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

Dear Mr Holland,

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

During the AMA's recent appearance before the Inquiry, members of the Committee requested that the AMA provide further information in relation to a number of issues. These are dealt with below.

**Budget analysis**

The AMA notes the analysis contained in the submission provided by the Department of Health Ageing (DoHA) does not support the public statements made by the Government that the 2011/12 Budget mental health package was worth \$2.2b. The DoHA submission (sub 199) at page 26 clearly shows that the total injection of additional funding in the 2011/12 Budget for mental health across all portfolios amounted to \$582.7m over the normal four year Budget cycle.

Taking into account the five-year framework announced in the Budget for the Government's mental health package, which the AMA notes was not applied to any other Budget initiative, the DoHA submission shows that the total injection of new funding amounts to \$918.8m.

There appears to have been some confusion caused by the evidence given by DoHA officials during hearings when they stated that the mental health package in the 2011/12 Budget involved an **injection** of \$1.5b in new money<sup>1</sup>. This evidence appears to be inconsistent with the Department's own submission and, in the AMA's view, is misleading.

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<sup>1</sup> Draft Hansard Transcript. Monday 5 September 2011. Eg: page 7 & 22

The quality of the debate over the true value of the Government's investment in its mental health package is not well served when Departmental officials talk up expenditure measures without appropriate reference to savings measures. Looking at the first year of the mental health package, the DoHA submission shows that overall Commonwealth expenditure across all portfolios on mental health is being cut by \$15.5m. Yet, if the same logic relied on by DoHA officials during their evidence to the Inquiry were to be applied, the conclusion would be that a \$47.3m injection of new funding was being made available.

This approach is nonsense and out of step with the community's understanding of what 'new money', in the Budget context, means. People expect that new money means just that – it is something over and above existing funding levels. The analysis of the 2011/12 Budget mental health package outlined in our original submission to the Inquiry is based on this approach.

The AMA analysis is consistent with the information provided in the DoHA submission. The AMA submission provides specific information on the health portfolio, which is where the AMA has an obvious interest. However, our submission also includes analysis encompassing the other portfolios included in the mental health package. The AMA, at page 3 of its submission, reaches the same overall conclusion as DoHA - *that over the normal four year Budget cycle the Government's mental health package is worth \$583m across all portfolios.*

The AMA's submission pulls no punches in its assessment of the mental health package and, in particular, we have included analysis of the package based on the normal four year Budget cycle. Given the chronic under-funding of mental health services, the community had real expectations that the 2011/12 Budget would deliver real funding increases with some immediacy.

The Government had also identified improved mental health services as a key priority and created enormous community expectations. However, 69 per cent of the additional funding for mental health in the 2011/12 Budget is not delivered until years 4 and 5 of the package. The AMA makes no apologies for highlighting that much of the Government's modest additional funding is delivered in the latter years of its package and extends beyond the Budget forward estimates. This reality must inform any assessment of the 2011/12 Budget commitments in relation to mental health, noting that the cuts to the Better Access Program clearly have a more immediate impact on patients.

### **Cuts to Medicare Rebates**

The AMA submission highlights that Medicare rebates for GP mental services will be cut by up to 49% when the Budget changes are implemented on 1 November this year. During the hearing Senators asked for more information as to how this figure was calculated.

Table 1 demonstrates the extent of these cuts by providing a comparison of patient rebates for GP mental health services under current Medicare Benefits Schedule (MBS) arrangements (including the estimated indexation adjustment that would have otherwise been applied on 1 November 2011) with the MBS rebates that patients will receive following the implementation of the Government’s cuts. These calculations confirm the figures provided by the AMA.

**Table 1**

MBS item	Current MBS arrangements			New MBS arrangements		
	MBS rebate 1/11/10	Indexed rebate 1/11/11	Expected indexation adjustment	New time tier	Proposed new rebate	% cut in rebate
2702	\$128.20	\$130.90	2.1%	<40 mins	\$67.65	-48.3%
2702	\$128.20	\$130.90	2.1%	40+ mins	\$99.55	-23.9%
2710	\$163.55	\$167.00	2.1%	<40 mins	\$85.00	-49.1%
2710	\$163.55	\$167.00	2.1%	40+ mins	\$126.00	-24.6%
2712	\$108.90	\$111.20	2.1%	N/A	\$67.67	-39.1%
2713	\$71.85	\$73.36	2.1%	N/A	\$67.67	-7.8%

- *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.*

**Medicare Rebates are a patient entitlement**

During hearings, the AMA was asked to respond to the suggestion that concerns about cuts to the Better Access Program were driven by providers because of a potential reduction in income.

In this regard, Medicare rebates are an entitlement for patients, not doctors. Doctors set their own professional fees and Medicare provides patients with a subsidy to defray the costs of these medical services. Cuts to Medicare rebates directly impact on patients and inevitably reduce access to services.

In relation to the Better Access Program, we note that 93% of GP mental health services involve no out of pocket costs for patients. Given that around 1 million patients access GP mental health services each year, including over 130,000 in the most disadvantaged

socio-economic areas<sup>2</sup>, the proposed reduction in Medicare rebates is a blunt policy initiative that will impact most heavily on some of the most disadvantaged patient groups.

I would also emphasise that the AMA's original submission to the Inquiry is evidence based, utilising information from independent evaluation of the Better Access Program commissioned by the Government as well as independent research commissioned by the AMA.

The AMA has also called for the total restoration of funding for the Better Access program, not just the GP component. We do not apologise for opposing a Government decision to cut funding for a successful program that is demonstrably improving the lives of people with mental illness.

### **Utilisation of BEACH data**

The AMA notes that when providing evidence during the hearing on behalf of DoHA, both Ms Huxtable and Mr Bartlett suggested that there is an element of non face-to-face time involved in all GP consultations. Mr Bartlett made reference to an estimated ratio of face to face versus non face-to-face time, which he stated the AMA had previously suggested.

On this basis, it was asserted that the use of BEACH data (which looks only at face to face consultation time) as the basis to adjust Medicare rebates for GP mental health services was not invalid<sup>3</sup>. Mr Bartlett also made comparisons to the level C Medicare consultation item, which has been similarly referred to by Minister Butler as an appropriate point of reference in determining the value of a Medicare rebate for a GP Mental Health Care Treatment Plan (GPMHTP).

The AMA does not agree with this analysis. Whereas the Level C and D Medicare consultation items are specifically linked to the time that a GP spends in face-to-face consultation, this is not the case with a GPMHTP. The current rebate structure for a GPMHTP was developed based on the complexity of the work undertaken, not the time spent in face to face consultation with a patient.

In addition, the requirements mandated by the MBS in relation to the preparation of a GPMHTP go well beyond the requirements specified in relation to a Level C or Level D Medicare consultation item. The additional requirements clearly involve more effort/skill and impose extra non face-to-face work on the part of a GP.

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<sup>2 2</sup> 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.

<sup>3</sup> Hansard. Op cit. Page 14.

To illustrate this point the AMA has prepared the attached matrix, which outlines the requirements specified in the MBS for a GMHTP and compares these with those specified for a GP Management Plan (utilised for people with chronic physical illness) and the Levels C and D consultation items.

This matrix not only highlights how weak the proposition put forward by the Department is, it also demonstrates that a more appropriate comparison point should be a GP Management Plan for chronic physical illness. Utilising this as a comparison point highlights that the Government's changes devalue mental illness, with the new rebates for patients with a mental illness being between 10 per cent and 50 per cent lower. This is despite a GP Management Plan imposing fewer responsibilities on a GP, particularly in relation to making arrangements for required referrals, treatment, and support services

**Online services as treatment or complimenting face-to-face treatment or primarily as an information/education platform.**

The AMA understands that research into this area shows good results in mild anxiety and depression. More controversial is the finding that some people with moderately severe depression and anxiety also seem to respond as effectively as simple drug mono therapy . There is also the proposition is that on-line services are helping to address hidden and unmet need in the community by helping people who have not sought treatment in the past. Some respondents to surveys have indicated that online treatment is more acceptable than seeing a mental health professional.

The major drawback is that severely ill people may not take advantage of more conventional treatment options if they depend on online resources. Online resources are an invaluable adjunct to other evidence based personal treatments that help break down stigma of mental illness. Ultimately, they cannot replace adequately resourced and funded clinical services and we note that online access can be difficult for some due to the digital divide (rural, indigenous, poor communities without personal, private online access).

**Intellectual Disability Health Check Medicare Item**

The Government announced the introduction of a new annual health assessment item for patients with an intellectual disability in 2007. This announcement was in response to a joint proposal and lobbying campaign by the AMA and Royal Australian College of General Practitioners (RACGP).

In October 2005 the AMA and RACGP developed a proposal for a health assessment for patients with an intellectual disability. The AMA included a call for this initiative in its 2006-2007 Budget submission. This health assessment was sought to provide GPs with the time required to gather a complex and lengthy patient history and provide a thorough health check.

The AMA championed this because of the very poor rate of appropriate diagnosis and treatment of medical conditions in people with intellectual disabilities. There are various reasons for this problem; most particularly how doctors grapple with the difficulties people with intellectual disabilities have in recognising and communicating symptoms.

Research at the time showed that annual comprehensive health assessments can make a major contribution to addressing this situation. In a randomised controlled trial with 453 people with intellectual disabilities, such assessments led to a many fold increase (2 to 29 times) in achievement of various health outcome indicators – these included immunisation rates, women’s health screening, assessment and recognition of previously undetected hearing and vision impairment, identification and treatment of obesity, as well as a distinct trend to early detection of previously unrecognised disease.

The AMA had input into the design of the original Medicare item and explanatory notes and GP groups were generally satisfied with the outcome, which was achieved through a consultative process with DoHA. In May 2010 the specific Medicare item for the Intellectual Disability Health Check was incorporated into a new time tiered rebate structure for health assessments, as part of a range of measures that sought to simplify the MBS.

Statistics on the current utilisation of these health assessment items for people with an intellectual disability are not publicly available. If rates of utilisation are low, then the AMA would welcome the opportunity to work with stakeholders to improve the level of awareness and take up.

The AMA appreciates the opportunity to provide this further information to the Inquiry and would be happy to answer any further questions that Committee may have.

Yours sincerely

Dr Steve Hambleton  
President