How to tackle a giant: creating a genuine evaluation of the Better Access Program

Sebastian Rosenberg and Ian Hickie

Objective: *This paper proposes a framework for a systematic evaluation of the Better Access Program, the largest single component of mental health reform announced under the Council of Australian Governments National Action Plan on Mental Health 2006–11.*

Method: *The article explores the genesis of the Program and considers extant data sets and information available with which to establish the impact of the Program on consumers and service providers.*

Results: *There are useful data available in Australia from which to derive pre- and post-implementation analysis about the impact of the Better Access Program. There is doubt as to whether these data form part of the Federal Government's current approach to evaluation of the Program.*

Conclusions: *Anything less than a genuine and comprehensive evaluation will leave Australia unable to assess the real impact of the Better Access Program. The merit of further expenditure in the vital area of primary mental health care will be in doubt as a consequence.*

Key words: *accountability, evaluation, mental health, psychology.*

In this report we are proposing a framework to ensure a systematic evaluation of the Better Access Program.

The largest single component of the National Action Plan for Mental Health 2006–11[1] announced by the Council of Australian Governments (CoAG) was the Better Access Program, which commenced on 1 November 2006. It focused primarily on enhanced access to evidence-based psychological therapies for those presenting to primary care[2] and was said to have built on some of the strengths of the earlier program, Better Outcomes in Mental Health.[3] In setting up the Better Access Program, the Department of Health and Ageing estimated forward expenditure on the Program of $538m over 4 years. The cost over this period is in fact now approaching $1.4bn. In an overall landscape characterized by relatively meagre investments in mental health over decades by successive governments, the Better Access Program is a giant investment.

The Commonwealth has now established a process to evaluate some aspects of the Better Access Program but this has occurred with little or no public disclosure regarding the methodology. This article therefore sets out the parameters for a genuine evaluation of the Program, designed to answer several key questions: how, if at all, has the Better Access Program made a real difference for people with mental ill-health in Australia; how much did we already know about primary mental health care against which to assess our progress; is the Program working as originally conceived and is the continued substantial Federal spending on the Program justifiable?

Unless the Government's current evaluation can clearly demonstrate its capacity to answer these questions, in our view there is a serious danger

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that the review process may be fatally compromised, designed more to reinforce the perspectives of those who provide the services (and the Government agencies that fund these activities) than to deliver a genuine evaluation as a platform for substantive improvements and reform of primary mental health care services.

BEFORE BETTER ACCESS

Studies of community and primary care in Australia have indicated that the rates of treatment for common forms of anxiety or depression were unacceptably low.[4–6] Even when treatment was provided there was also a relative over-reliance on medicines and an underutilization of evidence-based psychological therapies.[7] In 2001 the Australian Government introduced the Better Outcomes in Mental Health Program with an emphasis on providing better quality care for anxiety or depression to those people who were already attending general practices.[3] This Program not only provided financial support for the provision of psychological therapies by GPs and other trained mental health professionals such as clinical psychologists but also provided specific incentives for completing an episode of care. Family doctors were required to undertake additional psychological training to access the rebates associated with the scheme.

Importantly, the initial program did not seek to provide care to those who did not already use General Practice for their psychological needs (e.g. young persons, males, Indigenous Australians). That is, it was not about 'Better Access' but largely focused on providing better quality care for those already receiving medical attention. Furthermore, given its very limited funding, it was targeted on providing support for those from lower socio-economic backgrounds.

Through its use of Divisions of General Practice as the primary fund holders for the initiative, it also sought to overcome the traditional lack of access for psychological services experienced by those in rural and regional Australia. However, this approach also meant that access was limited to those persons attending practices that had participated in additional training or the related service improvement schemes supported by the Divisions.

INTRODUCTION OF THE BETTER ACCESS PROGRAM

In 2006, following the initial success of the Better Outcomes Initiative and in direct response to community reports documenting poor access to other mental health services,[8–10] the Howard Government introduced broadly based Medicare rebates for specialized psychological treatments, effectively removing the financial cap on the number of services that could be provided nationally. Professional groups strongly endorsed this move, largely on the grounds that all persons attending primary care would then be able to access such services. Better Access also reverted to the traditional fee-for-service and GP-referral mechanisms that underpin all other specialist healthcare practice in Australia. Most importantly, the move to Medicare-based funding removed any capacity for direct funds to those in greatest need (by demography, geography, socio-economic status or any other high-risk status).

In the context of the landmark COAG National Action Plan on Mental Health (2006–11),[1] the Better Access Program was the major initiative financed by the Federal Government. In reality, the program's emphasis was less on increased access and more on improving the quality of care for those who were already attending primary care services. In addition, the change from Better Outcomes to Better Access accurately reflected the movement away from an outcomes focus to a preoccupation with inputs. This is entirely consistent with the largely outcome-blind nature of Australia's National Mental Health Strategy, continuing a systematic failure to properly assess whether specific program developments actually deliver better health outcomes for those with mental ill-health. The Better Access Program set specific aims as shown in Box 1.

Better Access abandoned many of the key characteristics of the Better Outcomes Model, including:

payment for completed episodes of care rather than individual consultations;

implementation of diverse fund holding and practitioner payment models for individual practitioners;

supporting continuing GP-based service development, education and training;

capitalizing on the geographical distribution of Divisions of General Practice to achieve more equitable distribution of services.

Box 1. Aims of the Better Access Program

Encouraging more general practitioners to participate in early intervention, assessment and management of patients with mental disorders.
Streamlining access to appropriate psychological interventions in primary care.
Encouraging private psychiatrists to see more new patients.
Providing referral pathways for appropriate treatment of patients with mental disorders, including by psychiatrists, general practitioners, clinical psychologists and other trained allied health professionals.

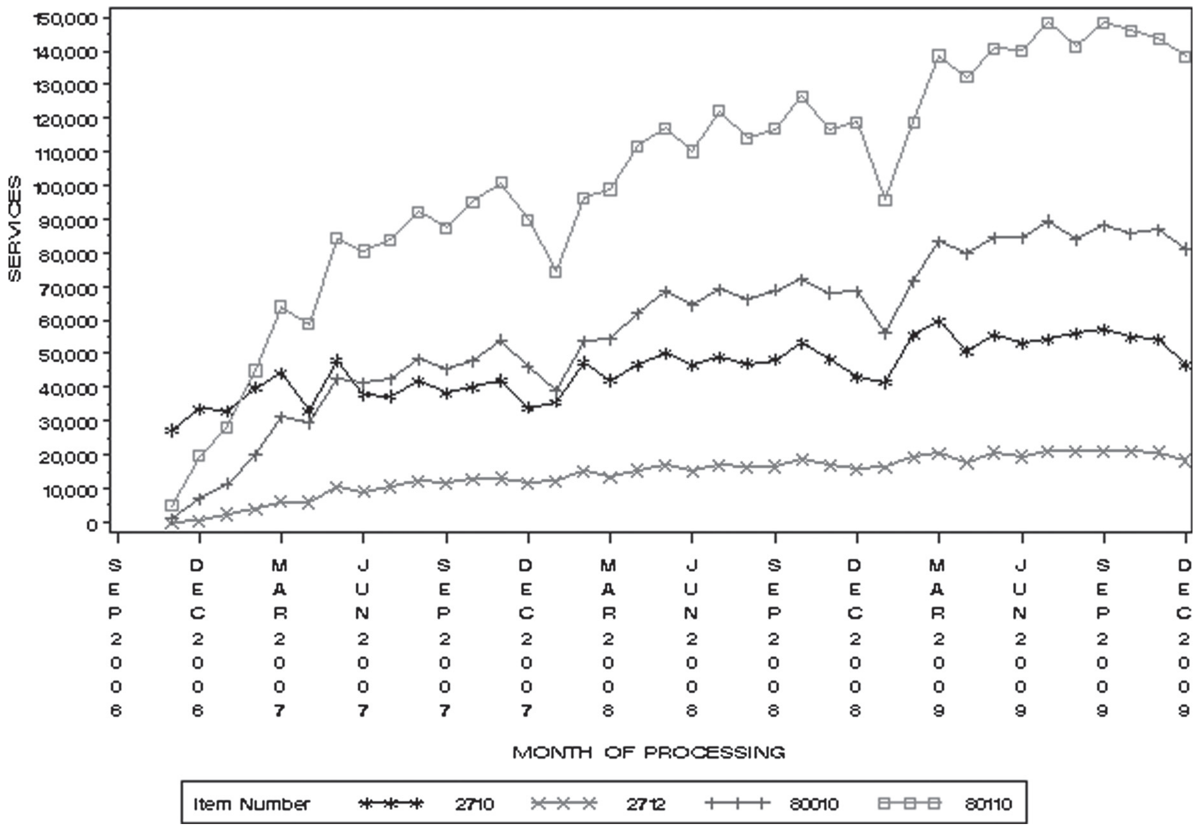

Figure 1: Uptake of Primary Better Access Medicare schedule items.

UPTAKE OF THE BETTER ACCESS PROGRAM

Since its commencement on 1 November 2006 the uptake of the Program has far outstripped the initial projections. As shown in Figure 1, to the end of 2009, 11.2 million services had been provided, including the creation of almost 1.7m GP Mental Health Care Plans (Item 2710). These GP Plans are the trigger for initiating patient participation in the Better Access Program, particularly receipt of psychology services.

It was intended that each Mental Health Care Plan be reviewed (Item 2712). It is noteworthy that the number of plans written outstrips the number of reviews by a ratio of 3:1. The growth in registered psychology services (Item 80110) has been relentless, unsurprising given this workforce is much larger than specialist clinical psychology (Item 80010). According to the latest report prepared by the Department of Health and Ageing,[11] there are now over 16 400 allied health service providers registered under Medicare.

The great majority of the specific psychological services delivered under the Program have been provided by registered psychologists (3.76m services) and then clinical psychologists (2.1m services). The Program has now cost over $1.1bn since November 2006. As stated, final expenditure over the life of the CoAG Action Plan could be three to four times more than initially estimated by Government.[12]

Analyses of data released by the Department of Health and Ageing in 2008 indicated that the services were being utilized largely by women, middle-aged persons and those in major urban and regional centres.[12] Those same data indicated that consumers were also paying considerable co-payments for each additional general practice, psychological and psychiatric service. A considerable debate emerged as to the extent to which services were being provided to persons who had not previously been treated or whether the new rebates were being provided largely to persons who had already received medical or psychological care.

The 2007–8 National Survey of Mental Health and Wellbeing[13] indicated that there had been little change over the last decade in the proportion of persons with common mental disorders such as anxiety, depression or substance misuse who receive psychological care in any 12 month period (35% in the 2007–8 survey as compared with 38% in 1997). Consistent with the reported impacts of our national community awareness campaigns focused on depression[14–16] there was, however, a suggestion that those with depressive disorders may now be more likely to be receiving psychological care (58% in 2007–8 compared with 44% in 1997).[6,17]

THE EVALUATION PROJECT DESIGN

Given the national significance of the Better Access Program, its potential to increase access to high-quality mental health care, the criticisms of its initial design and implementation and the escalating cost of the services, there have been repeated calls for systematic, timely, transparent and extensive evaluation. These calls were resisted strongly during the Howard Government, with the explanation being offered that evaluation would be undertaken once the Program was fully operational.

In mid-2009, the Department of Health and Ageing completed a competitive tender process to select external organizations to conduct various components of a broadly scoped evaluation. It is important to note that the authors of this article were members of organizations that tendered for various aspects of this work but were unsuccessful in their bids.

No information about the evaluation has been made public as yet by the Government, though the process is 1 year old. It is understood that the evaluation is not due to conclude until the end of 2010 with the possible release of interim information after various stages are completed. The overall task has been split into four components as shown in Box 2.

THE KEY EVALUATION QUESTIONS

It is critical that the evaluation be robust and transparent. One of our central critiques of the style of evaluation of the impacts of Australia's national mental health strategy over the last 15 years has been its preoccupation with reporting provider-based activity (and satisfaction) and locus of care (hospital vs. community) rather than a more critical focus on access, quality or outcomes.

At this time, funders, decision-makers and the community at large have a real and vested interest in whether the new services are accessible, represent value for money and/or lead to improved rates of recovery.

Box 2. Four components of evaluation of the Better Access Program

Component A: a study of consumers and their outcomes – being conducted by the University of Melbourne.
Component B: an analysis of Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) Administrative Data – being conducted by the University of Melbourne.
Component C – an analysis of allied mental health workforce supply and distribution – being conducted by the National Institute of Labour Studies, University of South Australia.
Component D: consultation with stakeholders – being conducted by KPMG Consulting.

In our review here, we focus on components A and D of the evaluation. Components B and C are primarily mechanical exercises, involving the mining of existing data sets and the presentation of relevant findings. With regard to component B, the massive uptake of MBS items has already been reported.[12] The current data set does not reveal how many Australians have a GP mental healthcare plan, merely the number of plans for which a Medicare claim has been lodged by a GP. We do not know how many of these Australians entered the mental health system for the first time only after 1 November 2006 or if they were previously receiving medical or psychological care. The great reluctance to link Medicare data to (de-identified) individuals for the purpose of more systematic data linkage (with other Federal Health and Social Services and State-based Hospital data) remains a major obstacle to proper evaluation of the impacts of this program (and others).

There are two key questions in relation to the evaluation of component C. The first is to assess the extent and impact of any flow of the psychology workforce from the public to the private sector. The second issue would be some assessment of the level of skills and training undertaken by the psychology workforce. The original advocates for Better Outcomes and Better Access emphasized the importance of provision of services by highly skilled clinical psychologists.[18] It is important to ask who has been serviced, and what has been the health impact of services now provided by registered psychologists? The massive financial impact of the decision to extend the rebate to this very large but significantly less trained workforce is already clear. The extent to which it has also undermined the professional status of clinical psychologists has now been raised in the public domain.[19]

A STUDY OF CONSUMERS AND THEIR OUTCOMES

The real crux of any genuine evaluation of the Better Access Program is component A.

The practice-based data that drove the initial development of Better Outcomes and then Better Access drew national attention to the low rates of detection of psychological disorders in primary care settings, and the overly medicalised forms of care being provided by Australia's GPs.[5] If the move Better Outcomes to Better Access has not impacted on these key measures of quality care then it should be judged a poor investment. We assume that current consumers, and the wider community, have a fundamental interest in accurate detection of mental disorders in primary care settings, access to those forms of care that are most likely to deliver improved outcomes (notably collaborative rather than individual practitioner-based care)[20] and access to choice in terms of available treatments. Previous research[4] has indicated that a range of consumer, professional, and practice-system based barriers to quality care are in operation alongside the more familiar geographical and financial obstructions. We would assume that a systematic evaluation would also include relevant qualitative and quantitative measures of these barriers.

In our view then, a genuine assessment of component A must be able to answer four major questions as shown in Box 3.

Given that the Program commenced on 1 November 2006, key comparisons will need to be both historical and concurrent. The current practice of GPs in identifying mental disorders and providing evidence-based care needs to be compared with pre-existing patient-based and provider-based data sets (such as the BEACH data set[21]). Importantly, a reliance on data generated by providers only will not provide information regarding enhanced detection or accuracy of assessment. A recent systematic review indicated the extent to which identification and treatment of depression in primary care settings remains a major logistical challenge.[22] If the evaluation proceeds without reference to historical data sets, or does not seek to collect data in ways that can be easily compared with earlier reports, then we have little chance of determining the true national impact of the Program.

Next, the various key components of the Program need to be compared in terms of their impacts on current consumers. Unlike the earlier Better Outcomes Program, such impacts cannot be limited to basic outcome measurements in those who received enhanced services.[23]

Of much greater relevance are factors such as:

- the identification rates of psychological disorder in persons attending general practice;
- the prevalence of all mental health treatments provided in primary care, including the provision of medical or psychological treatments by the GP alone;
- demographic, professional and practice system predictors of identification rates and the various treatment services provided to those with common mental disorders;
- the relative impacts of the different styles of treatments provided by GPs alone or in combination with other psychological service providers supported by the new rebates;
- the experiences of care of consumers.

Box 3. Four key questions for the evaluation of better access

1. To what extent does the program improve access to evidence-based mental health care for people who present to a GP with a common mental disorder?
2. What are the demographic and illness characteristics of consumers with mental disorders attending GPs who do and do not receive the new service enhancements?
3. To what extent do the various service enhancements result in better mental health outcomes for people attending GPs with a common mental disorder?
4. To what extent do the various service enhancements meet consumer needs and expectations?

We recognize that answers to these key questions, and systematic evaluation of the differential impacts of the current treatment strategies would require considerable investment but, relative to the size and scope of the Program itself, they would represent excellent value for money.

PRIOR EXPERIENCES WITH NATIONAL PRIMARY CARE DATA: THE SPHERE PROJECT

In the late 1990s, the nationally organized SPHERE Project collected data directly from 46 515 consumers attending 386 GPs throughout Australia (with oversampling from rural and regional centres). With the assistance of Divisions of General Practice, that process was repeated in 2001–03 and 2004–06.[24] The SPHERE Project investigates those aspects of practice organization, practitioner performance and consumer experience that are of key significance to the evaluation of the identification and treatment of common mental health problems in primary care settings. It focuses on:

- obtaining data direct from consumers (an approach that differs from the BEACH study);
- collecting relevant demographic, professional and system-based data;
- recording actual treatments (including referrals to specialised services) provided to all patients who reported mental disorders, not just those identified by the doctor.

More recent reports have emphasized the extent to which key groups, such as young people, have continued to report low access to quality care.[25] We are now proceeding to repeat key aspects of the SPHERE Project after introduction of the Better Access Program in 2006.

A key aspect of this later work is to ensure that the sample size is now adequate to permit detailed comparisons with the 1998 data. We estimate that it may be necessary to screen at least 25 000 clients attending at least

250 GPs to capture a true picture of the state of mental health services in primary care settings. Of those persons attending GPs, at least a third will have significant psychological disorders but only a much smaller proportion will be receiving specific treatments under the Better Access Program. More specific experiences of care will be evaluated using measures that were developed by the Picker Institute Europe[26,27] and have been deployed in Australia over the past few years.[9] The follow-up components of these studies will compare the outcomes of those people with psychological disorders who have received either GP care alone or GP care plus additional psychological services. This is the standard that we have applied to the evaluation of additional e-health based services and should, in our view, be the standard applied to additional in-person psychological services.

To date, under our National Mental Health Strategy, only the two National Surveys of Mental Health and Wellbeing (1997–98 and 2007–8) have provided data sets of sufficient size or methodological rigour to withstand external scrutiny and to make very important contributions to the latter development of national policy.[6,16] Other data sets have been collected on key sub-populations or within specific health care settings (such as primary care) by independent research groups (such as the SPHERE study among others). Only rarely have those data sets been large enough or existed as repeated measures to add further detail to our overall understanding of the state of access to high quality mental health services in this country. The danger now is that the studies supported through component A of the program evaluation will once again fail to inform the wider community or health policy makers as to the real impacts of the initiative. The need for improved health services research capacity has been clearly identified by the NHMRC.[28]

A repeat of the very limited approach taken for evaluation of the psychological services component of the Better Outcomes Program will also fail to resolve much of the current debate.

THE IMPORTANCE OF ADEQUATE STAKEHOLDER CONSULTATION

Component D of the evaluation of the Better Access Program concerned stakeholder consultation. In its tender submission, the Mental Health Council of Australia suggested a multi-pronged approach. (The authors assisted the MHCA prepare its tender submission to the Department of Health and Ageing which is unpublished. The Department does not generally publish responses to request for tenders.)

This included formal submissions, key informant interviews, web-based surveys, structured focus groups and a direct survey of consumer and carer experiences of care, using a recognized and validated approach to this type of survey of the type already deployed in Australia during the course of the Not for Service Report.[9,26]

The MHCA planned to engage around 5000 people who had been managed by their GP and/or referred for specialist care. This would have been possible through an approach to over 500 General Practices registered in the SPHERE GP database.

The evaluation now commissioned under the Better Access Program needs to demonstrate this type of thorough methodology in the collection of stakeholder views for it to be regarded as genuine.

CONCLUSIONS

The Better Access Program is the largest and most significant new investment made in mental health services for many years. As part of the 2009–10 Federal Budget, the Government removed access to social workers and occupational therapists under the Program. However, these only ever accounted for a tiny fraction of total expenditure under the Program which remains a runaway giant. The community deserves a rigorous evaluation process. It should form the basis for making informed choices about the merit of continued investment. In our view, it is critical that the evaluation pose the right questions and support the development and/or maintenance of databases that can answer the key questions now and into the future. This is a matter that should concern consumers, carers, health professionals, policy makers and taxpayers alike. Failure to address the issues identified here, particularly with regards to components A and D, will leave the utility of the Better Access Program in doubt. This outcome could seriously jeopardise future funding for this program and other major mental health service developments in Australia.

DISCLOSURE

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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