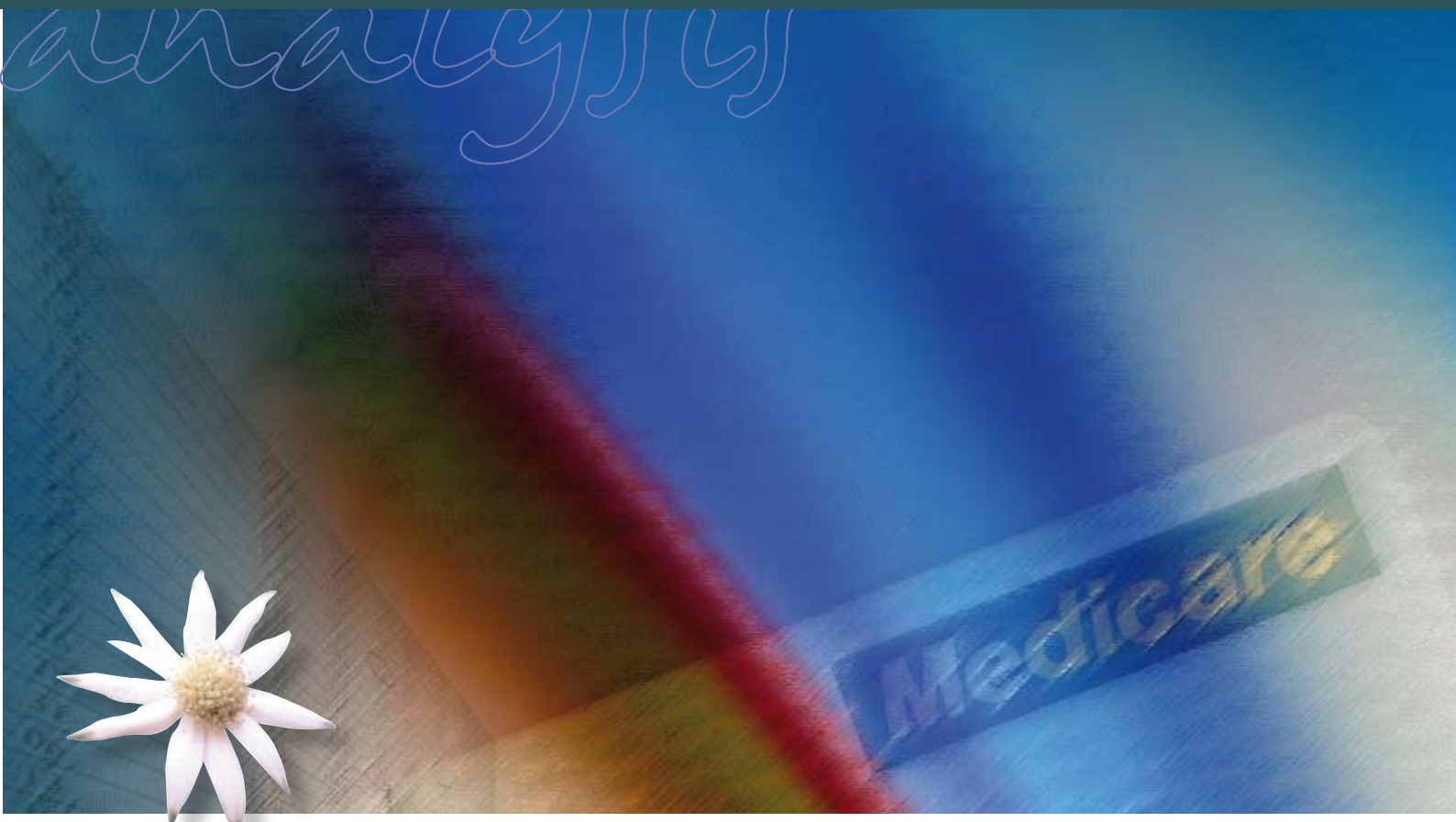
MENTAL HEALTH COUNCIL OF AUSTRALIA

COAG Mental Health Reform



Mental Health and the new Medicare Services:

2nd Report November 2006 – August 2008

September 2008

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Contents

Executive Summary

This is the second report prepared by the MHCA analysing aspects of the Better Access Program, a key component of the Council of Australian Governments (COAG) National Mental Health Plan which commenced in November 2006. The Better Access Program enables public access to services provided by psychiatrists, psychologists, other allied health professionals and general practitioners through the Medicare Benefits Schedule (MBS).

As with the first report published in July 2007, this report focuses primarily on the three new MBS items where uptake has been highest; MBS Item 2710 relating to General Practitioners (GPs) developing a mental health plan and referral; and MBS items 80010 and 80110 relating to psychologists providing assessment, evidence-based therapy and focussed psychological strategies.

The Australian Government is currently tendering for a project to evaluate the Better Access Program. This report does not intend to pre-empt this work. However, several key issues are apparent from the analysis provided in this report, which are consistent with the MHCA's first report into the Better Access Program. These issues should inform some of the fundamental questions that are to be answered in the Government's more detailed and outcome-focused evaluation.

Key Findings

Since November 2006, around 900,000 Australians now have their own individually tailored mental health care plan (MBS Item 2710). We currently know very little about these people, their conditions, their treatment and the degree to which the new mental health plans are reducing the impact of mental illness on individual consumers, their carers and the broader community.

We do know that the Better Access Program has had a real impact on mental health service delivery. The significant uptake of the new items outlined in the MHCA's first report has continued unabated, with over 5 million services being provided under the Better Access Program. The new Rudd Government has responded to this rapid uptake by increasing the budget initially allocated for the Program from $538m[1] for the period 2006-11 to $753m in the 2008-09 Federal Budget.

The four most frequently claimed Better Access items account for nearly 90% of all services claimed under the initiative. These are:

1. GP Mental Health Care Plan (MBS item 2710);
2. GP Mental Health Care Consultation (MBS item 2713);
3. Psychological Therapy Long Consultation (MBS item 80010 provided by clinical psychologists); and
4. Focussed Psychological Strategies Long Consultation (MBS item 80110 provided by registered psychologists).

By August 2008, some 22 months into the program, the total expenditure on these five items is $467m. This is more than three times the initial budget estimates made for the Program, which suggested total spending would be $142m by the end of June 2008.

While we cannot be sure what the future demand for these services will be, the demand curve remains upward and shows few signs of slowing.

Distribution of services remains an issue, with people not living in urban areas facing real disadvantage in terms of access to care under the new MBS items. Per capita service figures reveal the extent to which Australians not living in cities have less access to the new measures.

Women are twice as likely as men to have received some care under the Better Access Program. This trend tends to mirror the pattern of total GP presentations and may reflect broader patterns of help-seeking behaviour across genders[2] but seems more exaggerated for these mental health items. Further, we know the risk factors for adverse outcomes, such as suicide, are significantly higher for men then for women[3].

It should also be remembered that a key outcome of the Better Access Program was to encourage the development of a new teamwork approach to client management, shared between GPs, psychologists, psychiatrists and others. The extent to which the Program has proven effective in fostering this teamwork also remains very unclear, given that the predominant model of service provided under the Program is by individual practitioners in their own consulting rooms.

1 http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba - accessed 22 Sept 08
2 P.Galdas et al, *Men and health help-seeking behaviour literature review*, Journal of Advanced Nursing, vol 49, no:6,616-623,2005
3 G.Blair-West, Lifetime *suicide risk in major depression, sex and age determinants*, Journal of Affective Disorders, Vol 55, Issue 3:171-178, 1998

Recommendations

1. The MHCA strongly supports a more comprehensive evaluation of the Better Access Program with a particular focus on real outcomes for individual consumers of these services, their carers and the broader community. The commitment by the Federal Minister The Hon Nicola Roxon to supporting this form of evaluation in the coming 12 months is to be commended.
2. The Government should also fund the annual publication of data with regard to the Better Access Program, in particular:
   - the location of services provided;
   - information relating to whether services provided are to a new or existing client and other demographic information (such as CALD, indigenous etc.);
   - the nature of the conditions treated;
   - out of pocket expenses paid by the consumer; and
   - data on the health outcomes achieved by the Program.
3. A key challenge is to consider how to improve the reach of mental health services to meet the needs of those under-represented in current user profiles of the new Better Access Program. This includes people in rural and remote locations, young people and men.
4. Workforce distribution issues remain a critical challenge to future service planning and design. The Government needs an effective national mental health workforce strategy if the Better Access Program is to reach its potential. This appears to be particularly important in building collaborative care teams.

Introduction

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 Australian Government to enable Better Access to Psychiatrists, Psychologists, General Practitioners and other allied health professionals through the Medical Benefits Schedule (MBS)[4]. A range of new MBS items were devised and implemented on 1 November 2006[5].

The mental health sector had been calling for this type of program enabling better access to mental health services for some years. The MHCA and its 58 members nationally welcomed the advent of the Better Access Program and publicly lauded the commitment of our COAG leaders to improving the lives of people with a mental illness in Australia. The MHCA continues to support the Better Access Program.

This report builds on the first report prepared by the MHCA published in July 2007, which provided a short summary and analysis of the first six months of operation of the Better Access Program, from November 2006 to May 2007. This second report covers the total period since commencement, November 2006 to August 2008. The primary focus of this report is on the uptake of the new mental health MBS items and some of the trends in service use that have emerged. The MHCA's first report was greeted with considerable public interest and discussion. The MHCA hopes this second report is equally useful.

The MHCA acknowledges that the Better Access Program is but one of several initiatives under COAG designed to improve Australia's mental health system. While this Program has been going now for nearly two years, other COAG mental health initiatives are still very much in their infancy, leaving it difficult to meaningfully gauge any cumulative impact.

Federal, State and Territory governments are working now to design the shape of the next health care agreements. The data outlined in this report needs to be considered if the goal of increasing access and significantly reducing the prevalence of untreated mental illness is to be achieved.

The ongoing major problems facing mental health in Australia were not created overnight but developed over many decades. The previous Prime Minister rightly stated there would be no "quick fix"[6]. COAG has started a process of reform and investment to improve mental health in Australia. The challenge for our new group of COAG leaders is to build on these reforms towards long term solutions.

4 *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

5 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*

6 http://pandora.nla.gov.au/pan/10052/20060621-0000/www.pm.gov.au/news/media_releases/media_Release1858.html

Background

Australia will spend over $13 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 Australian Government began to offer payments to general practitioners (GPs), psychologists and a range of allied 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 Australian Government to the COAG National Action Plan on Mental Health 2006-11.

The stated aim of the Better Access Program was:

> ...to improve early detection, treatment and management of mental illness in the community through increased access to psychiatrists, psychologists and general practitioners (GPs) and encouraging health professionals to work together. Reforms will be made to the Medicare Benefits Schedule (MBS) to:

1. Allow private psychiatrists to see more new patients and refer on those patients who could be more effectively treated by appropriately trained psychologists and GPs;
2. Encourage more GPs to participate in early intervention, assessment and management of people with a mental illness; and
3. Increase access to appropriately trained psychologists and allied health professionals on referral from a GP with appropriate training[7].

The Mental Health Council of Australia has strongly supported the Better Access Program and these goals.

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 promote further discussion about what is, and what is not, being achieved through these new MBS measures.

7 *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

Data and Methodology for this Report

The bulk of the data used in this report are publicly available at the Medicare website, drawn directly from figures available in the Medicare Benefits Schedule (Item) Statistics Reports[8] and the associated Medicare Benefits Schedule (Medicare online)[9].

While public access to these figures is welcome, the MHCA's first report recommended more detailed figures be made available, particularly patient level data and the actual distribution of services provided. The MHCA sought some of this information directly from the Government in October 2007. The Government released its own analysis of the new Program in April 2008[10] reflecting a commitment from the new Rudd Government for more transparency in this area.

The MHCA request for additional data was met in September 2008. The MHCA is grateful to the Australian Government for these data, particularly with regard to the breakdown of services by urban and non-urban areas. The MHCA has reproduced the factual data without alteration.

Table 1 below lists all the MBS items included under the Better Access Program and reveals that just over 5.1m services have been provided between November 2006 and August 2008.

Table 1 - All Better Access MBS items by Services and Expenditure

Better Access Program MBS Item No.	Services Provided Nov 06- Aug 08	Expenditure $
2710	895,544	135,737,442
2712	233,590	23,693,995
2713	841,094	56,314,460
296	132,955	26,706,378
297	13,968	2,432,512
299	1,545	348,156
80000	18,470	1,424,624
80005	1,226	118,215
80010	946,224	108,020,536
80015	6,885	917,758
80020	6,251	212,418
80100	45,255	2,503,793
80105	5,205	390,412
80110	1,781,859	140,492,268
80115	37,711	3,678,865
80120	7,349	196,901
80125	1,223	59,180
80130	105	7,249
80135	17,784	1,326,734
80140	2,309	217,139
80145	489	12,376
80150	2,330	120,572
80155	860	60,283
80160	103,427	7,210,334
80165	5,070	439,300
80170	404	8,001
TOTAL	**5,109,132**	**$512,649,901**

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

9 see http://www9.health.gov.au/mbs/search.cfm

10 http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1/$FILE/UTILISATION%20OF%20MENTAL%20HEALTH%20ITEMS%20-%20April%202008.pdf - accessed 22 September 2008

Across all the new Better Access MBS items, four items stand out, as shown in Table 2 below.

Table 2 – Major MBS Better Access Items

Item No.	Descriptor	Occasions of Service	MBS Benefit Paid $m
2710	Preparation of a Mental Health Care Plan by a GP	895,544	135.7
2713	GP Mental Health consultation (20 minutes +)	841,094	56.3
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)	946,224	108.0
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)	1,781,859	140.5
Total		**4,464,721**	**440.6**

Together, these four items account for 87% of all claims over the period.

A total of $512.6m has been spent across all Better Access items between November 2006 – August 2008, with the same four highlighted MBS items accounting for $440.6m or 86% of total expenditure.

Given they account for such a high proportion of total services and expenditure, this report will focus on these four main MBS items.

This 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.

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.

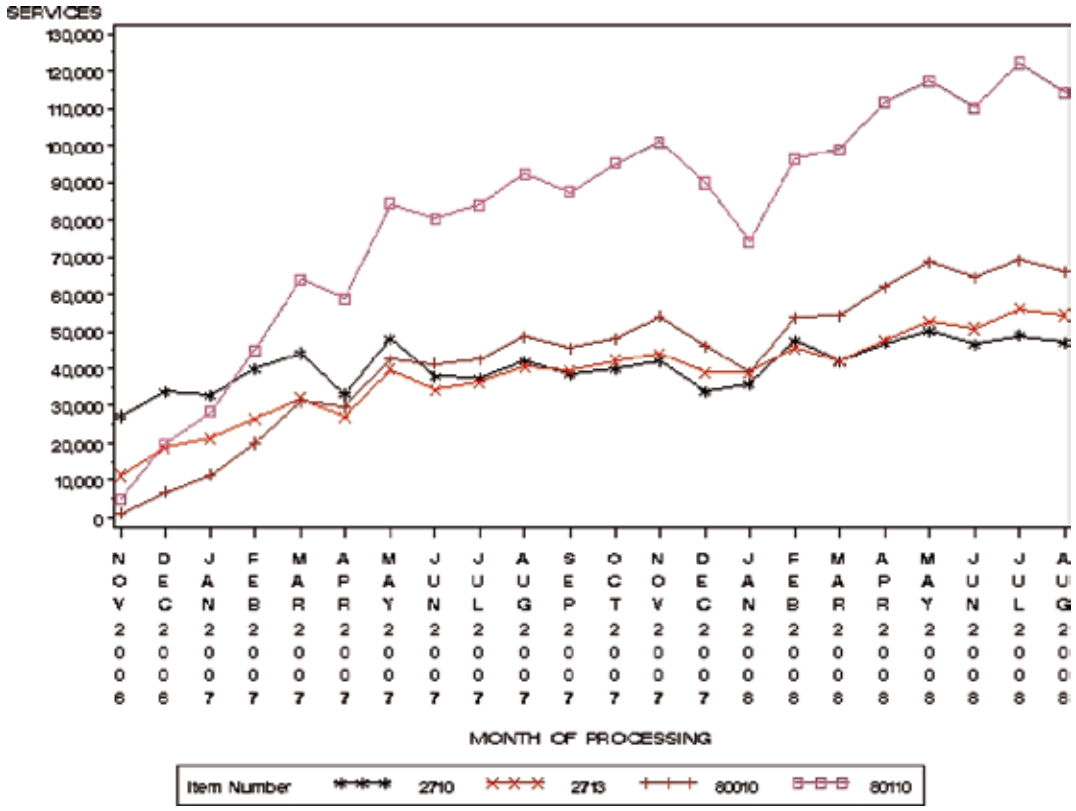
In preparing this report the authors had several telephone discussions with staff from the Department of Health and Ageing and Medicare Australia about the availability of statistics and interpretation of data. We thank them for their assistance.

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. Increasing demand for the new MBS items continues

Figure 1 – Demand for Major Mental Health MBS items



The August 2008 figures are generally a little lower than July but the overall upward trend continues, particularly the demand for focussed psychological strategies which is expanding rapidly. Another way to assess the level of demand for care is to consider the following:

- In July 2008, there were 48,950 claims made against Item 2710 (New mental health plan), making it the second highest claims month recorded (after May 2008) since the introduction of the item. August saw only a very slight reduction in this demand.
- July 2008 saw just over 69,141 claims made against Item 80010, making it the highest month for claims against this item since its introduction.
- July 2008 saw 122,222 claims against Item 80110, again a record.
- The July 2008 figure for Item 80110 was an 11% increase over the June 2008 claims figure and a 45% increase on claims made in July 2007.

Figure 1 also shows that while just under 900,000 Australians now have a GP Mental Health Plan (item 2710), there have been only 233,590 of these Plans reviewed (Item 2712). The original concept under the Better Acess Program was that the GP would develop a Plan, followed by sessions of psychology service, and then the plan would be reviewed by the GP to assess progress. At this stage, this last element of the model of care remains the exception rather than the rule with only 26% of all GP Plans reviewed.

2. Program costs are exceeding estimates

While it is still early days, overall community demand for services remains strong. Assuming the Program stops growing and the 2007-08 expenditure level remains, the overall program expenditure will be almost triple the original estimate made by the Government.

The original estimates made by Government for Better Access Program expenditure anticipated a high level of unmet need and on this basis factored in a 20% increase in demand year on year to 2011. Using this as a basis, it is possible to estimate a trended outcome for the Program[11]. This outcome is presented in Table 3 below, remembering that the 2006-07 and 2007-08 figures are actual.

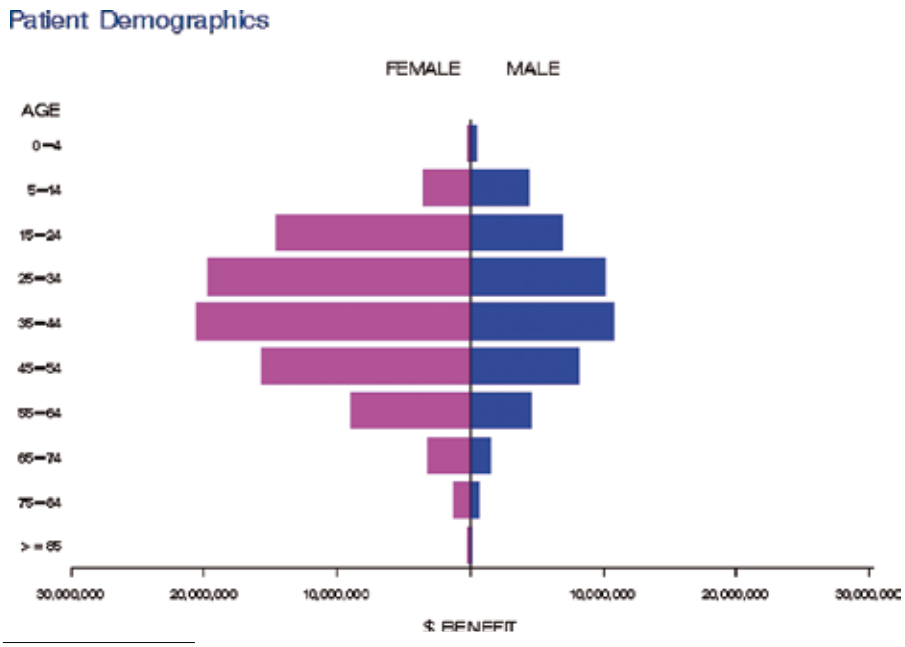
Table 3 - Better Access Program Costs - Estimates, Actuals and Trends

Year	Original Estimated Expenditure $m	Actual Expenditure and Trended Outcome (assuming no growth) $m	Actual and Trended Expenditure (20% program growth) $m
2006-07	51.2	147.3	147.3
2007-08	91.9	332.9	332.9
2008-09	108.5	332.9	398.4
2009-10	130.1	332.9	478.4
2010-11	156.3	332.9	574.0
Total	**538.0**	**1478.9**	**1931.0**

On this basis, the Government lifted its forward estimates for the Better Access Program from $538m over the period 2006-11 to $753m for the same period. There are budget offsets arising from this program particularly for GP services. However, the increase to the estimated Program budget may still fall short given the demand for services as shown above.

3. Access varies significantly according to age and sex

Figure 2 below illustrates the age and gender distribution for MBS item 2710 (GP mental health plan and referral).



11 http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2006-glance.htm#*

Figure 2 - MBS Item 2710 by Gender

There is an almost identical distribution for other items including items 80010 and 80110 (psychological services). Given the psychologist services are based largely on GP referral, this consistency is to be expected.

In financial terms, of the total $440.6 million paid to date for the four most popular MBS items, $291 million has been for services to females and $149 million for services to males. In other words, the new MBS items are twice as likely to be used by women as men. This is illustrated by Table 4 below which shows overall spending on the four main MBS items by gender.

Table 4 – Mental Health MBS Spending by Gender

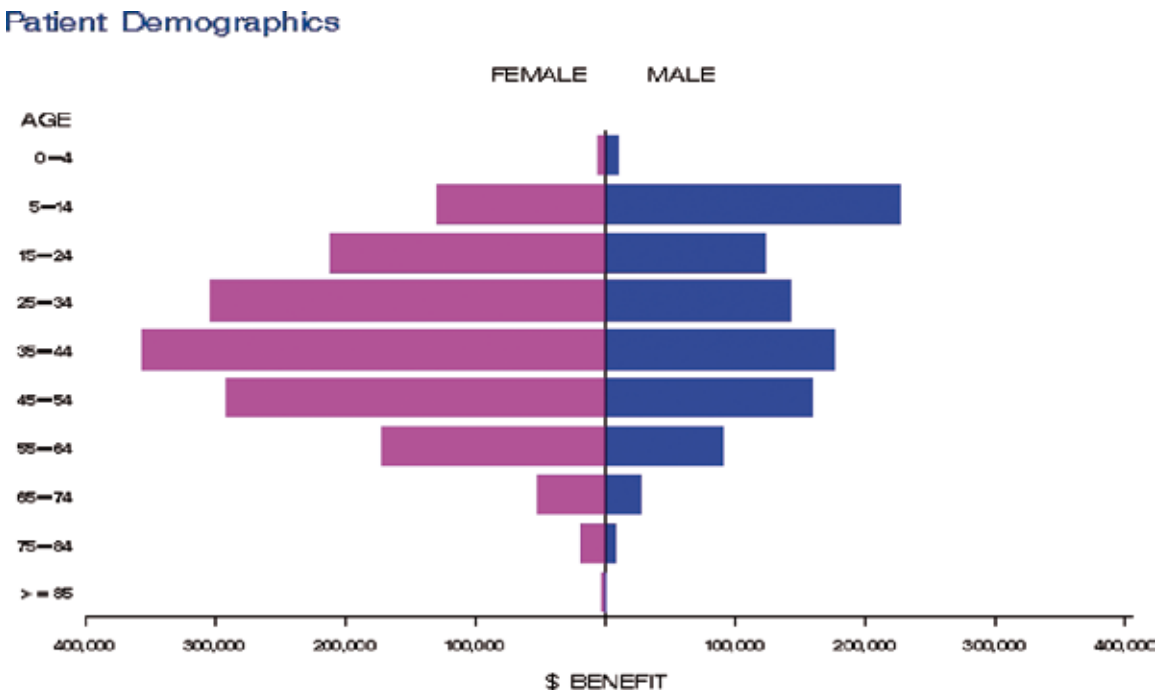
MBS Item	$m Male	$m Female
2710	47,780,064	87,957,378
2713	19,887,898	36,426,562
80010	35,860,183	72,160,353
80110	45,581,680	94,910,588
Total	**149,109,825**	**291,454,881**

The largest age cohorts for spending across these items are women aged 25-44 years.

Figure 3 - Item 80100

Figure 3 below shows one of the new items which has a slightly different demographic to the main items. Item 80100 is for a service provided by a registered psychologist lasting between 20 and 50 minutes. Item 80100 only accounts for 45,255 services nationally so it is by no means one of the larger mental health MBS items. As can be seen, there is a significant trend towards boys aged 5-14, quite unlike the main MBS mental health items.

Further analysis of this apparent anomaly in Table 5 identifies that Queensland has very high rate of claim for this item compared to other jurisdictions, with some 2602 services claimed against this item, of which 1672 were provided to boys and 930 to girls. There is no obvious explanation for this anomaly, especially considering the overall gender



ratio for this item is 62% female to 38% male.

Table 5 – 80100 Demographics by Age and State

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
Age									
0-4	53	56	127	3	4	9	1	0	253
5-14	2,021	1,042	**2,602**	144	319	104	62	0	6,294
15-24	1,678	1,805	1,567	304	434	69	97	12	5,966
25-34	2,220	2,970	1,796	332	573	90	164	15	8,160
35-44	2,456	3,897	2,146	324	562	85	151	14	9,635
45-54	2,673	2,810	1,831	317	349	70	145	4	8,199
55-64	1,333	1,563	1,317	234	271	37	33	2	4,790
65-74	293	556	375	107	101	16	4	0	1,452
75-84	140	136	116	48	12	1	0	0	453
>=85	15	24	13	0	1	0	0	0	53
Total	**12,882**	**14,859**	**11,890**	**1,813**	**2,626**	**481**	**657**	**47**	**45,255**

4. There are significant disparities in access according to location

Access to care under the new MBS items is very closely linked to where a person lives. The state by state rate of services provided in our featured MBS items is presented per 100,000 population in Table 6 below.

Table 6 - Rate per 100,000 population of Medicare services from November 2006 – August 2008

Item	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Nat Avg
2710	4,439	4,941	3,772	3,525	3,656	3,825	3,724	1,623	4,231
2713	4,128	4,427	3,573	4,077	3,648	3,174	2,632	2,113	3,974
80010	4,369	4,832	2,411	4,352	7,996	6,124	4,692	947	4,470
80110	8,360	12,106	8,295	4,503	3,700	6,808	7,845	2,456	8,418

Of particular note is the low rate of access to item 80010 in Queensland in comparison to the national average.

Victoria remains the leader among jurisdictions in the per capita access to focussed psychological strategies (Item 80110). WA and SA lag a long way below the national average for this item, but have significantly higher access to Clinical Psychology (Item 80010).

The NT has by far the lowest per capita service rate for all four MBS items.

However, while these state by state trends are useful, the significance of geography is perhaps highlighted more starkly when considering the split between urban and non-urban locations. Table 7 below provides this breakdown of services for three key MBS items in the 2007-08 financial year.

Table 7 – Urban vs non-urban 2007-08 services per '000 population, by gender

		Item								
		2710			80010			80110		
State	Region	F	M	Tot	F	M	Tot	F	M	Tot
NSW	Urban	34.0	17.9	25.7	47	22	34	82.0	37.9	59.1
	Non-Urban	32.9	17.0	24.6	22	10	15	64.4	30.4	46.6
	Total	33.7	17.7	25.4	41.3	19.0	29.7	77.8	36.1	56.1
Vic	Urban	38.4	19.3	28.5	51.9	23.3	37.1	122.8	53.8	87.0
	Non-Urban	34.7	17.5	25.8	24.1	9.4	16.5	80.4	35.7	57.1
	Total	37.5	18.9	27.9	45.3	20.0	32.2	112.7	49.4	79.9
Qld	Urban	31.0	15.4	22.9	26.6	13.1	19.6	82.2	35.8	58.1
	Non-Urban	28.8	13.8	20.8	15.5	8.3	11.7	72.8	30.7	50.5
	Total	30.1	14.8	22.1	22.3	11.2	16.5	78.5	33.8	55.1
SA	Urban	29.4	15.9	22.5	49.5	25.9	37.5	48.8	22.5	35.4
	Non-Urban	21.7	11.5	16.2	18.4	8.8	13.3	19.6	9.8	14.4
	Total	27.3	14.6	20.8	41.1	21.1	30.8	41.0	18.9	29.6
WA	Urban	31.7	15.9	23.4	94.4	42.7	67.4	41.3	16.8	28.5
	Non-Urban	22.3	9.9	15.6	25.5	9.9	17.0	22.1	9.1	15.0
	Total	29.3	14.3	21.4	77.0	33.9	54.2	36.5	14.7	25.0
Tas	Urban	36.1	18.1	27.0	95.4	45.0	69.7	75.2	36.4	55.4
	Non-Urban	24.6	12.6	18.3	27.0	15.3	20.9	57.2	20.7	38.2
	Total	29.4	14.8	21.8	55.2	27.2	40.8	64.6	27.0	45.2
NT	Urban	19.3	8.5	13.3	n/a	n/a	n/a	41.3	14.2	26.1
	Non-Urban	8.2	4.0	5.9	n/a	n/a	n/a	12.3	5.3	8.5
	Total	12.9	5.9	9.1	10.6	3.2	6.5	24.3	9.1	16.0
ACT	All	29.7	14.5	21.8	47.1	20.3	37.5	78.7	33.1	55.1
Nat Average		**32.7**	**16.6**	**24.3**	**42.2**	**19.4**	**30.3**	**79.0**	**34.9**	**56.0**

n/a Not available

Variations in the per capita access to services are least significant for Item 2710 reflecting the better access to GP services in non-urban areas. For Item 80110 however, the variations are significant. For example in South Australia the access rate is 35.4 for urban areas falling to 14.4 in non-urban areas. Similarly, significant variations occur for item 80010 between urban and non-urban areas. The gender split across services also reveals very significant differences.

It is possible to convert the data provided in Table 7 into 'access ratios', as in Table 8 below.

Table 8 - Items by Rural, Remote, Metropolitan Area (RRMA) for 2007-08 – Services per '000 Population and Access Ratios

	Items					
	2710	Access Ratio	80010	Access Ratio	80110	Access Ratio
Region						
Urban	25.3	1	36.5	1	61	1
Rural	23	.91	15.7	.43	46.8	.76
Remote	8.6	.34	4.2	.12	10.1	.17
Total	24.3	n/a	30.3	n/a	56.0	n/a

Table 8 confirms the significant variation in levels of access to the new MBS items across Australia. This is probably a reflection of workforce distribution. If we accept this assumption, the urban/rural/remote ratios above reveal that GPs (.91 rural and .34 remote) seem relatively well distributed compared to psychologists (.76 rural and .17 remote), who are better distributed than clinical psychologists (.43 rural and .12 remote).

5. Out of pocket costs to the consumer vary

Data on out of pocket costs to the consumer for services received under the Better Access Program are not regularly produced.

The Department of Health and Ageing released a special report into payment for the new items in April 2008[12]. This report showed there were additional gap and co-payments arising from the new MBS service items. These are presented in Table 9 below.

It should be noted that there is no gap payment for GP services (items 2710 and 2713), with the MBS Rebate being 100% of the scheduled fee. This is unlike psychology, clinical psychology or psychiatry services, where the rebate is only 85% of the scheduled fee. There is of course nothing to stop professionals charging above the scheduled fee.

Table 9 indicates the extent of the out of pocket costs where, in the capital cities, co-payments for consumers range on average from $16 for GP services to $66 for psychiatric services, with psychological services co-payments ranging between $22 and $35.

Table 9 - Fees, Gaps and Out of Pocket Costs

Item	Description	Schedule Fee	MBS Rebate	Gap	Average Capital City Co-Payment
2710	GP Mental Health Care Plan	$153.30	$153.30	$0	$16.48
80010	Psychological Therapy Service, in rooms, >50mins (clinical psychologists)	$132.25	$112.45	$19.80	$28.61
80110	Focussed Psychological Services, in rooms, >50mins	$90.15	$76.65	$13.50	$34.81
296	Psychiatry Consultation with New Client, in rooms, >45mins	$235.05	$199.90	$35.15	$66.14

12 http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1/$FILE/UTILISATION%20OF%20MENTAL%20HEALTH%20ITEMS%20-%20April%202008.pdf - accessed 22 September 2008

6. Uptake of the range of MBS services is variable

There are some other findings worthy of note which do not relate to the most frequently used MBS items.

First, the uptake of the new Medicare items relating to the use of occupational therapists, social workers and mental health nurses is negligible, although it is trending upwards – see Figures 4 and 5 below.

Figure 4 - Uptake of new Occupational Therapists Items

MBS Item No.	Service
80125	FPS Service – in rooms, 20-50 min consultation
80130	FPS Service – out of rooms, 20-50 min consultation
80135	FPS Service – in rooms, 50 min+ consultation
80140	FPS Service – out of rooms, 50 min+ consultation
80145	FPS Service – group session, 6-10 patients, 60mins +

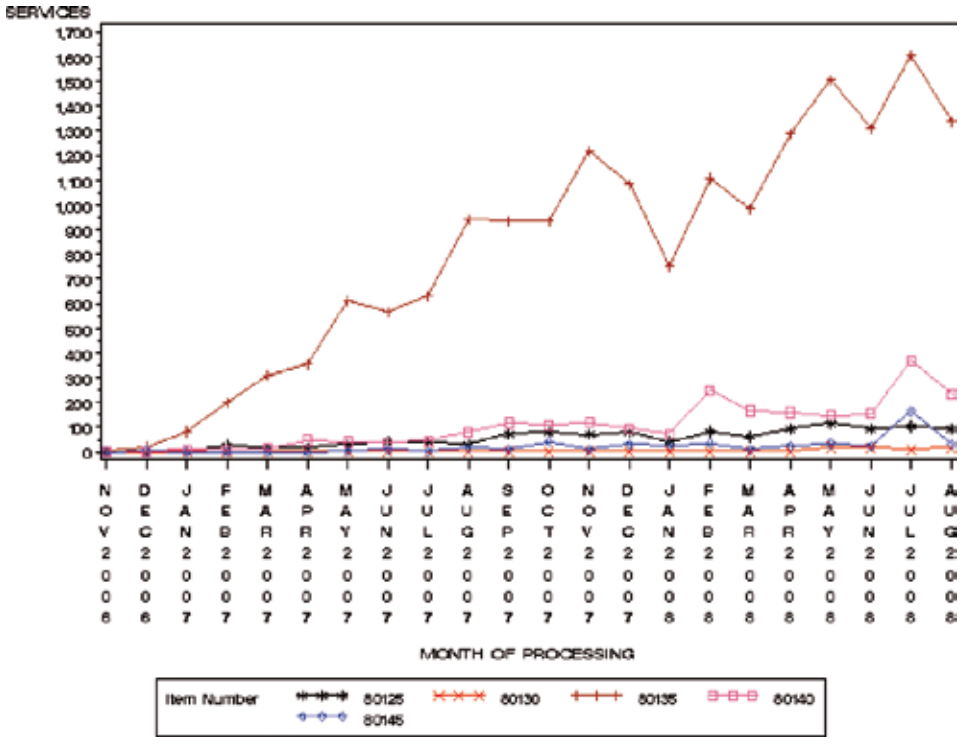
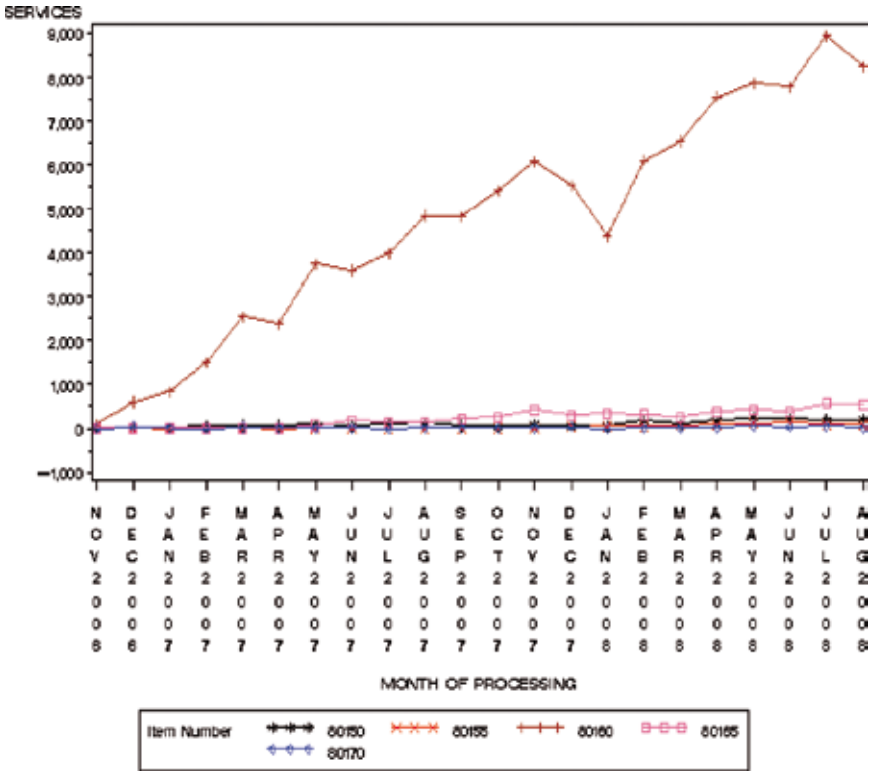


Figure 5 - Uptake of MBS Items for Social Workers

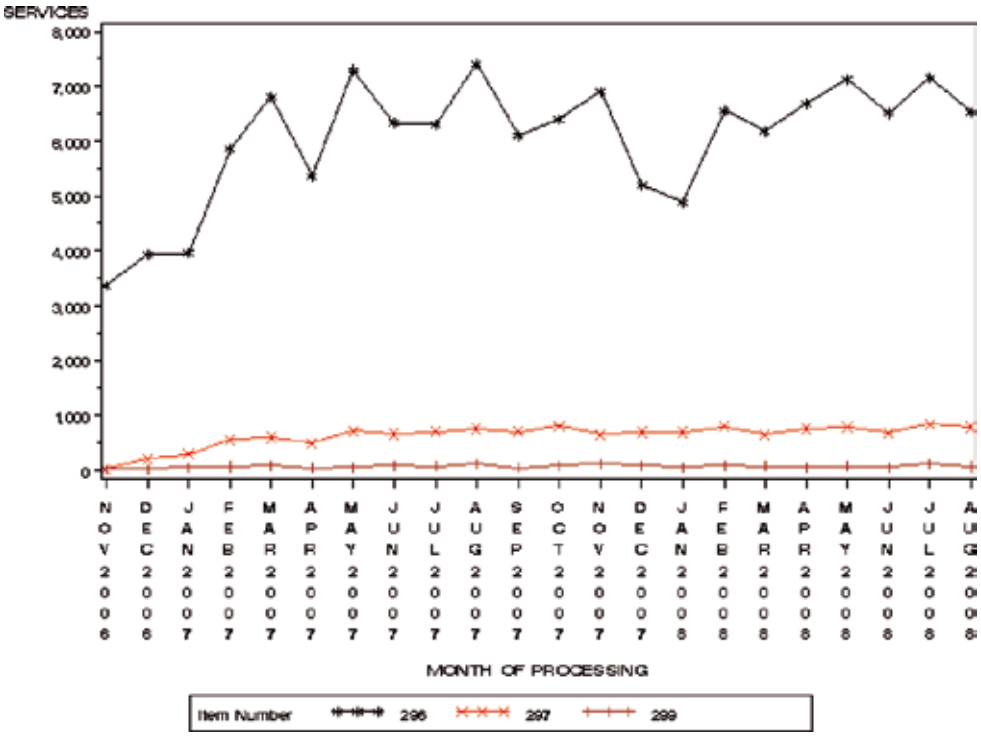
MBS Item No.	Service
80150	FPS Service – in rooms, 20-50 min consultation
80155	FPS Service – out of rooms, 20-50 min consultation
80160	FPS Service – in rooms, 50 min+ consultation
80165	FPS Service – out of rooms, 50 min+ consultation
80170	FPS Service – group session, 6-10 patients, 60mins +



The MBS mental health initiatives included new items for services to be provided by psychiatrists (items 296, 297, 299). Early data indicates some increase in the number of requests these items, but this is from a very low base in comparison with other services.

MBS Item No.	Service
296	Initial consultation on a new patient – in rooms 45mins +
297	Initial consultation on a new patient – in hospital 45mins +
299	Initial consultation on a new patient – home visit 45mins +

Figure 6 - Uptake of new MBS Items for Psychiatry



Last, an interrogation of the Medicare claims data also reveals that uptake of the new Medicare items covering group therapy, services outside of specialist consulting rooms and remote (phone) counselling is also negligible.

Discussion

The rapid uptake of the Better Access Program is testimony to the need for improved mental health services across Australia. Over 5 million services have been paid for, mostly GP mental health plans and focused psychological services.

The distribution of these services remains variable, probably related primarily to the availability of appropriately trained professionals.

Women have been the largest users of the services, and mostly in the middle age groups. This is largely a reflection of the pattern of GP access across the broader community.

Out of pocket costs for consumers partly reflect the level of gap between the scheduled fee and the MBS payments for the service. GP mental health plans receive 100% of the scheduled fee in their MBS rebate and have the lowest co-payment.

Rural consumers continue to be disadvantaged. Again this may reflect the inequality in the distribution of mental health professionals in per capita terms between urban, rural and remote areas.

There remain a lot of unanswered questions about the impact and outcomes of the Better Access Program on mental health in Australia.

The MHCA welcomes the Rudd governments committment to a more in-depth review of the program with a real focus on outcomes for people with a mental illness. This evaluation is critical to not only establishing the real impact of this program, but also to developing policies and practices that will strengthen Australia's response to mental illness.

Recommendations

1. The MHCA strongly supports a more comprehensive evaluation of the Better Access Program with a particular focus on real outcomes for individual consumers of these services, their carers and the broader community. The commitment by the Federal Minister The Hon Nicola Roxon to supporting this form of evaluation in the coming 12 months is to be commended.
2. The Government should also fund the annual publication of data with regard to the Better Access Program, in particular:
   - the location of services provided;
   - information relating to whether services provided are to a new or existing client and other demographic information (such as CALD, indigenous etc.);
   - the nature of the conditions treated;
   - out of pocket expenses paid by the consumer; and
   - data on the health outcomes achieved by the Program.
3. A key challenge is to consider how to improve the reach of services to meet the needs of those under-represented in current user profiles of the new Better Access Program. This includes people in rural and remote locations, young people and men.
4. Workforce distribution issues remain a critical challenge to future service planning and design. The Government needs an effective national mental health workforce strategy if the Better Access Program is to reach its potential. This appears to be particularly important in building collaborative care teams.

Conclusion

The challenge into the future is to ensure that the rapid uptake of these new MBS items can form the basis of improved mental health in Australia.

The first prerequisite to meeting this challenge is the availability of information about the program and its impact on consumers, carers and the broader community. The current Federal Government have taken positive steps in this area. More needs to be done to ensure timely and complete data is available to ensure policy decisions are evidence-based.

The second prerequisite is a preparedness to change current practice where it is not beneficial, and to address emerging gaps through structural changes and complementary measures that reach groups not achieving better outcomes through the program.

The previous head of the UK Government's Delivery Unit, Sir Michael Barber makes this point:

> "Leaders need excellent strategy functions and strong performance management systems, enabling them to steer well, identify flaws in implementation and intervene where necessary... The government departments responsible for major strategic reforms also need to develop this kind of capacity for themselves – and where they do not have the necessary real-time data or the skill and will to intervene where there are problems, inevitably reforms falter." *(Quoted in Shergold, Oct 2006, Implementation Matters)*

The Better Access Program is a key initiative that has the very real potential to make a real difference in the lives of hundreds of thousands of Australians.