

CHAPTER 10: DISCUSSION

10.1 OVERVIEW

The aim of this report was to present the findings of an in-depth analysis of administrative MBS and other data in relation to each of the seven evaluation questions posed in Component B of the Evaluation of the *Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule* initiative. *Better Access* is the first program to make significant levels of Medicare reimbursement available to allied health professionals for delivering mental health services. As such, the program has attracted considerable debate around the issues of access, affordability, equity, interdisciplinary care and impact on related services which have been considered in the current evaluation. This discussion chapter interprets the findings from the current study and contextualises them in relation to other available data and commentaries. It also includes a brief review of issues relating to the evaluation questions covered by Component B that were beyond the scope of the present evaluation.

10.2 INTERPRETATION OF FINDINGS

10.2.1 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE PROVIDED ACCESS TO MENTAL HEALTH CARE FOR PEOPLE WITH MENTAL DISORDERS? ACROSS ALL OF AUSTRALIA? ACROSS ALL AGE GROUPS?

Analysis showed that the uptake of *Better Access* has been substantial. In 2007, one in every 30 Australians received at least one *Better Access* service. In 2008, one in every 23 did so, and in 2009, one in every 19 did so. Most commonly, *Better Access* consumers made use of services delivered by GPs under the GP Mental Health Treatment Services items. These were followed by services delivered by psychologists under the Focussed Psychological Strategies and Psychological Therapy Services item numbers. Services delivered by psychiatrists under the Consultant Psychiatry item numbers and services delivered by social workers and occupational therapists under the Focussed Psychological Strategies item numbers were far less commonly utilised. Consistent with earlier reports,^{12, 51, 52} uptake increased dramatically in the first years of the initiative. Whilst the program has continued to grow, the rate of growth has slowed substantially.

The results of the analysis can further inform some of the debates about *Better Access* in relation to its accessibility. The first of these relates to the question of whether *Better Access* is meeting the needs of new consumers, who may previously have had difficulties accessing mental health services due to barriers of cost or location, or whether it is just providing a new avenue of treatment for people who were already receiving care. Although the analysis of MBS data cannot answer this question definitively, because the MBS data do not include individual-level information about use of other mental health services, analyses were undertaken to examine whether the program is attracting consumers who are new to *Better Access* or, conversely, is providing services to a consistent group of people on an ongoing basis. These showed that 68% of people who received any *Better Access* services in 2008, and 57% in 2009, had not previously

received these services. This findings suggests that the program is continuing to attract a substantial proportion of new consumers. Further analyses showed that the proportion of new consumers of allied health services was 71.4% in 2008 and 62.9% in 2009. This is consistent with findings from previous surveys of Australian psychologists who report that around 70% of their *Better Access* clients have not previously consulted a psychologist.^{53, 54} The figures are also consistent with evidence from an analysis of data from the 2007 NSMHWB which estimated that 62% of people who used *Better Access* allied health services in 2007 had not previously used allied health services.³⁷ The figures are somewhat higher than a previous finding that 47% of ATAPS clients had not had any prior contact with mental health care,¹² most likely because 'mental health care' may have included providers other than allied health professionals. Together, these findings suggest that Australia's primary mental health care reforms are meeting previously-unmet need. Having said this, it is acknowledged that the approach taken here uses a necessarily limited definition of a 'new' consumer and may have included people who, although new to *Better Access*, are existing consumers of other parts of the mental health system.

A second concern regarding *Better Access* is that it does not cater well to young people. Analyses showed that uptake rates for *Better Access* increased with age, peaking among adults in the 25-34 and 35-44 year age groups and then decreasing with age. These findings are broadly consistent with those of Russell,⁵¹ who found that that despite making up 19.4% of the Australian population, children and adolescents aged 0 to 14 years received only 7.4% of total *Better Access* services in 2008. The picture was more complex when the rates of uptake of specific groups of *Better Access* items was considered. Although young people showed the lowest uptake of GP and Consultant Psychiatry items, their uptake of Psychological Therapy Services and Focussed Psychological Strategies items was higher than that of older people. It should also be noted that relatively lower access by young people is not unique to *Better Access*: young people access all mental health services less often than other members of the population^{5, 27, 40} possibly because they are less likely to perceive that they have a need for mental health care.^{41, 42} Alongside the lower rates for young people, it was also found that the growth in uptake between 2007 and 2009 has been substantially greater for young people aged 0-14 years than for other age groups, particularly for the GP Mental Health Treatment, Psychological Therapy and Focussed Psychological Strategies items.

A third concern regarding *Better Access* is that it provides services to people who live in urban areas (where most private health professionals practice), and that people in rural and remote areas are not so well served.⁵⁵⁻⁵⁷ Again, the picture was complex, and levels of access varied according to the items under consideration. For the GP and Focussed Psychological Strategies items, the level of access was the same in rural centres as it was in capital cities, but it was reduced in other rural areas and particularly in remote areas. For Consultant Psychiatry and Psychological Therapy Services items, it showed a steady decrease across each category of geographical region from capital cities to remote areas. The growth in uptake between 2007 and 2009 tended to be higher for people from non-capital city areas.

A final concern with *Better Access* is that although it has improved access for people in affluent areas, it has had no impact in areas with high levels of socio-economic disadvantage. Once again, analyses showed that there were differential levels of impact, depending on the group of items under consideration. Uptake rates for Psychological Therapy Services items and, to a lesser extent, Consultant Psychiatry items, decreased as levels of socio-economic disadvantage increased. By contrast, uptake rates for GP Mental Health Treatment and Focussed Psychological Strategies items were somewhat lower only for persons residing in the most disadvantaged

areas. However growth in uptake between 2007 and 2009 tended to increase as level of socio-economic disadvantage increased. This was true for all item groups.

10.2.2 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE PROVIDED ACCESS TO AFFORDABLE CARE?

Concerns have also been raised about the affordability of subsidised *Better Access* services due to remaining out-of-pocket costs to the consumer. For example, some commentators^{56, 58} have presented evidence that only a minority of *Better Access* services with clinical and registered psychologists are bulk-billed, and that these consultations still incur a significant co-payment for consumers due to the gap between Medicare rebates and the fee recommended by the Australian Psychological Society (APS).

Analyses showed that, overall, more than half of the *Better Access* services delivered were bulk-billed (53.6% in 2007, 56.5% in 2008 and 58.6% in 2009). Of services for which a co-payment was made, the average co-payment was around \$35. Having said this, there was considerable variation according to the type of provider who delivered these services. In 2009, only 7.3% of services delivered under the GP items involved a co-payment by the consumer, whereas up to two thirds of the services delivered under the Consultant Psychiatrist (63.7%), Psychological Therapy Services (65.4%) and Focussed Psychological Strategies (57.4%) items did so. Findings from previous research suggest, however, that the majority of providers have a policy of bulk-billing at least some consumers. For example, 2007 and 2008 surveys of APS members who provided psychology services under the *Better Access* initiative found that 56-66% of these psychologists reported that they bulk-billed at least some clients.^{59, 60} Similarly, the average co-payment varied according to provider type, being lowest for GP items (\$20), close to the overall average for Psychological Therapy Services items (\$32) and Focussed Psychological Strategies items (\$37), and highest for Consultant psychiatrist items (\$82). The percentage of services requiring a co-payment decreased by 10.8% between 2007 and 2009. For services requiring a co-payment, the average co-payment increased between 2007 and 2009 by 4.5%.

The proportion of services that were bulk-billed increased as the level of remoteness and level of relative socio-economic disadvantage increases. The average co-payment was highest among people in remote areas (\$38) and people in capital cities (\$37) than those in other regions (\$31-\$33). The average co-payment decreased as level of relative socio-economic disadvantage increased (from \$38 to \$33).

There were some variations in average co-payments according to socio-demographic characteristics and provider type. Most notably, average co-payments were: lower among people aged 65 years and over for GP, Psychological Therapy Services and Focussed Psychological Strategies items; lower for people aged < 15 years for Consultant Psychiatrist and Occupational Therapist services; higher among people in remote locations for GP, Psychological Therapy Services and Consultant Psychiatrist items; and lower among people in areas of greatest socio-economic disadvantage for GP services.

10.2.3 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE PROVIDED EQUITABLE ACCESS TO POPULATIONS IN NEED?

Another area of concern regarding *Better Access* services relates to whether services are being delivered equitably in the Australian population. It has been suggested that the initiative is

providing services to a number of people who may not have a clinical need for these treatments, and who live in affluent and urban areas (where most allied health professionals practice), while at-risk groups (e.g., young people, people in rural areas or poorer urban areas, people with low income) with legitimate need may be missing out.

Analyses designed to examine whether mental health services are being equitably distributed in the Australian population were undertaken. Specifically, these examined whether the prevalence of need for mental health treatment was predictive of total *Better Access* services used and allied health *Better Access* services used, at the level of Division of General Practice. They also considered the extent to which other factors, such as potential to access treatment and other Division characteristics, were also predictive of *Better Access* service use.

Analyses showed that, at a Division level, rates of total and allied health *Better Access* services were associated with levels of mental health need. However other factors were also found to play a part in explaining rates of *Better Access* service use. Higher rates of total and allied health *Better Access* services used were found in Divisions that have higher rates of GP supply, and Divisions located in Victoria. Lower rates of *Better Access* services used were found in Divisions with relatively more people living in socioeconomically disadvantaged areas and Divisions with relatively more people living in remote locations. The model explained just over half the variation in total *Better Access* (54.7%) and allied health *Better Access* services (51.0%) used. In summary, these results suggest that, while need (or demand) for *Better Access* service is important, supply factors are also important.

Several of the results from the models warrant additional comment. Firstly, variables relating to potential to access services (GP supply, remoteness, state/territory) collectively contributed a slightly larger proportion (approximately 6.5% more) of the variance in total *Better Access* services used than allied health *Better Access* services used, whereas socioeconomic disadvantage contributed a similar proportion of additional variance in total (8.19%) and allied health (8.17%) *Better Access* services used, after all other variables were taken into account. Mental health need contributed a slightly larger proportion of the additional variance explained in allied health (6.10%) than total (3.27%) *Better Access* services used, after variables relating to potential to access services were taken into account. Secondly, the models showed that state/territory variation was an important factor, even after controlling for other variables in the model, including those measuring potential to access treatment (GP workforce supply and remoteness). These differences may reflect supply of allied health professionals and psychiatrists. Thirdly, remoteness of the population within Division was found to be an important predictor of service use. It should be noted, however, that examining need for *Better Access* services in isolation from other components of the mental health system, as was done in the current study, does not take into account the fact that need in some populations may be met by other available services. In the case of remote communities, the ATAPS projects may be covering at least some of the need that cannot be met by *Better Access*.

It is also useful to consider the findings of the current study in the context of other, relevant studies. Only one published study to date has examined the relationship between need for mental health treatment and *Better Access* service use. This previous report³⁷ used individual-level data from the 2007 NSMHWB to explore the use of *Better Access* services provided by allied health professionals among people with a need for mental health treatment. This study found that most people estimated to have used *Better Access* services provided by allied health professionals in the first year of the initiative had a 12-month ICD-10 mental disorder (81.7%) or

another indicator of treatment need (11.5%), i.e., a lifetime ICD-10 disorder, 12-month symptoms (but no lifetime diagnosis) for at least one disorder, or lifetime hospitalisation for a mental health problem. The study also found that, among people with a 12-month affective or anxiety disorder, the probability of *Better Access* service use was predicted by having more complex needs (e.g., more severe disorder, comorbid affective and anxiety disorder) but not by urbanicity (i.e., living in an urban area versus a rural or remote area), residing in an area of relatively lower socio-economic disadvantage, or other socio-demographic factors (such as age and gender). In other words, the previous study was more suggestive of *Better Access* providing equitable access for people in need.

There may be several methodological reasons for the apparent discrepancy between these two sets of findings. The first relates to the populations under study. In the current study, the regression analyses considered use of *Better Access* services in the entire Australian population, with level of mental health need used as the main predictor of interest. In the previous study, the regression analyses were restricted to people defined as having need, either: (1) people who had used *Better Access* services (a form of expressed need); or (2) people with narrowly-defined mental health need (i.e. a 12-month affective or anxiety disorder; a form of comparative need). The second relates to the dependent variable of interest. In the current study, the rates (i.e. amounts) of service use (in the general population) were examined, whereas the previous report examined whether individuals (with need) were or were not users of *Better Access* services. The third relates to differences in the measurement of mental health need. The current study relied on a synthetically modelled measure of mental health need (based on information about age, gender, and section of state) at a Division level, whereas the previous report was able to measure need directly at an individual level. In addition, the current study used a broadly defined measure of mental health need, whereas the previous report focused on people with mental health needs as defined by the presence of 12-month affective or anxiety disorders. A fourth relates to differences in the independent variables used in the two studies. The previous study was unable to examine the effects of remoteness on the probability of *Better Access* service use, as the geographical classification available for analysing the 2007 NSMHWB subsumed all non-metropolitan areas into a single category. It also focused on whether probability of *Better Access* service use was higher among people in the least socio-economically disadvantaged areas, rather than whether it was lower for people in the most disadvantaged areas. A fifth relates to the ecological nature of the current study. Analyses were conducted using aggregate (as opposed to individual-level) data, and it cannot be assumed that conclusions based on group-level data will hold true at the individual level. The use of Division-level data also meant that only a limited range of independent variables was available. For example, it would have been useful to look at supply of allied health professionals and psychiatrists per Division, but these data were not available for the current work.

Taken together the two studies provide complementary perspectives on equity with respect to the *Better Access* initiative. Both studies are consistent in showing that mental health need is associated with *Better Access* service use. The current study suggests that, at a population level, need is an important determinant of the extent of *Better Access* service uptake rates, although there are also some inequities. Namely, these services are used to a greater extent in areas that are likely to have higher rates of appropriate health care professionals, and used to a lesser extent in remote and socio-economically disadvantaged areas. The previous study, which focused on access to *Better Access* services within the populations defined as having need, suggests that the vast majority of *Better Access* services users have a need for treatment, and

that use of *Better Access* services is driven by clinical factors (i.e. having more complex needs), but not by socio-demographic or socio-economic factors.

10.2.4 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE PROVIDED EVIDENCE-BASED MENTAL HEALTH CARE TO PEOPLE WITH MENTAL DISORDERS?

Evidence-based mental health care refers to the provision of care that, according to current best evidence, gives a person with mental illness the best possible chance of recovery or remission. The data available for the current evaluation did not permit an examination of whether the care provided at individual sessions was evidence-based (although, as noted earlier, *Better Access* is premised on evidence-based treatments such as cognitive behavioural therapy), but it was possible to explore whether certain patterns of service delivery were evident that might give some indications of the extent to which evidence-based care was being delivered. Hence it was renamed 'protocol-based care'.

Two examples of protocol-based care were considered. The first of these related to the patterns of care delivered following a GP Mental Health Treatment Plan. The *Better Access* protocol dictates that a GP Mental Health Treatment Plan is required in order for a referral to be made from a GP to an allied health professional for Psychological Therapy Services or Focussed Psychological Strategies. It also recommends that at the end of treatment with the allied health professional, the consumer should be referred back to the GP for a review. The rationale underpinning this protocol is that this promotes good continuity of care. Analyses estimated that approximately one fifth of consumers received both a GP Mental Health Treatment Plan and a GP Mental Health Treatment Review, which is perhaps less than ideal, and may suggest a need for educational strategies to encourage the use of the Review item by GPs. It should be noted, however, that the fact that the GP Mental Health Treatment Review item was not used does not necessarily mean that a review has not occurred. It is possible that other items are being used to capture the content of the session in which the review occurs.

The relationship between GP Mental Health Treatment Plans and Psychological Therapy Services or Focussed Psychological Strategies was also explored. Analyses showed that 58% of *Better Access* consumers received at least *Better Access* one allied health service following their first Plan. Conversely, 41.8% did not. The extent to which this occurred varied according to age, gender, region of residence and level of socio-economic disadvantage. Older people aged 65 years or more had the highest percentage of non-receipt of allied health services following a Plan (53.3%), whereas young people aged 15 years or less had the lowest percentage (29.8%). Non-receipt of *Better Access* allied health services following a Plan was somewhat higher for males (44.0%) than females (40.6%). Analyses also showed that the likelihood of non-receipt of *Better Access* allied health services following a Plan increased considerably as level of geographical remoteness increased, being 19.6% lower for people in other rural areas, and 47.8% lower for people in remote areas. In addition, non-receipt of *Better Access* allied health services following a Plan increased as level of socio-economic disadvantage increased. Non-receipt of *Better Access* allied health services following a first Plan were 14.6% higher for people in capital cities, but were 14.4% lower for people in other rural areas and 15.1% lower for people in remote areas. These findings may, in part, reflect the lack of availability of allied health professionals in non-metropolitan regions, and possibly barriers relating to cost in people from socio-economically disadvantaged areas. It should be noted, however, that consumers who did not receive *Better Access* allied health services may have received psychological services from other sources, for

example: from allied health professionals under the ATAPS program (which is not recorded in the MBS); from their GP, which may be recorded using the *Better Access* GP Mental Health Consultation item (2713) or under another MBS item; or via privately funded services. Nonetheless, there may be a need to consider alternative frameworks or mechanisms for referrals under *Better Access*.

The second example of protocol-based care was the number of psychological services delivered by allied health professionals per person per calendar year. The protocol dictates that once an individual is referred by a GP to an allied health professional, he or she can receive six sessions of psychological care. Following a review by the GP, he or she may be offered a further six sessions. In exceptional circumstances, he or she may be offered a further six still, following a second review by the GP. This protocol is designed to promote good communication between providers, and to maximise efficiency of service delivery. Analyses were undertaken for all individuals who received psychological services in 2007 and 2008. These showed that, in both calendar years, around 75% received between one and six, 20% received between seven and 12, and 5% received between 13 and 18. This suggests that the protocol is being interpreted appropriately by providers.

10.2.5 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE PROVIDED INTERDISCIPLINARY PRIMARY MENTAL HEALTH CARE FOR PEOPLE WITH MENTAL DISORDERS?

Prior to *Better Access*, various studies had found that few Australians consulted multiple providers for mental health issues⁶¹ and, if they did, collaboration between these providers was poor⁷⁻⁹ despite there being ‘... *clear evidence that the best quality mental health services are delivered through collaborative care*’.^{58, p. 194} For this reason, one of the principles underpinning *Better Access* is that of interdisciplinary care. However some commentators have argued that the fee-for-service model underpinning *Better Access* does not provide a foundation for structural arrangements, such as co-location of GPs and allied health professionals, that may promote interdisciplinary care.^{56, 58}

More than half (55.1%) of *Better Access* users were estimated to have received interdisciplinary care, most commonly from combinations of GPs and allied health professionals. The remainder (44.9%) received GP care alone. The percentage of *Better Access* consumers receiving interdisciplinary care was the same in other metropolitan areas as in capital cities, and only slightly lower in rural centres, but was 15% lower in other rural areas and 33% lower in remote areas compared to all *Better Access* consumers combined. Rates of interdisciplinary care also decreased as level of socio-economic disadvantage increased. Specifically, in metropolitan areas rates of interdisciplinary care were 13% lower among people from the most disadvantaged areas, compared to all *Better Access* consumers combined.

A number of caveats should be noted in interpreting the findings regarding interdisciplinary care. Firstly, it is acknowledged that the definition of interdisciplinary care used in the current study is narrow, being limited to services available via Medicare. Whilst they do provide an accurate picture of the extent of interdisciplinary care provided under the *Better Access* Medicare items, they are an underestimate of interdisciplinary care if considering the full range of treatment options available. For example, some consumers, particularly those people in non-metropolitan areas, may be receiving psychological services via the ATAPS program (which are not recorded by Medicare). Secondly, the data available for the current evaluation also did not enable an

examination of the models under which allied health professionals work with GPs and other providers, and whether or not *Better Access* encourages co-location or other structural arrangements that may promote interdisciplinary care.

10.2.6 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE IMPACTED ON THE USE OF MEDICATIONS COMMONLY PRESCRIBED FOR TREATMENT OF MENTAL DISORDERS, IN PARTICULAR ANTIDEPRESSANT MEDICATIONS?

As noted earlier, several studies conducted prior to the introduction of *Better Access* had found that GPs were overwhelmingly the most common providers of mental health care in Australia.⁵ Concerns had been expressed that the treatment provided by GPs, was more often pharmacological than non-pharmacological,⁴² despite there being good evidence that non-pharmacological interventions, such as counselling, monitoring, and self-directed and therapist-directed therapies may be equally efficacious or preferable treatment options for mild to moderate mental illness.^{62, 63}

The current evaluation took the opportunity to examine patterns of prescribing pre- and post-the introduction of *Better Access*. There was no a priori hypothesis about the direction of any change. On the one hand, it might have been reasonable to expect levels of prescribing to go down, because of the greater ability of referral sources for non-pharmacological treatments. On the other hand, it might have been equally plausible that there would be an increase in prescribing, because *Better Access* may have increased GPs' knowledge and/or recognition of mental illness, and/or consumers' access to other medical practitioners (i.e., psychiatrists) who can prescribe these medications. Both of these possibilities were considered in the current evaluation.

Using Division level data, a significant change in trends for PBS-subsidised antidepressant supply was found between the two years pre- and the three years post- the introduction of *Better Access*. The rate of persons using antidepressant medications appeared to decrease slightly in the two years before the introduction of *Better Access*, however it is acknowledged that this decrease likely to be accounted for some high uptake medications coming off patent during this period, and offset by a corresponding increase uptake in non-subsidised medications. The rate of persons using antidepressant medications increased significantly (0.9% per quarter, on average) in the three years after the introduction of *Better Access*. The rate of scripts supplied also increased significantly (1.5% per quarter, on average) post-*Better Access*. In contrast, rates of anxiolytic use were stable over the pre- and post-*Better Access* periods.

A positive association was found between *Better Access* uptake and medication use at a Division level. The rate of persons within a Division using PBS-subsidised antidepressant medications, and the rate of scripts supplied, increased as the percentage of persons using *Better Access* increased. Similarly, the rate of persons within a Division using PBS-subsidised anxiolytic medications, and the rate of scripts supplied, increased as the rate of persons using *Better Access* increased.

Taken together, these findings tend to suggest that *Better Access* has had the effect of increasing consumers' access not only to the non-pharmacological treatments that underpin it, but to pharmacological therapies which have also been shown to have good evidence of effectiveness. It is acknowledged, however, that caution should be exercised in interpreting these findings. The PBS records subsidised medicines. It is estimated that approximately 75% of antidepressant

medication prescriptions and 73% of anxiolytic medication prescriptions dispensed by pharmacies are recorded on the PBS.⁴⁹ In addition, levels of antidepressant medication use prior to *Better Access* are likely to be underestimated in the current study because several commonly prescribed antidepressant medications came off patent in the two years preceding *Better Access* commencement.⁵⁰ A further caution relates to the ecological nature of the analyses undertaken. It may be that the change in trend in antidepressant medication supply observed after the introduction of *Better Access* would have occurred even in the absence of *Better Access*. However the finding that Division-level rates of medication supply were positively related to Division-level rates of *Better Access* uptake lend some support for this interpretation.

10.2.7 TO WHAT EXTENT HAS THE *BETTER ACCESS* INITIATIVE IMPACTED ON RELATED MBS SERVICES?

In the evaluation of the introduction of a large-scale initiative like *Better Access*, it is important not only to consider the program in its own right, but also to consider its impact on existing related programs. This was done by examining the relationship between *Better Access* and non-*Better Access* mental health MBS items, and the relationship between *Better Access* and ATAPS. Both sets of analyses were conducted at the Division of General Practice level.

Analyses showed no evidence, at a Division level, of any reduction in demand for non-*Better Access* mental health MBS related to the introduction of *Better Access*. Rates of non-*Better Access* MBS item use were stable in the two years before and after the introduction of *Better Access*. However Divisions with higher uptake of *Better Access* also had significantly higher uptake of other mental health MBS items. This was the case in both metropolitan and rural and remote regions.

The picture with ATAPS was more complex. ATAPS psychological services have proportionally greater penetration into rural and remote regions than metropolitan regions (whereas the reverse is true for *Better Access*). This pattern was not affected by the introduction of *Better Access*. At a Division level, overall demand for ATAPS psychological services was related to patterns of demand for *Better Access* services. Divisions with higher population uptake of *Better Access* appeared to have lower uptake of ATAPS psychological services. Higher rates of *Better Access* services used were also associated with lower rates of ATAPS psychological services used. However, further analysis revealed that this pattern differed according to rurality. In metropolitan regions, Divisions with higher uptake of *Better Access* also had significantly higher population uptake of ATAPS psychological services, but not higher rates of services used. In contrast, in rural or remote regions, Divisions with higher uptake of *Better Access* had significantly lower population uptake of ATAPS psychological services, and lower rates of ATAPS psychological services used. One possible interpretation is that, in metropolitan areas where there are more allied health providers, demand for services translates into higher uptake of both *Better Access* and ATAPS psychological services. In rural and remote regions, where there are fewer allied health providers, *Better Access* GP services may be partly meeting the demand for psychological services. This is consistent with evidence that people in rural and remote regions are more likely to receive *Better Access* care from GPs alone (see Chapter 7). In addition, rural Divisions have other avenues apart from ATAPS for providing mental health services, e.g., the Rural & Remote Program and More Allied Health Services Program (MAHS). It is also important to note that the extent of the relationship between *Better Access* and ATAPS is partly constrained by the fact that ATAPS services are limited by capped funding.

These findings may suggest that *Better Access* is filling a gap in the mental health service delivery system that was not previously being met by other related services. However, the introduction of *Better Access* does not appear to have negated the need for these other services, particularly in rural/remote areas. This interpretation is consistent with that of Bassilios and colleagues⁵² who conducted an earlier analysis of the relationship between *Better Access* and ATAPS and concluded that these initiatives appear to be providing complementary services to potentially different areas of the Australian population.

10.3 ASPECTS OF THE EVALUATION QUESTIONS BEYOND THE SCOPE OF THIS REPORT

This section provides a brief summary of additional issues relating to the evaluation questions considered by Component B but that are beyond the scope the present evaluation.

The first issue relates to increasing access to services for 'new' consumers. Measures of whether *Better Access* has improved access to mental health services may include: (1) whether *Better Access* is bringing previously untreated cases (i.e. people who would otherwise not receive care) into treatment services; (2) whether *Better Access* is improving access for people who previously may have received less adequate care⁵⁶ or, conversely; (3) whether *Better Access* users are people who were receiving mental health care under different means before the introduction of *Better Access* (for example, people who were previously paying for non-subsidised psychological services). Investigation of these questions is beyond the scope of the data available for the present evaluation. However, a previous report has considered the latter question using data from the 2007 NSMHWB.³⁷ This study estimated that 62.3% of *Better Access* service users had not previously received services from an allied health professional. A recent APS survey found that psychologists who provide *Better Access* services reported that 70% of these clients had never consulted a psychologist prior to *Better Access*.⁶⁰ These findings offer support for the contention that *Better Access* is providing services to a substantial proportion of 'new' consumers of allied health services, but cannot inform whether these consumers were previously receiving treatment from any other source. It may also be the case that, given its recency and breadth, *Better Access* is now the most popular choice of service for new consumers compared to other systems. More detailed research with current *Better Access* users and providers, including information about users' former mental health care, will best elucidate this issue. Some information about this will be available through Component A.

A second issue relates to equity. Equitable access to mental health care refers to all members of the population having equal opportunity to use services regardless of age, location and cultural background. In the present report, this was evaluated by considering whether the rates of uptake of *Better Access* services across sociodemographic sub-groups of the population was comparable to the rates of need (i.e., proportion of the population and prevalence of mental illness) in these subgroups. However, there are other, non-demographic indicators of need that must be considered when evaluating whether mental health services are being distributed to those who most need them. These include illness severity and comorbidity.⁸ It may be argued that, for equitable access, people with more severe levels of disorder should be receiving a larger number of *Better Access* services than people with mild disorder. The MBS data available for the present evaluation could not determine whether *Better Access* is providing a greater number of services to people with high need due to severe or chronic illness because diagnostic information about

consumers is not included in this dataset. Some support is offered by the analysis the qualitative reports of APS members who provide psychological services under *Better Access*, who have reported an increase in clientele being treated for “more severe mental health conditions” since the introduction of this initiative.⁶⁰ The previously mentioned analysis of data from the 2007 NSMHWB also shows that severity of disorder is a principal determinant of *Better Access* service use.⁶⁴ Further research involving individual level data from populations using *Better Access* services are needed to provide definitive conclusions on this issue.

A third issue relates the range of factors that may influence access to services. It is important to note that people’s access to mental health services is affected by multiple factors, including several beyond the influence of *Better Access*, and thus the scope of this evaluation. Facilitating the referral process to allied health professionals, and reducing the out-of-pocket cost of their services, are undoubtedly major steps forward to enhancing people’s access to evidence-based mental health services. However, the availability of health professionals to provide these services is also key.^{8, 59, 65} For example, a person with mental illness may still be unable to consult a clinical psychologist at a subsidised rate if there are no or few professionals in their geographic area. This is known to be the case in rural and remote areas.^{10, 55, 65} This aspect of access (i.e., enhancing the mental health workforce) is to be addressed with other components of COAG’s National Action Plan on Mental Health.¹⁵ However, it is important to note with regards to the present evaluation that the considerable uptake of *Better Access* MBS items may still mask significant unmet demand for mental health services in some areas due to an inadequate mental health workforce.

Further factors that may influence the uptake of mental health care outside the availability of Medicare-subsidised services include: (1) knowledge about the availability of, and individual eligibility to, *Better Access* services amongst potential consumers; (2) knowledge and perceived stigma about mental illness (and thus the willingness and ability to report symptoms to a doctor), and; (3) whether potential consumers choose to seek help for mental health symptoms.⁶⁶ Each of these factors may, in part, explain why greater rates of *Better Access* uptake are not always seen among the people who may be considered to most need these services. That is, subgroups of the population who are at high risk of mental illness, or most require subsidised services due to socio-economic disadvantage.^{37, 52} For example, it is possible that socio-economically advantaged people are more aware of the availability of *Better Access* services, and thus better able to request a referral by their doctor. These factors cannot be addressed (nor evaluated) by improving overall access to services, but rather, additional, ongoing efforts to education about the availability of these services, and mental illness more generally.

10.4 KEY METHODOLOGICAL ISSUES

A key methodological limitation of the current evaluation relates to the use of aggregated datasets. The use of models based on variables measured at an aggregated level, i.e. at the level of Division of General Practice, has several advantages and disadvantages. In the current evaluation, a key advantage of using aggregated datasets was the capacity to combine data from multiple sources, without recourse to complicated record linkage procedures. However, such analyses may be subject to the ‘ecological fallacy’, which is the assumption that conclusions based on group-level data will hold true at the individual level. Caution should be applied in interpreting the results of analyses based on aggregated datasets.

A second issue relates to the period over which data describing uptake of *Better Access* and other services were available. In the current evaluation, data capturing *Better Access* services received up until the end of the March 2009 quarter (generally for 2004 through 2008 data), or until the end of April 2010 (generally for 2009 data and first quarter 2010 data), were available. These data were provided in two stages, and were generated from two separate data extractions. The data provided in the initial data extraction were not revised in the subsequent extraction to capture adjustments for late claims, and thus may slightly undercount the number of services delivered. This also applied to the PBS data. Other caveats to the datasets and analyses used in this report are noted in the Method chapter, the individual results chapters, and earlier section of this Discussion chapter.

10.5 CONCLUSIONS

The current analysis of MBS and related data has shown that *Better Access* has improved access to evidence-based, multi-disciplinary mental health care for Australians. These improvements have occurred for people irrespective of their age and socio-economic status, and regardless of where they live. The analyses show that young people, people in the lowest socio-economic strata, and people in small rural and remote areas have not been as well served as their older, more affluent, urban counterparts. Over half of the sessions of care provided through *Better Access* are bulk-billed, although – like other Medicare-funded services – the proportion of bulk-billed services is higher for GPs and lower for specialists (e.g., psychiatrists and psychologists). Those with greatest levels of financial need are the biggest beneficiaries of bulk-billed services. High levels of uptake of *Better Access* services have not led to commensurate reductions in the use of other relevant mental health services or prescribing of antidepressant or anxiolytic medications. In fact, the opposite is true, which suggests that *Better Access* is a crucial piece in the web of Australian primary mental health care reforms, and is helping to meet previously-unmet need. Before this conclusion can be definitively drawn, however, further work is required to profile the mental health status of people using *Better Access* services, and the outcomes of *Better Access* care. The study of consumers and their outcomes, which is being conducted as part of the current evaluation, will be helpful in this regard.