

Report
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Actuaries
Institute.

The Mental Health Financial Safety Net

Unifying Australia's
fragmented systems



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About this Report

This report was commissioned by the Actuaries Institute as part of its [Public Policy and Thought Leadership program](#). Reports prepared in this program involve the Institute Public Policy staff working closely with the lead authors, a reference group and the Institute's volunteer network in order for the report to present the Institute's contribution, on behalf of its membership, to the discussion of an important societal topic.

Mental health remains a pressing public policy issue for the Australian community. It is one where actuaries can contribute and provide independent advice in the design and management of equitable and sustainable schemes, services and products.

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Acknowledgement of Country

The Actuaries Institute acknowledges the traditional custodians of the lands and waters where we live and work, travel and trade. We pay our respect to the members of those communities, Elders past and present, and recognise and celebrate their continuing custodianship and culture.

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1

Executive Summary



1. Executive Summary

Australia has developed a broad financial safety net to help fund mental health treatment.

Over the past few decades, society — both in Australia and internationally — has made significant progress in how mental illness is understood and addressed. The approach to mental health care and treatment is now widely recognised and tackled as a societal issue, rather than only at an individual level. Stigma has lessened, clinical treatments have become more effective and evidence-based, and access to care has expanded.

This shift reflects decades of advocacy, investment and reform that have transformed public attitudes and health policy. Left untreated, mental health conditions can worsen over time, leading to serious consequences for individuals' wellbeing, social participation and productivity. The growing acknowledgement of this reality has helped shape today's mental health system and the funding mechanisms that support it.

Mental ill-health is common among the community. According to the 2020-22 National Study of Mental Health and Wellbeing by Australian Bureau of Statistics covering the start of the COVID-19 pandemic, around one in five Australians report experiencing mental ill-health each year. Almost half (43%) of Australians aged 16-85 years old in 2020-2022 experienced a mental disorder at some point through life — an estimated 8.5 million people. Further, there are signs of a mounting youth mental health crisis. In 2020-2022, 39% of Australians aged 16-24 experienced mental health conditions annually — a rate that has nearly doubled since 2007. Among young women, almost one in two (46%) experienced a mental health condition in the last 12 months alone.

Australia today is supported by a wide range of systems and initiatives that together help millions of people fund the cost of mental health treatment each year. Whether delivered through public policy, community initiative or private enterprise, each has evolved in response to growing and unmet societal need. Together, these mechanisms — including Medicare, mental health helplines and private insurance schemes — form Australia's collective financial safety net for mental health care. How exactly these separate pieces of the safety net should come together remains a complex and underexplored challenge.

This report on the 'Mental Health Financial Safety Net' is intended to help those responsible for its design and management to fundamentally improve outcomes for those who rely on it.

This report identifies 22 funding supports that ease or offset the direct, personal costs of accessing treatment for diagnosable mental health conditions. We conservatively estimate that funding across these support mechanisms exceeds \$18 billion per year.



Rising mental health costs threaten sustainability of insurance systems

While insurers in Australia have made significant strides in funding for mental ill-health in recent years, ensuring sustainability is far from solved. For example, for total and permanent disability (TPD) individual insurance, annual claims due to mental ill-health have increased by a massive 433% (from \$39 million to \$208 million) between 2014 to 2022, far exceeding the 200% increase due to physical ill-health (from \$193 million to \$578 million) over the same period (KPMG, 2024). While it's positive that this life insurance benefit is responding to genuine community need, spiralling claim rates worsen affordability and pose a wicked problem given the voluntary take-up of individual life insurance. Insurers continue to wrestle with difficulties of providing affordable insurance cover for mental health that continues to meet community expectations. The story is the same in private health insurance where meaningful mental health coverage is confined to Gold-tier policies at prices out of reach for middle Australia.

Similar challenges present in state-based workers' compensation systems. Despite different state system designs, mental health claims now cost four times more than other claim types and require over five times longer leave from the workplace (Safe Work Australia, 2024a). Mental health claim rates also show the highest growth of any injury category, with a 43% increase in claim numbers over the past decade (Safe Work Australia, 2024b). This is despite recent legislative changes to some workers' compensation systems, including lifting the whole person impairment threshold for psychological injuries for lump sum or longer-term benefits. These ongoing reforms are contentious given the range of tensions on scheme sustainability. While justified by proponents as financially necessary, critics express concerns about the impact on injured workers who are limited or excluded from financial support without regard to solving the underlying challenge.

Needs have partly shifted towards the National Disability Insurance Scheme (NDIS) as a vital support mechanism for Australians living with significant and permanent disability, including those with psychosocial conditions. While the NDIS is not responsible for funding core clinical mental health services or treatment, its role in providing psychosocial supports has become increasingly important as other funding streams have been withdrawn (Productivity Commission, 2025a). In December 2023, the Commonwealth and state governments reached an in-principle agreement to co-fund foundational supports — a new category of disability for people who do not qualify for the NDIS but still require assistance with daily living. While the NDIS Review that informed this agreement included recommendations for psychosocial supports, the specific scope and implementation of these arrangements are still being negotiated and implemented, leaving concern around existing service gaps and inconsistent coverage.

These shifts reflect a broader pattern of cost-shifting across the mental health ecosystem. Responsibilities are being passed from one part of the financial safety net to another, without necessarily resolving the underlying structural gaps with how the mental health care system is funded, accessed and integrated as a whole.

From a system-wide perspective, Australia's mental health financial safety net is being challenged significantly. Its long-term viability is at risk.

Across the mental health financial safety net, consumers encounter three key challenges



Affordability challenges

There are currently many different funding mechanisms, but mental health care is not always 'affordable for all'. Mental health care affordability in Australia is hindered by high out-of-pocket costs, limits on subsidised psychological care sessions, restrictive insurance policies and gaps in public funding. Low-income individuals and those with low to moderate intensity needs face significant barriers — public supports are finite while private insurance can be costly or exclusionary.



Barriers to access

Access to funding does not always mean access to care. Access to mental health care in Australia is limited by geographic disparities, cultural barriers, administrative delays and workforce shortages. Rural areas lack providers, while culturally diverse groups and temporary visa holders face exclusion and stigma. Administrative processes for Medicare, NDIS and other supports delay care and can be complex, particularly for vulnerable people to navigate. Workforce shortages and high demand further strain the system, limiting availability and continuity of care.



Burden of navigation

Even with recent investment and increased access, Australia's mental health funding ecosystem remains fragmented. This fragmentation creates avoidable gaps in care, delays at critical transition points, and inefficiencies that weigh heavily on individuals already experiencing mental ill-health, which may also exacerbate the severity of their conditions. Poor coordination between systems can lead to duplication, conflicting eligibility rules and inadequate support as people move between primary, acute and community care. Misaligned funding structures can unintentionally favour crisis responses over prevention and continuity, leaving many people with unmet needs and contributing to long wait times.

These challenges are well documented, including through the Productivity Commission's (PC's) Interim Report reviewing the National Mental Health and Suicide Prevention Agreement (National Agreement). While the National Agreement covers the critical role of governments in delivering and funding mental health care and suicide prevention initiatives, fundamentally addressing these challenges requires taking the full and complete view of both public and private safety nets.

The way forward is to move to a more unified system

The key recommendation lies in adopting a well-targeted priority investment approach, where greater investment as soon as practicably possible in evidence-based prevention and early intervention in one part of financial safety net will more than save investment and expenditure otherwise required later in another part. This is consistent with the PC's recent Interim report on Delivering quality care more efficiently which recommends a National Prevention Investment Framework (Productivity Commission, 2025b). It is an approach that underpins a growing number of government programs, national and internationally.

We also recommend seven other actions for system stewards, government, regulators, insurers, health care providers and non-government organisations (NGOs) to progress over the immediate, medium and longer term across a total of five priority areas.

A common theme across many of these recommendations is improving data and risk-based capabilities to inform better evidence-based and earlier intervention measures. This reflects a need to piece together — through linked data, shared expertise and pooled resources for common objectives — a mental health financial safety net that is affordable, accessible and unified to support people as they move within and across different public and private systems. Ultimately, this will support an effective safety net to help people who might experience mental ill-health to cope, adapt and recover.

Figure 1: High-level recommendations

Priority Area for Actions	Immediate (2025-26)	Medium-Term (2027-28)	Long-Term (2028+)
 Whole-of-system Priority Investment Approach	1. Embed a whole-of-system priority investment approach targeting the issue of affordability, focusing on: - Identifying duplication, funding gaps and cohorts at risk - Evaluation equity and financial protection - Implementing reforms for integration and sustainability consider as part of Government's response to the PC's Review of the National Mental Health and Suicide Prevention Agreement.		
 Data Capability and Systems Intelligence	2. Implement a national mental health data strategy to address the immediate affordability challenges.	3. Develop a coverage and outcome framework that models and monitors the cost of failure points in the Mental Health Financial Safety Net.	
 Affordability Relief for At Risk Groups	4. Provide more effective affordability relief for financially vulnerable groups in relation to chronic conditions and frequent psychiatric service use.		
 Private and Public Sector Coordination	5. Develop a shared, evidence-based framework for assessing mental ill-health, and ensure claims pathways are trauma-informed and streamlined.	6. Review the coordination and integration of private and public funding mechanisms. E.g. gaps between Medicare, Private Health Insurance (PHI), Life Insurance and state-based workers' compensation (WC) schemes.	7. Identify opportunities for coordinated investment (e.g., pooled funding) to address gaps in prevention, continuity, and recovery of mental health care.
 Product Design Reform	8. Redesign insurance products and pursue innovations that provide more appropriate and cohesive mental health support. This includes, for example, extending coverage for evidence-based community mental health supports, offering less intensive cover in the more affordable product options and designing cover tied to the financial loss and to the principle of indemnifying income.		

While Australia has made significant progress in recognising and responding to mental health, there is still a long way to go. The recommendations outlined involve significant investment at a time when resources are already stretched, however, without reform the strain on people and systems is expected to only increase.

Reforming the financial safety net is not just a policy issue — it is a human one. The mental health crisis is not a distant threat; it is already here. For those experiencing it, the toll is profound, affecting not only the individual, but also their families, communities and workplaces.

This report aims to lay the groundwork for further coordination and action toward a stronger, more equitable financial safety net that, if designed well and built together, can help ensure that every Australian, now and in the future, can access the mental health care they need, when they need it most.

2

Introduction



2. Introduction

2.1 Purpose of this Report

This report explores ways to strengthen Australia's Mental Health Financial Safety Net (here on referred to as the 'financial safety net'). Just as the function of a safety net is to catch people if and when they fall, a mental health financial safety net should enable a person experiencing mental ill-health to afford and access the appropriate treatment, support and care.

The growing awareness of mental health challenges over the past two decades has prompted national conversation and action around improving access to care, prevention, promoting early intervention and reducing stigma. In 2025, Australia has a large and complex ecosystem of funding and support mechanisms for people living with mental health conditions. It must be recognised that despite the challenges faced by the current ecosystem and detailed in this report, Australia's mental health ecosystem has made significant progress in the right direction.

This report identifies and seeks to map how current funding mechanisms — across both public and private sectors, including Medicare, the Pharmaceutical Benefits Scheme (PBS), income supports and insurance systems — function collectively as the financial safety net.

This report is intended to help those responsible for its design and management, and those with the willingness to make it better, to question whether current available supports are sufficient, equitable and responsive to the needs of those they are intended to protect. It does this by examining the systemic challenges that influence how the financial safety net is experienced by consumers.

Finally, we suggest ways to strengthen the financial safety net. Ultimately, the direction is to move to a more integrated and cohesive ecosystem of support, to help people living with mental ill-health to afford appropriate treatment, support and care.

At its core, the role of an effective financial safety net ensures that individuals experiencing mental ill-health can always access the care they need without falling into poverty or debt.



2.2 About Mental Health in Australia

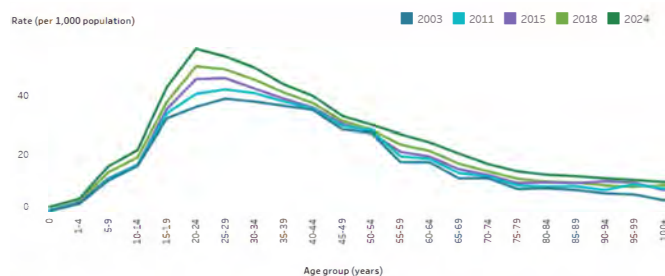
2.2.1 The burden of mental ill-health in Australia is significant and growing

Mental ill-health continues to have a profound and growing impact across the Australian population. According to the second and most recent ABS National Study of Mental Health and Wellbeing over the period 2020–2022, an estimated 8.5 million Australians (43%) aged 16–85 have experienced a mental disorder at some point in their lives. Of these, nearly half had experienced a mental disorder in the 12 months prior to the survey.

While overall prevalence has remained relatively stable since the prior 2007 ABS National Study, rates among young adults, particularly young women, have surged. Among females aged 16–24, 46% experienced a mental disorder in the previous 12 months, compared with 30% in 2007. Longitudinal data from Household Income and Labour Dynamics in Australia (HILDA) surveys support the finding that mental health and emotional wellbeing has declined across all gender and age groups over the past decade, with particularly steep declines in the 15–34 age group, especially those aged 15–24 (Wilkins, R. et al., 2024).

Higher prevalence is closely linked to an increasing burden of disease¹. Analysis by the Australian Institute of Health and Welfare (AIHW) from 2003 to 2024 finds that the burden deterioration in the ‘mental and substance use disorders’ group² of diseases across the Australian population, as measured in ‘disability adjusted life years’ (DALY)³, has increased across all ages and by 31% when standardising for age. This is despite the total burden of all disease groups across all ages having reduced by 11% over the same period. The AIHW also finds that younger adults shoulder the heaviest burden in mental ill-health across all ages.

Figure 2 – Burden of disease (age specific groups)



Source: AIHW (2024) Australian Burden of Disease Study 2024 – Interactive Report

For those living with a long-term mental illness, the day-to-day impact can be profound for them and their carers. The AIHW (2025a) also cites that according to the 2021 HILDA survey:

- around three in five students (58%) living with long-term mental illness experienced educational challenges related to their mental health;
- around three in five workers aged under 65 (59%) with long-term mental illness faced barriers to employment, such as needing adjustments, equipment or reduced hours; and
- around one in six people (17%) with long-term mental illness required daily assistance or supervision due to their condition.

¹ Burden of disease analysis measures the impact of diseases and injuries at a population level. It is the difference between a population's actual health and its ideal health, where ideal health is living to old age in good health (without disease or disability).

² The AIHW groups mental ill health and substance use disorders together because of their high comorbidity, complex bidirectional relationship, and shared negative impacts on health and wellbeing. A mental illness can increase the risk of substance use, while substance use can trigger mental health symptoms, and both conditions often co-occur in the same individual.

³ Disability-adjusted life years (DALY) is the AIHW's metric for summarising the total burden of a disease and injury (or a group of diseases or injuries) at a population level. One DALY equates to one year of healthy life lost to disease and injury.

2.2.2 Unmet need for psychosocial support and mental health treatment, care and support

Many Australians living with mental ill-health find it difficult to access timely or adequate treatment. According to the 2020-2022 ABS National Study, 45% of those who experienced a mental disorder in the previous 12 months saw a health professional for their mental health.

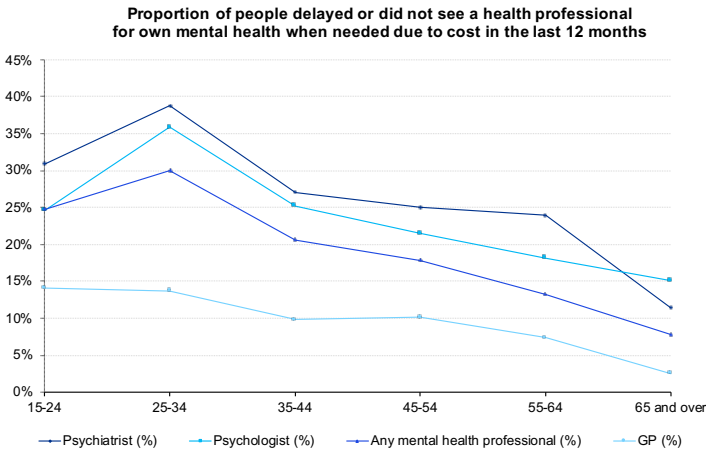
In Victoria during the start of the COVID-19 pandemic, unmet demand in community-based mental health treatment was estimated at 3.3 million hours in the year to 30 June 2020 (Royal Commission into Victoria’s Mental Health System, 2021).

In addition to clinical care, Australians with mental ill-health may also need psychosocial supports⁴ tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community. In 2022–2023, an estimated 647,000 Australians required psychosocial support, but 493,000 (77%) received no such support. This represents an unmet need of 14 million hours of support for people with severe mental illness and 2.8 million hours for those with moderate conditions (Health Policy Analysis, 2024).

Mental ill-health, especially when left untreated and risks deteriorating to crisis-point, has far-reaching personal and societal consequences. It is linked to lower educational attainment, reduced workforce participation, and increased use of emergency or hospital-based services. The PC estimated in 2020 that the total economic cost of mental ill-health in Australia was as high as \$220 billion per year (Productivity Commission, 2020).



Figure 3: Proportion of people with unmet treatment needs



Source: AIHW (2024) Australian Burden of Disease Study 2024 – Interactive Report

4 Psychosocial support refers to non-clinical, community-based supports that help people with mental health conditions or psychosocial disabilities improve their functional capacity, daily living skills and participation in social, educational and economic life, complementing but not replacing clinical mental health treatment.

3

Defining the Mental Health Financial Safety Net



3. Defining the Mental Health Financial Safety Net

3.1 What is the financial safety net?

The concept of a safety net can be easily understood by considering a physical safety net — it is designed to catch people when they fall. In public policy, the concept of the *financial safety net* refers to funding mechanisms that provide financial assistance in times of crisis, to lessen the impact and restore some stability. Former Australian Union Leader, Bill Kelty, in his foreword for *Safety Net: The Future of Welfare in Australia* defines the safety net as “...a concept and a belief that there should be universal minimum economic and social rights for every citizen.” (Mulino, 2022). He goes on to identify the key safety nets of “universal education, healthcare, wages and retirement benefits.”

From a financial perspective, the idea and operation of a safety net is not new. Globally, the International Monetary Fund and the World Bank have operated for almost a century as a global financial safety net to participating countries through their facilitation of international reserves, risk financing and risk pooling mechanisms.

In Australia, Medicare is Australia’s universal health insurance scheme that is designed to enable access by all Australians to a wide range of health and hospital services alongside state and territory provision of health services at low or no cost, and further support against cumulative financial pressure from high out-of-pocket costs⁵. The NDIS is a further example — a national scheme designed to provide funding to support people living with a permanent and significant disability. These publicly funded systems are closely linked to the idea of ‘social insurance’, a concept that prompts strong community views of equity and social rights.

Beyond these federal programs, Australia’s financial safety net also extends to private health, general and life insurance systems that provide additional coverage for those who can afford premiums, state-based workers’ compensation schemes that insure employees from work-related injuries and illnesses, and other employer-funded health and wellbeing initiatives. Together, public and private mechanisms, given their different scope, funding and eligibility criteria, form a complicated, many-layered approach to financial protection for the funding of health and disability.

3.2 Definition for this report

In this report, we define the ‘**Mental Health Financial Safety Net**’ as funding supports that ease or offset the direct, personal costs of accessing treatment for diagnosable mental health conditions.

This definition focuses on the individual consumer, rather than the clinician, service provider or funding body. While not intended to diminish the vital role of directly delivered mental health care through hospital systems, this report explores the cost, and hence affordability, of consumer access to mental health care.

The reality is more complex — the financial safety net is dynamic and interconnected with the ecosystem of mental health care itself. We also acknowledge, but do not explore in detail in this report:

- pricing decisions that impact supply and demand forces, which are different for different parts of the care sector and also impact on the size of out-of-pocket costs for consumers; and
- the high-cost burden of acute and emergency care, including emergency department (ED) presentations, psychiatric admissions, and crisis or emergency responses delivered through state systems, which often become the default pathway when early and community-based care is inaccessible.

The NDIS is accessible to Australians with permanent and significant disabilities, including psychosocial disabilities (such as schizophrenia, bipolar disorder, PTSD and severe anxiety). The NDIS provides funding for reasonable and necessary supports aimed at improving functioning and community participation. Currently, there are around 65,000 participants with a psychosocial disability as their primary disability who received \$5.6 billion in funding in the 12 months to March 2025 (NDIS, 2025b).

As the NDIS is not intended to cover participants for the costs of mental health treatment and direct care, it does not meet our definition of the Mental Health Financial Safety Net. However, recognising its vital role, this report positions the NDIS as a vital scheme that works alongside. We therefore comment where relevant on the NDIS in the context of the design and operation of the Mental Health Financial Safety Net.

⁵ The Medicare Safety Net operates to further help consumers receiving subsidised care from Medicare. Specifically, it provides additional financial relief to people who incur high out-of-pocket costs for out-of-hospital services (such as GP visits or psychology sessions under Better Access). Once an individual or family reaches a certain annual threshold, the government increases the rebate amount, reducing the remaining costs to the patient.

3.3 Not explored in this report

In this report, the Mental Health Financial Safety Net does not extend to a consumer's broader financial situation, that is their own wealth. This might include a person's personal and household wealth, comprising housing, superannuation⁶ and other assets. However, we acknowledge the crucial role these economic determinants play in contributing to a person's financial and mental wellbeing.

Informal mechanisms are not considered part of the 'financial safety net' for the purpose of this report. While this report focuses on formal funding mechanisms, we acknowledge the critical, and often invisible, components of the unpaid support provided by families and carers, whose time, emotional labour and lost income represent an enormous but unquantified contribution to the financial safety net.

We also exclude the specialised and broader supports and mechanisms provided by the Department of Veterans' Affairs (DVA), such as the tailored, veteran-centric programs, mental health care and disability employment services. We note the Royal Commission into Defence and Veteran Suicide, conducted between 2021 to 2024, acted as a critical accelerant to many changes currently being implemented within the DVA for serving and ex-serving Australian Defence Force members, including the establishment of the Defence and Veterans' Services Commission from September 2025. This Royal Commission also suggested support could be expanded to cover families of Veterans.

These mechanisms fall outside the defined scope of this report, but they remain vital to any whole-of-system understanding of how mental health is funded, experienced and delivered in Australia.



⁶ Australians can access their preserved superannuation early under limited circumstances, such as financial hardship or other compassionate grounds including to pay for medical treatment for themselves or their dependants.

4

Key Financial Support Mechanisms



4. Key Financial Support Mechanisms

Australians experiencing mental ill-health currently rely on a wide array of financial supports to access treatment, care and recovery services. This section briefly explores 22 support mechanisms that form what could be considered as Australia's Mental Health Financial Safety Net.

We set out, in Figure 4 and the list following, one way of grouping these mechanisms according to the degree of financial support provided.

Figure 4: Types of financial support mechanisms

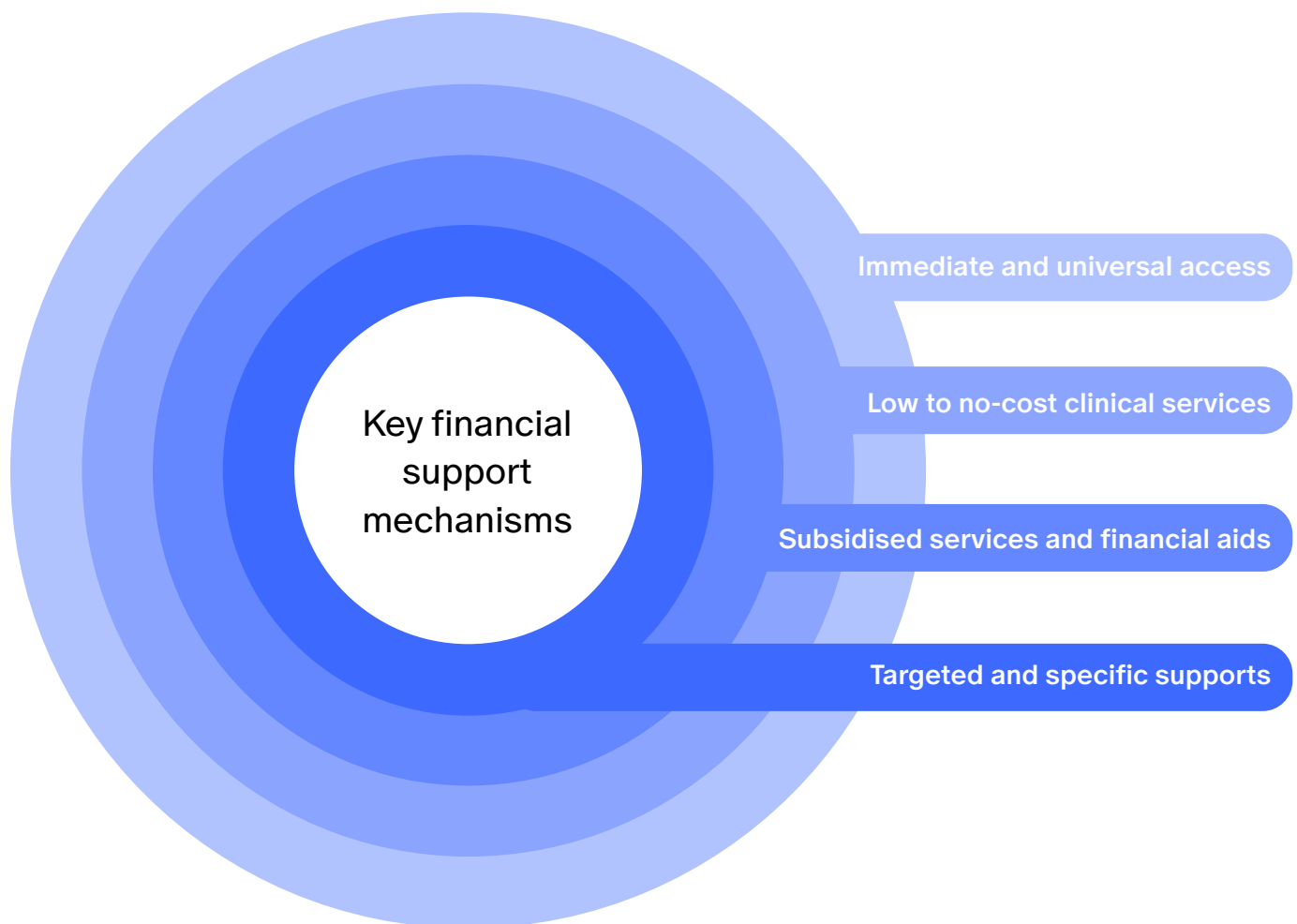


Figure 5: Key financial support mechanisms

Immediate and universal access Universally accessible, often free, and accessible immediately without eligibility requirements. • Digital mental health services (funded by Commonwealth, state/territory governments and donations, and delivered through not-for-profits and volunteers) • Helplines (funded by Commonwealth, state/territory governments and donations, and delivered through not-for-profits and volunteers)	Low to no-cost clinical services⁷ Low-cost or fully subsidised mental health care. Accessible through referral processes but relatively easy to access for those in need. • headspace • Kids Hubs • Community mental health care services • Medicare Mental Health Centres • General Practitioners
Subsidised services and financial aids Financial aids (income support) and subsidies to help fund or reduce the cost of mental health care. Stricter eligibility and administrative requirements may apply. • Pharmaceutical Benefits Scheme (PBS) • PBS Safety Net Scheme • Closing the Gap (CTG) PBS Co-Payment Program • Social Security Programs (including Disability Support Pension, JobSeeker, Carer Allowance and Mobility Allowance) • Better Access (a key Medicare initiative that funds clinical services under Mental Health Treatment Plans) • Medicare services outside Better Access Program • Commonwealth Psychosocial Support	Targeted and specific supports (public and private mechanisms) Targeted financial aids (income support) and specific supports to help fund or reduce the cost of mental health care. Potentially higher barriers to access (potentially due to assessment or income requirements). • Private health insurance • Workers' compensation insurance • Life insurance (including Total and Permanent Disability (TPD) and Income Protection (IP) insurance) • General Insurance Schemes – Public liability insurance; Personal accident insurance; Motor Accident insurance (also known as Compulsory-Third Party (CTP) insurance); Travel insurance • Employer initiatives, including Employee Assistance Programs (EAP)

Figure 5 lists Australia's Mental Health Financial Safety Net across the 22 support mechanisms. As set out in Figure 7 below, we conservatively estimate that funding across these support mechanisms, whether to help fund the direct, personal cost of mental health treatment or as income support for those experiencing mental ill-health, exceeds \$18.5 billion per year.

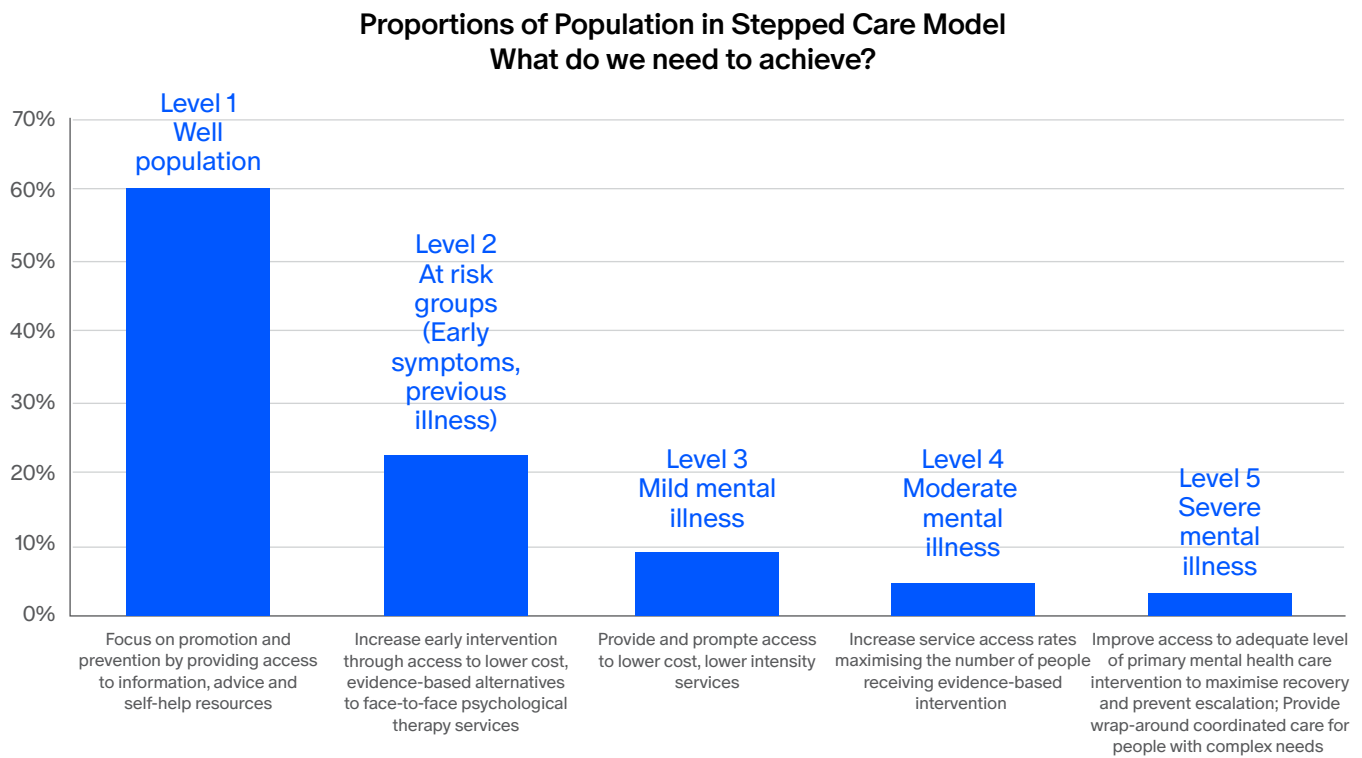
Over time, Commonwealth and state funding for mental health across primary care, acute services and community-based supports has increased substantially. According to the AIHW (2025b), total Government expenditure on mental health services has grown from \$8.1 billion in 2013–2014 to \$13.2 billion in 2022–2023. In that year, state and territory governments were responsible for 60% of mental health spending, with the Commonwealth contributing 35% and private health insurers covering the remaining 5%. We note this AIHW data relates to services only (and does not include income support) but highlights the significant role that state and territory governments play in delivering mental health services through hospital and community-based supports.

⁷ The list of low to no cost clinical services has been based on the Department of Health, Disability and Ageing list of mental health and suicide prevention contacts as at 10 June 2025. Retrieved from: [Mental health and suicide prevention contacts | Australian Government Department of Health and Aged Care](#)

Stepped Care Model

Each support mechanism in the ‘helicopter view’ summary on the following page, has also been categorised according to the ‘Stepped Care Model’⁸, which considers the level of care and need(s) of the individual. This framing provides a clearer picture of how different components contribute to the overall ecosystem — and where the risks of fragmentation, duplication or exclusion may lie.

Figure 6: Stepped care model



Source: Primary Mental Health Care Flexible Funding Pool Implementation Guidance – Stepped Care

8 The Stepped Care model is a systematic framework for organising mental health services that matches the intensity of interventions to the severity and complexity of a person's mental health needs. The model operates on the principle of providing the least intensive intervention that is likely to be effective first, with the ability to "step up" to more intensive treatments if the person doesn't improve sufficiently (Primary Health Networks, 2021).

Figure 7: Australia's Mental Health Financial Safety Net – 'Helicopter View' Summary⁹

	Key financial mechanism	Description	Level of care (indicative)	Population coverage	Annual funding identified / estimated (\$m / \$b)	People accessing (approx. each year)
	Immediate and universal access					
Public and NGOs	Digital mental health services	Digital services offer self-guided resources and community support. Current providers include ReachOut, SANE, MindSpot, ThisWayUp, BeyondBlue's NewAccess, Remedy's MindStep. From January 2026, a new Government funded National Early Intervention Service (NEIS) will provide free cognitive behavioural therapy (CBT) via phone or video by trained professionals through accredited service provider organisations. Services will be accessible without a diagnosis or GP referral.	Level 2: Low intensity	All Australian residents (27.2m as of June 2024)	\$85m across: \$73.6m for NEIS (initial allocation of \$589m over eight years from 2025) \$11.5m to continue existing digital mental health services (\$46m over four years from 2025)	- NEIS expected to support 150,000 people by 2029 - MindSpot performs 30,000 assessments - ThisWayUp provides program to 300,000 users - ReachOut reaches two million young people - SANE delivers 5,000 digital psychosocial programs
	Helplines	Helplines offer immediate and real-time support through direct communication channels. Helplines include Lifeline, 13Yarn, Beyond Blue, Kids Helpline and SANE.	Level 2 to 5: Low intensity to Acute and specialist	All Australian residents	\$270m across: \$115m for Lifeline & 13Yarn \$83m for BeyondBlue \$59m for KidsHelpline \$13m for SANE	- Lifeline and 13Yarn: 1 million calls, 1.4 million visitations to crisis support and self-led support services - Beyond Blue: 3.2 million website sessions; 300,000 reached out to Support Services - Kids Helpline: 100,000 calls and 100,000 counselling sessions - SANE: 10,000 calls
	Subtotal				\$355m	

⁹ Figures were obtained in October 2025 from publicly available data under best endeavours. Due care has been exercised in collating the financial information from publicly available sources, but precise and detailed breakdowns of expenditures specific to the financial safety net are often not accessible. While we have made efforts to check the data for accuracy and consistency, users are advised to interpret the information cautiously and refrain from relying on it as definitive.

	Key financial mechanism	Description	Level of care (indicative)	Population coverage	Annual funding identified / estimated (\$m / \$b)	People accessing (approx. each year)
Low to no cost clinical services						
Public and NGOs	headspace	headspace is an early intervention mental health service for young people aged 12-25 years. The model blends Medicare-funded psychological services with broader wraparound supports.	Level 2: Low intensity	Australian residents aged 12-25 (4.8m as of June 2024)	\$85m (for YE 30 June 2024). (NB: additional \$200m committed by Federal Government for 58 new, upgraded or expanded headspace services)	100,000 people across 500,000 sessions
	Kids Hubs	Kids Hubs (previously known as 'Head to Health Kids') is an early intervention mental health and integrated wellbeing service for children aged 0-12 with mild to moderate developmental, emotional, rational and/or behavioural challenges, and their families. There are nine Kids Hubs in operation across VIC, NSW, QLD, WA and NT, with plans to reach 17 Kids Hubs and expand more nationally by June 2027.	Level 2 to 3: Low to Moderate intensity	Children aged 0-12 (4.1m as of June 2024).	30m+ across federal and state funding for Kids Hubs and Parenting Education and Support Grant.	Data not materially and/or publicly available
	Community mental health care service (state-based)	A wide range of community care services are delivered through a range of state government initiatives and cover crisis and acute support, hospital and community-based care, psychosocial support, rehabilitation and recovery-focused services.	Level 2 to 5: Low intensity to Acute and specialist	All Australian residents	\$2.9b from state governments	Data not materially and/or publicly available
	Medicare Mental Health Centres	Medicare Mental Health Centres (previously known as 'Head to Health' Clinics) offer free, walk-in care for people experiencing mental health distress or needing connection to support services. There are 61 centres in operation as of August 2025.	Level 3 to 4: Moderate to High intensity	All Australian residents	\$130m to establish Head to Health and to upgrade to Medicare Mental Health Centres (NB: additional \$225m committed by federal government to add 31 new centres)	Data yet to be collected/available. Expected to support 150,000 per year
	General practitioners	General Practitioners provide a variety of mental health treatment services. They are part of the Better Access program.	Level 2 to 4: Low to High intensity	All Australian residents	\$300m from: \$180m mental health care plans \$120m treatment	2.1m patients with 3.3m services
	Subtotal				\$3.4b+	

	Key financial mechanism	Description	Level of care (indicative)	Population coverage	Annual funding identified / estimated (\$m / \$b)	People accessing (approx. each year)
	Subsidised services and financial aids					
Public	Pharmaceutical Benefits Scheme (PBS)	The PBS subsidises a wide range of essential medicines, including many prescribed for mental health conditions, to reduce the financial burden on individuals and families.	Level 2 to 5: Low intensity to Acute and specialist	All Medicare card holders (27 million Australians)	\$691m specific to mental health-related pharmaceuticals via the PBS	49m subsidised prescriptions, of which 76% relates to antidepressants and antipsychotic drugs (number of people not available)
	PBS Safety Net	The PBS Safety Net provides further medicine subsidies to patients and their families to manage otherwise high costs of medicines each year. In 2025, the thresholds at which lower or no cost medicines apply are \$277.20 for concession card holds and \$1,694 for general patients.	Level 2 to 5: Low intensity to Acute and specialist	All Medicare card holders	Specific amount not available, although the broader funding from the PBS Safety Net scheme is around \$130m each year (\$525m funding over 4 years from 2022)	Approx. 1.8 million out of 2.3 million enrolments have utilised the safety net. These enrolments relate to all pharmaceuticals including for medication not used to treat mental ill-health
	Closing the Gap (CTG) PBS Co-payment Program	The CTG PBS Co-payment program provides further affordability relief for Aboriginal and Torres Strait Islander peoples living with chronic diseases to access PBS medicines at low or no cost.	Level 2 to 5: Low intensity to Acute and specialist	Eligible Aboriginal and Torres Strait Islander Peoples	Specific amount not available, although the broader funding of the CTG PBS Co-Payment Program is around \$2.8m	660,000 people are registered as eligible. These registrations relate to all pharmaceuticals including for medication not used to treat mental ill-health

	Key financial mechanism	Description	Level of care (indicative)	Population coverage	Annual funding identified / estimated (\$m / \$b)	People accessing (approx. each year)
Public	Social security programs	These income support mechanisms are financial support programs that provide support that can be used to offset some of the broader financial burdens faced by vulnerable populations including individuals who are unable to work due to mental illness or related factors. These mechanisms do not provide for direct treatment costs, rather income support. Key examples include the Disability Support Pension (DSP), JobSeeker payment, Carer Allowance and Mobility Allowance.	Level 1 to 5: Self-management to Acute and specialist (e.g., DSP recipients)	Eligible Australian residents	\$8.8b+ from: \$8.2b from DSP - No specific amount from JobSeeker Payment which broadly funds \$13.9b to all recipients \$649m from Carer and Mobility Allowance	- Around 300,000 DSP recipients have a psychological or psychiatric (primary) condition - Around 400,000 Jobseeker recipients have partial work capacity, including from psychological or psychiatric impairment - Around 150,000 people care for those with mental or behavioural disorders as their primary condition
	Better Access Program (excluding GP services)	A key Government program that enables eligible individuals to receive Medicare-subsidised sessions with general practitioners (GPs), psychiatrists, clinical psychologists, registered psychologists, social workers and occupational therapists.	Level 2 to 4: Low to High intensity	Medicare card holders with a diagnosed mental disorder	\$1.0b from: \$36m treatment plans \$936m treatment	80,000 treatment plan services from psychiatrists - Clinical psychologist treatment - 500,000 patients with 2.7 million services - Other psychologist treatment - 700,000 patients with 3.2 million services - Other allied health provider treatment - 110,000 patients with 500,000 services - Psychiatrist - 200,000 initial patient consultation services
	Medicare services outside Better Access Program	These largely represent services provided by psychiatrists.	Level 2 to 5: Low intensity to Acute and specialist	All Medicare card holders	\$400m	600,000 patients with 2.7 million services

	Key financial mechanism	Description	Level of care (indicative)	Population coverage	Annual funding identified / estimated (\$m / \$b)	People accessing (approx. each year)
Public	Commonwealth Psychosocial Support Program	Provides targeted services for people with severe mental illnesses and associated psychosocial functional impairment who have needs that can be appropriately met through short-term, low intensity support to live independently in the community — for those who are not eligible for, or not currently accessing, the NDIS.	Level 5: Acute and specialist	Australian residents who meet eligibility requirements	\$136m	25,000 people
	Subtotal				\$11.0b+	
Targeted and specific supports						
Private	Private health insurance	An optional Government-incentivised health insurance system in Australia that provides access to private hospitals, choice of doctor (Hospital cover), and covers services not fully covered by Medicare (Extras cover). Members may access low intensity digital mental health services, however this depends on each service's eligibility criteria.	Level 1 to 5: Self-management to Acute and specialist	12.4 million people have Hospital cover 15.1 million people have Extras cover	\$650m+ across: \$600-700m for in-hospital mental services \$47m for sessions with a psychologist	500,000 mental health related claims / sessions for Extras cover - Data from hospital and Digital Mental Health services not available
	Workers' compensation insurance	Compulsory insurance for Australian employees who are injured or become ill due to their work. It provides compensation for medical expenses, rehabilitation costs and wage replacement during recovery, with each state and territory having its own workers compensation scheme and regulations.	Level 2 to 4: Low to High intensity	Australian Employees (14.6m)	\$0.9b for mental health treatment costs, income replacement costs and other ancillary costs (for 'serious claims' reported by Safe Work Australia for 2022/2023) ¹⁰	15,000 people claiming due to psychological injury (11% of all workers compensation claims)
	Life insurance and income protection	Life insurance is an optional Government-supported insurance system in Australia that provides financial benefits for death (Life Insurance), temporary disability (Disability Income Insurance), and total and permanent disability (TPD) including for mental health conditions. Many, but not all, working Australians automatically receive basic coverage through their superannuation fund. Funding is paid as a lump sum payment or as an income replacement and cannot be used by an insurer to directly fund treatment.	Level 2 to 4: Low to High intensity	9.3 million people for TPD insurance 5.6 million people for DII	\$2.2b mental health related claims from: \$1.3b from TPD insurance \$0.9b from DII	Around 14,000 people from: 7,000 people claiming on TPD insurance for mental health (30% of TPD claims) 7,000 people claiming on DII for mental health (20% of DII claims)

¹⁰ Safe Work Australia data, while slightly out of date, covers all of Australia and schemes contribute data on a consistent basis. Since 2023, a number of schemes have continued to see increases in mental health claims. In NSW, the proportion of mental health conditions claims increased for 2024–25 at 11.9% (10.4% in 2023–24 and 8.0% in 2022–23). In Queensland, the proportion of psychological and psychiatric statutory claims increased for 2023–24 at 8.1% (6.8% in 2022–23). In Victoria, the March 2024 changes to restrict the criteria for mental health claims are anticipated to reduce claim volumes although reports indicate it is too early to conclude.

	Key financial mechanism	Description	Level of care (indicative)	Population coverage	Annual funding identified / estimated (\$m / \$b)	People accessing (approx. each year)
	Public liability insurance; Personal accident insurance; Motor Accident insurance; Travel insurance	There are a range of other insurances (general insurance schemes), which coverage typically includes mental health. Funding may relate to negotiated settlements or court awards, and do not necessarily have a direct link to direct treatment and income replacement costs.	Level 2 to 5: Low intensity to Acute and specialist	Relevant Policyholders	Data not materially and/or publicly available	Data not materially and/or publicly available
Private	Employer initiatives	Employer funded mechanisms for their employees to provide free, walk-in care for people experiencing mental health distress. This includes Employee Assistance Programs (EAPs) offering confidential counselling, mental health resources and referral services, as well as employer-paid sick leave that enables employees to take time off for mental health treatment without loss of income. These mechanisms provide treatment services and income replacement.	Level 1 to 4: Self-management to High intensity	Relevant Employees	Relevant Employees Data not materially and/or publicly available	Data not materially and/or publicly available
	Subtotal				\$3.8b+	
	Total				\$18.5b+	

5

Systemic Issues and Challenges



5. Systemic Issues and Challenges

Australia's Mental Health Financial Safety Net — whether viewed as individual components or as an interconnected ecosystem — is difficult to monitor, navigate and manage. Each mechanism operates under its own rules, eligibility criteria and funding cycles, often requiring specialist knowledge and inadvertently reinforcing siloed approaches to care.

These systemic limitations reduce the effectiveness of care. They contribute to delays, lower service uptake, and increase reliance on emergency and crisis responses, particularly for those who cannot access timely or sustained support (Productivity Commission, 2020; Mental Health Select Committee, 2022).

From a consumer perspective, the challenges typically fall into three core areas.

Affordability challenges

While there are multiple funding supports in place, mental health care is not always an affordable option. Consumers often face out-of-pocket costs, limits on subsidised services and uncertainty about long-term affordability.

How much do I need to pay? Can I access the funding I'm entitled to? What happens when my subsidised sessions run out, but I need long-term support?

Barriers to access

Access to funding does not guarantee access to treatment. Lengthening waitlists, workforce shortages and uneven service availability can limit timely care.

Who can help today? Will I be able to get help before my symptoms worsen? What happens if services in my area are full or unavailable?

Burden of navigation

Australia's mental health funding ecosystem is highly fragmented. Consumers often struggle to move between services or maintain continuity of care when their needs shift.

Will I keep getting help if my condition changes? Will services coordinate my care across different parts of the system?

For people with lived experience, these challenges can translate into real-world dilemmas such as:



What happens when a person with high-intensity needs nears or exhausts their allocation of 10 Medicare-rebated mental health sessions in one year?



How can a person living with a mental health condition financially protect themselves and their household if they cannot reasonably access private insurance?



Where can a person turn to if their mental health condition is serious and long-term, but not deemed severe or permanent enough to qualify for the NDIS?

These examples underscore a broader issue: Australia's current system places the burden of navigation, continuity and affordability on the individual. Without clearer accountability and stronger integration across supports, the financial safety net will continue to be uneven, especially for those with complex or evolving needs. Figure 8 summarises how these three areas of challenge are observed across the various support mechanisms of the Mental Health Financial Safety Net.

Figure 8: Observed consumer: challenges across key financial support mechanisms

Key financial support mechanism	Level of care (indicative)	Affordability challenges	Barriers to access	Burden of navigation
Immediate and universal access				
Digital mental health services	Level 2 to 4: Low to High intensity			
Helplines	Level 2 to 5: Low intensity to Acute and specialist			
Low to no cost clinical services				
headspace	Level 2: Low intensity			
Kids Hubs	Level 2 to 3: Low to Moderate intensity			
Community mental health care service (state-based)	Level 2 to 5: Low to Acute and specialist			
Medicare Mental Health Centres	Level 3 to 4: Moderate to High intensity			
General Practitioners	Level 2 to 4: Low to High intensity			
Subsidised services and financial aids				
PBS general subsidised medicines	Level 2 to 5: Low intensity to Acute and specialist			
PBS Safety Net	Level 2 to 5: Low intensity to Acute and specialist			
CTG PBS co-payment program	Level 2 to 5: Low intensity to Acute and specialist			
Social security payments	Level 1 to 5: Self-management to Acute and specialist			
Better Access Program (excluding GP services)	Level 2 to 5: Low intensity to Acute and specialist			
Medicare services outside Better Access Program	Level 2 to 5: Low intensity to Acute and specialist			
Commonwealth Psychosocial Support Program	Level 5: Acute and specialist			
Targeted and specific supports				
Private health insurance	Level 1 to 5: Self-management to Acute and specialist			
Workers' compensation insurance	Level 2 to 4: Low to High intensity			
Life insurance and income protection	Level 2 to 4: Low to High intensity			
Public liability insurance; Personal accident insurance; Motor accident insurance; Travel insurance	Level 2 to 5: Low intensity to Acute and specialist			
Employer initiatives	Level 1 to 4: Self-management to High intensity			

5.1 Affordability challenges

5.1.1 Out-of-pocket costs

Many mental health treatment services are publicly subsidised and form the bedrock of Australia's financial safety net. However personal and direct out-of-pocket costs remain and can be significant for a range of reasons.

- **Psychology services:** Affordability is limited by disparate funding mechanisms. For example, under Better Access, Medicare covers only part of the psychologist session fees, leaving consumers to pay \$80 to \$120 per session unless the provider bulk bills (DHAC, 2022a). This creates a strong disincentive for low-income consumers to engage or continue with therapy. Consumers face a similar situation if they have exhausted their private health insurance benefit limits.
- **Specialist fees:** Specialist doctor fees are often not fully subsidised and quickly add up across multiple visits. For example, out-of-pocket cost for an initial consultation with a psychiatrist can be up to \$670, the highest rate amongst specialist doctors (Grattan Institute, 2025).
- **Medication costs:** Despite co-payment caps, prescription medications can be a financial burden, particularly when managing multiple conditions. In 2025, PBS co-payments for general patients were \$31.60 per script or \$7.70 for concessional cardholders. As the threshold is reset each calendar year, consumers incur more out-of-pockets from the start of each calendar year. As indicated by the ABS Patient survey, many low-income households delay or go without medication, thus also missing out on the PBS Safety Net.
- **Other costs:** There can also be other out-of-pocket costs such as the cost of obtaining a mental health referral by a General Practitioner (GP), with typical out-of-pocket costs around \$40 per session (DHAC, n.d.), plus indirect costs like travel and time taken off work.

"There is almost zero access for people on Centrelink or low incomes to see a psychiatrist for assessment or medication review. Community mental health generally no longer provide access to a psychiatrist. Clients can't afford to pay the gap fee. Even though there are Medicare items such as Item 291 for referral to a psychiatrist, the gap fee can still be more than \$200 for this appointment. This has a significant impact on the treatment of complex mental health clients, as they are often in need of comprehensive assessment and appropriate medication support for acute symptoms. There is significant inequity for clients in this area. Similarly, clients who cannot afford to pay the gap fee (or ongoing full fee after 10 sessions) for a psychologist are often left without any treatment options for complex mental health issues. These clients are often not acute enough (i.e., suicidal) for community mental health support and often bounce between crisis services (homelessness, unemployment, lack of food and basic needs) without any appropriate mental health care." (Psychologist regional¹¹)

¹¹ Page 15 of [NSW-mental-health-system-on-the-brink.pdf](#)

5.1.2 Limits and caps on subsidised care

The Better Access initiative provides Medicare benefits to eligible patients for selected mental health services provided by GPs, psychiatrists, psychologists (clinical and registered), eligible social workers, occupational therapists and other prescribed medical practitioners. The Better Access initiative currently caps individual psychological therapy sessions at 10 per calendar year, with extensions only permitted under limited circumstances (DHAC, 2022a). However, for individuals with moderate to severe mental illness — such as major depressive disorders — evidence suggests that 15 to 20 sessions, or more, may be required to achieve sustained clinical improvement (Productivity Commission, 2020) or ongoing management.

An evaluation of the Better Access Initiative was undertaken in 2022. It found that affordability was the highest priority for future reforms. The incidence and size of co-payments have risen consistently over time. Utilisation of the program is lowest for people with low incomes, despite their relatively higher level of need.

"Private psychology is inaccessible for low-income consumers. Very few psychologists bulk-bill and their fees are very high." (Psychiatrist city¹²)

"Removal of bulk billing for private psychiatry limits access to a psychiatrist at all to most Australians. Inability of public system to provide psychiatrists to assess and manage ADHD in adulthood leads to dysfunction and slide into criminality resulting in ASPD [Antisocial Personality Disorder] diagnosis for many who have unrecognised and untreated ADHD. People with mental illness and history of interactions with CJS [Criminal Justice System] are stigmatised against by public mental health services and not provided with the treatment they need to both get well and to protect the community." (Mental health nurse regional¹³)

How much are people paying out of pocket?

In the year to June 2025, there were 12.9 million Medicare Benefits Schedule (MBS) services¹⁴ provided by psychologists, allied health professions, GPs and psychiatrists. The MBS rebate for these services amounted to over \$1.6 billion (excluding the rebates of the Original Medicare Safety Net and Extended Medicare Safety Net¹⁵).

Estimated out-of-pocket costs incurred by Australians for these services are about \$1.4 billion for the year ending 30 June 2025^{16, 17}. The three largest areas are:

- \$805 million for psychologists and allied health professionals for 6.8 million services, with an average out of pocket cost per service of \$176;
- \$475 million for psychiatry for 2.8 million services, with an average out of pocket cost per service of \$125; and
- \$153 million for GPs for 3.3 million services, with an average out of pocket cost per service of \$48.

For outpatient psychiatry services, the range and average of out of pockets are significantly higher than other services. For the two most common psychiatry services, being:

- appointment of 30 to 45 minutes (MBS items 304) – 81% of patients paid out of pockets costs, with an average of \$196 and 10% paying more than \$234 per service.
- appointment of 45 to 75 minutes (MBS items 306) – 77% of patients paid out of pockets costs, with an average of \$196 and 10% paying more than \$301 per service.

¹² Page 13 of [NSW-mental-health-system-on-the-brink.pdf](#)

¹³ page 11 of [NSW-mental-health-system-on-the-brink.pdf](#)

¹⁴ Based on MBS items considered to be mental health services under AIHW 2025 KPI 8 (i.e., Population access to clinical mental health care) of the National Mental Health Performance Framework 2020. Service data from Services Australia MBS data – extracted 12 August 2025.

¹⁵ In 2023, approx. 84,000 accessed the OMSN and 1.1 million accessed EMSN across all MBS health services.

¹⁶ We estimate the out-of-pocket cost by applying the number of services to the average out of pocket payment, based on data from the Department of Health, Disability and Ageing and Australian Psychological Society. Cost estimates have been calculated for 95% of services under each specialty. Psychology services include MBS items 80110, 80010, 91170, 91167, 80160, 91184, 91182, 82355, 82363, 82350, 80115, 91176 and 10968. GP services include MBS items 2713, 2715, 2712, 2717, 92127, 2700, 92126, 279, 92116 and 2701. Psychiatry services include MBS items 304, 291, 294, 296, 297, 300, 302, 306, 308, 319, 322, 324, 326, 328, 342, 343, 345, 347, 14217, 14220, 14224, 91827, 91828, 91829, 91830, 91837, 91838, 91839, 91873, 92435 and 92437.

¹⁷ Cost estimates have been calculated for 95% of services under each specialty. Psychology services include MBS items 80110, 80010, 91170, 91167, 80160, 91184, 91182, 82355, 82363, 82350, 80115, 91176 and 10968. GP services include MBS items 2713, 2715, 2712, 2717, 92127, 2700, 92126, 279, 92116 and 2701. Psychiatry services include MBS items 304, 291, 294, 296, 297, 300, 302, 306, 308, 319, 322, 324, 326, 328, 342, 343, 345, 347, 14217, 14220, 14224, 91827, 91828, 91829, 91830, 91837, 91838, 91839, 91873, 92435 and 92437.

For some, limits and caps on subsidised care can make the immediate financial burden outweigh the health burden. According to the ABS Patient Experience statistics (ABS, 2024), in the year to June 2024 (2023-2024), an estimated 38% of the Australian population that needed mental health support delayed receiving services. This is trending upwards from an estimated 34% in the year to June 2021 (2020-2021). Of the individuals who delayed receiving care, 20% reported in 2023-2024 this being due to cost, an increase from 12% in 2020-2021. Of those in 2023-2024 that delayed treatment due to cost:

- 10% delayed a GP visit (6% in 2020-2021);
- 26% delayed a psychologist visit (17% in 2020-2021); and
- 29% delayed a psychiatrist visit (18% in 2020-2021).

5.1.3 Private health insurance premiums and caps

Private Health Insurance (PHI) provides an additional safety net that complements Medicare's mental health coverage in Australia through:

- hospital cover for in-hospital psychiatric treatment as a private patient with choice of doctor and shorter waiting times; and
- extras cover for additional psychology, counselling, or mental health social worker consultations beyond Medicare's annual limits, with benefits varying by policy.

However, private health insurance responsiveness to mental health needs in practice is often very limited. While private health insurance extras policies can, in theory, help fund additional psychotherapy sessions beyond what's available to individuals through Better Access, in practice, most offer only modest annual limits and fixed per-session rebates that are not responsive to inflation or clinical complexity. Annual benefit caps on extras cover are often as low as \$200–\$500 for psychological services, which can be exhausted after two to four sessions. Gap payments for psychiatric hospital care can make private health insurance an ineffective financial safety net for some, disproportionately affecting those with limited financial flexibility.

Moreover, private health insurers are legally prohibited from paying benefits for any service that attracts a Medicare rebate. This potentially includes services that are more flexible and less resource intensive services, such as out-of-hospital psychiatric treatment. Consumers can be left in a difficult position: once they commence treatment under Better Access, they cannot rely on private health insurance to top up their care or offset out-of-pocket costs for those same services — a situation that undermines both continuity of care and financial protection.

Despite strong tax incentives for higher income individuals to take out private health insurance, private health insurance more broadly continues to be challenged with maintaining sufficient coverage levels. According to the latest APRA's Private Health Insurance Quarterly Statistics as of March 2025, the participation rates for private health insurance hospital cover and extras cover are approximately 45% and 55%, respectively. However, participation is not even across the population. The ABS Patient Experiences statistics (ABS, 2024) showed the participation of first quintile socio-economic disadvantage group to be 35%, compared to 79% of the fifth quintile. Those who do not have private health insurance instead rely on public hospital systems, and mostly cite affordability as the reason for lack of cover.

There have been some offsetting policy changes to improve affordability for consumers. One feature of the private health insurance second wave of reforms in 2021 was the increase in the age of dependants from 24 years to 31 years. In the case of dependants with a disability, the age limit has been removed. We note, however, the definition of a disability remains with the insurer, and insurers can define this on a case-by-case basis.

In light of the persistent financial sustainability challenges faced by the sector and ongoing consideration of reform, there remains an ever pressing need to review product designs and offerings for mental health to ensure they remain attractive, relevant and affordable to the broad population. There is evidence of recent positive steps with private health insurers increasingly providing direct lower-cost mental health support services, e.g., digital wellbeing services and training programs, 24/7 hotlines and virtual psychological sessions. Eligibility for these services differs between different levels of cover.



5.1.4 Life Insurance — balancing fair and affordable cover

Life insurance acts as an additional privately funded safety net beyond the funding and services tied directly to public and private health care systems.

Most working Australians typically have some level of automatic death and disability insurance cover as part of Australia's superannuation and retirement income system and delivered through group insurance. This applies to over three quarters of those with life insurance. The provision of group insurance at default coverage levels does not rely on individual health circumstances and therefore includes some mental health cover for all individuals under the group policy. To balance the cost of this insurance cover, superannuation funds can only provide a relatively basic level of default insurance cover.

Additional levels of cover including for mental health must be sought through the 'individual' life insurance market¹⁸. The individual life insurance market is an additional voluntary system that is obtained through a financial adviser or by applying directly with a life insurer. Insurers are allowed to risk-rate individuals who apply for cover. Risk-rating, also known as underwriting, is the process by which an insurance company assesses and evaluates the risk of insuring an individual applicant to determine whether to offer coverage, at what premium rate, and under what terms and conditions. Health questionnaires and medical underwriting usually form part of the application process.

Many risk-rated insurance products respond in some way to mental health conditions, noting however that mental health conditions can be difficult to assess in terms of severity, permanence and recovery trajectory. More generally for insurance benefit designs to be sustainable, they must cover risks that are insurable, and a sufficient number of consumers must be prepared to pay the cost. For individual consumers, the best and most generous policy without any exclusions would likely be unaffordable. To be valuable for consumers, coverage needs to strike a balance between responding to the needs of people who need to claim (due to mental ill-health or otherwise) and being affordable for consumers.

There are also some particularly difficult challenges with the inherent product design of TPD insurance. With around 60% of life insurance payments due to a mental health condition now as a single lump sum through TPD insurance, there is growing acknowledgement that single lump sum payments may not be the best way to support people who experience serious mental health issues. Experience has often shown that products that pay significant lump sums, such as TPD insurance, provide perverse incentives that can work against the original design and intent of the insurance, since they rely on a person establishing that they are permanently unable to work. A lump sum benefit may be less appropriate for mental health conditions than income stream products, which assume an eventual return to work may be achievable.

In practice during underwriting, some consumers who present with a history of mental illness can access limited cover — through time-limited exclusion clauses, additional price loadings, capped benefit periods or additional evidentiary requirements (such as psychiatric confirmation or restrictions on self-reported symptoms). But for those considered too high risk, they may find themselves unable to get cover at all at an affordable price. While these practices reflect risk mitigation strategies and are subject to anti-discrimination laws, they can contribute to a structural pattern of exclusion, particularly for people with fluctuating or episodic conditions. The ability to obtain insurance, therefore, does not always equate to accessible financial protection.

At the claims stage, a person's disability is assessed by looking at their ability to perform alternative roles with additional education, training or experience within a reasonable period and any rehabilitation, retraining or reskilling considered reasonable. However, the inflexible funding structures in other parts of the safety net sometimes affect how life insurers can support consumers to access the care that may speed up their return to work or wellbeing. Life insurers are not permitted under existing rules to directly fund the psychological care required, even if it is clinically recommended, if that treatment is coverable by Medicare or private health insurance. As a result, consumers with higher needs are often left to pay for themselves, or navigate overlapping rules and exclusions across funding systems, with little flexibility or integration. The issue impacts people claiming on their TPD insurance, where some TPD claims arguably could have been prevented had treatment been provided earlier.

Tellingly, consumer and industry groups have both expressed concern with the scale and complexity of supporting mental health through life insurance. The Public Interest Advocacy Centre (PIAC), a consumer group, has highlighted serious issues relating to systemic mental health discrimination, where it found that some people with mental health histories were being denied insurance coverage or subjected to unfair exclusions (PIAC, 2021). At the same time from a sector sustainability perspective, the cost of mental health permanent disability claims has increased by 433% (from \$39 million to \$208 million) between 2014 and 2022, vs a 200% increase in physical ill-health claims (from \$193 million to \$578 million) over the same period (KPMG, 2024).

All of these pressure points — at product design, underwriting and the claims stages — present a common dilemma. On the one hand, insurers are responding to affordability pressures from growing claims volumes and higher payouts through the design of these products. On the other, they face persistent criticism for excluding individuals from cover. Fairer, more nuanced, contemporary treatment of mental health conditions is increasingly expected.

There is a common understanding that risk should be assessed through evidence-informed models that distinguish between different diagnoses, treatment histories and levels of functional impact. This shift in mindset is happening slowly¹⁹ and advocates call for more and continued progress.

¹⁸ Individual life insurance cover can be, and is, often accessed through superannuation.

¹⁹ For example, Section 2.1 a) of the Life Insurance Code of Practice requires that life insurers design new products that do not incorporate a blanket exclusion specific to mental health in the general terms and conditions of the standard form contract, consistent with obligations under Australian Discrimination Law. Concerningly, the independent monitoring body, the Life Insurance Code Compliance Committee, has recently found that some life insurers are still relying on blanket mental health exclusions or rigid underwriting practices, limiting coverage for Australians who disclose a mental health condition.

5.2 Challenges in consistent measures of 'consumer affordability'

Currently, affordability measures of the mental health care system are monitored and published through a range of government and regulatory agencies:

- The AIHW's Mental Health Performance Framework 2020 measures the proportion of people who accessed clinical mental health care (public hospital, private hospital and MBS).
- The ABS's Patient Experience surveys approximately 30,000 people each year to measure the proportion of people who did not use a medical service due to cost — by socio-economic disadvantage and medical specialty (GP, psychiatry, psychology and allied health).
- APRA's Private Health Insurance Statistical Publications measure gap payments by medical specialty (available under hospital cover) and ancillary benefit types (available under extras cover).
- The Department of Health, Disability and Ageing's Medical Cost Finder tool helps consumers to understand the level of gap payments for all MBS items (medical services only) at a postcode level.

However, these measures are either high level or service level specific. There are important gaps in our understanding of affordability, such as:

- How is affordability perceived for different mental health conditions, given some conditions are long term and chronic in nature?
- How is affordability perceived for vulnerable groups and people with comorbidities?
- How is affordability perceived for people with no family financial support?
- How does affordability change over a consumer's journey through different care settings (e.g., gradual transition from low intensity to moderate intensity care; or moving suddenly to high/acute intensity to post-hospital care; or moving to aged care setting)?
- How does affordability interact with other social supports (e.g., NDIS participant with a Disability Support Pension)?
- How is affordability connected to other social determinants of health?

Answering these questions will enable design of more targeted funding policies through a more granular understanding of point-in-time affordability of population sub-groups, longitudinal view of the safety net and linkage of the financial safety net to the broader system of supports. This can only be achieved through greater data sharing and linkages between different departments, agencies and service providers.



In its landmark 2020 Mental Health Inquiry, the PC called for a nationally coordinated strategy to improve data useability (Recommendation 24 – Action 24.1). The need to consider affordability and access is acknowledged by Government as part of the finalisation of the National Mental Health and Suicide Evaluation Framework in 2023. Yet progress remains lacking. In the PC's June 2025 Interim Report from its review of the National Mental Health and Suicide Agreement, it found that data on performance and outcomes measures remain disaggregated and outcome measures are not always present. The PC's Interim Report is exploring the value and feasibility of having a public dashboard to track and report on progress of the next National Mental Health agreement.

Affordability issues are eroding the financial safety net for mental health

Consumers receive valuable care and resources from the financial safety net but desire more affordable options that respond to individual needs. While programs like Better Access provide valuable subsidies, consumers often face high out-of-pocket costs for psychology services, specialist consultations and medications, creating particular challenges for those with limited financial resources. Private health insurance and life insurance products offer additional avenues of support for those with greater means, but limitations, caps and exclusions undermine their ability to play a more active role alongside public systems. Better integration across funding systems aligned with consumers' needs would support more mental health treatment options and maintain better continuity of care. Establishing a system-wide and person-centred understanding of affordability pressures requires a nationally coordinated data strategy.

5.3 Barriers to access

Accessibility is a key principle of Australia's health system and recognises the various barriers that hinder people in need with differing circumstances from accessing appropriate support. Navigating the system is not simple. The Black Dog Institute characterises system navigation as "a skill many consumers and carers have to learn through trial and error"²⁰. Access to subsidised care, such as through Medicare and the PBS, often depends not just on an individual's clinical need, but is also affected by personal circumstance, such as location, cultural background, as well as the broader availability and capacity of the mental health system. These all impact their ability to access treatment.

"I believe young people find it difficult to access high quality, low-cost or free health care services, particularly mental health services. Often access to these mental health care services in NSW is limited to those who can afford it either through private health insurance, or out of pocket payments. Without access to these services, the mental health of young people is suffering." (Youth worker²¹)

"It would have been useful if I did not have to pay \$700 of my own money to get an autism diagnosis!" (Consumer seeking a diagnosis to access the NDIS²²)

5.3.1 Geographic disparities

Access to funded care varies widely by location, with rural and remote areas facing significant access barriers.

Limited providers in an individual's locality leads to long waits and high relocation or travel costs, increasing the risk of disengagement or deterioration (AIHW, 2023b).

NDIS access is similarly restricted, with regional participants reporting limited service availability, especially those with experience in complex or trauma-informed care (NDIS, 2024a).

While digital options such as telehealth have helped to improve access in some regions, telehealth does not fully replace in-person, relational care, especially for those with high care needs, low digital literacy, no internet connection or unstable housing.

20 Page 15 of [0138 Black Dog Institute.pdf](#)

21 Page 18 of [0074 Youth Action.pdf](#)

22 Page 14 of https://assets.pc.gov.au/_data/assets/pdf_file/0020/241436/sub496-mental-health.pdf

"The situation in this area is so bad now, that many people cannot access a GP AT ALL. Many surgeries have closed their books. People requiring mental health services cannot wait 6 weeks for an appointment." (Allied health worker regional²³)

"I have to travel interstate [to] New South Wales, Sydney and that's what I've done for twelve years. I have to rely on others when I drive, because there's no way I can get to New South Wales without driving. ... I had to pay for us to stay at a youth hostel overnight, and plus all our meals and all that. So, it's not just the cost of going to the psychiatrist." (ACT Consumer²⁴)

"There are less psychiatrists in rural areas compared to Metro areas. Waiting lists can be up to one year — this is unacceptable. There are fewer psychologists and the gap fee after the GP MH Care Plan is prohibitive for many (up to \$100 gap). Most GPs in rural areas do not bulk bill, so even getting a referral costs \$38. If you are on a Centrelink payment these fees act as a deterrent to seeking help. It is not surprising that people on low earnings have poorer mental health." (Mental health care professional rural²⁵)

5.3.2 Cultural and structural access issues

Cultural safety, trust and navigability are essential to equitable access — yet some cultural groups experience systemic barriers when interacting with the financial safety net, despite being eligible. The issues are often broader systemic disadvantage.

- Aboriginal and Torres Strait Islander peoples face structural and cultural barriers, with limited local and culturally safe providers, and deterrents like historical trauma, racism and poor service experiences (Productivity Commission, 2020). Despite widespread awareness and outreach campaigns, many individuals, especially vulnerable populations, may not know how to access these helplines.
- People with Culturally and Linguistically Diverse (CALD) backgrounds face language barriers, stigma within their communities, and a lack of interpreters or culturally matched clinicians, leading to low uptake and poor retention in mental health care (Mental Health Australia, 2023).

This can result in affected individuals having to bear higher burdens to access the mental health treatment, care and support that is local and culturally safe to them. These inequities lead to compounded disadvantages, more acute conditions and hence service use, and longer delays in receiving appropriate care.

"My parents were staying at my house at the time to help me with my toddler. Immediately, my mum was quite distressed that police turned up first. That's a very common reaction because, to us, it is like this injection of maybe our liberty is going to be taken away or people are going to judge us or not understand our behaviours, which we have experienced our whole lives. It can be really scary, to the point that many of my community don't even reach out to begin with, and that's why our suicide rate is seven times the general population. That is just not acceptable." (Consumer²⁶)

5.3.3 Administrative frictions and delays

Accessing funding and treatment for mental health care is very confronting for anyone going through it, especially for the first time. Separate eligibility conditions, assessments and paperwork are often involved with each funding and support mechanism, resulting in administrative frictions and delays in accessing care.

For people with high intensity or complex needs, public systems often require a multi-step process to access specialist care, involving GP referrals, development of treatment plans and the need to face regular reviews and reassessments to maintain eligibility for such support. This can be particularly challenging for young people, those managing multiple conditions and/or medications, or multiple family members, first-time users and/or vulnerable populations, i.e., populations with low health literacy (NSW Parliament, 2024).

Administrative processes are also demanding for providers. Allied health professionals participating in publicly subsidised programs must navigate item-specific claiming rules, tracking of session caps, and mental health treatment plan reviews (RACGP, 2024). In the case of consumers eligible for the PBS safety net, the lack of automation means around 500,000 eligible people miss out on utilising the PBS safety net each year (CHF, 2025).

In private insurance and as explored earlier, some claim assessment processes, such as for TPD, may inherently feel adversarial in nature, resulting in poorer outcomes for consumers living with mental health conditions. For consumers claiming on a mental health condition, the nature of the condition combined with product complexity with a variety of inclusions, exclusions and limits, contributes to generally longer times taken to report and assess claims.

23 Page 13 of [NSW-mental-health-system-on-the-brink.pdf](#)

24 Page 33 of <https://assets.pc.gov.au/2025-07/sub114-mental-health-review-attachment.pdf?VersionId=HVZrrk2HuVALoSsvQNOJGAbQNOEuqwmN>

25 Page 2 of [0003 Name suppressed.pdf](#)

26 Page 22 of [Transcript - PC 2 - Mental health care inquiry - 22 September 2023 - CORRECTED.pdf](#)

"The public mental health system has too many criteria for acceptance of patients ... The public system cannot cope with the influx. Clients therefore have nowhere to go. This is a serious issue of accessibility for this group and undermines the whole mental health system with this revolving door, ineffective and risky service." (Psychologist regional²⁷)

"I applied for the DSP [Disability Support Pension] but they rejected my application. I'm appealing, but what am I meant to do in the meantime? I am receiving Newstart, but it is not enough to live on. Newstart is not even enough to get by. I'm struggling to pay my rent, I have to choose between food, medicine and paying my bills. My local Centrelink office keeps advising me to apply for work, but I can't work anymore, I'm not well enough. I hate this. Don't they know that if I could work, I would? I've had to go without heating this winter, as the bills were too high. Living like this, without enough money or support: it is unspeakably awful: it makes you feel like no-one cares, like you don't matter. I want to see my psychologist but I can't even afford to do that. I'm in a dark place." (Consumer²⁸)

5.3.4 Mental health professional workforce shortages

A key challenge across the mental health system is the limited supply of trained clinicians, particularly in public settings and outside major metropolitan areas, as well as specialities, such as paediatric psychiatrists, child psychologists, and speech and occupational therapists. It is a well-documented national challenge. These challenges compromise the responsiveness and continuity of care for consumers.

The uneven availability and long-standing workforce shortages of psychologists, psychiatrists, mental health nurses and allied health professionals, especially in rural and regional areas, mean that despite eligibility there may simply be no local providers available to deliver care (National Mental Health Workforce Strategy Taskforce, 2022). In particular, psychologists and social workers in the public health care system report higher than average burnout and high caseloads, limiting preventive or therapeutic care and leading to over-reliance on acute services and poor continuity. At times of large-scale crisis or peak times, accessing helplines intended for immediate crisis support might also feel restrictive with longer wait times.

Better Access faces increasing pressure from demand exceeding supply, resulting in long waits and limited access to therapists with appropriate skills in trauma, complex presentations or culturally safe care (DHAC, 2022a). A persistent workforce shortage and a reduction in new entrants to the initiative were reasons why the temporary COVID-19 expansion from ten to twenty subsidised sessions under Better Access was not retained, effectively imposing a level of rationing to enable the initiative to partially meet growing demand.

To boost the capacity of the mental health workforce, the Australian Government has developed and published in 2023 the National Mental Health Workforce Strategy. According to the published strategy, an estimated 32% shortfall in mental health workers in 2019 will, if current shortages are not addressed, grow to at least 42% by 2030 (DHAC, 2023). Yet despite the developed strategy and commitments made, shortages in the workforce have continued to persist because this new national strategy did not contain any funding commitments or clear accountability structures (Productivity Commission, 2025a).

"High staff turnover at [NAME OMITTED] Centre for Mental Health and [NAME OMITTED] Community Health Centre which means inconsistency with recovery of the consumer and no rapport or relationship formed to assist them on their recovery journey. High staff turnover also shows lack of communication with others in that organisation which then creates a breakdown of communication to carers and consumers which impacts on their recovery. High stress in those two services and very limited workers compared to where it needs to be therefore also creating stress on the workers which effects how they work with consumers and carers. There needs to be more staff at public mental health services as not everyone can access private health systems due to financial hardship." (Community mental health worker city²⁹)



27 Page 14 of [NSW-mental-health-system-on-the-brink.pdf](#)
 28 Page 16 of [Response-to-Productivity-Commission-Inquiry-into-the-social-and-economic-benefits-of-improving-mental-health.pdf](#)
 29 Page 17 of [NSW-mental-health-system-on-the-brink.pdf](#)

5.3.5 Gaps for low to moderate intensity care needs

People with lived mental health conditions that result in low to moderate level of care needs may face additional challenges accessing mental health care and treatment in the Australian ecosystem. This cohort is sometimes referred to as the “missing middle”, for whom mental health conditions and needs are not deemed to be “permanent or sufficiently severe” to be eligible for support from the NDIS and other clinical mental health services.

Yet, low to moderate intensity level of needs can relate to conditions that are episodic and fluctuating. For people living with these conditions, they may experience functional impairment, repeated hospital admissions or job loss similar to those with high intensity needs, yet they are ineligible for long-term coordinated support. When other options like insurance and welfare support are also unavailable for the reasons discussed above, they are at increased risk of further reliance on intermittent, high-cost crisis care.

Those who fall just short of NDIS or other clinical treatment criteria often struggle to access equivalent psychosocial supports in the community, especially when other funding streams (e.g., Commonwealth Psychosocial Support, the DSP) are limited, fragmented or poorly integrated with primary care and housing services (NDIS Review, 2023). In this sense, the issue of access for this cohort can often present itself as one of affordability of self-funded care and treatment. There is now recognition that more needs to be done, in concert with State and Territory governments, to provide psychosocial support as part of foundational support outside the NDIS, but consensus has yet to be reached across jurisdictions.

The path forward likely requires enabling greater supply-side capacity and efficiency through digital and AI-integrated delivery models.

“[W]hat I mean by that is having the experience of feeling like my existing supports were not enough, and ... being told that, you know, I don’t meet the criteria to access certain supports. ... So, then being limited to the private system, and then the sort of, having to get into the private system and those other barriers of, you know, costs and accessibility.” (Consumer³⁰)

The financial safety net may not work for all — it depends on “where” you fall

Access to funding does not ensure access to care. Access is impeded by geographic disparities, cultural barriers, administrative delays and workforce shortages. Rural areas lack sufficient providers, while culturally diverse groups and temporary visa holders face exclusion and stigma. Enrolment processes for Medicare, NDIS and other supports delay care and can be complex, particularly for vulnerable populations. Workforce shortages and high demand further strain the system, limiting availability and continuity of care.

5.4 Burden of navigation

Australia’s mental health system is characterised by multiple funding sources, service providers and administrative structures, all operating with different priorities, eligibility rules and levels of government oversight. In other words, the notion of a financial safety net for mental health is not a coherent whole in practice but a patchwork of different mechanisms, each with different design and scope. Even if each element is functioning well within its intended design and scope in isolation, poor integration across systems can create serious issues for people with mental health conditions and inefficiencies across the broader care and funding landscape.

“There is no ‘continuum of care’ for MH [mental health] clients anymore: no ‘over-arching responsibility’ taken for a client’s care. Each issue requires negotiating complex access points, and each service provider operates in isolation of others (in a fragmentally funded environment that itself is not stable). This leads to crisis management, rather than planned care, to the detriment of clients’ health and service providers’ ability to provide good quality care.” (Mental health nurse city³¹)

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5.4.1 Poor transitions across systems

Transitions between systems represent some of the highest-risk moments for people with mental health conditions. Some programs are recognised for prioritising and ensuring a smooth process for referrals and care transitions, such as the Hospital Outreach Post-Suicidal Engagement (HOPE) program in Victoria, but this experience is not always consistently felt in all parts of the ecosystem, where transitions are often mixed, creating opportunities for individuals to fall through the cracks. Examples include:

- **Community to hospital and back:** Transitions between community-based care and hospital admissions are often not coordinated, particularly where providers do not share records or treatment plans. Consumers discharged from acute settings may be sent home without follow-up or are referred to under-resourced community teams with long waitlists (Productivity Commission, 2020).
- **Custody to community:** Individuals exiting prison often face an abrupt loss of Medicare eligibility and lack of continuity in mental health care or medication access. While some prison health services provide support on release, the handover to community providers is rarely seamless — creating a high-risk period for relapse, crisis or reoffending (AIHW, 2022c).
- **Youth to adult services:** Young people receiving care through youth-specific services like headspace may encounter a cliff-edge transition into the adult mental health system at age 25. This can mean new eligibility rules, new providers and new care plans, often without adequate preparation or support (Hendrickx et al., 2020).
- **Digital support to intensive services:** There is a need to ensure well-structured transitions from immediate need (e.g., digital support) to long-term or more intensive needs (e.g., community-based supports or specialist supports).
- **Coordination of supports:** NDIS and related psychosocial support reforms should complement other financial safety net supports and health care (Medicare-funded therapy, state-funded clinical care) as they are implemented and rolled out.
- **When insurance coverage ends:** Transitions between and from private insurance coverage to public health systems represent natural friction points that could undermine continuity of financial support and care. For example, there are different definitions of mental ill-health among insurance benefits that can be challenging to understand/navigate, and / or once the coverage for private health insurance or workers compensation ends.

"I am frustrated that the system can feel set up for managing crises but not preventing them from happening, which is what I value as a GP. I called the Mental Health NSW line about a patient who planned to stop taking their depot medications for schizophrenia due to side effects. I was seeking a psychiatrist review to put him on another medication to prevent relapse. Unfortunately, the mental health clinician I talked to seemed dismissive as the patient was not actively in crisis. The Mental Health NSW team did contact the patient, but he did not respond. After being off his medication, he relapsed, and ended up with a police charge and hospitalised. When I call a service I want them to trust the judgement of us as general practitioners — that if we think it is important, then it is. That we know our patients, and we know preventive care." (General practitioner city³²)

5.4.2 Lack of interoperability between systems

The mental health system lacks a unified infrastructure for planning, funding and data sharing. This is particularly evident between major systems that theoretically serve the same consumers at different points in their mental health lifetime journey.

Medicare and the NDIS operate as separate systems with different assessment processes, provider lists and funding rules. A person receiving Medicare-subsidised psychological services may still be required to undergo an entirely separate assessment to access NDIS-funded psychosocial supports — for example, a GP mental health treatment plan for access to Medicare Better Access, a functional assessment for NDIS, and a separate psychiatric report for income protection insurance — even if this is required to support the same condition (NDIS, 2024a). These processes are not aligned and can be emotionally and administratively exhausting.

Insurers, Primary Health Networks (PHNs) and state-funded services often work in silos. There is limited coordination of care pathways, shared records or pooled funding. Consumers engaging with multiple systems may receive overlapping services or duplicative assessments, while still missing essential supports (Mental Health Australia, 2023).

This lack of system-level interoperability reduces both cost efficiency and care effectiveness, and contributes to ongoing policy confusion around who is responsible for what.

Some services require both a GP referral and a separate mental health care plan, which can lead to conflicting pathways and delays in care commencement. The complexity of access requirements often disadvantages those in distress, those without regular GP relationships or those with limited health literacy (RACGP, 2024).

5.4.3 System navigation burden on consumers

The net result of poor integration is a system that is difficult to understand, hard to access and fragmented in delivery. People with lived experience frequently report feeling like they are starting over every time they move between services or funding streams. There is often no continuity of care or provider knowledge, and minimal system navigation support. People who understand the rules and can navigate the system are more likely to get funding or treatment than those who struggle with the process or lack help.

The burden of managing eligibility, appointments, claims and referrals falls heavily on the consumer, often at a time when their capacity to manage this burden is at its lowest. This contributes to disengagement, dropout and reliance on acute services as a last resort. These challenges are not merely administrative; they represent a failure of system design to centre on user experience and continuity of care.

"NDIS is too complicated for those who need it most. More affluent families will be able to navigate the system and get funding more easily. It is very difficult to access private psychiatry services, so people saturate GPs/public services in crisis." (General practitioner city³³)

5.4.4 Misalignment of care and funding mechanisms

Funding can be misaligned from where care is most effective, favouring crisis-driven hospital care while underinvesting in community-based, preventive and recovery-oriented supports. Public funding is skewed towards acute care, leaving community mental health teams under-resourced, and people with low to moderate needs are either turned away or referred to long waitlists. This results in a system where individuals may perceive that the only option left is to seek support when they have deteriorated to crisis point, at which stage care is more costly, less effective and more traumatic. This system is therefore unsustainable.

Some Nordic countries demonstrate what is possible with integrated, prevention-focused systems. For example, Denmark provides free psychological counselling for 18-24 year olds and guarantees psychiatric assessment within one month. Norway has community mental health centres integrated with primary care. Over 90% of primary care practices in the Netherlands and Sweden have integrated mental health professionals.

Consumers' burden remains high when navigating the patchwork of the current financial safety net

Australia's mental health care ecosystem and the funding that underpins it is yet to be properly integrated. This is discouraging support usage. Poor coordination between systems like Medicare, NDIS and private insurance creates gaps in care, inefficiencies and heavy administrative burdens on users especially at critical transition points. These systemic failures across mental health services continue to worsen and push consumers toward acute care, compromising recovery and sustainability.

The silver lining — recent investments to boost the financial safety net for mental health

There has been significant investment from the Federal and State governments in targeted transition programs across Australia aimed at addressing care transitions. Examples include:

- NSW Pathways to Community Living Initiative (PCLI) — transition of long-stay mental health patients (12 months or more) into appropriate community-based living and services
- QLD Youth Step Up Youth Step Down (SUSD) Facilities — residential mental health service providing short-term, intensive support as a transition between hospital and community care
- VIC Hospital Outreach Post-Suicidal Engagement (HOPE) — community-based suicide prevention support program providing aftercare service as a transition from Emergency Department or as an inpatient following a suicide attempt.

Besides targeted programs, the Federal Government has committed to increased facilitation for consumers to navigate the mental health care system (Treasury Ministers, 2024). Formerly known as 'Head to Health' Clinics and previously designed to provide integrated health care for youths, Medicare Mental Health Centres are now being expanded and extended to the broader population as part of a nationally consistent National Service Model last set in April 2025. These centres aim to provide:

- immediate support to people who are experiencing crisis or at risk of suicide;
- short to medium-term support and care before longer-term care can be implemented; and
- a central point to connect people to other services (service navigation and referral). It assists individuals with moderate to high levels of mental illness and their families/carers to navigate health, mental health and broader social services.

There are currently 55 centres operating. By mid-2026, it is expected 61 centres will be in operation.

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6

Policy and Future Directions



6. Policy and Future Directions

This chapter outlines a set of recommendations aimed at strengthening the Mental Health Financial Safety Net. Rather than prescriptive solutions, the recommendations are about shaping a future direction for all stakeholders responsible for different parts of the financial safety net — including governments, insurers, providers, consumers and researchers, including the actuarial profession and beyond — to work towards a more affordable, accessible and unified ecosystem. The major themes of the recommendations are:

- addressing the structural problems undermining the current financial safety net — including affordability, access and integration;
- focusing action on points of influence across sectors that can unlock greater coordination, continuity and affordability; and
- developing smarter funding designs that support better and more effective resource allocation.

The case for reform is clear. But so too is the complexity of implementation. Reforming a fragmented mental health support system — especially one that spans multiple major public funding mechanisms like Medicare and the PBS, as well as private insurance — requires both clarity of direction and sequencing of effort. The affordability challenges require immediate attention, while resolving barriers to access and burden of navigation will involve a longer-term solutions and bigger scale reforms.

Figure 9: Further detailed recommendations

Priority area	Recommended actions	Lead actors	Timing
Whole-of-system priority investment approach	1. Embed a whole-of-system priority investment approach to improve affordability, focusing on: • identifying duplication, funding gaps and cohorts at risk; • evaluating equity and financial protection; and • implementing reforms for integration and sustainability. A priority investment approach acknowledges the need for further reform at a time when resources across many parts of the financial safety net are already stretched. It recognises that meaningfully addressing mental health requires sustained investment over multiple budget cycles with cross-sector collaboration to address root causes rather than crisis responses. This is consistent with the PC's recent Interim report on Delivering quality care more efficiently which recommends a National Prevention Investment Framework. It is an approach that underpins a growing number of government programs, nationally and internationally. We recommend this action be considered by the Commonwealth Government as part of responding to the Productivity Commission's Review of the National Mental Health and Suicide Prevention Agreement when finalised, specifically Draft PC Recommendation 4.2 'Building the foundations for a successful agreement', in concert with the State and Territory governments, and involving all parts of the financial safety net. A whole-system priority investment approach would also support Draft PC Recommendation 4.1 'Developing a renewed National Mental Health Strategy' with a view to providing an agreed objective for the mental health system for the next 20–30 years and to provide greater direction for the next and subsequent National Agreements.	Department of Health, Disability and Ageing (lead), Treasury, AIHW, Productivity Commission	Immediate and Medium (2025–2028)

Priority area	Recommended actions	Lead actors	Timing
Data capability and systems intelligence	2. Implement a national mental health data strategy to address the immediate affordability challenges: • Improve data sharing to enable development and granular monitoring of performance metrics of incidence, degree and persistency of affordability issues, with regard to consumers' use of multiple funding mechanisms and transitions to different care settings. • Share data (e.g., population, services, claims) with mental health researchers and advocacy groups to enable targeted policy development and investment in mental health care that address affordability as a priority.	AIHW (lead), ABS, Department of Health, Disability and Ageing, state health departments, NGOs, Treasury, Productivity Commission, Researchers, actuaries, funding analysts, economists	Immediate (2025-2026)
	3. Develop a coverage and outcome framework that models and monitors the cost of failure points in the Mental Health Financial Safety Net, evidence of unmet needs, delayed treatment, underinsurance and preventable hospitalisation. The framework would integrate funding streams and treatment pathways and address socio-economic access barriers across public and private systems. The framework should include mechanisms for transparent reporting, independent oversight and adaptive policy responses. It must also enable longitudinal tracking of consumer outcomes across funding transitions (e.g., from PHI to DSP) and identify cost-effective interventions that reduce avoidable system burden.		Medium (2027-2028)
Affordability relief for at risk groups	4. Provide more effective affordability relief for financially vulnerable groups in each component of the financial safety net, particularly individuals with chronic mental health conditions and frequent psychiatric service use. As an example, leverage targeted policy mechanisms such as co-payment relief and MBS rebates for psychiatric care within the Medicare Safety Net to reduce cost-related barriers to treatment and to mitigate under-treatment risks.	Department of Health, Disability and Ageing (lead), Treasury	Immediate (2025-2026)

Priority area	Recommended actions	Lead actors	Timing
Private and public sector coordination	5. Develop a shared, evidence-based framework for assessing mental health conditions across both private and public sector contexts to improve consistency across products and sectors (e.g., DSP, Life Insurance). This includes designing processes that recognise the psychological impact of repeated assessments and complex documentation requirements and therefore embeds safeguards against re-traumatisation, particularly for individuals experiencing mental health challenges. Assessment processes would prioritise empathy, transparency and simplicity, reducing the need for consumers to retell distressing experiences, navigate fragmented systems or manage excessive paperwork.	Department of Health, Disability and Ageing (lead), Treasury, peak insurance industry bodies (e.g., Council of Australian Life Insurers, Private Healthcare Australia, Insurance Council of Australia), Comcare and state workers compensation insurers	Immediate (2025–2026)
	6. Review the coordination and integration of private and public funding mechanisms, in particular: - gaps arising from the funding rules across Medicare, Private Health Insurance and Life Insurance; - the ongoing appropriateness of existing state-based workers' compensation scheme designs, including moving towards a more nationally consistent scheme; and - customer financial outcomes during and after periods of insurer support (e.g., transition from workers compensation to DSP).		Medium (2027–2028)
	7. Identify opportunities for coordinated investment (e.g., pooled funding) to address gaps in prevention, continuity of care and recovery. Pooled funding opportunities could include: - progressing the National Mental Health Workforce Strategy to improve capacity of the mental health professional and services workforce; and - providing better information for consumers and support with system navigation.		Long term (2028+)

Priority area	Recommended actions	Lead actors	Timing
Product design reform	8. Redesign insurance products and pursue innovations that provide more appropriate and cohesive mental health support. In Private Health Insurance, providers should consider ways to: • extend coverage for evidence-based community mental health supports; • have affordable cover tiers include less intensive mental health supports to address current and changing consumer needs; • simplify and, as much as possible, standardise varying provider definitions of “dependants with a disability”; and • deliver “no or low gap” mental health care arrangements, including potentially through integrated delivery and funding models for psychiatric and psychology services. In Life Insurance, providers should consider best-practice ways to: • design cover to ensure the insurance benefit is not excessive when compared to the financial loss and consideration of benefit designs that indemnify people for lost income, which may include (in combination, not in silos): — coverage to care companions — refining strategies to balance the mix of lump-sum and income-stream payouts; and • promote a fair, efficient and contemporary experience for consumers that seek to access, purchase and potentially claim on their life insurance in relation to mental health. To meet legal requirements and evolving community expectations, insurers should continuously ensure risk assessment models are kept up-to-date and appropriately distinguish between different diagnoses, treatment histories and levels of functional impact.	Insurers (lead), peak insurance industry bodies, mental health advocacy groups	Immediate and Medium (2025-2028)

In Closing

While extensive in scope, Australia’s Mental Health Financial Safety Net remains fragmented and challenged to deliver cohesive, equitable, and timely support. Rising demand is exposing structural weaknesses across the system — from inconsistent access and affordability to duplication, regulatory misalignment and unmet need. The financial safety net is uneven, with a growing risk that Australians experiencing mental ill-health will fall through it.

A fit-for-purpose system must do more than respond at the point of crisis. It should enable timely, affordable access to care, support people in stepping up or down service levels as their needs change and reduce financial hardship as a barrier to recovery. This requires a coordinated ecosystem that integrates both public and private mechanisms — and is designed around people, not products.

Implementing the recommendations in this report will involve rebalancing costs across funders, including governments, insurers (i.e., insurance consumers) and the wider community. While some reforms may require increased investment in the short term, these costs are not additional in an absolute sense: they reflect a redirection away from reactive, high-cost endpoints toward earlier, more effective forms of support, with an aim to improve future economic and broader social outcomes overall. Over time, the goal is a more sustainable system — one that reduces pressure on emergency and acute services, supports workforce participation, and delivers better outcomes for consumers and the broader economy.

This report sets out a direction for reform. It does not seek to represent the voices of clinicians, consumers, or carers — but to support them by contributing a structural, actuarial and systems perspective. In doing so, the Actuaries Institute hopes to inform more coherent policy, smarter investment decisions and a stronger financial safety net for all Australians.

7. Statement on Language

Language in mental health policy and research carries weight. The terms used throughout this report have been carefully considered to try and balance respect, accuracy and clarity across diverse audiences — including people with lived and living experience of mental illness, policymakers, service providers and the broader community.

This report does not attempt to resolve the many debates about preferred terminology in mental health, but rather aims to use language that is consistent, inclusive, and fit for purpose within a financial and policy context.

Consumers

In this report, the consumer refers to people in Australia who seek or receive treatment for a diagnosed mental health condition. This includes:

- Adults and children experiencing mental illness or psychological distress;
- People with mild, moderate, or severe symptoms, whether episodic or persistent;
- Those who could be formally diagnosed and therefore eligible for clinical treatment;
- Those accessing treatment from mental health professionals;
- Those accessing funding for this treatment through public systems, private systems or a combination of both; and
- Carers or family members who access supports as part of the care process.

“Consumer” is widely used in Australian mental health policy and advocacy, particularly in relation to service co-design, funding access and systems reform. While the term has limitations — particularly in its framing of health care as a market transaction — it remains useful in the context of this report, which focuses on the economic and systemic perspectives of accessing care.

The report uses “consumer”, “individual”, and “person/people” interchangeably depending on the context:

- “Consumer” is typically used when discussing funding mechanisms, access or entitlements, such as rebates or subsidies;
- “Individual” is used in analytical or demographic contexts, e.g., when discussing eligibility criteria, age cohorts or claimants; and
- “Person” or “people” is used when referring more broadly to the human experience of mental illness, recovery and support.

This intentional variation is used to balance technical precision with human-centred language, and to ensure the report remains respectful and accessible while staying grounded in policy analysis.

Treatment

The term “treatment” is used throughout the report to refer to evidence-based clinical interventions provided to individuals with a diagnosed mental health condition. This can include:

- Consultations with General Practitioners (GPs), psychiatrists, psychologists, and a diversity of allied health professionals;
- Prescription medications for mental health conditions;
- Hospital-based psychiatric care including via Emergency Departments and community-based therapeutic services; and
- Care coordination and structured psychosocial supports where clinically indicated.

“Treatment needs” refer to the level and type of mental health support a person requires to manage symptoms, improve functioning, and support recovery. This may include clinical care (such as psychological therapy or psychiatric treatment), medication, peer support, social interventions or a combination of approaches. Unmet treatment needs occur when individuals are unable to access, afford or receive appropriate care aligned to their condition or circumstances.

Mental disorder, illness and ill-health

In this report, the terms “mental disorder”, “mental illness” and “mental ill-health” are used interchangeably to reflect the varying language used across key data sources, including the Australian Institute of Health and Welfare (AIHW), the Department of Health, Disability and Ageing and the Australian Bureau of Statistics (ABS).

While we recognise that these terms have differing clinical and policy definitions, we adopt this approach to reflect the magnitude of the issue as reported, and to ensure consistency with national datasets and studies.

In this report, the distinction between mental and physical health is not deliberate and may arise inadvertently due to the focus of discussions on the mental health financial safety net and support ecosystem; however, it is not intended to detract from a holistic, whole-person approach to wellbeing. We acknowledge the limitations of this framing and encourage ongoing efforts to improve clarity, nuance and person-centred language in mental health reporting.

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