



The Royal
Australian &
New Zealand
College of
Psychiatrists

KEEPING YOUR HEAD ABOVE WATER: AFFORDABILITY AS A BARRIER TO MENTAL HEALTH CARE



A REPORT PREPARED FOR
THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. Psychiatrists are medical doctors who undertake additional training to qualify as specialists in the treatment of mental illness. Founded in 1963, RANZCP has more than 5000 members, including around 3700 fully qualified psychiatrists and almost 1200 trainees. The RANZCP has branches in every Australian state and territory and a head office in Melbourne as well as a national office in Wellington, New Zealand. In both countries, all psychiatrists must be accredited by RANZCP before they can practise. For more information go to www.ranzcp.org

Keeping your head above water: Affordability as a barrier to mental health care

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About psychiatrists

A psychiatrist is a specialist medical doctor who assesses and treats patients with mental health problems. Psychiatrists play key roles in mental health care in Australia and New Zealand. Working in private, public or academic practice they see consumers in hospitals, their private rooms, clinics and other community settings. They play pivotal roles in the teaching, research and administration of mental health care as well as advocating for and leading improvements in service provision.

Psychiatrists treat all types of mental illness, emotional disturbance and abnormal behaviour, from mild or episodic conditions to those that are severe, persistent and life-threatening. They work with people of all ages and from all ethnicities and backgrounds. At its core, psychiatry involves listening carefully and sensitively to people's most personal thoughts and feelings, understanding their mental state, and working with them to identify and implement appropriate treatments including psychotherapy, psychotropic medication, social strategies and other interventions.

Psychiatrists often work in collaboration with general practitioners (GPs) and other health professionals to best meet the mental health and emotional needs of consumers. Psychiatrists also work in partnership with consumers and their families and carers, and are attuned to the array of social and cultural factors that impact on the individual patient.

Psychiatrists are the leading experts in the field of mental illness in Australia and New Zealand. Through the Royal Australian and New Zealand College of Psychiatrists (RANZCP), which is an accredited specialist medical training body, they receive rigorous training, which enables them to provide optimal patient care, work collaboratively in the interests of patients with other health professionals, act with the highest professional and ethical standards, undertake research to improve mental health care and lead mental health services.

In Australia and New Zealand most psychiatrists are members of the RANZCP. For more information about psychiatrists or psychiatry go to www.ranzcp.org.

About this report

The RANZCP has been aware for some time that mental illness in interaction with other chronic diseases is one of the biggest challenges to public health systems in Australia and New Zealand.

This high rate of co-morbidity among people with mental ill health is associated with a far shorter life expectancy in all developed countries. Some estimates suggest that the lives of both men and women with severe mental illness are up to 30% shorter than those of the general population (Piatt, Munetz & Ritter 2010). Excess mortality amongst people with severe and persistent mental illness is a consistent finding amongst a range of international studies, indicating that this is a global phenomenon.

The RANZCP believes that much more needs to be done to address the gap in physical health and life expectancy between those who live with a mental illness and those who don't. Psychiatrists are responsible not just for the clinical care of consumers but also for providing clinical leadership, teaching and training, researching, and advocating for better psychiatric health in the community.

This is the first in a series of papers that will examine the barriers to health care for people with mental illness and other physical illnesses, and what can be done to reduce these barriers. This report examines the extent to which cost can be a barrier to care for people with mental illness and other chronic illnesses. This report focuses on the situation in Australia, with another to be developed for New Zealand.

This report was developed by consultants from CEG Consulting under the guidance of the Board of the RANZCP and with the involvement of psychiatrists and consumers.

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Summary

'Sometimes it feels like a kind of creeping euthanasia, the slowly increasing expense of health care costs that will slowly undermine our health and eventually kill us.'

– Ann, consumer

People with mental illnesses in the Australian community face a broad range of costs associated with their condition. These include the direct costs of their care, indirect costs associated with receiving treatment and a range of additional expenses and forgone benefits. Many people with mental illnesses also have physical illnesses and disabilities, in some cases related to their mental illness, and therefore also incur costs associated with these conditions. As a result of these factors, people with mental illnesses are already significantly financially disadvantaged compared with the general community. People with mental illnesses also experience a number of social disadvantages, such as stigma and discrimination, which can increase the burden of their illness.

As people are now more aware, mental illness continues to be a major health and social issue, with one in five Australians experiencing mental illness in any one year (ABS 2008). Almost half of Australian adults (45%) are affected by mental illness at some time in their life (ABS 2008). Evidence shows that disorders of the brain (the field of neurology) and mind (the field of psychiatry) impose the greatest burden of Australian health of any disease group, contributing over 22% of aggregate losses, well ahead of cancer (11.3%) or heart disease (9.9%) (Begg et al 2007).

Despite some improvements in the provision of mental health services in recent years, there remain a number of cost and other access barriers preventing people with mental illnesses from receiving appropriate—or in some cases any—care. Overall mental health services are not funded to a level which reflects the extent of mental illness within the Australian community, resulting in significant unmet need for care (DoHA 2009). This means that preventive and lower-cost interventions are often not provided to people in the early stages of mental illness, leading to more serious conditions, which ultimately impose higher social and economic costs on the community. Those consumers who do access care often experience financial hardship in order to do so, which can compound the disadvantage they experience as a result of their illness.

The RANZCP is concerned that existing problems experienced by people with mental illnesses in accessing appropriate care are likely to be made worse by the 2014–15 Federal Budget¹ (Russell 2014). In particular, if specific funding measures are implemented in the manner proposed by the Government, they will significantly increase the financial stress experienced by many people with mental illness and create additional cost barriers to accessing care (Russell & Rosenberg 2014). These measures are likely to have an adverse impact on the majority of people with mental illnesses, with a more significant impact on specific subgroups including:

- people with co-morbid physical conditions requiring regular care
- people who are regular users of prescription medicine for either a mental or physical condition
- people on low incomes, including people who are homeless and/or unemployed
- people with severe mental health conditions, such as psychosis and schizophrenia.

Unless the relevant Budget measures are significantly modified, or appropriate compensatory mechanisms are implemented, the barriers to people with mental illnesses accessing high-quality, timely and preventive care are likely to increase. This will result in the development of more serious illnesses and lead to more potentially preventable crisis situations, creating a higher demand for hospital-based mental health services and other interventions, including those from the community sector and law enforcement sectors. Overall this will increase the burden of mental illness on the Australian community.

¹ The 2014–15 Federal Budget Papers are available at www.budget.gov.au.

SUMMARY TABLE: 2014–15 FEDERAL BUDGET MENTAL HEALTH IMPACT

Budget measure	Details	Impact on mental health consumers	Impact on health system	Recommended solutions
GP/primary care co-payments	<p>A \$7 co-payment for GP visits and pathology tests.</p> <p>A \$6 co-payment for prescription medicines.</p>	<p>Reduced access to primary health care and preventive care. Consumers seek less cost-effective forms of care (e.g. hospital emergency departments) as they are free at the point of service. This results in more serious mental health problems developing (Doggett & McAuley 2013).</p>	<p>Increases in serious mental health problems results in higher overall costs to the health system. High health care costs can compound existing disadvantage resulting in a less equal society.</p>	<p>Undertake specific consultation with people with mental illnesses to identify community and consumer values and priorities for co-payments.</p> <p>Ensure an adequate safety net is provided for people on low incomes and/or with high health care expenses.</p> <p>Allow for deferred payment and/or payment over time.</p> <p>Consider exempting specific services, such as pathology testing for people on specific medications.</p>
Social security and pension changes	<p>Increased conditions for the disability support pension and other social security patients.</p>	<p>Increased stress.</p> <p>Less time to focus on accessing care and self-management.</p> <p>Lower incomes (for some).</p>	<p>Reduced self-management and increased stress among people with mental illnesses is likely to result in their conditions becoming more serious and requiring more intensive treatment.</p>	<p>Provide increased and targeted assistance to people with mental illnesses to ensure their specific needs are being met and they are not disadvantaged due to these changes.</p> <p>Increase targeted employment support programs.</p>
Freeze on MBS rebates	<p>Increased costs to consumer of GP and psychiatrist services.</p>	<p>Consumers forgo other expenses (such as food and rent) to afford medical care. This increases stress and both physical and mental health problems (Jorm 2014).</p>	<p>More serious mental and physical health problems result in higher overall costs to the health system.</p>	<p>Implement a single safety net, including Medicare, allied health, PBS and other health services.</p>
Partners in Recovery	<p>Decreased access to this program.</p>	<p>Serious and long-term mental illnesses may worsen among people without access to this program (Jorm 2014).</p>	<p>Increased severity of mental illness in the community will result in higher rates of hospitalisation and higher health and social costs.</p>	<p>Ensure people with mental illnesses living in the community can access appropriate care and support.</p>

Budget measure	Details	Impact on mental health consumers	Impact on health system	Recommended solutions
COAG mental health initiatives	A cut in Commonwealth support for COAG mental health initiatives, including telephone counselling and support for children.	Consumers experience fewer services and increased fragmentation of care across Commonwealth and state/territory boundaries.	Decreased collaboration across the Commonwealth and state/territory services results in less efficient care due to gaps and duplication of services.	Link co-payments to value so that consumers are encouraged towards the most cost-effective care option. Increase research to address identified data gaps, in particular for people with chronic illness.
Mental Health, More Options Better Outcomes	Reduced funding for allied mental health services.	Consumers have reduced access to allied mental health care (Russell 2014).	Barriers to cost-effective allied health care lead to the development of more serious mental health problems.	Remove cost barriers to efficient and cost-effective allied mental health care for people with serious mental health problems.
Mental Health Nurse Incentive Program	Increased funding for mental health nurses.	Mental health providers have increased capacity to meet the needs of consumers due to support from dedicated mental health nurses.	Better primary mental health care helps keep people out of hospital and increases their productivity and contribution to the community.	n/a
Youth mental health	Increased funding for youth mental health services.	Increased capacity among services to meet the needs of young people with mental illnesses.	By identifying and treating mental health problems among young people effectively, the social and economic burden of illness may be reduced.	n/a

Background

'At the moment we are just managing. His health is OK, with some financial support from me, he is managing, but we are living at the edge really, there is not much extra at all. I am on a fixed income and also need to look after myself and maintain my house.'

– Kate, carer

The impact of the 2014–15 Federal Budget measures on people with mental illnesses needs to be contextualised within the current health care environment, taking into account existing levels of mental health funding and gaps in service provision. This section outlines key aspects of current mental health funding arrangements and their impact on consumers with mental illnesses.

Interactions with the health system

People with serious mental illness often present to public hospitals when they experience an episode of illness.

After a period of treatment and once symptoms become less acute they will be discharged, either to the outpatient department of the hospital that will continue to provide mental health services until the illness stabilises or to a primary health care setting where care is provided by GPs and/or by psychiatrists in private practice. Most people with serious mental illness live in the community and are treated by GPs and psychiatrists. Their interaction with public hospitals is short term.

Consumers and psychiatrists consulted as part of the process of developing this report highlighted a number of resourcing and structural problems within the health system that make it both costly and complicated for people with co-morbid mental and physical health problems to maintain good health. Specific problems included:

1. There are not enough psychiatrists in the public hospital system. This results in psychiatrists in both the acute and outpatient setting being stretched and not able to spend sufficient time with patients to develop detailed care plans and coordinate care with family, carers, and GPs.
2. Although treatment, pathology and medication provided within a public hospital setting is free, once care moves into a primary care setting many consumers must meet a range of 'out of pocket' costs associated with their care. This situation will worsen if the costs of medications are increased in line with 2014–15 Federal Budget measures. Consumers will also face increased costs for pathology and an increased co-payment for seeing their GP if measures from the Budget are implemented.

3. Increasing the cost of primary care, medication and pathology would present a barrier to care and would have a negative impact on the ability of people with mental illness to manage their physical and mental health care.
4. Coordination of care between GPs, psychiatrists and other health services is largely unsupported in the current health financing system. Navigating the health system can be complex and expensive for people with both mental and physical illness.
5. The existing mental health system is underfunded, with many people missing out on care altogether or not receiving adequate care.

There is robust evidence that the current level of funding for mental health services in Australia does not match the level of need for care.

The Australian Institute of Health and Welfare (2013) estimates that mental disorders account for 13.1% of Australia's total burden of disease and injury and cost the Australian economy up to \$20 billion annually, including lost productivity and labour participation. A recent report by Medibank Private Limited and the Nous Group (2013) estimates that Australia spends \$13.8 billion on direct mental health expenditure and at least \$14.8 on non-direct mental health expenditure. The estimated total expenditure of \$28.6 billion is equal to only 2.2% of Australia's GDP. This research is supported by qualitative research that has found that many consumers with mental illnesses do not access the care they require. In fact, research has shown that less than half of Australians with a mental health disorder receive appropriate support and treatment (Hosie et al. 2013). Based on this research, the National Mental Health Commission (2013) has called for a doubling in the proportion of the Australian population who receive 'timely and appropriate mental health services and support'.

Due to this existing level of unmet demand, even small increases in the proportion of people unable to access mental health care, combined with the impact of Australian population growth, will produce a cumulative increase in demand that is significantly beyond the capacity of current mental health services (Hosie 2013).

Consumer costs and affordability—key concepts

Due to the complex funding arrangements within the Australian health care system, people with mental illnesses can incur costs associated with their care in a number of ways. These include the direct cost of care, other direct (non-health) costs associated with their condition and indirect costs. These are outlined in more detail below.

Direct costs of care

The direct costs of care comprise a number of different types of payment associated with health care.

These include:

- the 'gap' payment for GP and allied health services (the difference between the fee and the Medicare or private health insurance rebate)
- the co-payment for Pharmaceutical Benefits Scheme (PBS) medicines
- the 'excess' charged for private hospital visits (the difference between the private hospital charges and any rebates from private health insurance)
- the total cost of non-PBS medication
- the total cost of an allied health consultation (for someone without private health insurance).

These costs are relatively easy to identify and quantify.

Direct (non-health) costs

The direct costs for additional non-health goods and services required as a result of a mental health condition can include a range of different expenses incurred as part of the process of accessing health care. These include:

- the cost of travel, meals and accommodation required to receive treatment
- the cost of childcare required in order to access treatment
- the cost of paying someone to look after a farm or business while seeking treatment.

These costs are relatively easy to identify but are often omitted from studies on the cost of specific illnesses. The level of cost incurred can depend upon the type of care accessed as well as other factors, such as location. Typically people living in rural and remote areas face significantly higher costs when accessing care than those in urban areas.

Indirect costs

Indirect costs that result from mental illness are often significant. They include:

- forgone salary due to an inability to work
- lost productivity to the community
- the loss of the contribution someone with a mental illness could make to their family, but is prevented from doing so due to their condition.

These costs are more difficult to identify and are often not included in assessments of the overall costs of these conditions.

Affordability

Affordability of mental health care is a function both of the actual cost of the care and the resources available to the consumer. These differ from person to person and can be impacted both by income level and by other expenses required for daily living. An out-of-pocket cost that is affordable for a single person may be financially out of reach for someone on the same income with children, or someone with a physical illness or disability that also requires regular treatment. As the Budget measures impact both upon the cost of health care and the income level of some consumers (in particular those receiving the Disability Support Pension (DSP) or other social security payments), it is important to consider both of these factors when assessing their impact.

Other issues that can impact upon affordability of health care are timing and payment systems. Health care costs are often unpredictable and often coincide with reduced earning capacity. This can result in short-term cash flow problems even for people who may usually be able to afford their health care costs. For example, people may be unable to afford an upfront payment for a service but could manage the cost over a longer period. People with mental illnesses may find managing unpredictable costs particularly difficult due to the impact of their illness on their ability to plan and deal with unforeseen events. For this reason, it is also important to look at the proposed payments systems when assessing the impact of any new payments on people with mental illnesses. Payment mechanisms that allow people to delay or stagger payments can increase the affordability of services to consumers.

The health care needs of people with mental illnesses

Psychiatrists treat people with mental illnesses of all ages and backgrounds, with a wide range of conditions that differ in their presentation, duration, severity and impact. It is therefore difficult to make any general statements about the health care needs of this consumer group. However, there are some common characteristics in the health care needs of people with mental illnesses that can be identified, based on existing research and the consumer consultations undertaken in the preparation of this report.

- Many consumers have more than one mental illness. It is common for people to have a diagnosis of two or more conditions, which may require different types of treatment (ABS 2008).
- Co-morbidity of mental and physical illnesses is very common. Sometimes these illnesses may be unrelated but often a physical illness can be associated with having a mental illness (ABS 2008). Physical illnesses are also associated with some medications used to treat mental illness.
- Mental illnesses may be persistent or episodic but even people whose condition is not always symptomatic may require regular health care, for example to monitor their condition and prevent further occurrences of their illness and to monitor the side effects of medication (AIHW 2012).
- Older people are particularly at risk of having problematic co-morbid conditions as they often have physical conditions that complicate assessment and management of their mental health conditions. This is further complicated as treatment costs for mental illness increase substantially with age (McCrone et al. 2008). People with mental illnesses often require care from family members or friends that is just as intensive and time-consuming as the care of someone with a physical illness or disability. However, often this caring role is not recognised and supported.²
- One group at specific risk of increased disadvantage are people with severe psychotic illnesses. People with these conditions have poor physical and mental health; 78% are unemployed, 63% are impaired in their ability to socialise, and 50% have attempted suicide at some point in their life. Their physical health is also poor, with 82% suffering from obesity, over half having metabolic syndrome, and 20% having diabetes (Jorm 2014).

2 More information on the role of carers of people with mental illnesses is available on the SANE website at www.sane.org.au.

Existing safety nets/assistance for specific groups

To accurately assess the affordability of mental health services to consumers it is important to take into account both the broad range of costs associated with care as well as any targeted assistance or subsidy programs for which they are eligible.

Currently, there are two main safety nets in place within the Australian health system that are designed to assist consumers facing high levels of co-payments. They are the Medicare Safety Net and the PBS Safety Net. Different levels of subsidy are available to people on health care concession cards.³

A tax-based rebate system for out-of-pocket medical and health costs (the net medical expenses tax offset) is currently being phased out but still applies to some consumers.⁴ The Department of Veterans' Affairs (DVA) has a separate system of health subsidies for veterans.⁵ There is also a Patient Assistance Transport Scheme (PATS) to assist rural consumers with travel costs associated with health care.⁶

Health Care Cards

Health Care Concession Cards (HCCs) are issued by the Federal Government to people on low incomes, recipients (and in some cases ex-recipients) of some allowances (such as DSP, Mobility Allowance and Carer Allowance) and people caring for foster children. HCCs entitle recipients to the concessional rate of PBS pharmaceuticals and some other concessions for health, education and transport expenses from federal, state and local government as well as private providers.

3 More information on the Medicare and PBS safety nets can be found at www.health.gov.au.

4 Net Medical Expenses Tax Offset (NMETO) is currently being phased out. Some taxpayers will still be eligible for the offset in 2014–15. This includes those who have received the offset in previous years, however the amount of the offset may be reduced depending on their adjusted taxable income. More information is available on the Australian Taxation Office's website, www.ato.gov.au.

5 More information can be found at www.dva.gov.au.

6 PATS is a subsidy program that provides money to pay for some travel, escort and accommodation costs when rural and remote consumers travel long distances to receive medical care and treatment. PATS is funded by both Commonwealth and state/territory governments and levels of benefit and eligibility criteria differ between jurisdictions.

Medicare Safety Net

The Medicare Safety Net provides additional rebates for high-level users of out-of-hospital medical services, such as GP and specialist consultations, ultrasounds, X-rays and blood tests. There are three different levels of the Medicare Safety Net: Original; Extended Concessional and FTB Part A; and Extended General.

The first level meets the cost of the gap (i.e. it rebates 100% of the Schedule Fee) for out-of-hospital services, once an annual threshold is reached. The next two levels pay for 80% of out-of-pocket costs for most out-of-hospital services (some services are capped), with two different thresholds depending on consumers' income level and responsibility for dependents. Currently, the threshold for the Extended Medicare Safety Net is \$1221.90 but from 1 January 2015 this will increase to \$2000 for families, couples and individuals.

The Schedule Fee is the price the government sets for each Medicare-funded service. This bears no direct relationship to the fee for the service (which is set by the provider) and often consumers will be charged much more than the Schedule Fee. The Medicare benefit (i.e. the amount the government pays) will be 75% or 85% of the Schedule Fee depending on whether the service is delivered in a hospital or in a community setting, such as specialist consulting rooms. A consumer's co-payment for a medical service includes both the difference between the Medicare Benefit and the Schedule Fee and any amount the provider charges above the Schedule Fee. The 'Gap' Medicare Safety Net only counts the first amount and not the second, which is covered by the other two levels of the Medicare Safety Net.

From 1 January 2016, a Single Medicare Safety Net for out-of-hospital services will replace the Extended Medicare Safety Net, the Original Medicare Safety Net and the Greatest Permissible Gap.

The Single Medicare Safety Net will have three thresholds:

1. \$400 for singles with a concession card or families with a concession card.
2. \$700 for singles with no concession card or families receiving Family Tax Benefit Part A with no concession card.
3. \$1000 for families with no concession card.

The definition of 'family' will also be broadened to include those under 22 years of age that are financially dependent on their parents, as well as couples living apart due to ill health or injury.

Pharmaceutical Benefits Scheme Safety Net

The PBS Safety Net reduces the cost of PBS-listed medicines for high-level users. Once an annual threshold is reached, the price of additional medicines drops for the rest of the year. There are two levels of the PBS Safety Net: general and concessional. Once the annual threshold is reached, general consumers receive their medicines at the concessional price and consumers with a concession card receive them free. Some costs associated with PBS medicines, such as brand premiums are not counted towards the safety net thresholds. The recent Budget also included increases to the threshold of the PBS Safety Net so that people will need to spend more before qualifying for subsidies. This is discussed later in the paper.

Problems with existing safety nets

'I see the GP about once a month and pay \$78 upfront, getting \$37.05 back. I see the psychiatrist once every 3 weeks for about 20 minutes. From 1st November the fee will be \$115 with a Medicare rebate of \$73.50, so there is a gap to be paid. A few days ago I saw my diabetes educator under a chronic disease management plan and paid \$75 up front... you have to have money in the bank before you see anyone. I have postponed appointments because I didn't have sufficient funds.'

– Ann, consumer

As discussed above, there are a number of safety nets and targeted scheme which have been put in place to help consumers, including people with mental illness, afford health treatment related goods and services. However, while these can help address some of the equity and efficiency problems that arise for consumers when accessing mental health services, they do not provide adequate assistance to many people.

Specific problems with the current system of safety nets include:

- They are difficult to understand and often require consumers to keep records of their expenses and apply for benefits. This can be particularly problematic for people who have cognitive impairments. Some consumers miss out on receiving the benefits of safety nets due to administrative problems or because they are not aware of their eligibility.
- Their application is inconsistent (some operate on an individual basis, some on a family basis, some use calendar year outlays and some use financial years). Frequent changes are made to safety net arrangements, which affect consumers' eligibility and the level of benefit they receive. These changes make it difficult for consumers to understand, and increases the administrative complexity of the system.

- They often do not address the need for high up-front payments for health care. Consumers are often required to pay the full cost of a service and apply afterwards for a rebate. This can prevent access to services for people with cash flow problems (health problems often coincide with cash flow problems due to the impact of illness on the capacity to work).
- They often don't support the choice of the most effective or efficient care option. For example, people who reach the PBS Safety Net will have a greater incentive to seek a pharmacological treatment for their condition, rather than a medical or allied health treatment, even if it is not the most cost-effective.
- They are based on annual expenditure. This advantages consumers whose health care expenses occur in a short timeframe over those who require lower levels of care for longer periods, as many people with mental illnesses do.
- Mechanisms to address inequity, such as health care cards, identify people on the basis of income level or carer status, but do not accurately target those who have difficulty affording health care. There are many consumers who do not qualify for health care cards or pensions but who experience difficulty in meeting their health care costs.
- The safety nets operate in isolation. There is no consistent approach across all forms of health and medical care. This advantages people whose health care needs focus on one specific type of care (e.g. medical or pharmaceutical) but disadvantages consumers who require different forms of care, such as a GP, psychologist and counselling.

2014–15 Federal Budget

The 2014–15 Federal Budget contained a number of measures directly affecting people with mental illnesses. There were both savings and funding measures but overall the Budget resulted in a net loss of funding to mental health programs. A number of these measures require legislative change that must be approved by the Senate in order to take effect. Therefore, there is currently some uncertainty over their status and it is likely that they will be amended as part of the negotiation process between the government, minor parties and crossbenchers.

The following section outlines the main Budget initiatives likely to affect people with mental illnesses. It identifies the impact they are likely to have on consumers' access to appropriate care, taking into account the existing cost and other barriers that mental health consumers experience. These include three major system-wide changes that will impact consumers across the spectrum of the health and social welfare systems. There are also a number of discrete mental health programs affected by the Budget, which will have a more narrowly defined impact within their target population.

'I don't think the government should make medicines any more expensive than they already are. For people on multiple medications, like me, even a small increase adds up really quickly.'

– Amber, consumer

System-wide changes

'We're really anxious about any increase in our health care costs and all this stress can make my conditions worse.'

– Jaisen, consumer

Primary health care co-payments

The government will achieve savings of \$3.5 billion over five years by reducing Medicare Benefits Schedule (MBS) rebates from 1 July 2015 by \$5 for standard general practitioner consultations and out-of-hospital pathology and diagnostic imaging services. The government is encouraging the providers of these services to collect a patient contribution of \$7 per service for GPs and \$6 per service for pathology.

For patients with concession cards and children under 16 years of age, the MBS rebate will only be reduced for the first 10 services in each year, after which it will return to current benefit levels. A new Low Gap Incentive will replace bulk-billing incentives for providers of these services. The Low Gap Incentive will be paid to providers where they provide services to patients with concession cards or children under 16 years of age and only charge the \$7 patient contribution for the first 10 services in a year, or where they charge no patient contribution for additional services in that year. Services that are provided as part of a chronic disease management program will be exempted from the co-payment.

The measure will also remove the restriction on state and territory governments from charging patients presenting to hospital emergency departments for GP-like attendances.

Impact on people with mental illnesses

People with mental illnesses seeking treatment within the primary health care sector are likely to face additional payments if they receive bulk-billed services or use prescription medicine. It is also important to note that the \$7 co-payment cannot be counted towards meeting the safety net threshold.

There is some provision within the Budget measures to support regular users of primary health care services. For example, there is an annual \$70 cap on co-payments for people with a pension or concession card and some specific chronic disease management services are exempt.

However, it is not clear how the annual cap will be applied when people access different GPs for care and there may be a requirement that consumers continue to pay the co-payment and receive a rebate at a later date. It is also not clear which services being provided as part of a chronic disease management plan are exempt from the co-payment.

Increasing cost barriers to accessing GP services will have a profound impact upon the way in which mental health care is provided within the Australian health system. GPs play an important role in both treating mental health problems and as a care coordinator and referrer of people with mental illnesses to other mental health professionals. Data shows that mental illness comprises a significant component of GPs' work. In 2011–12 an estimated 12.1% of all GP encounters were mental health-related encounters, which translates into nearly 15 million mental health-related GP encounters per year. In addition, there were an estimated 3.1 million encounters that did not involve a specific mental health-related problem but where psychologically related management was initiated (Britt et al. 2012).

Of these 18 million encounters involving mental health issues, only 2.2 million services were provided using MBS items defined to be mental health-specific, as distinct from general surgery consultations. Therefore, most people receiving mental health services from a GP would not be eligible for the co-payment exemption provided for services provided under a mental health care plan.

Given that there has been an annual average increase of 6.0% in the estimated number of mental health-related GP encounters recorded since 2007–08, it can be expected that the demand for mental health services from GPs will continue.

In addition, it is important to note that the introduction of co-payments into bulk billing practices may result in the cost inflation of GP services. \$7 is not a maximum co-payment amount and GPs may decide to charge above this amount to cover the cost of the additional administration required to process co-payments. This was confirmed by Richard Bartlett, Acting Deputy Secretary of the Department of Health, in a recent hearing of the Inquiry into out-of-pocket costs in Australian health care. Mr Bartlett said, 'You would assume some of the doctors may choose to charge some people larger co-payments—they may vary the amount of co-payment.'⁷

Ethical issues also arise in relation to consumers who are being cared for under mental health legislation. These consumers may also be required to meet the cost of co-payments for medical and pathology services, despite the fact that they are considered involuntary patients and unable to consent to treatment.

The co-payment will also increase the cost of care for co-morbid physical illnesses. People with mental health issues have a life expectancy of 16 years (males) and 12 years (females) less than the general population, primarily due to chronic physical illnesses such as cardiovascular disease. Increasing the cost of care for physical illnesses is also likely to result in poorer health outcomes for people with mental illnesses (Lawrence, Hancock & Kisely 2013).

The most common management of mental health-related problems was for the GP to prescribe, supply or recommend medication (64.7%) (Britt et al. 2012). This highlights the fact that many consumers seeking treatment for a mental illness will often face multiple co-payments for a single episode of care, i.e. a \$7 co-payment for the GP consultation, a \$6 co-payment for prescription medication and in some cases an additional \$7 co-payment for pathology services to monitor the effects of the medication.

If consumers are unable to afford the cost of these services, they and their health care providers need to choose which services are most important. Where consumers cannot afford specific services they may be exposed to potential side effects that are undetectable without pathology services or develop complications that are not picked up and treated.

Pathology co-payments

People with mental illness are high users of pathology services. This is especially true of people with severe or chronic mental illness such as schizophrenia or bipolar disorder in which the medication carries potentially serious side effects. Consequently, increased pathology costs impact highest on the most vulnerable group of mental health consumers.

The 2014–15 Budget included measures for a new \$7 co-payment for pathology. As is the case with the GP co-payment these costs will not count towards meeting the Medicare Safety Net Threshold. Currently, the vast majority of pathology tests are bulk billed so the \$7 co-payment will be felt by all consumers especially those taking clozapine, lithium or any medication that increases the risk of diabetes. Psychiatrists are concerned that the proposals for an additional co-payment for pathology would not support good clinical care.

For many people with serious mental illness, effective treatment requires medicines that need tight monitoring in order to work. They can also have serious side effects. Both the Therapeutic Goods Authority (TGA) and the RANZCP's therapeutic guidelines⁸ require regular monitoring, including extra visits to the GP, blood tests and other pathology, in order to test effectiveness and avoid the potential harms of these medicines. Members noted that even where there is no co-payment many people with serious mental illness find these tests onerous. The co-payment could tip the balance away from people coming in for these essential tests, with the possible consequences being a serious deterioration in their health and an increased likelihood of hospitalisation, and even death.

7 Transcripts of the public hearings of this Inquiry can be found at http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare/Report

8 www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/APY520-pdf.aspx

One example is that of consumers with serious mental illness who are already at heightened risk of diabetes. A number of new generation anti-psychotic medications can also increase the risk of developing metabolic disorder and diabetes (De Hert et al. 2009; Bak et al. 2014). At a minimum, people require six-monthly metabolic monitoring, which requires extra consultations either with a GP or a psychiatrist. They also need a range of tests, including those for blood sugar and cholesterol, and ECGs to monitor heart function. People with metabolic syndrome also require tests, and visit their doctor much more frequently to maintain their health. Failure to monitor metabolic syndrome can lead to the development of type 2 diabetes as well as cardiovascular disease, exposing people to ongoing serious chronic illness.

A second example is where people with bipolar disorder are treated with lithium. Given the potential toxicity of lithium, regular blood tests are required to ensure that side effects are avoided and that the medication is being given at the most effective dose. The following example was provided by a carer whose son has bipolar disorder.

‘The thing I worry about is that this is a barrier and a disincentive for him to go to the doctor. He already finds it quite onerous to go to the doctor once a month and have the blood tests, and the co-payments for GPs and for pathology will be a barrier to him going. Monitoring the lithium levels is really quite essential to him staying well. So I can see that he won’t go to the doctor and he gets ill again and has to be hospitalised.’

– Kate, carer

Another example of a medication that requires intense monitoring is clozapine, which can be effective in treating people with schizophrenia in whom all other treatments have failed. However, it can also have a range of serious side effects including liver problems, cardiac abnormalities, seizures and neutropenia—a deficiency of white blood cells which can impair immune function (MedicineNet 2014). The TGA requires that people prescribed clozapine must undergo regular testing in order to continue being prescribed the medication. Initially, these tests are required weekly. More frequent visits to the GP or psychiatrist are also required.

With a new co-payment for each pathology test as well as visits to the GP, the additional costs can mount up over time. While many people with serious mental illness are on HCCs, a number are not. Below is a table that estimates the additional costs of pathology for a person commencing treatment with clozapine, who is receiving care in the community and does not have an HCC. This calculation does not measure the cost of the medication itself or the additional visits to a GP or psychiatrist that would also be required. The costs are so significant that people who are working, or who might find a job during the course of their treatment, may find earning an income will put them above the threshold for the HCC. It may not be worth their while to work and bear the costs of these tests without assistance. There is no ceiling for these costs, nor are they counted in terms of meeting the Medicare Safety Net.

Table 1. Out-of-pocket pathology costs for a consumer without an HCC who is commencing treatment with clozapine

	Pathology tests required	Total cost (estimate)
Pre-treatment	- 7 blood tests - 1 cardiac assessment	\$56
Week 1–18	- 5 weekly blood tests (90) - 2 additional blood tests, required 2 times (4) - 2 blood tests, required 5 times (10) - 5 cardiac assessments	\$763
Week 19–52	- 3 quarterly blood tests (9) - 2 additional six-monthly blood tests (4) - 1 annual cardiac assessment	\$98
Estimated annual costs of pathology		\$917

Table prepared with information from the Clozapine Protocol (South Australia, Health Department) and Mental Health Directorate Procedure, Commencement of Clozapine (Victoria).

This table does not include the cost of the medication itself or the additional visits to a GP or psychiatrist that would also be required.

Co-payments for medications provided under the Pharmaceutical Benefits Scheme

The 2014–15 Federal Budget also included proposals for additional charges for medication provided under the PBS. The changes will take effect from 1 January 2015. People without HCCs will pay an additional \$6 per prescription, increasing the total amount they will pay from \$37.70 to \$42.70 per medication. Concession card holders will pay an additional \$0.80, lifting the amount they have to pay from \$6.10 to \$6.90. The PBS Safety Net threshold (the amount that consumers must spend before they are entitled to further subsidies in their medications) has also increased. Concession card holders will now have to spend \$427 on medications, up from \$366, before they qualify for further subsidies. Non-concession card holders will have to spend \$1597.80, up from \$1452, a difference of \$145.

While many people with serious mental illness are eligible for an HCC, not all of them are. Some of the most disadvantaged people are those who have a serious mental illness and a physical illness, but miss out on an HCC because their income is marginally too high. They still have to meet a higher cost of medication, which can be significant.

'As well as my mental health issues, I have other complex illnesses. I developed diabetes within about six months of going on Zyprexa some years ago.'

– Ann, consumer

Below is an estimate of Ann's existing costs for medication over a three-month period, as well as the impact of the \$6 co-payment. Like many people who have both physical and mental illnesses, Ann does not qualify for an HCC.

Social security and Disability Support Pensions

New eligibility conditions for the DSP and other social security payments were announced in the Budget.

These are as follows:

- People under 35 years of age on the DSP will be reviewed (with a few exceptions) and placed on a 'program of support' or risk losing their DSP benefit.
- From 2017 the DSP and other pension and equivalent payments and Parenting Payment Single will be indexed to the Consumer Price Index (CPI), rather than average male weekly earnings (which typically increases at a higher rate than CPI).
- From 1 January 2015, the age of eligibility for new applicants for the Newstart and Sickness Allowance payments will increase from 22 to 24 years. People aged under 25 years will receive youth allowance, which is \$100 per fortnight lower.
- The Pensioner Education Supplement, which helps students with illnesses or disabilities with the ongoing costs of full-time or part-time study, has been abolished.

Impact on people with mental illnesses

Overall, these changes make it more difficult for people to qualify for the DSP and other social security payments. This will have a significant impact on people with mental illnesses, who are over-represented among people on the DSP and those receiving unemployment benefits (ABS 2008). The proposed changes to these payments will make it harder for people with mental illnesses to access the care they need. It will reduce their income and increase their obligations in order to receive their payment.

Table 2. Example of medication cost over a three-month period for a consumer without an HCC

Medication	Existing costs	Co-payment
Seroquel 300mg	\$73.80 (2 scripts)	\$12
Lamotrigine 100mg	\$147.60 (4 scripts)	\$0 (non PBS medication)
Escitalopram 20mg	\$50.60 (4 scripts)	\$24
Galvumet 50/1000mg	\$110.70 (4 scripts)	\$24
Rosuvastatin 5mg	\$97.32 (3 scripts)	\$18
Irbesartan 75mg	\$40.62 (3 scripts)	\$18
Meloxicam 7.5mg	\$77.28 (6 scripts)	\$36
Nexium 20mg	\$77.10 (4 scripts)	\$24
Tramal 50mg	\$59.20 (2 scripts)	\$12
Stilnox 12.5prn	\$23.90 (1 script)	\$6
Total	\$758.12	\$168
Total cost with co-payment		\$920.12

Specifically, RANZCP is concerned about the creation of a false dichotomy between 'permanent impairment', 'episodic disability' or 'permanent impairment but a partial capacity to work' especially with the stated intention to only offer financial support to people with a 'permanent impairment'. From a psychiatric perspective this demonstrates a lack of understanding of the complexity of chronic mental illness and the myriad impacts of this on a person's life and capacity.

There is a particular risk for young people aged under 30 years with an 'episodic' mental illness. These individuals will be ineligible for the DSP but will also be unable to access Newstart for the first six months.

The changes are also unlikely to improve the employment opportunities for people with mental illnesses. International evidence shows that post-placement support is the most important factor to support people with a mental illness back into sustained employment (Russell 2014). The changes will also make it more difficult for people with mental illnesses to study and therefore may reduce their future opportunities for employment. The emphasis placed on ensuring carers maintain links to the job market, and the likely decrease of their income, neglects to recognise the essential role these people already perform, and the cost savings they provide the Australian community.

People with mental illness often have low incomes (ABS 2008). The compounded impact of poverty and disadvantage can both increase the severity of mental illness and hinder the prospects for recovery.

Medicare Benefits Schedule rebates freeze

As part of the Budget, the government announced that from 1 July 2014 the indexation of all MBS fees will be suspended, excluding GP attendance items and associated bulk-billing incentives, for a further 24 months. Indexation of the fees in the DVA Schedule of Benefits will also be suspended from 1 July 2014 for 24 months. This measure will affect specialists, allied health professionals, nurse practitioners, midwives and dental surgeons who provide Medicare- or DVA-eligible consultations and procedures. These changes will not affect the fees for pathology and diagnostic imaging services, which are not indexed annually.

Impact on people with mental illnesses

Psychiatrists have been requesting a review of the MBS items that relate to psychiatry for several years, due to changes in practice that mean a number of anomalies exist. Psychiatrists currently receive only 85% of schedule fee for treatment rather than 100% of the schedule fee as received by GPs. There are also very few items that relate to the care of carers for people with mental illness despite it being well recognised that they need support. Another area of concern has been the cessation of funding incentives for telehealth. All of these impact on the health of people with mental illness, and will not be able to be addressed during a freeze on fees and services.

Patients that are not bulk billed may also experience higher out-of-pocket costs for non-GP services provided under Medicare, if their provider decides to increase their fees. This includes both private psychiatry and psychologists providing Medicare-eligible services. These increases in costs are on top of the co-payment for primary health care services and, when added together, could significantly increase the cost of mental health care. If people are unable to access appropriate care due to these increases in payments their condition may worsen, leading to more serious mental (and potentially also social) problems.

Specific programs

'We can't afford private health insurance and are just scraping by with our current health care expenses. If they go up we will have to give up some things that we think of as essential, such as life insurance, and cut our food budget.'

– Jaisen, consumer

Partners in Recovery

The Partners in Recovery (PIR) program helps people with severe and persistent mental illness and complex support needs. In the Budget, the government deferred the establishment of 13 PIR organisations for two years (saving \$53.8 million). It is not clear what will happen to funds provided for 2015–16, and whether these have already been taken, unnoticed, as savings.

Impact on people with mental illnesses

People with these conditions have poor physical and mental health. 78% are unemployed, 63% are impaired in their ability to socialise, and 50% have attempted suicide at some point in their life. Their physical health is also poor, with 82% suffering from obesity, over half having metabolic syndrome, and 20% having diabetes. The loss of the PIR services, which were designed to care for this disadvantaged group, and the introduction of new co-payments to visit a GP is likely to have a greater impact on people with these illnesses than those with less severe conditions.

This Budget cut will specifically impact upon people with persistent mental illness in locations that were planning to establish PIR organisations. While it has not been formally evaluated, both consumers and health professionals involved with the PIR program strongly support it as a cost-effective initiative to support this group of consumers.⁹ Without adequate support, there is a risk that people targeted by this program will have poorer mental health outcomes and a lower chance of participating fully in employment and social/community life.

COAG mental health initiatives

As part of the Budget, the government withdrew or downgraded Commonwealth support for a number of COAG mental health initiatives, including telephone counselling and support for children. These are services that were agreed to with the States and Territories as part of The Roadmap for *National Mental Health Reform 2012–2022* (COAG 2012).

Impact on people with mental illnesses

As a result of these cuts, consumers will experience fewer services and increased fragmentation of care across Commonwealth and state/territory boundaries. Over time, decreased collaboration across Commonwealth and state/territory boundaries is likely to result in less efficient care due to gaps and duplication of services.

Mental Health, More Options Better Outcomes

In the Budget sitting of Senate Estimates, the Department of Health provided figures indicating that just under \$10 million (over 4 years) was being cut from this program (SFPALC 2014), which includes the Access to Allied Psychological Services (ATAPS) program. Through ATAPS, patients are eligible for a maximum of 12 sessions per calendar year with an allied mental health professional—six time-limited sessions with an option for a further six sessions following a mental health review by the referring GP.

Impact on people with mental illnesses

Psychiatrists work closely with GPs, psychologists and other health professionals. Programs such as ATAPS provide a rare support for this collaboration between medical and community health professionals, and encourage early intervention and prevention of more serious mental health problems in the community. The Department of Health did not provide details of how services would be affected by the funding. However, if the funding cuts result in fewer services being available, this would have a significant impact on many people with mental illnesses, particularly those with acute and short-term needs. Without the subsidy provided by this program, many consumers would be unable to afford mental health services. Without access to early and preventive mental health care, there is a risk that emerging problems will become worse and result in more serious illnesses in the long term.

⁹ More information on Partners in Recovery can be found at www.pirinitiative.com.au.

Mental Health Nurse Incentive Program

The Budget provided \$23.4 million to maintain existing service levels for the Mental Health Nurse Incentive Program. These funds are provided for mental health nurses in private psychiatry practice, general practice and Indigenous health services to provide services such as home visits, medication monitoring and management and improving links to other health professionals. Participating organisations are able to claim an establishment payment of up to \$10,000, and incentive payments based on the number of sessions for which the mental health nurse is engaged.

Impact on people with mental illnesses

This program provides important support for mental health professionals to enable them to provide more comprehensive care to consumers. Although the program received funding in the Budget, it should also be noted that funding levels have now been capped at existing service levels for three years, with no knowledge or recognition of what this means for service provision.

Youth mental health

Specific youth mental health initiatives were announced in the Budget, including:

- \$14.9 million over four years for ten new headspace youth mental health centres
- \$18.0 million over four years to the Orygen Youth Health Research Centre to establish and operate a National Centre for Excellence in Youth Mental Health
- \$2.5 million over two years for an e-health platform for young people.

Impact on people with mental illnesses

These initiatives should increase the capacity of mental health services for young people with mental illnesses and promote high-quality research into youth mental health issues. This should benefit young people with mental illnesses and prevent the development of more serious and lifelong mental health problems. However, many other decisions relating to changes to eligibility for DSP and Newstart will negatively impact upon young people with mental illness. Also, while young people are an important target group for mental health services, it should be noted that most people with mental illnesses are adults (who are not a target group for these services) and many young people access mental health care through GPs and mainstream health professionals, rather than dedicated youth services. They will therefore be affected by changes to these mainstream mental health services resulting from the Budget, such as the proposed GP co-payment and MBS rebate freeze (discussed in more detail previously).

Aboriginal and Torres Strait Islanders: specific issues

The needs of Aboriginal and Torres Strait Islander Australians in relation to mental health are also going to be adversely impacted by the proposed Budget measures. Due to the history of Indigenous Australians, in particular the destruction of their cultures via the processes of European colonisation, the disempowerment and marginalisation of Aboriginal and Torres Strait Islander peoples and the widespread removal of Indigenous children from their parents (the Stolen Generation), Indigenous communities today experience high levels of both physical and mental illness compared with the general population.

In particular, Aboriginal and Torres Strait Islanders have significantly higher rates of cardiovascular disease, rheumatic heart disease, diabetes and renal failure. Overall, the life expectancy for Aboriginal and Torres Strait Islander people is estimated to be from 11 years (males) to 9 years (females) lower than the non-Indigenous population.

Aboriginal and Torres Strait Islander people also experience high levels of disadvantage in relation to housing, education and employment. In adult life, Indigenous Australians are much more likely to be unemployed and living in poverty or on very low incomes, compared with non-Indigenous Australians. They are also much more likely to be living in over-crowded or sub-standard housing, be homeless or be incarcerated. In addition, Aboriginal and Torres Strait Islander people are at a much higher risk of violence than the general population, both as adults and as children.

Given these factors, it is not surprising that Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than non-Indigenous Australians and have higher rates of many mental illnesses, including depression. Aboriginal and Torres Strait Islander people also experience harmful rates of alcohol and other substance use. Aboriginal and Torres Strait Islander men are hospitalised at over four times the expected rate for severe mental illness related to substance abuse, and at more than double the expected rate for severe chronic mental illnesses such as schizophrenia (Productivity Commission 2009).

The mortality rate for Aboriginal and Torres Strait Islander people from mental and behavioural disorders due to psychoactive substance use is almost 12 times the rate for the Australian population in men and almost 20 times the rate of the Australian population for women. In addition, the rates of death by suicide for Aboriginal and Torres Strait Islander people are almost three times the rate for the Australian population generally (ABS 2010).

Improving the physical and mental health status of Aboriginal and Torres Strait Islander Australians should be a high priority for all Australian governments however many of the proposed Budget measures will create additional barriers to closing the gap between Indigenous and non-Indigenous Australians. The following measures will particularly impact upon Aboriginal and Torres Strait Islander communities:

- The introduction of GP and primary health care co-payments. As Indigenous Australians have lower average incomes and higher than average health care needs, they will be particularly impacted by any increase in primary health care costs. At specific risk will be people with chronic conditions, such as diabetes, which require regular monitoring and care in order to prevent disease progression.
- A cut of nearly \$550 million over five years to Aboriginal and Torres Strait Islander programs over the next five years. This is likely to decrease the capacity of services to meet community needs.
- Only 12 months funding provided for Aboriginal health and legal services. This creates uncertainty about their future and makes it difficult to recruit and retain high-quality staff.

The head of the National Aboriginal Community Controlled Health Organisation, Justin Mohamed, has argued that co-payments for GP visits, pathology and medicines will be a significant barrier to Indigenous people seeking care.

'We simply can't put any barriers in the way of Aboriginal people seeking health care or we risk the gains we are making in Aboriginal health.'

Mr Mohamed said Indigenous people use both services provided by community-controlled health services and mainstream health services (Karvelas 2014).

This view was echoed by psychiatrist Dr Peter O'Brien, who provides services as part of the Aboriginal Medical Service and is Chair of RANZCP's Section of Rural Psychiatry.

'Within a mental health setting people are already reluctant to seek the treatment they need. I can see a co-payment for this population would be very problematic. It will end up costing the health system more because people might not see the GP, they might stop taking their medication and become ill again. Getting someone who is ill in a remote community in to a hospital can be expensive, complicated and dangerous. You have to fly them in, sometimes over huge distances and if they are quite disturbed you have to fly them in a heavily sedated state.'

Dr O'Brien also said that the Aboriginal Medical Service might choose to absorb the costs of the co-payment and pathology costs. However, this would mean that 'they will have to cut costs in other areas. There will be other services that they will be unable to provide.'

Special issues in rural and remote communities

There are a number of issues specific to rural and remote areas that impact on the cost of care for people with mental illness.

Firstly, the shortage of both GPs and psychiatrists means that people can struggle to get access to medical care in the first place. It also means that both GPs and psychiatrists are much less likely to bulk bill.

For many people in rural and remote areas, a psychiatric consultation conducted through video conferencing (telehealth) appeared to have some promise in delivering affordable access to psychiatrists and also improving the integration of care between psychiatrists and GPs. However, the reduction of the telehealth incentive payment (this payment was removed by the previous government), in addition with the proposed freezing of the MBS in the 2014–15 Federal Budget, has made it increasingly difficult for psychiatrists to offer this service.

Psychiatrists have reported that telehealth can provide a range of benefits, including:

- providing affordable access to psychiatrists in rural and remote areas
- providing access to psychiatrists for people who might find it difficult to travel to attend appointments
- encouraging collaborative care between GPs and psychiatrists as the consultation usually occurs in the GP's rooms and the mental health plan is developed collaboratively
- reducing travelling time for psychiatrists, which enables them to provide more services.

However, the RANZCP is concerned that since the removal of the incentive payment for telehealth, psychiatrists are now getting 20% less in subsidy for providing this service. For many, this will mean that it will not be viable to continue to offer this service, especially at the current bulk-billed rate. There are problems charging patients who are far away and GP practices are sometimes unwilling to meet the cost of collecting fees for doctors not within its practice. The proposed freezing of the MBS will exacerbate this problem to the point that the RANZCP anticipates that this service will become much less available.

Other issues

'I can see this Budget driving people like me away from education and from seeking employment and back into hospitals just because we can't afford to keep ourselves healthy any more.'

– Amber, consumer

Groups most at risk

One group at specific risk of increased disadvantage resulting from the Budget measures are people with severe psychotic illnesses. People with these conditions have poor physical and mental health, 78% are unemployed, 63% are impaired in their ability to socialise, and 50% have attempted suicide at some point in their life. Their physical health is also poor, with 82% suffering from obesity, over half having metabolic syndrome, and 20% having diabetes (Jorm 2014).

The loss of the PIR services, which were designed to care for this disadvantaged group, and the introduction of new co-payments to visit a GP, is likely to have a greater impact on people with these illnesses than those with less severe conditions.

Lack of consultation

The Budget changes have been criticised by some stakeholders as not reflecting consultation with the mental health sector. The previous government commissioned a national study of the priorities in mental health research, which included an extensive survey of the views of stakeholders in the sector. The additional funding provided in the Budget bears little relationship to the priorities of the sector.

Federal/state relations

A major barrier to the delivery of coordinated care to people with mental illnesses is the lack of agreement between federal and state/territory governments in a number of key areas. Resolving jurisdictional issues and increasing coordination across federal and state/territory areas of responsibility would make a significant contribution to improving the quality of care provided to people with mental illnesses. However, the 2014–15 Federal Budget does not address this issue and in fact increases the current confusion over the roles of the state and federal governments in relation to mental health. What was clearly most important to the federal government was who pays, shifting responsibility from government directly to the service user.

Medicare Locals

The government's changes to the roles and structures of Medicare Locals (MLs), including the closure of the peak body for MLs, the Australian Medicare Locals Alliance (AMLA), may also impact upon people with mental illnesses. MLs are currently responsible for administering and coordinating a range of primary mental health services, depending on the region. This includes the ATAPS program, which provides access to effective, free or low-cost treatment for people with a mental illness who may not otherwise be able to access services. If the changes result in fewer resources being available to MLs this may reduce the level of mental health service provision in local communities and/or the capacity of local providers to work with GPs to provide coordinated care to people with mental illnesses.

Summary of impacts of Federal Budget measures

'I think these policies are the worst ones ever. They are taking away from those most in need and driving people into criminal behaviours like taking drugs and stealing.'

– Jaisen, consumer

An Access Economics report (2009) found that the financial cost of mental illness in people aged 12–25 alone was \$10.6 billion including health care, lost productivity, tax and welfare payments. Overall, the Budget measures will increase the cost of care for people with mental illnesses and create additional barriers to accessing appropriate services for both physical and mental health problems. As outlined below, the additional costs and reduced level of social security support proposed by the government, when imposed on an already significantly disadvantaged group, are likely to result in significantly higher levels of mental illness and an increased burden on the Australian community.

The impact of specific Budget measures is outlined below.

1. Increased barriers to access: Higher costs will make essential and preventive health care harder to access (in particular for people on regular medication or with co-morbid physical conditions).
2. Creation of financial hardship: Higher health care costs and reduced disability and pension payments will create financial stress for many people with mental illnesses. Some consumers will be forced to forgo essentials, such as food and electricity, in order to afford their care. People may also delay treatment and, as a result, their illness may become more severe.
3. Increased stress: Many people with mental illnesses already experience high levels of stress and anxiety. Increasing health care costs may add to this stress and compound existing health problems.
4. Increased hospital use: If people with mental illnesses cannot afford regular primary health care, it is likely that they will increasingly seek care from public hospitals. This results in higher health costs overall and poorer consumer outcomes.

Recommendations

'Any access to health care really should be as easy as possible and there should be no disincentive for people with a mental illness to seek help. The pathway to getting help should be really clear and we shouldn't be putting a barrier like cost in people's way.'

– Kate, carer

The following recommendations should be considered in relation to the implementation of the 2014–15 Federal Budget measures in order to reduce their adverse impact on people with mental illnesses and to decrease the burden of mental illness on the Australian community.

1. No additional costs should be imposed for mental health services until a comprehensive audit is undertaken on the existing out-of-pocket health care costs for people with mental illnesses.
2. Increased consultation should be undertaken with the mental health sector, including consumers and health care providers, to assess the impact of the proposed Budget measures on people with mental illnesses.
3. People with mental illness (and other chronic illnesses) should be permitted to earn more from paid work before losing their Health Care Concession Card (ie. the income threshold should be higher). They should also be permitted to retain their Health Care Concessions Cards for a period at least six months after commencing paid work.
4. A single safety net for all health care costs, including Medicare, PBS and allied health, should be implemented.
5. Where co-payments for health services occur, there should be a provision for people to defer payment so that there is no upfront cost barrier to accessing care.
6. The incentive payment for telehealth consultations should be reintroduced to encourage more psychiatrists to provide this cost-effective service, particularly for consumers living in rural and remote areas.
7. The Department of Health should, in consultation with consumer groups and the Pharmacy Guild, develop mechanisms that would:
 - a) track medication spending regardless of which pharmacy consumers use; and
 - b) allow for 'automatic' registration for the Medicare Safety Net for some groups of consumers.

Appendix: Consumer case studies

As part of this project a number of consumers were interviewed about their health care costs and the impact of the Federal Budget initiatives on the affordability of health care. The following case studies have been prepared based on these interviews, and with the agreement of the individual consumers.

Case Study 1: Ann

'I'm 59 and married. We live in our own home but we are still paying off a mortgage. I stopped work four years ago. Because of my illness I didn't enter the workforce until I was 36 and then I had 19 years of part-time work. I get a small amount of income from superannuation and from insurance. I am fortunate that my husband is employed four days a week, although he is not particularly well paid. We don't qualify for any concessions and both of us pay significant gaps when we go to the doctor. And then there's the cost of medication...

If I wasn't married I would be desperately poor.

The cost of health care is really worrying me. Doctors' fees keep rising and the Medicare rebate has been stagnant for many years. When I talk to friends who are mental health consumers there is an increasing sense of anxiety. People are making very hard choices. There seems to be no end point in sight: when does the government stop pruning and cutting?

I don't have a health care card because our combined income is too high, so I don't get bulk billed when I visit the doctor. My mental health care comes from my GP and my psychiatrist. I see the GP about once a month and pay \$78 upfront, getting \$37.05 back. I see the psychiatrist once every three weeks for about 20 minutes. From 1st November the fee will be \$115 with a Medicare rebate of \$73.50, so there is a gap to be paid. A few days ago I saw my diabetes educator under a chronic disease management plan and paid \$75 up front. The scheduled fee for this is \$62.25 and the benefit is \$52.95. It's a similar situation for the psychologist under a mental health care plan.

In real life you have to have money in the bank before you see anyone and once you've paid the full cost the receptionist organises the Medicare rebate to go into the bank account. This doesn't happen immediately so you have to watch out for any overnight direct debits from your bank account because the money may not be there to cover them. I have postponed appointments because I didn't have sufficient funds. I have to have blood tests and other pathology every six months, and at the moment they are bulk billed. We've just met the Medicare Safety Net. We usually have about nine months carrying the full charge and then some help for three months. But there continues to be a gap because

the doctors and other health professionals we see don't charge Medicare rebate. It gets confusing: there is the Medicare rebate for a consultation, then there is the scheduled fee, and finally there is the actual charge set by individual practitioners.

Medication is a huge impost. As well as my mental health issues, I have other complex illnesses. I developed diabetes within about six months of going on Zyprexa some years ago. I take three drugs for my psych problems and five drugs to manage the other health conditions. Two of the drugs I am on aren't on the PBS and they are expensive. I largely use generic drugs as they cost less. My husband is also on medication and there are times when everything falls due. There have been trips to the chemist when I've paid \$200 just to get essential medication. We've just met the PBS Safety Net which reduces the cost of medication. I understand the safety net and make it work by always using the same chemist so they keep an eye on how much we've spent. It took me quite a while to work out how the safety nets work. No one tells you this and if you are a bit disorganised and stressed it can be really difficult to keep track of everything. I don't use a Webster Pack— that costs too much and the system doesn't cope with changes to the dose that go with the ups and down of illness.

If I was on Centrelink payments I would not be able to afford many medications and would need to limit visits to doctors. I would have to make some very difficult choices that would affect my quality of life and life expectancy. I already know my life expectancy is shorter than other people's; I have accepted this. It is an enormous scandal that people with enduring mental health conditions live about 25 years less than other groups. But, there's little in the system that meaningfully and effectively helps us deal with the underlying issues.

Sometimes it seems that government and society is engaging in a kind of creeping euthanasia, the slowly increasing expense of health care costs that will further undermine our health and limit our ability to have a contributing life. Perhaps it is an unintended consequence. I realise that there are financial realities and dilemmas about the cost of health care, but there are also ethical issues. Can the value of a human life be measured financially? Are some citizens more worthwhile than others? The rhetoric about lifters and leaners suggests that it is. It is so shaming to listen to this.

We have private health insurance and it costs a fortune. It's about \$250 a fortnight for both of us and, as with Medicare, there are always gap costs. When I go to the dentist I don't get expensive treatments like root canal work. I see a dentist who is listed with the health insurer and this keeps the costs down a bit. Affordable dental care is essential for me because when I get depressed my immune system doesn't work that well and I get abscesses and lose teeth.

At the moment my health care costs are a burden I manage but every year it gets harder. The Medicare rebate isn't going up but the doctors' fees do. With the proposed co-payments, the costs of seeing a doctor, pathology tests and medication will also increase. It's a triple whammy. Meanwhile, our earnings are going down. Often things just go on the credit card and when the tax return comes the credit card gets paid off. Sometimes we go without things so we can afford medication and health care. We are really careful about turning on the heating, for example. We don't drink or smoke or go on expensive holidays.

I think that people with lifelong mental health conditions and other chronic diseases and disabilities should be given access to concessional systems, regardless of income. We have health care costs far in excess of other people and our incomes are lower. I am on a mental health care plan to see a psychologist, which is great, although there is a gap. Mental health plans work quite well if you just have mild to moderate illness but not for the low prevalence disorders. It would be really useful if people with enduring mental illnesses were provided with more subsidised appointments. This seems logical because not all groups have the same needs. With the psychologist I space out my appointments—not based on clinical need—to make sure I don't run out before the end of the year.

There is another unintended consequence of the way health care is funded. My GP, psychiatrist, psychologist and diabetes educator don't speak to each other so I don't really get co-ordinated care and the cross fertilisation of ideas. I don't blame them for this as they are incredibly busy and there is nothing in the funding system that encourages them to talk to each other and share information. Fee for service pays for individual service, not linkages or case coordination. I am the linkage, but when I'm really unwell it is difficult to fulfil this role adequately.

The RANZCP should be congratulated for looking at these issues and I'd like to see more opportunities like this for consumers to be involved in co-producing position papers and research. We have special insights based on our day-to-day experiences. We need to get the system to work better for all of us. Allowing politicians to set the agenda based on budget concerns rarely results in equitable or innovative solutions.'

Case Study 2: Jaisen

'I'm married with three kids and living with my family in a regional town. I'm on the Disability Support Pension and also do both paid and voluntary work part-time. My wife is on the Carer Allowance. We are paying off our house but if our health care costs go up we may not be able to afford our mortgage payments.

I have a complex mental illness diagnosis, including bipolar disorder, anxiety and post-traumatic stress disorder. I also have a degenerative spinal condition and diabetes. I take a number of different medications for my mental illnesses as well as prescription pain-relieving drugs for my spinal condition.

My GP bulk bills, which is brilliant, but we do face a lot of other health care costs. My medication costs are high until we reach the PBS Safety Net, which we generally do after about six months. I also need regular X-rays, CT scans and blood tests, which also incur fees.

Two of my children are on the autism spectrum, one with Asperger syndrome and one with high-functioning autism. They need specialised psychology services, which are very difficult to obtain in my town and cost around \$600 a visit, since we have to pay for travel costs. We received some limited funding (for only one of the children) from the government for this but it ran out very quickly.

I have some dental problems but have to rely on the public system for treatment which can involve waiting months or years. Recently I had a bone spur in my mouth that was rubbing against my tongue and I just pulled it out myself. Luckily our kids are covered by school dentistry so we don't have to pay for them.

Transport costs add to our health care expenses. We have a car and drive to most of our appointments, which means \$1.80 an hour for parking. We often have to pay this twice as we need to go to the doctor and then drive to the pathology centre for blood tests. My wife needs to accompany me to appointments because I forget details, like what medications I am on, so depending on whether our kids are in school or not, we may also need to pay for childcare.

Often we need to see specialists who are not available in our town. This involves a trip of two hours each way to the nearest regional centre. That involves petrol money plus parking and any other expenses we incur while we are there.

We can't afford private health insurance and are just scraping by with our current health care expenses. If

they go up we will have to give up some things that we think of as essential, such as life insurance, and cut our food budget. We may also lose our Family Tax Benefit A because of changes in the Budget, which would reduce our income further.

We're really anxious about any increase in our health care costs and all this stress can make my conditions worse. I run two parenting support groups, one specifically for parents of children with autism, and if I become unable to run these any more due to my stress levels, these groups would not function and parents who need support would miss out. When I get depressed and anxious it also really impacts upon my wife and kids. My wife can't leave me alone at all and has to go everywhere with me as I have a history of self harm.

I think these policies are the worst ones ever. They are taking away from those most in need and driving people into criminal behaviours like taking drugs and stealing. I don't think they should introduce any increased payments for people on low incomes. If they need to, there should be only one payment for the GP and no extra payments for any extra services, such as pathology tests. They also need to make sure that GPs and psychiatrists keep bulk billing because otherwise it would be impossible for people on low incomes to afford these services.'

Case Study 3: Amber

'I'm a single woman, living alone in a rented house. I work and study part time and am also on the Disability Support Pension. I have a serious and long term mental illness as well as diabetes and asthma.

I see a range of health care providers, including a GP and psychiatrist regularly. I am on ten different medications and also require regular pathology tests. Fortunately both my GP and psychiatrist currently bulk bill so my main health care expenses are my medication and any allied health services that I need, such as dentistry. Most of my medication is on the PBS but some—such as Vitamin D supplements—I have to pay for. I have private health insurance only for extras as it helps me afford dental services and any other allied health care that I need. I would like to have hospital insurance but I can't afford it. I don't have a car and take public transport to go to medical appointments so my main additional expense is my bus fares.

Currently, I can just manage my health care expenses if I budget carefully. However, if the additional co-payments go through I estimate that it will cost me an extra \$60 per month in health care costs, which I will struggle to afford. It is very stressful worrying about how I will manage these expenses and I will have to look at cutting back in other areas, like buying only the cheapest types of food and not buying any clothes.

I am also worried because I currently get the Pensioner Education Supplement which is likely to be abolished. This will make it impossible for me to continue studying and means that I won't have as many opportunities to find employment in the future. I think it's really unfair of the government to take away a crucial support for people who are getting skills and qualifications so that they will not have to rely on the DSP in the future.

The stress of worrying about health care costs makes my mental illness worse and also affects my diabetes and asthma. I have been hospitalised before for both mental health issues and severe asthma. Keeping up with my medications and reducing my stress helps me stay out of hospital and get on with my life. I can see this Budget driving people like me away from education and from seeking employment and back into hospitals just because we can't afford to keep ourselves healthy any more.

I don't think the government should make medicines any more expensive than they already are. For people on multiple medications, like me, even a small increase adds up really quickly. I also think that if they are going to introduce a co-payment it should be only one payment for all the services people need. We shouldn't have to pay for the GP visit and then also for medication and pathology as for people with serious illnesses these costs add up quickly. I also think they definitely shouldn't get rid of the education payment for people on the DSP. This is crucial for supporting people with disabilities to get some skills to enter the workforce and not be reliant on social security over the long term.'

Case Study 4: Kate

'I am 71. I have been a teacher and a public servant. I am retired, I own my house and I live on my own. I have some super and am also on a part pension.

I am the President of Mental Health Carers Australia and advise governments on a range of policy issues relating to mental health. I also talk to families of people with a mental illness all the time.

My son is 37 and has bipolar disorder. He is quite high functioning and has a PhD and is good at research and writing. He doesn't live with me but I help him and his family out financially in quite a major way. I have bought them cars and I just help them out with things so they can manage things. He is separated from his wife and two children and the cost of living is quite high.

My son's main source of income is the DSP. He does get some work writing and researching from time to time but it is very difficult for him to find work, particularly since the funding to universities has been cut.

My son is very lucky to have a bulk-billing GP. He needs to see the GP once a month and needs a referral to have blood tests for his lithium levels at least once a month. He is on three or four medications. As his GP visits and pathology are bulk billed, the main expense is the medication.

He doesn't have private health insurance as it is too expensive. If he needs to be hospitalised, which he has been many times over the years, he relies on the Royal Hobart Hospital. As he doesn't have health insurance, visits to the dentist are prohibitively expensive, so he never goes. I couldn't tell you the last time he went to the dentist.

A few years ago he was quite overweight and pre-diabetic but he is an amazingly disciplined person and just stopped drinking and lost the weight and his physical health is not bad at the moment.

At the moment we are just managing. His health is OK, with some financial support from me, he is managing, but we are living at the edge really, there is not much extra at all. I am on a fixed income and also need to look after myself and maintain my house.

Any extra health care costs would be a complete disaster for us and would impact on me and his ex-wife and his family. He will have to pay \$7 extra to see a GP, which is a huge expense for someone in his position. He will also have to pay \$6 for pathology and extra for medications.

The thing I worry about is that this is a barrier and a disincentive for him to go to the doctor. He already finds it quite onerous to go to the doctor once a month and have the blood tests, and the co-payments for GPs and for pathology will be a barrier to him going. Monitoring the lithium levels is really quite essential to him staying well. So I can see that he won't go to the doctor and he gets ill again and has to be hospitalised.

It is really very stressful when he is ill, so stressful it undermines my own health. I also have to pick up some of the things that he does, like look after the kids. It means that I have less time for all the other community and advocacy work that I do.

Last year, he had to move in with me for a while and it was really not good for either of us. The risk is that he would have to live with me again and it would be terrible for both of us.

Any additional cost of health care would be really, really problematic.

I don't find any of the safety nets that accessible and to be honest with you, my son is an adult, he is not on my Medicare card and he would need to register for the Safety Net himself. I want to preserve my relationship with him and so I am careful not to interfere all the time.

Having said that, I am pretty sure that he hasn't registered for the Safety Net. The more complex these things are, the less likely it is that consumers will work it out and there is no assistance to help them to do it.

I strongly feel that there shouldn't be any additional co-payments, particularly not for people with a mental illness. Any access to health care really should be as easy as possible and there should be no disincentive for people with a mental illness to seek help. The pathway to getting help should be really clear and we shouldn't be putting a barrier like cost in people's way.'

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