RACGP

Royal Australian College *of* General Practitioners

RACGP submission to the Productivity Commission Inquiry into Mental Health's Draft Report

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RACGP submission to the Productivity Commission Inquiry into Mental Health

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Executive summary

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to make this submission to the Productivity Commission Inquiry into Mental Health's Draft Report (Draft Report).

Australian general practice plays a central role in the provision of mental health care. Those who require mental health care generally turn to a general practice team for help, which they can easily do without a referral. General practice is the most accessible route for those who require mental health care, the most clinically effective (for the patient and their family) and highly cost effective compared with other specialist or tertiary care. General practice also provides for 'opportunistic' mental health care services, where a patient presents for another (related or unrelated) issue.[1]

General practitioners (GPs) provide evidence-based, patient-centred care to people living with mental health-related issues, and are therefore best able to provide appropriate, tailored and long-term mental health care for their patients. The RACGP's 2019 *General practice: Health of the nation* report again found that psychological issues (eg depression, mood disorders, anxiety) remain the most common health issue managed by GPs.

In Australian general practice, patients receive comprehensive, whole-patient care encompassing both mental and physical health needs. Unlike other settings, general practice does not draw a distinction between mind and body. Assessment and treatment of mental illness is informed by a holistic, whole-of-person approach.

The RACGP believes that the most cost-effective way of preventing and managing mental health illnesses in Australia is to integrate mental health care into primary healthcare. The productivity gains of treating patients with mental health-related issues early cannot be understated. Primary care-led mental health services will help to keep patients out of the hospital system at a much lower cost to all levels of government and patients.

The therapeutic relationship between an individual and their GP presents an ideal situation to prevent, identify, treat and manage mental health-related issues. The ongoing relationship between patients and the general practice team can help to facilitate early intervention for emerging mental health-related symptoms, assessment of mental health-related risks (including suicide risk), and effective management of chronic mental illness. GPs are best placed to address the physical health morbidity and mortality gap of people with serious mental illness. GPs also have a critical role in providing care coordination and appropriate referral to specialist services.

The general practice setting also creates an ideal situation for population-based mental health promotional activities and stigma reduction. GPs are well placed to engage a patient about any potential or existing mental health-related issues, assist in empowering patients, and address important contributing factors (eg co-morbid physical illness) to improve their overall wellbeing.

This submission will highlight and reiterate some of the ways in which supporting general practice for the prevention, diagnosis and management of mental health-related issues can improve health outcomes and provide significant cost effectiveness to the economy as highlighted in the RACGP's original submission to the Productivity Commission. Productivity is limited when large numbers of individuals who need coordinated care are unable to access their GP or be referred to appropriate psychological services.

Summary and key recommendations

MBS-rebated psychological therapy

- Trial increasing the maximum number of Medicare Benefits Schedule (MBS) rebated psychological therapy available to patients (note: appropriate safeguards and measures need to be implemented to prevent any unintended negative consequences).
- Increases to the maximum number of MBS-rebated psychological therapy must include return communication back to the patient's general practitioner (GP) within the first four to six weeks, then regularly thereafter.
- MBS rebates available for focussed psychological strategies services provided by GPs who have additional training in that area should not count as part of the maximum number of MBS-rebated psychological therapy services available to patients.
- There should be flexibility to increase the number of sessions beyond an arbitrary maximum number with appropriate input from the patient's regular GP.

MBS items for mental health care

- The Productivity Commission should recommend the following changes be made to the MBS:
  - Rebates for the preparation and review of Mental Health Treatment Plans (MHTPs) and consultations for mental health should more closely align with remuneration GPs receive for coordinating care of chronic physical health problems.
  - The item regarding preparation of MHTPs should not be time-tiered, as per the equivalent item for physical health.
  - Items to support the development and review of team care arrangements for mental health should be introduced, with fees matching those of the equivalent items for physical health.
  - An item for mental health consultations lasting over 40 minutes should be introduced, with fees matching those of the equivalent item for physical health.
- The Productivity Commission should recommend:
  - Allowing GPs to include time spent on activities on patient care when the patient is not present as part of the overall duration of a consultation; or
  - Increasing the value of rebates to reflect the additional and unavoidable time impost involved in providing coordinated care to patients.
- Provision of extra funding to increase a patient's access to a regular GP after hours is valued by patients and reduces emergency department visits; however, continuity of care should also be prioritised.
- Expansion of certain services (eg apps, hotlines, outreach services) that offer 'convenience' in out-of-hours consultations should not be at the expense of improving access to other evidence-based forms of care.

Management plans

- The requirements for the MHTP should be reviewed and evaluated to enhance its purpose as a tool for engaging patients in a plan for their care, rather than being viewed simply as a mechanism for referral.
- A clinical threshold model that provides GPs with the flexibility of granting patients access to psychological therapy services or focussed psychological strategies should be implemented.

Electronic mental health treatment options

- Any recommendation around the use of e-mental health treatment options must be cognisant of the barriers; there should be better integration between digital and face-to-face pathways to care.

Telehealth services

- The requirement for the provision of telehealth mental health services where the patient must be located within a telehealth eligible area (Modified Monash Model areas 4–7) is currently applied too rigidly, and should be flexible.
- The remuneration provided for case conferencing under the MBS does not adequately address the work, skills and expertise required of GPs and other members of the multidisciplinary team, and must be adequately increased to address this.

Mental health nurses

- Mental health nurses should be integrated as part of the general practice team, and work in collaboration with, and under the leadership of, GPs.
- GPs in all stages of their career, including medical students and interns, should have opportunities and be encouraged to provide mental health care services through rotations and training placements to promote early exposure to, and interest in, the sector.
- Other mental health professionals should also be given the opportunity to provide mental health care services embedded within the general practice environment.

Advanced specialist training in mental health

- The introduction of any specialist registration system for GPs with advanced specialist training in mental health should sit within the existing General Practice Mental Health Standards Collaboration (GPMHSC) Framework. Any proposal to amend the registration arrangements for GPs to recognise those who have specialist qualifications in mental health must include input from, and be administered by, the RACGP and GPMHSC.

Telephone advice

- The Draft Report's recommendation to create an MBS item that would allow psychiatrists to provide advice over the phone to GPs is supported; however, remuneration should also be made available for the consulting GP to compensate their time.

Co-funding arrangements

- Efforts to create new regional structures aligned across the primary and hospital sectors around the country should be encouraged to allow greater patient access to secondary and tertiary mental health care; however, we caution on the negation of any benefit through unintended consequences.

The Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) is Australia's largest medical organisation, representing more than 42,000 members who provide over 158 million general practice services each year to nearly 22 million Australians.

The RACGP's mission is to improve the health and wellbeing of all people in Australia by supporting general practitioners (GPs), general practice registrars and medical students through its principal activities of education, training and advocacy. It does this by assessing doctors' skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, helping GPs with issues that affect their practice, and developing standards that general practices use to ensure high-quality healthcare.

The RACGP provides answers to the questions posed by the Productivity Commission that are most relevant to the general practice profession.

MBS-rebated psychological therapy

The RACGP supports the Productivity Commission Inquiry into Mental Health's Draft Report's (Draft Report) recommendation of trialling increases to the maximum number of MBS-rebated psychological therapy sessions available to patients. However, appropriate safeguards and measures need to be implemented to prevent any unintended negative consequences.

Any changes to the maximum number of MBS-rebated psychological therapy available to patients need to be in line with the available evidence. Inappropriately increasing the maximum number of sessions could drive up the number of patients who do not obtain any meaningful benefit from these referrals. For example, the minimum number of psychotherapy treatments that will produce a desired outcome may not be achieved by the full 20 sessions recommended in the Draft Report.

Regardless of the maximum number of MBS-rebated psychological therapy, return communication back to the patient's GP within the first four to six weeks, then regularly thereafter, must be included in any planning. Patients should also be supported to continue to see their GPs regularly to review the Mental Health Treatment Plans (MHTPs). This will ensure patients are receiving the most appropriate high-value care that addresses management goals.

MBS rebates for focussed psychological strategies (FPS) services provided by GPs who have additional training in that area should not count as part of the maximum number of MBS-rebated psychological therapy services available to patients, as is currently the case. The RACGP is supportive of the stepped-care model, but this model cannot be achieved if GPs are not encouraged to offer lower intensity (and potentially less expensive) interventions in situations where they are likely to be beneficial. Furthermore, in rural and remote areas, access to psychologists can be limited.

The current rules restrict the potential scope of practice of GPs with an interest in mental health, acting as a barrier to capacity building in general practice.

It is essential that the role of generalist GPs and GP teams is not sidelined in any proposed increase in access to mental health care. Patients with mental health related issues often experience multimorbidity that generalists are best suited to address effectively and sustainably .One way to keep the needs of patients central (rather than the needs of providers) is to keep GPs as the coordinators of care and stewards of any referral process. For example, most people with severe mental illness die of cardiovascular disease; GPs are therefore essential to help manage physical illness alongside mental illness.

Overall, the RACGP believes the MBS should be fit for purpose; as such, it needs to give patients, their GPs and psychological services flexibility to increase the number of sessions beyond an arbitrary maximum number. However, this must include appropriate input from the patient's regular GP.

MBS items for mental health care

The RACGP notes there is a possible misunderstanding in the Draft Report of how rebates for mental health services provided by GPs are applied and how they compare to rebates for physical health services. MHTP preparation and review items should not be confused with mental health consultations. Instead, the appropriate comparison would be between MHTP preparation and review items and chronic disease management planning and review items; and mental health consultations with general consultation items.

MBS rebates for mental health services are in fact lower than those for equivalent physical disease services. For example, the development of a chronic disease management plan receives a higher rebate than its mental health equivalent and has no minimum time requirements. In addition, unlike MBS items for general consultations, there is currently no item for mental health consultations >40 minutes, which may be a more appropriate length of time for some mental health related attendances.

MBS items for mental health care coordination are also unavailable to GPs. The significant work involved in organising complex care requirements among multiple providers, including formulating detailed or multiple referrals and liaising with other providers and carers, is not supported through the MBS, in contrast to existing physical health team care arrangements.

The RACGP provides an overview of current MBS items for similar mental health and physical health services in Appendix 1.

The RACGP strongly believes that the Productivity Commission should recommend the following changes be made to the MBS:

- Rebates for the preparation and review of MHTPs and consultations for mental health should more closely align with remuneration GPs receive for coordinating care of chronic physical health problems.
- The item regarding preparation of MHTPs should not be time-tiered, as per the equivalent item for physical health.
- Items to support the development and review of team care arrangements for mental health should be introduced, with fees matching those of the equivalent items for physical health.
- An item for mental health consultations lasting over 40 minutes should be introduced, with fees matching those of the equivalent item for physical health.

In addition, MBS rebates for complex care delivery and coordination, whether physical health or mental health, do not reflect the true cost of providing the care, including through the lack of remuneration for time spent performing important tasks such as:

- writing progress notes.
- liaising with families and carers.
- liaising with nursing and support staff, community care staff, hospital staff, allied health professionals and other specialist medical practitioners.
- gathering information on medical history beyond the consultation time.
- making follow-up phone calls post-consultation.
- completing paperwork required by government agencies (eg reports on health status for social services).
- discussing medication regimes with pharmacists and/or psychiatrists.

The RACGP encourages the Productivity Commission to recommend that relevant MBS items be amended to adequately value and support the critical work undertaken by GPs in monitoring and managing care by either:

- Allowing GPs to include time spent on activities on patient care when the patient is not present as part of the overall duration of a consultation; or
- Increasing the value of rebates to reflect the additional and unavoidable time impost involved in providing coordinated care to patients.

The MBS Review Taskforce is currently considering other changes to the MBS as a result of work undertaken by the General Practice and Primary Care Clinical Committee. Several proposed changes will negatively affect the ability of GPs to provide comprehensive and

high-quality services; however, the proposal to introduce additional payments to GPs to improve support care coordination is of particular merit.

The RACGP recommends the Productivity Commission evaluate the proposed changes by the MBS Review Taskforce and consider how the proposed changes will negatively affect the ability of GPs to provide comprehensive and high-quality services. The RACGP has previously highlighted some of these in our submission to the MBS Review Taskforce.[2]

The RACGP notes the Productivity Commission appears to be broadly supportive of changes to the MBS proposed by the Mental Health Reference Group. The RACGP supports most of the proposed changes, with some reservations and concerns. However, much more can be done through the MBS than has been proposed through the MBS review process. This includes support for patient access, support for the stepped care model and for the ability of GPs to provide high-quality and efficient services, as noted above and elsewhere in this submission.

Provision of after-hours services

The RACGP agrees that the delivery of more out-of-hours GP services could prevent presentations to emergency departments for mental health conditions. As patients sometimes require medical care outside the normal opening hours of their regular general practice, they value an ongoing relationship with a practice or GP who provides medical care on a 24-hour basis or are linked to their usual GP or practice.

The proposed arrangement, whereby state and territory governments would co-fund the delivery of these services with the Federal Government appears to be a reasonable and workable suggestion.

Coordinated care, such as the documentation of GP preferences for care, including processes for GP follow-up, in appropriate circumstances, prior to arranging an ambulance transfer is important. Effective clinical handover of care is also critical in the after-hours period as a lack of, or inadequate, transfer of care is a major risk to patients. Continuity of care should also be prioritised. After-hours services should refer the patient back to their usual GP, if they have one, or to an appropriate and accessible general practice.

The RACGP cautions on the expansion of services (eg apps, hotlines, outreach services) that offer 'convenience' in out-of-hours mental health consultations by doctors. These services should not be expanded unless issues of integration and referral back to the GP are addressed. These services may not:

- be of high-quality or meet the needs of people seeking urgent and expert medical attention for mental health issues
- have any obligation to provide feedback to the patient's usual GP or practice for follow-up, resulting in the fragmentation of care
- provide enough support to people linking in with longer term primary care services, and patients often do not get stepped up to the next level of care.

Management plans

MHTPs are an essential starting point for the delivery of mental health care. However, the RACGP wishes to emphasise that the establishment of a MHTP is intended to allow a GP to appropriately assess and plan for their patient's mental health care needs. Its optimal intended use thereafter is to empower the patient to achieve the proposed management goals.

The MHTP should therefore **not** be regarded solely as a referral document to other psychological services. GPs should be supported to appropriately refer patients to other psychological services, if necessary, with the right referral document.

The following should be noted:

- GP assessment of mental health is a complex, time-consuming and thorough task.
- Baseline assessment of severity of mental illness is needed for subsequent stepped-care.
- GPs provide complementary and supplementary patient psychoeducation.
- GPs provide interim and ongoing care for patients in parallel with intermittent appointments with another mental health professional. MHTP helps assess patient progress towards the patient-centred goals set out in the plan.
- The proscriptive, itemised MBS description of MHTP leads to the use of templates, which might be contributing to anecdotal poor usefulness of the written document – even though the process of planned care is highly useful.
- The unintended consequence of not having a specific appointment type that leads GPs through a process of assessment and planning would be a loss of ability to implement stepped care.
- MHTP are currently the poor cousin to the GP Management Plan (GPMP) and Team Care Arrangement (TCA) for physical illness because in the MHTP assessment and care coordination are required. These separate functions are separately funded for physical illness.

The RACGP believes the requirements for the MHTP should be appropriately reviewed and evaluated to ensure its purpose as a tool for engaging patients in a plan for mental health care are still relevant. Part of this evaluation should bear in mind that currently, both assessment of mental health and completing a management plan are billed under the same MBS item number. Any changes to the MBS item number need to be cognisant of the time and complexity required of GPs to complete this.

Screening tools

The use of screening tools to obtain a diagnosis could in itself present significant issues around barriers to care. Any clinical threshold should take a holistic view of the patient rather than a threshold score attained on a psychological instrument. While GPs work from a dimensional perspective, the current MBS rules around MHTP require a categorical diagnosis.

Often, screening tools are single-disease specific and fail to consider multimorbidities and patient needs. Additionally, the inclusion and exclusion criteria from available systematic reviews and research literature are often too restrictive and unhelpful for these patients.This creates an environment where those who may benefit from early intervention may not be able to access the most appropriate mental health care because they fail to reach certain disease thresholds. The therapeutic relationship between an individual and their GP presents an ideal situation to prevent, identify, manage and treat mental health-related issues.

The RACGP advocates for a clinical threshold model, that provides GPs with the flexibility of granting patients access to psychological therapy services or focussed psychological strategies.

Electronic mental health treatment options

Electronic mental health (e-mental health) treatment options often relate to online interventions for the prevention and management of mental health illness. While there is evidence to suggest that e-mental health can be used effectively to manage mild-to-moderate depression and anxiety, consideration must be given to the patient's literacy skills before they are enrolled for e-mental health interventions.[3]

Significantly, there is currently a lack of evidence for the use of e-mental health treatment options for:

- complex or severe mental illness
- comorbid personality disorders
- substance dependence
- people who have an elevated risk of self-harm or suicide and require urgent clinical management.

Any recommendation around the use of e-mental health treatment options must be cognisant of the above barriers; there should be better integration between digital and face-to-face pathways to care.

The RACGP supports the idea of e-mental health as a complementary activity to face-to-face services, but not as a substitute for all patients. Additionally, support of e-mental health should not be at the expense of adequate funding for other types of interventions.

More information on the use of technology in mental health can be found in the RACGP's *e-Mental health: A guide for GPs*.

Telehealth services

The current evidence base points to the same level of effectiveness of telehealth mental health services conducted between a patient and their usual GP and face-to-face consultations in achieving improved health outcomes.[4]

Current government incentives for the provision of telehealth services need to be strengthened and supported to enable patients, especially those in rural and remote areas, to access mental health care.

The RACGP is pleased that the Draft Report contains recommendations to make improvements to the use of telehealth mental health services.

However, the RACGP believes the requirement for the provision of telehealth mental health services where the patient must be located within a telehealth eligible area (Modified Monash Model areas 4–7) is currently applied too rigidly. Telehealth services should be available for patients who have difficulty accessing face-to-face services, regardless of where they live. This might be because of physical disability, agoraphobia or to assist with continuity of care with a particular practitioner.

Regular or ad-hoc counselling by phone can provide support and relief to patients, and reduces the burden on the hospital system and other acute care services. Enacting changes to the MBS to enable telehealth consultations between a patient and their regular GP would also ensure the ability of GPs to provide effective out-of-hours support. Depending on the GP and their general practice's capability, GPs could provide out-of-hours mental health services to their patients.

Multidisciplinary approach

Efforts to support multidisciplinary care and foster collaboration and integration across services is needed to improve patient experience and outcomes.

The regular occurrence of team meetings and case conferencing, whether face-to-face or via teleconference, is vital to any multidisciplinary approach. Importantly, members of the multidisciplinary team (ie GPs, mental health nurses, psychologists, psychiatrists, social worker, occupational therapists) should have input during the team meetings, and be supported to use their expertise to advocate for the benefit of their patient.

The RACGP argues that the remuneration provided for case conferencing under the MBS does not adequately address the work, skills and expertise required of GPs and other members of the multidisciplinary team, and must be adequately increased to address this. The rigid and inflexible MBS rules around the use of these item numbers also adds to the barriers. Anecdotally, the lack of remuneration for, and rigid rules around, case conferencing is one of the reasons members of the multidisciplinary team are reluctant to participate.

Efforts to integrate services within general practice, such as the Mental Health Nurse Incentive Program, should also be considered and supported as a way of encouraging collaboration and integration. Beyond this, the RACGP would support trials examining the utility of consultation–liaison models in-house and in-house support from state-funded mental health services as part of the mix.

Mental health nurses

General practice is generally the first port of call for Australians with any healthcare and medical needs. As such, GPs are trained to be able to treat a wide range of physical and mental health conditions that focuses on a whole-person approach.

GPs are skilled in managing uncertainty, undifferentiated illness and complexity. They use the best available evidence in the light of patient's individual circumstances. The care of a patient with a mental health condition cannot be managed in isolation and with a single-disease approach. A holistic approach that considers the patient's medical, family, social and environmental circumstances is required to plan and manage their health. Importantly, there is currently a lack of acknowledgement or knowledge of social prescribing as a cost-effective strategy for enhancing healthcare.

Mental health nurses play an important role in the mental health care of patients in general practice; however, they cannot and should not replace the role of the GP.

The unique nature of being based in the community (especially for rural and remote GPs), means that GPs are acutely cognisant of their patients' circumstances and the community in which they serve.

The RACGP therefore supports the recommendation to increase the number of mental health nurses in Australia. However, the RACGP strongly recommends that they are integrated as part of the general practice team, and work in collaboration with, and under the leadership of, GPs. Additionally, there should be provisions to upskill existing practice nurses rather than just undergraduate nurses.

The Government's evaluation of the Mental Health Nurse Incentive Program demonstrated this is largely an effective model.

Advanced specialist training in mental health

The RACGP believes learning is a lifelong journey. We support GPs, irrespective of where they are in their professional life, by offering a wide range of programs and activities through different modes. The activities reflect current technology and best practice in the delivery of education and training, and recognise the individual needs of GPs.

The RACGP believes GPs in all stages of their career, including medical students and interns, should have opportunities and be encouraged to provide mental health care services through rotations and training placements to promote early exposure to, and interest in, the sector. Additionally, other mental health professionals should also be given the opportunity to provide mental health care services in the general practice environment.

Mental health is firmly embedded in the RACGP's *Curriculum for general practice* and *The Fellowship in Advanced Rural General Practice: Advanced Rural Skills Training – Curriculum for mental health*.

Additionally, the focus of the RACGP's Continuing Professional Development (CPD) program is to encourage and facilitate reflective learning to help GPs identify opportunities that can enhance their daily practice with changes that will improve patient safety and care. Importantly, as adult learners, GPs take responsibility to meet their individual learning that is relevant to their scope of practice. This helps to develop, maintain, update and enhance knowledge, skills and performance to ensure that GPs deliver appropriate and safe care to their practice population.

GPs will often choose to build on their existing skills in mental health through formal education (eg mental health first aid, focussed psychological strategies skills training, postgraduate qualification). For example, a significant number of GPs (in excess of 90%) have completed the GPMHSC accredited Mental Health Skills Training.

Anecdotally, GPs would like to engage in further mental health training, but are often deterred by the financial cost and the time away from practice. Additionally, even GPs who have access to higher MBS-rebated psychological therapy have advised that the remuneration is often inadequate.

The RACGP also manages the General Practice Mental Health Standards Collaboration (GPMHSC), a program funded by the Australian Government to establish and maintain standards for continuing professional development in mental health care for GPs. It is important to highlight the importance of the GPMHSC, which has a world-leading track record in engaging consumers and carers in the standard setting process.

The RACGP believes the introduction of any specialist registration system for GPs with advanced specialist training in mental health should sit within the existing GPMHSC Framework. Any proposal to amend the registration arrangements for GPs to recognise those who have specialist qualifications in mental health must include input from, and be administered by, the RACGP and GPMHSC.

Telephone advice

The RACGP is supportive of the Draft Report's recommendation to create an MBS item that would allow psychiatrists to provide advice over the phone to GPs. Giving GPs access to a psychiatrist via phone or telehealth for guidance on managing difficult problems may improve quality of care, as sometimes a patient's specialist appointment can be in several months' time.

The previous GP Psych Support service, operated by the RACGP until funding from the Federal Government was discontinued in late 2013, was considered useful by GPs, as noted in the Draft Report.

It is currently unclear how the funding of any proposed new service will operate. While a new MBS item may be suitable, this would only be applicable if the psychiatrist was part of the GP-led care team for a specific patient. However, should the psychiatrist only be providing general advice the MBS is not the appropriate funding mechanism; it is out-of-scope of the MBS system to provide funds for a non-treating health practitioner.

The RACGP strongly recommends that remuneration should also be made available for the consulting GP to compensate their time. Any funding and/or provisions made available to the psychiatrist should also be applicable and accessible to GPs. If an alternative funding arrangement is implemented the GP could be remunerated through GP care coordination MBS items proposed elsewhere.

Co-funding arrangements

The RACGP supports proposals that permit state and territory governments to co-fund the delivery of healthcare services in general, not just for mental health care or out-of-hours GP services. This would reduce the fragmentation currently embedded within Australia's healthcare system. It would also allow an additional much-needed income stream for general practice to better provide essential patient services (eg complex case management, care coordination).

GPs play a critical role in mitigating the risk of misdiagnosis or delayed diagnoses, inappropriate or delayed treatment and adverse events resulting in physical or psychological harm. They are responsible for ensuring that care is not unnecessary, duplicated, fragmented or contradictory, which wastes health care resources. They also aim to deliver evidence-based, high-quality and necessary health care services to reduce the use of more expensive services (to the patient and the funder).

Co-funding by state and territory governments for essential case and care management and/or non-patient facing services will ensure that GPs can continue to fulfil these roles as challenges to the health system increase. This will effectively and efficiently keep patients from inappropriately accessing specialists' consulting rooms, emergency departments and hospital beds. Significant savings would be realised by the healthcare sector if GPs and general practice were better supported in this patient and health system stewardship role.

The RACGP's proposal aligns with its *Vision for general practice and a sustainable healthcare system*, which outlines a sustainable model of high-quality and patient-centred care that aims to address many of Australia's longstanding healthcare challenges. With the appropriate recognition and valuation of the crucial contribution general practice makes to keeping Australia healthy, we can help ensure that the health system works well for patients, providers and funders. The RACGP welcomes the Productivity Commission's support and recognition of the importance of general practice in mental health. We hope to work closely with the Productivity Commission to strengthen the current mental health system in Australia.

The mooted single pool for allied mental health care must be separate from general practice services and requires additional, not redistributed, investment.

Proposed reorganisation

The RACGP believes that efforts to create alignment across the primary and hospital sectors around the country should be encouraged to allow greater patient access to secondary and tertiary mental health care. However, the RACGP cautions that any reorganisation on the administrative front may negate any benefit through unintended consequences; specifically, creating confusion among medical practitioners and patients.

Conclusion

The RACGP looks forward to hearing about the Productivity Commission's progress and outcomes, and further participation in hearings and written submissions.

Appendix 1. Mental health and physical health services provided by GPs

Service	Mental health MBS item	No.	Fee	Physical health MBS item	No.	Fee
Preparation of treatment plan	Preparation of a GP MHTP lasting at least 20 minutes (no mental health skills training)	2700	$72.85	Preparation of a GP management plan	721	$146.55
	Preparation of a GP MHTP lasting at least 40 minutes (no mental health skills training)	2701	$107.25			
	Preparation of a GP MHTP lasting at least 20 minutes (additional mental health skills training)	2715	$92.50			
	Preparation of a GP MHTP lasting at least 40 minutes (additional mental health skills training)	2717	$136.25			
Review of treatment plan	Attendance by a GP to review a GP MHTP	2712	$72.85	Attendance by a GP to review a GP management plan	732	$73.20
Consultation	Attendance relating to mental disorder and consultation lasting at least 20 minutes	2713	$72.85	Professional attendances at consulting room – Level C 20–40 minutes	36	$73.95
				Professional attendances at consulting room – Level D >40 minutes	44	$108.85
Coordination				Attendance by a GP to coordinate the development of team care arrangements	723	$116.15
				Attendance by a GP to coordinate a review of team care arrangements	732	$73.20

The discrepancies noted in the table above can lead to significantly lower support for GPs and/or higher out-of-pocket costs for patients over the course of treatment for a mental health-related issue. For instance, assuming the GP has undertaken the additional mental health skills training, a hypothetical initial treatment period of three months may comprise:

- three mental health consultations of 45 minutes each (item 2713)
- an attendance of 30 minutes for the development of a treatment plan (item 2715)
- a consultation of 45 minutes to coordinate team care arrangements (item 2713 [proxy, no equivalent item]) and

- reviews of both the treatment plan and team care arrangements of 30 minutes each (items 2712 and 2713 [proxy, no equivalent item]).

The combined total of the rebates for mental health items is $529.60, compared with the equivalent physical health items at $735.65 – a difference of $206.05. This arises despite the same amount of time being dedicated to patient care (with value decreasing 28%, from $163 per hour to $118 per hour, in this example) and despite the additional training undertaken by the GP. This out-of-pocket cost must either be borne by the GP and/or transferred to the patient.

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