THE IMPACTS OF ANXIETY AND DEPRESSION ON THE MENTAL HEALTH COST CURVE

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(25 min presentation + 10-15 min Q&A)

Introduction

- Add my own acknowledgement of the traditional owners of the land on which we meet, and pay my respects to their elders past and present. And to acknowledge Aboriginal and Torres Strait Islander peoples in the room today.

- As I'm sure is the case with all health funds, I agree with Informa's overview of this conference that it will be innovation and new business strategies that will drive solutions to the issues facing private health insurance, including health inflation and cost management.

- Much of that innovation will be need to be business system innovation.

- Mental health, or mental ill health, is definitely a segment of the health care system that warrants a focused effort on innovation because the current system appears to be failing.

- Professor Ian Hickey, who is co-director of the Brain and Mind Centre at the University of Sydney, says depression is the condition most likely to take you out of school, out of work and impact on participation in your family life. Since the mid-1990s we have known that depression is the fastest growing area of chronic disability in the world. But we are not responding fast enough—we could do much better.

- I note this week data has been released that people with a serious mental illness are dying on average 14 to 23 years earlier than other Australians. Ahead of a speech to the National Press Club this week, Professor Allan Fels, Chair of the National Mental Health Commission, said people with a mental illness are six times more likely to die of cardiovascular disease and four times more likely to die of respiratory disease. This is alarming.

- In Australia, the use of antidepressants has doubled from 2000 to 2011. A 2013 study by the OECD across 33 countries revealed nearly 9 percent of the Australian population is prescribed anti-depressants, second only to Iceland. And this is despite the fact that the Better Access program was introduced about 10 years ago to provide access to psychological therapies.

- So, after a decade of this model, as an adjunct to current practice perhaps we need to look to other pathways for the many Australians suffering mental ill health.

- I'm hoping to do four things today before I open up for questions.

- **First,** I'll put mental health in some context, both in the broader health system and within private health insurance.

- **Second,** I'll look at what bending the cost curve on mental health could look like.

- **Third**, I'll run you through a program we have implemented that is beginning to do just that.

- **And finally,** I'll explain my concern about how the current funding arrangements for mental health service delivery are stifling innovation, the very theme of this summit.

Peter and Susan's story

- But I want to start with Peter and Susan.

- When we look to define mental health—or put some parameters around it—we understandably default to quantitative data.

- Prescriptions for antidepressants, GP mental health plans commenced, hospital separations—these are all valid measures.

- But how mental health, or mental ill health, actually feels, how it presents, is harder to pin down. It does so in a myriad of ways.

- **(PP SLIDE 2)** This is a quote from Peter, a 63 year old who works full-time as a general manager. He is one of the clients in the mental health program I mentioned.

- You can read it for yourself, but Peter's feelings of sadness and worthlessness are personally crushing for him. And his anxiety about being at work is telling in terms of the ripple effect into workplaces and the broader economy.

- **(PP SLIDE 3)** And this is a quote from Susan, a 31 year old part-time worker in a corporate environment.

- Again, Susan's personal thoughts about the difficulty of facing work situations, and of her eating for comfort suggest a ripple effect through other elements of the health system and the economy.

- So as I proceed to look at mental health more broadly, keep Peter and Susan in the back of your mind. They could be your work colleague, your family, or your friend.

Mental health—the big picture

- So, what *is* the environment in which private health insurers are operating when it comes to mental health?

- Given everyone in this room is likely to know, or at least know of, a Peter or a Susan, it's not surprising that the prevalence data is stark.

- Here is a very quick overview.

- The most recent ABS National Survey of Mental Health and Wellbeing is, unfortunately, ten years old now. But there is little to suggest quantum shifts in prevalence, and there has been useful recent work done by the Department of Health & Ageing and the Australian Institute for Health & Welfare.

- **(PP SLIDE 4)** At a population level, one in five adults experience a mental disorder within a 12 month period.

- Most prevalent are anxiety disorders such as social phobia, which affect one in seven adults, or 14 percent of the population.

- Within a given year, about 6 percent of adults suffered affective disorders, most prominently depression.

- The Department of Health has more recently sought to understand the severity and impact of these mental health disorders.

- In 2013, the Department of Health found between 2 and 3 percent of Australians—around 600,000 people—have severe mental illness. This includes not only those with psychosis, but also those with severe depression.

- Around 4 to 6 percent of people have a moderate disorder, and 9 to 12 percent a mild disorder. By extension we are talking about millions of people.

- More recent ABS work in FY14 on the mental health of young people aged 4-17 found one in seven had met the clinical criteria for a mental health disorder in the last 12 months. That's 560,000 of our children.

- Over 7 percent, or 280,000 young people suffered a major anxiety disorder and nearly 3 percent, or 112,000, a major depressive disorder.

- In terms of Australia's overall disease burden, calculated in 2011, anxiety and depression accounts for about 6 percent.

- Sorry for this blizzard of statistics, but it all points to one thing. Young or old, mental health is a big problem, and it's not going away.

- **(PP SLIDE 5)** I have one more prevalence statistic I perhaps find most telling. According to an Ernest & Young/Reach Out Australia report in 2015 entitled "A Way Forward: Equipping Australia's Mental Health System for the Next Generation", 75 percent of mental health problems first appear before the age of 25.

- Yet more than 70 percent of young women and 80 percent of young men who need help and support at that time don't get it, either through the public or private healthcare system.

- Bear that in mind as we proceed.

Mental health within PHI

- Those here from private health insurance won't be shocked to know that hospitalisation costs for mental health episodes is one of the highest for healthcare funders and is continuing to increase at one of the fastest, if not the fastest rate.

- **(PP SLIDE 6)** Across the private health insurance sector, the hospital benefits paid out for mental and behavioural disorders has increased from just over $75 million in 2013 to $120 million in 2016, that's a 60 percent increase in just 3 years.

- **(PP SLIDE 7)** The number of episodes of care has increased 53 percent in 3 years.

- **(PP SLIDE 8)** And the number of bed days has increased 50 percent in the same 3 years.

- Australian Unity has a similar experience with its outlays for mental health.

- Our own data shows that the average length of hospital stay for recurrent depression is 19 days, and most people will present with multiple admissions each year.

- Our average hospital cost per patient, at near $20,000 a year, is slightly higher than the industry average of about $17,000.

- And given that depression is the condition most likely to take you out of school, out of work and impact on participation in your family life, this clearly goes well beyond the impact on the health system.

- It is clearly not a sustainable situation for the individuals, funders or the economy more broadly.

Bending the mental health cost curve

- It doesn't require much imagination to start to worry about the mental health cost curve.

- More patients being diagnosed each year, increasing utilisation, and a funding model where payments are made for activity not outcome.

- Just to service population growth, we will need *more* acute mental health hospitals both in the public and private sector, *more* MBS subsidised mental health-related services, *more* GP mental health plans, *more* mental health professionals, *more* nurses, *more* carers, *more* medications.

- Then there is the opportunity cost of people with poor mental health. Sick days, underemployment, lost productivity, people living on government support—including disability payments—rather than earning and paying taxes.

- Last year the Royal Australian and New Zealand College of Psychiatrists released a report about the economic cost of serious mental illness. It calculated the economic cost of people with mental illnesses including schizophrenia, bipolar disorder, psychosis and severe anxiety and depression to be in the order of $56 billion, or 3.5 percent of the economy.

- And I agree with Professor Allan Fels, who in commenting on this report said mental health was a significant problem for the economy and the current substantial public investment is reaping poor returns. He calls it "payment for failure".

- The public investment is more than considerable, with $8.5 billion in FY15 in mental health spending currently dominated by acute care funding for states and territories.

- As a funder via private health insurance, the growth in claims data for mental health has stood out for eight years. We were seeing people time and again bounce in and out of hospital for severe anxiety and depression even when their length of stay was considerable.

- The cost to the fund was large, and growing—seemingly uncontrollably.

- As mentioned, we had hospital data showing people suffering an episode of severe anxiety and depression staying in hospital for an average of 20 nights.

- And they were returning to hospital for similar stays three or four times a year.

- I was personally shocked to hear this when we first started looking at this data.

- It quickly became clear to us that there is a very big gap between people coming out of hospital and the services offered in the community or primary care.

- I will say there **has** been increased investment in primary mental health care—principally through the Better Access program—however it is very difficult to gauge the success of this investment, as there is little information available on outcomes, either in terms of recovery rates or the cost-effectiveness of interventions.

- So, about six years ago, we decided to act.

MindStep concept

- We searched for some time for the right model of care.

- We were looking for a community-based, stepped model of care that would help fill that gap between a hospitalisation for depression and/or anxiety and treatment by a GP or primary care clinician.

- Eventually we adapted a model from the UK public health system known as Improving Access to Physiological Therapies, or IAPT.

- The model was also used more recently by Flinders Medical Centre in South Australia in acute settings.

- It is a Cognitive Behavioural Therapy (or CBT) program for individuals diagnosed with clinical depression and/or anxiety.

- Why did we choose to adapt this approach? For many reasons.

- **First,** it works. More than one million people have participated in the program in the UK. It shows demonstrable improvement in individual outcomes, with a recovery rate of just under 50 percent through IAPT's first three years.

- **Second,** it is credible, repeatable, and scalable. It is based on the clinical guidelines in place within the NHS in the UK.

  Third, it is a model of care that fits within our current Remedy Healthcare model of care. It is highly targeted, measurable and recognises that people seldom live with just one chronic condition, usually depression and anxiety is co-morbidity with a range of physical chronic diseases and people need to be treated holistically. Our experience shows that one in three people with a chronic physical disease also have anxiety and/or depression.

MindStep uses phone-based coaches to deliver structured, guided self-help, along with tailored workbooks in areas such behaviour activation and relapse prevention. The program also has very clear protocols for "stepping up" care as necessary and strict clinical oversight.

- **(PP SLIDE 9)** We see MindStep as filling a critical gap in the current system. Too often, people come out of hospital after an episode of depression or anxiety without sufficient support in the community.
- This can and does lead to a debilitating (and expensive) cycle of hospitalisations.
- Under the Stepped Care model that you can see here, the MindStep program can potentially break that cycle as it is positioned between primary care and low intensity community-based care.

So what exactly does MindStep do?

- **(PP SLIDE 10)** It provides weekly telephone support over 3-4 months, offering guided self-help for anxiety and depression through CBT.
- Importantly, it is designed to complement, not replace, the usual care provided by clinicians, either the GP or mental health specialists.
- And we constantly evaluate, both individuals undertaking the program, and the program itself.
- Each call between coach and client is reviewed and assessed by a clinical supervisor, who is a mental health professional.
- Evidence-based clinical risk assessment tools are utilised at each and every session to determine clinical progress and assess risk.
- The software provides real time alerts to coaches and supervisors in the event of escalating psychological distress.
- We have a Chief Medical Officer, Dr Nancy Huang, who oversees the clinical governance of the program.

MindStep results

- Our MindStep program has now been fully operational for over 18 months.
- Based on the first nine months of data, the recovery rate for all enrolled clients is 58 percent, higher than the UK IAPT version of the program.
- And three in four people experienced a clinically significant improvement in symptoms.

- Once enrolled, the drop-out rate was just 14 percent, with a further 5 percent deemed not suitable for the program, with 18 percent stepped up to more intensive interventions.
- Importantly, there is clear promise on the cost side.
- In an independent evaluation of the claims data from our own fund, there was a reduction of readmissions by 2.5 episodes which equates to a 39 percent reduction in the readmission rate, and a fall of 12.5 days in length of stay or 53 percent. Based on the reduction in length of stay alone, there has been a reduction in claims costs of $7,819 per participant.
- While it's true that it is still early days in terms of results, they are clearly promising.

Peter and Susan

- But let me come back to Peter and Susan.
- Peter and Susan have both been through the MindStep program.
- **(PP SLIDE 11)** The graphs on the right are a little hard to decipher, but they are PHQ, GAD and W&SAS scores. Essentially the news is good for Peter.
- More telling is the qualitative input from Peter, how he is managing his anxiety in the home with his family and in the workplace.
- **(PP SLIDE 12)** It is a similar story with Susan, who is now able to manage full days in her workplace.

Conclusion

- It's tempting to end on this uplifting example of how an innovative mental health program, created in response to swelling mental health costs and gaps in care within the private health insurance system, has changed lives for the better.
- But I won't.
- Instead, I want to point out that this type of innovative approach, which is ripe for use in the public system as well as the private, and can reach people anywhere in the country, is failing to be recognised within the current mental health funding arrangements.
- For example, GPs typically put in place a metal health plan for patients presenting with anxiety and depression, which primarily entails funding for a set number of visits to a psychologist or psychiatrist.

- Outcomes in this fee-for-service approach can be highly variable and difficult to measure in terms of recovery rate and cost-effectiveness. Innovation within this pathway is also difficult.
- As funding moves towards Primary Health Networks, our experience to date suggests that most of the PHN commissioning for anxiety and depression is based around the current ATAPS funding methodology and delivery model.
- Again, the appetite for innovation appears low.
- So I'll leave you with a call for health care policy makers to lift their gaze from what has been done before to what can be done.
- For me, there's not that much risk in that, and the potential for great reward.
- Thank you.

ENDS