

DOCTORS REFORM SOCIETY

Box 992
Gosford
NSW, 2500

Ph (02) 9264 9084
Fax (02) 9267 4393
email drs@drs.org.au

Submission to Senate Select Committee Inquiry into Mental Health

'All people in need of mental health care should have access to timely and effective services, irrespective of where they live

Australia's universal health care system guarantees access to basic health care (including mental health care) as a fundamental right. Individuals in need of care should not only have timely access to such care, but the services they receive should be of a quality that is at least consistent with other developed countries, if not better. Access to and quality of care should be equitable, and people should not be disadvantaged by, for example, being on a relatively low income, having particularly complex needs or living in a rural area.'

The above is the first principle listed in the Mental Health Plan 2002-2003. It stands in stark contrast to the reality for people with mental health problems.

Evidence abounds of the financial and geographical barriers to timely access to equitable health care.

Financial Barriers.

In 2002, the Commonwealth Fund, a Harvard based health policy research institute, published the results of a face to face survey of 250 adult Australians in the community who had ongoing medical conditions of all types. They found that 16% of non-institutionalised sicker adults surveyed had not seen a doctor when sick over the preceding two years because of cost, and 23% had failed to fill out prescriptions due to cost.¹

In 2004, the Fund published a second report, detailing results of a telephone survey of 1400 adult Australians. It found that 17 % did not get medical care because of the cost of the doctor's visit, 18% skipped a medical test, treatment, or follow-up because of cost, 12% did not fill a prescription because of cost, and that 29%, almost 1 in 3, indicated that cost was the problem in at least one of the above.²

Unfortunately, as many who work in the mental health field will indicate, the financial resources of those afflicted by mental illness are in general, much worse than the general population. Thus, it would be reasonable to assume that the above results are a conservative estimate of the financial barriers such people faced in 2004.

On the basis of the above one could also reasonably question the statement contained in the principle 'Australia's universal health care system guarantees access to basic health care (including mental health care)'. Although there is universal access to a rebate for medical services and prescription drugs, it is clearly inadequate to prevent cost being a major financial barrier to service access. Since the survey, however, the rebate for general

practitioner services has been increased leading to a small increase in the bulk billing rate. One might hope that this would mean the figure of 17% not getting medical care because of cost should now have fallen substantially. Unfortunately, the earlier survey in 2002, was done when the bulk billing rate was 74.9%, at least 2% higher than in December 2004, and that survey also demonstrated that even with bulk billing rates at that level, financial barriers to access were a major problem.

Additionally, since the 2004 survey, the financial barrier to accessing prescription medicines has been increased by 30%, with the approval of both major Federal political parties. Thus, the survey figure of 12% not filling prescriptions because of costs in 2004 may now be higher in the general population, and higher again for those with mental illness.

It is a concern that such evidence exists to suggest that the very wording of the first principle in the National Mental Health Plan 2002-2003 contains some seriously misleading statements. It is of even more concern that since that plan was written, action has been taken with respect to prescription medicine which makes the situation even worse.

It is important to recognize however, that there was an apparent recognition of the existence of these financial barriers to accessing medical services as evidenced by the introduction of the “you beaut’ Medicare safety net”. As is well demonstrated by very recent events, there is nothing safe about safety nets. Such events would question the commitment of the Federal Government to that first principle.

There remain major problems with safety nets however. Firstly, many patients with mental illnesses will not require \$500 or \$1000 of medical services (separate from drugs as this is a different safety net) and so will receive no benefit from the safety net. Secondly, many of those who do have financial difficulties with access are struggling to budget on a weekly basis. The safety net will not help them until they reach the threshold, which may not happen until July or even December. They may therefore fail to access appropriate health services early in the year, decompensate, end up in hospital, all for the want of \$20. Thirdly, accessing the Medicare safety net, whilst automatic for singles, is not automatic for couples and families, so some people will not be aware that they are entitled to it. Lastly, accessing the PBS safety net requires registration and continued updating of prescriptions onto the safety net by the patient, which patients with mental illness will not infrequently fail to manage because of their disordered lives.

But the basic problem with safety nets is that the perceived increased need for them is an indication that the structure of the health system as it is, is flawed. Co-payments are preventing people access to quality health service. Without measures to reduce co-payments, the Commonwealth Fund will continue to document financial barriers to access for a significant percentage of Australians. Those with mental illnesses will be amongst the most likely to suffer.

Although many people with mental illnesses do continue to function well within the community and do not perceive any significant financial barriers to service, the huge over-representation of people with a mental illness in the criminal justice system is a clear indication that financial barriers are likely to be a major problem for many with

mental illnesses. Thus, the place of the private health industry in addressing the major problems of mental health care is very small. It is the most expensive and least equitable option for improving health care and will inevitably fail those who most need improved care.

Despite several pages of the Mental Health Plan 2002-2003 devoted to 'Access', detailing many types of access which need to be improved, there is nothing written which suggests that the above concerns will be addressed. Small initiatives to improve co-operation between the many health and community professionals who can contribute to providing the seamless care which would be best for patients are already occurring and can undoubtedly be improved. The major structural changes however, to prevent financial barriers remaining a major problem, have been quietly ignored. This may facilitate a co-operative approach between State and Federal Governments of different political persuasions. In terms of accessing adequate health care however, it is tinkering at the edges.

Geographical Barriers

It is well recognized that there is a major geographical maldistribution of medical and allied health services, and mental health services are no exception. The complexity of reasons for this have led to many different approaches to addressing this problem, and governments are to be congratulated on some of the initiatives. For example, the pooled funding model for aboriginal health services in some areas (in which PBS, Medicare, and other money is pooled and used locally) has led to a much more patient focused use of taxes to improve health care and inevitably mental health care. But the general shortage of doctors, engineered by government policy, inevitably leads to a maldistribution, and governments are only recently addressing this issue.

At the more local level the chronic shortage of public psychiatric inpatient beds and community services has led in many states to strict geographic regionalisation of care. There are in consequence regional variations in availability of acute care and an inability to efficiently compensate for this by cross border flows from undersupplied regions to regions with some reserve capacity. The ability of units to refuse admission on the basis of regional responsibilities can produce damaging outcomes, especially in a context of global shortage of capacity.

An example of this is the case of a woman from a rural region who became acutely psychotic during the care of her extremely premature baby in a tertiary unit in Melbourne. She was initially compulsorily admitted to a neighbouring acute unit and was able to be managed near her baby. She then escaped and when recaptured by the staff of the neonatal unit attempts were made to readmit her to the neighbouring psychiatric unit, which had already been managing her. Admission was refused on the grounds that, on the basis of her residential address, responsibility for her care rested with the regional unit 200 km to the North. High level intervention was required to avoid a perverse and damaging management decision. Such stories are common.

This should not detract from the main point, which is that the fundamental problem is of inadequate resourcing of public psychiatric care. Public psychiatry deals with the overwhelming majority of severe, intractable psychiatric illness in the community and is not adequately resourced to do so.

In addition, when the public sector is inadequately resourced, only the severely ill are able to access care. Crisis management becomes the modus operandi for the public mental health system. Dealing with the less obviously and less severely affected, or with those with co-morbidity such as drug and alcohol abuse, is left to others, and access for such services is also either inadequately resourced or requires copayments and is thus limited.

Shortage of Public Sector Psychiatrists.

The focus on support for private health care and fee for service care has contributed to a well recognized shortage of psychiatrists in the public system compared to the private system. Despite a reported 37% increase in mental health medical staff from 1993 to 2002³, reports from GPs and patients of the difficulties accessing these doctors indicates that these figures are hiding the reality. The 'you beaut safety net' introduced by the Federal Government was heralded by the AMA who then produced an article describing a scenario in which, with careful restructuring of fees, a private psychiatrist could make an extra \$2,320 from one patient in one year, with no extra treatment or benefit for the patient.⁴ Such policies encourage psychiatrists to work in private practice rather than in the under-resourced public system.

Conclusion

There are many excellent policies contained in the Mental Health Plan 2002-2003, which build on policies from previous Plans. Policies require implementation and it is at this level that different priorities emerge. Efficiency gains are to be commended and a restructuring of delivery of mental health services so that they are more co-ordinated and take account of the many different factors contributing to death and disability associated with mental illness is to be encouraged. If however, at the same time, macro policy changes make access to the health system less equitable, the net result is unlikely to be positive. Access to mental health services does not, by itself, guarantee good outcomes. Without access however, there is no chance of good outcomes. Those who have problems accessing health care are more likely to have more serious disease and greater disability arising from disease. The way to have the greatest impact on mental health in Australia is to focus on those who have the worst disease outcomes. This requires putting equity gains on at least an equal footing with efficiency gains. This is not the current situation and indeed the direction of macro health policy is towards increasing inequity.

1. Commonwealth Fund 2002 <http://www.cmf.org/publications/publications.htm>
2. Commonwealth Fund 2004 <http://www.cmf.org/publications/publications.htm>
3. Medical Journal of Australia 2005, 182:396-400
4. VicDoc, April 2004 (AMA, Victorian Branch, Newsletter)

Dr Tim Woodruff
President