

Minding the Gaps

Cost barriers to accessing health care for people with mental illness



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

Foreword



The Royal Australian and New Zealand College of Psychiatrists has been aware for some time of the very serious problems faced by people experiencing the combination of mental illness and various physical health conditions. These are amongst the most significant causes of disability and reduced life expectancy in Australia and New Zealand. The reasons are diverse including lifestyle, medication side-effects, stigma and difficulties in accessing appropriate medical care. Responding to this multiplicity of factors is core to good psychiatric care. The problems faced by our patients are especially concerning because so much more can be done to help.

In addition of course to the role we have in directly providing high quality care, which remains a top priority for us, as psychiatrists we have a much broader brief. In our professional roles we have responsibility for providing leadership of mental health care, for teaching and training, for research and for advocating for better psychiatric health and for better care for the community.

This advocacy role is important, both when on behalf of a single patient, and where necessary to drive systemic change. This change may be in the realm of direct care, but in a modern medical system there is no denying the importance of a holistic client centred approach which recognises the many barriers that exist to good health. Affordability is a key challenge even in countries like New Zealand with a strong health system and a universal health care ethos.

This report is the second in a series (available on the RANZCP website) which aim to engage clinicians, health professionals, government and the wider community through policy review, economic modelling, case studies and consultation around the issues facing people with severe mental illness. It includes quotes and stories from people with mental illness about their experiences, and lessons for as well as teachings from, psychiatrists about better mental health care and recommendations for health policy.

In the future we hope to improve the situation for people with mental illness and reduce the impact physical health conditions have upon their life enjoyment and expectancy. No one should be asked, as we are told on page 22, to choose between their quality or their quantity of life.

A handwritten signature in black ink that reads "Murray".

Dr Murray Patton

President

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists

Our Vision

To enhance the mental health of our nations through leadership in high quality psychiatric care.

Our Values

Collaboration
Excellence
Integrity
Respect

Compassion
Innovation
Sustainability

Our Purposes

Advance the profession

A commitment to advancing the profession of psychiatry by facilitating the provision of high quality psychiatric care through the delivery of training and continuing medical education.

Improve the mental health of the community

A consultative approach to improving the mental health of the community through collaborative working models to better support mental health services.

Meet the needs and expectations of the membership

A dedication to meeting the needs and expectations of the membership to ensure the future growth of the College and enhance the collegial spirit.

Enhance external engagement and relationships

The enhancement of external engagement by building domestic and international relationships, to strengthen the College's influence and leadership across the mental health sector.

View our full Strategic Plan for 2015–2017 online at www.ranzcp.org/strategicplan

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Minding the Gaps:

Cost barriers to accessing health care for people with mental illness

A report prepared for the Royal Australian and New Zealand College of Psychiatrists

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About psychiatrists

A psychiatrist is a specialist medical doctor who assesses and treats people 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), psychologists and other health professionals, case workers and peer workers from non-government organisations 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 is concerned about the high rate of physical illness among people with mental illnesses in Australia and New Zealand (as well as other developed countries). This co-morbidity compounds the disadvantages already experienced by people with mental illnesses and is associated with a far shorter life expectancy. 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).

Research was conducted recently in New Zealand among women diagnosed with breast cancer who had been in contact with a mental health service. It was found that women with a diagnosis of psychosis were two and half times more likely to die from their illness than the general population (Cunningham 2010). Excess mortality among people with severe and persistent mental illness is a consistent finding from 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 the general population. This will require a collaborative effort from a broad range of stakeholders involved in mental health, including governments, consumers, health care providers and psychiatrists.

Psychiatrists play a key role in the provision, management and coordination of care of people with mental illnesses. Psychiatrists are also responsible for providing clinical leadership, teaching and training, researching, and advocating for better psychiatric health in the community. As such, we are committed to working within our profession to drive positive changes that will improve the care of people with mental illnesses in New Zealand.

This paper is one in a series of papers that will examine the barriers to health care for people with mental illness and other physical illnesses, and look at 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 in New Zealand. A similar paper has also been prepared looking at cost barriers to accessing care for people with mental illnesses in Australia.

This report was developed by consultants from Lucem Consulting under the guidance of the Board of the RANZCP and with the involvement of psychiatrists and consumers. Particular thanks go to Dr Murray Patton, Dr Margaret Aimer, Dr David Codyre and Dr Erik Monasterio for their input, and also to Claire, Gary, Graham, Brody and Sheree for sharing their expertise and experiences.

For more information relating to this report contact:

The Royal Australian and New Zealand
College of Psychiatrists Head Office
309 La Trobe Street, Melbourne, Victoria 3000
Telephone: +61 3 9640 0646

or RANZCP's New Zealand National Office
PO Box 10669 Wellington 6143
Telephone: + 64 4 472 7247

Email: ranzcp@ranzcp.org

Executive Summary

It's important to see how mental and physical health are linked. You have to have hope in the future in order to be healthy and often people with mental illnesses – particularly those in residential care – sometimes lack hope.

Claire – mental health consumer

In New Zealand, as in other developed countries, people with mental illnesses experience significantly higher rates of premature mortality and morbidity than the general population. This is associated with multiple and inter-related causes, including lifestyle factors, the side effects of medication, and stigma and discrimination within the health sector. Cost barriers to accessing care and other financial and funding issues are one factor that can affect the treatment received by a person with a mental illness and the outcomes of that treatment.

It is critical that people with mental illnesses are able to access all forms of mental and physical health care that they require to maximise their wellbeing. New Zealand provides a high rate of subsidy for many mental health services and treatments, including psychiatry in the secondary and tertiary care sectors. However, there are still gaps in accessing care for some people with mental illnesses, in particular those with more serious and complex mental health problems living in the community. The most significant is the relatively high cost barrier to accessing GP services, in particular for an initial diagnosis.

Lack of identification of multi-morbidities in primary care can contribute to inadequate monitoring and management of conditions and treatments including medications. A lack of timely and appropriate medical care can result in the deterioration of preventable and/or treatable mental and physical health problems or contribute to these, potentially requiring hospitalisation or other increased service use (Mitchell et al, 2012). There is evidence that better management of people with multi-morbidities in primary care can improve self-management of conditions, prevent hospital admissions and reduce costs (Katon, et al 2010, Morgan et al, 2013; Codyre 2015). Reducing the cost barrier to accessing GP services and improving current funding systems to support the delivery of high quality, accessible and comprehensive care for people with mental illnesses should be a priority.

New Zealand's regionalised system of health funding and service provision, where priorities are set through District Health Boards (DHB) and funding provided to address health needs in particular communities, has both strengths and weaknesses. On the one hand it can encourage innovation and locally tailored solutions and there are excellent models of this in New Zealand. However there are also geographical inequities in the availability of and access to high quality services reflecting local priorities and resources, including the availability of an appropriately skilled workforce. In addition there are few mechanisms to ensure that treatments and programs are all based on the best evidence and that 'best practice' models and knowledge are shared between different DHBs. People who have complex physical and mental health needs may be hard to reach and engage in treatment and can easily be overlooked unless DHBs have a specific focus on reaching this group and engaging them in treatment. Importantly, there is no consistency between different districts and the appropriateness and affordability of care can vary significantly.

This paper is one of a number of policy papers that the RANZCP will produce on the issue of physical and mental health and the policy recommendations presented here should not be seen as a comprehensive solution to this multifaceted and complex issue. However, it is clear that some changes would make the system more affordable and accessible for people who are struggling with both physical and mental illness.

Firstly, there needs to be a clear focus on improving the health outcomes for people with co-morbid physical and mental illness at both the national and regional level. While there has been concerted energy and investment into mental health policy and programs since the early 2000s this focus seems to have waned in recent years and people with serious mental illness are still struggling with poor physical health and a life expectancy that is up to 30 years behind that of the rest of the population.

Leadership from the Ministry of Health and District Health Boards in setting targets to improve system responsiveness and health outcomes for people with both physical and mental health would be invaluable. Mechanisms to evaluate innovative developments at service level and to disseminate 'best practice' models would also be helpful, as would better data at both the district and national level.

The cost of care for consumers is a key issue, particularly at the level of general practice, and the funding system should support GPs to actively manage chronic health problems amongst people with both physical and mental health issues. The cost to consumers should also be contained.

There is good evidence about the value of integrated and collaborative care services for improving both the physical and mental health of people with multi-morbidities. These include models which include use of peer workers in a variety of capacities such as working with consumers in validated programs to protect and maintain their physical health, including those who may be disengaged or hard to reach. These service models are important 'seeds of the future' and should become a key component of the suite of services offered to people with serious mental illness.

A funding loading for all mainstream health programs (eg smoking cessation, fitness programs) to specifically target these programs to people with mental illness would be valuable.

Finally, the RANZCP recognises that affordable healthcare is just one dimension of a complex issue that will require not just funding but commitment and cultural change from various players within the mental health system, including psychiatrists. In this context, the 'Equally Well' project which has initiated discussion and engagement around this issue is most welcome.

The RANZCP has role to play in ensuring that psychiatric practice is responsive to this new agenda and that the best evidence based programs are supported and disseminated. We are committed to working collaboratively with clinical colleagues, consumers and others within the mental health and health sectors to develop and advocate for solutions. Most importantly, the RANZCP would like to see actions that will start to turn around the appalling health outcomes for people with serious mental illness.

Methodology

This report was developed using the following methodology:

- Literature review and analysis: a review of key relevant literature from New Zealand and international sources relevant to this issue.
- Policy landscape: an assessment of the current policy landscape, in particular the recent cross-sectoral initiative being led by Te Pou, 'Equally Well'.
- Interviews with key stakeholders, including clinicians, peak bodies, consumer representatives and service providers.

Background

Mental and physical health needs are intertwined – the health system needs to address them both and should not treat them as separate. However, many [mental health] clinicians don't take that holistic view and don't consider physical health needs to be as important.

Gary – mental health consumer

In New Zealand, as in many other countries, people with mental illnesses are at a significantly higher risk of premature mortality. While research in the New Zealand setting is limited, a recent study found that men and women using mental health services in New Zealand have more than twice the risk of death when compared with the New Zealand population after adjusting for age (Cunningham 2014). Men and women with psychotic disorders were found to have an even higher mortality rate – three times that of the general population. The study also found that Māori using mental health services have higher mortality compared with the Māori population as a whole, but that the life expectancy gap was smaller than it was for non-Māori (Cunningham 2014).

Earlier research also looked at outcomes for women diagnosed with breast cancer who had a history of mental health service use. It found that these women were nearly twice as likely to die from their cancer compared to other women, after adjusting for confounding by age and ethnicity. Outcomes were particularly bad for women with a diagnosis of psychosis who were found to have two and half times the risk of death compared with the general population. Women with another mental health diagnosis (or no diagnosis) were found to have one and a half the general population's risk (Cunningham 2010).

The causes of this premature mortality are not straightforward and include multiple, complex and inter-related contributing factors (Wildgust et al. 2010). Some of these are directly related to underlying mental illness. For example, there is good evidence that suicide and accidents are important contributors to the high death rates (Cunningham 2014). However, research has shown that, among people with serious mental illness, the major cause of premature death is from potentially avoidable physical illnesses such as cancer and cardiovascular disease (Cunningham 2014).

Some of the causes may be directly associated with treatment for mental illness. For example, the increased risk of death from cardiovascular disease is likely to be caused, at least in part, by the use of antipsychotic medications, which have adverse metabolic and cardiac effects (Newcomer 2007). A recent international review found that monitoring of the side effects of psychiatric drugs tends to be inadequate (Mitchell et al. 2012b). This was confirmed anecdotally to be the case in New Zealand in the stakeholder interviews undertaken as part of this project.

Other risk behaviours for cancers and cardiovascular disease, such as smoking (Aubin 2012) and unsafe alcohol use, have also been found by research to be more prevalent among people with mental illnesses (New Zealand Health Survey 2006–07). However, the New Zealand Health Survey also found that alcohol consumption patterns vary significantly across the population of people with mental illnesses, including different consumption patterns in Māori communities, and that the rate of abstinence from alcohol was significantly higher among people with mental illnesses.

There is also evidence from other countries that people who use mental health services are less likely to receive appropriate treatment for their cardiac disease (Mitchell et al. 2010). While this has not been documented in New Zealand, there is some evidence of discrimination by health services towards people with mental illnesses that may result in a lower quality of care. For example, a study by Wheeler (2014) found that 18.4% of people with a mental illness reported that they had received less care because of their illness, due to discrimination and/or communication issues.

Discrimination has been shown in international studies to result in a lack of adequate preventative care or treatment for physical health problems for people with mental illness (Lawrence et al. 2010). Discrimination by health service providers has been reported by people accessing mental health services internationally, including in New Zealand (Peterson et al. 2007). While there is no specific data on discrimination within psychiatry in New Zealand, interviews with consumers and clinicians confirmed that both groups were aware of attitudinal barriers across the spectrum of the health system affecting the care provided to people with mental illnesses. As a peak psychiatry body, the RANZCP is committed to addressing stigma and discrimination, and to working collaboratively with consumers and other health care groups to eliminate attitudinal barriers to the provision of high quality and comprehensive care to people with mental illnesses.

Other important issues are cost barriers to accessing care and other financial factors affecting treatment outcomes. These can occur in relation to the direct costs of health care and also indirect costs, such as a forgone salary for a person no longer able to work due to their illness. While this paper focusses on cost barriers to care and other funding issues related to the provision of health care for people with mental illnesses, these need to be seen in the context of other factors influencing access to care for people with a mental illness. These factors do not operate independently and in many cases can interact to compound the disadvantages this group of health consumers face within the New Zealand health system.

Policy landscape

Mental health care can feel like chronic suicide. The drugs and the illness take a toll on your physical health but it's like a permanent holding pattern with no-one focussing on getting you well. As long as I kept taking the medication and didn't cause problems, they would have been happy for me to sit on the couch for the rest of my life waiting to see my key worker every couple of weeks.

Brody – mental health consumer

The health care system of New Zealand has undergone significant changes over the past two decades, evolving from a national, fully public system to the regionally based mixed public-private system that exists today. Central to the structure of the New Zealand health system are the 20 District Health Boards (DHB), which are funded by the Ministry of Health. DHBs are responsible for organising health care in each district and meeting the standards set by the Ministry of Health. The boards for each DHB are elected every three years, with the exception of one of the eight board members, who is appointed by the Ministry of Health.

The DHBs oversee the Primary Health Organisations (PHO), which cover the entire country. These were established in 2002, with a mandate to focus on the health of communities. There are currently 46 PHOs (there were originally 81). They are funded by DHBs and are required to be entirely non-profit, democratic bodies that are responsive to their communities' needs. Almost all New Zealanders are enrolled in a PHO.

Reforms to the system of mental health care have also occurred over this period with a significant investment being made in the area of mental health. These reforms have included the introduction of a number of targeted programs to address the specific needs of people with mental illnesses. These include Primary Mental Health Initiatives; E-therapy for adults – *Beating the Blues*; best practice depression guidelines in primary care; depression Electronic Decision Support Tool (e-DST); the National Depression Initiative; and suicide prevention programs.

However, despite these interventions, people with mental illnesses still experience problems accessing adequate mental health care and higher rates of physical illness, including higher mortality rates, than the general population.

This issue has recently received attention at a policy level and has been identified as priority in both *Blueprint II* (Mental Health Commission 2012) and *Rising to the Challenge* (Ministry of Health 2012). Key strategies identified in these policies to improving both mental and physical health outcomes for people with mental illnesses include:

- wellbeing programmes targeting people with mental illnesses, including smoking cessation support and physical health monitoring processes
- improvements in collaboration and integration between primary and secondary health care sectors
- early intervention in psychosis services to help young people manage the weight gain that is associated with antipsychotic medication.

In this policy context, the Equally Well initiative has been developed by the Platform Trust and Te Pou o Te Whakaaro Nui (the National Centre of Mental Health Research, Information and Workforce Development). This initiative has included the development of a comprehensive literature review of research on the physical health of people with mental illnesses, and an assessment of the evidence for interventions in this area (Te Pou 2014b). A consensus position paper (Te Pou 2014a), based on the literature review, was then developed in conjunction with a number of stakeholders, including the RANZCP. This paper called for people who experience mental illness and/or addiction to be identified at a national policy level as a 'priority' health group across the whole health system, requiring specialised and properly resourced interventions in relation to their physical health.

This was followed by an inter-disciplinary summit on 10 November 2014, which was attended by more than 100 people from across the health and mental health sectors. The summit explored the health and physical disparities between people who experience mental health and/or addiction issues and the rest of the population. The consensus position paper was endorsed by more than 30 national bodies attending the summit, and a framework for collaborative action has been developed to coordinate action in this area (Te Pou 2015).

Both psychiatrists and consumers interviewed for this project reported that they strongly supported the aims of this project and its inter-sectoral and collaborative approach to addressing the multiple areas of disadvantage within the current system.

Financial issues affecting people with mental illness

Overall, people with mental illnesses are at a significant financial disadvantage compared with the general population.

There are a number of reasons for this:

- People with mental illnesses have lower than average incomes, largely due to the difficulties of obtaining and keeping a job while managing the symptoms of a mental illness.
- People with mental illnesses have higher than average needs for medication and treatment for both mental and physical health issues, which can result in higher health care expenses.
- Many people with mental illnesses also have an addiction to tobacco, alcohol and/or illicit drugs, which results in a high level of expense.
- Discrimination against people with mental illnesses can make it more difficult for them to find housing, resulting in higher housing costs.
- Many people with mental illnesses live in temporary or unstable housing where they are unable to prepare low cost meals and therefore have to pay higher prices for food.
- Many people with mental illnesses are not able to fulfil the administrative requirements to access subsidies for people on low incomes (for example due to cognitive impairment or other lifestyle issues) and therefore face higher costs when accessing services.

The overall impact of this financial disadvantage is that people with mental illnesses face a number of cost barriers to establishing and maintaining healthy lifestyles, including the challenges of being able to afford adequate housing, food, health care and medical services.

While a shortage of mental health specialists and other health professionals has been identified as creating a greater access barrier for some than cost issues, these two issues should not be seen as separate. For example, overall workforce shortages allow providers a greater choice of location for their work, which can result in an undersupply of providers in disadvantaged areas. For the significant proportion of people with mental illnesses who live in disadvantaged areas, this creates a dual access barrier of higher costs and fewer providers.

Costs associated with mental health care

If you are on a pension of \$145 a week then \$35 to see a GP is impossible to manage.

Claire – mental health consumer

People with mental illnesses typically incur costs directly associated with their illness as well as expenses that are indirectly associated with having a mental health problem (discussed in the next section).

New Zealand has a public health care system in which primary care attracts a part-charge at the point of access, but all public secondary services, including mental health care, are provided free of charge. Despite this high level of public funding, many people with mental illnesses still face cost barriers to accessing appropriate care. These barriers vary geographically and across population groups.

Most mental health care, particularly for those with more severe illness, is provided by the public and not-for-profit sectors, and is increasingly provided in the community. Public services were previously designed to cater for the 3% of the population with the highest mental health needs (Ministry of Health 1997). However, in recent years their focus has broadened to include the treatment of mild and moderate mental health disorders as well as prevention and early intervention services (Mental Health Commission. 2012). There is no comprehensive data available on the out-of-pocket costs faced by people with mental illnesses accessing health care (see additional research proposed in 'Recommendations' below). However, the stakeholders interviewed as part of this project identified a number of costs typically encountered in the process of receiving health care, many of which were seen as a barrier – or potential barrier – to accessing care.

This is supported by the findings of the most recent New Zealand Health Survey (2006/2007) in which around one-third (32.7%) of people with a mental illness surveyed identified cost as a barrier to accessing a GP when needed.

This was higher than that of the general population, although a significant number of this population (26.6%) also nominated cost as a barrier. Interestingly, the survey also found that people with a mental illness were more than four times as likely to identify 'lack of transport' as a barrier to accessing mental health care (17.4% compared with 4.1% of the general population). This is likely to be due to financial issues, as a lack of transport is strongly correlated with a low income and financial stress. The importance of affordability of care to people with mental illnesses was also highlighted in a recent New Zealand study (Wheeler et al. 2014), which reports that 19% of people with a mental illness stated that a reason for choosing their primary health care provider was cost, compared with 6% of the general population.

These findings are reflected in a report from the Commonwealth Fund that compared cost barriers to access to care across a number of OECD countries (Commonwealth Fund 2010). The report found that over one-quarter (26%) of adults with a chronic illness reported cost-related access problems in the 12 months prior to the survey. This was high by international standards, and higher than comparable English-speaking Commonwealth countries including the UK (11%) and Canada (20%). In fact, 18% of New Zealanders surveyed reported that in the past 12 months they had a medical problem but did not visit a doctor due to cost issues. This was higher than any other country surveyed, apart from the USA.

Cost-related access problems in the past year

Percent	AUS	CAN	FR	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
Did not fill prescription or skipped doses	18	15	11	14	8	12	7	7	9	4	30
Had a medical problem but did not visit doctor	17	7	10	12	7	18	8	6	11	7	29
Skipped test, treatment, or follow-up	19	7	9	13	8	15	7	4	11	4	31
Yes to at least one of the above	30	20	19	22	15	26	14	11	18	11	42

Source: 2011 Commonwealth Fund International Health Policy Survey of sicker adults in eleven countries

General practitioners

It is important that health professionals know how to build rapport with mental health consumers and have the time to do this so that they can address physical health issues in a way that maintains their relationship. There is a really fine line between bringing someone's weight to their awareness and adding to the shame many people already feel about their mental illness.

Sheree – mental health consumer

Most often the main cost barrier to accessing health care for people with mental illnesses that was identified by stakeholders was the cost of visiting a general practitioner (GP). The cost of this varies according to the provider, their location and the individual consumer, but it can range from \$15 to \$70 for adults (visits for children are free). There are subsidies for people on low incomes (Community Services Card [CSC] holders) but a co-payment is still required. Some subsidies for people on low incomes and frequent users are provided. These are discussed in more detail below.

GPs are critical health care providers for people with mental illnesses. They are often the first point of contact with the health system and act as a gateway to other sectors, such as secondary and allied mental health care. GPs also play an important coordinating care management for people with mental illnesses whose care is being provided in the community. For people with a serious mental illness, GPs play a vital role in helping them to manage both their mental and physical health and, importantly, to manage the side effects of psychotropic medication. However achieving the most health impact in primary care may require innovations in models of service delivery to meet the needs of this group (Smith et al, 2012). There is increasing evidence of the effectiveness of primary care-based models of integrated and collaborative care in addressing multi-morbidities including amongst people with serious mental illness (Katon et al, 2010).

PHOs and general practices are funded via a blended payments system, including fee-for-service with patient co-payments (up to half of the cost of a GP visit), plus capitation via payments, based on the numbers of the enrolled PHO population. This means that a significant component of funding for PHOs and their general practices is based on the number of people enrolled, not the number of times a provider sees patients. While there is some evidence that capitation-based funding systems benefit people with chronic disease through providing incentives to improve long-term management of conditions (Bodenheimer 2002), their capacity to provide high quality and comprehensive care relies upon a funding formula that accurately reflects the increased level of care required for complex patients.

Currently the funding system in New Zealand does not include people with serious mental illnesses as a specific group attracting additional funding, despite the high level of complexity involved in providing them with comprehensive

mental and physical health care. Adequate funding for the provision of primary health care and for the effective integration of primary and secondary care is essential in order to improve both the timeliness and effectiveness of care provided to people with mental illnesses. In particular, it is crucial for the funding system to support close collaboration between GPs and psychiatrists. In some cases for instance very complex patients can require weekly case conferencing with both a psychiatrist and the treating GP to appropriately manage their care, and that this is very difficult within the current funding and caseload structure.

There are also a number of barriers to people with mental illnesses accessing GP services, for both mental and physical health care. Most New Zealanders are enrolled with GPs who are part of a PHO. People enrolled with a practice usually pay a lower fee when visiting a GP than those who are not enrolled. Enrolment with a specific practice can be difficult for some people with mental illnesses, in particular people who have unstable housing or who are homeless. They find it difficult to fulfil the administrative requirements and may change locations regularly. Stigma and discrimination by some GPs and practice staff can also make it difficult for people with mental illnesses to enrol with the practice most convenient to them. Typically GPs and practices differed significantly in the quality of care they provided to people with mental illnesses. Often support workers, and their clients with mental illnesses, got to know the GPs who had a particular commitment to working with this patient group and would gravitate to them. Depending on their location, this can mean increased transport costs when accessing these services.

Some general practices focus on meeting the needs of particular disadvantaged groups, including homeless people, and those with addiction issues. These practices can provide people with mental illnesses with free or low cost GP services and can help reduce the barriers to accessing care. However, these practices are mostly located in larger urban centres and are not easily accessible for many people with mental illnesses.

One psychiatrist commented that the variation in quality of care across the primary care sector was a significant cause of frustration. 'Ideally, every patient should receive the same level of care from every GP and primary health care team. However, in my experience it can be a bit of a lottery as to where patients end up. This is an equity issue for consumers and does not reflect well upon our system as a whole.'

There are some programs that support GPs to provide services to people with mental illnesses in the community and reduce or remove the out-of-pocket costs incurred by patients. For example, a program in the Wellington area subsidises GP services for people with mental illnesses who have been discharged from hospital or another mental health facility. This program pays the GP and there is no cost to the patient. While the aim of this program – to reduce cost barriers to accessing care – is strongly supported, the overall level of funding for it was seen appears inadequate. One GP reported receiving only an additional \$97 per year to manage the care (in conjunction with a team) of a person with a psychotic mental illness who had complex mental and physical health needs and needed to be seen by her at least once a month.

Ensuring timely access to GP care for people with mental illnesses or those who may have the symptoms of a mental illness is essential in order to provide appropriate diagnosis, early intervention and treatment services. Cost barriers to accessing care can result in people with serious mental illness delaying seeing a GP until their symptoms, whether related to physical or mental health, have become more severe. This may mean that their condition becomes more serious and requires longer term and/or more intensive treatment. A number of stakeholders interviewed said that it was very common for people with mental illnesses to delay seeking treatment until they were in a 'crisis' situation. One psychiatrist noted that, by the time people are seen by psychiatrists, their condition may have deteriorated to the point that they require hospitalisation. Earlier intervention by a GP may have prevented this from occurring.

Another issue mentioned by stakeholders was that funding for primary care is capped and programs can be limited, regardless of demand. Also, funding for programs and services targeting people with mental illnesses can be reduced or removed if funding runs out. For example, a program run by the Capital and Coast PHO offers six free sessions with a psychologist (on the recommendation of a GP) for people with less serious mental health problems (mostly mild depression and anxiety) to access cognitive behavioural therapy. However, funding for this program is capped and once it reaches its annual limit no more services are funded. This can create a 'timing lottery' for people accessing some publicly funded programs and services. Some of those most in need of this service may miss out, depending on when in the funding cycle they try to access care.

A number of the programs available are specifically targeted at people with less serious mental health conditions which whilst valuable appears counterintuitive to the need experienced by people with serious mental illness. There are some programs, such as the 'green scripts' initiative, which enable GPs to provide subsidies for lifestyle-related assistance (for example, gym memberships or vouchers for visiting public pools). These programs have a broad target group, but may not be suitable for most people with serious mental illnesses as they do not provide the level or type of support required to promote lasting changes in their lives. Similarly, the program run by Capital and Coast DHB to support GPs to manage the care of people with mental illnesses in the community does not pay GPs for the level of care required to provide quality care to people with complex mental illnesses.

There are limited examples of evidence-based programs with positive outcomes that support people with mental illnesses to develop a healthy and active lifestyle and become active partners in managing their illnesses. One example is the *My Health, Our Life program*, based on the Chronic Disease Self-Management Program (CDMSP) developed at the Patient Education Centre at Stanford University, run by East Tamaki Healthcare (this is described in more detail in the case study on page 19). However, there is no mechanism at the national level to identify these programs and promote their translation into other settings.

Although costs were not the only access barrier identified by the health care providers interviewed, affordability issues were thought to be a significant factor for many of their clients. Cost barriers to accessing care or inadequate funding of services can also result in a focus on the most immediate or urgent symptoms and restrict more comprehensive models of managing chronic illness. The consequence may be that there is a lost opportunity to more actively manage 'non urgent' health to prevent serious problems from developing.

There is no available research on whether access barriers to GP care result in increased hospitalisations for mental health problems. However, delaying access to care to the point where conditions which were previously preventable or manageable now require hospitalisation would represent an inefficient use of health care resource and impose significant additional health and social costs on the community.

Psychiatry

Psychiatrists need to be aware that they may be the only health professional that a patient may see for six months. Any health issue that needs to be addressed needs to be dealt with at that time.

Sheree – mental health consumer

Most psychiatry in New Zealand is provided by the public health system and is provided with no out-of-pocket cost to the patient. Private psychiatry services are not common and incur a cost of around \$180 an hour. In most part psychiatrists are employed by DHBs and provide both community-based and inpatient services and act as consultation/liaison for GPs, school and allied health/social service agencies. In the provision of primary mental health care, psychiatrists typically work as part of a team, either at a general practice, community health centre or mental health services, in conjunction with GPs, practice nurses, case workers and other care providers. The main access barrier to psychiatry has typically been due to a shortage of psychiatrists rather than cost.

However, while cost barriers to accessing psychiatrists were not identified as a major issue for most people with mental illnesses, a number of funding and clinical practice issues were identified as creating a barrier to improving the mental and physical health care of this patient group. In particular, a number of stakeholders discussed the need for a clearer articulation of the specific roles and responsibilities of each inter-disciplinary team member in providing care for people with mental illnesses. This was specifically the case for physical health needs related to treatment for a mental illness, such as psychotropic medication, where it was not always clear whether responsibility for monitoring and managing the physical health risks of medication use lay with the treating psychiatrist, the GP or elsewhere. In addition, funding arrangements to support the integration of secondary and primary mental health care were not always clear or were inadequate. This could create barriers to effective treatment, for example, if a psychiatrist was not funded adequately to provide services in a primary health care services where this was the most appropriate location for people with mental illnesses to receive care.

Allied mental health services

Psychology and counselling services are provided by DHBs as part of their primary mental health care services. Often these services are provided in conjunction with a GP and psychiatrist as part of a team-based approach to primary mental health care. For consumers with a mental health diagnosis and treatment plan these services are provided at no additional cost.

Others can access psychologists and counsellors outside of these programs but then incur the cost themselves. There are some private providers of these services but there is an overall workforce shortage and most have waiting lists. The cost for private psychologist and counselling services can be \$200–250 for an initial visit and \$100–150 for follow-up visits. However, some counselling is provided free (for example, for people who have been sexually assaulted or abused) and many workplaces provide a limited number of free counselling sessions for staff who are having personal or work-related difficulties under Employee Assistance Programmes (EAP). There are also some lower cost counselling services run by charities and/or religious organisations, but these are limited and often have long waiting lists.

Medicines

There is also some confusion about who is supposed to look after my mental and physical health – I've previously had conflicting advice from my GP and psychiatrist and also once ended up on mental health medication prescribed by my GP and physical health medication prescribed by my psychiatrist.

Claire – mental health consumer

Prescription medication is heavily subsidised via Pharmac and adult New Zealanders enrolled with a doctor in a PHO will usually pay \$5 per item for subsidised medicines from a community pharmacy. However, this may cost up to \$15 if the prescription is from a specialist, or if the prescription is not from the doctor they enrolled with. Prescription medicine for children under six is usually free. For some medicines, consumers also pay an extra part-charge. Some drugs are not subsidised at all, and must be fully paid for.

There are also some additional charges for medication incurred by some patients that are not included in the co-payment. For example, many pharmacies charge a fee to patients if a script is faxed to them by a GP or hospital. They also charge a fee for making up Webster packs (which is required by some institutions and respite care facilities). Non-prescription (over-the-counter) medicines must be paid for in full.

There is a subsidy scheme for high-level users where prescription medication is free once an annual threshold is reached. However, some people reported that even the low cost of medication could be a barrier to some people, in particular those with addiction issues. Service providers interviewed who managed CAT (Crisis Assessment Teams) reported that they were often required to pay for medication themselves because the patient could not afford to fill their script and they wanted to prevent them from having a further crisis.

Case study of innovative practice: The Kia Kaha program

In New Zealand, the Kia Kaha program, developed in primary care in Auckland as a collaboration between East Tamaki Healthcare and Counties Manukau District Health Board, works with patients with long-term conditions, most of whom are poorly engaged in planned healthcare, to address psychosocial needs, build self-management skills, and help these people engage as active partners in getting their health needs met. A significant proportion of service users have 'high psychological distress and high levels of psychosocial issues and complexity'. Recognising the high need for improved outcomes in this area, the Program had the ambitious target for its first year of achieving a 25% reduction in unplanned hospital and GP utilisation for 125–150 individuals with long-term medical and mental health conditions, who were frequent presenters in ED/inpatient care. The Program used improvement science methodology to implement into routine practise, two evidence-based interventions proven to improve physical health state and reduce healthcare utilisation – providing access to flexible packages of talking therapy/CBT, and the Stanford Self-Management Education programme (a manualised peer-led course comprising six two-hour sessions over six weeks). While those engaged in the program over the first months did indeed gain significant benefit, initially over 50% of those who met program criteria did not want to participate. A trial of flexible, peer-specialist outreach, engagement, and support, lifted this to over 95% of eligible people enrolling. The program is delivered in primary care by a team of four (1.5 FTE health psychologists, and 1.0 FTE peer specialists), supported by a consultant psychiatrist. In its first 12 months (July 2013 to July 2014), the Program achieved a 45% reduction in ED/admission rates for enrolled participants, and a 25% reduction in unplanned GP consultations, as well as significant reductions in symptoms of generalised anxiety and depression, and modest improvements in measures of physical health state (eg, weight, BP, HbA1c). The cost saving from reduced Emergency Department visits and admission rates has 'paid for' the programme in a little over a year, and it is expected that further savings will accrue over time. Through the 12–18 months follow-up post-intervention for the initial cohort, gains have been maintained and the ongoing trend is one of gains further improving with time. Feedback from participants has been uniformly positive, succinctly summed up by one who commented "... this program is frickin' awesome, it has given me back my life!".

(with thanks to Dr David Codyre for providing details of this case study.)

Pathology/radiology

Pathology and/or radiology tests ordered by the GP (for example, monitoring of medication levels) are provided at no cost to the patient. However, private radiology clinics charge for all tests undertaken, unless they have been contracted to provide them by a local DHB service. Breast screening is free for women aged 45–69 who enrol in the breast screening program. Cervical screening is free for women aged 20–70 who have ever been sexually active.

Blood tests are mostly funded by the DHB and will not usually incur additional patient payments. This means that for most people with a mental illness who are enrolled with a practice, there are no out-of-pocket costs for pathology and radiology required for treatment or screening purposes.

Dental

Dental services for adults are not universally subsidised and most people have to pay the full cost of their own dental care. Some DHBs may provide limited dental services, usually for eligible people on low incomes (this may mean having a CSC). Some hospital dental outpatient departments may provide emergency pain relief and tooth extraction for people on low incomes (usually CSC holders). A part-charge or fee may still be payable for these services.

Dental health is critical to the overall health and wellbeing of people with mental illnesses. Dental problems can significantly affect quality of life and adversely affect people's relationships and ability to cope with other challenging issues. Poor quality dental health can make it much more difficult for people to participate in the workforce and can also affect their self-image, social life and nutrition. Untreated dental decay can also result in more serious problems requiring hospitalisation, thus increasing overall health care costs. For example, gum disease has been shown to significantly increase the risk of cardiovascular disease. This is particularly relevant for people with mental illnesses who are on psychotropic medication and already face an increased risk of developing this condition.

Medical devices

Medical devices are a broad category of products including any instrument, apparatus, implement, machine, appliance, implant, software or material used in the delivery of health care. Medical devices used directly by consumers as part of self-management of illnesses and disabilities include inhalers for asthma medication, wheelchairs and other mobility devices, and hearing aids. The funding arrangements for medical devices in New Zealand vary significantly depending on the type of device and its use by consumers. A number of devices are subsidised by Pharmac and some are provided free of charge through targeted programs. Many of these programs are administered by Enable New Zealand, including programs subsidising wheelchairs, modified vehicles, hearing aids and glasses.

Of particular relevance to people with mental illnesses are the medical devices required for managing diabetes (particularly insulin-dependent diabetes). As discussed above, some medications used to treat mental illnesses have metabolic effects that significantly increase the risk of developing

type 2 diabetes. Managing diabetes, particularly once it has progressed to the insulin-dependent stage, typically requires a range of equipment, including blood glucose monitors, test strips and injecting equipment. These are subsidised through a range of different arrangements by Pharmac and in some cases are provided at no cost to consumers.

However, in reality, the funding arrangements are complicated and often have administrative requirements that can be difficult for people with serious mental illnesses to fulfil. This can create a situation in which 'on paper' consumers have access to the equipment they require to manage their diabetes but in reality they face a number of barriers to obtaining the benefits to which they are entitled.

Appendix A provides a more detailed description of the range of different types of equipment required by someone with diabetes and their funding arrangements, highlighting the situations in which consumers may incur out-of-pocket costs.

Non-medical costs associated with mental illness

In my role I have heard a number of reports of people with mental illnesses having their physical symptoms ignored because health care workers are focussed on mental health conditions. The problem is not a lack of services – it is the culture of the health system and the way the services are organised.

Graham – mental health consumer

The non-medical costs associated with mental illness can include a range of different expenses incurred as part of the process of accessing health care:

- 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 areas face significantly higher costs when accessing care than those in larger towns and cities.

Indirect costs that result from mental illness are often significant but are more difficult to identify and are often not included in assessments of the overall costs of these conditions. Indirect costs include forgone salary due to an inability to work, lost productivity to the community and 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.

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 with a physical illness or disability that also requires regular treatment.

Safety nets/subsidies

I have had to pay \$1000 out of my own pocket for tests recommended by my psychiatrist. This is very difficult to afford for someone on a low income.

Sheree – mental health consumer

There are a number of safety nets and subsidies in place to assist New Zealanders with a mental illness in affording their health care needs.

High-level users of medicines can apply for a Pharmaceutical Subsidy Card (PSC), which allows the cardholder and named family members to pay a lower amount on the government prescription charges after they reach a total of 20 prescriptions per year (non-income tested). To apply for a PSC, consumers must either use the same pharmacy each time for their prescriptions or keep prescription receipts and take this into a pharmacy that can issue PSCs.

People who live in households with low incomes or that have high health care needs can apply for a CSC or High Use Health Card (HUHC). The CSC is available to low-income individuals or those receiving a benefit, and their dependent family members. Eligibility is based on family size and income. To be eligible for the HUHC, an individual needs to have visited the doctor 12 or more times in one year, with the consultations being related to a particular condition, or condition(s) which are ongoing. This card is not means tested and applications need to be made by a doctor on behalf of a patient. The HUHC gives the same amount of subsidy as the CSC for GP visits.

CSCs and HUHCs also allow adults and older children to pay a lesser charge per item for medicines, and nothing for children under six.

Summary of key issues

Short consultations are a major barrier to comprehensive care. In a 10-minute consultation there is basically only time to ask how the current medication regime is going and re-issue any scripts.

Gary – mental health consumer

Overall, there are many positive features of the New Zealand health system in relation to diagnosing and treating mental illnesses. For example, compared with other health systems, many people with mental illness have access to hospital and community-based mental health care, including psychiatry, without cost. In both the primary and secondary care sectors, there is a team-based approach to mental health care, with psychiatrists working with GPs and other health professionals to provide care to people with mental illnesses. The costs for medication to consumers are also low (on average) by international standards. There are also a number of targeted programs providing additional services and/or financial aid to people with mental illnesses.

However, there is a significant cost barrier for many consumers to accessing GP services, which creates an initial 'roadblock' to entering the rest of the health system. This high up-front cost for accessing GP services may prevent people with early-stage and emerging mental health problems from seeking treatment, which can make their treatment and rehabilitation processes more challenging.

These costs can also create a disincentive for people with mental illness to seek help for symptoms that are related to monitoring the side effects of their medication and other aspects of physical health, and therefore probably contributes to the high levels of co-morbidity (both physical and mental illness) and premature death in this population. This barrier was noted by consumers and psychiatrists, with both groups reporting that in their experience this could result in the progression of a preventable illness or condition to the point that it would require hospitalisation. Removing the current barrier to access for GP services for people with mental illnesses should therefore be the first priority in addressing overall access issues.

There are also 'hidden' gaps in other programs and services targeting people with mental illness, which may inadvertently result in a reduction in their overall access to care. There are a number of policies and programs undertaken at the DHB level that can be difficult to access for people with a mental illness (for example, due to their administrative requirements). Targeted programs often serve people with the least complex and serious mental health problems (for example, mild depression or anxiety) and do not meet the needs of people with more serious and complex mental health issues, in particular psychosis. Some stakeholders interviewed felt that mental health programs should be more carefully targeted at people with serious mental health issues who could be 'hard to reach'. A number of the consumers and psychiatrists interviewed identified specific programs that, in their opinion, were effective in improving the health of people with mental illnesses, but they also expressed concern that these were often not available as widely as they should be in order to meet demand.

Geographical inequity and inconsistency in terms of the affordability, availability and quality of health services is also a major issue in New Zealand as the approach to mental health care is not consistent across the country. This needs to be addressed at both the national and regional levels in terms of setting targets for the provision of services to people with comorbid physical and mental health issues. Unless this happens it is likely that this group of vulnerable consumers will continue to fall through the gaps in terms of physical health outcomes.

While there are examples of local innovation (for example the Kia Kaha program discussed on page 15), there are few mechanisms to evaluate the effectiveness of programs or to promote models of best practice. A lack of an evidence base for some programs is an issue of concern, given that there were examples of alternative strategies with demonstrated outcomes being implemented elsewhere in New Zealand.

There is also scope to improve current funding arrangements to increase the capacity and incentive for health services and care providers to provide more comprehensive care to people with mental illnesses. While the health financing system does not prohibit the delivery of high quality services to people with mental illnesses, there are areas in which funding could be structured in a way that more actively supports this type of care. For example, funding for mental health programs could be more effectively 'ring fenced' to prevent it from being eroded when global budgets are cut. Other funding-related strategies could include the provision of incentives to GPs and services for meeting defined targets, for example, regular monitoring of physical health indicators for people with mental health conditions.

Given the crucial role that psychiatrists and GPs play in both providing and coordinating care for people with mental illnesses, it is important that the primary health care financing system supports effective communication and interaction by members of a mental health care team. This includes funding for the non-face-to-face services that are required to coordinate care, such as case conferencing and care planning. Funding arrangements should also support the provision of longer consultations where these are required to provide both physical and mental health care.

Additional loadings should also be provided for the care of people with very complex mental and physical health co-morbidities, in recognition of the additional time and expertise that is required to manage their care. Funding should also be made available for additional training in mental health issues for GPs, practice nurses and other practice staff where required.

Recognising people with mental illnesses as a priority, as recommended by the Equally Well Consensus Position Paper, would provide a policy platform on which to address the range of cost barriers and funding issues outlined above, reducing the morbidity and mortality gap between people with mental illnesses and the general population. Some specific recommendations to progress action on these issues in a number of different spheres are outlined in the next chapter.

The Way Forward: Recommendations

Cultural change among the medical profession is also important in order to provide effective care to people with mental illnesses. I have had doctors who have dismissed my physical health problems which turned out to be significant (but treatable) problems. Many doctors also don't take side effects of drugs seriously. Once when I was asking about the side effects of the drug I am on to see if there were any alternatives a doctors said to me 'You have to decide whether you want quality of life or quantity of life'.

Claire – mental health consumer

The following recommendations largely focus on cost and funding issues associated with health care provided to people with mental and physical illnesses and do not attempt to address all the dimensions of this complex problem. They should be seen in the overall context of a broader policy agenda that the RANZCP will be working to develop in forthcoming papers to address the 'health gap' between people with mental illnesses and the general population. A more comprehensive list of recommendations addressing different barriers to health will occur as a part of these initiatives.

The RANZCP is keen to collaborate with other interested stakeholders to achieve real change in this area and would welcome opportunities to contribute to working groups and advise policy. The RANZCP will also be working through its internal structures, such as medical training and education, to prioritise progress in this area.

Setting national targets and encouraging collaboration

New Zealand's flexible, area based funding model encourages service innovations that fit local circumstances. However there are few mechanisms (or incentives) to encourage DHB's to measure the effectiveness of their programs, unless they have been identified as a priority area, or to make use of (and share) best practice information and evidence. For consumers, this can result in services that are extremely inconsistent in terms of cost, quality, availability and appropriateness.

Our recommendations in the area are as follows:

- 1) The Ministry of Health should work with DHBs and stakeholders to set national targets focussed on the physical health needs of people with serious mental illness. (eg around preventable hospitalisation, screening for side effects of medication, engagement with health promotion programs). These should be reported and made publicly available in order to encourage basic consistency across the system.
- 2) Collect and make available better data at both the DHB and national level in order to:
 - a) accurately assess the size and scope of the problem of co-morbid physical and mental health problems and
 - b) assess the effectiveness of measures to address these issues at both the local and national level.

In order to promote best practice models:

- 3) Funding should be made available to evaluate innovative new models of service delivery.
- 4) The Ministry of Health should establish an interdisciplinary practice network to review current programs and to share and publicise best practice examples.

The RANZCP has commissioned economic modelling that will describe and quantify the overall combined burden of co-morbid physical and chronic mental illnesses (including both low-prevalence and serious and enduring high-prevalence conditions) for both Australia and New Zealand which can inform this policy development. This will include:

- direct health costs, including visits to GPs and specialists, hospitalisation, medication, pathology and allied health
- indirect costs, such as transport and childcare expenses.

The RANZCP will make this research available to support the development of better policy in this area.

Funding

A range of funding changes should be introduced in order to reduce the current cost barriers to accessing care. These include:

- 5) A funding loading for all mainstream health programs (eg smoking cessation, other health promotion programs) to specifically focus people with mental illnesses who can be hard to reach.
- 6) A mechanism to fund better access to GPs, specifically to manage risks for other chronic illnesses and the side effects of medications. This should include funding for case conferencing and care planning.
- 7) Encourage greater use of peer workers (at no cost to the consumer) to:
 - engage people with mental illness with health services and health promotion activities.
 - assist consumers in the administrative process required to get access to subsidies eg for diabetes aids.
- 8) Specific targets for the provision of screening, monitoring and treatment services for people with mental illness in funding agreements with DHBs (see also recommendation 1).

Together these recommendations would provide a policy framework and the practical changes required to identify and address current cost barriers to accessing care for New Zealanders with a mental illness and promote more comprehensive and higher quality health care to improve both the mental and physical health of this vulnerable group.

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Appendix A: Diabetes management equipment – subsidies and costs

Blood glucose meters

People with insulin-dependent diabetes can obtain one specific brand of blood glucose meter free. If this is lost or damaged, or if the subsidised brand is not suitable for an individual consumer, they have to pay for another one.

A limited number of test strips for the specific brand of blood glucose meter subsidised by the government are provided free. If people require additional strips they generally have to pay for them themselves (there are some exceptions for pregnant women and others on the specific direction of the treating doctor).

Insulin syringes

A limited number (100) of disposable insulin syringes and pen needles are subsidised if prescribed on the same form as the one used for the supply of insulin, or when prescribed for an insulin patient and the prescription is endorsed accordingly. If people require additional syringes or are not able to get them on prescription they need to pay for them.

Glucagon

Glucagen Hypokit is fully subsidised with a CSC but those without this card need to contribute a co-payment. Urine ketone strips incur a prescription charge and blood ketone strips for other brands of meter (the Optium and Xceed) are not subsidised and consumers have to pay full price for these.

Ketone testing

One Freestyle Optium blood ketone diagnostic test meter per patient will be subsidised every five years for the purposes of blood ketone diagnostics only. The patient must have had one or more episodes of ketoacidosis and be at risk of future episodes.

Ketone test strips

A limited number of test strips are available on prescription, for example, up to 50 Accu-Chek Ketur-Test or Ketostix urine test strips can be obtained per prescription. If additional test strips are required, people may be able to obtain them from a health service free or may have to pay for them.

Appendix B: Consumer interviews

Claire

I am being treated under the Mental Health Act which involves taking medication. I have no say in the medication that I take. I have had experience of both residential and community-based mental health care.

Currently I am struggling to keep my weight under control, even though prior to going on this drug I have always been very lean. I have seen a dietician and watch what I eat. I also walk every day but am still putting on weight.

I don't have regular general health checks. Going to the GP costs me \$40 the visits are only 10–15 minutes each and there is only time for her to check my medication – not do any other health care. For other people costs are definitely an issue. If you are on a pension of \$145 a week then \$35 to see a GP is impossible to manage. Even if there are some GPs who are cheaper they are often further away so there are transport costs and on top of this there is the cost of medication.

There is poor communication between my GP and psychiatrist – my GP doesn't know what medication I am on. I asked her to find out from my psychiatrist because I don't always remember the name of the drug or the dosage level but she hasn't found out yet. There is also some confusion about who is supposed to look after my mental and physical health – I've previous had conflicting advice from my GP and psychiatrist and also once ended up before on mental health medication prescribed by my GP and physical health medication prescribed by my psychiatrist.

It's really important that all health professionals in a care team share information. I think the GP should be coordinator of overall care but both the GP and the psychiatrist are responsible for ensuring that physical health issues are being addressed. This is definitely important for anyone on medication that affects their metabolism but also important for other issues, for example, problems with thyroid function can affect mental health.

Physical health is definitely an issue for residential patients. They are less active and often have a poorer diet. They often can't easily get to a doctor and even if they could they might not be able to afford it. There is an NGO that pays for one visit a year for residential patients from a GP but this is not nearly enough to ensure their physical health needs are met.

What would help would be more workshops and education for people with mental illnesses about how to keep healthy. It's important to see how mental and physical health are linked. You have to have hope in the future in order to be healthy and often people with mental illnesses – particularly those in residential care – sometimes lack hope.

Improving physical health can improve self-esteem and confidence and this can also improve mental health. Free access to a gym and regular access to a dietician would also help but it is important that dieticians have some specific training in the issues relevant to people with mental illnesses. Some dieticians' views are quite old fashioned and not helpful for people struggling with metabolic problems.

People with mental illnesses should also have access to the same products and services that people who are overweight for other reasons can access, for example medication like Reductil.

Cultural change among the medical profession is also important in order to provide effective care to people with mental illnesses. I have had doctors who have dismissed my physical health problems which turned out to be significant (but treatable) problems. Many doctors also don't take side effects of drugs seriously. Once when I was asking about the side effects of the drug I am on to see if there were any alternatives, a doctor said to me "You have to decide whether you want quality of life or quantity of life".

At a higher level I think PHARMAC should focus on approving drugs which have fewer side effects. It's also important for the College of Psychiatrists to have a good relationship with the Director of Mental Health.'

Gary

'Mental and physical health needs are intertwined – the health system needs to address them both and should not treat them as separate. However, many clinicians don't take that holistic view and don't consider physical health needs to be as important.

I think that it is part of the duty of care of both the GP and specialist to ensure someone is looking after all the needs of their patients. If they are not doing it themselves they should ensure that someone else is.

Short consultations are a major barrier to comprehensive care. In a 10-minute consultation there is basically no time to ask how the current medication regime is going and re-issue any scripts.

I think that as well as doctors, patients also have responsibilities. They need to be prepared for specialist visits, armed with the information they need and the questions they have.

Triage by practice nurses would be useful in providing more comprehensive care. They could ask questions about lifestyle and physical health issues and alert the doctor to anything important.

I work in a highly deprived area where most people are on low incomes. Most general practices charge \$10 for concessional patients but if people can't pay they just give them an account but don't follow it up. Some people end up owing practices hundreds of dollars and never pay it back. If people can't find or don't know about these practices they can pay \$50 for a visit and up to \$70–\$80 after hours. This is definitely a barrier to access.

People with acute illnesses are often better off as they receive care free through the public system. If you aren't as acutely ill you can wait years to access public system while putting up with pain and other serious symptoms. Most people can't afford private specialists, unless they are lucky enough to have very generous private health insurance.

While cost barriers are not as serious an issue in my opinion as a lack of understanding by care providers of mental illness and overall poor quality care, I do think they are important for many people.'

Graham

'In my role I have heard a number of reports of people with mental illnesses having their physical symptoms ignored because health care workers are focussed on mental health conditions. The problem is not a lack of services – it is the culture of the health system and the way the services are organised.

One woman I know who suffered from anxiety was suffering from extreme pain. She was taken by ambulance to the hospital and because she put up her hand when the doctors in Emergency came to treat her they called security and she was taken away to a mental health ward. It wasn't until she had had a mental health assessment that they even started to deal with her physical pain.

Costs can be an issue, particularly for people coming out of hospital when they have a number of expenses to deal with, like setting up their house and buying groceries. But cultural and attitudinal issues within the health sector are more important. Even when there is no cost to accessing care, people with mental illnesses still find it hard to get the care they need.

I am collecting a database of stories of people within the mental health sector who have been treated badly by the health system. There are so many stories of people seeking care are being told that they are making it up or basically having their symptoms ignore. It's a major problem and one that needs to change so that people with mental illnesses get treated the same as everyone else.'

Brody

'Addiction and mental illness are linked. There is too much focus on the medical model and trying different drugs. For me, tai chi and my own regime of fitness and nutrition helped my emotional regulation – there should be more done to help people with their physical health needs.

Mental health care can feel like chronic suicide. The drugs and the illness take a toll on your physical health but it's like a permanent holding pattern with no-one focussing on getting you well. As long as I kept taking the medication and didn't cause problems, they would have been happy for me to sit on the couch for the rest of my life waiting to see my key worker every couple of weeks.

It's easy for mental health needs to always take precedence over physical health needs. To stop health care providers having to juggle both there should be someone in the care team whose job it is to focus solely on physical health needs.'

Sheree

'I've really benefitted from some of the programs run by DHBs, like the Pro-care program. This funded six free sessions with a GP for the year which could be for mental or physical health care. It meant that I didn't have to put off going to the GP because of cost. It also really helped as a transition from secondary mental health care – it can be really hard to stop secondary care when you still need support. Often people are learning how to manage their budget, dealing with getting their life back on track at the same time. Getting those free GP visits seemed like a vote of confidence in me – recognising that I still needed help but that I would get better.

Unless you are made of money or your parents bought you health insurance when you were born – the only way you can see a psychiatrist is if you are sick enough to need to be in hospital or have a crisis. There are so many psychiatric drugs – GPs can't be across them all so it's really important that psychiatrists and GPs communicate. Not all the drugs have a good evidence base, many of them haven't been around long enough for us to know what the long-term effects are.

I had a friend with a tumour, her GP thought her mental health team was following up poor test results and the mental health team thought the GP was. By the time the tumour was found it was 30cm and she only had weeks to live.

All GPs should have more mental health training, the RANZCP should push for this. Also, all GPs should have access to a psychiatrist for consults around medication. Specialist mental health GPs would be great as well but all GPs should know how to be respectful and communicate with people with mental illnesses. It is important that health professionals know how to build rapport with mental health consumers and have the time to do this so that they can address physical health issues in a way that maintains their relationship. There is a really fine line between bringing someone's weight to their awareness and adding to the shame many people already feel about their mental illness.

When we complain about care we have received, people with mental illnesses not taken seriously. Each psychiatrist needs to be aware that they may be the only health professional that they see for six months. No-one coordinates care – someone needs to oversee it.

It would be easy to have a basic screen by a nurse or on an iPad to ask basic questions before we are seen by the GP. Otherwise in a 15-minute appointment there is no way they can address everything.

I needed to pay for tests which cost \$1000 and also need some supplements which are only partly subsidised. People are often locked into mainstream bio-medical drugs because of cost and lack of knowledge. I think we should be open to a wider range of treatments – particularly for people who have been in the system longer term. There is a need for more research into efficacy of these treatments.

It would be wonderful if GPs had some training on alternatives to anti-depression medication and their side effects. They shouldn't be the first port of call and not prescribed just because it is easiest for GPs.'



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