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Use of Reimbursed Psychology Videoconference Services in Australia After Their Introduction: An Investigation Using Administrative Data

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ABSTRACT

Background: In November 2017, the Australian government approved reimbursement for psychology consultations conducted by videoconference under the Better Access initiative to address inequitable access of mental health services across regions in Australia.

Objective: This project uses publically available activity data from the Medicare Benefits Scheme to quantify the uptake of videoconference for psychology resulting from the initiative change.

Methods: Data were extracted from the Medicare Benefits Schedule item reports using the item codes for standard consultations and the new item codes for videoconference consultations. Activity data from 2 years before and the first year of the change to the Better Access initiative were compared to examine the uptake of videoconference for psychology. Data were stratified by allied health profession, sex, age and state jurisdiction.

Results: In the 1-year period after the introduction of reimbursed videoconference consultations, approximately 5.7 million in-person consultations and 4141 videoconference consultations were funded by Medicare in Australia. Videoconference consultations comprised 0.07% of the total consultations performed in that 1-year period and showed an increased trajectory. The results can guide future research into evaluating the clinical outcomes of patients via both in-person and videoconference delivery modes.

Conclusions: Videoconference mental health services were used in the first year that they were available, although they only accounted for a small percentage of all mental health consultations provided by allied health professionals. This finding lays the foundation for future work which could examine the effectiveness of the scheme in reducing inequity and investigating the economic benefits of the expanded initiative to the government and society.

Keywords: health insurance reimbursement, Medicare, mental health services, telehealth, telemedicine, telepsychology, videoconference.

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Introduction

Mental health conditions place an enormous burden on the Australian health system.[1,2] The inequity of access to metropolitan and rural mental health services in Australia has contributed to the poorer health outcomes of rural and remote communities.[3] This is a consequence of uneven service distribution, social and financial factors, travel requirements, turnover of the workforce, cultural barriers, and stigma.[3,4] The shortages were exemplified through the 2014 National Mental Health Commission review highlighting that the 30% of Australians that live in rural and remote locations receive unmatched funding and healthcare access compared to individuals in metropolitan areas.[5,6] The issues of recruiting and retaining a workforce in rural Australia mean that reducing staff turnover has become the focus of fiscal policies over patients' wellbeing.[4,7]

In 2006, the Australian government introduced the Better Access initiative, funded under the Medicare Benefits Schedule (MBS), Australia's national reimbursement system for health services.[8] This policy initiative was designed to improve outcomes for people with common mental heath disorders by enabling patients with a mental disorder to claim a rebate for up to 10 mental health treatment sessions per year. Despite the significant investment for these services, the Better Access initiative has failed to adequately

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address service gaps for those living in regional and rural areas.[9] Videoconference, a subset of telehealth, is a key tool for improving equitable access of mental healthcare services across rural and remote regions of Australia.[10] Videoconference enables clinical health services to be provided from a distance and provides a potential solution to some of the barriers to mental health service delivery in rural Australia.

On November 1, 2017, the Australian government expanded the Better Access initiative to include new videoconference consultations. Under the expansion of the Better Access initiative, eligible patients are able to access reimbursed videoconference mental health services delivered by eligible registered or clinical psychologists, social workers, occupational therapists, and general practitioners.[11] Patients assessed as having a mental health disorder living in areas 4 to 7 on the Modified Monash Model (regional or remote areas, which tend to be towns with populations <15 000), who are located at least 15 km by road from the treating provider are considered eligible for videoconference services.[11] In 2017, approximately 14% of the Australian population lived in Modified Monash Model areas 4 to 7.[12]

Earlier evaluations of the Better Access initiative before the introduction of reimbursement for videoconference have highlighted the success of the initiative in increasing general psychological service use,[13] but noted that increasing remoteness was consistently associated with lower service activity.[14] Given the recency of the Better Access initiative updates to include videoconference, the impact of expanding this scheme to include videoconference consultations on service access is unclear. Using Medicare activity data, this article describes the impact on mental health service activity of the addition of videoconference services to reimbursement via the Better Access initiative in November 2017.

Methods

A retrospective review of MBS activity data was conducted to quantify the use of videoconference services after the expansion of the Better Access initiative to include videoconference services on November 1, 2017. This study was deemed exempt from an ethics review by The University of Queensland Human Research Ethics Committee (clearance number: 2018002354).

Data collection

MBS activity data were obtained from the Medicare Australia Statistics website using patient demographic item reports stratified by sex, state of residence, and age.[15] Aggregate quarterly activity data for 2 financial years (FYs) before and monthly data for 1 year after the addition of videoconference item numbers to the Better Access initiative (July 2015 to October 2018) were accessed. Because Australian FYs start in July and end in June, FYs were selected for the 2 years preceding the initiative change. Data were extracted for item codes for in-person and videoconference services for sessions of any duration undertaken in or outside of consultation rooms provided by clinical psychologists (items 80000-80015), registered psychologists (items 80100-80115), social workers (items 80150-80165), and occupational therapists (items 80125-80140).[11] Data for item codes for mental health services provided by general practitioners and consultant psychiatrists were excluded as separate item codes for reimbursement for medical consultations undertaken by videoconference had not been established at the time of the initiative change. For the period November 2017 to August 2018, up to 7 of 10 sessions were able to be provided through videoconference under the Better Access initiative, with one of the first four sessions required to be delivered in-person. From September 2018, eligible patients were allowed to access all of their sessions (up to 10 per year) via videoconference.

Data analysis

Descriptive statistics were used to examine service use during the 3-year period. Activity data (number of consultations) were categorized by profession delivering the service and by patient demographics (sex, state of residence, and age). Because sessions that were <50 minutes in duration accounted for a small proportion of overall activity, all MBS item codes were aggregated and reported collectively for each profession and modality.

Results

Before the introduction of a videoconference modality, the MBS funded approximately 4.9 million and 5.2 million in-person mental health consultations delivered by allied health professionals in the 2015 to 2016 and 2016 to 2017 financial years, respectively. In the 1-year period after the introduction of videoconference under the Better Access initiative, the total number of Medicare-reimbursed episodes for mental health services was approximately 5.7 million for in-person and 4141 for videoconference consultations. This shows that videoconference consultations represented 0.07% of the total psychological services in the first year after its introduction. Based on the estimated Australian population in June 2018, the average mental health service use reimbursed under this initiative was approximately 22 600 in-person and 17 videoconference consultations per 100 000 people. It should be noted, however, that approximately 14% of the Australian population are located in the geographical area (Modified Monash Model regions 4-7) for eligibility to access the Medicare mental health videoconference item numbers under the Better Access initiative. Table 1 presents the annual in-person and videoconference mental health service activity for July 2015 to October 2018 by profession of the service provider, patient sex, state jurisdiction and patient age group.

Difference by allied health profession

The pattern of allied health professional activity was observed to be stable across the 3-year data collection period, with registered and clinical psychologists delivering the majority (93%) of mental health services and social workers and occupational therapists delivering the remaining (7%) consultations (Table 1 and Fig. 1). This pattern in allied health profession activity remained largely consistent between modalities in the first year after the introduction of videoconference; however, registered psychologists accounted for slightly more videoconference consultations compared to in-person consultations after the initiative change.

Patient sex and age

Female service use accounted for >60% of the total Medicare-reimbursed mental health service activity, remaining stable across the 3-year data collection period. This sex difference persisted across modalities, with female service use accounting for 69% of videoconference consultations. Patients aged 25 to 54 years had the highest mental health service use across the 3-year data collection period, contributing to more than half of both the in-person and videoconference consultations.

Differences by state jurisdiction

Australia's three most populated states (New South Wales, Victoria and Queensland) accounted for approximately 80% of in-person and videoconference consultations across the 3 years of