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STANDING COMMITTEE ON ECONOMY AND INFRASTRUCTURE

REFERENCES COMMITTEE

Subcommittee

Inquiry into primary health and aged-care services

Melbourne — 2 November 2011

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Research Officer: Ms V. Delgos

Witnesses

Mr D. Stokes, senior manager of professional practice, and

Mr B. Li, senior policy adviser, Australian Psychological Society.

**Necessary corrections to be notified to
secretary of committee**

The CHAIR — Thank you for joining us today. Today's hearings, as you know, relate to the inquiry that our committee is undertaking into primary health and aged-care services, specifically the measurement, including budget measures, of primary health and aged-care services and outcomes.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council's standing orders. Therefore you are protected against action for what you say here today, but if you go outside and repeat the same comments, they may not be protected by this privilege. All evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website.

We have allowed 5 to 10 minutes for you to make a presentation, if you would like to begin like that, with the rest of the time taken in exploring your presentation with some questions. I ask if you could begin by introducing yourselves and providing your business mailing address so that we can send you a copy of the transcript.

Mr STOKES — My name is David Stokes, and as described, I am the senior manager, professional practice, for the Australian Psychological Society, and this is my colleague Bo Li, who is the senior policy adviser for the same body. We are a national membership body for psychology and the main body representing psychology in Australia and in Victoria. The reason we have become involved in this obviously is that it is broaching the area of health care and aged services, both areas that many of our psychologists have interface with.

I will just describe briefly the society, and it might help you in understanding our interest in this particular topic because ours has been a sort of fairly high-level policy contribution to the discussion rather than about specific aspects of either of those areas.

We represent some 20 000 psychologists across Australia with something around just over 6000 psychologists here in Victoria. Probably over half of them are registered psychologists under the national registration act, so like doctors, dentists and nurses we come under the AHPRA board as a registered profession. But we also have probably just under half of our members who have acquired a specialisation by postgraduate study and experience, and we have nine areas of specialist endorsement. Perhaps the ones that are most relevant to this discussion are clinical psychologists, clinical neuropsychologists, counselling psychologists, health psychologists and forensic psychologists. There are four others, but I will not go there.

It is important to recognise that we come at this from quite a diverse range of professional interests. Particularly the clinical psychologists, the neuropsychologists and the health psychologists would be focused on many of the issues and interface with many of the patients and clients that come within this domain. Many of them are in private practice, but probably the majority of them are employed in some area of either government or private activity, such as hospitals, community health centres, schools, private hospitals and private agencies of one type or another.

It is because of that diversity that I guess this range of issues that you have raised have particular interest to us, but also it is because psychologists are somewhat obsessed with measurement and concerned to do that both rigorously and accurately, respecting both reliability and validity, that we have looked at your submission and your documents and made some comments. Thank you for the opportunity. This is something we treasure — the opportunity to put the psychological perspective — and that is what we will try to do.

In summary, because we have been fairly explicit both in our analysis of your documentation and in our recommendations, our issues are about definitions because we do not think you can measure without good definitions, and we have made a fair bit of that play, and I hope that has been seen as positive, not critical. We have also done a fair bit of thinking and contribution about the area of measurement and how that might be done, and we have particularly drawn your attention back to the national health performance framework, which we think brings considerable benefit because it has been well developed and well tested, and I think it contributes in terms of your selection of measurement tools. I think probably that is as good a summary of our contribution as we can give, and we are happy for you to address any specific issues you would like us to further comment on.

The CHAIR — Thank you.

Mr RAMSAY — I was waiting for more, actually.

Mr STOKES — I am happy to talk about the major recommendations if that would be of assistance.

The CHAIR — That would be.

Mr STOKES — But I am happy for you to grill us over our recommendations too, whichever you wish us to do.

The CHAIR — Perhaps if we can explore the definitions question a little more because, unlike us, you work in the health system. On the question of the difference between the terms ‘primary care’ and ‘primary health care’, could you perhaps speak to that?

Mr STOKES — Yes, I am happy to. It did seem to us to be a little bit unclear at times which you were referring to, and it is important to understand both. We always see primary health care as the big domain and covering anything, even involving environmental change and social interface in the community, right back, of course, to the interface at primary care level. So while primary care is critical and absorbs many resources in the health-care sector, we have a view of this as being a much broader thing, so that primary health care is that broader view.

In that context let me argue what we constantly argue to yourselves and the health-care industry: that the psychologists take a biopsychosocial view of health, which says it is not just medical; it is both psychological and it is social, and if you do not take that broader view, you are often not providing effective interventions. Therefore that is why primary health care becomes our concern to define and to measure, because in that you are looking at both the social end of the person’s life as well as their biological end. Okay? I guess that is the reason why we have said, ‘Please let’s be clear what we’re talking about here because we can’t measure until we are’.

The CHAIR — That was very helpful, and particularly to hear from you at the earlier part of our discussions, because getting the definitions straight will be important for us all.

Mr STOKES — Absolutely.

The CHAIR — While we grapple with these notions of how you might measure experience at the GP or admissions to hospital — the way that they relate — and aged-care experiences, how would you propose that we measure, or what aspects of the social element of health care would you propose we consider measuring?

Mr STOKES — There were a number of things we highlighted, and Mr Li can butt in when I do not say it quite correctly. One of the first things we talked about was the definition of access being both equal and equitable. That is an example of that, and I think we gave you some case study examples to try to make some sense of those rather subtle distinctions. In many instances in our community there are facilities available so there is equal access, but it is not always equitable because the nature of the individual, including their circumstances and both their education and social backgrounds, impacts on whether they actually access that facility in an equitable fashion. That is one of the things that we want to make sure we measure. Are we actually creating good access, and are we tapping into the issues of access being both equal and equitable? They are crucial aspects of that access discussion.

When we apply that to the issue of, for instance, effectiveness, effectiveness has got to be both biological and social. We gave you the example somewhere that a drug can be shown to be very effective and yet in actual fact its side-effects or impact on the life quality of the individual may be very poor so that the individual says, ‘It may be helping my pain, but it is wrecking other aspects of my life’, and that might be through headache, nausea or something of that nature. We are saying, ‘Let’s not just measure the biological effectiveness but also the social impact on the individual’. On our notions of effectiveness, I think we talked about the two aspects being — —

Mr LI — Are you talking about technical versus allocative? Essentially definitions of effectiveness are being seen as clinician-assessed effectiveness versus quality of life assessed by the individual. While the

clinician may think it is more effective to take one tablet every 4 hours as opposed to two tablets every 2 hours, for instance, the individual may assess that as being more onerous on them because their quality of life suffers as a result of, for instance, taking the more concentrated form of the drug. There is a fine balance between what is effective from a clinician's point of view versus what is assessed as effective from an individual's point of view. It is not always easy to capture that in a health-care setting, because quite often those assessments are done exclusively from the clinician's point of view and not so often from a patient's point of view. How you achieve that balance between the clinician and the consumer is always the trick to ensuring that whatever is being delivered is of benefit to the patient.

Mr STOKES — The paradigm example is that so much of drug effectiveness is measured by randomised clinical trials using biological measures: blood pressure, levels of toxins in the system and things of that nature. We are asking that we also look at the patient's feelings about this so the quality of life becomes an important dimension in any assessment of effectiveness.

Mr LI — If I can draw on that a bit further, the other aspect is in an aged-care setting. In an aged-care setting it is very clinically effective, if I can call it that, to have the patients get up at 8 o'clock in the morning to have their showers and breakfast, have their lunch at midday, have their dinner at 5.00 p.m. and be in bed by 7.00 p.m. We know that not many elderly people have that routine in their lives. They may well prefer to get up late, stay up late and go to bed at 10 o'clock at night. When you are delivering the aged-care service in a residential setting it is very effective to have everyone sticking to the same routine, but from a quality of life perspective that can make a patient feel depressed, isolated and totally bewildered by the new experience they have to go through. Not only are they transplanted into a totally foreign environment, they have to stick to a new routine and so forth. Their quality of life and their mental health suffers as a result of being in a nursing home.

Mr STOKES — I guess what we are saying is that the typical measures of efficiency within the systems are not always the whole picture. Until you broaden it out to that biopsychosocial model of health you miss some of those important dimensions.

Mr RAMSAY — What systems do you have in place to monitor and measure the quality of care for psychologists?

Mr STOKES — Multiple. Let us take a private practice clinician working with depression or anxiety. Many psychologists use 'before' and 'after' measures of those sorts of things — things like the Beck depression inventory or the depression scales of one type or another. When the patient comes to see you, you do a 'before' measure. Some psychologists are even fastidious enough to do 'before' and 'after' measures for sessions. But at the very least you would say, 'Okay, we're going to aim to re-evaluate in 10 sessions to see where we've got'. We have lots of psychologists who can provide us with data about patients who come in with significant or serious depression at session 1, which, just for argument's sake, has gone right down to livable with by session 10.

Those would be our measures, but at the same time, because most measures of depression look mainly at symptoms of depression, you will also be asking the patient questions like 'How did you find the treatment?' and 'Did you find the therapist understanding and listening?'. All the sorts of quality issues about how a patient feels about a service would also be assessed. You know your treatment has been effective but also that you have made the patient feel supported and positive. It interacts with the outcomes of therapy anyway, but you want to know that separately — that there has been a quality service provided, as well as an effective treatment outcome.

That is the sort of thing we are talking about: you have to look at both. This is particularly true in a medical setting where it is much more bio. They may do a very effective job, but you and I know that the best surgeons are sometimes the least helpful in terms of interpersonal relationships and you come away thinking, 'That was a bloody awful experience, but least I'm better'. In that sense, we are looking at both aspects of the process. We understand that you have to focus on the clinical outcomes initially, but we also feel if you are not also taking notice of the person's experience of that process, you are missing out on an important dimension. Does that answer your question?

Mr RAMSAY — Yes. From a physical sense, how do you monitor and collect the data in relation to patients or their therapists? I am sorry, I am not familiar with some of the clinical terms.

Mr STOKES — It depends on the practitioner, but usually it is a questionnaire-based process. When the patient comes in and says, 'I've been referred to or want to see a psychologist', one of the introductory aspects, once the nature and cost of the service has been clarified, is giving them a questionnaire while they are waiting in the waiting room. Some feel that that is too impersonal, so they will do that in the first session of treatment. You will give them a questionnaire which relates to their level of distress, anxiety, depression or inability to lose weight — there are a lot of health psychologists in this domain too. In a neuropsychology sense it would be getting some good history of where the patient has been, what they are suffering and what their problems are. You would do some form of assessment; some of it would be standardised, and some of it would be just conversation based. That gives you a baseline from which you can see whether you can move the patient from being significantly depressed, anxious or unable to follow their diet to the place where they have actually had some success with that process.

Mr LI — I will just add that mental health is not a neat case, if you like. There are studies demonstrating that with chronic diseases such as diabetes or even acute events such as heart attacks there are associated mental health comorbidities. It is not unusual for someone experiencing a heart attack to feel anxious and depressed because they do not know what their lifestyle is going to be for the next 10 or 20 years; they do not know what their life expectancy is. The physical event might have been the trigger, but there are huge ongoing mental health implications as a result of that acute event. While you are fixing up the biological aspects in an emergency room or in a surgery — doing a bypass and what have you — that fixes up the physical symptoms, but it is the ongoing issues of mental health, anxiety and depression, as David mentioned earlier, that will have a longer lasting impact and will involve a huge range of clinicians out in the community.

You may well have people who suffer a heart attack who need specialist support to help them stay motivated to take their medication, because if they do not take that medication they might end up in the emergency room in another 6 or 12 months time. How do you keep a person motivated despite their anxiety and depression? How do you keep a person motivated and engaged in the community? It is not unusual for somebody to withdraw from the community after a heart attack because they fear that they might have another one. It is those intricate psychosocial aspects that are not always immediately addressed in a hospital acute setting but are much more readily addressed in a psychosocial, primary health-care, broad-level setting involving a multitude of clinicians.

Mr STOKES — There is also striking evidence that using psychological interventions post-heart attack reduces the subsequent risk of further heart attack quite substantially. About 30 per cent do not have recurring heart attacks if they get those psychological interventions. There is evidence that those psychological issues in actual fact increase the risk of further cardiac events. That is the sort of stuff we are conscious of and why we work very much in the health sector with a variety of conditions. Does that answer your question? I am not sure I am convinced that I have answered your question.

Mr RAMSAY — You have given me a better understanding. I do not have a clear understanding of your professional role, so regarding the submission there was some doubt about the measurement standards already in place. I guess I was throwing back to you and saying, 'What systems do you use to provide that performance management?'

Mr STOKES — We have talked about the measure that would be equivalent to the medical measure of a drug trial, which is the standardised scale of depression, in the case of depression. There are also the questions: 'How did you find the service?', 'Did it quite meet your needs?' and 'Could it have done some things better?'. It is more the experience of the service rather than the actual outcome of the service that we are also concerned about.

Let us now take it to the hospital situation, because that is probably closer to some of the costs that you are interested in. We would be saying that we are not satisfied that all the measures of effectiveness incorporate comprehensive measures of the patient's needs being satisfied by the process. They need to be more obviously built into the process, and we have used quality of life as an example because that is a standard way of measuring a patient's feelings about the service. We have given you an example; we suggested that the SF-36

is a well-trying measure, but I would go on to say that we are emphatic about the situation that the measures you use for quality of life must fit the population you are dealing with. We are much happier with quality of life measures that are specific to cardiac patients, residential aged-care patients or even community-based aged-care patients, because they seem to be much more sensitive to the needs of those groups and are therefore much more reliable measures of the concerns that we have about the psychosocial end of the patient's experience.

Mr LI — I guess it is always hard to put a dollar value on that patient experience aspect of things. The closest parallel I can draw would be the way in which the community health system operates here in Victoria. We have a very good hospital system, overburdened as it may be. It gets people into the system and out of the system in a reasonable period of time. However, it is that post-discharge transition back into the community and preventing those in that sick population from re-presenting themselves to the hospital that is where the community health services really do come into play. What they do is encourage the patient to look after themselves, improve their lifestyle, attend exercise classes, join walking groups, attend psychology sessions or attend group therapies so that they can stay healthy and remain healthy — relatively — in the community, as opposed to having a relapse and presenting back at the hospital.

How do you measure prevention? It is something that is always difficult. Here is a model in which you can see that there is the interplay between the acute side of things and the psychosocial subacute side of things, where the community is actually helping patients to remain healthy, thereby preventing expensive admissions or readmissions to the hospital, which would burden the system again.

Mr STOKES — So there is another area of measurement that we do not often explore: post-discharge, what did the patient engage in? Did they just go home and continue their lifestyle as it was, or are there ways of measuring those who actually engaged in community health-based activities or referrals to primary care services — physios, psychologists, social workers et cetera — or those who particularly made some different lifestyle choices? The evidence that exercise and fitness is probably more important than anything else in terms of maintenance and avoidance of further health-care problems does not pervade much of our health-care planning. We sort of expect that once we have done the discharge, then good luck if we can actually see those people benefit from what is available, but how much management into the community happens for those people? Some trials where there is considerable investment in follow-up to make sure that people have moved into resources that are available and made lifestyle changes would be a great way of measuring the effectiveness of our health-care system. That is the primary health-care system rather than the primary health system.

Mr RAMSAY — I am just thinking. I have never had a heart attack — and I am touching wood fast — but the psychological impact of having a heart attack, apart from the care and then the after-care, is about losing faith in your body, so when you leave hospital and you have had the stent or whatever service that has been required, where do you fit in your head how you move on? To my mind I would find it particularly difficult given that I would have no trust in what my body was able to do or not do in the future. I see that area as being quite critical — for your profession anyway.

Mr STOKES — That is very important, but also there is the loss of sense of control. Up until this point I seem to have my life in control, and suddenly from within or without — however you view it — I have lost an area of control, because there is an area of uncertainty.

There is also a third area I do not think we fully acknowledge, and it is something that is happening in our study of post-transplant experiences. There are direct physical responses to poor health which impact on the incidence of anxiety and depression. There is no question that something like 50 per cent of people experience depression post-cardiac surgery. Do you know that? Is that clearly set out in the community? No. In actual fact it has been, because of the biomodel, that once you have had your heart attack and you have had your surgery and you are supposed to have recovered, all that stuff just sort of gets ignored and swept under the carpet. We talk a lot to post-bypass surgery patients, and there is a psychological impact — for the reasons you say, but I am sure for even greater reasons — which has enormous consequences for people's ability to work, to continue to work and to fire like they used to fire. It is important that we recognise those aspects.

Mr LI — Perhaps I will just extend that a bit further into the aged-care setting, if time permits. The incidence of depression amongst residents of residential aged nursing homes is much higher than that of the community. I do not know the exact figures, but it is something like three to four times higher, the reason being the case that I illustrated earlier: they have to change to a foreign environment and different routine and also quite often the actual place of residence and the staff are not equipped to deal with some of the psychological symptoms that residents experience. For example, they may well act in a strange manner because the environment has made them more anxious and more fearful. The usual response, or part of the usual response, might be to put them onto some sort of medication to calm them down, whereas the actual root cause of it is psychological distress. Until that psychological distress is identified and addressed the medication can only hide the symptoms, to a certain extent, and then there is the whole issue of polypharmacy where you have to get some other drugs to counteract the side effects of this drug and so on and so on.

We have had studies done in New South Wales by experienced psychologists which demonstrate that if you can address some of the psychological and behavioural aspects of residents, that decreases not only the stress placed on staff and the system but also the costs associated with medications and so forth, so there is another dimension which we need to draw the committee's attention to.

The CHAIR — So how would you approach psychological wellbeing in aged care differently?

Mr STOKES — I guess there are two things we would suggest. If we are going to identify and clarify our goals more precisely, they need to be separate from those in primary care. That is our first contention. The second thing we would say is that you have to look at the broader set of dimensions. It is not just a health or medical issue; it is a health-care issue. For our ideal residential aged care there would not just be the structural and system efficiencies; there would be measurement of the patient's mood, psychological health and physical health as well as interventions that are appropriate to all those needs.

There is a lot of evidence, and Bo has made reference to some of it, that when you manage the mood issues that are very prevalent in aged-care facilities — higher than you would believe — you see that up to 50 per cent of patients have some form of mood disorder. In the community it is 20 per cent, so it is clearly overrepresented in aged-care facilities. What we are saying is that if you are going to address those, you are also reducing some of the costs. We can demonstrate that GP visits drop astronomically when you manage some of those mood and behavioural issues. That is a cost that residential aged care or Medicare has to cover. We are saying that we are not covering the whole range of needs that are being addressed there. Those need to be looked at too.

I am talking big-picture stuff, but coming back, our concerns are that your definitions and measurements could be more rigorous and could meet some of those dimensions in a more effective way if you truly want to look at efficiency and effectiveness, which were the two things we focused on. I think we have identified the effectiveness one. We also talked about looking at efficiency, which was both technical and — the word has gone from my head.

Mr LI — Allocative.

Mr STOKES — Allocative! So we do think that there are ways in which their whole approach could be sharpened, and I would be more than happy to confer further on the sorts of ways in which measurement has been done by psychologists in those domains, but we generally made references to and gave you some references that were appropriate to that discussion.

The CHAIR — Can I just explore the short-form health survey — SF-36 — that you referred to earlier? Could you just describe that to us a little?

Mr STOKES — What that is like?

The CHAIR — And perhaps indicate how that may be used in terms of measuring outcomes and/or even outputs?

Mr STOKES — These people would argue that this is a general tool that can be used across the health system. While we recognise that, in terms of ease and efficiency, having one tool is easier than a dozen, we

would argue that it will give you a general measure. You will get much better value, accuracy and validity if you take location-appropriate tools. Location can include conditions. Rehabilitation, for instance, would be one setting where you would be happily using one set of tools. Aged-care residential places would be another set of tools, which will give you much better information than just the short form of the health survey, but it is a start because at least it is addressing it, and, as you will see, the components that it picks up on are exactly the sorts of things that we are concerned about. They go beyond the physical and include the physical because they are talking about vitality, mobility, loss of pain and so forth, but they also look at the whole question of emotional and social functioning so that they are looking at a broader spectrum.

That is essentially what we are saying — for effectively measuring whether a system is working, you need to look at a broader spectrum of issues, and that is an example of one of the measures. We are not endorsing it as the godsend to the whole process. We are saying it is one example of a well-honed, well-developed, well-standardised and validated test, but there are a heap of them out there and we think they are better if they are, if you like, either condition or locality-focused.

Mr LI — I think many of the community health centres in Victoria have their own patient satisfaction questionnaires and those kinds of questionnaires that tend to engage with the consumer to see whether or not their services and needs were met in an appropriate manner. That is different, as David said earlier about some of the efficiencies of drugs or what have you. A lot of those are location and disease-group specific, so they may not have the same scientific rigour and validity as SF-36, but that is not to say that they are any worse in terms of the quality of data they capture, because they are focusing on a specific group's specific needs. There has to be that balance between having a well-standardised tool but also some of the location-specific tools that David mentioned earlier that can capture some of the local population's needs and experiences.

The CHAIR — How local would you ideally make those locations?

Mr STOKES — It would not be unreasonable for a community health sector to have its own tool.

Mr LI — Yes.

Mr STOKES — Because many of them would be similar at least. I guess what we sometimes like to do is perhaps have a generalised system-based tool but also a condition-based tool as well so that the diabetes patients might get a different instrument to the cardiac rehab patients just so you get added data and pick up any sensitivities that need to be acknowledged. I am not dismissing that all the medical research does not include an attention to quality of life, but I am yet to see a piece of medical research which eliminated the drug on the basis of its effect on quality of life. They do take note of it, because they are concerned not to end up having iatrogenic consequences to their medication which they have not acknowledged, but at the same time the focus is usually on the physical and physical measure outcomes rather than on psychosocial issues. That is what we are saying. We need to make sure that both components are attended to.

The CHAIR — If I can just go back a bit to where you were talking about the data that your members, particularly I suppose in clinical psychology, collect. Where does that all go? Does it all come somewhere?

Mr STOKES — We would love to think that it found its way into much more meaningful settings.

The CHAIR — And the waiting room form that you described, is that the same in all of the different waiting rooms?

Mr STOKES — There would be half a dozen measures of depression, for instance, which are acceptable. The Beck Depression Inventory is one, the DASS is another, which is the Depression Anxiety and Stress Scale. There are a couple. Anybody who uses those is using a well-validated instrument. If somebody says, 'Look, the DASS was 34 when they came in and it was only 10 when they left' — this is after 10 sessions — then you know exactly what that means and it is a well-validated and true scale which has international acceptance. As long as they are using a standardised scale, and there would be, I would say, about half a dozen that would be accepted as being well-validated measures, then, yes, that is meaningful data.

You asked what happens to it. Having collected that data, most clinicians would use it for their own information, but we will occasionally do a call-out and say, 'Can you send us a set of before-and-after

measures so we can put it in our report to government?'. So it goes to government by second-hand means, not by any standardised procedure. I have worked in the public health system for many years, so I know that many of us collected data that stayed in the hospital and got no further, which was always a bit sad because it did have an impact on clinical outcomes. Clinical outcomes are generally seen as too difficult for the whole organisation to take on, so it does system measures — how many patients got admitted? How many got discharged? You know, those sorts of measures. We have always been interested in clinical outcomes, because if you do not actually improve the benefit to the patient, what have you actually spent the money for?

The CHAIR — If there was a standard, mandated dataset that was required of your members, how do you think they would react to that?

Mr STOKES — Most of them would be delighted because they are committed to the notion, and the rest of them ought to be delighted. I am being a bit facetious, but do you know what I mean? It is a good clinical practice and we would endorse that. We may have to have an interim period while that becomes the process, but I think, given that there is a lot of public money going into those services, that accountability is always something that this society has been committed to.

The CHAIR — Again on this notion of outcomes and outputs and how they might work together, on a couple of occasions you mentioned '10 sessions' — does that number come from some type of benchmark or standard for treating depression or an anxiety condition?

Mr STOKES — There is literature out there which supports the notion. In many instances it depends on the intensity of the illness and the comorbidity, so it is impossible to say what is going to be ideal until you measure the actual nature of the condition with which the patient presents. Better Outcomes is an initiative the federal government put in place for the treatment of mental health disorders. I can tell you from their data that we know that for many less significantly depressed people, or can I use the word 'uniquely depressed' — that is, they do not have comorbid conditions — somewhere around five or six sessions has a major impact. But what we also know is that for those with a very significant depressive illness and comorbidities particularly — so there is a complex set of factors lying behind it — you do not get the real benefits until about 18 sessions. That is what caused us considerable distress recently when the federal government cut from a maximum of 18 to 10 the number of sessions available for all mental health patients — through psychologists and that Better Access service. Although that is okay for a large number of the uniquely depressed, or less significantly depressed, it certainly is not so for the significantly, seriously and complexly depressed, if you like. So there is data out there, and I used 10 because that is what it has all now been reduced to as a maximum per year, per patient. But to us, 10 is not the — —

The CHAIR — Panacea to all things.

Mr STOKES — Yes.

Mr LI — It is the average, it is not the ultimate goal.

Mr STOKES — The ultimate goal is that you have got to allow that flexibility if you really want to treat that population effectively, and that flexibility is essentially being removed by the recent government moves.

Mr LI — Comorbidity is not just in a physical sense either. It could be they are from a socioeconomically disadvantaged background. Going back to access of service again, they may actually have difficulty getting to the psychologist because they have to catch a train and change to a bus in order to see the psychologist. Having that complexity means that there has got to be more work involved in the therapeutic sense to engage with the patient so that they can overcome some of their illnesses in a shorter period of time. While 10 is the average, for somebody living in the western suburbs perhaps and coming from a lower socioeconomic background they may well need 14 or 18 sessions, because the travelling time and so forth means that they do not get the amount of support that they otherwise would have got.

Mr STOKES — And cultural differences make a big difference.

The CHAIR — And that would be further compounded for people in rural and regional communities?

Mr STOKES — Absolutely.

Mr LI — Absolutely — access is always an issue for people in rural and remote areas. While Medicare is a universal entitlement scheme, we are yet to see that entitlement translated into universal access, which I have thought to come in here and say many times.

Mr STOKES — Which is a good example of equal and equitable access, which is what we were also talking about.

Mr RAMSAY — We just need some of your brethren to work in rural and regional areas.

Mr STOKES — In actual fact our percentages are not bad. We have got about 25 per cent of our practitioners working in that triple-r area. The population is about 30 per cent; so we are well ahead of psychiatrists, who are down around 10 per cent. We still need to improve — I am not taking away from that; and we are certainly working to those ends — but we are not doing too badly.

Mr RAMSAY — Sorry. I meant in a general sense, clinicians generally.

Mr STOKES — I agree — our brethren in the bigger sense?

Mr LI — Our brethren in the health workforce sense.

Mr RAMSAY — Yes, the bigger brethren.

The CHAIR — It is good to hear your members are holding up their end of the bargain.

Mr STOKES — Yes. I will fight for my members if you give me a chance.

The CHAIR — Mr Ramsay and I could declare our colours representing an electorate with some very large populations, and then there are some other remote and smaller communities that have difficulty attracting a variety of specialists.

Mr STOKES — It happens even in local areas. I live in Ballarat. You cannot get to see a GP in Ballarat, and you have to be on their books or you are finished. So, yes, I know what you mean, and it is a very important issue that we need to work on.

The CHAIR — Do you have any more questions?

Mr RAMSAY — No, I think we have covered them pretty well.

Mr STOKES — Have we explained what we meant?

The CHAIR — Yes. Thank you very much both for your submission and for taking the time to come and present to us, to answer questions and to help us with this very complex area that we are grappling with. We appreciate it very much.

Mr LI — Thank you.

Mr STOKES — Thank you, nice to have met you.

Witnesses withdrew.