

WHAT'S NEW IN MENTAL HEALTH

**A brief summary of recent reports,
publications and issues around
mental health programs.**

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Recent reports and publications

1. Reports

Report 1 - Goss J. 2008. *Projection of Australian health care expenditure by disease, 2003 to 2033. Cat no. HWE 43. Canberra: AIHW*

Available at: <http://www.aihw.gov.au/publications/hwe/pahced03-33/pahced03-33.pdf>

The projected change in expenditure for mental disorders for the period 2003 to 2033 is \$7.0 billion (135%), up from \$5.1 billion to \$12.1 billion.

The change is due to:

General population growth	\$2.2 billion
Expected increase in services / case	\$4.4 billion
Excess health price inflation	\$0.3 billion
Predicted increase in incidence of disease	\$0.2 billion

The modeling does not include any change in the proportion of mental disorders treated.

Diabetes (436%) is projected to have the largest increase in expenditure, followed by dementia (364%), Parkinson's disease (334%), digestive disorders (234%) and sense disorders (236%). In fact only injuries (116%), congenital (104%), neonatal (88%) and maternal services (84%) are lower than mental health.

Report 2 - Garling P. 2008. *Final report of the Special Commission of Inquiry: Acute care services in New South Wales hospitals.*

Available at:

http://www.lawlink.nsw.gov.au/lawlink/Special_Projects/ll_splprojects.nsf/pages/acsi_fin_alreport

This report deals only with mental health issues in the acute care setting. The following summary of issues that specifically refer to mental health is taken from, and referenced to, the overview document.

- One of the reasons why the NSW Health system is “on the brink” is that young people are presenting to public hospitals in greater numbers than anticipated, especially to the Emergency Departments. Many of these young people have mental health problems, coupled with drug and alcohol dependence. (1.15)
- Treatment of mental illness in NSW public hospitals is under-resourced, over-stretched, and in ‘catch-up’ mode in terms of increasing funding, training and recruiting additional workforce, and building more facilities. (1.167)

- There is an overwhelming shortage of acute mental health inpatient beds in NSW, particularly in rural areas. (1.169)

Recommendations relating to mental health:

- Rec 107: Within 18 months, each hospital which operates an Emergency Department should establish a safe assessment room at a location, if not adjacent, then proximate to the Emergency Department.
- Rec 108: Within 18 months, each hospital which does not have a psychiatric emergency care centre (PECC) within a peer group down to and including B2 – Major Non-Metropolitan Hospital – and which operates an Emergency Department, ought also to establish a PECC at a location adjacent or proximate to the Emergency Department, unless there is easy access to a PECC located at another hospital within a reasonable transfer distance.
- Rec 109: Mental health patients re-presenting to a mental health inpatient facility or PECC should be admitted to that facility without prior admission to the Emergency Department unless that person requires specialised emergency medical care.
- Rec 139: NSW Health should examine how health services which are regulated by state legislation, including mental health, can best be delivered so as to ensure the efficiency and quality of patient care between differing hospital regimes in different but adjoining States and Territories.

Report 3 - Australian Bureau of Statistics 2008. *National Survey of Mental Health and Wellbeing, 2007.*

Available at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/4326.0>

The ABS survey involved 8841 respondents. This was a 60% response rate, lower than most ABS surveys. The survey only looked at common/high prevalence mental disorders. The survey only involved households – it did not obtain information from nursing homes, boarding houses etc.

The survey, the first since 1997, cost \$7million, funded by DoHA. There are currently no plans for a follow-up survey.

Findings:

- One in 5 Australians will have a mental illness in any year.
- 45% will have a mental illness during their lifetime.
- Co-morbidities are commonplace, particularly among the young, with significant ‘out of role’ impacts (days off work etc).
- 65% of people with an identified need for mental health care got no care/ services in the past 12 months.

- Of this group, 85% of people are not seeking help – for reasons unknown.
- Of the 35% of people receiving mental health services, 21% of had no lifetime prevalence of mental illness. Not known if these people are ‘worried well’, people seeking preventive care, carers seeking advice about loved ones.
- Of the 35% of people receiving s services, only 35% felt their broader social needs were being met by the system (housing, community support etc).
- Little evidence that people use self-help techniques (moodgym, internet etc) – much more likely to pursue these techniques if already getting services.
- The ABS survey contains no information on patient satisfaction or experiences of care.

Report 4 - Eckersley R. 2008. *Never better – or getting worse? The health and wellbeing of young Australians. National centre for Epidemiology and Population Health, ANU.*
 Available at: <http://www.australia21.org.au/pdf/Youth%20Health%20Text%2008.pdf>

Although death rates may have fallen among people 25 and under over the last 20 years, their health and wellbeing have been declining on a range of measures. There is a growing under-estimation of the impact of non-fatal, chronic illness, especially mental disorders.

Some 30% of young people are suffering significant psychological distress at any one time, with less severe stress-related symptoms such as frequent headaches, stomach-aches and insomnia affecting as many as 50%.

Factors contributing to the decline in mental health include family conflict and breakdown, education and work pressures, media and technological impacts, dietary changes and environmental pollution. Young people are now less likely to feel a strong sense of identity, purpose, belonging and security.

The report’s recommendations include the need to conceptualise health as more than providing health care services, spending more on prevention and mental health programs, and efforts to foster the importance of health rather than wealth in the community and in public policy.

Report 5 - *The beyondblue Depression Monitor 2007/2008.*
 Available at: http://www.beyondblue.org.au/index.aspx?link_id=59.1084

The survey’s results reveal that while awareness has been generally improved across the board since 2002, many Australians still harbour negative attitudes about mental health problems and are reluctant to talk openly about mental health with their doctor.

Awareness of anxiety disorders is relatively low with only 7% of participants listing them as a major mental health problem. This result is curious considering one in four Australians will experience at least one type of anxiety disorder during their lives - making it the most common mental illness.

Awareness levels of postnatal depression (PND) have not changed at all over the three surveys, with only 1% recognising it as a mental health problem. It is the least identified of any mental health disorder. This is despite the high prevalence of PND. Up to one in seven new mothers in Australia will develop the illness, which can be very serious and potentially affect the cognitive and emotional development of the child.

Antidepressants are widely misunderstood by the community. While 70% believe they are helpful for treating mental illness, just over half (56%) believe they are very or highly addictive.

32% of respondents said that people with depression can't be trusted in positions of responsibility, 31% said people with depression shouldn't stand for politics, and 15% said people with depression who work in high profile jobs, e.g. pilots, solicitors, doctors, should quit their jobs.

A high proportion of respondents (78%) said they would feel embarrassed to talk about depression with their doctor. Half indicated this may be because they did not believe their doctor would take their case seriously.

One-third believe GPs are too busy to deal with depression; 43% disagreed with the statement that GPs are well trained; 17% say GPs feel irritated and annoyed when dealing with depression; 42% believe GPs prescribe medication without proper diagnosis; one-third thinks that when dealing with depression, GPs feel other people are in more urgent need of treatment.

Report 6 - Sane Research Bulletin 8: Intimacy and mental illness. February 2009.

This survey conducted in late 2008 highlights that the social isolation experienced by people with a mental illness includes a lack of emotional and physical intimacy.

Findings include:

- 49% of those surveyed were not in a close relationship with another person (compared to around 15% of the general population);
- 43% reported they did not have a close friend with whom they could discuss things;
- 13% of people reported in physical intimacy (hugging, touching) over the past 12 months;
- 35% had no sexual contact in the last 12 months;
- Half of all respondents said they had not discussed issues affecting intimacy with their doctors, even though 65% said their medication affected sexual desire and function.
- 46% were not receiving regular pap tests, breast screening or checks for prostate cancer. One-third had never been tested for STDs.

2. **Publications of interest and relevance**

Kisely S, Sadek J, MacKenzie A, et al. Excess cancer mortality on psychiatric patients. Canadian J Psych. 53(11); November 2008.

Available at: <http://publications.cpa-apc.org/media.php?mid=696&xwm=true>

Canadians suffering from mental illness have a death rate from cancer that is 65 per cent higher than others in the general population. The higher mortality rate exists even though those with mental illness are not significantly more likely to develop cancer.

While the data do not explain why the death rate is so much higher, researchers believe the most likely culprit is stigma: that health professionals are failing to see beyond mental health to diagnose physical ailments in a timely manner, even grave ones such as cancer. People with mental health problems who develop cancer are less likely to be screened and diagnosed, and are more likely to experience delayed treatment.

Degotardi, V. Current models of child and adolescent mental health service delivery. MJA 2008 vol 189 (9) 207-508.

Available at: http://www.mja.com.au/public/issues/189_09_031108/deg10375_fm.html

Throughout Australia, the current public model of mental health care for children and adolescents uses generic mental health workers (case managers) who learn “on the job” rather than being required to receive specific psychiatric training and certification before they are employed. These allied health professionals are expected to make diagnoses and to provide counselling and other therapies for which they may not have had any specific academic training.

The author argues that such case management is inferior to a multidisciplinary team approach which provides a safer and more efficient method of service delivery.

Maybery DJ, Reupert AE, Patrick K et al. Prevalence of parental mental illness in Australian families. Psychiatric Bulletin Vol 33; January 2009.

Summary only available at: <http://pb.rcpsych.org/cgi/content/abstract/33/1/22>

Based on population estimates, 23.3% of all children in Australia have a parent with a mental illness, with 1.3% (60,000 children) having a parent whose mental illness is severe, and 20.4% of mental health service users have dependent children.

While parental illness does not necessarily mean poor outcomes for children, the more severe mental illnesses have been associated with less sensitive and competent parenting, significantly greater mental illness in offspring, insecure infant attachment, and lower quality of mother-child relationship.

Lindstrom K, Lindblad F & Hjern A. *Psychiatric morbidity in adolescents and young adults born preterm: A Swedish national cohort study.* *Pediatrics* 2009; 123:e47-e53. Available at: <http://pediatrics.aappublications.org/cgi/content/full/123/1/e47>

By their early 20s, people born between 24 and 28 weeks of pregnancy were more than twice as likely to have been admitted to hospital for a psychiatric illness - 5.5 per cent compared with 2.6 per cent for those whose mothers carried them to at least 39 weeks. They were also more than twice as likely to have killed themselves or to have tried to do so.

Even those born only a month before full term - at 33 to 36 weeks - were 30 per cent more likely to be treated in hospital for mental illness.

Experts say the research findings underline the importance of prenatal care in ensuring healthy brain development.

Ferrie JE, Vahtera J, Kivimaki M et al. *Diagnosis-specific sickness absence and all cause mortality in the GAZEL study.* *J Epidemiol & Community Health* 2009; 63(1):50-55.

Available at: <http://pt.wkhealth.com/pt/re/jech/abstract.00004773-200901000-00011.htm;jsessionid=J21TzS2byzTfL0L1p1G4dWzKn2G1qh6XmzrGpJhGXKcNwGp2pTsM!-313167034!181195629!8091!-1>

Employees who miss extended periods of work due to mental illness may be at increased risk of subsequent fatal disease. In a study conducted of French workers, the authors found that absence for mental illness was the commonest reason for absence due to illness in women (14% vs 8% in men). Over a three year period, those who had an absence of more than seven consecutive days due to mental illness had a 35% increased risk of fatal disease if male or a 24% increased risk if female.

Dennis C-L, Hodnett E, Kenton L et al. *Effect of peer support on prevention of postnatal depression among high risk women: multisite randomized controlled trial.* *BMJ* 2009; 338:a3064.

Available at: http://www.bmj.com/cgi/content/abstract/338/jan15_2/a3064

This Canadian study shows that a telephone-based peer support program is effective in reducing post-natal depression. Women identified as being at high risk for post-natal depression who received these services were half as likely to develop depression by 12 weeks post-partum as those receiving standard care.

Cipriani et al. *Comparative efficacy and acceptability of 12 new-generation antidepressants: a multi-treatments meta-analysis.* *Lancet* 2009. Online publication; 29 January 2009.

Available at: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60046-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60046-5/fulltext)

The study systematically reviewed 117 randomised controlled trials (25,928 participants) from 1991 up to Nov 30, 2007, which compared new-generation antidepressants at therapeutic dose ranges for the acute treatment of unipolar major depression in adults.

Clinically important differences exist between commonly prescribed antidepressants for both efficacy and acceptability in favour of escitalopram (Lexapro) and sertraline (Zoloft). Sertraline might be the best choice when starting treatment for moderate to severe major depression in adults because it has the most favourable balance between benefits and acceptability.

Note that Zoloft is the most prescribed antidepressant in Australia. Lexapro is a relatively new drug to the market which has an additional cost to patients over the PBS co-payment due to a therapeutic premium.

Some international perspectives

Smith-Merry, J. Improving mental health and wellbeing in Scotland: A model policy approach. Aust e-Journal for the Advancement of Mental Health 7(3) 2008. Available at: www.ausienet.com/journal/vol7iss3/smith-merry.pdf

Scotland's National Programme for Improving Mental Health and Wellbeing, launched in 2003, is a holistic mental health promotion policy that aims to reduce the high levels of mental ill-health in the Scottish population.

This paper highlights the progress made. It attributes mental health reforms to the following factors:

- An environment of bureaucratic reform;
- Significant public scrutiny of the high levels of mental illness as reflected in the high suicide rate;
- The creation of a supportive political, policy and legislative framework;
- The cementing of national initiatives within local services;
- The creation of regulatory indicators; and
- A shared understanding of positive mental health.

Lim K-L, Jacobs P & Dewa C. How much money should we spend on mental health? The Institute of Health Economics, Alberta, Canada 2008. Available at: <http://www.ihe.ca/documents/Spending%20on%20Mental%20Health%20Final.pdf>

This report presents four different approaches to address the issue of government spending – the Benchmark Approach, the Behavioral Approach, the Budgeting Approach and the Economic Evaluation or Cost-Benefit Approach.

Two of these approaches are used to address the question of how much money should be spent on mental health in the Canadian context. (Canada currently spends about \$6 billion / year on mental health, about 5.4% of total health expenditure).

Using the Benchmark Approach, it was estimated that mental health spending in Canada should increase by \$4 billion over five years. Alternatively, using the Budgeting Approach, it was estimated that mental health spending should increase incrementally, reaching about \$11 billion in five years.

The authors caution that the final answer depends on the goals set and the assumptions made. Moreover, too large an increase over a short time span may simply drive up prices without bringing forward an increase in services that are needed.

Information about Commonwealth funded mental health programs

There have been no further progress reports on the Commonwealth's component of the COAG National Action Plan on Mental Health (2006 – 2011) since September 2008.

Medicare Better Access program

An analysis of the services provided by GPs and allied health professionals and the cost to Medicare in calendar year (CY) 2008, compared to CY 2007 was provided in February. This is at Appendix A.

Information found in a note on the internet about the 21 October 2008 meeting of the Queensland Divisions' Mental Health Network indicates that there is a "significant underspend" in Better Access education and training.

Analysis of PBS data on anti-depressants.

See Appendix B.

Headspace

In December 2008 the Commonwealth Government announced \$35.6 million in funding to *Headspace* to enable it to continue its work. The funding will be provided over 3 years, commencing July 2009. This is a reduction in funding over the levels previously provided for the start-up phase of this initiative.

During the 2004 election, the Howard Government committed \$50 million / 4 years to 2007-08 for youth mental health, but the roll-out of this initiative was considerably delayed. *Headspace*, the Youth Mental Health Foundation, was finally launched in July 2006, with funding of \$54 million / 3 years.

A recent article in Australian Doctor reports that *Headspace* is struggling to recruit GPs for its 30 established centres.

An evaluation of *Headspace* is currently underway.

Direction for new National Mental Health and Disability Employment Strategy

On 22 December 2008 the Minister for Employment Participation and the Parliamentary Secretary for Disabilities and Children's Services released a paper that sets the direction for the National Mental Health and Disability Employment Strategy, which is due for release in 2009. The Terms of Reference for the Strategy were released in February 2008 and a nation-wide consultation process on a discussion paper then occurred.

See:

<http://www.workplace.gov.au/workplace/Publications/PolicyReviews/EmploymentStrategy/>

Information from the states and territories

The Australian Capital Territory, New South Wales, Victoria, South Australia, Western Australia and Tasmania are all currently in the process of reforming their mental health laws.

New South Wales

Mental health spending

For the last few years, mental health services has accounted for about 8% of the total NSW Health budget. In 2008-09, the amount was \$1.092 billion (8.3%). (from Garling report).

Mental health data

The Health of the people of New South Wales: Mental health data book.

Available at:

http://www.health.nsw.gov.au/publichealth/chorep/databooks/men_databook.asp

- In 2007 in NSW, around 12% of adults (11% of males and 13% of females) reported high or very high levels of psychological distress.
- Around 3% of adults in NSW report very high levels of psychological distress and overall adults cut down on their activities in almost 1 day per month on average due to psychological distress.
- Suicide rates have been dropping in NSW since 1997 but, still, 493 people died by suicide in 2006. This was 5% fewer than in the previous year. Males accounted for almost 80% of suicides in 2006.
- In 2006-07, there were more than 10,000 hospitalisations of NSW residents for intentional self-harm. Females accounted for 60% of these hospitalisations.
- In 2007, around 1.0% of NSW children aged 17 years or under were prescribed stimulant medication for attention deficit hyperactivity disorder (ADHD). This was well below the estimated prevalence of ADHD.
- In 2005, one in 6 (16.6%) high school students reported high levels of psychological distress. Out of those who experienced high psychological distress one third talked to no-one about it and another one third talked to someone but found it not at all helpful.

Better treatment for mentally ill prisoners

A report in the Sydney Morning Herald (December 12, 2008) discussed reforms recently enacted to forensic mental health legislation. According to some estimates, nearly half of prisoners have some form of mental illness.

Up to 2000 NSW prisoners will receive improved psychiatric care in jail which will be co-ordinated with treatment after release. This treatment will be under the supervision of

the Mental Health Review Tribunal, with individual treatment orders made by a panel comprised of a judge, a forensic psychiatrist and another mental health practitioner.

About one-fifth of these 2000 prisoners have been judged unfit to stand trial on account of their mental illness. Of the remainder, about 1000 might otherwise be eligible for parole, but the parole board does not regard them as capable of adjusting to community life. It is expected that this new program will help accelerate such people's parole.

Court diversion programs are currently preventing about 1600 mentally ill people a year from receiving a jail sentence.

A new forensic hospital, operated by NSW Justice Health, will be opened at Long Bay jail. The challenge will be to get enough staff. Philip Mitchell, the chairman of the NSW Mental Health Priority Taskforce, said that young doctors are now competing for training places in forensic mental health, and many senior doctors had applied to work in the facility, but the recruitment of mental health nurses was a problem.

Victoria

New mental health strategy

A new, whole-of-government mental health strategy for the next decade *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019* was released on 13 March.

Key elements of the strategy include:

- A mental health advice and referral telephone service available to the public 24 hours a day, to be running by the end of 2009;
- A focus on early intervention with more child and youth mental health services; Help for parents and families experiencing mental health problems;
- Improved access to specialist care through centralised psychiatric triage systems and a more integrated community crisis response involving police, ambulance, mental health teams and hospital emergency departments;
- New approaches to supporting people with mental health problems in the justice system, reducing the need for custodial sentences where appropriate;
- Supporting recovery and participation in the community through new care co-ordination arrangements and flexible support packages;
- Reducing inequalities through service redesign and partnerships to provide culturally responsive mental health care for Aboriginal people, migrant and refugee communities, and a more integrated response to people with mental illness and co-existing disabilities;
- Fostering partnerships and accountability through local planning and service co-ordination, streamlining components of the mental health service system under common catchments;
- Promotion of positive mental health and wellbeing in schools, workplaces and other community settings; and

- Mental health needs will be a key factor in government social inclusion programs and there will be an emphasis on reducing risk factors related to alcohol and drug use and suicide.

At the time of the announcement, the Minister for Mental Health, Lisa Neville, announced a suite of immediate actions, including:

- \$1.8 million for programs targeted at identifying emerging mental illness, supporting community workers to provide a front line response and hiring more experts in post-traumatic stress disorders to work with bushfire-affected communities;
- An Australian first Chief Child Psychiatrist to put children's needs first in establishing clinical standards in the treatment and care of mental illness; and
- The launch of two new child and youth mental health demonstration projects – one in Grampians and one in Melbourne's southern suburbs. The \$13.5m initiative aims to ensure earlier assessment, treatment and support for more children and young people with a broader range of problems.

Strategy available at:

<https://www.dhs.vic.gov.au/mentalhealth/reformstrategy/documents/mhm-strategy0209.rtf>

Mental health review

The Minister for Mental Health, the Hon Lisa Neville MP, announced a review of the Victorian *Mental Health Act 1986* (the Act) on 8 May 2008 and in December she released the *Review of the Mental Health Act 1986: Consultation Paper - December 2008*. The public consultation will be led by the Community Consultation Panel and will inform the development of a report for the Minister for Mental Health in 2009. Closing date for submissions was Friday 27 February 2009

FOI reveals mental health system is failing to met targets

The State Opposition has released data obtained under FoI laws that show Victoria is failing to meet its Government-set targets:

- Almost one-third of mental health patients wait more than eight hours in hospital emergency departments before finding a bed.
- One-third of mental health patients do not get follow-up community care after they are released from hospital.
- Two-thirds of mental health patients cared for in the community are not properly assessed on arrival.
- Many hospitals reported a severe lack of mental health beds.

South Australia

Mental Health Bill 2008

A Bill to replace the *Mental Health Act 1993* was introduced into the SA Parliament on 12 November 2008. This Bill is based on a review released in 2005 and draft legislation released for public comment in 2007.

The main changes in the legislation include:

- A clearer articulation of the rights of people using mental health services and their carers;
- Greater emphasis on community care rather than hospital or institutional care;
- Recognition of the particular circumstances of children; and
- Acknowledging the unique cultural perspective of Indigenous people.

The second reading speech on the Bill is available at:

<http://www.health.sa.gov.au/mentalhealth/Default.aspx?tabid=55>

Implementation of recommendations from review of community mental health services

The “Review of Community Mental Health Services in South Australia” (January 2008) (Available at: <http://www.publications.health.sa.gov.au/mhs/16/>) made 22 recommendations which are currently being implemented. A draft Model of Care for adult mental health services in the community has been developed.

Queensland

Queensland appears to be the only state or territory where the COAG Mental Health Group regularly and publicly reports on its progress on the initiatives in the COAG National Action Plan on Mental Health, 2006-2011.

See <http://www.health.qld.gov.au/coag/implementation/qcmhg.asp>

However it does appear that there have been no meetings or reports since August 2008.

Tasmania

Tasmanian Transcultural Mental Health Network

Late last year the Tasmanian State Government awarded the Migrant Resource Centre (Southern Tasmania) \$15,000 to establish and manage the Tasmanian Transcultural Mental Health Network. Multicultural Mental Health Australia, through funding from the Department of Health and Ageing, matched this funding with an additional \$15,000. This funding complements a further allocation of funds worth \$25,000 from the Tasmanian Government to each of the Migrant Resource Centres in Hobart and Launceston to provide early intervention mental health support to their immediate communities.

The Tasmanian Transcultural Mental Health Network aims to link CALD consumers, carers and relevant community organisations with an interest in transcultural mental health.

APPENDIX A: AN UPDATED ANALYSIS OF THE MEDICARE BETTER ACCESS MENTAL HEALTH PROGRAM

EXPLANATIONS AND DISCUSSION

Medicare reimbursements to GPs, psychologists and other mental health professionals for services provided under the Better Access program continue to grow at an exponential rate. The program delivered 3.719 million services in 2008 at a cost of \$363.5 million dollars. This represents an increase of 47% in services and 48% in costs over 2007. These figures do not include services provided by psychiatrists (around \$200 million) and it does not include the cost of education and training (although it appears that education and training programs have been slow to be rolled out and are well under budget).

General Practitioners

Services provided by GPs cost \$152 million (42%).

This included 557,864 GP mental health plans and 190,877 reviews of mental health plans (See Figure 1)

In 2007 there were 469,804 GP mental health plans. Assuming these plans are reviewed annually, only 190,877 (40%) of 2007 plans were reviewed in 2008. What does this mean for continuity of services to patients?

In 2008 GPs provided 629,362 mental health consultations, an increase of almost 50% over 2007 (See Figure 2).

GPs also provided 36,477 focussed psychological strategies to their patients – a figure little changed from 2007. These services are only reimbursed when provided by GPs who have received the appropriate training which most GPs would have received under the now defunct Better Outcomes in Mental Health program. It appears that while GPs are seeing more patients for mental health problems, fewer GPs are receiving specific training to help them manage these patients.

Psychologists

Services provided by psychologists cost 202.6 million (56%).

The number of services provided by clinical psychologists increased 64% over 2007; the number of services provided by general psychologists increased by 46% (See Figures 3 & 4).

56% of psychology services are provided by general psychologists.

Other mental health professionals

Services provided by occupational therapists cost \$1.6 million in 2008 (20,917 services compared to 9,301 in 2007). Services increased by 125% over 2007. However it appears that these services, which grew rapidly from a low base in 2007, have leveled off since July 2008 (See Figure 5).

Services provided by social workers cost \$7.3 million in 2008 (101,667 services compared to 48,304 in 2007). Like occupational therapists' services, these also grew dramatically (by 110%), but the growth rate has leveled off since July 2008 (See Figure 6).

How many patients are getting mental health services under this program?

Assuming 1 plan / patient, these figures indicate that the maximum number of patients treated under the Better Access program in 2008 was 748,741 – up from 580,430 in 2007.

A total of 2.970 million services were provided to these patients. This averages around 4 services / patient with a mental health plan. This is up from around 3.5 services / patient in 2007.

How services are distributed / by state and territory

(see Table 2)

64% of Better Access services went to NSW and Victoria, states with 57% of the population. The Northern Territory received less than one-third of the services it should have received on a population basis.

South Australia did better than expected on a population basis in several areas of such as GP delivered focused psychological strategies, clinical psychology services and occupational therapy services. Previous work has also shown that South Australia receives the highest number of Better Access funded psychiatric services when these are considered on a population basis. However general psychology services are lower than expected.

Western Australia received a high number of clinical psychology services on a population basis, but general psychology services are low.

Workforce shortages may account for the low rates of services in Tasmania, the ACT and the Northern Territory.

How services are distributed / age sex and age

(see Table 3)

58% of services go to patients aged 15-44, despite the fact that this age group represents only 42.8% of the population, and two-thirds of these services go to women.

Services provided to the age group 45-64 is in line with the population, although again, two-thirds of these services are to women.

The younger aged groups (0-14) are underserved, although this is the only segment of the population where males receive more services than females – they get 55% of the services.

The oldest ages groups (65 and over) are also greatly underserved.

Use of GP mental health plans

The greatest increases in uptake are seen for children and young adults.

Across all age groups there is a slightly greater increase for males than for females.

However young people and males are less likely to have their mental health plans reviewed.

Use of GP mental health services

These services are provided primarily to females aged 25-54.

Greater than average increases are seen for younger (1-14) and older patients (aged 65+) of both sexes.

GP delivered FPS services

As noted previously there has been little growth in these services over 2007 levels, and it appears that men are increasingly less likely to receive these services.

There has been some growth in FPS services provided to women 85+.

Clinical psychology services

Women received almost twice as many services as men, and 43% of all services were delivered to women aged 25-54. However the rate of provision of services for males of all ages has increased at a higher rate than for women.

The greatest increases were seen in services to young females aged 0-14 and females aged 85+.

The majority of services delivered were for sessions of at least 50 minutes (Medicare rebate \$115:00)

Psychologist delivered FPS services

Two thirds of these services were delivered to women, mostly to those aged 25-54. However as noted for clinical psychology services, the rate of provision of services for males of all ages has increased at a higher rate than for women.

The greatest increases over 2007 are seen for the youngest and oldest ages groups of both sexes.

Again, the majority of services delivered were for sessions of at least 50 minutes (Medicare rebate \$78.40)

Occupational therapist delivered FPS services

Although increases over 2007 appear substantial, the actual numbers of services delivered are relatively small.

37% of services are to males aged 0-14, with one quarter of all services going to males aged 5-14.

Social workers delivered FPS services

Females use more services than males in all aged groups other than 5-14.

The greatest increase in services over 2007 is for males aged 75-84.

Table 1: Better access to GPs, psychologists and other mental health professionals

2008 data – services and cost
 2007 data provided in italics for comparison

Item	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Total services	Cost (\$m)
2710 GP mh plan	35,678 <i>32,822</i>	47,483 <i>39,891</i>	42,122 <i>44,197</i>	46,834 <i>32,965</i>	50,128 <i>48,047</i>	46,650 <i>37,972</i>	48,950 <i>37,381</i>	46,986 <i>42,091</i>	48,164 <i>38,312</i>	53,359 <i>40,047</i>	48,536 <i>42,173</i>	42,972 <i>33,908</i>	557,864 <i>469,804</i>	85.8 <i>70.7</i>
2712 Review mh plan	12,443 <i>2,433</i>	15,220 <i>3,919</i>	13,297 <i>6,117</i>	15,485 <i>6,057</i>	17,054 <i>10,340</i>	15,448 <i>9,099</i>	16,929 <i>10,780</i>	16,559 <i>12,260</i>	16,712 <i>11,675</i>	18,702 <i>13,016</i>	17,095 <i>13,140</i>	15,933 <i>11,796</i>	190,877 <i>110,626</i>	19.6 <i>11.1</i>
2713 GP mh consult	38,844 <i>21,332</i>	45,572 <i>26,616</i>	41,882 <i>32,015</i>	47,690 <i>27,074</i>	52,691 <i>39,705</i>	50,879 <i>34,186</i>	56,138 <i>36,349</i>	54,461 <i>40,612</i>	57,587 <i>30,559</i>	65,392 <i>42,146</i>	59,956 <i>44,100</i>	58,270 <i>38,947</i>	629,362 <i>422,641</i>	42.7 <i>28.1</i>
2721-2727 GP FPS	2,392 <i>2,585</i>	3,253 <i>2,789</i>	2,973 <i>3,348</i>	3,153 <i>2,548</i>	3,353 <i>3,232</i>	3,219 <i>2,782</i>	3,275 <i>3,316</i>	3,080 <i>3,244</i>	2,968 <i>3,046</i>	3,134 <i>3,325</i>	2,944 <i>3,093</i>	2,733 <i>2,766</i>	36,477 <i>36,094</i>	3.9 <i>3.7</i>
80000-80020 Clin psych	40,240 <i>11,677</i>	55,551 <i>20,679</i>	56,115 <i>32,138</i>	63,965 <i>30,685</i>	70,888 <i>44,055</i>	66,960 <i>42,519</i>	71,274 <i>43,939</i>	68,459 <i>50,380</i>	71,476 <i>47,134</i>	74,787 <i>49,895</i>	70,849 <i>56,217</i>	71,545 <i>48,071</i>	782,131 <i>477,389</i>	90.1 <i>53.7</i>
80100-80120 Gen Psych	78,021 <i>30,344</i>	100,968 <i>47,740</i>	104,132 <i>67,426</i>	117,820 <i>61,928</i>	123,545 <i>88,675</i>	116,570 <i>84,576</i>	129,041 <i>88,289</i>	120,552 <i>97,122</i>	123,620 <i>92,049</i>	134,110 <i>100,194</i>	124,725 <i>106,531</i>	126,349 <i>95,428</i>	1,399,453 <i>960,302</i>	112.5 <i>74.9</i>
80125-80145 Occ ther	900 <i>105</i>	1,480 <i>239</i>	1,226 <i>343</i>	1,574 <i>424</i>	1,820 <i>688</i>	1,601 <i>664</i>	2,252 <i>726</i>	1,717 <i>1,079</i>	1,907 <i>1,144</i>	1,994 <i>1,170</i>	2,332 <i>1,423</i>	2,114 <i>1,296</i>	20,917 <i>9,301</i>	1.6 <i>0.7</i>
80150-80170 Soc wkr	4,839 <i>877</i>	6,648 <i>1,588</i>	6,988 <i>2,679</i>	8,221 <i>2,490</i>	8,747 <i>3,927</i>	8,570 <i>3,863</i>	9,865 <i>4,240</i>	9,112 <i>5,119</i>	9,518 <i>5,161</i>	9,871 <i>5,741</i>	9,122 <i>6,634</i>	10,166 <i>5,962</i>	101,667 <i>48,304</i>	7.3 <i>3.4</i>
Total													3,718,748 <i>2,534,461</i>	363.5 <i>246.3</i>

Figure 1

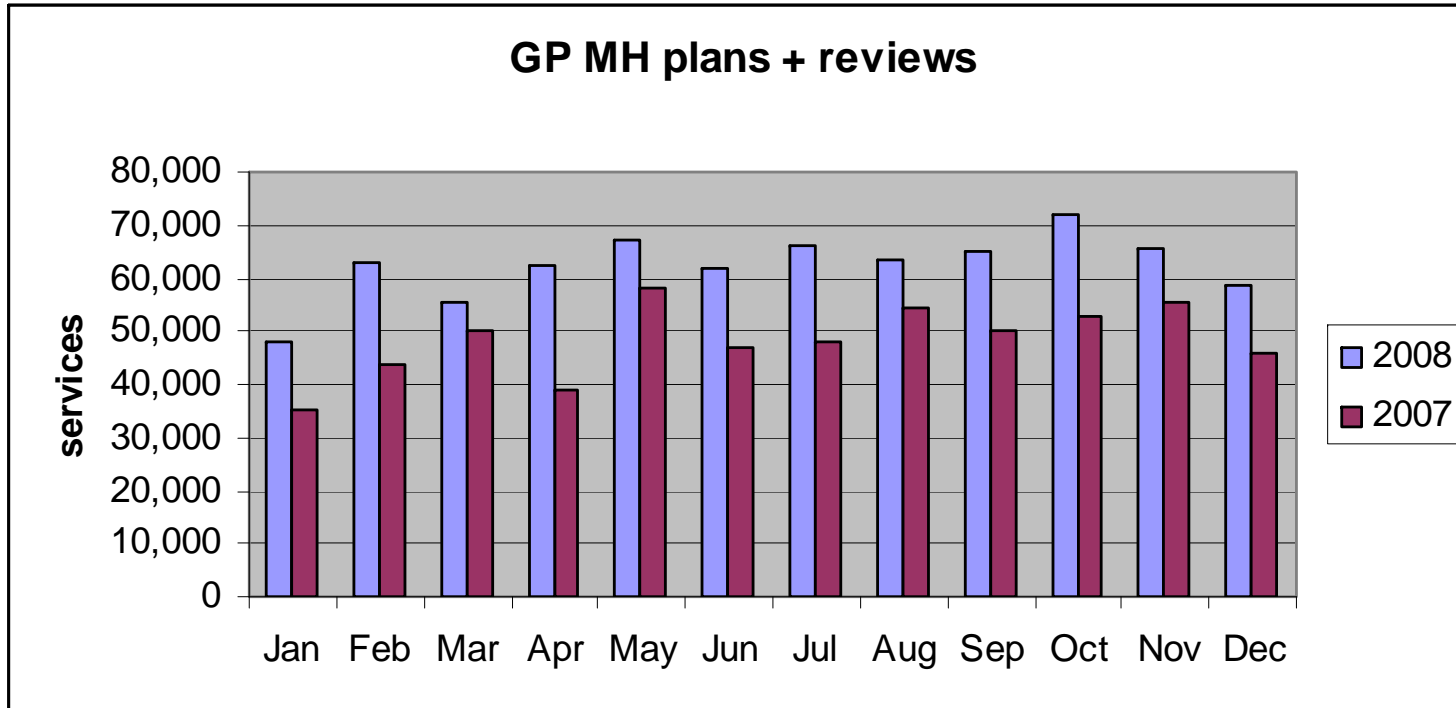


Figure 2

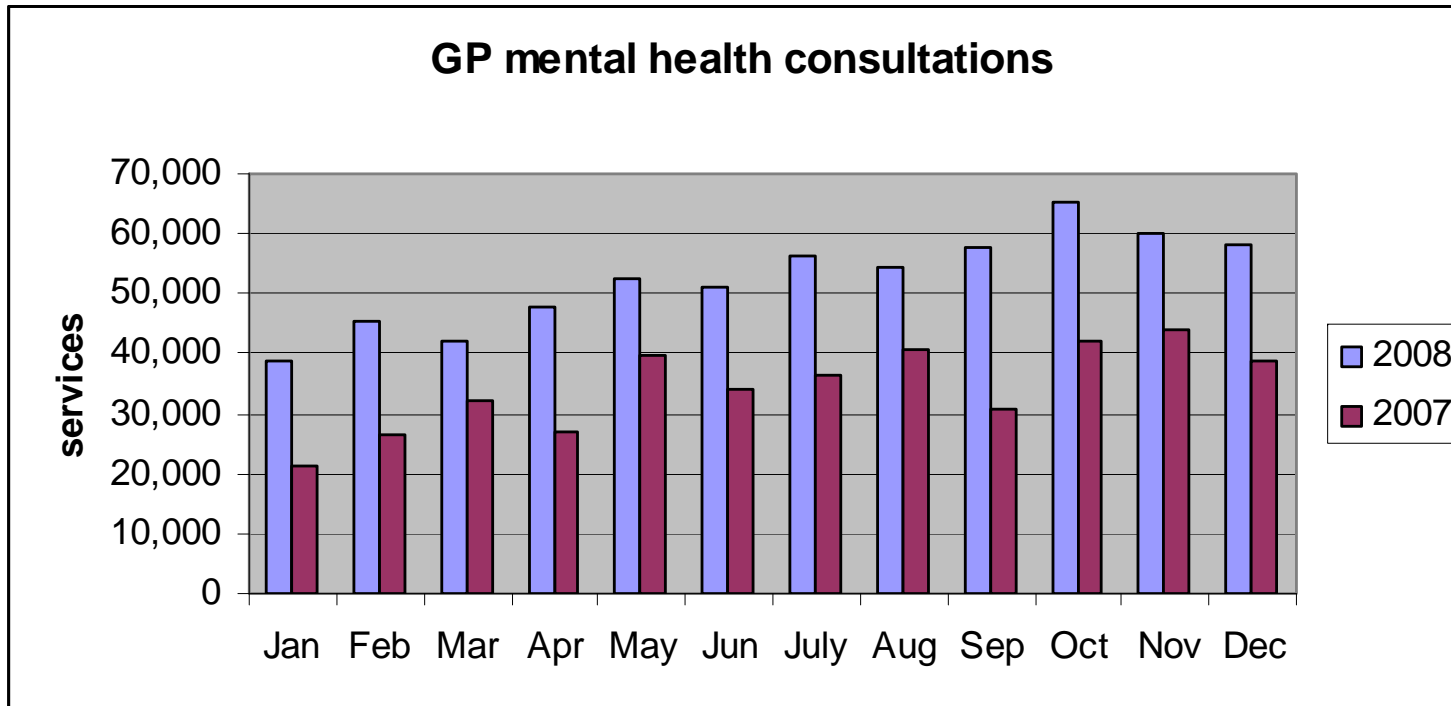


Figure 3

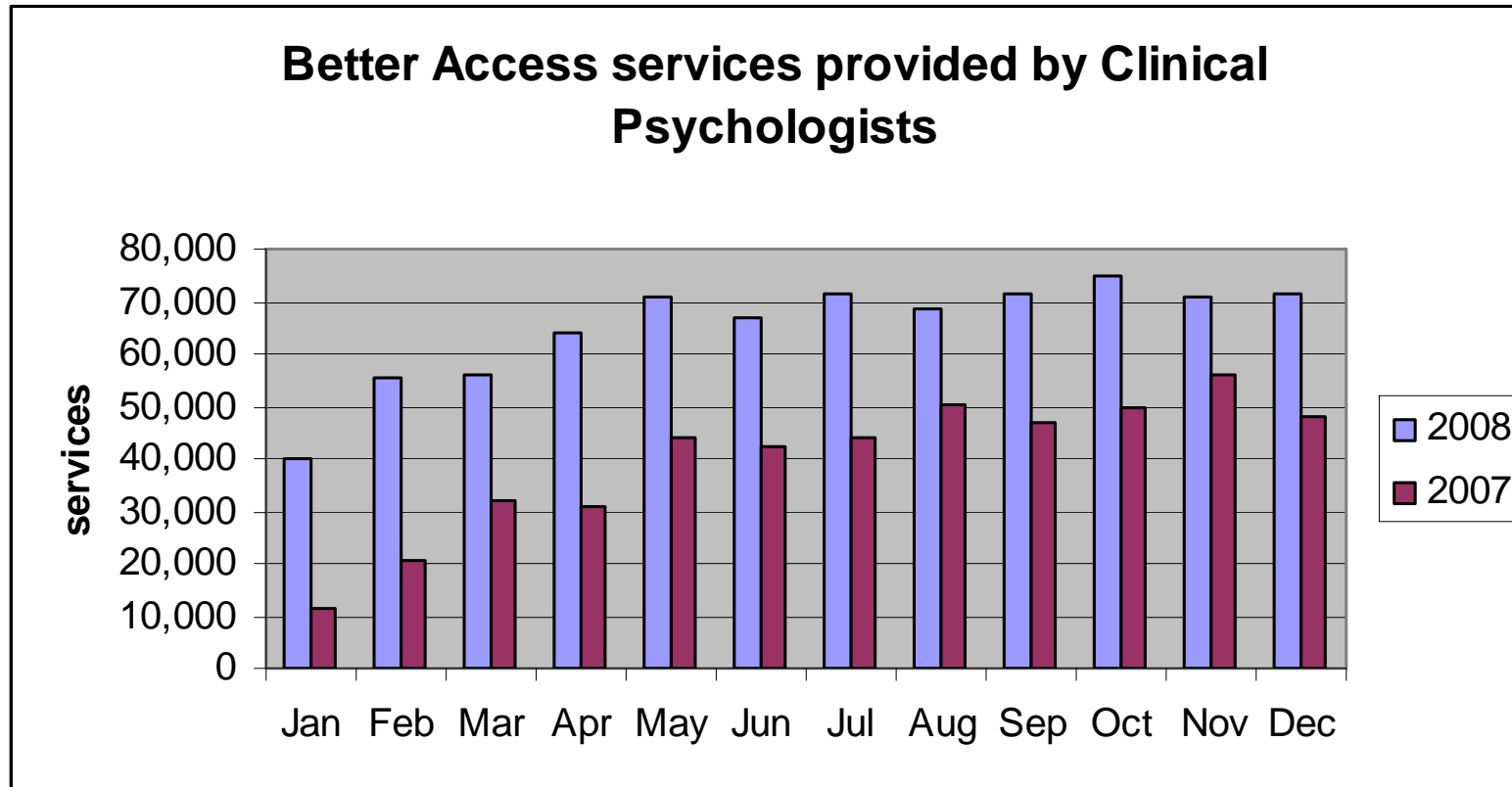


Figure 4:

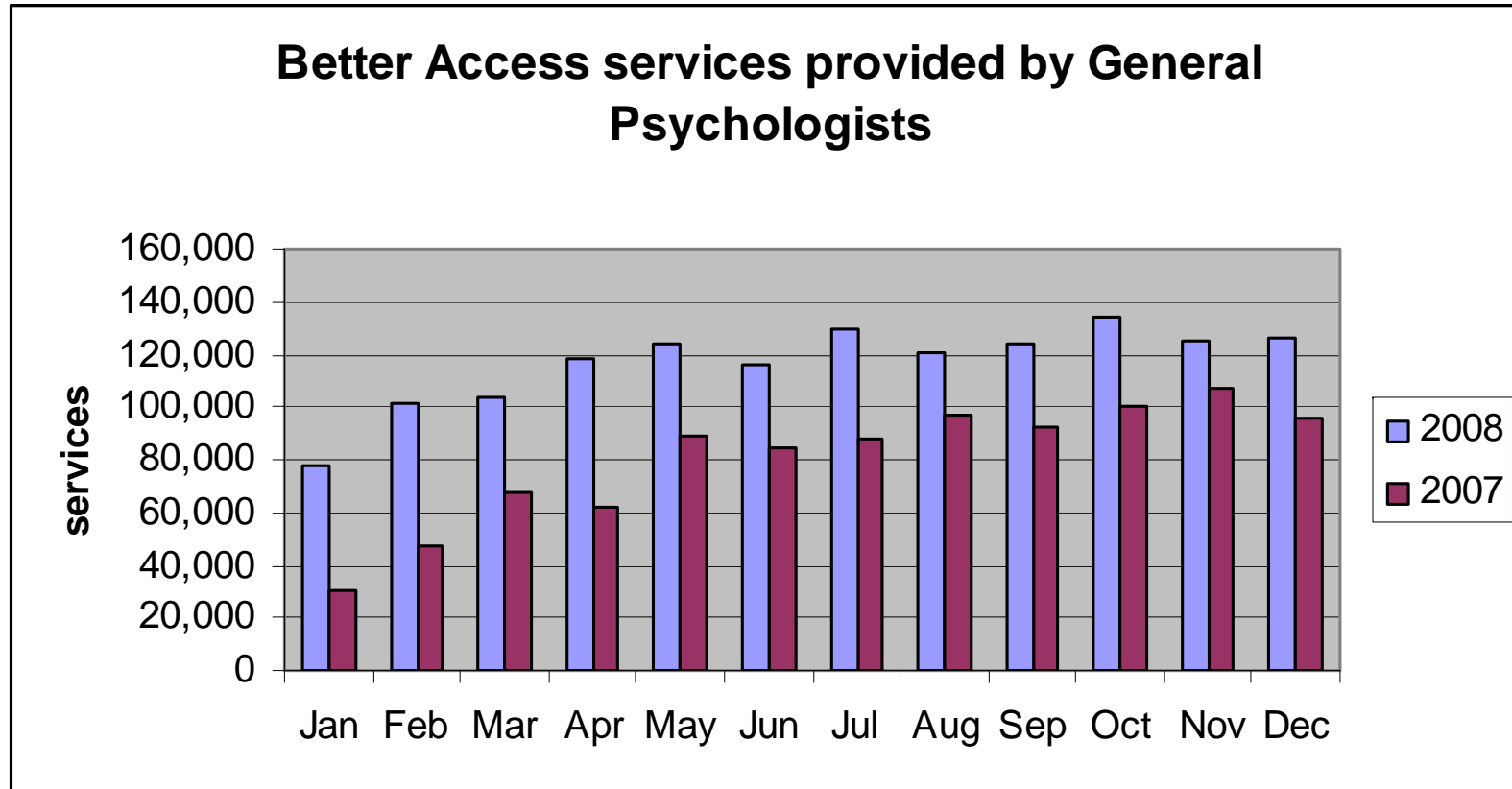


Figure 5

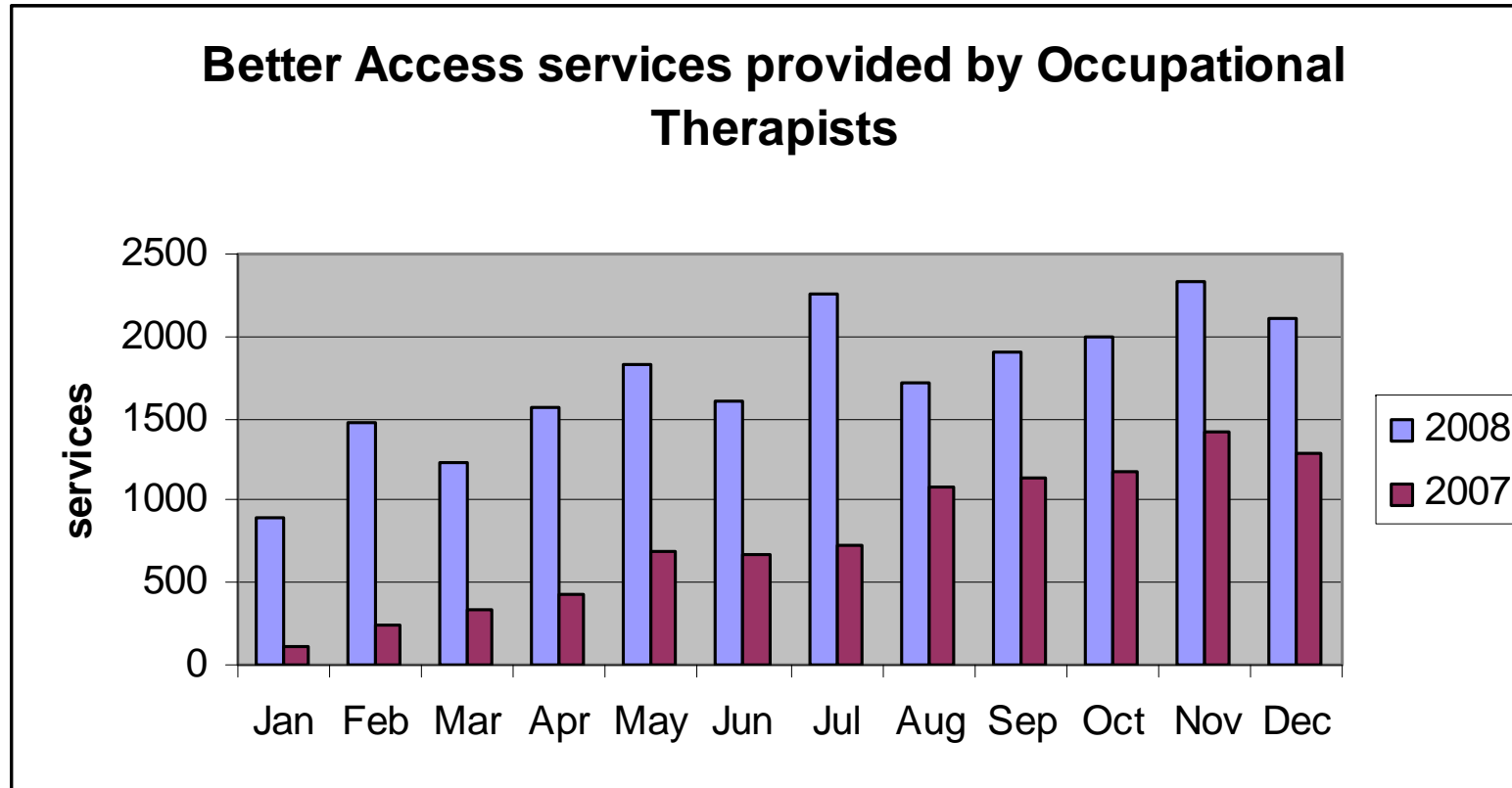
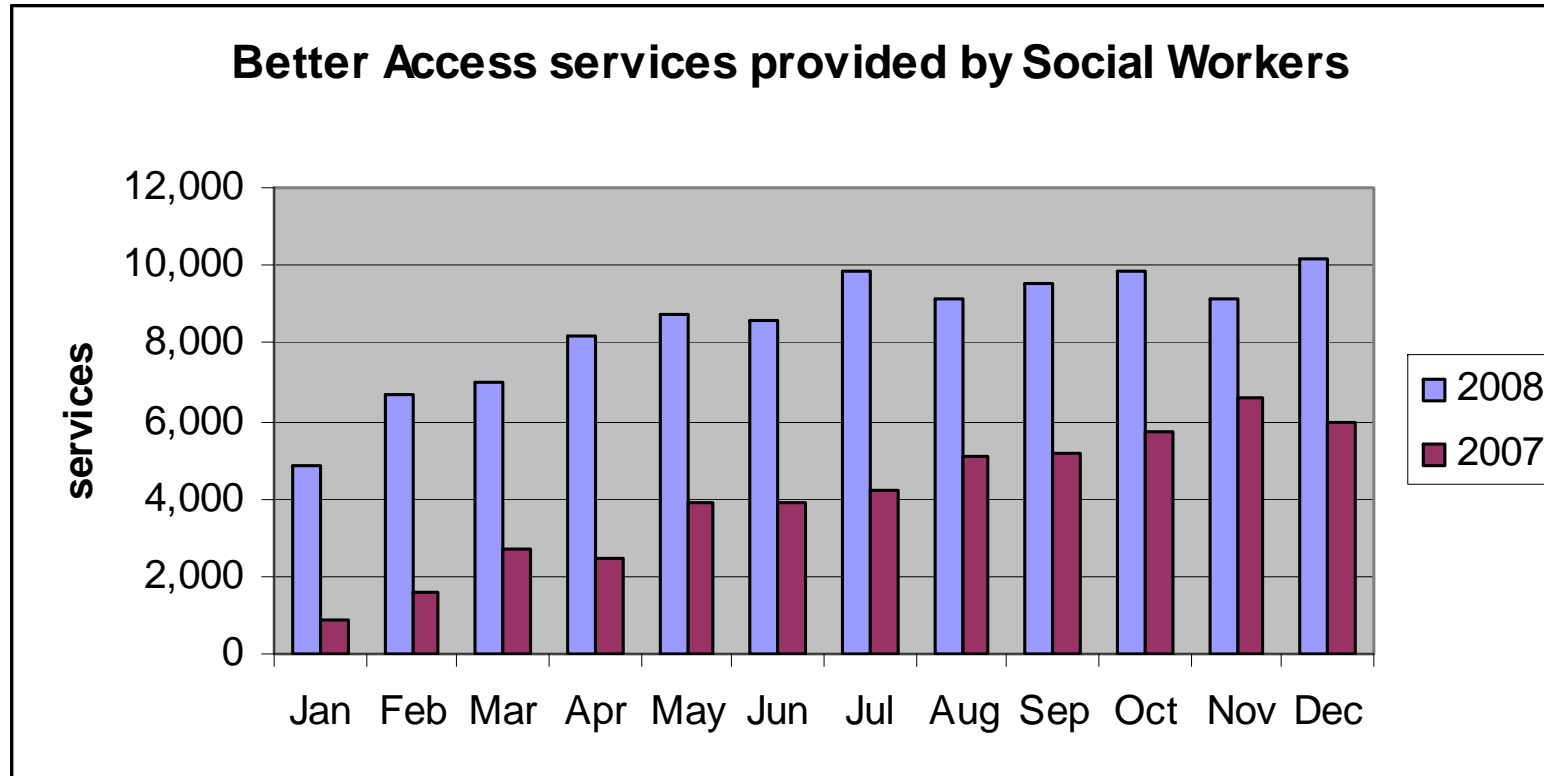


Figure 6



**Table 2: Delivery of Better Access services by State and Territory
Calendar year 2008**

	NSW	Vic	Qld	SA	WA	Tas	ACT	NT	Total
Popln (m) (%)	6.967 (32.6)	5.298 (24.8)	4.279 (20.0)	1.602 (7.5)	2.163 (10.1)	0.498 (2.3)	0.344 (1.6)	0.220 (1.0)	21.374
GP mh plans (%)	191,415 (34.3)	158,571 (28.4)	101,338 (18.2)	36,723 (6.6)	48,323 (8.7)	11,282 (2.0)	7,912 (1.4)	2,300 (0.4)	557,864
GP plans review (%)	66,313 (34.7)	57,537 (30.1)	32,171 (16.8)	11,302 (5.9)	17,192 (9.0)	3,620 (1.9)	2,256 (1.2)	486 (0.2)	190,877
GP mh consults (%)	211,210 (33.6)	173,116 (27.5)	116,433 (18.5)	50,129 (8.0)	57,361 (9.1)	11,463 (1.8)	6,613 (1.0)	3,037 (0.5)	629,363
GP FPS (%)	13,192 (36.2)	10,642 (29.2)	6,421 (17.6)	4,079 (11.2)	1,364 (3.7)	313 (0.8)	329 (0.9)	137 (0.4)	36,477
Clin psych (%)	255,320 (32.6)	202,259 (25.8)	91,485 (11.7)	63,968 (8.2)	128,894 (16.5)	25,506 (3.3)	13,184 (1.7)	1,515 (0.2)	782,131
Gen psych (%)	458,337 (32.7)	496,955 (35.5)	273,999 (19.6)	54,667 (3.9)	65,741 (4.7)	22,751 (1.6)	22,601 (1.6)	4,402 (0.3)	1,399,453
Occ ther (%)	7,736 (37.0)	5,799 (27.7)	2,767 (13.2)	2,251 (10.8)	1,689 (8.1)	530 (2.5)	38 (0.2)	7 (0)	20,917
Soc wkr (%)	35,331 (34.7)	34,430 (33.9)	14,798 (14.5)	6,968 (6.8)	7,387 (7.3)	2,139 (2.1)	445 (0.4)	169 (0.2)	101,667
Total services (%)	1,238,854 (33.3)	1,139,309 (30.6)	639,412 (17.2)	230,087 (6.2)	327,951 (8.8)	77,604 (2.1)	53,378 (1.4)	12,053 (0.3)	3,718,748

**Table 3: Analysis of use of Medicare mental health items under Better Access program, by age and sex
Calendar year 2008**

Medicare service	Age groups									
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
GP m h plans & review (F) (% 2007)	1,356 (+59.7)	19,649 (+47.5)	78,249 (+29.6)	106,294 (+24.8)	113,614 (+26.4)	87,710 (+26.3)	51,562 (+29.6)	18,725 (+30.1)	7,363 (+28.6)	1,374 (+17.8)
Plan/review	10.2	4.8	3.5	2.9	2.6	2.5	2.4	2.3	2.5	2.0
GP m h plans & review (M) (% 2007)	2,589 (+62.4)	25,079 (+49.4)	37,417 (+35.1)	54,249 (+27.6)	58,866 (+27.0)	45,196 (+27.0)	26,261 (+31.0)	8,792 (+28.8)	3,518 (+29.0)	397 (+18.1)
Plan/review	7.8	4.8	4.3	3.4	3.0	2.8	2.5	2.5	2.4	2.7
GP mh consult (F) (%2007)	211 (+104.8)	4,388 (+51.6)	54,983 (+46.5)	80,500 (+44.7)	96,443 (+49.0)	82,726 (+50.7)	51,983 (+55.9)	24,160 (+62.6)	11,308 (+57.6)	2,347 (+70.9)
GP mh consult (M) (%2007)	291 (+91.4)	4,403 (+70.9)	26,072 (+48.2)	46,877 (+42.3)	54,284 (+42.3)	43,602 (+44.8)	27,775 (+53.6)	11,305 (+60.6)	5,028 (+60.6)	676 (+75.6)

	Age groups									
Medicare service	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
GP psych strategies (F) (%2007)	6 (-25.0)	249 (+10.2)	2,782 (+1.1)	4,813 (+7.3)	5,527 (-2.3)	4,790 (-5.4)	3,476 (+6.5)	1,445 (+12.2)	639 (+3.9)	110 (+120)
GP psych strategies (M) (%2007)	6 (-60.0)	180 (-6.2)	1,282 (-9.7)	2,708 (-0.6)	3,228 (-1.5)	2,485 (+1.7)	1,716 (+6.0)	653 (+6.2)	314 (+7.2)	39 (-7.0)
Clin Psych services (F) (%2007)	1,698 (+87.6)	25,530 (+70.7)	78,191 (+60.3)	119,663 (+59.8)	124,861 (+60.2)	95,042 (+63.0)	52,237 (+64.2)	14,438 (+67.1)	3,920 (+64.0)	546 (+73.9)
Clin Psych services (M) (%2007)	3,295 (+69.3)	38,821 (+76.3)	36,343 (+70.1)	52,842 (+77.0)	59,859 (+68.9)	46,869 (+68.7)	26,847 (+77.9)	6,662 (+77.9)	1,927 (+69.8)	168 (+110.0)
Gen Psych services (F) (%2007)	2,295 (+63.6)	44,409 (+67.3)	127,309 (+41.4)	203,057 (+39.3)	234,271 (+45.4)	180,340 (+43.8)	100,989 (+45.5)	29,398 (+46.2)	8,675 (+43.6)	1,453 (+101.8)
Gen Psych services (M) (%2007)	4,511 (+73.0)	63,185 (+59.7)	57,557 (+52.0)	86,327 (+43.1)	106,208 (+47.1)	83,878 (+44.7)	48,628 (+52.1)	12,596 (+47.0)	3,668 (+46.2)	522 (+157.1)

	Age groups										
Medicare service	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
Occ Ther (F) (%2007)	554 (+282.0)	1,536 (+254.7)	1,368 (+93.2)	1,743 (+97.4)	2,130 (+92.1)	1,845 (+93.6)	815 (+83.6)	269 (+60.1)	106 (+60.6)	15 (+50.0)	
Occ Ther (M) (%2007)	2,641 (+217.4)	5,087 (+178.6)	597 (+91.3)	525 (+96.6)	695 (+55.8)	561 (+48.1)	293 (+42.2)	82 (+20.6)	51 (+88.9)	4 (+400.0)	
Soc wkr (F) (% 2007)	127 (+4.1)	2,487 (+52.9)	9,590 (+119.2)	16,088 (+108.8)	19,959 (+102.8)	14,215 (+108.2)	7,746 (+121.7)	2,194 (+121.3)	804 (+86.1)	173 (+56.6)	
Soc wkr (M) (%2007)	147 (-3.3)	2,701 (+87.3)	3,354 (+96.2)	5,397 (+127.8)	7,094 (+123.7)	6,273 (+156.4)	2,779 (+127.4)	867 (+166.8)	1,177 (+914.6)	23 (+155.5)	
Total services (F)	6,247	117,897	352,472	532,158	596,805	466,668	268,808	90,629	32,815	6,018	
Total services (M)	13,480	138,955	162,622	248,925	290,234	228,864	134,299	40,957	15,683	1,829	
Total M+F	19,607	256,852	515,094	781,083	887,039	695,532	403,107	131,586	48,498	7,847	
% of population	19.4%		42.8%			24.5%		13.1%			(1.6%)
% of total services	7.4%		58.7%			29.5%		5.1%			(0.2%)

APPENDIX B: RECESSION AND DEPRESSION

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Introduction

The current economic crisis is increasing the level of financial stress confronting Australians, at a time when out-of-pocket health care costs are high. The heaviest burden will fall on those with the poorest health and the greatest need, people with chronic illnesses, including those with mental illness.

Despite the universal cover offered by Medicare, free public hospital care and the significant subsidization of prescription medicines by the Pharmaceutical Benefits Scheme (PBS), sick Australians face some of the highest co-payment costs within the Organisation for Economic Co-operation and Development (OECD) countries (1), and have out-of-pocket costs close to those faced by Americans (2). An international study released by the Commonwealth Fund (3) shows that in 2008, 36 percent of chronically ill Australians said that they had failed to fill a prescription or skipped medication doses, did not visit a doctor when they had a medical problem or did not get recommended tests, treatment or follow-up because of cost.

A recent Australian survey conducted by the Menzies Centre for Health Policy and The Nous Group reinforces these reports. This survey, conducted in July and August last year, found a direct correlation between reported levels of financial stress and missed medical tests and treatment, failure to collect a prescription and skipping doses of medication, and going without needed dental care. These Australians were 50 percent more likely to report their health as fair or poor compared to those whose families were not under financial stress, only half as likely to have private health cover (reported levels at 28 percent compared to 60 percent) and 78 percent said they found it difficult to access non hospital based medical services out of hours, at weekends and holidays (4).

A current study looking at what pharmacists do when they become aware that patients are non-compliant with their prescription medication regime has highlighted that chronically ill patients often struggle to afford to fill all their prescriptions and make choices about which medicines they must go without, at least for a certain period of time (5).

PBS co-payment and safety net threshold increases

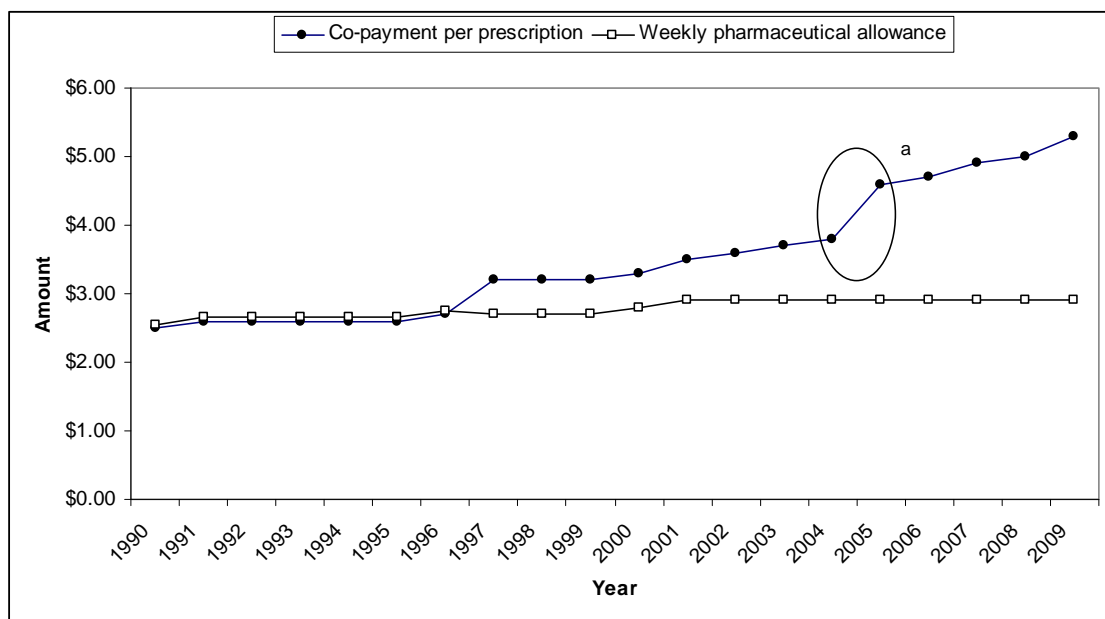
The 1 January 2009 increase in PBS co-payments and safety net thresholds passed almost un-remarked, but for many these increases (see Figure 1) will be an additional health cost

they can ill afford. Since 2006, the safety-net thresholds have increased by the equivalent cost of two prescriptions a year, meaning that fewer patients are eligible for fully-subsidised medicines as the year progresses. People with concession cards must now pay \$318.00 (the cost of 60 prescriptions) before they qualify for the PBS safety net. In 2004, the PBS safety net threshold for concession card holders was \$197.60 (equivalent to the cost of 52 prescriptions).

The fact that concession card holders pay only \$5.30 for each prescription may seem a small impost, but many of these people are chronically ill and need multiple medications (6). They also have substantial other health costs – for medical care, equipment and aides, care and transport (7).

Once again, as for the past 12 years, the annual increase in PBS co-payments is not matched by an increase in the Pharmaceutical Allowance paid to pensioners (Figure 1 and Table 1).

Figure 1: Historical co-payment amounts for concessional beneficiaries and weekly pharmaceutical allowance provided to pensioners.



a: January 2005 24% co-payment increase

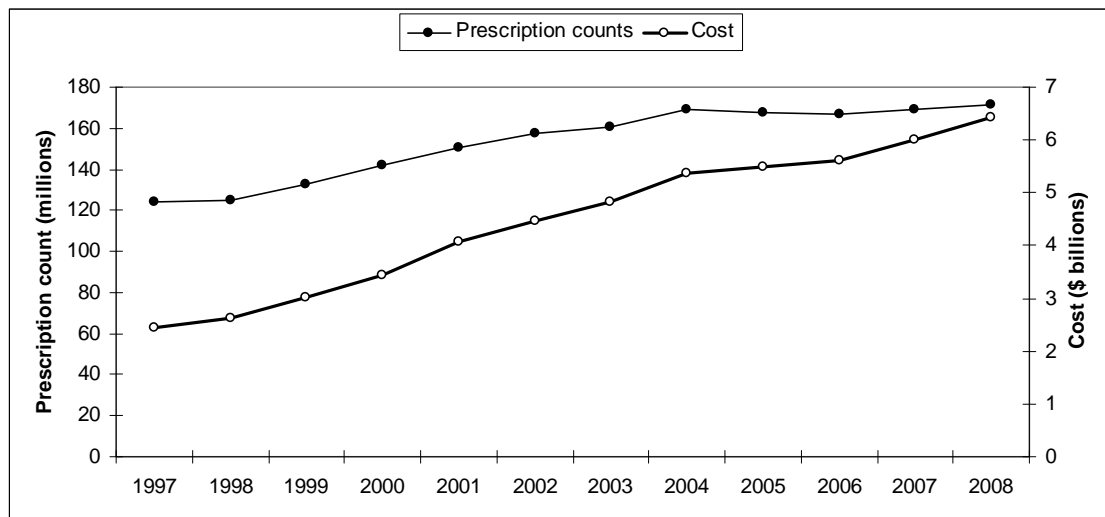
Table 1: Historical co-payment amounts and safety net thresholds for concessional beneficiaries.

Year	Co-payment amount	Safety-net threshold	Equivalent cost of safety net
1990	\$2.50	\$130.00	52 prescriptions
1991	\$2.60	\$130.00	50 prescriptions
1992	\$2.60	\$135.20	52 prescriptions
1993	\$2.60	\$135.20	52 prescriptions
1994	\$2.60	\$135.20	52 prescriptions
1995	\$2.60	\$135.20	52 prescriptions
1996	\$2.70	\$140.40	52 prescriptions
1997	\$3.20	\$166.40	52 prescriptions
1998	\$3.20	\$166.40	52 prescriptions
1999	\$3.20	\$166.40	52 prescriptions
2000	\$3.30	\$171.60	52 prescriptions
2001	\$3.50	\$182.00	52 prescriptions
2002	\$3.60	\$187.20	52 prescriptions
2003	\$3.70	\$192.40	52 prescriptions
2004	\$3.80	\$197.60	52 prescriptions
2005	\$4.60	\$239.20	52 prescriptions
2006	\$4.70	\$253.80	54 prescriptions
2007	\$4.90	\$274.40	56 prescriptions
2008	\$5.00	\$290.00	58 prescriptions
2009	\$5.30	\$318.00	60 prescriptions

The impact of PBS co-payments on prescription numbers

Previous studies by the authors and their co-workers (8,9) have shown that when the PBS co-payments rose sharply, by 24% in January 2005, there were substantial falls in dispensings of prescription medicines (Figures 2, 3).

Figure 2: PBS prescription and costs to government before and after the 2005 24% co-payment increase.

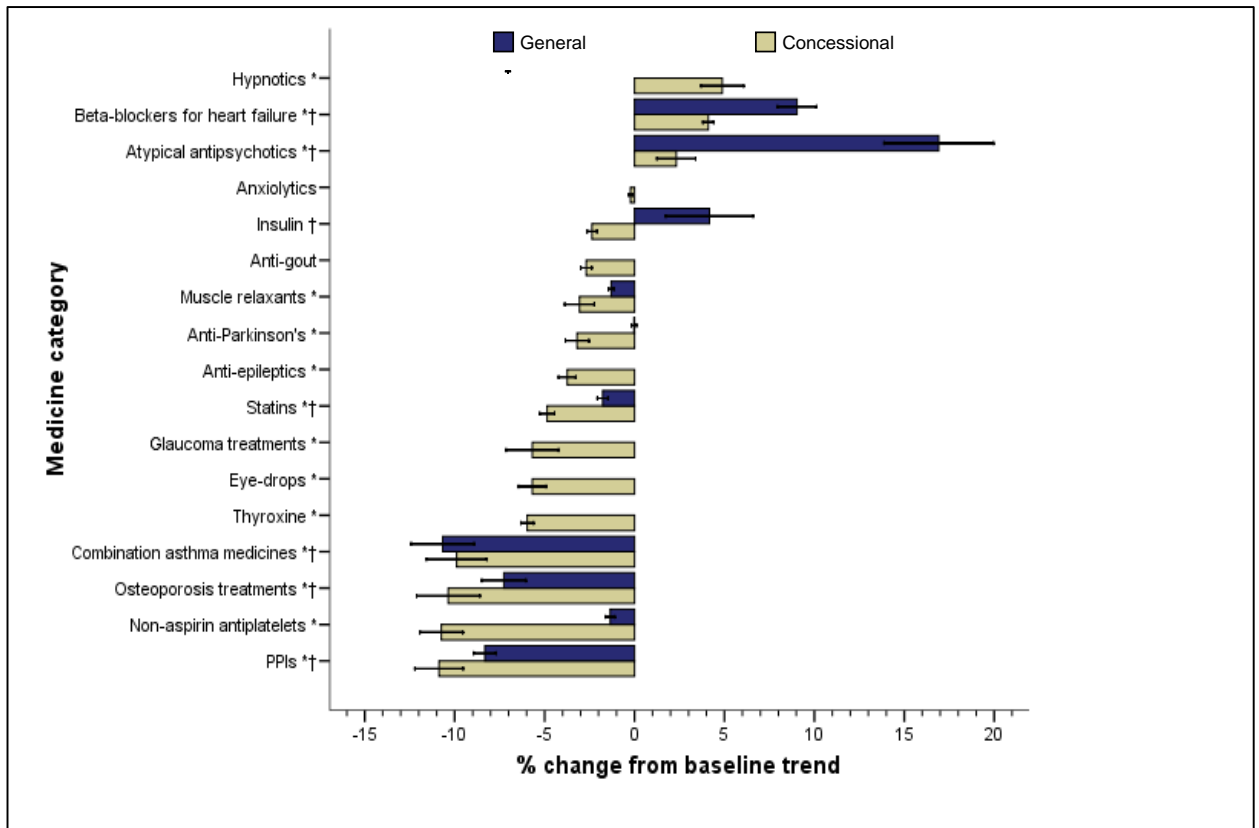


In the calendar years (CYs) up until 2005, the average growth rate for prescriptions dispensed in Australia was 5.25%. There were fewer prescriptions dispensed in CY 2005, 2006, 2007 than in CY 2004, and only in CY 2008 have prescriptions numbers started to rise again (by 1.1% over the previous year). If prescription growth rates had continued at 5.25%, then 26.4 million additional prescriptions would have been dispensed in CY2008 than was actually the case (171.2 million). While a temporary drop in prescription numbers following the introduction of the co-payment increase was expected, the long-lasting nature of this drop was not.

There are a number of confounding factors impacting on these figures, however, including many medicines falling off data capture with each rise in co-payments. Work from Hynd et al (9) examined categories of medicines that were not affected by changes in data capture, as all medicines remained above the co-payment thresholds for the period being studied. The study found that the impact of the 24% increase in co-payments was not distributed equally across all therapeutic categories of medicines, and fell heaviest on concession card holders (Figure 3).

While it is possible that some patients reduced ‘unnecessary’ use of these medicines, previous evidence suggests that co-payment increases often result in decreases in both ‘essential’ and ‘non-essential’ medicines (10, 11). The most likely explanation for the decreases seen across many categories of essential medicines is that patients were struggling to afford their needed medications (Figure 3).

Figure 3: Percentage change (95% CIs) in dispensings after the January 2005 increase in patient co-payments to concessional and general beneficiaries compared with the baseline trend. (9)



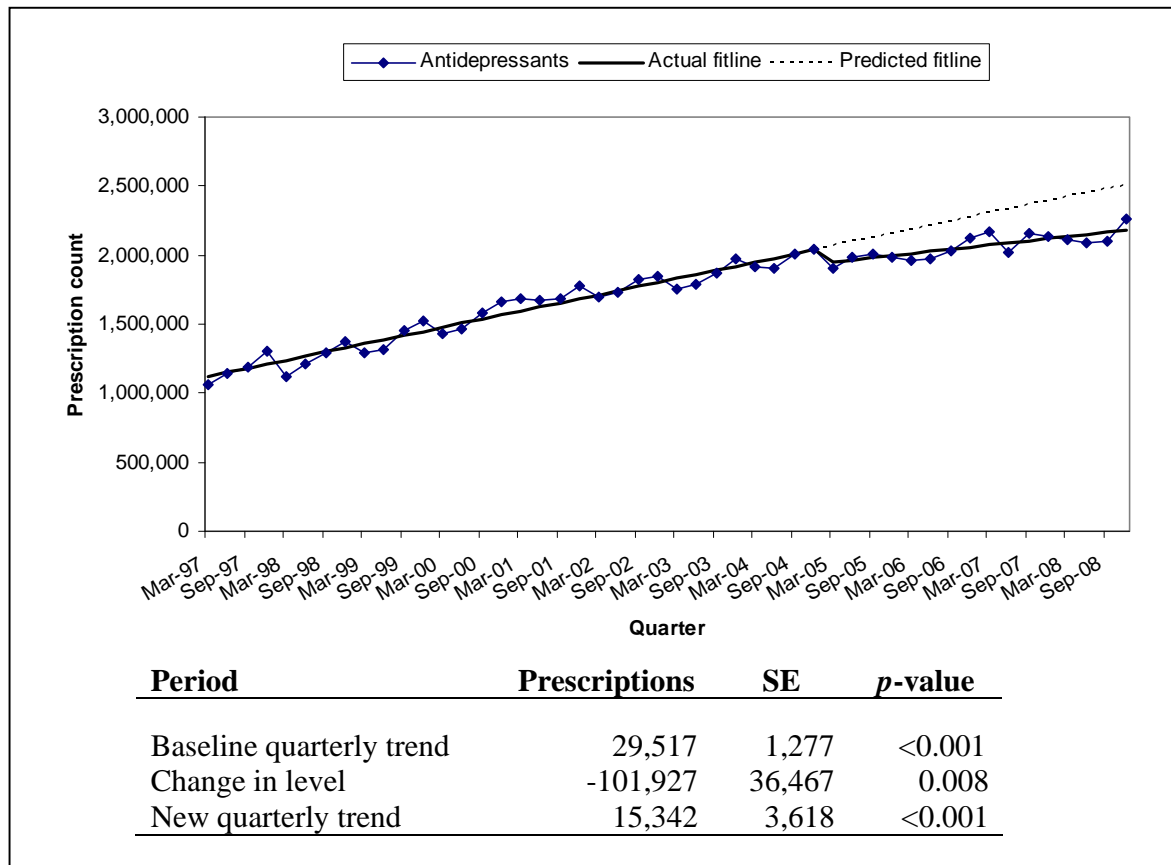
*Indicates significant percentage change in dispensings to concessional beneficiaries, $p < 0.001$.
 †Indicates significant percentage change in dispensings to general beneficiaries, $p < 0.001$.

The impact of PBS co-payments on PBS medications for depression

We were interested in the impact of PBS co-payment increases on medicines used to treat depression, which is now Australia's most debilitating illness (12). Recent current events such as the global economic crisis are likely to contribute to this disease burden, at least in the short term. We were also interested to see if the Medicare Better Access to Mental Health Services program, introduced in November 2006, had resulted in a change in the prescribing levels of these medications.

We analysed the number of PBS prescriptions for medicines used to treat depression which were dispensed to concession card holders, in each quarter between January 1997 to December 2008 (Figure 4) (13).

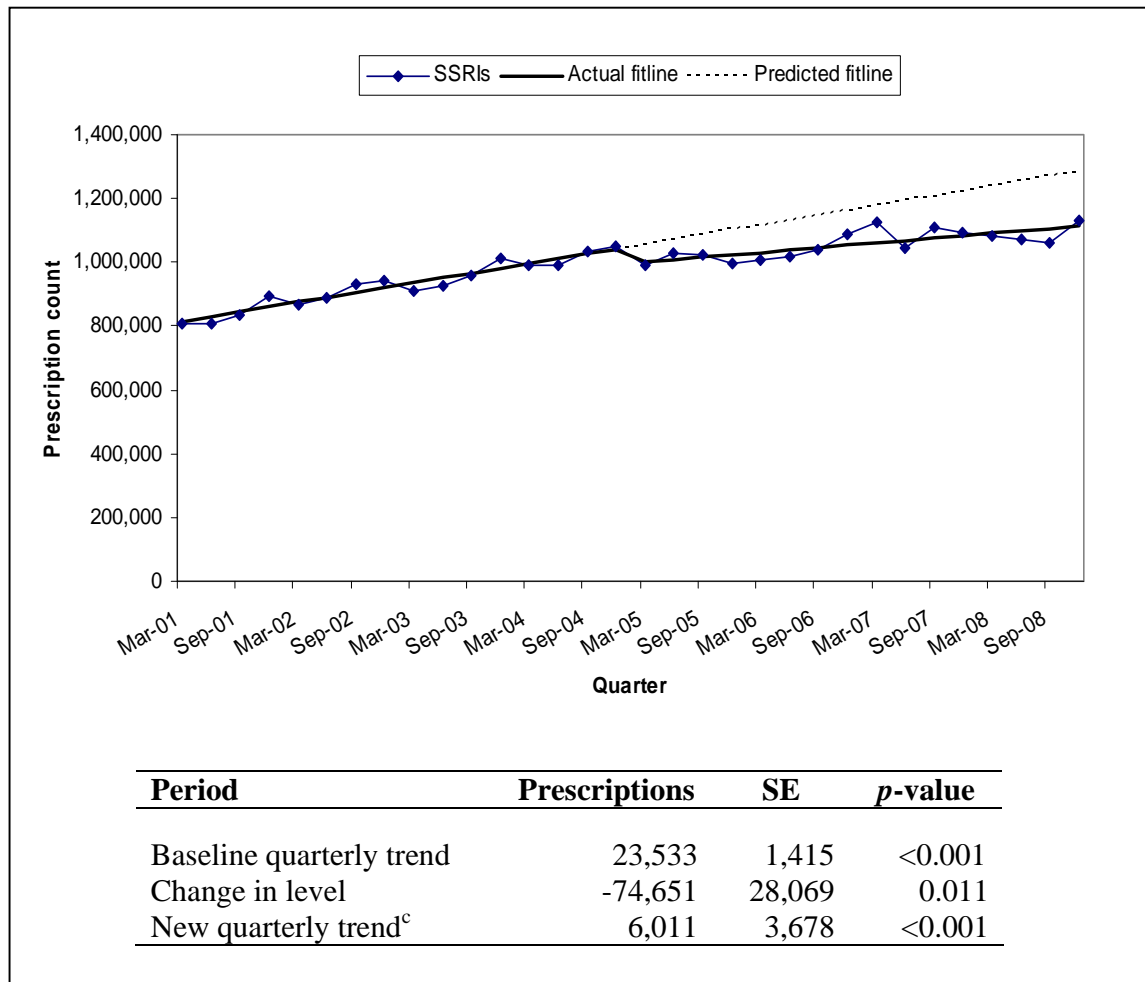
Figure 4: Aggregated script volume of all antidepressant medicines dispensed to concessional beneficiaries in Australia before and after the 24% rise in co-payments (by date of processing).



Prior to January 2005, an additional 29,514 antidepressant prescriptions were being dispensed to concessional beneficiaries each quarter, on average (Figure 4). After the January 2005 increase in co-payments, there was an immediate drop of approximately 100,000 prescriptions, and only 15,342 additional prescriptions were dispensed each quarter, on average, after this point in time. The actual number of prescriptions dispensed to concession card holders at the end of December 2008 was 2,264,096. The value that would have been expected in December 2008, had the 2005 24% co-payment rise not occurred, is 2,509,562. The actual dispensing trend after January 2005 is an average of 9.6% lower than would have been expected, had the co-payment rise not occurred (this is a significant fall $P < 0.001$).

Antidepressants can be categorised into four groups: 1) tricyclics, 2) monoamine oxidase (MAO) inhibitors, 3) selective serotonin reuptake inhibitors (SSRIs), and 4) 'other' antidepressants. We looked specifically at the SSRI category as these medications are the most commonly prescribed of the antidepressants (13) and are recommended because of their efficacy and tolerability (14) (Figure 5).

Figure 5: Aggregated script volume of all SSRIs dispensed to concessional beneficiaries in Australia before and after the 24% rise in co-payments (by date of processing).



Prior to January 2005, an additional 23,533 SSRI prescriptions were being dispensed to concessional beneficiaries each quarter, on average (Figure 5). After the January 2005 increase in co-payments, there was an immediate drop of approximately 74,000 prescriptions, and only 6,011 additional prescriptions were dispensed each quarter, on average, after this point in time. For SSRIs, the actual count of prescriptions dispensed at the end of December 2008 was 1,131,378. The number of prescriptions that would have been expected in December 2008, had the January 2005 co-payment rise not occurred, is 1,283,494. The actual trend after January 2005 is an average of 9.5% lower than would have been expected, had the co-payment rise not occurred (this is a significant fall $P < 0.001$). (i.e. 62% of the fall in antidepressant medications is due to a fall in prescriptions filled for SSRIs)

Discussion

The clear evidence from our data is that there has been a decline in the rate of PBS prescriptions filled for antidepressant medications, and that this decline is coincident with a large increase in co-payments and the safety net thresholds. Moreover, the rate decline seen for these medicines from the first quarter of 2005 has remained constant through to the end of December 2008. As a consequence, in the December 2008 quarter, there were 245,466 fewer antidepressant prescriptions dispensed than might have been expected.

The most significant issue here is whether there is a major discrepancy between the number of prescriptions that doctors are writing for their patients and the number of prescriptions that patients are filling and taking, and the impact of increasing co-payments and financial pressures on the number of prescriptions filled.

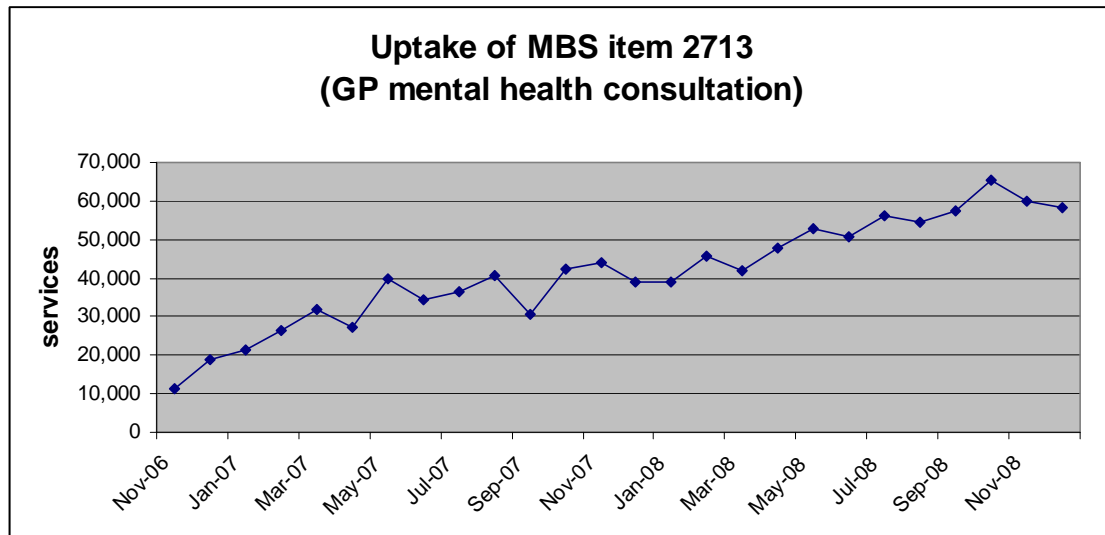
We are not able to definitively answer this question with the data available to us. While we acknowledge that there are a variety of confounding factors that come to bear on this issue, we do believe that current evidence gives rise to very real reasons for concern, especially in the current economic climate, that financial pressures are having an adverse impact on the ability of many Australians to comply with their medication regimes.

The most recently available BEACH data show that the prescribing rates by general practitioners (GPs) for psychoanalytic drugs (the majority of which are antidepressants) increased from 2.1 / 100 problems managed in 1998-98 to 2.4 / 100 problems managed in 2006-07 (15). This suggests that a significant (but unknown) number of prescriptions go unfilled.

There is no evidence to hand to suggest that this drop in prescription numbers is due to a greater focus on treatments for depression such as Cognitive Behavioural Therapy (CBT) that may diminish the need for medication.

The Medicare Better Access to Mental Health Services Program, introduced in November 2007, now provides reimbursement for mental health services delivered by psychologists, social workers and occupational therapists, but none of these health professionals has PBS prescribing rights. There has however been a rapid growth in the use of the relevant MBS items for GPs, such that by December 2008, there were 60,000 GP mental health specific consultations a month (Figure 6).

Figure 6. Increase in GP mental health consultations (MBS item 2713) in Australia between November 2006 and December 2008.



In 2006-07 the average rate of prescribed medications for GPs was 83.3 / 100 encounters (15). Assuming this prescribing level for mental health consultations (item 2713), would indicate an expected increase in prescriptions of 122,451/ quarter by December 2008.

Of course this increase in prescriptions is only seen if the increase in mental health consultations reflects new patients accessing care for their mental health problems. The recent ABS National Survey of Mental Health and Wellbeing highlighted that in 2007 there had been no increase in the number of people with a mental health problem receiving services (35%) over the number reported a decade earlier (38%) (16).

Both Prime Minister Kevin Rudd and US President Barack Obama have acknowledged that health care is as much an economic issue as it is an issue of social justice and equity. However it is clear from this data that, as the economic crisis deepens, there is a very real risk that those most dependent on the health care system will miss out on needed services.

That will mean reduced quality of life for them, diminished productivity for business, increasing pressure on the public hospital system and increased health costs for government budgets. Under such circumstances, there are no winners, only losers.

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