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2014 APHCRI / ICES International Visiting Fellowship Final report

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Final report on 2014 APHCRI / ICES (Institute of Clinical Evaluative Studies) International Visiting Fellowship

EXECUTIVE SUMMARY

Australia and Canada are both high-income countries with health care systems that aspire towards universality. If this aspiration is being fulfilled then we would see more equity of access to mental health services, especially for those in low socioeconomic populations and those living outside of major cities. Mental illness is associated with socioeconomic factors and service utilisation is also associated with geography, but population-level information on this is limited.

This study used national surveys and national health service activity data from Australia and Canada, and aimed to better understand factors affecting equitable access to mental health care. We focus on general practitioners / family practitioners (GP / FP) and psychiatrists, given that we have service activity data with reasonable comparability. While both providers are prescribers of medication, both also play important roles in providing people with access to appropriate bio-psycho-social interventions that may assist with symptom management and relapse prevention.

Key messages

- > One person in ten has experienced severe psychological distress during the previous month in both Canada and Australia. In urban and rural areas this rate was similar.
- > GP / FP services for mental health in both countries decreases by about 50% (per population) as we move from major urban to rural areas. Psychiatry services decrease by 70% or more.
- > Severe distress is related to income in both countries, affecting many more people in the poorest income quintile (21-26%) compared to the richest (6%).
- > Considering the lowest income quintile in both countries, Australians showed a five percent increase in severe distress compared to Canadians, and this was a statistically significant increase. If we consider this distress as avoidable, then this would affect over 160,000 Australians every month.*
- > One could attribute this five percent increase to the distributed rate of federally-funded psychiatry services in Australia at about one-third the rate in the poorest income quintile areas compared to the richest areas. In Canada, these service rates are the same in the poorest and richest quintile income areas.
- > The greater number of GP / FP services delivered in Canada (per population) across all income quintiles might be associated with factors including less stigma, perhaps less onerous claim systems and the law that prohibits physicians from charging gap-fees in Canada.
- > The available service data suggested that more equitable psychiatry services in Canada particularly for those with low incomes might be associated with the law that prohibits Canadian physicians from charging gap-fees.
- > Australian psychiatry service activity reported herein can be interpreted as an extreme minimum, as other non-Medicare data was out-of-scope. Unlike in Canada, which has only one health care system, Australia has the federal-funded (Medicare) system plus separate State and Territory systems.

- > Collating all Australian mental health service data together would improve the capacity for research including future contributions to primary care and mental health policy research.

* This increase was maintained after adjusting for demographic differences of age and sex in the two countries.

Background

ABOUT THE FELLOWSHIP

This APHCRI / ICES Visiting Fellowship supported an early career researcher to attend and perform research, as a visiting scholar, at the Institute for Clinical Evaluative Sciences (ICES) in Ontario, Canada. ICES has developed vast, longitudinal databases that can be accessed for a wide range of research purposes. ICES multidisciplinary teams include expert scientists, statisticians and epidemiologists, as well as specialists in knowledge translation and information security, privacy and information technology. Their expertise at using ICES' array of linked datasets is the foundation of the innovative approach to research at ICES. ICES research results in an evidence base that is published as atlases, investigative reports and peer-reviewed papers, and is used to guide decision-making and inform changes in health care policy and delivery.

The visit was for two months and occurred between July 6th 2015 and August 21st 2015. The project preparatory work completed in the months prior to the visit made it possible for the Fellow to maximally use their time on-site at ICES. At ICES, the Fellow spent the two months conducting the required analyses and drafting two research papers. One of these papers reports ICES registry data and the other reports national survey data from the 2012 Canadian Community Health Survey, Mental Health. The Fellow's collaboration with ICES is continuing through extending the publications and investigating other opportunities to work together.

The ICES supervisor was Elizabeth Lin, PhD, Adjunct Scientist, Centre for Addiction & Mental Health, Institute for Clinical Evaluative Sciences (ICES) and Associate Professor, Department of Psychiatry, University of Toronto. Alex Kopp, Chief Data Analyst and senior data analyst at ICES cut the data.

The objectives of the APHCRI / ICES Visiting Fellowship included 1) providing the Visiting Fellow with an overseas research and policy immersion experience focused on health policy as seen from a family medicine and/ or primary care perspective; 2) sharing lessons learned from Australia and developing a multinational perspective and network of contacts to facilitate policy exchange and ongoing collaboration; 3) developing infrastructure and improving the capacity of Australian Primary Health Care researchers, and 4) providing the overseas research centre with a source of ideas, energy, competencies and services that enhance its performance and contributions to primary care policy research.

INTRODUCTION TO THE RESEARCH

More equitable access to mental health care for vulnerable populations are objectives of both Australian and Canadian governments, especially for those in low socioeconomic populations and those living outside of major cities. Both countries have mental health services that are part of a universal health care system; thus equitable access should be achievable. Whilst many previous studies from both Australia and Canada have documented that mental illness is associated with socioeconomic factors and service utilisation is also associated with geography, population-level information on this is limited.

In both countries, the roles of general practitioners / family practitioners (GP / FP) and psychiatrists include medication management as well as providing people with access to appropriate bio-psycho-social interventions that may assist with symptom management and relapse prevention. In Australia, as well as Canada, primary care is the highest prevalent setting for mental health care and therefore this study includes mental health services provided by GP / FP. Service activity data from GP / FP and psychiatrists is similar in both countries, thus enabling a comparison.

Overall, the Fellowship research used national surveys and national health activity data from Australia and Canada, and aimed to better understand factors affecting equitable access to mental health care.

RELATED AUSTRALIAN RESEARCH PRIOR TO THE ICES VISIT

The new research initiated by the Fellowship built on the Fellow's recent population-level research using Australian national data (Enticott, et al. 2015; Meadows, Enticott, et al. 2015):

- > In a recent study in which the Fellow had an important role and was acknowledged as the second author (Meadows, Enticott, et al. 2015), the Fellow examined national mental health care data and highlighted important socio-economic and geographical disparities associated with utilisation of Federally-funded (Medicare) adult community-based mental health services across Australia. Increasing remoteness was consistently associated with lower service activity; for example, per 1000 population, the annual rate of use of general practitioners / family practitioners (GP / FP) mental health visits was 79 in major cities and 25 in remote areas. Apart from GP / FP usage, higher socioeconomic disadvantage in areas was typically associated with lower usage; for example, per 1000 population per year, psychiatry visits were 117, 55 and 45 in the highest, middle and lowest advantaged quintiles, respectively (Meadows, Enticott, et al. 2015).
- > Another recent study lead by the Fellow, examined psychological distress and mental health using national health surveys in Australia. This study examined the Kessler Psychological Distress Scale (K10) data in National surveys. Overall, approximately one person in ten reported recent psychological distress at high/very-high level. This finding varies more than twofold depending on socio-economic status of area with 16.1%, 13.3%, 12.0%, 8.4% and 6.9% affected in the most to least disadvantaged quintiles respectively across Australia in 2011/12. In the most disadvantaged quintile, the percentage (24.4%) with mental disorders was fifty percent higher than that in the least disadvantaged quintile (16.9%) in 2007 so this trend was less strong than for K10 distress (Enticott et al. 2015).

Methods

PSYCHOLOGICAL DISTRESS IN CANADA AND AUSTRALIA

The prevalence of elevated psychological distress across Canada and Australia was compared as measured by the Kessler Psychological Distress Scale (K10) data available in recent national surveys.

The hypotheses were

- > In both Canada and Australia, the overall rates of severe psychological distress will be similar, both overall and within sub-groups of household income quintiles and broad geographic areas.
- > In both countries, the highest rates of psychological distress will be in areas characterized by low income.

Data sources

The Canadian national survey examined was the 2012 Canadian Community Health Survey – Mental Health (CCHS-Mental Health), which contained both K10 and mental health disorder information. This survey data is available publicly. Although this research did not use ICES data, it was informed by the extensive resource dictionary available at ICES and Canadian team members who provided the context on how to interpret findings within the Canadian health setting.

Two Australian national surveys were examined. These were the 2011/12 National Health Survey (NHS) as it had recent K10 data; and the 2007 National Survey of Mental Health and Wellbeing (NSMHWB) as it had mental disorder information not available in the NHS.

Main outcome measure

Severe distress defined as the K10 bands of high or greater distress.

Geographic regions

Comparable broad regions examined were metropolitan (population >100,000) and non-metropolitan areas: census metropolitan areas (CMA) and non-CMA in Canada; and major urban and non-major urban in Australia.

Ethical clearance

Ethical clearance was not required as the publicly available data used was in non-identifiable format, and satisfied section 5.1.22 of the National Statement on Ethical Conduct in Human Research.

Statistical analyses

Descriptive frequencies were used and population weights applied to report the prevalence of elevated distress in each country, and within sub-groups defined by common socio-economic and demographic factors that are known to influence mental health. Several multivariate models were created to adjust for age and gender. The multivariate method was logistic regression to determine odds ratios (ORs) for the outcome of severe distress (yes/no).

Peer-reviewed journal publication (in progress)

The Fellow will be the first author and the other authors listed below are in alphabetical order with the final order and included names yet to be decided. The working title for this paper is, "Prevalence of psychological distress and mental health disorder in Canada and Australia." Enticott J.C., Lin E., Meadows G.N., Patten S. (Canadian colleague), Shawyer F. (Enticott et al. submission expected 2016a).

MENTAL HEALTH SERVICE ACTIVITY RATES BY GEOGRAPHICAL AND SOCIO-ECONOMIC MEASURES

In this part of the research, the hypotheses are that

- > Psychiatrist and primary-care mental health services are utilized equitably throughout Ontario
- > Visits to a psychiatrist will be more equitable in Ontario, Canada, compared to Australia.

The second hypothesis is based on the differing fee structures in the universal health scheme of each country: In Canada it is illegal to charge more than the provincial guided fee code amount; whereas in Australia, physicians can charge a co-payment above the Medicare fee. This co-payment has no upper limit and is paid by the patient or sometimes by private health insurance if the patient has this extra insurance.

Data sources

ICES data, specifically the OHIP database. This database has information about all physician consultations in Ontario, Canada including the location of each visit plus diagnosis codes. Data from the previous eight years were examined: July 1, 2007 to June 30, 2011; and July 1, 2011 to June 30, 2015. The earlier period allowed for a direct comparison with the Fellow's Australian study (Meadows et al. 2015) and is reported within this document.

National Australian Medicare data from 1 July 2007 to 30 June 2011. Data included all Federally-funded (Medicare) mental health services.

Main outcome measures

Adult service use rates, similarly defined in my Australian paper (Meadows et al. 2015).

Ethical clearance

ICES ethical and privacy clearances obtained.

Statistical analyses

Descriptive statistics are reported and compared between Australia and Canada.

Peer-reviewed journal publication (in progress)

The Fellow will be the first author and the other authors listed below are in alphabetical order with the final order and included names yet to be decided. The working title for this paper is, "An analysis of Ontario community-based mental health service activity rates by geographical and socio-economic measures, and comparison with Australia." Enticott J.C., Glazier R., Kurdyak P., Lin E., Meadows G.N., Patten S. (Canadian colleague), Shawyer F. (Enticott et al. submission expected 2016b).

Results

PSYCHOLOGICAL DISTRESS IN CANADA AND AUSTRALIA

One person in ten has experienced severe psychological distress in the previous month prior to survey in both Canada and Australia. More precisely, this is 12.0% (95% Confidence Intervals: 11.5-12.5) in Canada, and 11.1% (95% CI: 10.5-11.8) in Australia.

The percentages of those experiencing severe distress were similar in metropolitan and non-metropolitan areas in both countries. In Canada the percentages were 11.8% (95% CI: 11.2-12.4) in metropolitan areas and 12.7% (95% CI: 11.9-13.5) in non-metropolitan areas. Similarly in Australia the percentages were 11.0% (95% CI: 10.2-11.9) in metropolitan areas and 11.5% (95% CI: 10.0-12.9) in non-metropolitan areas.

Severe distress was related to income in both countries, significantly affecting many more people in the poorest income quintile (21-26%) compared to the richest (6%), see Figure 1. After adjusting for effects of age and gender, the relative odds for Canadians having severe distress in the poorest income quintile compared to the richest quintile were 3.5 (95% CI: 3.0-4.1), and for Australians were 6.1 (95% CI: 4.7-8.0). Even after adjusting for additional factors of working status and education level, the relative odds for Canadians having severe distress in the poorest quintile were 2.3 (95% CI: 2.0-2.7), and for Australians were 3.1 (95% CI: 2.2-4.3).

In the lowest income quintile in both countries, Australians showed a 5% increase in severe distress compared to Canadians, and this was a statistically significant increase. i.e. prevalence of severe distress in the poorest income quintile was 26.4% (95% CI: 23.3-29.4) in Australia and 20.8% (95% CI: 19.5-22.3) in Canada, see Figure 1.

More severe distress in Australians within the poorest quintile compared to Canadians was also evidenced in the multivariate logistic regression analysis. After adjusting for effects of age and gender the relative odds for having severe distress in the poorest income quintile compared to the richest quintile in Australians was 6.1 (95% CI: 4.7-8.0), which was significantly higher than in Canadians with 3.5 (95% CI: 3.0-4.1).

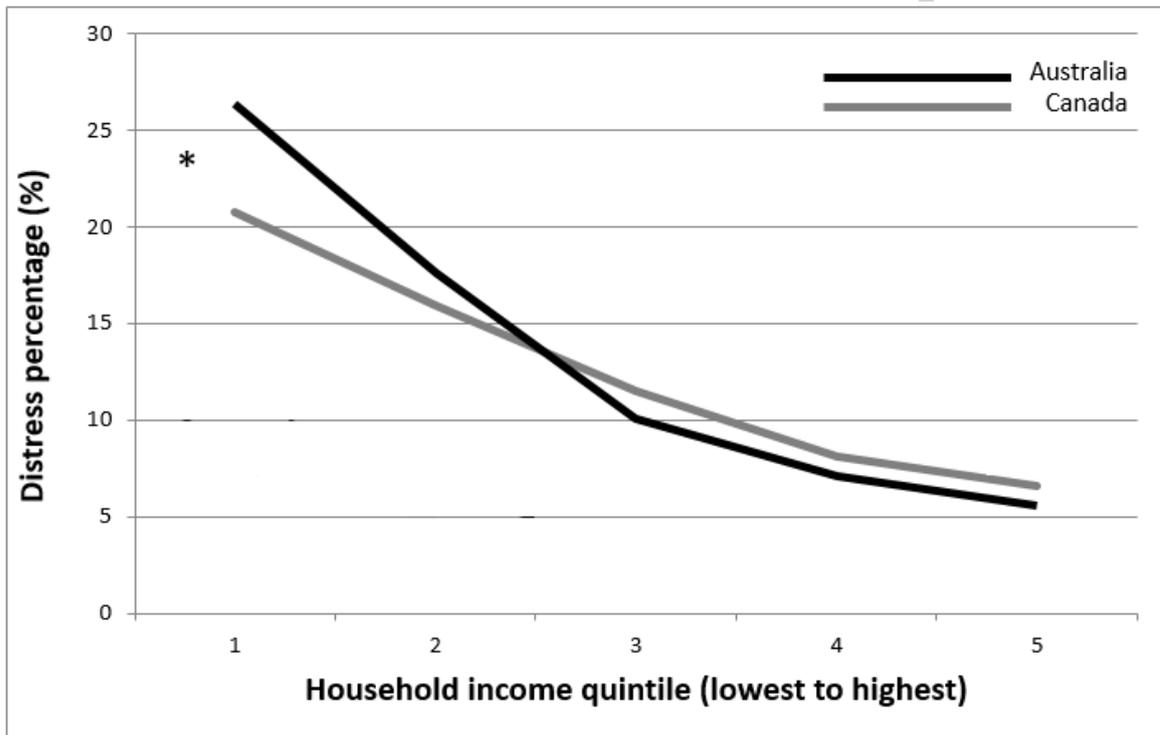


Figure 1. Severe psychological distress by household income in Australia and Canada.

*In the poorest household income quintile there was a significant difference between the two countries as Australia had a significantly higher percentage (26%) with severe distress compared to the 21% in Canada.

MENTAL HEALTH SERVICE ACTIVITY RATES BY GEOGRAPHICAL AND SOCIO-ECONOMIC MEASURES

This research involved the examination of over 45 million service utilisation data-points in the OHIP database. The Canadian health services data was comparable to the Australian Federally-funded Medicare Benefits Scheme items, which we had for the same time period (Meadows, Enticott, et al., 2015). Table 1 shows the service rates per 1,000 people in the population.

Table 1 shows that Australia has lower activity levels compared to Canada, as psychiatrist and GP / FP mental health service rates (per population) are approximately 2 to 3 times greater in Canada than in Australia. This disparity would decrease if we could include the non-Medicare public services in Australia.

GP / FP services for mental health in both countries decreases by about 50% (per population) as we move from major urban to rural areas. Psychiatry services decrease by 70% in Ontario, Canada, and 86% in Australia. See Table 1.

Psychiatry services in Australia appeared to be less equitable compared to Canada, as the service rates for psychiatry (per population) in Australia are distributed at about one-third the rate in the poorest income quintile areas compared to the richest areas. Whilst in Canada these service rates are the same in the poorest and richest income areas. See Table 1.

GP / FP service rates for mental health in both countries appears to be similar regardless of income quintile, see Table 1, which indicates that these services are more equitable.

Table 1. Mental health services: use rates per 1000 population per year, 1 July 2007 to 30 June 2011

	General Practitioner / Family Physician		Psychiatrist	
Year (fiscal year)	Ontario/Canada	Australia	Ontario/Canada	Australia [§]
2007/08	289	55	151	74
2008/09	282	71	153	72
2009/10	277	79	154	71
2010/11	267	90	154	71
Geographical regions				
Urban	297	78	170	79
Rural	171	44	51	11
Neighbourhood income quintile[^]				
Quintile 1 (poorest)	293	67	167	23
Quintile 2	279	75	143	31
Quintile 3	270	72	131	54
Quintile 4	275	80	139	71
Quintile 5 (richest)	270	71	180	67

[^] Australian median income for Local Government Areas as derived in the 2011 census, and Canadian Neighbourhood income based on 2006 census at the Dissemination area level.

[§] Australian psychiatry service activity rates can be interpreted as an extreme minimum, as other non-Medicare data was out-of-scope.

Discussion

We set out to test four hypotheses, which were:

1. In both Canada and Australia, the overall rates of severe psychological distress will be similar, both overall and within sub-groups of household income quintiles and broad geographic areas.
2. In both countries, the highest rates of psychological distress will be in areas characterized by low income.
3. Psychiatrist and primary-care mental health services are utilized equitably throughout Ontario.
4. Visits to a psychiatrist will be more equitable in Ontario, Canada, compared to Australia.

This research found our first hypothesis was in part supported since some similarities were found in the prevalence of severe distress in both Canada and Australia. Similarities included the overall prevalence of severe distress affecting approximately one person in ten during the previous month in both countries. The overall prevalence was similar also in metropolitan and non-metropolitan areas in both countries. The hypothesis that rates of severe distress in both countries would be similar within each quintile for household income, however, was not entirely supported. Severe distress in the lowest income quintile (26%) in Australia was five percent higher compared to those in Canada (21%), and this was a significant increase. In the other four quintiles differences between the countries were less than four percent and considered as essentially the same.

The second hypothesis was supported as a pattern of the highest rates of severe distress in the poorest income quintile (21-26% severe distress), then decreasing to finally reach a minimum rate of 6% in the richest quintile was similar in both countries.

The third hypothesis was reasonably supported as both psychiatrist and GP / FP mental health services appeared to be utilized reasonably equitably throughout Ontario. Service rates for both service providers in the richest and poorest income quintiles were similar.

The fourth hypothesis was also found to be supported, as the Australian psychiatry services appeared inequitable as there were service rates (per population) at approximately only one-third in the poorest income quintile compared to the richest quintile in Australia. Whilst in Canada, the rates were similar in the poorest and richest quintiles.

While conducting this research, another finding emerged that indicated that Ontario's universal mental health care has GP / FP and psychiatry raw service counts and service rates (per population) that are 2-3 times greater than that seen in Australian's universal (Medicare) mental health system. Australian psychiatry (universal / Medicare) fee codes do not represent all psychiatry services, and it is likely that the overall number of psychiatry visits in Australia would increase if we could include the State and Territory funded psychiatry services too. Accessing this other mental service use information is a future study that was initiated during this collaborative project with ICES.

IMPLICATIONS

Canada and Australia are both high-income and independent countries having histories that include British colonisation, and both countries have mental health services that are part of a

universal health care system. Both Canadian and Australian health and social policy-making need better information on socio-demographic and geographic associations with needs for mental health (Kurdyak et al. 2014; Meadows et al. 2015). The APHCRI / ICES visiting scholarship enabled this examination of equity into mental health care services in another country with a universal health care system, Canada. By comparing the Australian and Canadian results, we can gain key insights for creating equitable mental health care.

WHERE TO INTERVENE?

- > At the population-level, severe psychological distress is common and affects approximately one person in ten each month in both Canada and Australia. Severe distress can be managed successfully with appropriate medication management and bio-psycho-social interventions provided or overseen by GP / FP and psychiatrists.
- > Severe distress is related to income in both countries, affecting many more people in the poorest income quintile (21-26%) compared to the richest (6%). Effective interventions to reduce severe distress may achieve the biggest impact in low income areas.
- > Considering the lowest income quintile in both countries, Australians showed a five percent increase in severe distress compared to Canadians, and this was a statistically significant increase and also a population-level policy significant finding. This finding remained significant even after adjusting for demographic differences of age and gender between the two countries.
 - If we consider this distress as avoidable, then this would affect over 160,000 Australians every month.
 - This further supports that interventions to reduce the high rate of severe distress in the lowest income quintile (26%) in Australians might be effective in achieving at least a similar rate as that seen in Canadians in the lowest income quintile of 21%.

SERVICE PROVISION

- > The rate of severe psychological distress was similar in urban and rural areas in both Canada and Australia. Yet GP / FP services for mental health in both countries decreases by about 50% (per population) as we move from major urban to rural areas. Psychiatry services decrease by 70% or more.
 - More services outside major cities are needed in both countries.
- > Equity in service provision does not mean equal access in each neighbourhood income quintile, since need for mental health care is greater in areas with greater disadvantage. True equity would reflect greater service provision in the poorest income quintile following a similar pattern as that for severe distress.
 - The pattern for true equity was not evidenced in either country, although Canada demonstrated better equity in both GP / FP and psychiatry service delivery with similar service rates in the lowest and highest income quintiles.

- The available service data suggested that the more equitable psychiatry services in Canada particularly to those with low incomes might be associated with the law that prohibits Canadian physicians from charging gap-fees.
- > The greater number of GP / FP services delivered in Canada (per population) across all income quintiles might be associated with factors including less stigma, perhaps less onerous claim systems and the law that prohibits physicians from charging gap-fees in Canada.
- > Australian psychiatry service activity reported herein can be interpreted as an extreme minimum, as other non-Medicare data was out-of-scope. Unlike in Canada, which has only one health care system, Australia has the federal-funded (Medicare) system plus separate State and Territory systems.
 - Registries collating all Australian mental health service data together are urgently needed to improve the capacity for health policy research.

OUTCOMES

- > Outcomes of this Fellowship visit are many; in addition to this report, two papers having both Canadian and Australian authors are expected to be submitted to an international peer-reviewed journal(s) in 2016.
- > Investigations on how to obtain Non-Medicare mental health data from the States and Territories in Australia have commenced, and this future project will enrich the current service comparisons between Canada and Australia.
- > An abstract for a Primary Health Care conference in 2016 is planned for submission for a potential presentation by the Fellow, pending funding availability. These results will also be presented at various forums in 2015 and 2016 including the Monash University Department of Psychiatry Day, and the Research Unit's in-house seminar series, School of Primary Health Care seminar series and at least two Health Services and Psychiatry conferences held within Australia or Canada. The Canadian conference will be subject to acquiring a travel grant.
- > Another outcome was the experience the Fellow had to develop a multinational perspective on mental health service provision, and this new knowledge is informing and improving the Fellow's ongoing epidemiological-based health services research.
- > The network of contacts made in Canada by the Fellow have resulted in ongoing collaborations which are assisting the Fellow and the Fellow's research unit with improving the capacity of Australian Primary Health Care including mental health, and future contributions to primary care policy research.
- > Collating all Australian mental health service data together would enormously improve the capacity for research including future primary care and mental health policy research, and I am now an advocate for such a data registry. Establishing platforms and registries such as those in ICES that facilitate so much meaningful health services research in Canada, is something that the Fellow would like to contribute towards establishing in Australia.

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* Submission expected 2016. Fellow will be first author but other author list and order yet to be confirmed.

Appendix

FELLOWSHIP EXPERIENCE

Notes about the Fellow's experience during this Visiting Fellowship at ICES, are below, with particular attention given to the logistics of the Fellowship.

- > ICES data registries are enormous and unlike anything in Australia
- > The compulsory 'privacy' training was efficient and actually very useful
- > Visiting in summer (Canadian summer) was best, as the Fellow would have needed special outdoor clothing in the winter (as it is common to reach cold temperatures of minus 20 degrees Celsius)
- > Many forms to fill out before the Fellow could look at any data
- > It would have been more efficient if the Fellow had completed those forms before leaving Australia
- > Staying close to the facility was good; it made travel to work easy (and quick)
- > There were no hotels near the facility. Instead the Fellow used AirBnB
- > Visiting while students are on holidays meant that the Fellow could have arranged accommodation in a dormitory of a nearby university
- > ICES is most familiar with visiting scholars staying for a year. Many ICES staff appeared 'stressed' that the Fellow's visit was short and worried that they would be instructed to help me without much time
- > Being self-reliant was a most needed characteristic for a visiting scholar on a 'short' visit
- > The Fellow had a very supportive ICES supervisor, Dr Betty Lin, who arranged her diary to spend 2-3 days per week with me. This was probably the most important thing that made the Fellow's visit a success.
- > It would have been good to have been given a schedule of staff/team meetings that the Fellow could go to. The Fellow only went to meetings that they heard about by chance, and invited themselves.
- > Overall a successful visit, and the Fellow has two draft papers resulting from the trip