

COAG Mental Health Reform



Mental Health and the new Medicare Services: An Analysis of the First Six Months

July 2007

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Executive Summary

This report presents an analysis of the first six months of the new program Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule. It focuses primarily on the three new MBS Items where uptake has been high – MBS Item 2710 relating to General Practitioners (GPs) developing a mental health plan and referral, MBS Items 80010 and 80110 relating to psychologists providing assessment, evidence-based therapy and focussed psychological strategies.

Key Findings

The new MBS Items are having a real impact, although we need further analysis to know exactly what that impact is. The challenge into the future is to ensure that these new MBS items do not exacerbate existing mental health service gaps.

There has been a large uptake of the new MBS Items with over 170,000 services provided in May 2007 alone, mostly for psychological services.

Of the \$78 million already committed to funding the three most popular new MBS Items, \$52 million has been spent on services for women, \$26 million on men. Perhaps of more importance than gender is age. While 75% of all mental disorders commence before the age of 25 years¹, these new services are not reaching this most at-risk and hard to reach group.

Distribution of services across Australia is not uniform, with some States making much higher levels of claims for the new services on a per capita basis. The distribution of claims appears to broadly match the distribution of health professionals.

Recommendations

1. The budget amounts allocated to the new MBS Items promoting better access to mental health services need to be reviewed in light of extraordinary demand.
2. There is an urgent need for more detailed analysis of the MBS Item data. As a first step Medicare should be asked to provide details on:
 - the location of services provided – e.g. by Local Government Authority
 - patient information relating to whether each service is a new service to a new patient or a service provided to an existing patient, and the nature of the conditions being treated
 - data to track out-of-pocket expenses payable by the patient for these services and rates of bulkbilling.
3. The available evidence suggests a much greater emphasis needs to be placed on early intervention and increasing young people's access to mental health services.
4. The provision of psychological services in specialist consulting rooms clearly dominates the new MBS Items, and this approach needs to be monitored, particularly in terms of evidence-based practice, including client outcomes.
5. There is a pressing need for increased emphasis on developing a national mental health workforce strategy that makes better use of existing mental health professionals.

¹ I Hickie, P McGorry, *Increased Access to Evidence-based Primary Mental Health Care: will implementation match the rhetoric?*, Medical Journal of Australia, 2007; 187 (2); 100-103



Introduction

2006 saw unprecedented attention and new funding given to address the issue of mental illness in Australia. This was most welcome, particularly the leadership shown by the Prime Minister and the NSW Premier.

By far the largest single component of the \$1.9bn COAG mental health reform package announced in July 2006 was \$538m allocated (over five years) by the Commonwealth to enable Better Access to Psychiatrists, Psychologists, General Practitioners, and other allied health professionals through the Medical Benefits Schedule (MBS)². A range of new MBS Items were devised and implemented on 1 November 2006³.

It is important to remember that while the MBS initiatives constitute the largest element of the COAG funding package, they are but one of several different initiatives designed to improve Australia's mental health service system.

This report provides a short summary and brief analysis of the new MBS Items. Using the limited data available from the first six months of their operation, this report discusses the uptake of the new Items and some of the emerging patterns which are presented in ten key findings below and five recommendations. It has been prepared in response to numerous requests for the Mental Health Council of Australia (MHCA) to provide some commentary on the implementation of new measures developed as part of the Council of Australian Government (COAG) mental health package.

It is important to note that the information presented in this report is largely drawn directly from figures available in the Medicare Benefits Schedule (Item) Statistics Reports⁴ and the associated Medicare Benefits Schedule (Medicare online)⁵. While the public availability of these statistics is to be commended, there are clearly many limitations to these figures, not the least of which is the level of patient data available and the actual distribution of services provided.

Another factor that needs careful consideration is that this is only the first six months of a new scheme of payment and service provision. Ongoing patterns of use are not established and this first report should be seen as having limited scope in terms of longer term predictive power. Despite these limitations this report reveals some significant trends in the patterns of access to the new MBS items, as well as highlighting a number of fundamental questions that need to be addressed.

In outlining his government's determination to address Australia's mental health crisis, the Prime Minister stated there would be no "quick fix"⁶. It is hoped this report will stimulate further discussion and analysis to ensure Australia continues to make positive steps towards an effective, accessible and responsive mental health service for Australians.

2 Council of Australian Governments National Action Plan on Mental Health 2006-11, see http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf

3 A summary of the relevant changes can be found at: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Medicare-Benefits-Schedule-mbs-publications>

4 see http://www.medicare.gov.au/statistics/dyn_mbs/forms/mbs_tab4ag.shtml

5 see <http://www9.health.gov.au/mbs/search.cfm>

6 http://www.pm.gov.au/media/release/2006/media_Release1858.cfm

Background

Australia will spend over \$12 billion dollars this financial year supporting access to medical services through the Medical Benefits Scheme. This scheme provides direct payments to providers of medical services based on a fee for service model. The health service provider submits a return to Medicare detailing the MBS service provided and the Australian Government makes the appropriate Medicare payments based on an established schedule of fees and services.

As part of its laudable COAG mental health initiatives implemented in November 2006, the Commonwealth government now offers payments to general practitioners (GPs), psychologists and a range of associated health professionals to provide specific mental health services (MBS items) including the development of a mental health plan (GPs) or assessment, evidence-based therapy and focussed psychological strategies (psychologists).

These items are part of the \$538m *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* initiative, which is a principal contribution of the Commonwealth to the COAG National Action Plan on Mental Health 2006-11.

It is important to note that the primary purpose of these new MBS measures is to increase access to mental health services across Australia. These measures are not seen as a solution to all mental health problems and issues, but seek to increase the availability, accessibility and use of targeted mental health assessment, planning and evidence-based treatment.

The Mental Health Council of Australia strongly supports these new measures.

At the same time, there is an obvious need to monitor the outcome of these new measures and seek to improve their effectiveness wherever possible.

This report seeks to provide a starting point for discussion about what is, and what is not, being achieved through these new MBS measures.

The questions raised by this report need to be addressed if Australia is to make the most of its growing investment in mental health services.



Methodology for this Report

This report draws on the MBS Item Statistics Reports which provide data on requested items in the Medicare Benefits Schedule. These reports were accessed via the Medicare website during the first and second weeks of July. The primary focus of this report is on the new Medicare items relating to mental health services.

An initial scan of all relevant mental health related Medicare items was undertaken to identify numbers of services in each category. This included:

- MBS Items 2710, 2712, 2713 (all relating to the development of a mental health plan by a medical practitioner);
- MBS Items 80000, 80005, 80010, 80020, 80100, 80110, 80120, 80125, 80135, 80145, 80150, 80160, 80170 (all relating to psychological services from psychologists, social workers or occupational therapists);
- MBS Items 291, 293, 296 and 353 (all relating to consultant psychiatrist services); and
- MBS Item 10956 (allied health item relating to services provided by an eligible mental health worker).

The uptake of some of the new items has been very substantial. Table 1 below indicates that since their introduction in November 2006, new MBS Items 2710, 80010 and 80110 account for 706,961 occasions of service funded under Medicare to May 2007. These three items each attracted more than 40,000 services in May 2007 alone, five times higher than any other mental health-specific Medicare item:

Table 1

MBS Item Occasions of Service Nov 06 – May 07

MBS Item No.	Description	Occasions of Service	Occasions of Service
		Nov 06-May 07	May 07 Only
2710	Preparation of a Mental Health Care Plan by a GP Benefit: 75% = \$112.50 100% = \$150.00	258,831	48,047
80010	Psychological assessment and therapy for a mental disorder by a clinical psychologist lasting at least 50 minutes (up to 12 planned sessions a year) Benefit: 85% = \$110.00	142,717	42,407
80110	Focussed psychological strategies for an assessed mental disorder by a registered psychologist lasting at least 50 minutes (up to 12 planned sessions a year) Benefit: 85% = \$75.00	305,413	84,318
Total		706,961	174,772

Based on this initial review, the authors of this report chose to focus the majority of the report on analysing these three higher uptake MBS Items where there were significant numbers of services.

The report also briefly notes some of the more significant findings from other relevant MBS Items.

The analysis consists largely of comparison of services by gender, age, jurisdiction, and per capita distribution.

There is also some comparison to workforce availability. GP data is drawn largely from Medicare items for GP services (Item 23) as an indicator of GP servicing patterns in each jurisdiction. Psychologist availability data is primarily drawn from the mental health workforce analysis reports from the Australian Bureau of Statistics and the National Health and Labour Force Series from the Australian Institute of Health and Welfare.

The discussion section also briefly raises some additional issues including MBS Item service patterns compared to prevalence data drawn from a range of sources including the 1997 National Survey of Mental Health and Well-being.

In preparing this report the authors had several telephone discussions with Medicare staff about the availability of statistics and interpretation of data.

There were also discussions with relevant staff within the Department of Health and Ageing who are responsible for some of the statistical interpretations.

The Mental Health Council of Australia currently has a formal written request for further information from Medicare. The additional information requested will provide a more detailed analysis of the three key MBS Items for mental health based on LGA level data. This additional information will also enable analysis of service distribution across Australia. Medicare staff has indicated this data may be available in two to three months time.

Please note: Those interested in further analysis may wish to access the MBS Data files held on the MHCA website – www.mhca.org.au



Key Findings

1. There has been a very substantial uptake of the new Medicare items

Since November 2006 when the capacity to apply for the three key MBS items was introduced (2710 – GP mental health care plan, 80010 - psychological assessment and therapy, 80110 - focussed psychological strategies), the number of requested payments for services under these MBS Items has risen from nil to over 170,000 claims in May 2007. This represents a very significant uptake of these three new MBS payments.

Figure 1 (below) also provides uptake on two other new MBS Items as a comparison. These MBS Items are for similar services, but for less time per session.

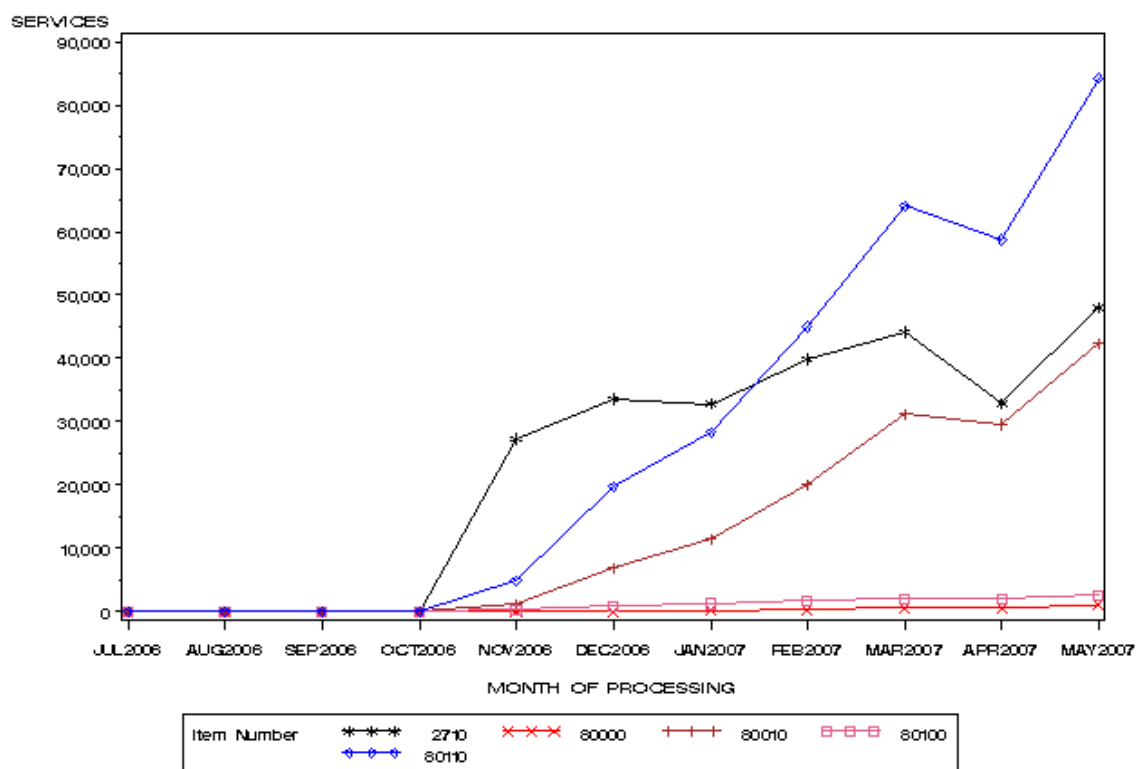
Item 80000 – psychological assessment and therapy by a clinical psychologist lasting between 30 minutes and 50 minutes (up to 12 planned sessions a year)

Benefit: 85% = \$75.00

Item 80100 – focussed psychological strategies by a registered psychologist lasting between 20 minutes and 50 minutes (up to 12 planned sessions a year)

Benefit: 85% = \$53.15

Figure 1



- The cost of this increase in the use of Medicare is likely to be higher than \$200 million per year in the first year

Table 2

Summary of total payments for the three MBS Items 11/06 – 05/07

Item 2710 \$38.8 million

Item 80110 \$23.3 million

Item 80010 \$15.9 million

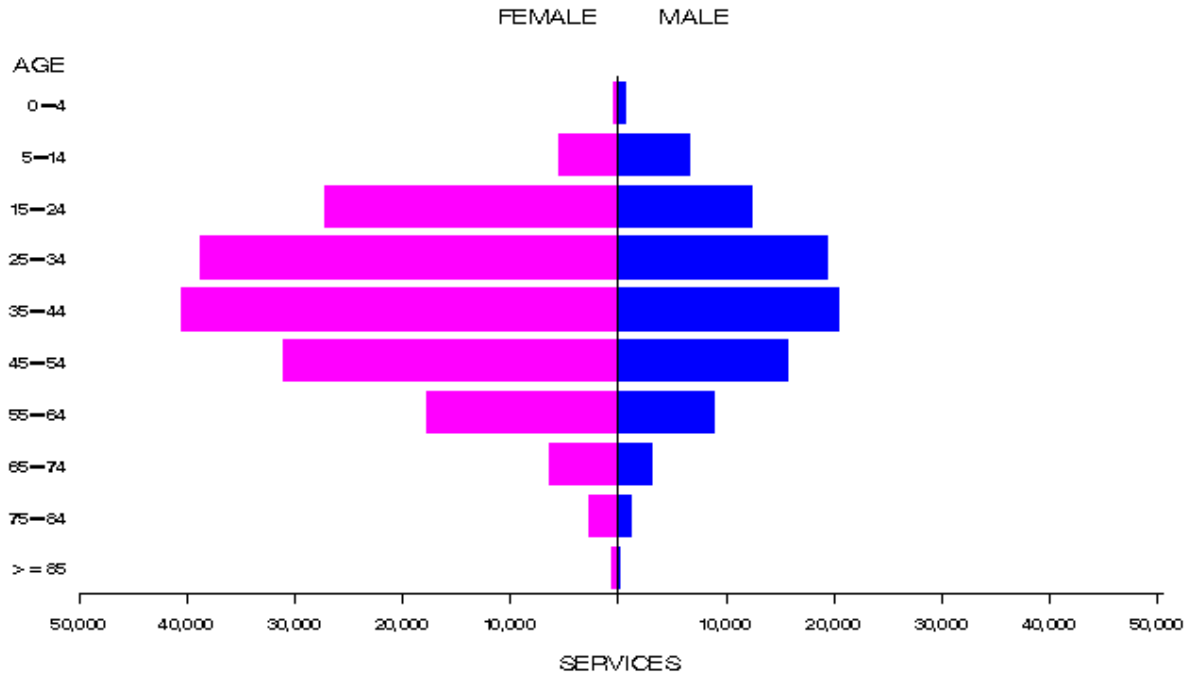
Total \$78.0 million

In May 2007, alone these three services cost over \$18 million. Even with no increase on the level of services funded from May 2007, the likely minimum 12 month cost will exceed \$220 million.

- The new services are yet to have a significant impact on people under 25 years of age. Women outnumber men two to one with 25 to 44 year old women the greatest beneficiaries of the new MBS measures

Figure 2

Patient Demographics



The above graph illustrates the age and gender distribution for item 2710 (GP mental health plan and referral). It is an almost identical distribution for other items including Items 80010 and 80010 (psychological services).

Given the psychologist services are based largely on GP referral, this consistency is to be expected. In financial terms, of the total \$78 million paid to date for the three most popular MBS Items, \$52 million has been for female services and \$26 million for male services.



4. Boys aged 5-14 years appear to be the only male group gaining higher access to MBS items than their female peers

See figure 2 above showing the only group where males have larger number of services is the 5 – 14 age group.

5. The new services are most predominantly in the major metropolitan areas

Despite phone and written requests to the responsible authorities, the MHCA has not yet been able to obtain a breakdown identifying MBS services provided by region, or even a simple rural / metropolitan analysis. However, the services provided across all relevant MBS items is almost exclusively within specialist consulting rooms, suggesting the location of GPs and psychologists is the biggest predictor of where services will be provided. Given most clinical psychologists are located in metropolitan areas⁷, it is not unreasonable to assume the vast majority of psychological services are occurring within metropolitan locations.

6. The patterns of uptake of the new MBS items in each jurisdiction are largely dependent on population and availability of GPs

Table 3

Number of Medicare services from November 2006 – May 2007

Item	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
2710	90,956	77,288	44,235	14,506	21,821	5,490	3,585	950	258,831
80010	45,416	42,070	13,519	7,308	27,411	4,555	2,135	303	142,717
80110	97,785	111,664	60,532	12,030	12,667	6,238	3,653	844	305,413
Total	234,157	231,022	118,286	33,844	61,899	16,283	9,373	2,097	706,961

7. Victoria has a much higher rate of psychological servicing (Item 80110) than all other jurisdictions while WA has a higher rate of clinical psychological services (Item 80010) than all other jurisdictions and the NT has by far the lowest rate per capita services for all three MBS Items (see Table 4 on next page).

Victoria has twice the average number of psychological services (MBS Item 80110) per capita as the average across all other jurisdictions.

WA has more than double the average per capita number of clinical psychological services (MBS Item 80010) as all other jurisdictions, although total per capita psychological services (both MBS Items 80010 and 80110) are still significantly lower than Victoria.

The jurisdiction with by far the lowest level of servicing across all three MBS Items is the NT where access to GPs and allied health services is very limited.

⁷ *Psychology Labour Force 2003*, National Health Labour Force Series Number 33, Australian Institute of Health and Welfare, Canberra, 2006, p. 5

Table 4**Rate per 100,000 population of Medicare services from November 2006 – May 2007**

Item	State								Nat Avg
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
2710	1,310	1,486	1,071	920	1,046	1,103	1,044	457	1,234
80010	654	809	327	463	1,314	915	622	146	680
80110	1,409	2,147	1,466	763	607	1,253	1,064	406	1,456

Other key findings not relating to the three most frequently used MBS items include:

- 8. Uptake of the new Medicare items relating to the use of social workers, occupational therapists and mental health nurses is negligible.**
- 9. Uptake of the new Medicare items covering group therapy, services outside of specialist consulting rooms and remote (phone) counselling is also negligible.**
- 10. The MBS mental health initiatives included new items for services to be provided by psychiatrists (including Items 291, 293, 296, 297, 299 and 353). Early data indicates some significant increase in the number of requests these items, but this is from a very low base in comparison with other services.**

Discussion

There are many issues raised by these findings, however it is important to again stress the limitations of this report.

This data represents only the first six months of the new MBS Items that are primarily seeking to promote better access for mental health services.

The level of uptake is clearly extremely high in all three new MBS Items highlighted in this report, and this suggests that these measures are having a positive impact in meeting community demand for these services and moving towards the achievement of their primary purpose – increased access. From a budgetary perspective, \$538m was set aside for this new initiative to be spent over a five year period. The data available indicates that almost double this amount will be needed if there are no further increases in services and the levels of demand seen in May 2007 persist. If the use of these services continues to grow the cost of these measures will be much higher.

At the same time, the lack of patient data does not allow any significant analysis relating to key variables such as breakdowns by location (rural versus metro) and the extent to which these payments are for new patient services or simply existing patients now attracting a Medicare rebate for services they were already receiving.

Similarly, there is currently no patient outcome data available with which to assess whether these new services are resulting in improved mental health. Data at this level is fundamental to justify the likely increase in expenditure.



The domination of these services by adult women is understandable given this is the group that have previously been the most likely to access existing services⁸ and the group with the highest levels of high prevalence mental health disorders such as depression and anxiety. They are also the group most likely to use GP services, although women are very significantly over represented in these three new MBS Items in comparison with their representation in standard GP consultations.

Very significantly, while 75% of all mental disorders appear before a person is 25 years of age, the current data indicates this group has yet to access these new MBS items. A key at-risk group requiring early intervention primary care appears to be missing out on the benefits of the new MBS arrangements.

It also appears that high risk groups such as young men in rural Australia, are the least likely to have access to these new largely metropolitan-based MBS-supported services. Paradoxically, there is clear evidence that this is precisely the group with the greatest suicide risk and in most in need of such services⁹.

The workforce implications are also significant. The reality is that access to these new MBS Items is primarily dependent on the availability of GPs and psychologists. We know that there is an unequal distribution of these professionals across Australia and, consequently, there will be unequal access to these new measures. Workforce issues are critical to access issues, and further analysis of the figures against workforce distribution would aid in the development of mental health workforce strategies.

It is difficult to say with any certainty why Victoria has such a high level of uptake of psychological services. Clearly the availability of psychologists is one factor, however, the lower number of GP Mental Health Planning services (an indication of the number of patients) in comparison with some other jurisdictions suggests Victoria may be ahead in the number of psychological services per client. Another explanation might be that Victoria's psychiatric disability rehabilitation support services network may be better placed to quickly take up opportunities afforded by the new MBS Items.

Similarly, the reason psychologists in WA use MBS Item 80010 at higher levels than other jurisdictions suggest a greater availability of MBS-registered clinical psychologists.

The explanation behind the larger number of boys accessing the new MBS items is not clear. As most parents know, pubescent boys can be a little difficult as they begin to adopt peer referenced values in contrast with parental expectations. A further factor may be increased community concerns in relation to attention deficit-type disorders.

While it is disappointing that there is so little uptake of other MBS Items including out of consulting room services and group therapy, this may be an initial trend that will be addressed over time as the assessment and 12 psychological sessions allowed per individual patient are expended.

There is a welcome increase in referral to psychiatrists and their involvement in assessment and associated services, however, the capacity for these services to grow is limited by the availability of psychiatrists across Australia. Again, this raises the issue of workforce capacity and distribution. The need to more effectively use the existing mental health workforce appears to be reinforced by these findings.

There is no doubt that the new MBS Items are impacting on service delivery across Australia. If the goal is to increase access, the early indications are the measures have been successful, however, the level of success is partially dependent on the degree to which these are new patients who might not previously have accessed these services.

Ideally, it would be revealing to be able to analyse corresponding data about numbers of people accessing non-MBS services such as community based mental health services. This may indicate whether the increased number of mental health services being claimed for under the MBS has had an impact on other mental health services.

8 McLennan W, *Mental Health and Wellbeing: profile of adults, Australia 1997*, Australian Bureau of Statistics, 1998.

9 Caldwell T, Jorm A and Dear K, *Suicide and Mental Health in Rural, Remote and Metropolitan Areas of Australia*, *Medical Journal of Australia*, 2004: 181 (7)

Data is also required to better assess the types of conditions being treated under the new MBS arrangements. The service patterns do not reflect total mental disorder prevalence rates across the community. It is important to raise questions about how high prevalence, but low service access groups, such as men with substance abuse problems, are being encouraged to access these or other more appropriate services.

Similarly, it is critical to develop data with which to assess the impact of these new MBS services on health outcomes both for those who access the services, and, at a broader level, whether the new measures are reducing the prevalence and/or severity of mental health problems in the community.

Recommendations

1. The budget amounts allocated to the new MBS Items promoting better access to mental health services need to be reviewed in light of extraordinary demand.
2. There is an urgent need for more detailed analysis of the MBS Item data. As a first step Medicare should be asked to provide details on:
 - the location of services provided – e.g. by Local Government Authority
 - patient information relating to whether each service is a new service to a new patient or a service provided to an existing patient, and the nature of the conditions being treated
 - data to track out-of-pocket expenses payable by the patient for these services and rates of bulkbilling.
3. The available evidence suggests a much greater emphasis needs to be placed on early intervention and increasing young people's access to mental health services.
4. The provision of psychological services in specialist consulting rooms clearly dominates the new MBS Items, and this approach needs to be monitored, particularly in terms of evidence-based practice, including client outcomes.
5. There is a pressing need for increased emphasis on developing a national mental health workforce strategy that makes better use of existing mental health professionals.

Conclusion

This report indicates the new MBS Items are being accessed at very high levels and suggests these measures have had a positive impact on the provision of mental health services across Australia. The exact nature of that impact is not entirely clear and warrants further investigation. There are also a number of critical areas that need to be addressed if better access to mental health services is to extend to those who might previously have not been able to access services.

The challenge into the future is to ensure that these new MBS items do not exacerbate existing mental health service gaps.

