GRATTAN Institute

A redesign option for mental health care: submission to Productivity Commission review of mental health

January 2020

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Summary

Australia has two mental health systems: one a predominately uncapped, fee-for-service, Commonwealth-funded system with high out-of-pocket payments for patients, the other a predominately capped, inpatient-oriented, state-funded system. Coordination of the two is poor, resulting in gaps and overlaps.

The disjunction between Commonwealth Medicare-funded out-of-hospital services and state inpatient-oriented systems creates a yawning gap for people who need intensive community support but not inpatient care: the missing middle. There are no agreed regional plans that establish service models, levels of service to meet needs, resource levels, workforce and service development strategies, data and reporting arrangements, or governance and management accountabilities.

We agree with the conclusion in the Productivity Commission's draft report that mental health services are inadequate, particularly for people with more complex needs who need comprehensive support and care at home and in the community. But we do not support either of the Commission's proposals for institutional change. Instead we suggest that existing arrangements should be redesigned, strengthened, and reformed.

We propose a *redesign model*. Primary Health Networks should have a bigger role in commissioning mental health services. In particular, they should be responsible for commissioning community mental health services currently provided by states. Inpatient mental health services would remain a state responsibility.

A new model needs to balance consistent action and policies across the nation with local autonomy. This is best achieved in the context of negotiated frameworks, where the Commonwealth and the states agree on priorities, and the PHNs are responsible for commissioning services to achieve the agreed goals.

The Commonwealth and the states should negotiate regional mental health agreements with each of the 31 PHNs. The agreements should specify:

- a common regional approach to determine needs and service demand
- consistent data and reporting systems
- agreed service models for different types and levels of need (particularly for people requiring complex care in the community)
- agreed levels of service provision based on need
- common access, referral, and coordination arrangements so patients can move seamlessly through the system
- agreed levels of funding contributions by Commonwealth and state governments to achieve the goals set out in the agreements.

Table of contents

1 Medicare mental health funding is poorly targeted 5

2 The status quo is not good enough 8

3 Structural redesign is needed 10

List of Figures

1.1 Medicare mental health services are growing rapidly 5
1.2 Prescription rates have changed dramatically 6
1.3 High income and metropolitan people get more services 7
1.4 Medicare services are poorly targeted 7

1 Medicare mental health funding is poorly targeted

There are two mental health systems in Australia: one a predominately uncapped, fee-for-service, Commonwealth-funded system with high out-of-pocket payments for patients, the other a predominately tightly capped, inpatient-oriented, state-funded system. Coordination of the two is poor, resulting in both gaps and overlaps.

Medicare-funded mental health services have expanded rapidly without adequate checks and balances. The rich get dramatically more services than the poor. People in the cities gets more services than people in the country. The boundary between normal psychological distress and more serious problems that require intervention is blurred. Much clearer guidance and checks and balances are needed to make sure the right people get the right professional services.

1.1 Unchecked service expansion

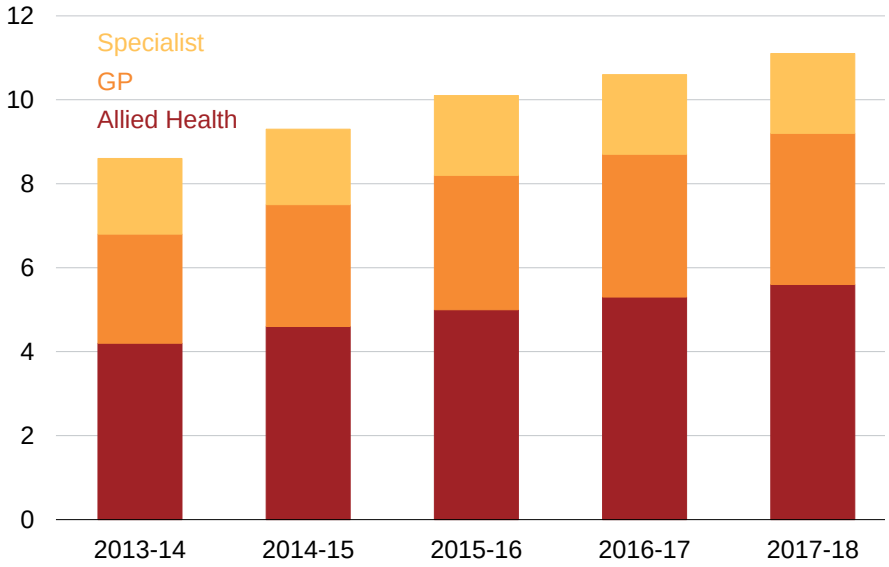
Few would dispute that good mental health should be a general policy aim, but not all psychological distress is a mental illness. The boundaries between the two are blurred, and formal diagnostic classification systems for mental illness have been heavily criticised.[1]

Most people cope with and recover from everyday psychological distress themselves with informal support.[2] Misclassification and inappropriate treatment can have significant adverse consequences.[3]

Medicare-funded specific mental health services have expanded dramatically without adequate evaluation and review to make sure the right care is provided at the right time to the right people.[4]

Medicare payments for mental health services grew by 28 per cent in the five years from 2013-14 to 2017-18. Most of this expansion resulted from more services by allied health staff (mainly psychologists) and GPs (see Figure 1.1). Total out-of-pocket payments by patients increased by 72 per cent over the same period.

Figure 1.1: Medicare mental health services are growing rapidly
Mental health services (millions)



Source: Australian Institute of Health and Welfare (2019a).

1. Wakefield (2016); Khoury et al (2014); Pickersgill (2014); and Gornall (2013).
2. Slade and Longden (2015).
3. Wakefield (2016).
4. Rosenberg and Hickie (2019).

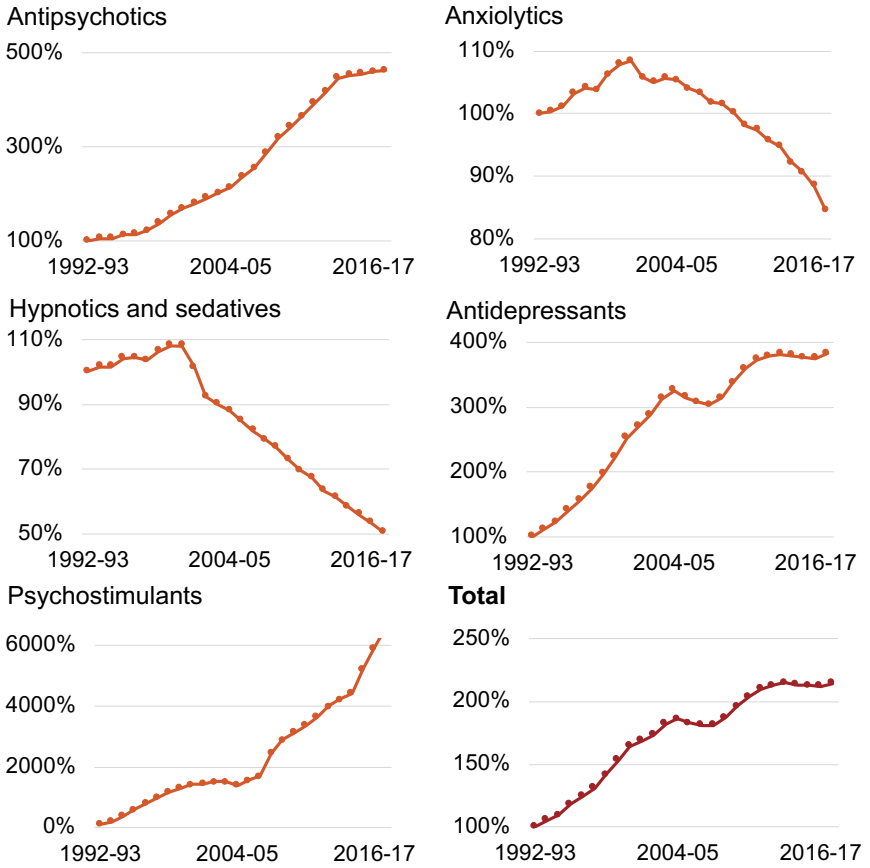
Access to a range of Medicare-funded mental health services is currently coordinated through GP mental health plans. In 2018-19 Medicare paid for 1.3 million GP mental health plans. GPs should review mental health plans,[5] but only 500,000 plans were reviewed.

As with primary care more generally,[6] there is little or no collection or analysis of patient-level data on the diagnosis, treatment, and outcomes of Medicare-funded mental health services.

The way this expansion of Medicare-funded mental health services has been structured has been criticised, and it may not achieve the best outcomes for patients given the level of spending.[7]

Longer-term trends show that prescription rates for psychostimulants have grown by a staggering 65-fold since the early 1990s – largely as a result of the growth in children being diagnosed with Attention Deficit Hyperactivity Disorder. Prescription rates for antipsychotics and antidepressants have risen four-fold over the same period (see Figure 1.2).

Figure 1.2: Prescription rates have changed dramatically
Percentage change from 1992-93



Source: Australian Institute of Health and Welfare (2019b).

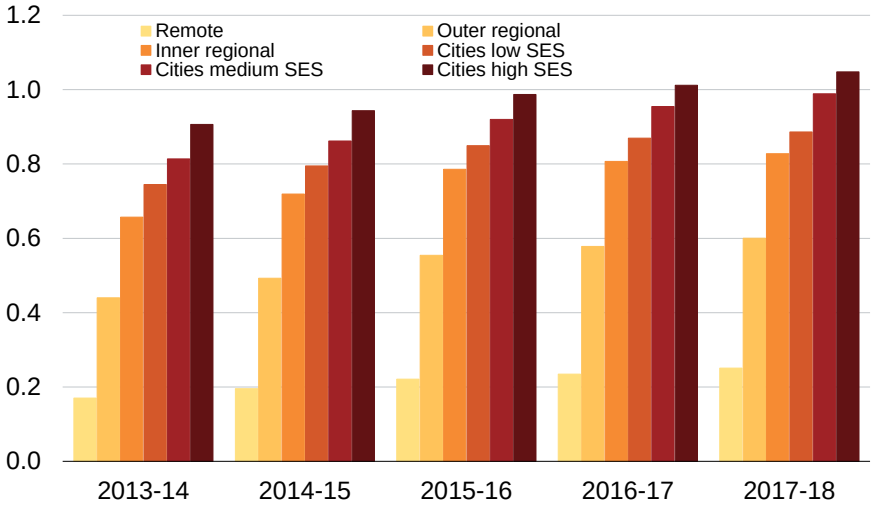
5. Department of Health and Ageing (2011).
6. Swerissen et al (2018).
7. Rosenberg and Hickie (2019).

1.2 Poor service targeting

Medicare mental health services have expanded dramatically, but they are poorly targeted. In the major cities, people who live in wealthier areas use about 20 per cent more Medicare-funded mental health services per person than people who live in poorer areas.

Australians who live in remote and outer regional areas are much less likely to use mental health services than people who live in major cities (see Figure 1.3). People on high incomes who live in major cities are about 70 per cent more likely to use Medicare-funded mental health services than people who live in outer regional areas.

Figure 1.3: High income and metropolitan people get more services
Services (per person)

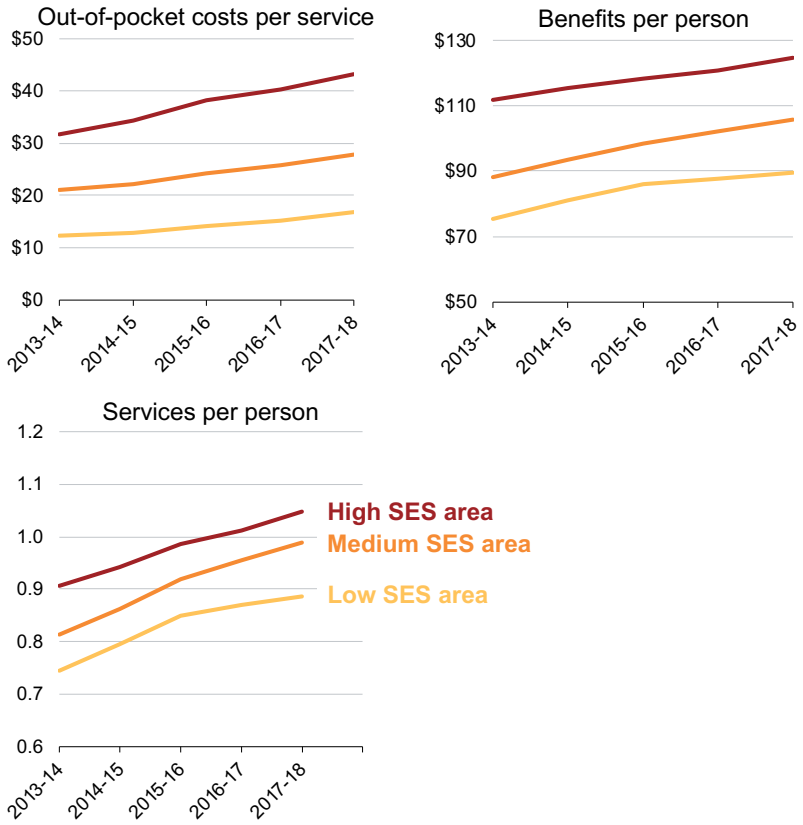


Notes: SES means socioeconomic status.

Source: Australian Institute of Health and Welfare.

As Figure 1.4 shows, Medicare spends about 40 per cent more per person on people who live in wealthy areas compared to people who live in low-income areas – despite low-income people being more likely to suffer psychological distress and mental illness.[8]

Figure 1.4: Medicare services are poorly targeted



Notes: SES means socioeconomic status and comparisons are for high, medium and low SES populations in metropolitan settings.

Source: Australian Institute of Health and Welfare (2019a).

8. Isaacs et al (2018).

2 The status quo is not good enough

As the Productivity Commission's draft report makes clear, poorly targeted Medicare services have expanded dramatically, but significant numbers of people suffering serious psychological distress, who are unlikely to recover without professional assistance, do not get the care and support they need.[9]

2.1 The missing middle

The disjunction between Commonwealth Medicare-funded out-of-hospital services and state inpatient-oriented systems creates a yawning gap for people who need intensive community support but not inpatient care: the missing middle.[10] Often their only option is to go to a hospital emergency department and get admitted as an inpatient, because community based mental health services are not available.

Mental health funding through Primary Health Networks (PHNs) has expanded significantly. But more intensive, Commonwealth-funded community based mental health services for people with more serious problems are not well developed. Primary and community services for people with complex mental health needs are not fit for purpose.

These problems are not unique to mental health services. They are common for people with chronic health conditions, frail older people who need support at home and in the community, and for people with disabilities.

Often people with these episodic and long-term care needs have a complex set of physical, social, and psychological problems. They need competent, integrated services that provide timely, comprehensive care at home and in the community.

Primary and community-based services have to be available seven days a week for extended hours. They have to be able to provide individual and group therapy, medical management, safe and supportive environments, and support to families, schools, and workplaces. This requires well organised, team-based care with a strong focus on recovery and rehabilitation.

2.2 Mental health care plans

Current mental health care planning leaves much to be desired: too few plans are reviewed, and GP care planning appears to work better for people with physical illnesses rather than mental illnesses.[11]

Patients need a GP-developed mental health plan to get access to Medicare-funded psychology and allied health services. But the number of funded services available to each patient is capped, and generally those services require an out-of-pocket payment. Patients who can't afford the payment don't get the care.

The Commonwealth Government has significantly increased funding of PHNs to commission 'stepped care' in the community. Stepped care provides graded support for eligible patients and has been shown to be more cost-effective than usual care.[12] But even with stepped care, the missing middle problem persists.

2.3 Services are poorly integrated

As with health services more generally, Commonwealth and state funded mental health services are poorly integrated. There are no agreed regional plans that establish service models, levels of service

9. Productivity Commission (2019).
10. Rosenberg (2015).
11. Banfield et al (2019).
12. Stiles et al (2019).

to meet needs, resource levels, workforce and service development strategies, data and reporting arrangements, or governance and management accountabilities.

2.4 The need for change

A deluge of plans over the past few decades has produced positive rhetoric. But problems persist, much to the despair of patients, carers, and mental health professionals, all of whom now suffer from 'obsessive hope disorder'.[13]

As Mendoza and colleagues argued in 2013, Australia should have a mental health system with:

- Robust planning, policy, and accountability.
- National frameworks and service models.
- A bigger share of overall health spending
- Alignment between the different levels of governments, so patients know how to get the services they need.
- Nationally harmonised laws that protect the rights of all people affected by mental illness and their families.
- A workforce that feels valued and respected and is supported with continuous investment in training and development.
- Services that are co-designed and managed by communities.
- The infrastructure to support Australia as a world leader in mental health research and development.[14]

As the Productivity Commission's draft report shows, Australia does not have such a system. The status quo cannot continue.

13. Mendoza et al (2013).
14. Ibid.

3 Structural redesign is needed

We agree with the conclusion in the Commission's draft report that mental health services are inadequate, particularly for people with more complex needs who need comprehensive support and care at home and in the community.[15] But we do not support either of the Commission's proposals for institutional change. Instead we suggest that existing arrangements should be redesigned, strengthened, and reformed.

3.1 Current institutional arrangements

The states have primary responsibility for public hospital services, including emergency and inpatient mental health services. The states have also developed a range of community based mental health services for people with more complex needs.

The Commonwealth and the states/territories have agreed that the Commonwealth is primarily responsible for primary health care.[16]

The Commission's draft report reinforces the need for close integration of mental and physical health care.

3.2 The Commission's alternatives

The Commission's draft report proposes two models to fix the current incoherent jumble of mental health care arrangements:

- A *renovate model,* with state and territory governments continuing to have responsibility for public hospital and community mental health services, continued separate Medicare funding, and a stronger role for PHNs as the agencies that commission primary mental health services.
- A *rebuild model,* with new mental health regional commissioning agencies established by state governments assuming responsibility for commissioning all mental health services other than those funded by Medicare. The new agencies would be funded under a pooling arrangement between the Commonwealth and the states. The Productivity Commission describes this model as 'more ambitious'.[17]

Our concern is that neither model addresses the critical issues in mental health.

The *renovate model* leaves two distinct community mental health systems: one operated by state authorities, and the other a set of services commissioned by PHNs. The model does not close the gaps or end the duplications in community services. It leaves services for the missing middle still missing.

The *rebuild model* is bolder and transfers responsibility for a range of mental health services to the states, leaving the Commonwealth with responsibility for Medicare-funded mental health services. Apart from the pragmatic difficulty of achieving such a realignment of functions, the rebuild model has three inherent flaws.

Firstly, the model is exposed to the problem of the institutional black-hole: hospitals suck funding from other health services. The acute nature of hospital services, their higher political profile, and the generally higher status of their staff, conspire to make it easier for hospitals to attract funding and for their needs to be seen as more

15. Productivity Commission (2019).
16. Council of Australian Governments (2011).
17. Productivity Commission (2019, p. 954).

urgent and more important. They are often able to gain additional funding at the expense of community services.

The Commission's rebuild proposal risks the emphasis shifting back to capped funding for institutionally dominated, hospital-based mental health care, and further fragmenting the primary and community care system.

Secondly, establishing a separate, siloed mental health commissioning agency could further weaken the links between mental health and physical health services, when what is needed is closer integration of those services.

Thirdly, the rebuild model leaves all Medicare-funded mental health services outside the state commissioning agencies' purview, remaining as Commonwealth funded. This would inhibit logical development of mental health services where psychology and allied health services currently funded by Medicare might better be funded as services commissioned by PHNs.

3.3 What is needed: a 'redesign' model

Reform should focus on the missing middle: people with more complex mental conditions who need more comprehensive episodic or ongoing care at home and in the community. This should involve strengthening community mental health services. These reforms should build on existing initiatives.[18]

We propose a *redesign model*. PHNs should have a bigger role in commissioning mental health services. In particular, they should be given responsibility for commissioning community mental health services currently provided by states. Inpatient mental health services would remain a state responsibility.[19]

Under our redesign model, there would be increased cooperation between the Commonwealth and the states, underpinned by tripartite mental health agreements between the Commonwealth, the states, and PHNs.

3.3.1 Negotiate regional agreements

The Commonwealth and the states have agreed that the Commonwealth has principal responsibility for primary care. The Commonwealth stimulated the creation of 31 PHNs to develop and integrate primary care services. Mental health reform should build on those institutional structures already in place.

A new model needs to balance consistent action and policies across the nation with local autonomy. This is best achieved in the context of negotiated frameworks, where the Commonwealth and the states agree on priorities, and the PHNs are responsible for commissioning services to achieve the agreed goals.

The Commonwealth and the states should negotiate regional mental health agreements with each of the 31 PHNs. The agreements should specify:

- a common regional approach to determine needs and service demand
- consistent data and reporting systems
- agreed service models for different types and levels of need (particularly for people requiring complex care in the community)

18. The Commonwealth has committed $1.45 billion over three years to plan and commission regional mental health services through PHNs; Australian Government (2019).

19. Stephen Duckett chairs the Board of a Primary Health Network and Hal Swerissen is also a member of the board of a Primary Health Network.

- agreed levels of service provision based on need
- common access, referral, and coordination arrangements so patients can move seamlessly through the service system
- agreed levels of funding contributions by Commonwealth and state governments to achieve the goals set out in the agreements

Regional agreements are an important tool for achieving change, but without funding reform to more clearly focus on need, and particularly on people with more complex mental health problems, change will be difficult.

Consistent with the recommendations of the National Mental Health Commission, these agreements should be informed by the best available evidence about effective mental health care.[20]

3.3.2 Redirect Medicare funding

Medicare funding for mental health has been increased in an attempt to meet needs, but as we have argued, funding has been poorly targeted. A number of reforms are needed.

Current item-based Medicare mental health funding should gradually be redirected to commissioned funding, because commissioned funding leads to better targeting of more accessible and competent primary and community services for people with more complex needs.

Sequencing and staging will be important. Before item-based Medicare funding is redirected, commissioned services should be put in place, so patients with more complex needs have better access to services on a GP or hospital referral.

As a first step, there should also be much greater evaluation of the appropriateness and effectiveness of Medicare-funded mental health services. We agree with the Commission that people suffering mild psychological distress should be encouraged to self-manage, while also being provided with support, including online resources.

Funding for GP mental health plans and reviews should be more closely monitored and evaluated. GPs should be given greater guidance on appropriate mental health interventions, and mental health plans should be more focused on people with greater needs. GPs who use mental health plans well should get quality incentive payments through the Practice Incentives Program.

As more comprehensive commissioned services become available, GPs should increasingly focus their referrals of Medicare-funded specialist psychological and psychiatric services on people who have more serious and complex mental health conditions, as part of integrated, team-based care facilitated through commissioned funding.

PHNs should also ensure that GPs can get advice from psychiatrists about patient management without referring the patient.

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