RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

29 July 2011

Dear Secretary

RE: INQUIRY INTO COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

Thank you for the opportunity to make a submission to the *Inquiry into Commonwealth Funding and Administration of Mental Health Services.*

The submission from the Rural Doctors Association of Australia (RDAA) is enclosed at **Attachment A**.

While the RDAA welcomed the announcement of additional spending on some areas of mental health in the 2011-2012 Federal Budget, we were dismayed to see that the Government proposed to fund this additional spending by reducing funding for mental health support delivered by GPs by cuts to funding for MBS items under the *Better Access* initiative.

Rural doctors across Australia share the frustrations of patients with mental illness, and their families, about the lack of access to available mental health care services and limited opportunities for ongoing management of these chronic conditions. Rural doctors and their patients need better support to ensure that ongoing mental health management, and not solely crisis management, is available around the clock, both in rural practice and hospital settings, in collaboration with other mental health professionals.

Better levels of funding are also required for preventative mental health initiatives—and the education and training of doctors, nurses and other health professionals in mental health skills—at the local level.

The MBS items under the *Better Access* program were originally created to facilitate the delivery of quality mental healthcare in general practice, including both face-face consultation time and the coordination of mental healthcare services. They represent an investment in a framework for the better management of patients with mental illness. RDAA strongly opposes any rationalisation of these MBS items.

If you require any further information, please do not hesitate to contact me on (02) 6239 7730.

Yours sincerely

Jenny Johnson
Chief Executive Officer

ATTACHMENT A

RDAA SUBMISSION: INQUIRY INTO COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

RDAA is pleased to provide the following comments the *Inquiry into Commonwealth Funding and Administration of Mental Health Services*.

Mental health and mental health care in rural and remote Australia

Mental health conditions are estimated to be responsible for around 13% of the total burden of disease in Australia.[1] In the burden of disease rankings, mental health disorders as a disease group are ranked third behind cancer and cardiovascular diseases because of the impact of mental health disorders on morbidity and mortality.[2]

The prevalence of mental illness among people living in rural and remote areas is estimated as similar to the prevalence in our major cities. However, suicide rates in Australia have consistently been found to be higher in rural communities than in metropolitan areas,[3] with the death rate as a result of suicide for males aged 15-24 years tending to rise with increasing remoteness.[4]

Unfortunately, the percentage the total burden of disease the burden of mental illness is not reflected proportionately in the percentage of health expenditure on mental health services.

Australians living in rural and remote areas suffer from a significant relative disadvantage in relation to accessing mental health services compared to metropolitan areas. Many people do not receive the support and care they need, and consequently have worse outcomes than if they were living in a city. The inability of young Australians living in rural and remote communities to access mental health services is a particular concern. The onset of mental illness is usually between 15 to 25 years of age. If young Australians experiencing the onset of mental illness do not receive appropriate ongoing support and treatment, this will affect their ability to recover, finish their education and lead fulfilling lives in the community.

General practice is well positioned to deliver mental health care. Consulting a GP is the most common action related to health care undertaken by Australians. Around 61% of females and 49% of males aged 25–64 years

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[1] In 2003, mental health conditions were estimated to be responsible for 13% of the total burden of disease in Australia: Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez A 2007. The burden of disease and injury in Australia, 2003. AIHW cat. no. PHE 82. Canberra: Australian Institute of Health and Welfare.

[2] Australian Institute of Health and Welfare 2010. Mental health services in Australia 2007–08. Mental health series no. 12. Cat. no. HSE 88. Canberra: AIHW.

[3] Tanya M Caldwell, Anthony F Jorm and Keith B G Dear, *Suicide and mental health in rural, remote and metropolitan areas in Australia*, MJA Volume 181 Number 7, 4 October 2004.

[4] Moon L, Meyer P, Grau J. Australia's young people: Their health and wellbeing (1999) Canberra, AIHW.

have check-ups with a GP at least once a year.[5] At a national level, GPs provide an average of 2.39 million consultations a week.[6] This frontline contact with a doctor provides a unique opportunity to provide care for acute and chronic health conditions, including mental illness.

In 2008-09, the Bettering the Evaluation and Care of Health survey of general practice activity estimated that over 13.2 million GP-patient encounters involved management of a mental health issue, an increase on average of 5.7% each year from 2004-05.[7]

The funding of GP Mental Health Care Medicare items

The introduction of GP Mental Health Care Medicare items in 2006 under the Better Access initiative recognised and supported the important role GPs can play in undertaking early intervention, assessment and management of patients with mental disorders.

In RDAA's view, the decision to rationalise mental health rebates for GPs in the 2011-2012 budget devalues the work GPs undertake in this area and will discourage GPs from undertake ongoing training and continuous professional development in the area of mental health. This will ultimately impact on the ability of patients to access high quality primary mental health care.

Patients requiring personalised, time-intensive, mental health care will now be paying more for this care, as GPs will be placed in the position of having to charge patients a larger gap to make up for the shortfall. This will result in less mental health plans being done, particularly in socio-economically disadvantaged, small rural communities.

Arrangements should be in place to support and enhance the capacity of primary care providers in rural communities - rural generalists (in the first instance), allied mental health professions and community health services - to recognise and treat mental health problems and disorders more effectively.

Building a sustainable rural health workforce

Ultimately, mental health problems and disorders will only be recognised and treated more effectively in rural and remote areas if there is an appropriately skilled rural health workforce available on the ground to deliver health care services.

The current health policy framework is failing to meet the needs of rural and remote communities. This failure is reflected in the health status of people in these communities, the considerable underspend in Medicare in comparison

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[5] Australian Institute of Health and Welfare (AIHW), 2010, *Australia's Health 2010,* AIHW, Canberra, at 314.
[6] Ibid at 344. These figures are based on Medicare funded services and do not include those funded in other ways, for example through Aboriginal Medical Services or the Department of Veterans Affairs.
[7] AIHW 2010. Mental health services in Australia 2007-08. Cat. no. HSE 88. Canberra: AIHW.

to metropolitan areas, and the ongoing difficulty in attracting doctors and other health workers to these communities.

Parts of rural and remote Australia have been in a state of permanent undersupply of appropriately trained GPs and specialist medical practitioners for decades. The seriousness of the situation cannot be over stated. Australians living in rural and remote areas having much poorer access to local health services, significantly worse health outcomes and a significantly shorter life expectancy than Australians living in metropolitan areas.

Initiatives that increase GP training places in rural and regional Australia, have simply not addressed the rural medical workforce shortage and kept pace with the increasing demand for rural medical services. While the regionalised general practice training program has been operating for almost ten years now, there is evidence that this program has yet to deliver a sustainable general practice workforce to rural and remote Australia.[8] Retention also remains a key issue. In January 2008, just over a quarter (27%) of previous rural pathway registrars were still working in rural practice[9]. In other words, many doctors taking the rural stream do not remain in rural practice.

A particular concern for rural and remote communities is the steady disappearance of doctors with advanced skills training from the rural landscape. This unique group of doctors provide highly skilled services across a number of disciplines that traditionally include obstetrics, emergency medicine, surgery and anaesthetics. However, there is a growing recognition that doctors working in rural and remote areas also required advanced skills in general medicine, paediatrics, acute mental health and Indigenous health.

People living in rural and remote areas rely on the availability of these doctors to ensure procedural and other advanced and acute medical services are available within their local community, helping to avoid delays in diagnosis and treatment, mortality and long term morbidity and the financial and emotional hardships associated with the need to travel long distances for diagnosis and treatment.

RDAA believes a National Advanced Rural Training Pathway (NARTP), modelled on Queensland's Rural Generalist Pathway (RGP) and adapted for local circumstances, will ensure that doctors will be able to acquire the skills and confidence to service the needs of rural communities.

The RGP in Queensland has had some early success delivering doctors to rural areas by offering a rural generalist training pathway that delivers the opportunity to perform procedural work and an attractive remuneration package. This initiative offers a fully supported career structure for junior doctors wishing to pursue a vocationally recognised career in rural generalist medicine.

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[8] Campbell, DG, Greacen, JH, Giddings, PH and Skinner LP, *Regionalisation of general practice training – are we meeting the needs of rural Australia?* MJA, Volume 194 No. 11.
[9] Ibid, at S71.

The proposal for a NARTP is about creating a new rural training program that uses existing pathways and existing training infrastructure in a more focused way to provide a tailor-made medical workforce to meet the specific needs of rural and remote communities. It is not about establishing a new specialist college and a new specialist discipline.

The proposed new pathway will integrate current general practice training, with advanced special skills training in emergency medicine, procedural obstetrics, anaesthetics and surgery, acute mental health, paediatrics and indigenous health.

Evidence suggests that the opportunity to perform procedural and higher level clinical work increases the attractiveness of general practice as a career choice.[10] This is clearly demonstrated in a recent study that concluded that the probability of a junior doctor choosing to become a GP (which is around 39%) rises by 16% with an increase in procedural work.[11] The study also concluded that increasing GP earnings by one third (or $50,000) would lead to a 12% rise in the probability of a junior doctor choosing to become a GP.[12]

These findings suggest that an advanced rural training pathway that offers a mix of general practice and hospital work, and the introduction of financial rewards for rural doctors with advanced skills training, are likely to attract more junior doctors into a career in rural generalist medicine.

These findings also suggest that the time has come to rethink how we use existing training pathways, infrastructure and resources to train and retain doctors for rural practice.

[10] Sivey, P, Scott, A, Witt, J, Joyce, C and Humphreys, J, *Why Junior Doctors Don't Want to Become General Practitioners: A Discrete Choice Experiment from the Mabel Longitudinal Study of Doctors* (2010) Melbourne Institute Working Paper Series. Working Paper No. 17/10, University of Melbourne.
[11] Ibid, at 20.
[12] Ibid, at 20.