

Chapter 3: Question 1 – Has Better Access improved access to mental health care?

1a. What is the overall level of uptake of Better Access services?

Since the inception of Better Access, uptake has been substantial and has grown steadily in subsequent years. Data from Component B show that in 2007, 710,840 Australians (one in every 30) received at least one Better Access service. In 2008, 951,454 (one in every 23) Australians did so, and in 2009, 1,130,384 (one in every 19) did so. Better Access uptake increased by 31.7% between 2007 and 2008 before slowing to 18.7% between 2008 and 2009 (see Table 3). After accounting for some people who received services in more than one year, this equates to 2,016,495 unique individuals who received services over the three year period.

Table 3: Persons receiving any Medicare Benefits Schedule-subsidised *Better Access* services, 2007, 2008 and 2009, Component B

2007 ¹		2008 ¹			2009 ¹		
N persons	Rate (per 1,000) ²	N persons	Rate (per 1,000) ²	Increase since 2007	N persons	Rate (per 1,000) ²	Increase since 2008
710,840	33.8	951,454	44.5	31.7%	1,130,384	52.8	18.7%

1. 2007 and 2008 figures have regard to all claims processed up to and including 30 April 2009; 2009 figures have regard to all claims processed up to and including 30 April 2010.
2. Rate per 1,000 total population.

In each year, the vast majority of Better Access consumers (more than 85%) received at least one Better Access service from a GP. This is consistent with the functions of the GP mental health treatment plan and review item numbers (2710^b and 2713, respectively) as gateways to further Better Access services. Focussed Psychological Strategies services provided by general psychologists had the next highest uptake rate; just under one third of Better Access consumers received one or more of these services in each year. These were followed by uptake rates for Psychological Therapies services provided by clinical psychologists, then Consultant Psychiatrist services (see Table 4).

Table 4: Persons receiving Medicare Benefits Schedule-subsidised *Better Access* services by provider type, 2007, 2008 and 2009, Component B¹

Provider type	2007 ²			2008 ²			2009 ²		
	N persons	% of persons	Rate (per 1,000) ³	N persons	% of persons	Rate (per 1,000) ³	N persons	% of persons	Rate (per 1,000) ³
General Practitioner	618,867	87.1	29.5	817,738	85.9	38.3	971,836	86.0	45.4
Consultant psychiatrist	87,947	12.4	4.2	93,736	9.9	4.4	100,434	8.9	4.7
Clinical psychologist	98,612	13.9	4.7	151,587	15.9	7.1	189,418	16.8	8.9
General psychologist	213,963	30.1	10.2	289,785	30.5	13.6	348,417	30.8	16.4
Occupational therapist	2,011	0.3	0.1	3,701	0.4	0.2	5,103	0.5	0.2
Social worker	10,918	1.5	0.5	20,157	2.1	1.0	28,276	2.5	1.3

1. The sum of persons receiving services under each item group will be greater than for all Better Access items because a person may receive services from more than one type of provider.
2. 2007 and 2008 figures have regard to all claims processed up to and including 30 April 2009; 2009 figures have regard to all claims processed up to and including 30 April 2010.

^b And, from 1 January 2010, MBS item 2702.

3. Rate per 1,000 total population.

Component B also explored the annual costs associated with Better Access services. Table 5 shows that almost than 2.7 million Better Access services were provided in 2007. This increased to 3.8 million services in 2008 and to more than 4.6 million in 2009. The total cost of these services to government, in terms of benefits paid, increased from \$288.9 million in 2007 to \$389.4 million in 2008, and to \$478.1 million in 2009.

Table 5 also shows that more than half of Better Access services delivered were bulk-billed. The average co-payment was around \$35. The proportion of services that involved a co-payment and the average co-payment varied considerably according to the type of provider who delivered the services. For example, in 2009, only 7% 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 (64%), Psychological Therapy Services (65%) and Focussed Psychological Strategies (57%) items did so. One factor that may account for the lower rates of bulk-billing rates for allied health providers, compared to GPs, relates to the types of MBS items being claimed. Component B found that the overwhelming majority of allied health services provided are long (i.e., 50+ minute) consultations.

Table 5: MBS-subsidised Better Access services received, bulk-billing rate, fees charges, benefits paid and average co-payment, by Better Access item group, 2007-2009, Component B

	Total services		Bulk-billed services N	Fees charged ² %	Benefits paid ² \$	Services with co-payments		Average co-payment (\$) ⁴	Total patients N
	N	%				N	%		
2007¹									
GP items ³	1,012,497	91.4	925,910	119,225,281	117,636,222	86,587	8.6	18.35	618,867
CP items ³	94,590	32.0	30,231	25,901,960	21,222,543	64,359	68.0	72.71	87,947
PTS items ³	507,367	26.8	136,073	71,707,903	60,739,728	371,294	73.2	29.54	98,612
FPS items ³	1,078,995	32.6	351,413	114,779,148	89,272,270	727,582	67.4	35.06	226,169
Total	2,693,449	53.6	1,443,627	331,614,292	288,870,763	1,249,822	46.4	34.20	710,840
2008¹									
GP items ³	1,375,025	92.3	1,269,689	152,526,591	150,519,438	105,336	7.7	19.05	817,738
CP items ³	101,678	33.9	34,437	27,812,365	22,676,030	67,241	66.1	76.39	93,736
PTS items ³	785,174	31.9	250,397	108,649,361	92,264,952	534,777	68.1	30.64	151,587
FPS items ³	1,524,723	38.3	584,050	157,551,394	123,987,143	940,673	61.7	35.68	312,035
Total	3,786,600	56.5	2,138,573	446,539,711	389,447,563	1,648,027	43.5	34.64	951,454
2009¹									
GP items ³	1,659,534	92.7	1,538,270	182,427,744	179,971,434	121,264	7.3	20.26	971,836
CP items ³	109,734	36.3	39,846	30,529,663	24,816,904	69,888	63.7	81.74	100,434
PTS items ³	1,000,129	34.6	345,693	139,410,904	118,370,909	654,436	65.4	32.15	189,418
FPS items ³	1,894,584	42.6	807,337	194,849,261	154,976,465	1,087,247	57.4	36.67	379,284
Total	4,663,981	58.6	2,731,146	547,217,572	478,135,712	1,932,835	41.4	35.74	1,130,384

1. 2007 and 2008 figures have regard to all claims processed up to and including 30 April 2009; 2009 figures have regard to all claims processed up to and including 30 April 2010.
2. Fees charged, benefits paid, and average copayments are expressed in 2009 dollars.
3. GP, General practitioner; CP, Consultant Psychiatry; PTS Psychological Therapy Services; FPS, Focussed Psychological Strategies.
4. ^a Only services for which the consumer contributed a co-payment are included in the calculation of the average co-payment.

The average co-payment was lowest for GP items (\$20 in 2009), somewhat higher for Psychological Therapy Services items (\$32) and Focussed Psychological Strategies items (\$37), and highest for Consultant psychiatrist items (\$82). For services requiring a co-payment, the average co-payment increased between 2007 and 2009 by 4.5%. However, the percentage of services involving a co-payment decreased by 10.8% over the same period. This pattern was evident across all item groups, regardless of provider.

Separate analyses of service-level Medicare data conducted for the Post-Implementation Review of Better Access¹⁸ and the Australian Institute of Health and Welfare’s annual reports on mental health services^{19 20} have also shown increasing levels of Better Access service provision over time. So too have independent analyses conducted by other researchers.²¹⁻²⁶

1b. Has Better Access increased the treatment rates of people with mental disorders?

In answering this question, we need to monitor trends in the overall treatment rate for people with mental disorders in Australia since the implementation of Better Access. In order to estimate the proportion of Australians with mental disorders who have received mental health treatment each year, we need to know:

1. how many Australians had a mental disorder in each year and
2. the number of these persons who were treated in each year.

The major challenge in obtaining these estimates is the absence of a single data source that can directly address the issue.

The 1997 and 2007 National Surveys of Mental Health and Wellbeing can examine changes in the rates and patterns of mental health treatment over time because each survey collected information about individuals’ mental health status and their use of a diverse range of health services. Previously published analyses of data from these surveys (see Table 6) suggest that service use rates for common mental disorders (that is, affective, anxiety and substance use disorders) remained relatively stable over the 1997 to 2007 period, a finding that was counter to expectation.^{12 13 16}

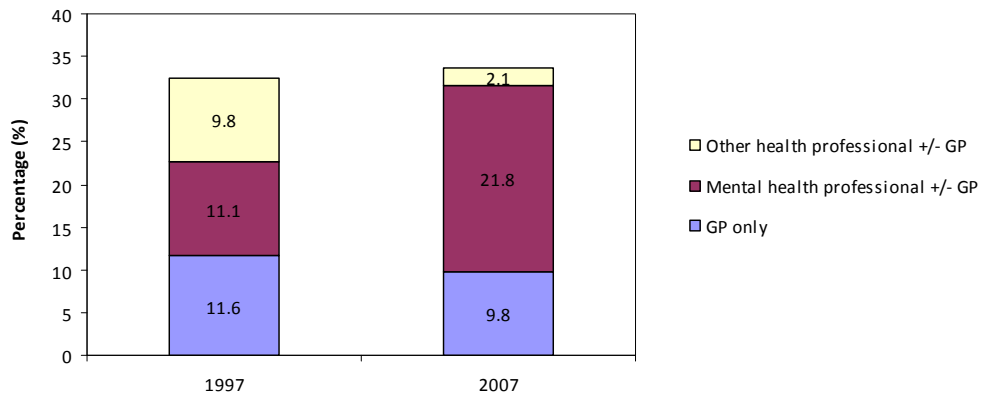
Table 6: Proportion of people with a 12-month mental disorder who received services for a mental health problem, 1997 and 2007 National Survey of Mental Health and Wellbeing

Disorder class	1997 NSMHWB	2007 NSMHWB ³
12-month ICD-10 affective disorder	60.4 ¹	58.6
12-month ICD-10 anxiety disorder	45.2 ¹	37.8
12-month ICD-10 substance use disorder	27.9 ¹	24.0
Any 12-month ICD-10 disorder	38.0²	34.9

1. Parslow and Jorm, 2000
2. Australian Bureau of Statistics, 1998
3. Burgess et al, 2009

Component F used National Survey of Mental Health and Wellbeing data to examine whether the use of different types of providers for mental health problems changed between 1997 and 2007.¹⁰ These showed a shift towards greater use of mental health providers. Figure 1 shows that, in 2007, the proportion of people with a 12-month mental disorder who sought treatment from a mental health professional (psychiatrists, psychologists and other mental health professionals) doubled, while the proportion who sought treatment from a GP alone or from another health professional decreased.

Figure 1: Proportion of people with a 12-month disorder who used services for a mental health problem, 1997 and 2007 National Survey of Mental Health and Wellbeing, Component F



These analyses suggest that, between the two surveys, access to specialised mental health care for people with mental disorders had improved. This may reflect the combined early impact of the Better Access program in its first year (introduced November 2006), and its precursor, the Better Outcomes in Mental Health Care program that was more modest in financial investment and population coverage.^c

The National Survey of Mental Health and Wellbeing has two major limitations that preclude its use in estimating the impact of Better Access on rates of treatment of mental disorders. The first is that the 2007 survey was conducted between August and December 2007, and therefore does not capture the first full year operation of Better Access for all respondents. Nor can it provide any information on the impact of Better Access in the years following its initial establishment in 2006-07. The second limitation is that the survey data do not provide complete coverage of the Australian population. Specifically, the 2007 survey did not sample Australians who were younger than 16 years of age or older than 85 years of age. In addition, the scope of the survey was restricted to those living in households. It therefore excluded elderly people in hospitals and aged care facilities with mental disorders, and others with mental disorders living in non-household residential establishments.

To overcome the limitations in the epidemiological data, the Department of Health and Ageing conducted a modelling exercise using routinely available data to estimate the change in treatment rates between 2007 and 2010¹⁷. This model used administrative data on health service utilisation collected by the Commonwealth and states and territories to answer the question: *What percentage of Australians with a current mental illness can be estimated to have accessed a health service for assistance with their illness?*

Details of this modelling were provided to the consultants for inclusion in this report. The consultants reviewed the methodology and key assumptions of the modelling and undertook additional analysis to assess the effects of uncertainty in key parameters and assumptions on the estimates. The purpose of the uncertainty modelling was to assess the extent to which apparent increases in the proportion of persons with mental disorders who receive mental health treatment may be due to sampling error or uncertainty in key parameters used in the Department's model. The details of this work are described in Appendix 2.

^c This program delivers similar services to those offered through Better Access, but does so through projects run by Divisions of General Practice

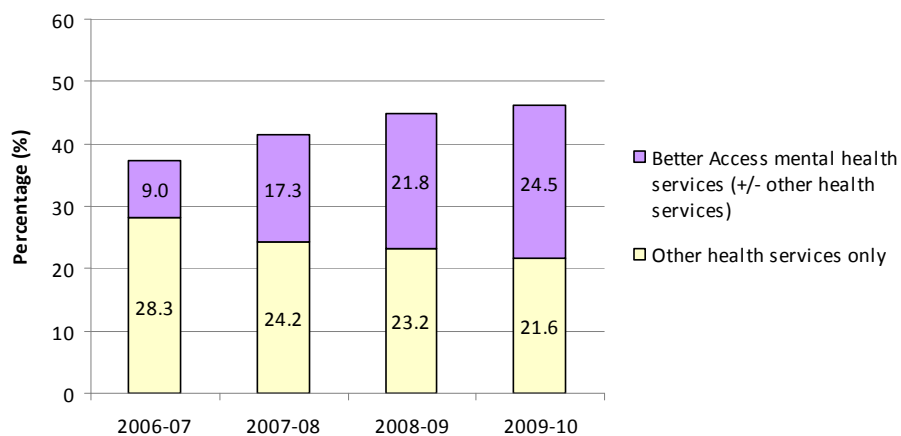
The results of the uncertainty modelling are summarized in Table 7 below. There are three key findings. First, the estimated proportion of persons with a current mental illness who received treatment increased steadily each year from 37.4% in 2006-2007 to 46.1% in 2009-2010, an overall increase of 8.7%. Second, the 95% confidence intervals indicate considerable uncertainty around each of these estimates. They generally fell within plus or minus 3.9% of the mean estimate. For example, in 2006-2007, the 95% uncertainty interval around the estimate of 37.4% ranged between 33.9% and 40.8% (a range of 6.9%). Third, the intervals around the best estimate for each year did not overlap for 2007-2008 and 2008-2009 with the best estimate in the year before. This was not the case for 2009-2010. This pattern of results indicates that the increase between 2006-2007 and 2008-2009 in the percentage persons with a mental disorder who received treatment was unlikely to be due to chance variations in the data. We can be less confident about the smaller increase between the last two years of the period, suggesting a possible slowing in the percentage treated in the most recent period. With this exception, overall, there has been a significant increase in the proportion of persons with a mental disorder who receive mental health treatment for that disorder in the past year.

Table 7: Percentage of persons with a mental disorder treated, results of uncertainty modelling

Year	Mean	95% confidence interval
2006-07	37.4	35.0 – 39.6
2007-08	41.5	39.7 – 43.7
2008-09	45.0	42.7 – 47.3
2009-10	46.1	43.8 – 48.4

The Better Access program appears to be the sole driver of increased treatment rates for mental illness. Figure 2 shows the contribution of Better Access persons treated to overall treatment rates, as estimated by the Department of Health Ageing model. The percentage of persons with a current mental disorder who were treated using Better Access mental health services (alone or in addition to other health services) rose from 9.0% in 2006-07 to 25.4% in 2009-10. Expressed another way, in 2006-07 Better Access persons treated represented one-quarter (24%) of all persons treated. This increased in successive years to 42% in 2007-08, 49% in 2008-09. In 2009-10 Better Access persons treated represented more than half (53%) of all persons treated.

Figure 2: Percentage of persons with mental disorders in the total Australian population treated using Better Access mental health services and other health services, 2006-07 to 2009-10



There are currently no nationally agreed targets for treatment coverage (i.e. the proportion of persons with a mental disorder who ideally should be treated). Expert opinion suggests that an attainable level of coverage with good quality treatment may lie between 60% and 67%.⁴¹⁻⁴³ Judged against these targets, the Department of Health and Ageing modelling suggests that Australia's mental health reforms have made significant progress in closing the gap between current and desirable treatment rates, but that there remains some way to go. In saying this, it is acknowledged however that just seeing a practitioner does not guarantee that good quality treatment has been provided. Although target setting is a separate exercise, information about treatment coverage needs to be supplemented with information about the extent to which treatment provided represents good value for money.

1c. Has Better Access reached groups who are traditionally disadvantaged in their access to mental health care and, if so, has the rate of Better Access uptake improved over time for these groups?

The summative evaluation was not able to assess this question for all groups who are traditionally disadvantaged in their access to mental health care, because no data were available for some (e.g., people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people). It was, however, able to consider access for young people and older people, people in rural and remote areas, and people in areas of high socio-economic disadvantage.

Component B explored the uptake of Better Access items according to the socio-demographic characteristics available in the Medicare Benefits Schedule data, namely, age, gender, geographical location and socio-economic disadvantage. Table 8 summarises the rates of Better Access uptake by socio-demographic characteristics in each of 2007, 2008 and 2009, and the percentage change in rates between years.

Lower rates of uptake were found among young people aged less than 15 years and older people aged 65 or more compared to the middle age groups. However, the relative growth in uptake between 2007 and 2009 was considerably greater for young people under 15 years (96.1%) than for all other age groups, followed by those aged 65 years and over (61.6%).

Additional analyses showed that young people also had the lowest uptake of the GP and Consultant Psychiatry items and the second lowest uptake of Psychological Therapy Services and Focussed Psychological Strategies items (older people having the lowest uptake of the two latter item groups). However, rates of growth between 2007 and 2009 were strongest among young people for the GP Mental Health Treatment (96.3%), Psychological Therapy (121.4%) and Focussed Psychological Strategies (104.9%) items. Growth was more modest (but similar to all other age groups) for the Consultant Psychiatrist (10.8%) items.

Table 8 also shows that uptake rates varied according to geographic region. They were somewhat lower for people residing in capital cities (53.7 per 1,000 population in 2009) than for those in other metropolitan centres and rural centres (59.0 and 57.6 persons per 1,000 in 2009, respectively). Compared to people living in capital cities, uptake rates were approximately 12% lower for people in other rural areas (47.3 per 1,000 in 2009) and approximately 60% lower for people in remote areas (21.5 per 1,000 in 2009). Additional analyses showed that this pattern of lower uptake for people in remote areas was consistent, regardless of item group. However, relative growth in uptake between 2007 and 2009 was greatest for people in remote areas.

With respect to socio-economic disadvantage, uptake rates were approximately 10% lower for people living in the most disadvantaged areas (48.5 persons per 1,000 population in 2009) than for people living in relatively more advantaged areas (between 52.4 and 53.6 persons per 1,000 population in 2009). However, relative growth in uptake between 2007 and 2009 was highest for people in the most disadvantaged areas. Additional analyses showed that these patterns were generally consistent across all item groups.

Table 8: Rates and percentage change in rates of use of any Medicare Benefits Schedule-subsidised Better Access services by age, gender, geographical region and socio-economic disadvantage for 2007, 2008 and 2009, Component B

	Rate (per 1,000) ³			Percentage change		
	2007 ¹	2008 ¹	2009 ¹	2007-2008 ¹	2008-2009 ¹	2007-2009 ¹
Age group						
0-14 years	10.1	14.8	19.7	47.7	32.8	96.1
15-24 years	35.9	47.3	57.3	31.7	21.2	59.5
25-34 years	50.6	65.2	75.2	28.7	15.5	48.6
35-44 years	52.3	68.5	80.0	30.9	16.8	52.9
45-54 years	44.1	57.5	67.4	30.6	17.1	52.9
55-64 years	33.2	43.6	51.8	31.2	18.9	56.0
65+ years	17.3	23.0	27.9	33.3	21.3	61.6
Gender						
Male	24.8	32.7	39.4	31.7	20.6	58.9
Female	42.7	56.3	66.2	31.6	17.7	54.9
Region^{2,4}						
Capital cities	35.2	45.8	53.7	30.2	17.3	52.7
Other metropolitan centres	36.7	48.3	59.0	31.6	22.1	60.7
Rural centres	35.0	47.5	57.6	35.6	21.4	64.6
Other rural areas	28.5	38.9	47.3	36.4	21.5	65.8
Remote areas	12.7	16.6	21.5	30.6	29.5	69.2
Socio-economic disadvantage^{2,5}						
Quintile 5 (Least)	36.1	46.1	53.4	27.7	15.8	47.9
Quintile 4	33.6	44.1	52.7	31.0	19.7	56.8
Quintile 3	33.4	44.1	52.4	31.9	18.7	56.6
Quintile 2	33.2	44.6	53.6	34.2	20.1	61.2
Quintile 1 (Most)	29.4	40.0	48.5	36.0	21.2	64.8
All Better Access items	33.8	44.5	52.8	33.6	18.7	58.6

1. 2007 and 2008 figures have regard to all claims processed up to and including 30 April 2009; 2009 figures have regard to all claims processed up to and including 30 April 2010.
2. Region based on Rural, Remote and Metropolitan Areas (RRMA) classification. Socio-economic disadvantage based on Index of Relative Socioeconomic Disadvantage (IRSD) classification.
3. Rates for gender, region and socio-economic disadvantage are age-standardised; Rates for age group are crude.
4. 2007, 1 case excluded due to missing data on RRMA.
5. Approximately 1% of cases excluded due to missing IRSD quintile data.

These findings are corroborated by analyses of service-level Medicare data conducted for the Post-Implementation Review of Better Access¹⁸ and the Australian Institute of Health and Welfare's annual reports on mental health services,^{19 20} and by independent analyses conducted by Russell.²¹⁻²³

A major limitation of the above analyses is that they did not control for the clinical characteristics of Better Access consumers, usually because they relied solely on Medicare data. They therefore cannot tell us whether services are being used by those who have a clinical need for them. Component B attempted to overcome this limitation by undertaking an ecological analysis that drew together Medicare Benefits Schedule data and data from the 2007 National Survey of Mental Health and Wellbeing. Data from both sources were aggregated at the level of Divisions

of General Practice. Levels of mental health treatment need^d in areas defined by the boundaries of Divisions of General Practice were modelled using the survey data. Analyses assessed whether Better Access services (total services and allied health services used per 1,000 population in 2007) were distributed across Divisions according to need. These analyses indicated that there were higher levels of Better Access service use in Divisions with higher levels of mental health need. Higher levels of Better Access use were also found in Divisions with higher levels of GP supply and Divisions in Victorian Divisions. Lower levels of Better Access use were found in Divisions with relatively more people in the most socioeconomically disadvantaged areas and Divisions with more people living in remote locations. Models including these factors accounted for over half the variation in total use of Better Access services (54.7%) and use of allied health Better Access services (51.0%).

An independent study by Harris et al used data from the 2007 National Survey of Mental Health and Wellbeing to explore the use of Medicare-subsidised allied health services among people with a need for mental health treatment.¹⁴ Survey respondents who reported using allied health services subsidised by Medicare in the past year (regardless of other mental health service use) were deemed to be Better Access allied health consumers^e. Respondents who reported symptoms consistent with a 12-month ICD-10 diagnosis of affective or anxiety disorder were divided into three mutually exclusive groups based on their reported use of services for mental health problems in the past year: Better Access allied health service consumers; people who had used other services; and people who had not used any services. Among people with a 12-month affective or anxiety disorder, Better Access service use, as compared to other service use or no service use, was predicted by clinical factors (i.e., more severe disorder, having an affective disorder) but not by urbanicity (i.e., living in a major urban area versus a rural or remote area), level of socio-economic disadvantage (i.e. living in areas of less disadvantage), or other socio-demographic factors (such as age, gender, education or employment status).

The latter two modelling exercises provide complementary information on equity of access to Better Access. They both show that mental health need is a key determinant of Better Access service use. The ecological study undertaken in Component B (which used aggregated data and examined Better Access use in the total population) suggested there were some geographical inequities. These probably reflect the lower availability of health care professionals in remote and socio-economically disadvantaged areas. The Harris et al study (which used individual-level data on the use of Better Access services within a population defined as having current need) suggested that the use of Better Access services is primarily driven by having more severe and complex needs, rather than by demographic or socio-economic factors.

Data from the BEACH program also suggest that when mental health need is taken into account differences on other variables diminish.^{27 28} Restricting the analysis to encounters where the patient presented with a mental health problem, Britt and colleagues showed that Better Access GP item numbers were equally as likely to be used for in GP encounters in major cities and outside major cities, and in areas of socio-economic advantage and disadvantage. People from outside major cities were just as likely as their counterparts from major cities to be referred to a psychologist (both before and after the introduction of Better Access). People in socio-

^d Mental health need was indicated by the presence of any one of the following: an ICD-10 12-month affective, anxiety or substance use disorder; 12-month symptoms (but no ICD-10 lifetime disorder); any psychiatric hospitalisation in the past 12 months; high or very high level of psychological distress on the K10 measure; 7 or more days out of role; or any suicidality in the past 12 months.

^e This assumption was justified on the basis that Medicare subsidised services claimed by psychologists, social workers and occupational therapists for non-Better Access mental health and other services constituted only 2% of all Medicare-subsidised mental health services provided by these providers in 2007.

economically disadvantaged areas were less likely than those in advantaged areas to be referred to a psychologist, although the differential was reduced after the introduction of Better Access.

A study of uptake of Better Access item numbers by women²⁹ showed somewhat different results with respect to socioeconomic factors. Byles et al compared the characteristics of four groups: women who used a Better Access MBS item; women who did not use a Better Access MBS item but had a recent mental health condition; women who did not use a Better Access MBS item but had a past mental health condition; and women who did not use a Better Access MBS item and did not have a mental health condition. They found that women who did not use a Better Access MBS item but had a recent mental health condition included more women who reported difficulty managing on their income and fewer women with post-school qualifications. However they did not find any differences between the groups in terms of area of residence.

As well as considering the relative level of access to Better Access by particular socio-demographic groups, Component B also profiled the costs of Better Access services according to consumers' socio-demographic characteristics. Table 9 summarises these data for 2009; patterns were similar for 2007 and 2008. The table shows that there were some variations in average co-payments according to socio-demographic characteristics. Notably, average co-payments in 2009 were: lower for people aged 65 years or more (\$33) than for all younger age groups; higher among people in remote areas (\$37) 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).

Additional analyses showed that there were also some variations in average co-payments according to socio-demographic characteristics and provider type. Most notably, average co-payments in 2009 were: lowest among people aged 65 years and over for GP, Psychological Therapy Services and Focussed Psychological Strategies items and lowest for young people aged less than 15 years for Consultant Psychiatrist items; highest among people in remote locations for GP, Psychological Therapy Services and Consultant Psychiatrist items but in the middle of the range for Focussed Psychological Strategies; and lowest among people in areas of greatest socio-economic disadvantage regardless of item group.

Table 9: MBS-subsidised Better Access services received, bulk-billing rate, fees charges, benefits paid and average co-payment, by gender, age, geographical region and socio-economic disadvantage, 2009¹

	Total services	Bulk-billed services		Fees charged ²	Benefits paid ²	Services with co-payments ²		Total patients	
	N	N	%	\$	\$	N	%	Average co-payment (\$) ³	N
Age group									
0-14 years	355,901	164,877	46.3	44,834,383	38,091,086	191,024	53.7	35.30	81,336
15-24 years	655,158	389,660	59.5	79,077,952	69,325,461	265,498	40.5	36.73	171,876
25-34 years	936,374	523,683	55.9	111,830,884	96,094,075	412,691	44.1	38.13	224,648
35-44 years	1,085,370	615,694	56.7	127,170,126	110,739,412	469,676	43.3	34.98	249,183
45-54 years	862,464	518,922	60.2	98,623,205	86,768,281	343,542	39.8	34.51	199,434
55-64 years	518,294	330,161	63.7	58,285,606	51,790,992	188,133	36.3	34.52	124,944
65+ years	250,420	188,149	75.1	27,395,417	25,326,405	62,271	24.9	33.23	78,963
Gender									
Male	1,643,579	992,585	60.4	195,046,140	170,876,697	650,994	39.6	37.13	419,561
Female	3,020,402	1,738,561	57.6	352,171,432	307,259,015	1,281,841	42.4	35.04	710,823
Region^a									
Capital cities	3,220,794	1,746,665	54.2	387,705,576	333,310,309	1,474,129	45.8	36.90	740,953
Other metro	406,611	268,669	66.1	45,903,547	41,348,924	137,942	33.9	33.02	101,922
Rural centres	577,181	392,727	68.0	63,045,538	57,295,844	184,454	32.0	31.17	155,054
Other rural areas	427,534	300,178	70.2	46,983,183	42,935,883	127,356	29.8	31.78	120,434
Remote areas	31,828	22,891	71.9	3,575,450	3,241,381	8,937	28.1	37.38	12,012
Socio-economic disadvantage^b									
Quintile 5 (Least)	1,385,364	598,025	43.2	176,843,753	146,864,097	787,339	56.8	38.08	298,207
Quintile 4	1,040,198	586,625	56.4	122,380,008	106,271,473	453,573	43.6	35.51	245,822
Quintile 3	905,743	578,173	63.8	102,605,607	91,598,973	327,570	36.2	33.60	228,413
Quintile 2	732,988	512,346	69.9	80,322,694	73,198,042	220,642	30.1	32.29	195,517
Quintile 1 (Most)	547,063	428,338	78.3	58,516,903	54,639,090	118,725	21.7	32.66	149,683

1. 2009 figures have regard to all claims processed up to and including 30 April 2010.
2. Fees charged, benefits paid, and average copayments are expressed in 2009 dollars.
3. Only services for which the consumer contributed a co-payment are included in the calculation of the average co-payment.

1d. Has Better Access reached new consumers?

Several sources of data shed light on this question. The most direct evidence comes from Component A.³ Consumers who were recruited to the study by clinical psychologists (n=289), registered psychologists (n=317) and GPs (n=277), were asked whether they had previously received mental health care. Table 10 shows that more than half of the consumers recruited by clinical psychologists and registered psychologists (58% and 51%, respectively) had no previous history of mental health care. The same was true for a sizeable proportion of the consumers recruited by GPs (42%). This suggests that around half of all Better Access consumers may be “new”, not only to Better Access but to mental health care more generally.

Table 10: Previous history of mental health care among consumers who participated in Component A¹

	No previous history of mental health care		Previous history of mental health care		Unknown	
	N	%	N	%	N	%
Consumers recruited by clinical psychologists (n=289)	168	58%	109	38%	11	4%
Consumers recruited by registered psychologists (n=317)	162	52%	127	41%	20	6%
Consumers recruited by GPs (n=277) ²	113	42%	149	56%	4	2%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.

Medicare claims data were used in Component B to address a related question: to what extent has Better Access attracted first-time consumers of these services in each successive year of its operation?⁵ These analyses, summarised in Table 11, revealed that, of the 953,161 consumers who had received at least one Better Access service in 2008, more than two-thirds (68.0% or 648,465 consumers) were first-time Better Access consumers. In 2009, more than half (57.0% or 644,295 consumers) of the 1,130,384 Better Access consumers were first-time consumers. The percentage of first-time consumers varied by provider type. It was greatest among consumers using Better Access psychiatrist items, and lowest among consumers using Better Access GP items. The 2710 Mental Health Treatment Plan item potentially provides the best estimate of new Better Access consumers, as it is the “gateway” to subsequent Better Access services for the vast majority of consumers. In 2008, 87.2% of consumers received a Mental Health Treatment Plan for the first time. In 2009, the figure was 77.1%. It is acknowledged, however, that the approach taken here uses a limited definition of a “new” consumer because it is based on Medicare Benefits Schedule Better Access item data only. It may have included people who, although new to Better Access, are existing consumers of other parts of the mental health system.

Data from the study of uptake of Better Access item numbers by women also suggest that the initiative has reached “new” consumers.²⁹ Specifically, this study found that 93% of women who used Better Access items had not previously seen a counsellor, psychologist or social worker.

Data from the BEACH program provide a contrary view. BEACH data showed that although proportion of encounters at which depression was managed by GPs increased significantly from 3.5/100 in 1998-99 to 4.0/100 in 2007-08, the management rate of “new” cases of depression remained constant (0.7/100 encounters in 1998-99 to 0.6/100 encounters in 2007-08). There was also no change in the management rate of “new” cases of anxiety or substance use disorders.^{27 28}

Two other studies have examined how many consumers of Better Access services provided by allied health professionals have previously used these same provider groups. The Australian Psychological Society’s surveys found that, on average, participating psychologists reported that 70% of their Better Access consumers had not previously consulted a psychologist.^{30 31} Harris et al’s analyses of population-level data from the 2007 National Survey of Mental Health and Wellbeing estimated that 62% of people who used Better Access allied health services in 2007 had not previously used allied health services for mental health care.¹⁴

Table 11: Number and percentage of first-time Better Access consumers in 2008 and 2009 derived from Medicare claims data, Component B¹

Item group	Received services in 2008			Received services in 2009		
	Total N	N received services for the first time in 2008	% received services for the first time in 2008	Total N	N received services for the first time in 2009	% received services for the first time in 2009
Any Better Access item	953,161	648,465	68.0%	1,130,384	644,295	57.0%
GP	818,434	597,996	73.1%	971,713	604,319	62.2%
GP item 2710	555,479	484,272	87.2%	638,756	492,339	77.1%
Consultant psychiatrist	94,398	86,977	92.1%	100,390	87,288	86.9%
Allied Health Professional	452,600	322,985	71.4%	550,354	346,108	62.9%
Psychologists	430,928	307,822	71.4%	520,588	328,750	63.1%
Clinical Psychologist	152,721	113,376	74.2%	189,418	126,778	66.9%
Registered psychologist	292,129	215,259	73.7%	348,417	233,247	66.9%
Social Workers	20,319	16,164	79.6%	28,276	21,078	74.5%
Occupational Therapists	3,719	2,918	78.5%	5,103	3,671	71.9%

1. Data had regard to claims processed up to and including 30 April 2010.

Taken together, these findings strongly suggest that Better Access has reached “new” consumers. Although it is possible that some of these people may have had no need for mental health care in the past. It would seem plausible that a substantial proportion had a prior need but were not able to access care. Better Access would appear to be potentially meeting some of the previously unmet need for mental health care experienced by Australians with common mental disorders.

1e. Has Better Access reached consumers with moderate to severe disorders, or has it predominantly provided care to those with mild symptoms?

As noted above, the Medicare claims data used in Component B only allowed Better Access consumers to be profiled in terms of basic socio-demographic characteristics (see Question 1c, above).⁵ They did not contain information about consumers’ diagnoses or the severity of their disorders. Two alternative sources of data had the capacity to assess these characteristics among consumers of Better Access services.

The first source was Component A³ which collected information about consumers’ diagnoses and levels of psychological distress at the commencement of treatment (that is, at their first session). Table 12 summarises the results. More than 90% of consumers recruited to Component A by clinical psychologists, registered psychologists and GPs had diagnoses of depression and/or anxiety. This compares with 13% of the general population. Around 80% of consumers recruited by each type of provider were experiencing high or very high levels of psychological distress (as assessed by the Kessler 10, or K-10). Again, this is much higher than the 10% observed in the general population.

Table 12: Clinical profiles of consumers who participated in Component A¹

		Consumers recruited by clinical psychologists (n=289) ²		Consumers recruited by registered psychologists (n=317) ²		Consumers recruited by GPs (n=277) ^{2,3}	
		Freq	%	Freq	%	Freq	%
Diagnosis	Depression and anxiety ⁴	99	34%	121	38%	113	41%
	Depression without anxiety ⁴	105	36%	117	37%	102	37%
	Anxiety without depression ⁴	66	23%	60	19%	38	14%
	Other ⁵	19	7%	19	6%	24	9%
Pre-treatment K-10 score	10-15 (Low psychological distress)	13	5%	8	3%	8	3%
	16-21 (Moderate psychological distress)	37	13%	43	14%	26	10%
	22-29 (High psychological distress)	103	36%	93	31%	81	30%
	≥30 (Very high psychological distress)	133	47%	159	53%	158	58%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.
3. Cells do not always sum to the total n due to some missing data.
4. With or without alcohol and drug use disorders, psychotic disorders, and/or unexplained somatic disorders.
5. Alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or unknown or missing diagnoses.

The second source of relevant information was the study by Harris et al which used data from the 2007 National Survey of Mental Health and Wellbeing to explore the use of Medicare-subsidised allied health services.¹⁴ This study found that the vast majority (93.2%) of consumers estimated to have used Better Access allied health services in 2007 had either a 12-month ICD-10 affective, anxiety or substance use disorder (81.7%) or another indicator of treatment need (11.5%)^f.

Byles et al reported similar findings in their study of uptake of Better Access item numbers by participants in the Australian Longitudinal Study on Women's Health.²⁹ They observed that women who used Better Access item numbers tended to have poorer mental health, and that this had often declined prior to use of the item numbers.

Harris et al's study also included information from the 2007 National Survey of Mental Health and Wellbeing about the level of severity, disability and psychological distress among consumers of Better Access allied health service consumers.¹⁴ The study selected people with a 12-month affective or anxiety disorder, and compared the characteristics of those who received Better Access allied health services with those who used other services for a mental health problem, or used no services. Almost half of the Better Access consumer group had a severe disorder (47.6%, as opposed to a mild or moderate disorder), 45.5% reported a high level of disability as measured by the World Health Organization Disability Assessment Schedule (WHO-DAS), 45.9% reported high or very high levels of distress as measured by the Kessler-10 (K-10), and 28.1% had experienced more than seven days out of role in the past 30 days. These proportions were comparable to those for people who used other mental health services (37.8%, 51.9%, 49.9% and 30.1%, respectively). However they were significantly greater than those for people who had not used services on all measures except the WHO-DAS (13.5%, 35.9%, 23.5% and 12.9%, respectively).

Harris et al's study also included information from the National Survey of Mental Health and Wellbeing about the level of severity, disability and psychological distress among consumers of Better Access allied health services.¹⁴ The study selected people with a 12-month affective or anxiety disorder, and compared the characteristics of those who received Better Access allied

^f Other indicators of treatment need were 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.

health services with those who used other services for a mental health problem, or used no services. Around half of the Better Access consumer group had a severe disorder (47.6%, as opposed to a mild or moderate disorder), 45.5% reported a high level of disability as measured by the WHO-DAS, 45.9% reported high or very high levels of distress as measured by the K10, and 28.1% had experienced more than seven days out of role in the past 30 days. These proportions were comparable to those for people who used other mental health services (37.8%, 51.9%, 49.9% and 30.1%, respectively). However they were significantly greater than those for people who had not used services on all measures except the WHO-DAS (13.5%, 35.9%, 23.5% and 12.0%, respectively).

Harris et al also used a multivariate logistic regression model to compare Better Access psychological service users to other mental health service users and non-mental health service users on a comprehensive set of demographic, socio-economic and clinical variables. Severity was one of only two variables that distinguished between the service use groups. Specifically, having a severe disorder and having an affective disorder (either alone or in combination with another disorder, as opposed to an anxiety disorder alone) increased the likelihood of using a Better Access allied health service. There were no variables that distinguished Better Access allied health service users from other service users. That is, Better Access consumers appeared to have more severe and complex disorders than those who did not seek treatment, and were not less severely ill than those seen elsewhere in the mental health service system (e.g., in specialist mental health sector services).

These findings suggest that, as a rule, Better Access consumers are not typically people with mild symptoms. Most have clinically diagnosable disorders – predominantly depression and/or anxiety, but also substance use and other disorders – or have other indicators of treatment need. Most are experiencing significant levels of psychological distress.