EQUALLY WELL
Supporting Submission

Following the Productivity Commission Review Hearing
20 August 2025

Introduction

This submission to the Productivity Commission follows the Equally Well hearing presentation on 20 August, where Commissioners requested additional information.

This supporting document summarises the issues discussed at the hearing and includes four case studies of integrated care models that support access to interventions to improve the physical health of people living with mental health issues. If additional information is required regarding the case studies or other evidence, Equally Well would be pleased to provide this as required.

Hearing Discussion

Opening Lived Experience Statement: Dave Peters

Transcript summary

"In an ideal world I would not be a consumer of mental health services and physical health conditions. I would be a whole body. We hear the term holistic care, but the reality falls far short of that promise.

If the system was working in my best interests, I would not be treated by separate services for separate parts of my body who don't talk or work collaboratively with one another. Or worse, being given conflicting advice about what is best for my whole health.

In an ideal world, myself and my carers are active and supported in the roles that we participate in, working with clinicians and service providers to produce a care plan for my ongoing treatment and recovery that has my voice, my needs and wishes at the centre.

In an Equally Well world, I am not facing 11-15 years less of a full life than most of the population or had to sideline other priorities in my career and life choices as a result of having fallen through the gaping cracks in our health system.

In a fair and equal world, I shouldn't have experiences where accessing health supports or professionals ends with me having my concerns dismissed or disregarded as a so-called symptom attributed to my mental health, rather than a legitimate question or concern in and of itself. Not being able to afford specialist professionals due to fixed or limited income. Going to a specialist doctor and being told my problem is of my own creation, and the solution is as simple as better managing my own situation instead of expecting someone else to fix it for me. Being dismissed as an addict, having my questions or concerns dismissed. One specialist prescribed a

medication that saw me gaining almost 40kg in 5 months and upon review dismissed my concern by telling me that was a known side effect of that medication. I was outraged that I had not been informed of any risks or potential impact of medication prior to beginning the medication!

In an ideal world, I would be able to self-advocate and have support and understanding for me to make the choices I need to make about my health and have the access and care that is accessible and understandable for other parts of the population.

I'd love to see people getting some health literacy/education on how their situation and health conditions can impact day to day life, and create barriers to living a good life, in depth discussion of treatment/support opportunities and support to link with and access supports for un-met needs, but also the support to frame the actions within my own sphere of influence as something that is equally, if not more important than medication alone, particularly due to the metabolic impact of many psychotropics. Support to implement effective mitigations such as diet and exercise, maintaining access and participation in the community, maintaining employment or economic participation, and not to let the impact of my health conditions interrupt or prevent that participation.

It's vitally important to acknowledge and account for the impact of increased cognitive load, assumption of power to implement change independent of support, privilege (financial/education/housing), confidence and space to challenge or question what you're told (without being labelled as non-compliant or aggressive), assumption of comprehension (either due to language, cultural or educational barriers) and impact of medication (sedation/cognitive/fatigue)."

> *"In an ideal world, I would be able to self-advocate and have support and understanding for me to make the choices I need to make about my health and have the access and care that is as accessible and understandable for other parts of the population."*

Introduction:
A fundamental breach of human rights: The premature[a], and excess[b] deaths of people living with mental health conditions.

Each month in Australia there are:

- 695 premature[a] deaths per 1 mill people with mental illness[1]
- 203 premature[a] deaths per 1 mill people in the rest of the population[1]
- this equals 1,704 excess,[2] or potentially preventable deaths per month for the 3.46 million people with mental illness.[1]

[a] Before the age of 75 years.
[b] The number of deaths above that expected on the basis the death rate of the total population.

1. The productivity impact of the preventable deaths of people with mental illness

Briefing outline

Most premature deaths are proceeded by weeks, months, years, or even decades of poor health. In 2016, the Royal Australian College of Psychiatrists estimated the cost of physical health comorbidity for people living with mental health conditions at $15 bill pa (0.9% of GDP).[3] Achieving health screening and health treatment equity for people with mental illness would result in a saving of $10.5 billion pa in the national productivity (2016 figures).

The productivity benefits of better physical health care for people living with mental health conditions arise from:

- reducing unnecessary admissions and demand on our hospitals[4, 5]
- reducing demand and GP and primary health care sectors
- improving the efficacy of mental health treatment[6,7, 8]
- lessening a major risk prevalence factor (60%) for suicide[9]
- improving the capacity of people living with mental illness to live productive, contributing lives[10]
- lessenoing community transmission of infectious diseases.[11]

From a human rights perspective, our commitment to the United Nations Convention on the Rights of People with Disabilities obliges us to:
"provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons"[12] (ratified by Australia in 2008).

The tragic, unnecessary deaths in the middle and late years.

When someone dies of a chronic condition such as cancer or cardiovascular disease it is generally not particularly remarkable since people dying of chronic physical health conditions is not uncommon. On the other hand, the impact of suicide deaths is immediate and disturbing, especially when it is a young person. While not diminishing the need for a national response to community suicide, 46 people with a mental illness die each day of a preventable physical health condition. These premature deaths are equally tragic, especially for the bereaved family, friends and immediate social network and equally warrant an immediate and committed response.

The compelling fact is that most of these deaths could have been prevented through access to **existing health programs** such as:

- Breast cancer screening
- Lung cancer screening
- Colon cancer screening
- Cervical cancer screening
- Vaccination

For instance, increasing cancer screening and treatment uptake rates for people with mental illness by 33% would result in 1,896 lives saved per annum (see Table 1). This is equivalent to halving the national suicide rate, simply by better utilisation of existing free national programs.

Cancer	Deaths per month[1]	Survival rate[13]	Increase on current screening uptake rates			
			100%	67%	33%	10%
Colon	160	70%	83	56	28	8.3
Breast	131	92%	83	56	28	8.3
Prostate	129	96%	64	43	21	6.4
Skin	72	93%	52	35	17	5.2
Lung	318	68%	195	131	64	19.5
Total	**810**		**479**	**321**	**158**	**48**

Table 1. Estimated number of lives saved per month, through increasing uptake rates of people with mental illness to five cancer screening and treatment programs

Improving access to **cardiovascular, respiratory, diabetes** screening and treatment services; **vaccination** and **smoking cessation** services would further reduce the number of preventable deaths.

Examples of health inequities:
The rate of hospitalisation and death due to influenzafor people living with mental health conditions are respectively 5 and 3 times higher than the rest of the population.[11] In 2016, for people living with mental health conditions there were more influenza deaths than suicide deaths.

Three times more women with mental health conditions (aged 45+) die of breast cancer than suicide.[1] If detected early, breast cancer survival rate is 92%[13] and breast cancer death rates dropped by 38% from 1990 to 2020;[14] whereas suicide rates have not materially changed over the same period.[15] Similar mortality patterns exists for colon cancer, skin cancer and lung cancer (see Table 1).

Transcript summary:

Professor Roberts spoke on the magnitude of the unnecessary early deaths of people living with mental illness, its impact on productivity and provided additional context to the hearing notes.

He first emphasised the urgency of action and highlighted that the 1,700 needless deaths per month, is more deaths than our worst month of COVID-19; but it happens every month, of every year. Underscoring the urgency of action is the fact that a one-year delay in cancer screening can make the difference between detecting a Stage One cancer (curable) or a Stage Four Cancer (terminal). With 42% of all early deaths in this cohort caused by cancer, screening is an obvious ‘start now’ priority.

Secondly, he stressed this is a fixable problem. We have existing screening and treatment programs which have proven incredibly effective in the rest of the population. The missing element is affirmative action to support this cohort to access these lifesaving services.

When responding to the Commissioner’s question on the Stigma and Discrimination Reduction Strategy, Prof Roberts supported the publication of this strategy, pointing out that systemic discrimination in the health sector is responsible for a significant number of deaths of people living with mental illness.

He provided the following examples of systemic discrimination:

- Diagnostic overshadowing by GPs and mental health workers (where the mental illness overshadows all other aspects of a person's circumstance, including physical health).
- The disconnect between physical health services and mental health services.
- Primary care and chronic care staff not being aware of the increased risk of poor health and the unique access barriers for this cohort.

Failure to introduce proven interventions such as screening, vaccination and early intervention programs at scale nationally, is a failure to maximise health benefits for people and health funding outcomes for the community.

Potential productivity impacts to be achieved through increased effectiveness of mental health, primary care and physical health that can decrease unnecessary demand on hospital and health services, represent a failure of the public health system to treat everyone's health needs equally, and to support with improved capacity to live a productive contributing life.

Proven actions known to make a difference: NSW scaling up access to vaccination programs; Queensland smoking cessation; SA live reporting of physical health outcomes of public mental health clients; Victoria embedding generalist equally well practitioners in primary care.

2. Achievable Actions

Briefing outline

a. Immediate actions

- funding vaccinations for people living with mental health conditions
- funding smoking cessation programs including nicotine replacement for people living with mental health conditions.

b. Scaling-up state mental health initiatives

States and territories have introduced world-leading initiatives to improve the physical health of people living with mental health conditions, such as:

- vaccination programs (NSW)
- smoking cessation support (Qld)
- on-line live reporting of physical health care KPIs (SA)
- embedded Equally Well nurses and GPs in multidisciplinary mental health teams (Vic)
- up-to-date physical health care standards for mental health workers (WA).

In addition, there are well-tested initiatives in the NGO sector such as the:

- Physical Health Prompt
- Back on track health (BOTH) and physi-cards
- Shared and integrated care programs.

These initiatives are in place and working. Notwithstanding their success, they are each limited to just one state. There is a unique opportunity to scale up these programs nationally. However, this requires Australian Government leadership and commitment.

c. Primary care reforms

GPs and Primary Healthcare Networks have a key role in screening, early intervention and treatment of people living with mental health conditions. Improved physical health outcomes for people with mental illness through enhanced support to the primary care sector, such as:

- extended GP consultations – for comprehensive physical health examinations
- funding GPs to participate in case-conferences and shared care planning with public mental health teams
- Equally Well practice nurses in GP clinics
- embedding GPs public mental health teams (1-2 sessions per week)
- actions and performance KPIs for PHNs
- the establishment of physical health care navigators to help people bridge the gaps between primary care and mental health care, and to overcome the access barriers to primary and chronic care.

Call for action

To underscore the chasm of this health inequity, the 20+ percent of adults who used mental health treatment services across Australia (in 2016/17), accounted for half of all deaths in the country and had over 5 times the risk of premature death. As one of our lived experience experts said, “the situation you walk past, is the situation you accept”.

This profound health inequity for a significant proportion of the Australian population requires an urgent and coordinated national response.

Transcript summary:

Dr John Allan spoke to immediate, medium and long-term actions. He reflected that the State mental health and national PHNs have actively engaged with this issue and have implemented world-leading initiatives (as have some national NGOs.) Building on this knowhow and evidence, we should be investing in scaling-up successful programs to a national level.

He also discussed the role of the primary care sector and ways to incentivise and support GP practices to better assess and support the physical health needs of people living with mental illness.

Finally, he stressed that since this cohort comprises over 20% of our total population, and given the current inequity, their physical health needs should be specifically addressed in all national prevention and chronic care strategies (eg diabetes, cancer, respiratory and heart disease).

Valuing physical health means prioritising and implementing programs that directly target systemic barriers to health equity. To gain meaningful reductions in the life expectancy gap, targeted investment is required to support practice change and programs and services to shift health outcomes and increase value outcomes.

Immediate investment *and priority is to scale up what is known to work. These are the levers already at hand for government – vaccination programs, screening programs and smoking reduction programs.*

Investment in primary care and incentives for new practice and accountability mechanisms is crucial. ***Over the medium term*** *such funding can be for extended physical health consults for people with lived experience, for virtual or live multidisciplinary consults and care planning, for GPs in mental health clinics/teams or for Equally Well nurses/health workers in GP practices.*

Longer term priorities *are for health literacy/awareness/training for mental health, primary care and chronic conditions staff - imperatives for a functioning joined up service. Practical steps include requiring all jurisdictions to include physical health of people with mental health conditions in their chronic care cancer/heart/respiratory/diabetes strategies and plans.*

3. Recommendations for the National Mental Health and Suicide Prevention Agreement

Briefing outline

Development of a National Equally Well Strategy and Implementation Plan with:

- clearly identified actions and commitments
- implementation progress indicators and timelines
- key performance indicator targets
- sufficient resources to support implementation and monitor progress
- actions that acknowledge the impacts of social determinants upon health equity, affordable health care and stable housing to support the recovery process for good physical health and mental health.

Implicit in this recommendation is the need for affirmative action to address these health access and outcome inequalities. It should be noted this population group is not a disconnected or hidden cohort. Every person in the National Datalinkage Report[1] has consulted a health professional. Thus, contact opportunities already exist to better support people living with mental health conditions.

Additional recommendations

- The creation of **peer link workers/physical health care navigators** to link people to available services and support community and hospital mental health teams to provide integrated care.
- The **development of resources** to better equip consumers and carers to receive quality health care.
- A **national awareness campaign** to increase awareness of the problem and solutions.
- **Training and education** tailored to the primary care and chronic conditions sector on the increased health risk profile of people living with mental health conditions.
- **Reconsideration of national prevention programs** for leading diseases, e.g. heart disease, diabetes and respiratory disease to take in consideration the increased risk and needs of people with mental illness.

Transcript summary:

A **National Equally Well Strategy and Implementation Plan** is essential to underpinning a nationally co-ordinated plan for implementation with clearly defined actions, performance measures and targets, with sufficient resources to monitor and support progress across domains that impact health inequity.

The number of preventable deaths alone at 46 per day should motivate urgent action, but this also needs to be holistic, strategic and effective to lift health gains across all communities, especially those with a greater risk of early mortality.

Inclusion of a physical health equity schedule to the next Agreement should be prioritised.

We spend millions of dollars in investing in the mental health of our young people. Investments in headspace, early psychosis programs, suicide prevention and work and study programs are significant to support young people when we know that 75% of mental ill health first occurs before age 25.

But how effective are the lifetime outcomes from these investments for people when their ongoing mental health journey sees active support and integration fall away? The data shows that getting timely access to physical health services becomes fraught (such as screening) across the adult years and their risk of premature mortality from a physical illness increases significantly compared to the general population.

This is an egregious disregard for the health of those young people over their lifespan. It is ineffective to not optimise the health and productive gains from the investment in young people and is a failure of responsibility of a health system that is not resourced or structured to give equal priority of care to all. This, however, can be addressed through proven expanding access and reach of current program and initiatives - starting now.

Wrap around services and supports shouldn't end because you turn 25 – it should be lifetime support to ensure that the proven physical health outcomes of prevention and early intervention are realised for all people with mental health issues – this is smart investment maximising the value from early intervention investment in adolescents and young adults.

Why a schedule?

Principally, the death toll alone of potentially avoidable deaths is an egregious harm upon people with mental health issues.

Many of the factors that affect mental ill health, and physical health can be similar, such as disadvantage, accessibility and availability of holistic health care.

But there are also issues unique to health inequity, such as the overshadowing of a mental health condition on a person's physical health, stigma, affordability and siloing of services.

A commitment to the Equally Well National Consensus statement is included in the current National Agreement, but without a clear understanding that health equity rests with how the health system (not the mental health system) is accountable for ensuring access to prevention, early intervention and treatment of physical illness. The 46 potentially preventable deaths a day from physical illness among people accessing mental health treatment is testament to this.

The next National Agreement should include a separate schedule on physical health equity enabling whole-of-government collaboration focusing on the distinct factors affecting the higher level of preventable deaths. The omission of physical health of people with mental health

from key population health strategies and embedding the health equity of people with mental health issues needs to be a priority at the community and primary care level.

The new schedule should take the Consensus Statement as its foundation, developed through co-design (and with communities such as Aboriginal and Torres Strait Islander peoples or people living with substance use disorders for example) and should focus on key priorities to be progressed over the term of the Agreement.

- Set expectations and responsibility for immediate action and investment – commitment by all jurisdictions to common action.
- Identify the start now and scale up initiatives already in place and proven – building better value care.
- Not delaying increased access to screening and early intervention for people, while a national Equally Well strategic plan is being developed – avoiding the costs of inaction / the opportunity cost.

Equally Well Case Studies

Case Study 1. Mental Health Clinic in a GP Practice

In Mudgee, NSW, a local health team set up a regular weekly clinic at a local general practice which has been happening since 2007. In this service the GP booked out one morning a fortnight to see clients of the public mental health service. The appointments and clients' attendance are organised by mental health workers to ensure all appointment times are used and transport or support provided to consumers if needed. Evaluations showed this straightforward, local arrangement was highly regarded by the consumers, carers, the mental health workers, GPs, and reception staff. Most importantly, it improved the physical health and mental health of the clients, resulting in a dramatic decrease in hospital admissions. This program has been running for more than 10 years across successive GPs. It required no additional funding or staffing, proving this approach is sustainable, provided it is supported by existing local mental health staff.[16, 17] *It is an example of how local partnerships and coordination can lead to dramatic improvements in care and outcomes, with little additional effort and no additional costs.*

Case Study 1. Mental Health Nurse Practitioner doing in-patient physical health screening

A mental health nurse practitioner in Melbourne working across 80 inpatient mental health beds focusses on proactively addressing physical health needs of patients. Understanding the Equally Well data and importance of early screening, she has taken a proactive approach with the support of her health organisation. One of the wards is a 25 bed women's mental health ward. A snapshot audit showed 18 of the women were eligible for cervical screening and of those 18, a third of them had either never participated in a cervical screen program or are way overdue. These patients were approached and offered the opportunity for cervical screening and five out of six agreed. So having one clinician go into a women's ward in one week, resulted in almost 100% of eligible participants participating in cervical screening. In addition, work is underway to arrange a pathway for patients to attend the local Breast Screen clinic to improve access. The mental health nurse practitioner also provides Hepatitis C treatment, STI screening and treatment, and metabolic health screening in their role in the in-patient setting.

Equally Well Case Studies

Case Study 3. GPs embedded in a mental health service

A GP from Melbourne previously working in private general practice in a low socio-economic area seeing patients with severe mental health conditions has established an Embedded GP Service within an area Mental Health Service. Patients accessing Public Mental Health Services face tremendous barriers to accessing holistic primary care with community GPs. The Embedded GP Service is known as a Reverse Integrated Care Model and this model is increasingly used in countries like the USA and Canada to address the increased morbidity and mortality of people living with severe mental illness. GPs are collocated in Community Mental Health Clinics alongside Psychiatrists and Case Managers facilitating ease of access to the GP at no cost to the patient.

The Embedded GP Service in Melbourne has been running for over three years now with three GPs working 17.5 hours/week each across the service. The multidisciplinary model of care is seeing benefits for patients, practitioners and the community. There have been improved outcomes for patients and positive feedback at being able to access a GP when receiving mental health treatment. The Embedded GP Service improves patient engagement with their physical health and wellbeing which positively impacts on patient mental health. Embedded GPs support Mental Health Clinicians from all disciplines to improve their own knowledge of physical health care and assist with implementation of physical health interventions for patients.

Both Quantitative and Qualitative Research to evaluate this program is currently in progress with preliminary results anticipated later this year. The hope is that this will encourage more Mental Health Services to offer this innovative model of care to this vulnerable patient group.

Equally Well Case Studies

Case Study 4. GP shared care program PHN

The GP Mental Health Shared Care Program in NSW is designed to enhance the recovery and physical health of service users whose care is coordinated between GP's and Community Mental Health Teams within Local Health Districts/Specialist Health Networks (LHDs/SHNs). Since 2017, the Program has been funded by the Central and Eastern Sydney Primary Health Network (CESPHN).

The Program operates across three local health districts in the CESPHN region: Sydney Local Health District (SLHD), South Eastern Sydney Local Health District (SESLHD), and St Vincent's Health Network (SVHN). Each district contributes toward the overarching objective of narrowing the significant life expectancy gap between individuals living with severe mental illness and the broader population. The Program seeks to address this disparity through improved integration of mental and physical health care. In 2025, the University of New South Wales (International Centre for Future Health Systems) undertook a redesign of the Program, offering recommendations to further strengthen its approach. A primary suggestion highlighted the need for an enhanced GP incentivisation model and emphasised that addressing consumers' physical health needs should remain central to the Program's strategy.

Contacts: Provided upon request.

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