

Australia's Better Access Initiative: Do the Evaluation Data Support the Critics?

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The Better Access Initiative was introduced in 2006 to improve the treatment rate of common mental disorders. The scheme extended the benefits under the Medicare national health insurance scheme to cover mental health services provided by GPs and specialist mental health providers. The greatest change was to extend Medicare rebates to cover psychologists and other allied mental health specialists. The new services have proved very popular with the Australian public and the original budgeted cost of the scheme has been well exceeded. Despite this popularity, Better Access has been the subject of a range of criticisms from some people in the mental health sector, which have been aired both in the public media and in the professional literature.

In this issue of the journal, Jane Pirkis and colleagues report data evaluating the clinical outcomes of people who received services from GPs or psychologists under the Better Access scheme [1]. This evaluation study joins a range of other evidence that has recently become available on Better Access [2-5]. The availability of this evidence allows an examination of whether the criticisms that have been made are justified.

Before examining the evidence in relation to the criticisms, it must be admitted that much of the evidence is not of the highest scientific standard. In a companion editorial, Nick Allen discusses the paradox that a scheme that receives such a large amount of public funds should be evaluated using methodologies that are weak within the hierarchy of levels of evidence [6]. On the other hand, once a government decides to roll out a new program universally across the country, the opportunity to carry out methodologically rigorous research with appropriate controls is lost. In such circumstances, we have to make the most of what evidence is available, however imperfect. Despite its limitations, the evidence still has much to tell us in relation to the criticisms of Better Access.

The criticisms and the evidence

It has produced a big blow-out in cost

At its inception, the Better Access scheme was described in the press as a “honey pot”, with “professional groups fighting for their share of the harvest” [7]. Once the scheme began, it soon became apparent that the cost would greatly exceed the initial estimates, leading to complaints that it was a “runaway giant” [8], with “costs spiralling” [9] and “unbridled growth” [10]. Indeed, the latest figures show that the cost is over two-and-a-half times the original estimate. While the unexpected cost has been seen as a failure of the scheme, it also reflects its popularity with the Australian public and the previous large unmet demand for psychological therapy. The cost also needs to be seen in light of what it provides. Pirkis and colleagues [1] report that patients typically change from having moderate-to-severe depression and anxiety to having normal-to-mild levels. Pirkis and Harris [11] have estimated that the average cost per episode is \$750, which is less than has previously been estimated as needed for the optimal treatment of depression and anxiety disorders.

It hits patients with out-of-pocket expenses

It has been argued that the Medicare fee-for-service system behind Better Access allows practitioners to increase their income by charging higher rates, so that they can get both the Medicare rebate and a co-payment from the patient [12]. These out-of-pocket expenses may be a particular barrier for people who are socioeconomically disadvantaged [10]. An analysis of Medicare data found that the percentage of services that attracted a co-payment varied greatly from 7% for GP services to 65% for psychological therapy services [5]. In 2009, the average co-payment was around \$36 per service. While co-payments were common, they were found to be

slightly smaller for those with greater socio-economic disadvantage, varying from \$33 in the most disadvantaged quintile to \$38 in the least disadvantaged [5].

The criticism about out-of-pocket expenses needs to be considered together with the previous criticism about the cost blow-out. Co-payments are not just meant to increase the income of practitioners. They are also a disincentive to over-use of services. Without co-payments it is possible that the cost blow-out would have been even greater.

It has failed to deliver equitable access in rural and socioeconomically disadvantaged areas

From its inception, there were fears that Better Access would improve services in affluent metropolitan areas, but not elsewhere [7]. It has been argued that the fee-for-service model of Better Access removes the capacity to direct funds into rural and socioeconomically disadvantaged areas that have traditionally been under-served [8]. A number of studies have reported data on the geographic and socioeconomic distribution of Better Access services. An early analysis of Medicare data up to 2008 found that fewer services were provided in rural and low socioeconomic areas [2]. Similarly, an analysis of service use by participants in the Australian Longitudinal Study on Women's Health found that socioeconomically disadvantaged women were less likely to use the services [3]. Contrary to these findings, an analysis of the National Survey of Mental Health and Wellbeing found no association of socioeconomic disadvantage or rural living with use of Better Access services [4], but this study may have lacked sufficient statistical power to detect small differentials. The most convincing findings come from an analysis of national Medicare data from 2009 [5]. This found very similar rates of service use for capital cities, other metropolitan areas and rural centres. Uptake rates were around 12% lower for 'other rural areas' and 60% lower for remote areas. When socioeconomic

disadvantage was examined, rates were around 10% lower in the most disadvantaged areas compared to the least disadvantaged. Despite these remaining inequalities, it is notable that the scheme has greatly increased access to services across all sections of the population, including people living in rural, remote and socioeconomically disadvantaged areas [5]. Furthermore, the data from Pirkis and colleagues on patient outcomes show that outcomes were just as good for people from rural and socioeconomically disadvantaged areas [1]. In conclusion, there is clearly a problem in remote areas, but otherwise the whole community has benefited from Better Access and the remaining differentials are small.

It discriminates by age and gender

There have been complaints that Better Access services are mainly used by middle-aged women, and that young people and men have not received services at the same level as the rest of the population [8,13,14]. However, such differences in age and gender service use may be appropriate if they reflect differences in the prevalence of disorders. Data from the 2007 National Survey of Mental Health and Wellbeing show that for affective and anxiety disorders, females had a higher prevalence than males, and those aged 25-44 had a higher prevalence than other age groups [15]. When type and severity of disorder are taken into account, National Survey data shown that age and gender do not predict use of Better Access services, implying that there is no age or gender bias [4]. However, another study which linked data from the Australian Longitudinal Study on Women's Health to Medicare records, did find evidence of age bias. Contrary to the view that Better Access discriminates against the young, this study found that Better Access service use was lower in very elderly women with mental disorders (aged in their 80s) compared to younger women (aged in the late 20s and early 30s) [3].

It provides services to the worried well rather than to those with serious mental disorders

Critics have charged that the Better Access scheme focuses on people with mild problems rather than those with severe mental disorders and labels those getting the most benefit as the “worried well” or those “troubled by life” [13,16]. However, the data reported by Pirkis and colleagues show that over 90% had a diagnosis of an anxiety or depressive disorder and that over 80% had high or very high psychological distress on the K10. Furthermore, the greatest symptom improvement was seen in those with the greatest pre-treatment distress. Similarly, an analysis of data from the 2007 National Survey of Mental Health and Wellbeing [4] found that only 7% did not have an ICD-10 mental disorder or other indicator of need for treatment. Indeed, around half were assessed as having a severe disorder. It is clear that the “worried well” comprise only a very small minority of Better Access Users.

It funds services for those who were already receiving them

It has been claimed that when Better Access was introduced, the rebates were largely provided to people who were already receiving medical or psychological care [8]. However, several sources of data show that most were receiving services for the first time. In the evaluation by Pirkis and colleagues, around three-fifths of patients seen by psychologists had not previously received mental health care, although this was true of only two-fifths of those seen by GPs [1]. Data from the National Survey of Mental Health and Wellbeing were used to estimate that 62% of the Better Access patients were new cases [4]. Similarly, data from the Australian Longitudinal Study of Women’s Health found that among women who used Better Access services, very few had previously reported seeing a mental health professional [3].

It devalues the specialized skills of clinical psychologists relative to other psychologists

Better Access provides funding for the services of both clinical psychologists and general psychologists without specialized clinical training. The decision to include general psychologists in the scheme has been controversial, with arguments that they are not adequately trained for the task, and has led to a rift between some leading clinical psychologists and the Australian Psychological Society, which represents all psychologists [17]. Because general psychologists greatly out-number clinical psychologists, their inclusion in the scheme has been seen as one of the reasons for the cost blow-out [8]. Indeed, in 2009, general psychologists provided around double the number of Better Access services as clinical psychologists [5]. However, do they produce different patient outcomes? The evaluation by Pirkis and colleagues [1] provides data on symptom scores pre- and post-treatment for clinical psychologists, general psychologists and GPs. From these data it is possible to calculate uncontrolled (pre- vs post-therapy) effect sizes. The standardized mean change score was 1.31 for clinical psychologists, 1.46 for general psychologists and 0.97 for GPs. The effect sizes for the two groups of psychologists are similar and are comparable to the mean uncontrolled effect size of 1.29 reported in a meta-analysis of psychological therapies in routine clinical settings [18]. On the data available, it appears that general psychologists produce equivalent outcomes to clinical psychologists and perhaps better average outcomes than GPs.

It has failed to encourage evidence-based psychological treatment

Better Access was designed to fund the delivery of evidence-based psychological treatments. However, it has been claimed that “service users have frequently reported receiving psychoeducation and non-specific counselling rather than the evidence-based CBT programs”

[10]. The evaluation by Pirkis and colleagues does not support this contention [1]. They found that around 90% of patients seen by psychologists received some CBT, as did over 70% of patients seen by GPs. On the other hand, analysis of data from the 2007 National Survey of Mental Health and Wellbeing found that Better Access users were more likely to receive information about their illness and non-specific counselling, but were not more likely to receive CBT [4]. However, the National Survey data were based on reports by patients rather than clinicians and may reflect a lack of knowledge about different types of psychological therapy. Arguably, the more important issue is whether patients receive treatments that benefits them, rather than whether it fits under the rubric of CBT. The data from Pirkis and colleagues show clear improvement in symptoms, with no difference in amount of improvement between those receiving some CBT compared to those not receiving it [1].

It has produced a drift of psychologists from the public to the private sector

When Better Access was introduced, there was concern that psychologists would leave public sector mental health services and set up in private practice [7,8]. However, workforce data on the number of psychologists in the public sector show a steady increase from 1995-96 to 2008-09, with no drop after the introduction of Better Access [5]. The same pattern has also been found for social workers and occupational therapists [5].

It has failed to develop collaborative care

Under Better Access, GPs have to draw up Mental Health Care Plans for patients, which may include referring them for psychological services. These plans are also meant to be reviewed, so that there is collaboration between the GP and psychological service provider. However, it has been pointed out that the number of plans drawn up greatly exceeds the number of reviews, suggesting that collaboration between the GPs and psychological service providers is not

occurring as it is meant to [8]. Critics have charged that “GPs have allowed their role in Better Access to dwindle to that of glorified referrers” [10]. On the other hand, there is some data from interviews with various types of practitioners that the Better Access model of service delivery has generally worked well [5]. The assumption behind this criticism is that on-going review by the GP must be a good thing for patients. However, whether patients benefit from a review is an empirical question. It is clear from the data reported by Pirkis and colleagues [1] that patients are generally getting better even though most are not being reviewed by the GP.

Scorecard on the criticisms

I have reviewed the evaluation data in relation to 10 criticisms that have been made. The only criticisms that are fully justified are those relating to a cost blow-out and patient co-payments. However, without patient co-payments the cost may have been even greater and other methods of rationing, such as service caps, may have been needed. Two other criticisms, relating to socioeconomic and geographic inequalities, also have some justification, but these inequalities are far less than might have been expected and are offset by the substantial increase in services that Better Access has given to these disadvantaged sections of the community. The remaining 6 criticisms receive little or no support.

At the time that Better Access was introduced, I largely shared the views of the critics, seeing an uncapped fee-for-service scheme as the wrong way to improve access to psychological services. Having examined the data, I have largely changed my mind. Better Access has generally fulfilled its promise of improving access, although it needs some tweaking at the edges to reduce remaining inequalities.

The big remaining question

The big remaining question is whether Better Access has improved population mental health.

Following large increases in antidepressant treatment [19], we have now seen a large increase in psychological treatment over recent years. There is good reason to believe that the widespread availability of these treatments should have reduced burden of disease due to depression and anxiety disorders [20,21]. However, we currently have no evidence that this has occurred.

Population monitoring of mental health is needed to find out whether this investment in treatment has been justified.

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