Australian General Practice Network

Submission to the Senate

Community Affairs References Committee

Commonwealth Funding and Administration of Mental Health Services

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AGPN is one of the largest representative voices for general practice in Australia. It is the peak national body of the divisions of general practice, comprising 111 divisions across Australia, as well as eight state-based organisations. Approximately 95 per cent of GPs are members of local divisions of general practice.

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Executive Summary

The Australian General Practice Network (AGPN) welcomes the opportunity to provide this submission to the Senate Community Affairs References Committee inquiry into Commonwealth Funding and Administration of Mental Health Services.

AGPN seeks to highlight the impact of the cuts announced in the 2011-12 Federal Budget Mental Health package to the *Better Access to General Practitioners, Psychiatrists and Psychologists Program* and to particularly focus on the clear evidence that the best health outcomes are achieved in systems that have a well-developed primary health care sector with general practice at its heart. The decision to reduce patient rebates for general practice mental health care is contrary to this evidence.

The relationship between a patient and their GP is the cornerstone of an effective primary health care system. The first principle of a strong health care system is that it be built around general practice, working with other care providers to deliver comprehensive, integrated care. Care teams that include relevant health professionals from different disciplines will support improved outcomes in primary mental health care.

The rebate cut announced in the Federal Budget will dilute access for those with high prevalence, chronic and disabling disorders such as depression and anxiety and will mean that those in need of a Mental Health Treatment Plan – often the very cohort with reduced ability to pay – will have to pay significantly more than those with a GP management plan for other complex and chronic conditions.

While the overall intent of the 2011-12 Federal Budget Mental Health package, including increased investment in targeted services for young people with mental illness and people with severe mental illness is extremely welcome, AGPN does not support the Government's decision to reduce the rebates to GPs to undertake vital care planning and coordination role.

Over the past 10-15 years, Australia has led the world in primary mental health care reform. The Better Access program, and its forerunner, the Better Outcomes in Mental Health Care program, have both demonstrated through independent evaluation, enhanced access and achieved positive outcomes. The rebate cuts are at odds with the direction of the Government's own health reform agenda and substantially erode a decade of reform and service improvement that has been welcomed by mental health consumers and shown to improve access.

The impact this policy will have on access to **headspace** and services under the Access to Allied Psychological Services (ATAPS) Program are likely to be significant, and contrary to the Government's aim to expand these areas. The GP Mental Health Treatment Plan is the referral trigger to ATAPS services and, within **headspace** services, the pathway to mental health nurse, psychology and psychiatry services so that true 'wrap around' care can be delivered to young people. **headspace** has already reported that their centres are already struggling to attract GPs. By reducing incentives for GPs to develop Mental Health Treatment Plans, the Government has created a structural barrier that will impede the success of these programs.

GPs play a pivotal role in coordinating all dimensions of a person's care out of hospital. Regardless of the number of programs available, the GP should remain at the centre of the patient's care to provide the overall continuity. The reductions to the GP Mental Health Treatment Plan rebate and the expanded measures announced in the Federal Budget are interconnected. It is unfortunate that they have become an 'either/or' proposition when maintenance and expansion of funding for primary mental health care, including services provided in the general practice setting, are warranted.

AGPN welcomes the previously announced Flexible Care Packages (FCPs) and Care Coordination (CC) measure for people with severe and chronic mental illness announced in the 2011-12 Federal Budget. Both these measures presents an exciting opportunity to better integrate and coordinate clinical and non-clinical care through local solutions. AGPN is concerned, however, that the Government is suggesting that FCPs will be implemented by Medicare Locals or NGOs on a contestable – or tender - basis. AGPN does not support a national tender process to allocate FCP funding and believes a partnership model for implementing FCPs would be more appropriate. This could be best achieved at the local level through planned and coordinated arrangements between primary, acute and social care service providers.

AGPN particularly welcomes the major expansion to the Access to Psychological Services (ATAPS) program in the Federal Budget. This program has proven capacity to improve access to affordable primary mental health care services as well as deliver improved patient outcomes. ATAPS serves well as a model of 'step-up, step-down' care with its capacity to integrate more intensive and less intensive interventions within a primary mental health care framework. An additional strength of ATAPS is its capacity to be tailored to local circumstances and to offer targeted interventions to particular groups in the community such as those at risk of suicide, women with perinatal depression and children. AGPN is concerned however, that the funding models for ATAPS support has not kept up with its expansion. AGPN would strongly advocate that investment must be

made in capacity to support service development and integration at the Medicare Local division of general practice level and that the 85:15 service to administration funding ratio be reviewed. This will facilitate the implementation of a quality assured program with capacity to support clinical workforce development and data collection among other things.

Under national health reform arrangements, Medicare Locals are being established as regional primary health care organisations with responsibility for service planning, coordinating and commissioning. The Commonwealth's intent for Medicare Locals is that they function as as 'meso' level organisations with responsibility for planning, coordinating and funding local health solutions. In some cases they may be direct providers of services but typically only in situations where there is market failure and no alternative provider exists. Medicare Locals are best placed to plan and implement FCPs and the CC measure in consultation with local stakeholders and providers, and in a manner which best integrates FCPs with existing service architecture. Medicare Locals and NGO providers of non-clinical care occupy completely different spaces in the system and it would not be in the best interest of patient outcomes and collegial Medicare Local and social care sector relationships if they were forced to act as competitors in any FCP implementation strategy.

Background

There is considerable disease burden and disability associated with high prevalence mental health disorders. These disorders are common and often co-exist with physical health conditions. Almost 40 per cent of Australians identify mental health issues as one of our country's two or three greatest challenges.

The high number of people with high prevalence disorders not accessing services suggests that our current mental health system is not adequate. Around two-thirds of people with mental illness do not receive any treatment in a 12 month period. Notwithstanding the progress made in recent years and the range of good programs and services available, access to these services is often patchy.

The Federal Government's National Health Reforms and the development of Medicare Locals as regionally based primary health care organisations, present an opportunity for much needed key structural reform. This reform will enable a reduction in the silos and gaps between services, to pool funds, coordinate and lead action in mental health and provide a focus on local priorities and social determinants across private, public and non-government sectors. An essential component of the reform is the integration of general practice into a broader primary health care context providing a mechanism for more integrated services and improved patient outcomes.

The solution is not just about more funding for more of the same type of services, but instead should focus on developing a reconfigured infrastructure with services that relate seamlessly, with the result that there is reduced pressure on hospital in-patient services as well as other forms of acute services.

There has been considerable, world-leading investment in a primary mental health care response over the past decade, resulting in measures aimed at developing a *system* of primary mental health care. These measures, for the first time, have recognised the GP as a vital part of the mental health workforce and the key to achieving more effective care coordination. These measures include:

- The Better Outcomes in Mental Health Care Program which includes:
  - education and training for GPs;
  - a Service Incentive Payment for the completion of mental health care plans;

  - ATAPS administered by divisions of general practice (offering up to 12 referred, no-cost sessions with a trained MH professional per calendar year to patients with a GP Mental Health Treatment Plan);
  - reform to psychiatry MBS items; and
  - specialist support for GPs from psychiatrists (e.g. in the form of the GP Psych Support Service); and

- Better Access - which enables GPs (through the completion of a Mental Health Treatment Plan) to refer to private allied health professionals registered under Medicare for provision of focussed psychological strategies. GPs who complete Mental Health Skills Training receive a higher rebate.

These initiatives were designed largely to improve coordination, integration and access to care for patients with mental health problems, through increasing affordability as well as geographic access and coordination.

Response to the Terms of Reference

The Government's funding and administration of mental health services in Australia, with particular reference to:

(a) The Government's 2011-12 Federal Budget changes relating to mental health;

The 2011-2012 Federal Budget made mental health a priority area for investment with six major initiatives:

- Improving outcomes for people with severe and debilitating mental illness ($571.3 million);
- Strengthening Primary Mental Health Care Services ($220.3 million);
- Strengthening the focus on the Mental Health needs of children, families and youth ($491.7 million);
- Strengthening social and economic participation ($2.4 million);
- A National Partnership Agreement on Mental Health ($201.3 million); and
- Ensuring quality, accountability and innovation in mental health services ($12.2 million).

The intent of these initiatives is to focus on delivering early intervention services and on providing care to priority groups that need additional services. However, the overarching policy objective of the new initiatives is to continue to provide more systematic, integrated treatment and access to care by:

- ending the fragmentation in the system and addressing the service and support gaps;
- ensuring that Australians with mental illness are receiving the right care and support to manage their illness and that they are connected with family and friends and with the other cornerstones of a productive life, such as education, secure housing and employment;
- laying the foundations for a new systematic approach to support people with mental illness; and

- building a better mental health system – a system that will work better for patients, their families, carers and health practitioners alike. A system that will support people to get well and stay well[1].

However, the Federal Budget initiatives included 'savings' taken from the Better Access program to offset the investments in these other areas. The changes to Better Access result in the following impacts:

- a reduction in the rebate GPs can access for completing a Mental Health Treatment Plan and a reduction in the number of sessions provided by Allied Health Professionals from 12 to 10 sessions in a calendar year. These changes will come into effect from 1 November 2011; and

- alignment of the new GP rebates to Level C and D long consultations. There will still be a higher payment for those GPs who have undertaken the Mental Health Skills training.

Overall payments will be as follows:

MBS Item	**Current**		**Future** Level D		**Future** Level C	
	Scheduled fee	Rebate	Scheduled fee	Rebate	Scheduled fee	Rebate
For GPs **who have** undertaken MH Skills Training (Item 2710)	**$163.35**	$138.85	**$148.75**	$126.43	**$101.10**	$85.92
For GPs **who have not** undertaken MH Skills Training (Item 2702)	**$128.20**	$109.0	**$117.10**	$99.55	**$79.50**	$67.60

[1] 2011 – 2012 Budget

(b) changes to the Better Access Initiative, including:

- ***(i) the rationalisation of general practitioner (GP) mental health services;***
- ***(ii) the rationalisation of allied health treatment sessions;***
- ***(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs; and***
- ***(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule.***

The implications and issues arising from the changes to the Better Access Initiative include:

- Devaluing of the GP's role in mental health care and loss of GP engagement in mental health care. This is a risk because it has significant implications for patient care and for the systematic provision of coordinated mental health care that the Government envisions.

- Currently, the Mental Health Treatment Plan is the gateway to accessing the Better Access initiative as well as ATAPS. There is a risk that, due to the proposed reduced remuneration for Mental Health Treatment Plans, GPs will do a GP management plan instead of a Mental Health Treatment Plan. If fewer Mental Health Treatment Plans are developed, fewer patients will be able to access ATAPS. If this gateway decreases through GPs developing fewer Treatment Plans, then patients needing mental health care will be denied access to appropriate mental health care.

- Additionally or alternatively, GPs may continue to prepare a Mental Health Treatment Plan but charge the patient a 'gap' to do so, representing a further barrier to patients accessing the right mental health care.
- The stigma associated with mental health is already a significant barrier to patients accessing care. Policy approaches to mental health care should be aiming to reduce the barriers to accessing care. GPs are the best placed health professionals to provide the longer term management and follow-up of patients with mental health issues and general practice is a more "normalised", less stigmatised, setting in which patients can seek that care.
- Reduced access to care for people with high prevalence disorders - for the reasons outlined above, many GPs are likely to continue to charge what they believe a Mental

Health Treatment Plan consultation is worth. The resulting gap payments may prove unaffordable to people from lower socio-economic backgrounds and impede their access to low cost ATAPS, or private psychology, referrals by virtue of the fact that they cannot afford a Mental Health Treatment Plan (currently a prerequisite of referral).

- Furthermore, the reduction of the number of allied health treatment sessions and the erosion of "exceptional circumstances" means that patients who would be regarded as having a "moderate mental disorder" will be disadvantaged. The budget initiatives fund services for patients with mild mental disorders through Better Access and ATAPS and serious and severe mental illness through FCPS, MHNiP and PHAMS but leave a gap for those with moderate mental disorders that do not need FCPs but require more than the capped number of sessions in Better Access.
- A reduced quality agenda – ATAPS is designed to treat short term, high prevalence disorders. Despite receiving care through ATAPS, patients still need long term management of their mental health (which often have physical co-morbidities, or vice versa). GPs are the best placed health professionals to provide this clinical care coordination. Despite differential rebates being offered for GPs with the mental health training, without sufficient remuneration overall, there may be a disincentive for GPs to undertake MH training.
- Mental health is a significant issue in the community, and mental health training continues to assist GPs to identify and manage mental illness. This could have an impact on mental health care in the community, including earlier diagnosis and treatment. (NB. Current uptake of mental health training is around 70 per cent of GPs which demonstrates the importance GPs assign to this area. Although this uptake is currently high, lack of incentives could impact on uptake of the training in new doctors entering general practice.)
- The GP care plans for both mental health and chronic disease stem from commitments to 'Enhanced Primary Care'. These items were introduced to remunerate a coordinated, team-based approach to the management of complex diseases including mental health. Moving the Mental Health Treatment Plan to a simple time-based remuneration model is at odds with the Government's commitment to a prevention and primary health care oriented system. Like the GP chronic disease management item (which is not remunerated on the basis of time) it is about quality care, coordination and longer term management of people with mental health issues.

Overall, there is a major risk that by disengaging GPs through the reduction in remuneration for the preparation of Mental Health Treatment Plans, long term follow-up of patients and the more systematic coordinated care of patients will be compromised. In turn, barriers to patients accessing subsidised, multidisciplinary care could be increased, with implications for a reduction in quality affordable care provision for patients with mental health problems. These potential barriers and risks do not reflect the policy intent of the Government's objectives for mental health, and risk increased fragmentation in the system.

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

There is evidence that the Access to Allied Psychological Services (ATAPS) program has filled a service gap for community based mental health services in rural, remote and outer metropolitan communities. While the Better Access program has also played a role in contributing to improving access to mental health care, factors such as workforce supply and gap payments will continue to affect equitable access. ATAPS should continue as a complementary referral pathway alongside Better Access. AGPN has strongly welcomed the Federal Budget measures which significantly expand ATAPS.

The broad policy intent of ATAPS has been to improve access to primary mental health care for those unable to afford other pathways. Many divisions of general practice are targeting their service to clients from lower socio-economic groups and to those population groups such as young people or Aboriginal and Torres Strait Islander people.

(d) services available for people with severe mental illness and the coordination of those services;

The Flexible Care Packages (FCPs) previously announced and the Coordinated Care (CC) Measure announced in the 2011-12 Federal Budget present an exciting opportunity to better integrate and coordinate clinical and non-clinical care through local solutions. AGPN is, however, concerned that the Government is suggesting that the CC measure will be implemented by Medicare Locals or NGOs on a contestable basis. AGPN does not support a national tender process to allocate FCP funding and favours a partnership model as the best option for implementing FCPs. This could be best achieved at the local level through planned and coordinated arrangements between primary, acute and social care service providers.

Under National Health Reform arrangements, Medicare Locals are being established as regional primary health care organisations with responsibility for service planning,

coordination and commissioning. As the Commonwealth's primary health care organisation infrastructure, Medicare Locals are designed, and will be best placed, to plan and implement FCPs in consultation with local stakeholders and providers, and in a manner which best integrates FCPs with existing service architecture. Medicare Locals and NGO providers of non-clinical care occupy completely different spaces in the system and it would not be in the best interest of patient outcomes nor relationships between Medicare Locals and the social care sector if they were forced to act as competitors in any FCP implementation strategy.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

(ii) workforce qualifications and training of psychologists, and

(iii) workforce shortages

There are ongoing workforce issues in primary health care in rural and remote Australia. In many rural areas, there is a limited supply of allied health providers so many divisions of general practice, although welcoming of the expansion of ATAPS, are also concerned about workforce capacity to deliver the services. With the increasing demand for mental health services in primary health care, there is concern that demand will always outweigh supply if we continue to rely on the traditional disciplines (i.e. psychology, social work, nursing and psychiatry) to meet the demand. There is an emerging case for consideration of a new, appropriately credentialled workforce/s that can provide a different level of service.

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

(i) culturally and linguistically diverse communities,

(ii) Indigenous communities, and

(iii) people with disabilities;

Accessing and using interpreter services to work with culturally and linguistically diverse (CALD) clients requires additional funding and training. Currently, there is no specific provision for funding interpreter services under ATAPS. CALD clients are not identified as a priority group for Tier 2 funding of ATAPS so where divisions of general practice have a high CALD population, most of the Tier 1 funding is used for providing services to this population. Many divisions of general practice redirect these clients to specialist agencies many of which are tailored to the acute mental illness of torture and trauma and not high prevalence disorders such as mild-moderate depression and anxiety. Allied

health providers usually need to be upskilled to work with interpreters as it is a specialised area of work. AGPN would recommend CALD as a priority group for Tier 2 of ATAPS.

The 2011-12 Federal Budget has earmarked funding for indigenous communities under the Taking Action to Tackle Suicide election package and has identified them as a priority group for Tier 2 of ATAPS. However, in most cases it is not simply a matter of implementing a mainstream program in indigenous communities but instead using the components of an effective mainstream program for developing a culturally appropriate program. This requires additional funding and expertise.

(g) the delivery of a national mental health commission;

The 2011 Budget Papers state that:

> *"…the Government has allocated $32 million over five years, including $12 million in new funding, to establish a new National Mental Health Commission in the Prime Minister's portfolio. The Commission will provide leadership, drive a more transparent and accountable mental health system, and give mental health national prominence. The core function of the Commission will be to monitor, assess and report on how the system is performing and its impact on consumer and carer outcomes. It will also provide a strong and consolidated consumer voice, which will contribute to more responsive and accountable policy and program directions within the sector.*
>
> *The Commission's first task will be to produce a National Report Card on Mental Health and Suicide Prevention in 2012 — delivering on a 2010 Government election commitment."*

While the Federal Government's investment in the National Mental Health Commission seeks to provide greater national significance to mental health issues, AGPN suggests that the Commission be established in such a way that would ensure strong collaboration with other mental health agencies (i.e. Mental Health Council of Australia, the new National Health Consumers Forum and Commissions at the state and territory level) to avoid duplication of effort across all agencies involved in mental health.

AGPN recommends consultation with the primary care sector in the establishment of the Commission as the sector is a significant provider of mental health services and coordinator of services across sectors and different levels of government.

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;

Australia is a world leader in the development of online consumer education and training on mental health issues. AGPN strongly supports the Federal Budget initiative of establishing an ehealth portal and consolidating educational modules and information. Access to online information and education has been found to be effective in raising awareness, increasing help seeking and improving outcomes in people with mild mental disorders. The online medium enables broader penetration and uptake and is more cost effective than face to face services, particularly in rural and regional areas.

i) any other matter

With significant health reform occurring in the primary care sector and substantial expansion and strengthening of primary mental health care, it is essential for the Government to invest in a ***comprehensive support infrastructure*** for the Medicare Local Network. There is a unique opportunity to develop sound foundations for delivering mental health services in primary care which include stakeholder engagement, service development, collaboration and partnerships, workforce capacity and quality improvement. Australia is at the forefront of developing a comprehensive primary mental health system of care but must invest in ***national infrastructure*** to support this development. This infrastructure should include strategic leadership and advocacy, national communications and information infrastructure, implementation support, workforce development and quality improvement.

Recommendations

To enhance the Government's funding and administration of mental health services, AGPN recommends:

- That the Mental Health Treatment Plan be brought more in line with the chronic disease GP management plan by removing the concept of level C and D payments so that GPs are 'rewarded' for quality and coordination not for time. GP chronic disease care plans are not rewarded on the basis of time and nor should Mental Health plans.
- Funding for implementing the CC measure should be provided to Medicare Locals that demonstrate partnerships with NGOs and the capacity to deliver coordinated care. This should not occur via a tender process that includes NGOs. Under National Health Reform, Medicare Locals are being established as regional primary health care organisations with responsibility for service planning, coordinating and commissioning. Medicare Locals, as the Commonwealth's primary health care organisation infrastructure, are best placed to plan and implement FCPs in consultation with relevant stakeholders and providers and in a manner which best integrates FCPs with existing service architecture. Medicare Locals and NGO providers of non-clinical care occupy completely different spaces in the system. It would be unfortunate if they were forced to act as competitors in any FCP implementation strategy.