

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.

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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.