

10/135

2 August 2011

Mr Ian Holland
Committee Secretary
Community Affairs References Committee
PARLIAMENT HOUSE
CANBERRA ACT 2600



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Dear Mr Holland,

Re: Submission to the Senate Community Affairs References Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services

The AMA welcomes the Senate Community Affairs References Committee Inquiry into funding and administration of mental health services currently before the Parliament. This Submission is directed at the following aspects of the Terms of Reference:

- a) The Government's 2011-12 Budget changes relating to mental health;
- b) Changes to the Better Access Initiatives, including:
 - i The rationalisation of general practitioner (GP) mental health services, and
 - iii. The impact of changes to the Medicare rebates and the two-tier rebate structure for clinical assessment and preparation of a care plan by GPs.
- f) The adequacy of mental health funding and services for disadvantaged groups, including:
 - ii. Indigenous communities.

In particular, this submission will ask the Inquiry to recognise the importance of significant further investment in mental health services and to recommend that the Government reverse its 2011/12 Federal Budget decision to cut Medicare funding for mental health services delivered by GPs and psychologists under the Better Access Program.

The submission also highlights the lack of consultation undertaken by the Government before it took this Budget decision and how it is symptomatic of a more general problem in the approach of the Government to changes to the Medicare Benefits Schedule (MBS) and the funding arrangements for general practice.

D11/4552

The Committee needs to highlight this disconnect and recommend that the Government talk with the medical profession first, before enacting changes to the MBS and other funding arrangements that will have significant consequences for the delivery of care and for patients.

What is the Better Access Program?

The Better Access (to Psychiatrists, Psychologists and General Practitioners) Program was introduced in November 2006 under the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011 in response to low treatment rates for common mental disorders. Its ultimate aim was to improve outcomes for people with these disorders by encouraging a multi-disciplinary approach to their care. In this regard, GPs were recognised as a core part of the general mental health workforce, working in collaboration with psychiatrists and psychologists.

Its key feature was the inclusion of a series of new item numbers on the Medicare Benefits Schedule to provide a rebate for selected services by relevant providers. MBS items numbers were established in relation the preparation of the GP Mental Health Treatment Plan, the review of the GP Mental Health Treatment Plan and for GP mental health consultations.

2011/12 Federal Budget mental health package

The creation of appearances is now far more important for leading politicians than is the generation of outcomes. This produces a good deal of deception, and an approach that I call "the politics of the moment"¹.

The Hon Lindsay Tanner. Sideshow syndrome 'eroding democracy'. The Australian Newspaper, April 30, 2011

Governments have long neglected mental health. This is despite the fact that mental illness affects everyone in some way. Almost half of the Australian population will experience mental illness at some stage in their life and one in five Australian adults experience mental illness in any one year.

In this light, the AMA has acknowledged the Government's stated focus on better mental health services in the 2011/12 Federal Budget. Indeed, the AMA released a substantial policy on mental health care prior to the 2011/12 Budget, which outlined a significant investment plan to address this important community issue, a copy of which is **attachment 1**.

However, the AMA is strongly opposed to the Government's decision to substantially fund its mental health package through significant cuts to Medicare rebates for patients to access GP mental health services as well as reduced funding support for psychologist

¹ Former Minister for Finance, the Hon Lindsay Tanner. Sideshow syndrome 'eroding democracy'. The Australian Newspaper, April 30, 2011.

services under the Better Access Program. **These cuts to vital mental health care services total \$580.5m.**

Mental health is an area where significant unmet need exists and this requires additional investment, not the reallocation of funds. It is too simplistic an approach to shift significant funding from one needy group of patients to another.

The Government has billed its mental health package as being worth \$2.2 billion over five years. While this sounds impressive, it is appropriate to consider the following words of the former Minister for Finance, the Hon Lindsay Tanner in the same article referred to above where he said *“the lesson is simple – whenever a politician cites spending figures to show what a fine job he or she is doing, examine the fine print very carefully.”*²

The reality is that the \$2.2b headline figure is misleading and it relies on the standard methods used to maximize political appearances that Mr Tanner described in the article. In this case, the \$2.2b headline number ignores the significant spending cuts to the Better Access Program. It includes \$745 million in funding previously announced (or that represents the continuation of existing programs) and it also makes funding commitments that go beyond the forward estimate years.

Unfortunately the headline number is being used to mask the significant cuts to the successful Better Access program that are being implemented as part of the package.

The AMA asked *Access Economics* to undertake an independent assessment of the mental health package in the 2011/12 Budget. This analysis shows that in the standard 4-year budgetary framework, within the health portfolio, the net new mental health spending is \$390 million. In the 5-year framework announced in this Budget for this program only, this rises to nearly \$650 million net new spending over this period.

This same analysis also contradicts the position of the Government where it has said the spending is front-loaded. The reality is that \$481 million (74%) of net new spending in the health portfolio is delivered in the last two years of the 5-year package. In fact, in the first year of the package in 2011-12, the net new spending is negative (-\$25.9 million).

These figures can be confirmed by a quick examination of the Department of Health and Ageing publication, *Health and Ageing - 2011-12 Budget at a Glance*³, which is published on the DoHA website. Despite the Government’s ongoing defence of its package and claims that \$2.2b in new money is being invested in mental health, the published facts tell a different story.

² Tanner. Op cit

³Health and Ageing - 2011-12 Budget at a Glance.

http://www.aph.gov.au/senate/committee/clac_ctte/comm_fund_men_hlth/index.htm Accessed 22 July 2011.

The AMA acknowledges that elements of the 2011/12 Budget mental health package extend to other portfolios, but even with this expenditure included it equates to a Budget package worth \$583m over four years. To put this into perspective it is much less, in both nominal and real terms, than the \$875 million of new money committed to mental health in the 2006-07 Budget.

The AMA believes that it is very important to put some perspective on the overall value of the package to ensure that the significance of the cuts to the Better Access Program can be properly appreciated.

Changes to the Better Access Program

General practice is at the front line of delivery of mental health services. A review of the Better Access Program in 2009 indicated that around 90 per cent of all registered GPs had delivered Better Access services and 85 per cent of these were through the patient's usual GP or usual general practice, suggesting that care is well coordinated and comprehensive.⁴

Changes to the Better Access Program announced by the Government in the 2011/12 Federal Budget will significantly reduce funding for general practice mental health services and allied psychological services. More than \$400 million over 5 years will be removed from Medicare rebates for patients to access GP mental health services and a further \$175 million over 5 years will be removed from funding for psychological services available under the Better Access Program.

The Budget cuts will apply to all four Medicare rebates for GP mental health services, with cuts of up to 49% imposed. Overall, the AMA estimates that the impact of the Budget cuts in relation to Medicare funding for GP mental health services is expenditure cut of around 30% over the next five years.

Impact of the Budget cuts on patients with mental illness

The Government's Budget cuts devalue the central role of general practice in providing mental health care and they will impact heavily on vulnerable patients and reduce access to vital GP mental health services by making them less affordable. People with mental illness will have to pay more to see their GP for vital mental health care, advice and referrals.

In this regard, the AMA commissioned an independent report through Essential Research⁵ to assess the impact of the Budget cuts on GPs and their patients.

⁴ Department of Health and Ageing (2009) *Post Implementation Review of the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS Initiative*

⁵ Essential research (2011) *MBS changes – GP Survey: An Assessment of the Impact of 2011-12 Budget Cuts to Medicare Funding for GP Mental Health Services*. Australian Medical Association, 2011.

Essential Research conducted an on-line poll of 763 GPs and their report finds that:

- It appears likely that up to 50% of GPs will be forced to maintain their current fee and charge patients a gap, whereas many patients currently face no out of pocket costs.
- It appears likely that up to 28% of GPs will stop utilising Medicare GP Mental Health Treatment items.
- 85% of GPs think that the Budget cuts will reduce patient access to mental health services.
- 58% of GPs think that the Budget cuts will lead them to spend less time with patients with mental health problems.

A copy of Essential Research's full report is **attachment 2**.

These cuts devalue mental illness

One of the consequences of the 2011/12 Budget cuts to Medicare rebates for GP mental health services is that from 1 November 2011, patients with a physical illness will get better support through Medicare than a patient with a mental illness.

When compared to the Medicare rebate for a GP Management Plan for physical illness, the new rebates for patients with a mental illness will be between 10 per cent and 50 per cent lower – even though a GP Management Plan does not impose the same responsibilities on a GP in relation to making arrangements for required referrals, treatment, and support services.

There was no consultation about these cuts

The AMA is not aware of any consultation with GP groups with respect to the changes announced in the Budget. Indeed, it would appear that the Government made the decision without reference to its own advisory group, the Expert Advisory Group on Mental Health, which it specifically established to provide the Government with advice on the important reforms needed in the mental health sector.

Subsequent to the Budget, we note the resignation of the only GP on the above advisory group, Dr Christine McAuliffe. Dr McAuliffe is a widely respected GP who is reported in the media as having resigned over the cuts to the Better Access Program. This is how her resignation was reported in *the Australian* newspaper on 14 July 2011.

Christine McAuliffe said the \$405 million cuts to GP mental health rebates in the May budget to fund the \$2.2 billion mental health plan were "a step backwards" and why she quit the Expert Advisory Group on Mental Health on Monday.

Dr McAuliffe's decision was a courageous one that has only served to highlight the lack of consultation by the Government over these changes. Stakeholders generally believe that the decision to make these cuts was driven by the advice of Treasury and Finance rather than the meaningful input of doctors working to deliver frontline mental health

services in the community.

Unfortunately, this approach is now becoming the norm for the Government when it announces changes to the MBS. Other recent cuts to funding for medical services, such as joint injections and cataract surgery have been managed in a similar clumsy way. Even the addition of a new item to the MBS (eg: child health checks) is often announced without reference to the medical profession and this results in problems with the operation of the relevant item and its ultimate level of take up.

We also note that the Government has not sought to use the Medical Services Advisory Committee (MSAC), to review the Medicare rebates for GP mental health services, despite MSAC being specifically funded in the 2011/12 Budget to conduct rolling reviews of the quality, safety and rebate levels of items listed on the MBS

The Government's failure to follow its own policy position that MSAC should review the rebate levels for items in the MBS also means that there has been no analysis by the Government of the impact of the Budget cuts on patients.

The cuts to the Better Access Program contradict the evidence

The decision to impose cuts on the Better Access Program is contrary to the findings of an independent review commissioned by the Government of the program by the Centre for Health Policy and Programs⁶, with the evaluation report and related component reports ("the evaluation") demonstrating that the program has:

- improved patient access to mental health services;
- achieved positive outcomes for patients with mental illness;
- been cost effective; and
- involved little or no out of pocket costs to patients for GP services.

The Government released the Centre for Health Policy, Programs and Economics evaluation report in March this year, with the following being the summary of the key findings:

Access to mental health care

The evaluation shows that the Better Access Program has significantly improved access to mental health care for people with common mental health disorders such as anxiety and depression.

According to the evaluation, one in every 30 Australian received at least one Better Access service in 2007, one in every 23 did so in 2008, and one in every 19 did so in

⁶ Pirkis, J., Harris, M., Hall, W., Ftanou, M. (2011) *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative Summative Evaluation*. Final Report. The Centre for Health Policy, Programs and Economics, February 2011.

2009. This significant growth in the utilisation of the program by patients clearly demonstrates that it has been meeting a significant unmet need in the community.

Almost 2.7 million Better Access services were provided in 2007; this grew to almost 3.8 million services in 2008 (an annual increase of 40.6%) and to more than 4.6 million in 2009 (an annual increase of 23.2%). The estimated proportion of persons with a current mental illness who received treatment also increased steadily each year from 37.4% in 2006-07 to 46.1% in 2009-2010, an overall increase of 23%.

After accounting for some people who received services in more than one year, this equates to over two million individuals who received more than 11.1 million services over the three-year period 2007 to 2009.

In relation to GP mental health services, the number of patients accessing these grew from 618,867 in 2007 to 971,836 in 2009⁷. The significant growth (57%) in the uptake of GP mental health items reflects GPs' important role in delivering mental health services, and the positive impact of the Better Access Program in reaching people in need and in delivering better health outcomes for people with mental illness.

Better Access is meeting the needs of 'new' patients, who may previously have had difficulties accessing mental health services.

The evaluation indicates that the Better Access Program is continuing to attract a substantial proportion of new patients and is meeting a previously unmet need. Approximately 68% of people who received Better Access services in 2008 and 57% in 2009 were new patients who had not used any Better Access services in preceding years⁸.

The evaluation also shows that, in each of 2008 and 2009, people who were receiving services for the first time in that year used the majority of Better Access services. This suggests that not only is Better Access attracting substantial numbers of new consumers in each successive year, but these new consumers are also consuming a larger proportion of services than existing consumers.

Better Access is reaching young people, people from rural and remote areas and people from socio-economically disadvantaged groups.

The evaluation indicates that although some groups have had greater levels of uptake of the Better Access Program than others, it has reached **all** groups including young people, people from rural and remote areas and people from socio-economic disadvantaged groups as illustrated by **Table 1**. Rates of uptake have consistently increased over time for all groups and, more importantly, rates of uptake increased most dramatically for those who have been the most disadvantaged in the past.

⁷ Harris, M., Pirkis, J., Burgess, P., Olesen, S., Bassilios, B., Fletcher, J., Blashki, G., Scott, A. (2010) *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners Through the Medicare Benefits Schedule Initiative: Component B "An analysis of Medicare benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) administrative data.* The Centre for Health Policy, Programs and Economics, 2010.

⁸ Component B Report. Op Cit.

Table 1 Percentage change in persons using any MBS-subsidised Better Access Program services by age, gender, geographical region and socio-economic disadvantage for 2007, 2008 and 2009⁹

	Rate (per 1,000 pop)			Percentage change		
	2007	2008	2009	2007-2008	2008-2009	2007-2009
Age group						
0-14 years	10.1	14.8	19.7	47.7	32.8	96.1
15-24 years	35.9	47.3	57.3	31.7	21.2	59.5
25-34 years	50.6	65.2	75.2	28.7	15.5	48.6
35-34 years	52.3	68.5	80.0	30.9	16.8	52.9
45-54 years	44.1	57.5	67.4	30.6	17.1	52.9
55-64 years	33.2	43.6	51.8	31.2	18.9	56.0
65+ years	17.3	23.0	27.9	33.3	21.3	61.6
Gender						
Male	24.8	32.7	39.4	31.7	20.6	58.9
Female	42.7	56.3	66.2	31.6	17.7	54.9
Region						
Capital cities	35.2	45.8	53.7	30.2	17.3	52.7
Other metro centres	36.7	48.3	59	31.6	22.1	60.7
Rural centres	35.0	47.5	57.6	35.6	21.4	64.6
Other rural centres	28.5	38.9	47.3	36.4	21.5	65.8
Remote areas	12.7	16.6	21.5	30.6	29.5	69.2
Socio-economic disadvantage						
Quintile 5 (least)	36.1	46.1	53.4	27.7	15.8	47.9
Quintile 4	33.6	44.1	52.7	31	19.7	56.8
Quintile 3	33.4	44.1	52.4	31.9	18.7	56.6
Quintile 2	33.2	44.6	53.6	34.2	20.1	61.2
Quintile 1 (Most)	29.4	40.0	48.5	36.0	21.2	64.8
All Better Access Items	33.8	44.5	52.8	33.6	18.7	58.6

The evaluation shows that growth in the uptake increased as remoteness increased and as level of socio-economic disadvantage increased. Growth in uptake among people in remote areas was 20% higher than the average across all Better Access consumers. For people from socio-economic disadvantage, growth in uptake was 10% above the average across all Better Access consumers.

The growth in uptake between 2007 and 2009 has been greatest for young people aged 0-14 years compared to all other age groups. At 96.1%, growth in uptake for young people aged 0-14 years was 60% higher than the average across all Better Access consumers.

The evaluation also found that the distribution of services used was positively associated with levels of mental health need, although the report did highlight that there is room to improve in areas of socio economic disadvantage as well as in remote Australia. Having

⁹ Component B Report Op Cit. Table 3.15

said that, the evaluation still makes it very clear (as detailed above) that Better Access has reached all groups and rates of uptakes have consistently increased over time for all groups, and increased most dramatically for those who have been the most disadvantaged in the past.

Despite this promising data, the Government has attempted to portray the Better Access Program as not reaching people in disadvantaged groups. Perhaps the best response to the Government's rhetoric can be found in the transcript of an interview with one of the evaluation report's authors, Jane Pirkis, on the Health Report with Norman Swan on 21 March 2011¹⁰. She makes the point that:

It's certainly true that people in the lowest socio economic areas and in remote areas received proportionally fewer services than those in more affluent city areas. But in absolute terms the number of services received and the number of people receiving services in those traditionally more disadvantaged areas were still quite high. So for example in 2009, 150,000 people in the most disadvantaged areas across Australia received services, which is far more than were receiving similar services pre Better Access.

According to the evaluation, *high levels of uptake of Better Access services have not led to commensurate reductions in the use of other relevant mental health services or prescribing of antidepressant or anxiolytic medications. In fact, the opposite is true, which suggests that Better Access is a crucial piece in the web of Australian primary mental health care reforms, and is helping to meet previously unmet need*¹¹.

The evaluation clearly shows that rather than implementing savage cuts to the Better Access and redirecting this funding to other programs, the Government should have looked to maintain its investment and instead found additional funds to support complimentary programs that build on the improvements that Better Access has made.

Access to Affordable Care

The evaluation indicates that for GP mental health services in 2009, 93% of services delivered involved no out of pocket costs to patients. For the small percentage of services that involved an out of pocket cost, the average co-payment was around \$20. This means that patients, particularly in disadvantaged groups, do not face a cost barrier when they need essential mental health care services from a GP.

The Government's Medicare rebate cuts of up to 50% will clearly impact on the level of out of pocket costs patients face and will particularly impact on people in disadvantaged groups.

¹⁰ Australian Broadcasting Corporation. <http://www.abc.net.au/rn/healthreport/stories/2011/3167686.htm>. Accessed 22 July 2011.

¹¹ Component B Report. Op Cit.

Good outcomes for patients

Better Access was shown by the evaluation to support improved mental health outcomes for patients. In this regard the evaluation states:

There is good evidence that Better Access has improved access to mental health care for people with common mental disorders. Uptake of Better Access services has been high in absolute terms, even among relatively disadvantaged groups in the community. Better Access is not just catering to people who were already in receipt of care and/or who have relatively mild symptoms; it is reaching significant numbers of people who have not previously accessed mental health care; and it is providing treatment for people who have severe symptoms and debilitating levels of distress.

Consumers are generally positive about Better Access as a model of service delivery and they appreciate the clinical care they have received. They are also reporting positive outcomes as assessed by reductions on standardised measures of psychological distress, depression, anxiety and stress. In the main, these outcomes are related to clinical and treatment factors rather than socio-demographic characteristics¹².

Cost-effectiveness of Better Access Program

The evaluation found that the Better Access Program is a cost-effective way of delivering mental health care. It said that the typical cost of a Better Access package of care delivered by a psychologist (which includes the preparation of the GP Mental Health Care Treatment Plan and the related review item) is estimated to be \$753.31. This is lower than the estimated optimal treatment cost for anxiety or depressive disorders of about \$1,100 in 2010.

From the AMA's perspective it appears somewhat incongruous that the Government, in asserting tight fiscal circumstances, is seeking to cut a program that has clearly been shown to be cost effective.

GPs are spending significant time in caring for patients with mental illness

The Government has cited Bettering of Evaluation and Care of Health (BEACH) data as one of the justifications for its cuts to Medicare rebates for GP mental health services. BEACH data looks at face-to-face consultation times for the preparation of a GP Mental Health Treatment Plan and the AMA understands that this data indicates a median time of 28 minutes, with 80% of plans being completed in less than 40 minutes.

Dr Helena Britt, who heads up the BEACH program, has publicly questioned the use of BEACH data in this way.¹³ She has confirmed that it does not include the time doctors spent outside sessions on related paperwork and liaising with other healthcare workers.

¹² Pirkis et al. Op Cit.

¹³ Kaye B. and Bracey, A. *Calls for mental health rebate cuts to be reversed*. Medical Observer, 24 May 2011.

She directly challenges the Government's interpretation of BEACH data, as shown in the extract below from a report in *Medical Observer*:

But Associate Professor Helena Britt, head of the Bettering the Evaluation and Care of Health (BEACH) program, said the 28-minute average GP consult for mental health – provided by her and quoted by Mr Butler – was only part of the time practitioners spent on mental health plans.

She said the data included only the face-to-face time between GPs and patients and did not include the time doctors spent outside sessions on related paperwork and liaising with other healthcare workers.

“I don't know what they're thinking, but it's possible that they have not considered these other time issues,” she told MO.

“The 28-minute average... is correct [but] I've questioned the interpretation.”

The Essential Research report¹⁴ referred to earlier in this submission concluded that, on average, GPs spend about 35 minutes on face-to-face consultation and 17 minutes on non face-to-face work when preparing a GP Mental Health Treatment Plan (MBS Item 2710). This suggests that the time involved in preparing a GP Mental Health Treatment Plan is not 28 minutes as suggested by the Government but 52 minutes.

What programs will fill the gaps created by cuts to Better Access?

The Government has decided to divert funds from the Better Access Program to other services such as Access to Allied Psychological Services (ATAPS), Headspace and Early Psychosis Prevention and Intervention Centres (EPPICs). To this end, the Government has announced an increase of \$206 million over the next five years to increase the size of the ATAPS program, \$197.3 million to establish 30 new Headspace sites and \$222.4 million to establish 12 new EPPICs.

The AMA estimates that the Government's 2011/12 Budget specific additional commitments in the health portfolio will benefit around 60,000 patients each year, although it is difficult to calculate a precise figure due to the uncertainty that exists around the timing of the roll out of new programs. While the AMA welcomes these investments, they should not come at the expense of Better Access Program, which has a very significant reach, benefiting around 1,000,000 people each year – including at least 150,000 people each year in the most disadvantaged areas.

ATAPS performance has been variable

The ATAPS program, which had its origin in a 2001/02 Budget measure, is aimed at addressing historically poor access to mental health care for specific groups in society, such as people in remote locations including those in Indigenous communities, youth and the homeless. The program enables General Practitioners (GPs) to refer patients

¹⁴ Essential Research. Op Cit.

diagnosed as having a mental disorder to an allied mental health professional for a capped number of sessions of focused psychological strategies at low or no cost.

The program is currently being managed by the Divisions of General Practice, although Medicare Locals are scheduled to progressively take over the day-to-day running of the program from 1 July 2011. However, since Medicare Locals are yet to be established (as opposed to announced), money from the successful Better Access Program is being diverted towards unproven and untested entities, further risking the delivery of vital mental health services.

The recently released ANAO Audit Report No.51 2010–11¹⁵ among other things concluded that while the ATAPS program is delivering valued services to those able to access mental health care under the capped program, the administrative arrangements established by DoHA have not consistently supported the achievement of program objectives. In particular, there has been variable administrative performance over the relatively long life of the program in relation to a number of important program elements including: the allocation of program funding on the basis of identified need; monitoring compliance with program requirements; and the administration of new ATAPS initiatives.

The report was also critical of ATAPS administrative costs. Originally about 85% of ATAPS funding was utilised by Divisions for service delivery and the remaining component was set aside for administration (15 per cent).¹⁶ Over recent years, the proportion of funding quarantined by Divisions for administering the initiative has substantially increased. Now many Divisions use a ratio of 75% service delivery to 25% administration. Redirecting funding towards administration results in less capacity to provide mental health services.

In contrast, every dollar allocated for the Better Access Program goes directly to the delivery of clinical care.

Headspace and EPPIC will take significant time to roll out

With regard to Headspace, which operates at 30 sites across the country, 30 additional sites were promised in the previous 2010/11 Federal Budget, of which 10 sites have been announced but none built.

This experience shows that it will take a number of years to roll out the extra Headspace sites announced in the latest Budget and we could expect to see the same experience with respect to the roll out of EPPICs. It should also be noted that the commitment to additional EPPICs appears dependent on the states/territories sharing in the costs of these. It is unclear as to what will happen if the state/territories decide not to contribute funding in the way the Commonwealth anticipates.

¹⁵ Australian National Audit Office (2011) *Administration of the Access to Allied Psychological Services Program*. Audit Report No 51 2010-11

¹⁶ Australian National Audit Office. Op Cit.

In summary, the Budget cuts will result in an immediate reduction in access to mental health services from 1 November this year with nothing in place to fill the void that will be left. In addition, funding for clinical services will effectively be diverted into ATAPS arrangements that have been shown to deliver less funding on the ground for services and still have to address a number of outstanding issues identified by the ANAO.

Recommendations:

Restoration of funding for Better Access as part of a real and lasting investment in mental health services

The Government's own independent evaluation of the Better Access Program stated that it is a crucial piece in the web of Australian primary mental health care reforms, and that it is helping to meet previously unmet need. The AMA recommends that the Committee endorse the Better Access Program and recommend that the Government reverse the funding cuts announced in the 2011/12 Federal Budget.

Consultation with the medical profession

The AMA calls on the Committee to recommend that the Government genuinely consult with the medical profession, including the AMA, before implementing changes to the MBS.

The adequacy of mental health funding and services for Indigenous communities

Australia's Indigenous population suffers from severe mental illness at up to 4.5 times the expected rate for their proportion of the population. Indigenous Australians also experience substantially greater levels of anxiety and depression than the rest of the Australian population. Poverty, racism, limited education, overcrowded housing, poor physical health, continuing exposure to trauma, residence in remote locations and substance abuse are all thought to be significant contributing factors.

While Indigenous Australians access public health and community services at a higher rate than other Australians, their access to specialist services, including psychiatric specialists, is more limited. Funding for increased access to psychiatrists, psychologists, and drug and alcohol counsellors is essential for substantial changes in the burden of mental illness and poor social and emotional well being among Indigenous people.

Workforce development in these specialties and appropriate cultural training is important. An effective funding and service delivery model would give priority to:

- the creation of a sufficient number of mental health Training Co-ordinator positions within Aboriginal Community-controlled health services;
- additional MSOAP funding for sessions conducted by Consultant Psychiatrists; and
- enhanced access by psychiatry registrars to the services within the Aboriginal Community-controlled sector (facilitated by the MSOAP Consultants and Training Co-ordinators).

This would allow more Aboriginal and Torres Strait Islander people to access specialist mental health services as well as increasing the exposure of consultants and psychiatry registrars to Aboriginal and Torres Strait Islander mental health issues.

Recommendation:

Workforce development in specialties associated with treating mental illness, as well as appropriate cultural training must be improved.

An effective funding and service delivery model would give priority to:

- the creation of a sufficient number of mental health Training Co-ordinator positions within the Aboriginal Community-controlled health services;
- additional MSOAP funding for sessions conducted by Consultant Psychiatrists; and
- enhanced access by psychiatry registrars to the services within the Aboriginal Community-controlled sector (facilitated by the MSOAP Consultants and Training Co-ordinators).

The role of GPs in helping care for patients with mental illness is extremely important, particularly as these patients often suffer from chronic physical conditions at the same time. According to Australia's Health 2010, mental disorders were more common among people with one of the chronic physical conditions recognised as National Health Priority Areas (diabetes, asthma, heart disease, stroke, cancer and arthritis)¹⁷.

No other health profession is so uniquely trained to manage the care of these patients and Medicare funding arrangements must recognise this and properly support patients with mental illness to access care the care they need from their GP, working collaboratively with other health professionals.

Yours sincerely



Dr Steve Hambleton
President

¹⁷ Australian Institute of Health and Welfare 2010. Australia's health 2010. Australia's health series no. 12. Cat. no. AUS 122. Canberra: AIHW.

Attachment 1



MENTAL HEALTH POSITION STATEMENT - 2011

Many Australians experience a mental illness at some time in their lives. The medical profession has a key role in responding to the initial presentation of illness, making a clinical assessment and then taking responsibility for this and following it through with other health professionals and support services. Accordingly, doctors, in particular general practitioners and psychiatrists, are well placed to identify the gaps in our current health system in the prevention, treatment and management of mental illness and to articulate the solutions that need to be put in place to improve the system for patients and support the medical profession in the medical and psychiatric care that they provide.

Several Federal Parliamentary Senate Inquiries have identified significant deficits in mental health funding. The National Health and Hospitals Reform Commission, the National Advisory Council on Mental Health, and the Mental Health Council of Australia, have all pointed to the need for reform of mental health service delivery arrangements. To date, Government responses have been inadequate. In particular, there continues to be problems with community-based mental health services. These have not been appropriately structured or funded since the Burdekin reforms that moved much of the care and treatment of people with a mental illness out of institutions and into the community. For people with serious mental illness living in the community, there is also a particular difficulty in accessing care by psychiatrists in community-based settings.

In 2006, the Council of Australian Governments (COAG) mental health reforms made some significant changes to primary mental health care, improving access for people with mental illness to general practitioners (GPs), psychologists and other relevant allied health care workers. More recent investments in further support and early intervention for young at-risk Australians, while not sufficient, were another small step towards improving primary mental health care in the community. However, because the current State-run public health sector does not generally provide long-term mental health care in the community, many people with serious mental illness often have to be readmitted to hospital at short notice. This puts additional pressure on the public hospital system because ongoing specialist clinical care in the community has not been available to them. In short, there is a clear unmet and urgent need to fund more acute mental health care as well as ongoing care in settings other than hospitals for people with severe and enduring mental health problems.

All Australians with a mental illness deserve to have ready access to quality mental health care based on their particular needs. This requires a significant expansion of services, intervention and support for people with mental illness across the whole continuum of care. Our Mental Health Policy identifies immediate priorities for government action and further investment across this continuum, including more investment and improved service delivery arrangements to support the following.

- Prevention, destigmatisation and community understanding.
- Early identification and intervention.
- Community-based care.
- Aged care.
- Subacute care.
- Acute care.
- Crisis and Outreach care.
- Special needs groups.
- Social, environmental and economic determinants of mental health.

The Policy also identifies the key whole of system enablers that need to be in place to ensure that the continuum operates appropriately. This includes having an appropriately sized and skilled workforce, better coordination across health care and support services, and significant additional overall investment in mental health services.

The 2010 COAG health reforms include agreement for the Commonwealth to have funding and policy responsibility for GP and primary health care services, including primary mental health care services. It also includes agreement for the States to work with the Commonwealth on system-wide primary health care policy and integration of service planning and delivery. This will, as acknowledged in COAG's communiqué, create strong incentives to support a healthier community and reduce pressure on hospitals and help reduce cost-shifting and blame-shifting. These reforms provide the basis for a significant improvement in mental health primary care and community-based care funding and co-ordination of mental health care across the whole health system.

ENHANCING THE SERVICE CONTINUUM

1. Prevention, destigmatisation and community understanding

Background

Progress towards genuine national mental health reform will not occur unless community understanding of the experiences of persons whose lives are affected by mental illness improves. Community awareness needs to encompass an understanding of the nature of mental illness and its treatment and recovery processes.

Priority areas for government action

- Sustained national community awareness campaigns to increase mental health literacy and reduce stigma.
- Public education campaigns for prevention and reduction in substance abuse.

- Promotion of good health and resilience in young people at school and in the community.

2. Early identification and intervention

Background

Early identification and intervention, particularly for people aged 0 to 25 years of age, is required to not only prevent or delay the development of future mental health problems, but also to promote the necessary conditions for healthy mental development.

Priority areas for government action

- Support for more online and telephone counselling and support services, such as Beyondblue and Lifeline, with comprehensive information about local referral pathways made available to ensure that patients get linked to the right service at the right time.
- Increased funding for specific child and adolescent health services, including but not limited to Headspace. Funding is required for the development and implementation of a rigorously evaluated prevention and early intervention program across all children 0–18 years and into early adulthood. There also needs to be a focus on specific prevention and early intervention programs to target key disorders such as conduct disorders, anxiety disorders, depressive disorders, self harm or risk of suicide, children of parents with a mental illness. Parenting support services and parenting programs, particularly for at-risk groups, to assist with early prevention of mental health problems. Screening of infants, children and adolescents is required to identify early symptoms of mental disorders and illness as early as possible. Evidence-based school programs are also needed to help identify high-risk children and facilitate early referral to mental health professionals.
- More youth friendly community-based services are required, including an increased in the number of Headspace centres to a minimum of 90.
- Rollout of more Early Psychosis Prevention and Intervention Centre (EPPIC) services, to create a properly resourced, staffed and accessible national network of at least 20, is necessary so that early intervention in psychosis becomes the norm.
- Support for more programs like *Docs in Schools* to enhance youth access to primary health care advice and support.

3. Community-based care

Background

Well coordinated and seamlessly provided community-based services, including both primary care and specialised community-based mental health services, reduce the need for hospital admissions and re-admissions and have the capacity to diminish the severity of illness over time. In particular, many people with mental illness are appropriately diagnosed and cared for in respect of their physical and mental health

problems by general practitioners in the community. It is imperative that community-based mental health care, including care provided in the community by general practice, is enhanced, supported, properly funded and better co-ordinated to ensure improved access to these essential services.

Priority areas for government action

- More access to medical care and shared care is required in the community for people with mental illness through improved Medicare Benefit Schedule (MBS) arrangements including:
 - increased MBS rebates for longer GP consultations for patients with mental illness who often have complex and multiple physical and mental health issues that need to be responded to;
 - a higher rebate for a prolonged Medicare attendance item for patients in crisis situations;
 - increased MBS funding for psychiatric care and treatment provided to patients with complex conditions by psychiatrists in community-based settings;
 - improved MBS arrangements to acknowledge and reimburse for more shared care and complex consultations for patients with co-morbidities;
 - improved MBS arrangements to recognise and reimburse for non-direct patient care required for patients with mental illness including time spent finding suitable services for patients and talking to families; and
 - more funding and services for patients with dual diagnosis.
- Improved access to private psychiatrists through sessional and visiting arrangements in community-based facilities is also required.
- More access to mental health assessment facilities for public patients is required, including through more and better resourced mobile outreach teams operating extended hours for high risk patients.
- Improved access to primary mental health teams is needed to provide support, one-off consultations, secondary consultations and some psychological services in GP premises.
- Increased use of mental health nurses in general practice is also critical and can be achieved by reviewing and streamlining existing program arrangements to make access easier.
- Improved access to specialised programs run out of community-based mental health services is needed to treat some specific clinical conditions that, for many patients, can be treated through community-based services including eating disorders, perinatal depression, personality disorders and self-harm.
- Improved access is required to community-based mental health care services in rural communities, as well as urban communities, to the maximum extent

possible, with the services customised to specifically meet local needs.

4. Aged care

Background

The Australian population is ageing with an increasing number of people living a healthy and independent life well beyond 65 years of age. Physical illness, neurodegenerative diseases and disability are, however, associated with increasing longevity. Anxiety and depression are common in the elderly and are often accompanied by physical ill health, dementia, disability or bereavement. People with life-long mental illnesses and related disabilities will also experience age-related frailty and diseases. Specific services for elderly people with mental health problems who are living in residential aged care or in the community need to be enhanced.

Priority areas for government action

- Support is required for better linkage between aged care and mental health services through joint single entry points and contacts.
- Support for better linkages between aged care psychiatric services in the public and private sectors and general practitioners to enhance shared care arrangements, including through the development of new consultative telemedicine case conferencing items on the Medicare Benefits Schedule.
- More acute care beds specifically for the elderly with mental illness, separate from general adult mental health facilities, integrated with the general hospital and with geriatric medicine/rehabilitation services.
- A mechanism to allow mental health services to arrange patient referral directly into residential and subacute aged care without going through an intermediary agency.
- Ensure that the elderly with mental illness, who live in residential aged care and in the community, have access to specialised mental health assessment and care and dementia care services, including by mandating a formal aged care accreditation standard that requires aged care providers to make available residents' access to medical care, including mental health care.
- Expanded choices in mental health care for people in residential aged care through subsidized transport assistance for residents to attend consultations with general practitioners and psychiatrists and for patients to be properly subsidized for the cost of general practitioners and psychiatrists visiting aged care facilities to conduct consultations.

5. Subacute care

Background

To truly achieve psychosocial rehabilitation in the community, the service continuum must be enhanced to include subacute step-up and step-down type care as an alternative to inpatient admission, or to provide support after an acute episode of illness.

Priority areas for government action

- More subacute beds (capital and recurrent funding) for long-stay patients and for residential rehabilitation. This will need to be supported by AMA Bedwatch reporting and transparency arrangements to monitor the establishment of new beds and recurrent funding for sufficient episodes of care through Local Hospital Network service agreements. Priorities identified by local clinicians should be sufficiently resourced through these service agreements.
- Step-up and step-down residential care, as an alternative to inpatient admission or for a period of transition after hospital discharge, with clinical services provided to residents by local clinical service providers through community-based services.
- More respite care for people with mental illness and their families.

6. Acute care***Background***

Acute care provides intensive treatment to a person who is experiencing an acute mental illness characterized by significant and distressing symptoms that require immediate treatment to de-escalate symptoms and reduce the risk of suicide and harm to self and others. While it is acknowledged that mental health care has been significantly de-institutionalised from hospital-based settings into community-based settings, there is still an ongoing need for this type of care and it needs additional resourcing.

Priority areas for government action

- More access to acute care in public hospitals is required. This must include capital funding and AMA Bedwatch reporting and transparency to monitor progress in establishing the additional acute care beds. It must also include funding for additional episodes of care through Local Hospital Network service agreements, with priorities that are identified by local clinicians sufficiently resourced through these agreements.
- Increased access is required to specialised public outpatient services providing diagnosis and ongoing treatment and psychiatric care for people with mental illness and dual diagnoses.
- Specialised mental health and dual diagnosis spaces, or departments must be established as part of public hospital emergency departments.
- Additional capacity is required in public hospitals so that patients have the option of being treated in single-sex mental health wards.

7. Crisis and Outreach care***Background***

A range of services is involved in crisis and outreach including health, police and ambulance services. These services need to be coordinated and properly supported

and expanded to facilitate the provision of appropriate care in these difficult situations.

Priority areas for government action

- Increased investment in crisis intervention services is required, particularly for those with severe mental illness and/or those at risk of suicide.
- Every acute mental health service should have a rapid-response outreach team.

8. Special needs groups

Background

There needs to be increased access to specialised mental health services for special needs groups, including people in indigenous communities, people with intellectual and other disabilities, those with significant drug and alcohol issues, older people, the homeless, people from culturally and linguistically diverse backgrounds, prisoners and people in detention centres.

Priority areas for government action

- Targeted prevention and early intervention programs for high risk special needs groups and individuals are needed.
- Increased support for drug and alcohol services, particularly to improve their expertise in assisting patients with mental illness, to expand options for GP referral for their patients requiring community-based support.
- Specialised, culturally sensitive mental health services are required, targeted to meet the needs of special needs groups.
- Cultural competence and sensitivity training and promotion are required for those who provide mental health care to patients from special needs groups.

9. Social, environmental and economic determinants of mental health, including education, employment, housing and supported accommodation, and social support

Background

There is a powerful relationship between a person's social position, his/her living conditions and his/her health outcomes. Poor access to education, employment, housing and social support all influence the amount of mental stress experienced and a person's ability to access treatment and care. Conversely, individuals experiencing mental illness are at higher risk of adverse social, environmental, economic, and health outcomes. People with enduring mental health problems experience significantly higher rates of physical illness, and are likely to experience social exclusion and discrimination as a direct consequence of their difficulties.

Priority areas for government action

- Social, environmental and economic determinants of good health need to be

addressed for people with mental illness, by improving access to education, supported community-based housing and public housing, social support including services to prevent neglect and sexual abuse of children, vocational rehabilitation, employment support and post-placement employment support to increase the employment rate for people with a mental illness to at least that of people with other forms of disability through innovative models of employment support and more psychiatric-specialist employment service providers, and ensuring that these services link to community mental health services to enable appropriate clinical support, particularly for those with severe and/or chronic mental illness.

WHOLE OF SYSTEM ENABLERS

10. Workforce

Background

It is critical that the mental health service continuum is supported by a high performing and sustainable mental health workforce, able to deliver high quality, recovery-focussed mental health services in a safe and secure environment. Increased investment in workforce training and support is needed to ensure that this goal is achieved and sustained in the future.

Priority areas for government action

- Increased number of funded psychiatrist trainee places are required.
- Appropriate psychiatrist trainee experience and scope of training must be provided, including through more training in private sector.
- Increased number of other mental health workers, especially mental health nurses.
- More continuing professional development and competency training opportunities for the primary health care workforce who choose to access it is very important, including for medical practitioners and practice nurses, at undergraduate and postgraduate levels and through online mental health courses and training and peer review groups as part of continuing professional development.
- Health support services must be available for mental health workers and doctors.

11. Co-ordination and access

Background

The mental health service continuum should be coherent and coordinated, facilitating access for anyone who develops an acute or chronic mental illness. It must be supported by genuine participation of consumers and carers in the design, delivery and monitoring of all facets of the care received in managing mental illness, with a focus on recovery.

Priority areas for government action

- Consumer and carer participation needs to be improved with input into shaping programs and service delivery arrangements and support for those who care for people with mental illness.
- Specific funding is required for mental health co-ordinators working with patients in the community and assisting with transition in and out of acute and subacute care.
- Access to on-line support needs to be provided for medical practitioners, particularly primary care providers, and consultations should be facilitated via increased access to telemedicine and e-health technology.
- Adequately resourced rural hospitals and general practices to enable timely and effective response to after hours medical and psychiatric care for patients with mental illness.
- Medicare Locals and Local Hospital Networks must play a key role to improve co-ordination, reducing access gaps and designing and supporting appropriate referral pathways at the local level, particularly in relation to improving the following.
 - Linkages between public and private sector community-based health and medical services.
 - Communication and linkages and referral pathways between non-government community-based services and other mental health care and primary care services.
 - Linkages between hospital-based mental health services and multidisciplinary community-based and subacute services, to support stepped prevention and recovery.
 - Collaboration and linkages between primary mental health care and specialist medical mental health care services and expertise.
 - Discharge planning arrangement and community follow-up to ensure that there is clarity about where a person will be discharged to, in terms of community-based care, and ensuring that information is formally provided on discharge from acute or subacute care.
 - Integration between children, adolescent and adult mental health services to ensure smooth transitions for patients over time.
 - Linkages between education, child protection, family court, corrections, allied health practitioners and community-based mental health services.

12. Research

Background

Mental health services should be evidence-based and continuously improve as a result of sound research in the area of mental health service delivery, including community-based primary care mental health.

Priority area for government action

- More mental health research should be funded, including in the areas of neuroscience (including an understanding of basic disease mechanisms), diagnosis, early intervention, clinical treatment and translational research in the area of mental health service delivery.

13. Increased funding*Background*

Increased funding is needed to address the gaps in our current mental health services and enable the delivery of comprehensive, integrated and coordinated mental health services for all Australians who may develop an acute or chronic mental illness at any stage of their life.

Priority area for government action

- An additional \$5bn over four years is required now to expand health and social services, as outlined in this Policy. This is essential to ensure that there is a properly resourced, co-ordinated and supported system to respond to mental illness amongst Australians.

Attachment 2

Australian Medical Association

MBS Changes – GP Survey

AN ASSESSMENT OF THE IMPACT OF 2011/12 BUDGET CUTS TO MEDICARE FUNDING FOR GP MENTAL HEALTH SERVICES

July 2011

Conducted for:

**Australian Medical Association
P.O. BOX 6090
Kingston
ACT 2604**



Conducted by:

Essential Research
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VIC 3053

Executive Summary

The followings are key findings from the online poll of 763 GPs about the changes to the Medicare Benefits Schedule (MBS) announced in the 2011/12 Federal Budget, that will reduce the level of Medicare rebates payable to patients who need GP mental health services:

What is the current situation?

- 80% of GPs had undertaken the additional mental health training required under MBS arrangements to utilise the GP Mental Health Treatment Plan item number 2710.
- For the two existing GP Mental Health Treatment Plan item numbers being 2702 (42%) and 2710 (47%), GPs were overall more likely to select 30-40 minutes as being the average face-to-face time associated with the relevant consultation item.
- In relation to item number 2710, which is the most commonly used of the two GP mental health planning items, 77% of GPs advised that they spent in excess of 30 minutes face-to-face with patients. The overall average face-to-face time spent with patients for this item number was 35 minutes.
- In addition to face-to-face consultation time with patients, GPs also spend significant time undertaking non face-to-face work. For example, it would appear that in relation to the preparation of a GP Mental Health Treatment Plan (item number 2710) it involves an average of 35 minutes face-to-face time with patients along with a further 17 minutes of non face-to-face work. This takes the average total time involved in the preparation of a plan to 52 minutes.
- For all of the current Medicare items for GP mental health services, the majority of GPs stated that 80-100% of patients were bulk-billed, meaning that most patients do not currently face out of pocket costs for these services.
- Bulk billing appears to be more prevalent in regional and rural areas.

What impact will the Government's funding cuts have when they come into effect on 1 November?

- It appears likely that up to 50% of GPs will be forced to maintain their current fee and charge patients a gap, whereas many patients currently face no out of pocket costs.
- It appears likely that up to 28% of GPs will stop utilising Medicare GP Mental Health Treatment items.
- 85% of GPs think that the Budget cuts will reduce patient access to mental health services.
- 58% of GPs think that the Budget cuts will lead them to spend less time with patients with mental health problems.
- 540 GPs took the time to provide comments and the vast majority of these were very critical of the Government's decision to cut Medicare rebates for GP mental health services and the impact this will have on patients' access to services.

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1.0 Introduction

This report summarises the results of a online poll of GP's about the changes to the Medicare Benefits Schedule (MBS) announced in the 2011/12 Federal Budget that reduce the rebate payable to patients who need GP mental health services.

The purpose of this research was to:

- assess GP awareness of federal government cuts to the MBS patient rebates for GP Mental Health services.
- get feedback about GPs' expectations of the impact of these cuts.
- assess the likelihood of changes to patients' access to these services.
- determine the extent to which patients might face increased out of pocket costs.

2.0 Survey Methodology

The survey was constructed by the AMA, in consultation with Essential Research.

The survey was hosted by Essential Research using QuestionPro software.

The survey was in the field from June 15th to 8th July 2011.

The survey was completed by 763 respondents.

The survey was started 1023 times.

The survey was viewed 1275 times.

SPSS software and Microsoft Excel were used to analyse and present the data.

Open-ended comments were permitted and these developed into a theme.

Current Medicare Item numbers for GP Mental Health Services

Item description:

- Item 2702: Preparation by a medical practitioner who has not undertaken mental health skills training in preparing for a “GP Mental Health Treatment Plan”.
- Item 2710: Preparation by a medical practitioner who has undertaken mental health skills training in preparing for a “GP Mental Health Treatment Plan”.
- Item 2712: Reviewing a GP Mental Health Treatment Plan.
- Item 2713: GP Mental Health Treatment Consultation.

3.0 Survey Reliability

Properly constructed sample surveys can provide results that are described as statistically reliable. The level of statistical reliability is dependent upon the sample size and (except where it is extremely small) the size of the population has no practical effect.

A survey that has 1000 respondents will provide results that are – at the 95% confidence level – subject to a sampling variation of between 2% and 3% at the total response level. Sub-samples, because of their smaller size, will exhibit larger sampling variances. The following table shows the sampling variances at the 95% confidence level for a range of sample sizes and response levels.

Sample Size	Variation where the answer is near the percentage of				
	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
100	6%	8%	9%	9%	10%
200	4%	5%	6%	7%	7%
300	3%	5%	5%	6%	6%
400	3%	4%	4%	5%	5%
500	3%	4%	4%	4%	4%
600	2%	3%	4%	4%	4%
700	2%	3%	3%	4%	4%
800	2%	3%	3%	3%	3%
900	2%	3%	3%	3%	3%
1000	2%	3%	3%	3%	3%

Overall the confidence level was set as 95%. In this report where variation in sub-samples is statistically significant a comment has been made.

For the purposes of simplicity we have rounded percentages to the nearest whole number. This may result in some percentage totals being 99% or 101%.

4.0 Summary of Results

4.1 Additional Training

Question *Have you undertaken the additional mental health training required under MBS arrangements to bill at the higher rebate level?*

	Total
Yes	80%
No	18%
I plan to in the next month	2%

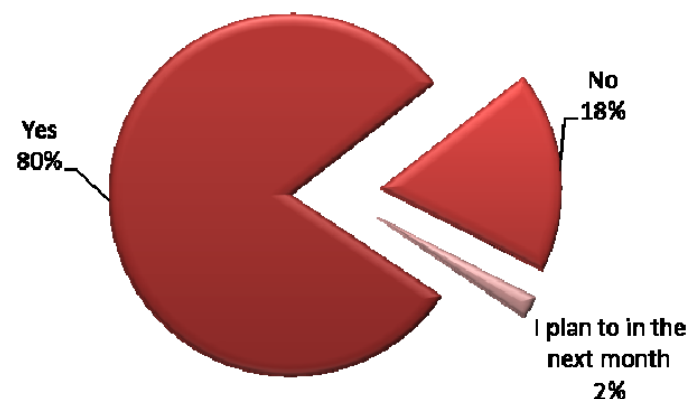


Figure 1: *Have you undertaken the additional mental health training required under MBS arrangements to bill at the higher rebate level?*

Key points:

- 80% of GPs had already undertaken the additional mental health training required under MBS arrangements to utilise the GP Mental Health Treatment Plan item 2710, which offers a higher rebate for patients.
- There was very little difference based on the location of the GPs' practice – although those in rural (21%) areas were a little more likely to state that they had not yet completed the additional training

4.2 Face-to-Face Time

Question For each of the GP mental health MBS items, please estimate the average face-to-face time associated with the consultation item?

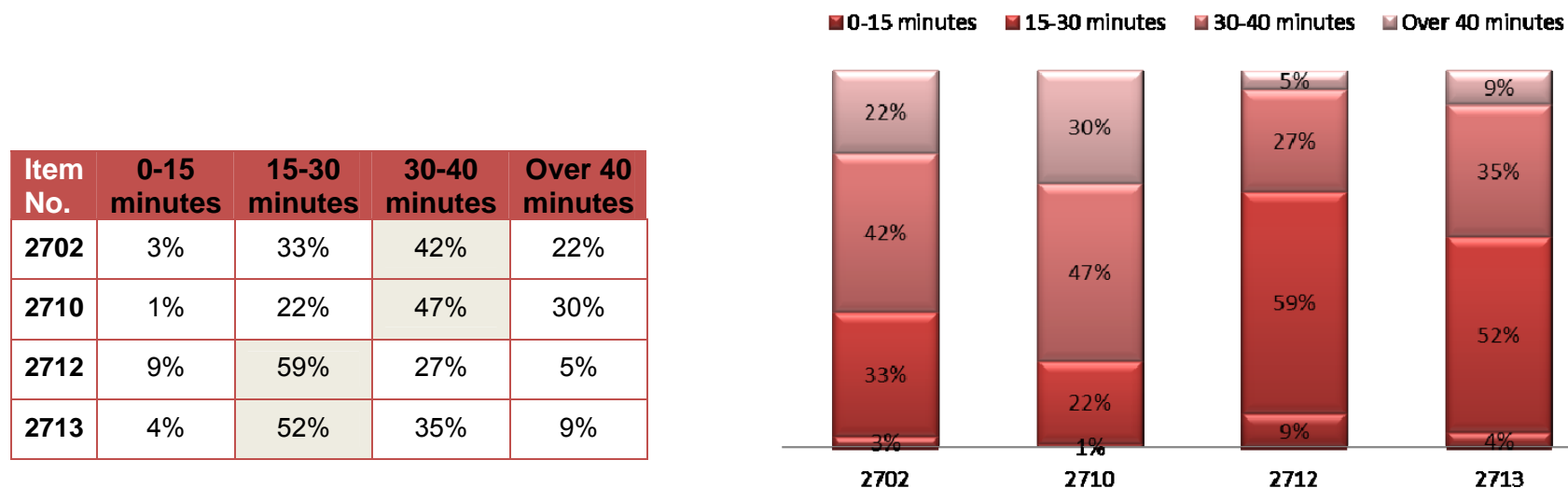


Figure 2: For each of the GP mental health MBS items, please estimate the average face-to-face time associated with the consultation item.

Key points

- For items 2702 (42%) and 2710 (47%), respondents were overall more likely to select 30-40 minutes as being the average face-to-face time. Indeed, in relation to item 2710, which is the most commonly used of the two GP mental health planning items, 77% of respondents advised that they spent in excess of 30 minutes face-to-face with patients.
- For items 2712 (59%) and 2713 (52%) respondents were more likely to select 15-30 minutes.

Item	Face-to-face		
	Average minutes spent on consultation		
	TOTAL	Have completed training	Have not completed training
2702	32	N/A	32
2710	35	35	N/A
2712	26	27	23
2713	28	28	28

Please note: these figures were calculated using the midpoint for each range. For the 40+ category a time of 45 minutes was estimated. These figures were calculated after those respondents who stated none/NA were removed. Respondents who plan to undertake training within the next month were not included as the sample was too small.

- The table above shows that respondents who had undertaken the training, on average, spent more time with patients for each item except for item 2713.

Using the midpoint for each range, the average time spent on items were; 32 minutes for item 2702, 35 minutes for item 2710, 26 minutes for item 2712 and 28 minutes for item 2713.

4.3 Non Face-to-Face Time

Question For each of the GP mental health MBS items, please estimate the average non face-to-face time associated with the consultation item?

Item No.	0-15 minutes	15-30 minutes	30-40 minutes	Over 40 minutes
2702	51%	35%	11%	3%
2710	51%	37%	9%	3%
2712	71%	23%	4%	1%
2713	74%	21%	4%	2%

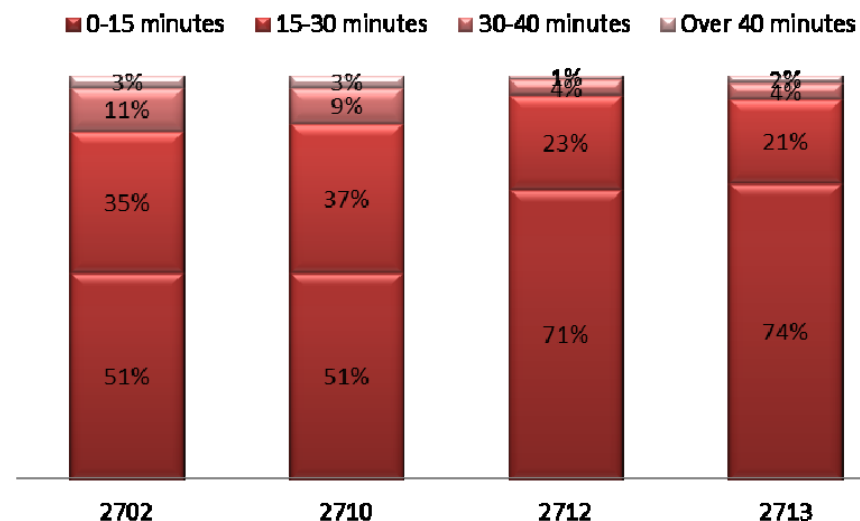


Figure 3: For each of the GP mental health MBS items, please estimate the average non face-to-face time associated with the consultation item.

Key Points

- For each of the above items, GPs were more likely to select 0-15 minutes with 51% selecting this option for item 2702, 51% for item 2710, 71% for item 2712 and 74% for item 2713.
- The results indicated that in addition to face-to-face consultation time with patients, GPs also spend significant time undertaking non face-to-face work. For example, it would appear that in relation to the preparation of a GP Mental Health Treatment Plan (item number 2710), it involves an average of 35 minutes face-to-face time with patients along with a further 17 minutes of non face-to-face work. This takes the average total time involved in the preparation of a plan to 52 minutes.

Item	Non face-to-face		
	Average minutes spent on consultation		
	TOTAL	Have completed training	Have not completed training
2702	18	N/A	18
2710	17	17	N/A
2712	13	13	13
2713	13	12	14

Please note: these figures were calculated using the midpoint for each range. For the 40+ category a time of 45 minutes was estimated. These figures were calculated after those respondents who stated none/NA were removed. Respondents who plan to undertake training within the next month were not included as the sample was too small.

- The table above shows that in terms of non face-to-face time there was little difference between those that have completed the training and those that have not.

4.4 Bulk Billing

Question For each of the GP mental health MBS items, please estimate the per cent bulk-billed?

Item No.	Less than 20%	20-40%	40-60%	60-80%	80-100%
2702	6%	1%	4%	6%	83%
2710	4%	3%	5%	7%	81%
2712	5%	4%	5%	8%	79%
2713	6%	4%	8%	12%	69%

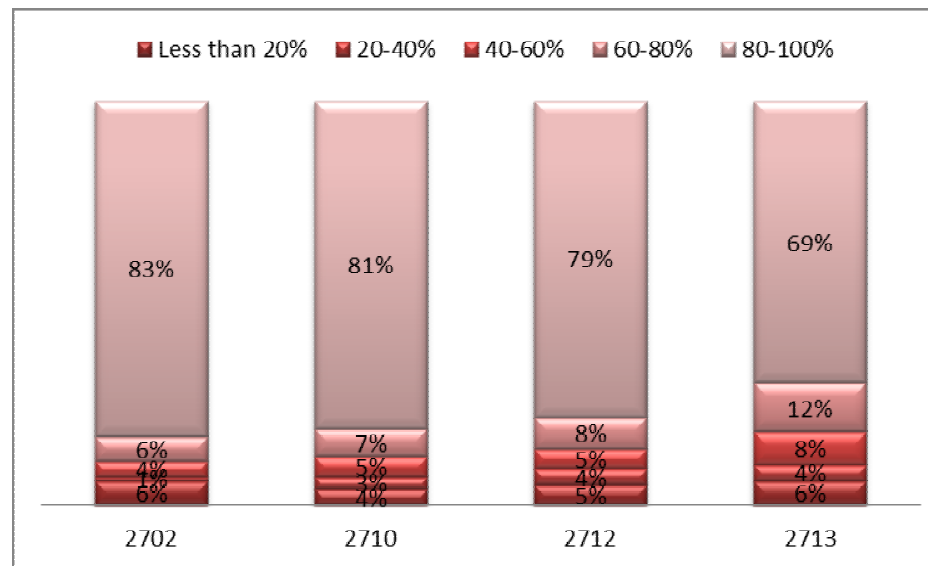


Figure 4: For each of the GP mental health MBS items, please estimate the per cent bulk-billed

Key points

- For all of the current Medicare items for GP mental health services, the majority of GPs stated that 80-100% of patients were bulk-billed, meaning that most patients do not currently face out of pocket costs for these services.
- The data (not reported here), also suggested that bulk billing is more prevalent in regional and rural areas.

4.5 MBS Items per Week

Question: For each of the GP mental health MBS items, please estimate the average number of services per week?

Item No.	Less than 5	5-10	10-20	20-50	50-100	100+
2702	85%	11%	3%	-	<1%	<1%
2710	78%	18%	3%	<1%	<1%	<1%
2712	81%	15%	3%	1%	<1%	<1%
2713	55%	26%	14%	5%	<1%	<1%

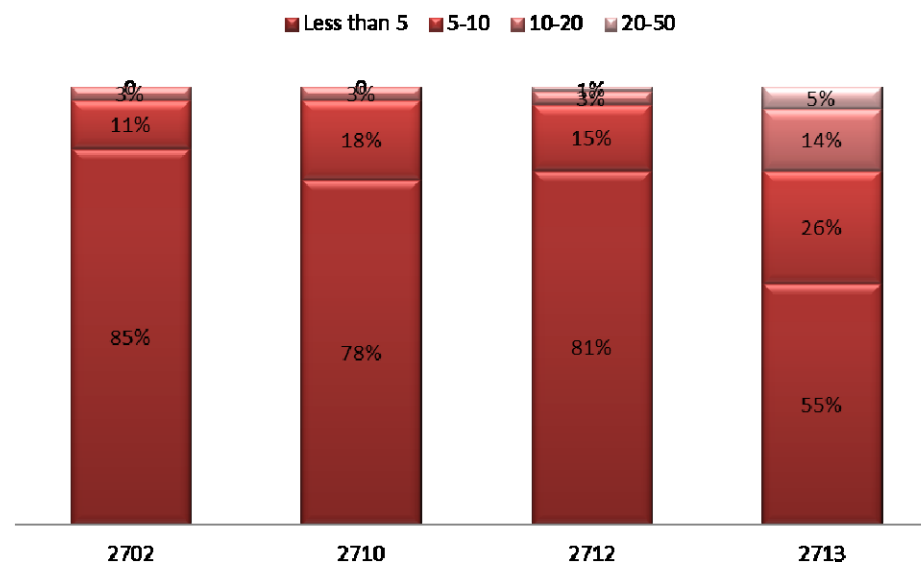


Figure 5: For each of the GP mental health MBS items, please estimate the average number of services per week?

Key points

- For each of the item 2702 (85%), 2710 (78%), 2712 (81%) and 2713 (55%) most GPs estimated that they had less than 5 services each week.
- The data (not reported here) showed there was very little difference across GPs based on the location of their practice for any of items 2702, 2710, 2712 or 2713.

4.6 GP Billing Practices

Question *In response to the cuts to the MBS rebates for GP Mental Health Treatment items, will you:*

	No	Yes	Definitely not	Probably not	Not sure	Probably yes	Definitely yes
Maintain your current fee and be forced to charge patients a gap?	31%	50%	10%	21%	19%	30%	20%
Lower your fees to bring them in line with the Government's new GP Mental Health Treatment rebate structure?	57%	25%	35%	22%	19%	19%	6%
Stop billing GP Mental Health Treatment items?	51%	28%	23%	28%	20%	23%	5%

Key points

- It appears likely that up to 50% of GPs will be forced to maintain their current fee and charge patients a gap, noting that the responses to section 4.4 indicated that many patients currently face no out of pocket costs.
- It appears likely that no more than 25% of GPs will lower their fees to bring them in line with the Government's new Medicare rebate structure for GP mental health services.
- It appears likely that up to 28% of GPs will stop utilising Medicare GP Mental Health Treatment items.

Question In response to the cuts to the MBS rebates for GP Mental Health Treatment items, will you:

		Inner Metro	Outer Metro	Regional	Rural	Remote
Maintain your current fee and be forced to charge patients a gap	Definitely not	7%	10%	12%	13%	14%
	Probably not	16%	22%	21%	28%	7%
	Not sure	19%	20%	21%	13%	21%
	Probably yes	32%	29%	27%	31%	29%
	Definitely yes	25%	20%	19%	15%	29%
Lower your fees to bring them in line with the Governments new GP Mental Health Treatment rebate structure	Definitely not	35%	34%	34%	40%	43%
	Probably not	23%	24%	23%	14%	14%
	Not sure	20%	19%	16%	16%	36%
	Probably yes	17%	20%	16%	24%	-
	Definitely yes	5%	3%	10%	7%	7%
Stop billing GP Mental Health Treatment items	Definitely not	27%	20%	26%	19%	21%
	Probably not	27%	28%	26%	35%	-
	Not sure	22%	23%	17%	16%	21%
	Probably yes	19%	23%	26%	26%	50%
	Definitely yes	5%	5%	4%	5%	7%

Key points:

- There was little significant difference across the responses of GPs based on the location of their practice, which suggests that the impact of the changes will be felt across the whole community.

4.7 Patient Access to Mental Health Services

Question *In response to the cuts to the MBS rebates for GP Mental Health Treatment items*

	No	Yes	Definitely not	Probably not	Not sure	Probably yes	Definitely yes
Do you think the Budget cuts will reduce patient access to mental health services?	8%	85%	2%	6%	7%	27%	58%
Do you think the Budget cuts will lead you to spend less time with patients with mental health problems?	32%	58%	11%	21%	10%	28%	30%

Key points:

- 85% of GPs think that the Budget cuts will reduce patient access to mental health services.
- 58% of GPs think that the Budget cuts will lead them to spend less time with patients with mental health problems

Question *In response to the cuts to the MBS rebates for GP Mental Health Treatment items, will you:*

		Inner Metro	Outer Metro	Regional	Rural	Remote
Do you think the Budget cuts will reduce patient access to mental health services	Definitely not	1%	*	3%	2%	7%
	Probably not	5%	8%	9%	2%	7%
	Not sure	7%	5%	9%	7%	21%
	Probably yes	30%	25%	21%	30%	21%
	Definitely yes	57%	61%	58%	59%	43%
Do you think the Budget cuts will lead you to spend less time with patients with mental health problems	Definitely not	10%	12%	14%	10%	14%
	Probably not	23%	19%	19%	20%	14%
	Not sure	9%	10%	10%	10%	14%
	Probably yes	27%	31%	26%	31%	7%
	Definitely yes	31%	27%	31%	29%	50%

Key points:

- There was very little difference across the respondents based on the location of their practice, which shows that the impact of the changes will be felt across the whole community.

4.8 Location of Practice

Question *To help us better analyse the results of this survey, how would you describe where your practice is located?*

	Total
Inner Metro	35%
Outer Metro	30%
Regional	18%
Rural	15%
Remote	2%

4.9 Comments

We asked GPs if they would like to comment on the Government's changes, and 540 took this opportunity. The vast majority of comments indicate enormous concern among GPs at the Government's cuts and the impact on patients' access to services. The following comments illustrate the general theme of the feedback.

- Yet another example of unilateral changes from this government without any consultation. They are incredibly arrogant and driven by ideology rather than any common sense.
- Do you feel angry? YES"
- Will probably pass more patients straight into public health system.
- I guess I will just go back to subsidising the Government as I do not think I can in all conscience let my patients suffer.
- I only started doing 2710s etc because finally the Government was offering some support for the ongoing care in mental health that all GPs do and have done for many years.
- Why is it that successful programs are the ones to get the boot? Given the mental health of this country, I would have expected the Feds to put more, not less, into the problem. It seems that we should be doing a bulk MHP for the Labor Party. They're MAD!!!
- Whoever is responsible for these changes, leave those of us who care without a voice = I WILL BE TAKING THIS MESSAGE TO THE PATIENTS, as they are the ones mainly effected, and the policy makers should be ashamed!!!
- When practice costs/time and skill are taken into account I think the new payments are completely unfair. The mental health consult not related to a plan has also been cut. I will probably charge a 36 instead and the patients will have a gap. GPs do more mental health than anyone else treating lots of the depressed/anxious who do not want to see a psychologist anyway.
- What the government doesn't realise is the expertise that is taken to deliver these consultations. The consultations are generally of demanding and complex nature, which is not measured by a single consultation time. There are generally consultations leading up to this mental health care plan that have not been adequately remunerated and require considerable mental energy by the practitioner. Mental health is generally more demanding than removing a small skin lesion, which by Medicare standards is more generously remunerated.
- The Government is once again devaluing the service of GP's and making it a less inviting profession. In the long term patients will suffer both from a monetary stance and lack of doctors.

- What about the problem of increased load on State Hospitals from GPs being less active in Mental Health?
- We have a Mental Health Nurse and Psychologist on site. Their viability may be under threat
- Vote labour more cuts for GPs worse off mental care for patients, less choice for patients
- Very upset about these changes. I feel I am being financially penalised for having an interest in mental health and a readiness to bulk bill patients from low socio-economic groups.
- "Very short sighted move lack of insight into how most people in the community access mental health care. More acute beds wont help keep the bulk of patients seeking healthcare from GP's from going to ED - or is that the aim. If 'care plans' are done properly they take 45-60 mins, not just seen on the day and timed.
- This policy decision has the potential to significantly reduce access to care for people with a mental health problem, back to levels prior to Better Outcomes. Again government and policy makers seem completely out of touch with how much of the mental health workload GPs currently do. If GPs stopped providing this service for a week and referred everyone to the mental health service they would quickly realise the enormity of their miscalculation!
- This is an obvious and cold cost-cutting decision by the existing Government, and any postulated saving is unlikely to aid the patients that most need Better Mental health Access.
- This is a recurring theme: Gov't brings in new scheme with much fanfare but when Doctors use it, they reduce it for budgetary reasons!
- This is a disgraceful decision by the Federal Government.
- This has been one of the most valuable changes the Govt has made to encourage GP management of mental health problems. I can't believe they would be so stupid as to put the program at risk in this way.
- This change will mean that I will have to review my policy on mental health care provision which is that this should be free to the patient to reduce barriers to them accessing. I will however have to consider starting to charge something for this service.
- These rebate cuts are further confirmation that this government falsely sees GPs as without value. How it will rule this view when GPs have become extinct, which these rebate cuts are contributing to.
- These people are vulnerable and need help as there is such a delay to get into public psychology services I believe they need to be helped to access appropriate treatment. As a lot of them are socioeconomically disadvantaged there is little option. Early treatment often means less treatment is required which in fact saves health dollars.

- These changes are devastating to a GP like me on so many levels, financially, practically, spiritually, morale etc; I specialise in Mental Health with years of MH experience, with a specialist interest in Psychopharmacology of Mood Disorders, use of drugs in pregnancy and lactation, Alcohol dependence AND I work in a low socio-economic area. I am exactly the type of GP who needs support to deliver highly developed MH services to people who need them the most and cannot afford them. I feel grossly devalued, this devalues my patients and it WILL change my practice.
- General Practice should be lauded for the gaps it has filled in a Mental Health system, not punished. The DOHA should look to the State based services who cannot or will not treat patients AND to the psychologists we support, and about whom we tell our patients: 'they will charge you but you can go to Medicare for a rebate'. We are the frontline dealing with first disclosures, distress and many other behaviours: there is no time based line for stopping a suicide /and no way to charge an appropriate fee for all the time incurred acutely and afterwards.
- The issue concerns politicians trying to save money on the backs of ordinary citizens, without accepting responsibility for the consequences. This needs to be repeatedly forced on those politicians to accept individual and joint liability for losses.
- The government needs to show it is serious about providing adequate mental health services to the people. With this cut in funding, I am most certainly going to reduce or cease provision of these services. I already work 16-hour days and have enough work without performing work that is under funded.
- The 'face-to-face' aspect is the biggest problem as most of the leg work is done after the patient has gone - eg it is impossible to contact psychologists and others in front of the patient as they all work from mobile phone or email message banks. The fee cut will be got around by me charging a 20 - 40 min 2710 at \$160 (ie about an \$80 out of pocket gap). Obviously those unable to pay will then have to take their chances with the Public System Mental Health Lottery!
- The burden of mental illness is already higher in people with chronic disease, the underemployed, the young and the old. These are not the people who can simply pay more. Access to psychologists under a Mental Health Plan arrangement has been an effective mechanism that has been extremely beneficial to many. It should be extended not restricted, and of course rebate cuts will act as a disincentive to doctors already under significant time pressures. This is a retrograde step.
- The Budget cuts to mental health services, will affect my practice in the mental health field as I now feel less inclined to practice in this field as it will not sustain my income and I will focus in other fields. This will eventually have a negative impact on my mental health patients, causing them to face the backlash of this budget cut, instead of helping them. Even if this cut is sustained, I would be inclined to charge a gap on the fee to my patients, giving them less reprieve from the fees.

- Sad day for mental health patients. Will likely increase workload of hospital A+E departments and significantly increase the morbidity of mental health patients in my small community.
- Patients with mental health problems have enormous problems accessing mental health care. GPs have filled this gap for decades and will continue to do so. All the reforms will make little difference on the ground and we will continue to have to do the heavy lifting. The current government has merely demonstrated how little it understands and how little it values the only truly flexible part of our current health care system.
- Patients with mental health problems are usually brittle and emotional. Most feel that they need urgent attention. It is very hard for a doctor to try to spend less time with them. Ultimately, most consultations in relation to mental health problems are long or very long consultations.
- My practice is predominantly in mental health and substance abuse, the new policy will disadvantage an already marginalized population and increase the morbidity and mortality in the community. I strongly support any action to resist these changes.
- Most patients who utilize this programme are disadvantaged - many homeless or in unstable social settings, chaotic lifestyles, drug addicts etc. Most have co morbidity with some chronic disease and already have out-of-pocket costs - if they actually get scripts filled. They are easily the most vulnerable of my patients. Either they will suffer a reduced standard of care or I will suffer economic detriment - and unfortunately for me my altruism will force me to make a decision that penalizes the party that can most easily bear the loss i.e. me!
- I think the other issue in this debate is the long-term continuity of care that some GPs offer to patients that do not fulfil the criteria to be referred to psychologists. These patients are often not easily treated, and unable to fund their own care. They require time and care that is not offered anywhere else in the mental health system. Please also note the unique skill that is the primary care generalist approach to mental health assessment - the skill to do a 2710 should be more highly valued than it already is. As a GP I have recently had a paper accepted in an international journal (Social Science Medicine) outlining this skill set as something our medical and funding community should value more than it currently does!
- I provide extended evening clinics to enable better access for employed people. These clinics have filled with long consult mental health, drug and alcohol patient problems. I cannot agree to continuing this, paying staff more money barely breaking even. I feel abused and I would tell my patients not to work under such conditions with such inconsiderate and reprehensible circumstances. I have special training and experience in managing very complex Mental Health patients. I meet with local psychologists after hours and provide a support service to them and other GP's. We have no nearby psychiatrists and many patients cannot access any community psychiatric support services. We battle on with some of the most difficult and

challenging cases providing both counselling and medication management. The whole basis of understanding mental illness diagnosis and management demands that time be spent obtaining a good history and this takes time.

- I have completed a Master of Mental Health for GPs as I am interested in mental health treatment. I have moved to a regional area where there are no local psychiatrists and those who visit charge a fee that is beyond most of my patients' ability to pay. The MHCP Medicare rebate has allowed me to help a significant proportion of my patients as I have been able to bulk bill them for these services. Should the changes take place, I will have no choice but to start charging for my time, which I am sure will provide a block to access of mental health care. Most of my MHCP are completed at home in my own time - I have been willing to do this due to the remuneration, however will not continue to do this in the future.
- I have been delighted with the positive effects of these current item numbers and the benefit to my patients and my understanding of my patients and my ability to spend more time with them without cost to them. Cost to them will change, because financially I just can't afford to subsidize them, and I am fully aware that numerous patients will not be able to afford any gap and will thus not seek the help they require, which they so efficiently get now. This is to me the single worst decision made under Medicare since it's inception.
- I am appalled at these cuts. I spend quality time with patients for difficult intensive mental health plans and spend considerable time doing the paperwork at home.
- Labor is wasting so much money on silly 'reforms' eg the white elephant 'Medicare locals'. Then cutting it from front line services. Where is these politicians morality???"
- "As a headspace doctor this will impact the service there dramatically. Patient access to services will be limited and recruitment of staff for the proposed new sites will be extremely difficult - (above and beyond current recruitment difficulties). Having seen the difficulties recruiting staff to our existing site, I cannot expect future sites to have much success with reduced MBS fees making it financially non viable for doctors.
- Appalled that these cuts will devalue my services and deny patients access when mental health is so much in the spotlight. Expect strongest possible AMA representation on this issue. There is passionate feeling at the coalface on this issue especially in rural areas.
- Access to mental health professionals is extremely difficult in the country The Better Access program, allowing patient to access a clinical psychologist has been invaluable in delivering mental health treatment to patients who have moderate to severe mental illness, in a community setting. We receive virtually no services from the public sector, and have very limited access to private psychiatrists, who if they will not bulk bill, remain inaccessible for the bulk of patients with serious mental

health problems. As the GP it is left to me to manage the bulk of mental health patients, and a multi-disciplinary approach is central to satisfactory service delivery. The 2710 is the trigger for psychology services and effectively the cuts in the rebate, which reduces the rebate below covering costs, will devastate the availability of the Better Access program.