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The Australian Psychological Society Ltd

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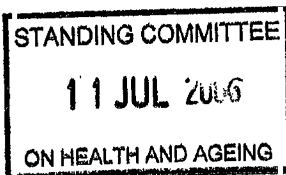
Submission to the ~~Senate~~ Committee on Health and Ageing


STANDING COMMITTEE
11 JUL 2006
ON HEALTH AND AGEING

Inquiry into Health Funding

(With particular reference to Items (a) (i), (iii), (v) and (b) (i), (ii) of Terms of Reference)

From the Australian Psychological Society

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Introduction

The Australian Psychological Society (APS) applauds the Standing Committee on Health and Ageing in its endeavours to wrestle with a very complex but important issue. The issue of funding of health services contacts many of the crucial policy issues that are both the strengths and the difficulties within the Australian health system. The strengths are found in the multifaceted approach to health services and a commitment to broad access across all areas of the community; the weaknesses emerge in the inconsistencies, duplications, even injustices, and quite diverse agendas that the various agencies possess.

Addressing the Terms of Reference

The terms of reference are particularly important and commendable in that they take a comprehensive view of the issue of health funding beginning with the issues of "efficiency" and "effectiveness" in the delivery of highest quality health care. This certainly is where the discussion needs to begin, as it must be the fundamental directive that constrains the mix of public and private funding in service delivery.

The Australian Psychological Society's Position

The APS has a strong interest in, and commitment to, the various aspects of health policy and practice in Australia. Through its membership of Psychologists (over 15,000), who function as practicing clinicians, academic researchers and educators, managers and government advisors, it exercises considerable presence and influence in this domain. The unique feature of professional psychologists is the fact that their professional training at the postgraduate level stands on the foundation of sound academic and theoretical study, which is so essential for the characterisation of the profession as scientist/practitioners. As a result, it has well-developed, research-based views on all aspects of health services, but particularly the issue of cost-effective interventions to which it is totally committed. It is grateful for the opportunity to represent its members and wider-community of psychologists' views to the Senate Committee.

The APS views health programs from three perspectives: appropriate services, appropriate providers of those services, and structural solutions to achieve the optimal combination of the two. The overriding philosophy driving the issues of appropriate services is that of evidence-based practice. This sets a standard for clinical interventions and programs that determines their appropriateness on the basis of clinical research and trials. It also provides guidelines for the funding, spread and location of services based upon established clinical practice and knowledge.

Providers of these services are determined on the principle of selecting those professionals best trained and experienced to provide that service. It involves not only selection but identifying training and development programs to support and disseminate that expertise. Finally it involves investigating and trialling models of delivery that optimally combine appropriate treatments with the best providers in a cost effective and efficient manner.

The APS supports its members with a structure of specialist colleges that facilitate professional development across the range of specialisations (academic, industrial, sport, forensic, developmental, clinical).

This Submission
The submission that follows highlights the overarching principles that should guide our health policy but then focuses on aspects of the funding process but most particularly the roles and responsibilities of the different levels of government (Item A), issues of accountability and quality management (Item C) and the rationalisation and defence of the private health sector (Item D).

Psychological Interventions and Evidence-Based Practice

Evidence Based Practice and Psychology
The APS's commitment to evidence-based practice has been a longstanding one. It has grown particularly out of the profession's commitment to a sound grounding of all psychology graduates in research, critical evaluation and sound ethical practice. This is rooted in a significant requirement of undergraduate training, that it contains a component of the understanding of research and a participation in its methodology and conduct. As a consequence many of the professional practitioners that acquire specialisation and expertise either through postgraduate training or years of continuing professional development, continue to engage in the research process and the validation of psychological interventions in professional practice.

As a consequence, the APS strongly supports its members' awareness of the outcomes of rigorous and well-conducted research, endorses with its membership those interventions for which evidence has been well established, and encourages practitioners to further demonstrate that effectiveness in clinical practice through outcome measures. It is this firm commitment to evidence-based practice that drives much of the APS's health policy directions.

These principles can be seen in the APS's current work in the mental health field. In many of the APS's submissions to Government, in its commitment to continuing professional development (CPD) and then its clinical practice guidelines, the endorsement of those interventions with best evidence receive the APS's highest endorsement. The document in Attachment One is an example of the sort of material that is made readily available to our APS members.

Role of Psychologists in Health
What is not commonly known among many health policy personnel and officers is the significant role that psychologists have in general health as well as mental health. There is now an abundance of evidence of the importance and value of psychological interventions for the physical disorders of cancer, heart disease, diabetes, respiratory illness and other common conditions. Some of that research evidence is summarised in Attachment Two.

Limitations of Evidence Based Research and Health Policy
There are, however, clear limitations to the evidence-based research and particularly as that impacts on health policy. Much of the evidence reported in the literature uses the NHMRC "levels-of-evidence" approach or something similar. According to this approach the highest level (Level I) occurs when there is positive evidence from a systematic review of randomised trials. The problem with this approach is that it does not take into account the distinction between "efficacy" - evidence from randomised trials - and "effectiveness" - the ability to still get the good results observed in research in real world service delivery settings. This distinction is important in health research but becomes critical in considering psychosocial service impacts.

For example, in cancer research one of the obvious gaps in both the research and treatment interests is that produced by the emphasis on breast cancer. Other forms of cancer, such as prostate cancer and bowel cancer, deserve both a research and treatment program development emphasis. Survey research, for instance, had shown that there is a significant unmet need that exists across a number of domains in the areas of psychological and health system/information. The more commonly reported needs were fears about cancer spreading, concerns about the worries of those close to them, and changes in sexual feelings (Lintz et al. 2003).

Another concern shared by many health psychologists and academics is the significant reliance on the clinical trial as the sole "respectable" grounds for scientific evidence. There is now increasing recognition that other forms of inquiry, particularly qualitative studies, provide equally valid and useful evidence.

However, despite these reservations, the APS strongly endorses the nations of evidence-based practice as the foundation for policy decision-making.

Not just effectiveness but cost effectiveness

Cost Effective Psychological Interventions
In Attachment Three, the APS identifies a number of treatment interventions for which there is not just evidence of effectiveness but also cost effectiveness. In so doing it addresses both the issues of "efficiency" and "effectiveness". While it recognises that policy changes should be well considered, deliberate and based upon a comprehensive review of evidence and practice, the APS is nonetheless critical of the slow speed of change that occurs in policy and practice in the face of such evidence.

Psychology and Mental Health
The best example, perhaps, is the area of mental health. There is now unquestionable evidence that many psychological interventions are as effective, if not more so, than that many of the conventional psychopharmacological treatments. This is particularly so for the very common depression and anxiety disorders, but gradually so for even below

prevalence disorders of schizophrenia and bipolar disorder. Certainly there is incontrovertible evidence that *psychological and psychopharmacological treatments in combination are the best practice for most if not all psychiatric disorders.*

However, observers would need to search for a long time to find evidence of such best practice principles affecting funding, organisational structures or clinical practice in both private and publicly funded services all organisations.

Psychology, Lifestyle Change and Adherence
Another good example of the potential role of psychology in cost-effective practice in general health is the area of *adherence.* Adherence is the issue of assisting patients in maintaining prescribe treatments, whether they are pharmacological or behavioural. So much of the success of treatment and the alleviation of patient distress rely on behaviour management and change. Psychology is the study of human behaviour and psychologists with clinical training are the experts in managing difficult behaviour, improving coping skills and reducing distress.

There is often an artificial distinction made in medical treatments between what might be called "physical treatments" and "psychosocial treatments". This is an artificial distinction in so many ways as the two overlap significantly both in terms of the processes themselves and in terms of the client's response to both. This overlap is not additive but interactive in its impact so that success in both is vital to overall success.

Any consideration of the successful treatment of physical illness needs to include work on strategies for adherence to treatment or life-style changes Nowhere is this more obvious in the area of obesity management and dietary change. But is it is nonetheless crucial in exercise, sleep management and any intervention that relies on lifestyle change.

Psychology and Illness Self-Management
Another area that exemplifies the gap between research evidence and implementation of policy is the area of patient/client self-management. Self-management involves the person with a chronic illness adopting activities, such as self-monitoring regular symptom checking procedures (breast screening, pap tests) and active management of symptoms, and lifestyle changes, such as treatment adherence and using support resources, to promote good health.

Self-management can be challenging to implement but outcome studies demonstrate a positive effect on medical, emotional, and functional outcomes (for example, see Browning & Thomas, 2003; Nodhturft, Haley & Price, 2003). Self-management outcomes are particularly good when practitioners and patients work collaboratively.

Self-management is based on four principles:

- Illness management skills are learned, self-directed behaviours;
- Motivation and self-confidence regarding illness management determine, in large measure, how well a patient is able to live with the illness;
- The social environment in the family, the workplace and the healthcare system can support or impede self-care;
- Adapting to the illness is improved by monitoring and responding to changes in the state of the disease, the symptoms and the patient's emotions and functioning.
  (Von Korff, Gruman, Schaefer, Curry & Wagner, 1997)

There are five core self-management skills: decision making, problem solving, utilisation of resources, forming partnerships with health care providers, and taking action. The salient point that is trying to be made about this whole area is that it is significantly psychological and that success with self-management rests very heavily on the competent education and instruction of the client/patient in the intelligent usage of psychological techniques.

Once again, seeking evidence of the alteration of a policy, infrastructure, funding and clinical practice that reflect such obvious sense and evidence supported change is likely to result in precious little evidence of change.

Addressing the Terms of Reference

Items A and C
Comments on roles and responsibilities of Government for health services and the issues of accountability

It is felt that the simplest way of contributing to the discussion is to make a series of specific points.

1 Despite the best efforts of centralised government, the implementation and even the policies that drive that implementation become diluted, distorted and extremely variable at the end point of delivery. It is clear that the concept of integrated and coordinated services are so difficult to implement. As a professional association, the APS is very conscious of the rights of the individual practitioner and their need to be professionally independent. In an organisational setting this translates to the need for various services to nominate their agendas and to have their own strategic plans for implementing such agendas. This means that it is very difficult for high-level organisations, such as the Department of Health and Ageing, to retain an influence on the policy and planning let alone the strategic implementation. Even clearly tied grants and funds cannot ensure standard approaches, agreed best practice or common interventions to disorders and diseases. For these reasons the notion of the implementation of best practice and cost-effective practice becomes very difficult.

2 Nonetheless, the APS sees the setting of policy, the enunciation of best practice and a multifaceted support for cost-effective health interventions as the responsibility of the highest levels of Government. The fact that many of the subordinate organisations may not comply should not deter the central bodies from its responsibilities. What is often lacking in such processes and procedures are accountability mechanisms that will serve to give evidence of compliance but also provide outcome measurements to further enhance the position taken by the policy setting body.

Too many projects and initiatives by Australian Government failed to institute accountability and review processes in advance of the initiatives commencement. Such processes are crucial to demonstrate successful outcomes, to draw attention to the importance of compliance and demonstrate serious commitment by the funding organisation.

3 It is not intended to imply in those statements above that there is no role for various levels of Government to manage and implement services. The importance of local services providers, who are able to modify and better implement specific services, is recognised and respected. Nonetheless, what tends to happen in many instances is that the various levels of Government (particularly State versus Australian) behave in ways that increases isolation and silo behaviour, thereby insulating the local area from the national policy processes.

Although we have seen some success in breaking down these barriers through the COAG process, even that mechanism appeared very insulated from stakeholder and non-governmental input. As an example of the imperviousness of many such structures to the broader opinion and input, the APS reports that the work of the Government Officials Working Groups was all but impossible to penetrate.

Items D and E

A strong private sector and the future (Items D and E)

1 It is recognised that the private sector is also multifaceted. Firstly there is a distinction between the private sector in a service provider sense and the private sector in a funding sense. In the funding sense, there is the private sector supported by Government (e.g. Medicare, MBS, Aged Care) and there is the private sector supported by private health insurance. In many respects these are quite different structures and managed on the basis of quite different processes and principles. For instance, the Government funded private services can be influenced to reflect government policy and principles. The private health insurance is funded system is likewise influenced by the nature of private health insurance but with some if not many different outcomes.

2 The APS experience with private health funds is that their health policy is very actuarial in nature, very medically oriented in the strictest sense and very slow to change. The concept that health policy in the private health insurance domain might be influenced by issues like access, effectiveness and best practice is not always inherent in their decisions. Clearly cost effectiveness is sometimes expressed in their global planning documents but their inclination to adopt new evidence and change current policy has historically been exceptionally difficult to achieve.

The APS recognises that “ancillary cover” or "extras", under which psychology services are addressed, has always been a second tier issue for most private health insurance companies. It is hardly surprising that ourselves, and other allied health agencies find their services totally inadequate and not supportive of best practice. Processes that are inconsistent with best practice are as follows:

- inadequate and rigid definitions of sessions to meet the needs of clients;
- Limited rebate levels insensitive to best practice number of sessions for disorders;
- failure to grapple with endorsing best practice in meaningful ways.

3 Despite these reservations and difficulties, the APS supports a healthy private sector both in the funding sense and in the vitality of a set of private health providers. At the same time it has a strong commitment to the retention of a highly professional and best practice oriented public sector. As evidenced in its endorsement of the new Medicare arrangements, the APS

strongly endorses the need for integration between these two sectors. Through its practice management standards, it's support for its members in both domains, and for its negotiations with both the State and Australian Governments as well as its relationships with other professional associations the APS is operationalising its policy of a community focused health policy providing both access and benefit for all stakeholders.

4 Our major message for the private sector, whether in terms of service provision or funding, is that it must be reactive and sensitive to shifting health policy change. It must also reflect in its policy and planning a consideration of some of the broader health issues. It is recognised that it cannot ignore its responsibilities to cost and profit, but it does need to register and take account of cost-effective developments and see that reflected in its practices and procedures.

5 The APS endorses the need for a viable private health insurance industry and supports the concept of shared responsibility by those who can take some responsibility for their health cover.

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Attachment One

The Effectiveness of Psychological Interventions for Mental Health Disorders

A summary of the systematic review of the literature on a broad range of psychological interventions for the mental health disorders that can be treated under the Better Outcomes in Mental Health Care initiative

Mental health problems have been identified as a leading contributor to disability and a huge social and economic burden worldwide. The World Health Organisation (2001) suggests that mental health problems represent five of the ten leading causes of disability and estimate that one in four people will suffer from a mental illness at some point in their lives. Individuals with a mental illness are heavy users of medical services with an average twice as many visits to a medical practitioner as individuals without mental illness. In particular, anxiety and depression are among the six most common conditions seen in medical practice. Mental health issues are also the health-related problem most likely to affect a person's ability to work, resulting in large costs to society associated with lost productivity (APA, 2003).

In order to best deal with these issues, the provision of treatment should be aimed at achieving the highest attainable level of health and well being for individuals with mental health problems. Treatments that offer the best outcome for the individual, and which are cost-effective for the health-care system, should be the treatment of choice. In Australia the funding of medical services in the treatment of mental health problems largely focuses on offering rebates for psychiatric services. These costs are significant with psychiatric consultation and resultant pharmacological scripts accounting for close to $1 billion dollars per year. If evidence exists to support particular psychological treatments as both more effective, and more cost-effective than the current treatments, these programs should be favoured and made universally available to those with mental health problems.

The evidence for psychological treatments for mental health problems

In 2005 the Department of Health and Ageing commissioned the Australian Psychological Society to undertake a systematic review of the literature on a broad range of psychological interventions for the mental health disorders that can be treated under the Better Outcomes in Mental Health Care initiative. This review graded studies according to a set of stringent criteria in terms of quality, relevance and strength. Strong evidence for the effectiveness of psychological interventions was found for a range of mental health problems. The findings of the review support findings by the Assessing Cost Effectiveness (ACE) studies, which were commissioned by the Mental Health Branches of the Australian Department of Health and Ageing and the Department of Human Services Victoria. The ACE studies found that psychological treatment provided by a trained psychologist was the most effective form of intervention for treating depression in adults, children and adolescents, as well as generalised anxiety and panic disorder; three high

prevalence mental health disorders (Haby, Tonge, Littlefield, Carter & Vos, 2004; Heuzenroeder, Donnelly, Haby, Mihalopoulos, Rossell et al. 2004; Vos, Corry, Haby, Carter & Andrews, 2005).

The systematic review conducted by the APS found support for the effectiveness of psychological interventions in a number of other mental health areas. Table 1 outlines findings from the review conducted by the APS. Psychological interventions are rated using the notations outlined in the legend below.

LEGEND:

- ★★★ Evidence obtained from a systematic review of all relevant high quality randomised controlled trials.
- ★★ Evidence obtained from at least one properly designed randomised controlled trial.
- ★ Some evidence exists but there is a need for more stringent research studies.
- † Current evidence is from case studies. Research studies are needed.
- O Denotes categories where no studies were located.

Table 1
Summary of the effectiveness of psychological treatment for mental health disorders

Mental health problem	Level of effectiveness
Depression	★★★
Bipolar disorder	★
Obsessive compulsive disorder	★★★
Panic disorder	★★★
Generalised anxiety disorder	★★★
Phobic disorders	★★★
Eating disorders	★★★
Psychotic disorders	★★★
Dissociative disorders	O
Adjustment disorders	★
Drug use disorders	★★★
Alcohol use disorder	★★★
Conduct disorder	★★★
Attention deficit hyperactivity disorder	★★
Enuresis	★★★
Sexual disorders	★★★
Sleep disorders	★★★
Chronic fatigue syndrome	★★★
Unexplained somatic complaints	★★★

Note. A full copy of this systematic review can be obtained by contacting The Australian Psychological Society

Conclusions

This systematic review conducted by the APS shows strong evidence for the effectiveness of psychological treatment for a range of mental health problems. Although in some severe cases a combination of pharmacological and psychological treatment may be most appropriate, psychological interventions should be the treatment of choice for a range of mental health disorders. The research suggests that psychological interventions are often more effective than drug treatments which result in long-term treatment with ongoing high costs to the health system. In contrast, psychological treatment is generally time limited and results in faster recovery for the individual and cost benefits for the health care system.

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World Health Organisation. *The 'undefined and hidden' burden of mental health problems.* WHO Fact Sheet, No. 218, November, 2001.

Attachment Two

The effectiveness of health psychology interventions

This document provides information on the effectiveness of psychological treatments for a range of health conditions and health behaviours. It summarises a review conducted by Associate Professor John Toumbourou, titled 'The effectiveness of health psychology interventions,' which investigated the evidence for efficacy and effectiveness of psychological interventions in the health area. By way of definition, efficacy relates to evidence of treatment effects in ideal situations, such as in a controlled research study, whereas effectiveness relates to treatments that are effective in real life contexts.

The role of psychology in health care

Although the discipline of psychology is often primarily associated with the treatment of mental illness, psychology has always had a significant role in other areas of general health such as health promotion, illness prevention, and the enhancement of conventional medical interventions. There is now substantial evidence demonstrating the effects of psychosocial factors (such as stress, worry, anxiety, personal attributes, and family dysfunction) on the incidence and progression of physical illness. Psychological treatments addressing these factors can therefore have a direct influence on the course of a physical illness, in addition to assisting with emotional adjustment to the health disorder. Psychologists in medical settings work closely with medical practitioners using non-pharmacological strategies such as stress management, pain management and treatment adherence to treat patients with various health-related problems.

There is evidence that behavioural and psychological interventions can also contribute to establishing and maintaining lifestyles and behaviours associated with improved health and quality of life (Spencer et al., 2003). Psychological interventions have an important role in preventing lifestyle-related illnesses such as diabetes and cardiac disease. The Australian Institute of Health and Welfare survey (1996) found that the three major categories of underlying causes of death in Australia were tobacco, diet/exercise and alcohol. Many harmful habits are resistant to change and people generally do not succeed in making major lifestyle changes without expert assistance. As well as receiving guidance from medical practitioners, dieticians or exercise therapists, people often require assistance to address underlying psychological issues such as negative thoughts and emotions before being able to successfully make lifestyle changes. Psychologists can provide the expertise to get people motivated about changing, and to plan, carry out, and maintain the steps required for change.

The effectiveness of health psychology

Table 1 outlines findings from a review of the effectiveness of psychological interventions in two areas: treatment and prevention. Treatment focuses on populations already experiencing the health issue being addressed and prevention is aimed at working with either the whole population or vulnerable sub-groups to reduce the risk of developing the targeted health outcome.

Psychological interventions are rated using the notations developed by Toumbourou et al. (2000) outlined in the legend that follows.

LEGEND:

*** Denotes evidence for outcome effectiveness. This required evidence that efficacy could be maintained in real-world service delivery contexts.

** Denotes evidence for outcome efficacy. This required the weight of evidence to be favourable across two or more experimental and well-controlled trials.

* Denotes an intervention manual has been documented and there may be some evidence for efficacy.

† Indicates areas warranting further research.

O Denotes categories where no studies were located.

Table 1
Summary of health psychology intervention effectiveness

Health Target	**Treatment Prevention**	
Evidence for interventions serving market demands. Interventions important to consumers and health providers.		
Chronic fatigue syndrome	**	O
Digestion, stomach/ bowel disorders	*	†
Headache pain**	†	
Muscular/ skeletal and joint problems	**	**
Sleep disorders	**	†
Evidence for interventions addressing health priorities.		
Tobacco use ***	**	
Alcohol related harm	***	***
Illicit drug use ***	**	
Cancer **	***	
Cardiovascular disease	**	***
Health system costs	**	**
Evidence for interventions to achieve optimal health.		
Positive child and youth development	**	**
Wellbeing, wellness and quality of life	**	**

Note. More detailed results can be found in the full paper by Associate Professor Toumbourou which can be accessed from The Australian Psychological Society.

Conclusions

The review presents sufficient support to demonstrate the strong evidence base supporting the application of psychological interventions to a variety of health conditions. Psychological interventions should be used to treat health problems and to prevent ongoing difficulties in areas that are major health priorities.

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Attachment Three

The Cost-Effectiveness of Psychological Interventions

A substantial amount of research now exists demonstrating the cost-effectiveness of psychological interventions for a range of mental health and physical health problems. This document presents the latest research findings demonstrating the cost benefits of psychological treatment in a number of health areas. Indeed, a number of studies demonstrate that psychological interventions can be as cost-effective, and in some cases, more cost effective than drug treatments (Miller & Magruder, 1999). This is particularly the case for mental health conditions such as depression and anxiety, and for physical health problems such as heart disease and obesity. Psychological interventions have been estimated to cost between 10%-50% less than medical treatment.

Following effective psychological interventions, patients tend to have low relapse rates and fewer GP visits and hospital admissions leading to ongoing cost savings within the health care system. This has been found to be the case for conditions such as heart disease, diabetes, hypertension, cancer and chronic pain. A brief review of the evidence for the cost-effectiveness of psychological treatments for mental health and physical conditions is summarised below.

Cost effectiveness of psychological treatment for mental health problems

Depression and anxiety are considered high prevalence disorders in the community. As an example, in the public health system the cost of treating depression runs at around $400 million per year and this does not include the indirect costs to society such as lost productivity and absenteeism. Studies have demonstrated the cost-effectiveness of psychological interventions for treatment of depression and anxiety.

In Australia, the Assessing Cost-Effectiveness (ACE) series of studies investigated 'best practice' cost effective services for mental health using standardised evaluation methods. This included systematic reviews and randomised controlled trials to investigate the efficacy of treatment and disability-adjusted life year (DALY) ratio to assess cost effectiveness. The DALY allows an assessment of mortality and disability from diseases, injuries and risk factors and enables comparisons to be made of factors that reduce expectations for healthy years of life.

Two ACE studies investigating the costs and benefits of a psychological intervention (cognitive-behaviour therapy; CBT) in the treatment of major depression were conducted. One of these explored depression in adults and found CBT to be both effective and cost effective, calculating a savings of approximately 30% to 50% when compared to drug treatment (between A$17,000 to A$20,000 per DALY saved; Vos, Corry, Haby, Carter & Andrews,

2005). In the study investigating depression in children and adolescents, CBT when administered by psychologists, was found to be the most cost-effective treatment (A$9,000 per DALY saved) and had a higher level of effectiveness in the treatment of depression than CBT administered by other health professionals and drug treatments (Haby, Tonge, Littlefield, Carter, & Vos, 2004).

The ACE studies also compared the cost-effectiveness of psychological and drug treatments for generalised anxiety disorder and panic disorder. CBT by a psychologist was found to be the most cost-effective intervention for both generalised anxiety disorder (A$6,900 DALY saved) and panic disorder (A$6,800 DALY saved). CBT also showed greater treatment effectiveness for the anxiety disorders than did drug treatments (Heuzenroeder, Donnelly, Haby, Mihalopoulos, Rossell et al. 2004).

Cost-effectiveness of psychological treatment for physical health problems

A number of studies have investigated the medical cost offset of providing psychological services to patients with chronic physical illnesses such as heart disease, diabetes, and hypertension and found significant cost benefits when psychological interventions are provided. Some examples are presented below.

In a study where stress management techniques were provided to patients with hypertension, Fahrion, Norris, Green and Schar (1987) found that following treatment over 50% of patients were well controlled without any need for medication. The average total medical costs saved per patient over a 5-year period were over US$1,300.

A study investigating psychological treatments for chronic pain conditions found that every dollar spent on psychological treatment led to a five dollar saving in medical costs (Gonick, Farrow, Meier, Ostmand & Frolick, 1981). In addition, one year after psychological treatment for chronic pain, patients had reduced their inpatient services by 72-81% and outpatient services by 41-50% (Jacobs, 1987).

In another study 700 patients with heart disease, hypertension and diabetes receiving psychological services were tracked for a three-year period and compared to a group of 1300 patients who did not receive psychological treatment. Those patients who received psychological treatment showed a 40% reduction in annual medical costs when compared to patients who were not given psychological services. Once the cost of psychological intervention was taken into account there was still a 5% net saving (Schlesinger, Mumford, Glass, Patrick, & Sharfstein, 1983).

Conclusions

There is now clear and compelling evidence that psychological interventions are both effective and cost-effective in treating a range of mental health and

physical health conditions. Psychological interventions are not currently easily accessible to many Australians because of the shortage of psychology positions in the public sector and the lack of funded support through initiatives such as Medicare for access to private sector psychologists. A change in policy to increase access to psychological services is likely to lead to improved health outcomes for the public and a cost offset for the health care system.

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