This is a submission expressing my concerns about the proposed changes to the Better Access to Mental Health funding.
As a general practitioner with an active interest in mental health, I am very concerned that some of the proposed changes will significantly disadvantage patient welfare, and are fundamentally unfair.

Mental health is a special interest area of mine. I have undertaken additional training in this area, in my own time and at my own expense, to allow me to offer a better service to my patients. I have recently registered to deliver focussed psychological strategies to my patients, and this is an increasing part of my practice.

REDUCTION IN REBATES FOR MENTAL HEALTH TREATMENT PLANS

It is quite unbelievable that rebates for mental health treatment plans will in some cases be cut by almost 50%. The onus should be on the government to explain how this can possibly not compromise care. In most case I spend around an hour, or even more, preparing a care plan for a patient. This includes preparing the documentation, and in many cases speaking to the psychologist on the telephone prior to the patient seeing them. The item number descriptor is detailed and exhaustive, and adhering to it requires this amount of time.

One of the major advantages of having Medicare rebates that accurately reflect the amount of work involved (unlikely the majority of the other Medicare rebates available) is that I am able to bulk bill patients for mental health treatment plans. This I do in the great majority of cases. This is of major importance to a group who, even if they do not possess pension or health care cards are often under acute financial stress due to their mental illness. If the rebates are reduced as planned, I will no longer be able to do this. I will need to either charge a substantial gap, or reduce the quality of the service I offer by spending less time.

I do agree with using a time-tiered system, however there should be 4 tiers, as are used for the health assessment item numbers. This should include a tier covering consultations of greater than one hour.
In addition, the descriptors should make it clear that a less detailed assessment and plan is expected for the shorter consultations. As mentioned above, it takes an hour or more to deliver the items in the current 2710 descriptor.
This system would allow for GPs with widely varying levels of interest and skill to refer their patients for psychologist care. In fact, I think this idea has the potential to have a money- saving component, as GPs with lesser levels of interest and skill will bill the briefer item numbers, leaving comprehensive assessment up to the psychologist.

The health assessment item numbers 701-707 in fact provide a good model. They include similar components to a mental health treatment plan – assessment, education, planning of care and appropriate referrals. The only real difference is that the conditions being assessed and managed are physical rather than mental. The rebates are higher, and the 4 tier system is much more comprehensive.
All principles of equity and fairness dictate that patients should have equal access to Medicare assistance regardless or whether their condition is physical or mental.
The item numbers 701-707 should be used for mental health treatment plans.

REDUCTION IN THE MAXIMUM NUMBER OF PSYCHOLOGIST SESSIONS FROM 18 TO 10

The other matter which gravely concerns me is the reduction in the maximum number of available sessions with a psychologist from 18 to 10. There are a subgroup of patients whom I see who will

be greatly disadvantaged by this. I refer patients for the extra 6 sessions (to take them from 12 to 18) quite sparingly, but they are patients who are in great need of the extra support and assistance. They are generally the ones least able to pay privately for extra sessions. There is a significant risk that these patients will in fact be disadvantaged by a 10 session course of therapy, as painful issues such as past abuse and severe trauma will be “opened up” but will be unable to be resolved satisfactorily in the available sessions.

CONCLUSION

There is no doubt in my mind that the proposed changes I have alluded to above will compromise patient care significantly.

General practice is at the heart of psychiatric care in the community. We are in the front lines, available to our patients within hours or at most a few days when they are in crisis. Access to both the public mental health system and private psychiatrists often involves inordinate waiting periods, unworkable expense or both. In addition to the consultations I actually get paid for, I spend uncounted unpaid time assisting and advocating for my patients to try and compensate for these shortcomings.

For my own part, I am committed to improving the mental health of my patients. There are many special interest areas of general practice to which I could choose to devote myself which would be easier, less stressful and better paid. However, this is where my passion, interest and skill lies. I was seriously considering undertaking further tertiary level training, involving considerable time and expense, in order to improve my service to my mental health patients further. I was encouraged in this by the fact that Medicare has supported general practice psychiatry in recent years through the Better Access programme and the provision of decent rebates for care planning. However, if the government proceeds to withdraw it's support from general practice psychiatric care, I will regretfully need to reconsider my decision.

Thank-you for considering my comments.