

- To be eligible for direct CDMP related funding from insurers the APS believes there should be a prescribed list of Allied Health Professionals who are required to meet accreditation standards through minimum qualifications in mental health, registration with a regulatory body and current professional membership.

- Careful consideration around this proposal is required to ensure appropriate education and accreditation of these service providers, as well as supervision by qualified mental health professionals, such as APS psychologists, to safeguard consumers and service providers.

The Australian Psychological Society advocates for the expansion of the current psychological workforce to meet the growing need for community mental health services. However, if the proposed reforms regarding inclusion of other mental health service providers under CDMPs proceed, the APS could work with the Department of Health and PHIs to mitigate the risks associated with utilising a less qualified workforce by collaborating on developing standards of accreditation, training programs and supervision protocols. This would help to avoid debate in relation to risk and professional substitution.

Expanded payments for CDMP expenses to include indirect service delivery of low cost interventions

- We support expanding CDMP expenses to include indirect service delivery of low cost services in line with stepped-care models of intervention, including subscriptions to mental health applications – under the condition that such services are regulated and prescribed by an appropriately qualified mental health professional.

- We support PHI rebates for evidence-based somatic interventions relevant to psychological trauma recovery, e.g. yoga, meditation and mindfulness practices in line with current research and recommendations.[13] [14] [15]

The reforms should also consider the following to optimise preventative healthcare outcomes:

- The definition of coordination and planning should be expanded to include professional care team meetings and case conferences to address initial treatment planning, review and final reports.

- The relevant patient cohort identified for eligible services could be established in consultation with an expert reference group (ERG), comprised of mental health professionals such as APS psychologists, who are aware of service entry points and the various needs associated with best practice outcomes in mental health care. The ERG should set industry-wide eligibility criteria for patient cohorts for identified mental health services.

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The APS can consult with the Department of Health and PHIs to:

- **Assist with restructuring, implementing and marketing out-of-hospital mental health services.**
- **Develop carefully designed hospital in the home mental health services, training programs for other mental health professionals providing CDMP services, accreditation regimes and ongoing supervision/case management to ensure quality products for PHIs.**
- **Provide accreditation of low-cost mental health services.**
- **Assist in the identification of relevant patient cohorts regarding their eligibility for services.**
- **Establish criteria for member eligibility.**

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In summary

The value proposition of PHI increases by allowing consumers to fully utilise their insurance in ways that they need and want e.g. by expanding the scope of psychological offerings in overall and 'extras' policies. The APS advocates for greater flexibility in policies by allowing customers to design their own bundles, or to 'flex extras limits' to use more of what they need, such as claiming for up to 80% psychological services if they choose, rather than having many smaller limits for services that they may not need.

The Australian Psychological Society advocates that PHIs increase consumer choice by stopping some providers requiring customers to exhaust Medicare Better Access rebates for treatment of mental illness before using their PHI. This hinders utilisation of PHI services, and cost-shifts towards public health services. PHIs should consider developing products that allow a number of psychologist sessions like Better Access. e.g. 20 sessions that can be used pre/post Better Access limits and include family, couples and group therapy as recommended in the APS White Paper.[16]

We believe that the definition of what constitutes a psychological service is not contemporary, it should be expanded and reviewed annually. Psychological services are not limited to mental illness, but can be used to promote health and wellbeing, to provide developmental and neurocognitive assessments and intervention and other health focussed areas such as pain management, cancer recovery and chronic illness.

By broadening the definition of psychological services greater value is derived for PHI customers and allows for products to cater to individual needs, or be targeted to specific life-stages (e.g. the offering for an elderly person suffering a chronic condition would be very different to a parent seeking assistance for their child.)

The Australian Psychological Society believes that there are missed opportunities for PHIs to provide corporate health programs that include proactive and preventative psychological input for mental health issues that can impact in the workplace e.g. stress management.

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